

Areas of concern in psychiatric music therapy: A descriptive analysis

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ABSTRACT

Psychiatric settings remain a large area of clinical practice for the music therapy profession. However, the percentage of psychiatric music therapists has remained relatively constant and music therapy students seem to be increasingly interested in other clinical areas. The purpose of this descriptive study was to survey psychiatric music therapists and identify their potential areas of concern for the future of psychiatric music therapy. The researcher emailed a brief survey to all members of the American Music Therapy Association listed in the “mental health” section of the 2009 *Member Sourcebook*. Fifty-three respondents participated for a response rate of 18.40%. There were significant main effects in areas of concern and theoretical orientations and there was a significant interaction between these two variables. Results indicated that outpatient care was the highest concern, followed by healthcare reform, brief treatment, and evidence-based practice. Participants rated job security as the lowest area of concern. Participants who identified themselves as having cognitive behavioral, eclectic, and humanistic orientations rated the importance of qualitative research and quantitative research equally. To corroborate data, themes from participants’ free response comments were coded. Participants most frequently indicated that research, training, employment, and licensure/credentials/reimbursement were areas of concern. Overall, results seem to be congruent with contemporary trends in the literature base and clinical practice. Limitations of the study, implications for clinical practice, and suggestions for future research are provided.

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Literature review

Since 1998, data from the AMTA Member Sourcebooks (AMTA, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009) have indicated here has been no increase in the percentage of music therapists working in mental health settings (see Fig. 1). Although music therapy originated in veterans’ hospitals and then was mostly utilized in psychiatric facilities and in institutions for people with cognitive impairments, it has continued to expand into other clinical areas. Due to this growth, music therapists now have a plethora of choices concerning clinical populations, work settings, and employment. It is likely that much of the expansion of music therapy into other clinical areas has resulted in a relatively stagnant percentage of music therapists working in psychiatric facilities.

In 1979, Braswell, Maranto, and Decuir (1979a, 1979b) published a two-part article surveying all clinical music therapists. Throughout these years, music therapists worked primarily in psychiatric facilities or institutions for people with various types of developmental and cognitive impairments. The researchers in these articles examined the institutions where music

therapists worked, personal data, clinical practice, and educational and clinical training. Since then, researchers have conducted various types of descriptive studies to learn more about the population of music therapists and contemporary clinical practice. Specific to psychiatric music therapy, there are descriptive analyses concerning psychiatric music therapists (Silverman, 2007) and music therapists working with clients in substance abuse rehabilitation (Silverman, 2009).

Cassity (2007) utilized Delphi methodology to predict components of psychiatric music therapy. A total of 33 clinical training directors of psychiatric music therapy internship programs participated in the study. Cassity found that participants predicted increases in brief therapy/short-term care, wellness music therapy, and neurological music therapy to be the major changes in theoretical orientation. Concerning music therapy interventions, participants predicted increases in drumming, substance abuse interventions, and anger management. The panel of experts also predicted that Board Certification would become mandatory and that health care providers would require music therapists to practice evidence-based music therapy. The value and relevance of this study cannot be understated, and, as legislators in the U.S. government have approved major changes in healthcare, the future of psychiatric music therapy will likely change.

Due to the many complexities of psychiatric music therapy clinical practice, identifying areas of concern for future research concentration and clinical practice seems especially imperative

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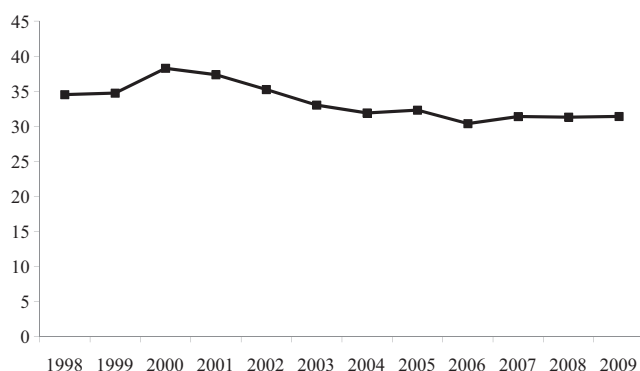


Fig. 1. Percentage of music therapists in mental health.

at this time. What sorts of education and clinical training might psychiatric music therapists need to continue providing quality treatment? What are their major clinical and professional concerns? Resultant data might help define future research agendas and provide better academic and clinical training for student music therapists interested in psychiatric work. Therefore, the purpose of this study was to determine areas of concern in psychiatric music therapy via survey methodology. Specific research questions were as follows:

1. What areas of clinical practice represent high and low concern for psychiatric music therapists?
2. Does the theoretical orientation of psychiatric music therapists affect areas of concern?
3. What themes emerge from participants' responses during an open-ended question concerning areas of concern for psychiatric music therapy? Are these themes congruent with participants' quantitative ratings?

Method

Participants

Potential participants were professional members of the American Music Therapy Association (AMTA) listed in the *2009 Member Sourcebook* (AMTA, 2009) who identified themselves as working with the mental health population, lived in the United States, and had an email address listed. Although 365 AMTA members were listed in the mental health section, 34 of these members did not have an email address listed in the *Sourcebook* and 15 lived in a foreign country. These potential participants were excluded from participation in the study. A total of 27 surveys were returned to the researcher due to an incorrect email address or other type of delivery failure. Additionally, the author did not include himself in the population. Therefore, the researcher emailed the survey to a total of 288 potential participants.

Instrument

The survey instrument was researcher-created and, in an attempt to garner a high response rate, brief (i.e., one page and able to be completed in less than 3 min). Specific items from the survey were based upon recent psychiatric music therapy research (Cassity, 2007; Coddling, 2002; Silverman, 2007, 2010b) and a psychotherapy Delphi Poll (Norcross, Hedges, & Prochaska, 2002). The instrument contained three sections: demographic data (five items: gender, age, years of practice, education, and theoretical orientation), quantitative ratings of areas of concern (17 items to be rated

on a 1 [not concerned] to 7 [very concerned] point Likert-type scale), and free response areas of concern.

Procedure

The author emailed the instrument to all AMTA members listed in the Mental Health section who had a working email address. Participants were emailed a consent form and asked to take part in the study. In an attempt to increase the number of respondents, the researcher re-emailed potential participants seven days following the initial emailing of the survey. The author's affiliated institution and the AMTA approved the study before the author emailed the survey to participants.

Quantitative analyses

In order to analyze areas of concern data by respondent theoretical orientation, the researcher collapsed participants' orientation responses into three categories: cognitive behavioral ($n = 15$), eclectic and integrative ($n = 28$), and psychodynamic and humanistic ($n = 9$). This categorization was utilized in a Delphi poll for psychologists (Norcross, Garofalo, & Koocher, 2006). The researcher utilized a repeated measures factorial analysis of variance to determine if there were differences in areas of concern (within-subjects) and theoretical orientation, gender, years MT-BC, and highest educational level attained (between-subjects). Gender, years MT-BC, and highest educational level attained did not reach significance nor did they interact with any variables. These demographic variables were eliminated from subsequent analyses.

Qualitative analyses

The researcher identified and established code categories during repeated readings of the data, but not prior to these readings (Atkinson & Hammersley, 1998). The researcher created a manual with definitions and examples to analyze themes and trained an independent music therapy clinician, educator, and researcher to code responses. These researchers then examined data together and verified code categories (Bruscia, 2005; Maxwell, 2005). Initial reliability, calculated by dividing the number of agreements by the number of agreements and disagreements, was .93. The researchers then met, debated, and resolved all discrepancies.

Results

A total of 53 surveys were returned for an overall response rate of 18.40%. Concerning gender, 48 (90.57%) participants were female while 5 (9.43%) participants were male. Participants had a mean age of 44.13 years ($SD = 12.49$) and had been practicing as Board Certified music therapists for a mean of 16.55 years ($SD = 11.49$). Concerning highest degree earned, 20 (37.74%) respondents indicated they had earned a bachelors degree, 27 (50.94%) indicated they had earned a masters degree, and six (11.32%) indicated they had earned a doctoral degree (PhD or Doctorate of Arts).

As Mauchly's Test of Sphericity resulted in significance concerning the between-subjects factor of area ($W[135] = 291.39$, $p < .001$), the Greenhouse–Geisser adjustment was used for this variable. Main effects were significant for area of concern ($F[8,71,409.25] = 7.50$, $p = .001$, partial $\eta^2 = .14$) and orientation ($F[2,47] = 3.23$, $p < .049$, partial $\eta^2 = .12$). There was also a significant interaction between area of concern and orientation ($F[32,752] = 1.53$, $p < .033$, partial $\eta^2 = .06$). Thus, there were significant differences in areas of concern and by orientation and an interaction between the variables. Overall, respondents from the cognitive behavioral ($M = 5.19$, $SE = 0.25$) and humanistic ($M = 5.17$, $SE = 0.32$) groups tended to have higher overall ratings of concern

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