Professional Preparedness: A Satisfaction Survey for Music Therapists in the United States

Xueyan Hua

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PROFESSIONAL PREPAREDNESS: A SATISFACTION SURVEY FOR MUSIC THERAPISTS IN THE UNITED STATES

by

Xueyan Hua

A thesis submitted to the Graduate College in partial fulfillment of the requirements for the degree of Master of Music
School of Music
Western Michigan University
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This study investigates the satisfaction level among undergraduate or equivalency students, who have completed their degree program, in regards to their professional education and preparedness for professional practice in the United States. Out of a sample of 7,183 Board-Certified Music Therapists (MT-BC) invited to complete an online research survey, 777 (n=777) MT-BCs completed the survey. Due to time limitations, qualitative data was not analyzed.

Major findings include: (1) 8.79% of respondents completed no more than two pre-internship clinical practica; (2) 88.46% of respondents were satisfied with their clinical practicum settings; (3) 92.72% of respondents were satisfied with the relevancy of courses; (4) 92.73% of respondents were satisfied with their program’s teaching quality; (5) 92.88% of respondents were overall satisfied with their undergraduate training; (7) 78.58% of respondents would choose the same university or college music therapy program again; and (8) 23.74% would like to choose a different profession, if possible.

Statistically significant differences and relationships were found between the satisfaction level with undergraduate or equivalency curriculum and the relevance of the courses, as well as the satisfaction level with undergraduate or equivalency curriculum and the quality of teaching. Furthermore, there was correlation between the music therapists’ graduation years and the satisfaction level of the undergraduate or equivalency curriculum.
ACKNOWLEDGEMENTS

It has been over seven years since I came to Western Michigan University, and it is fast approaching that I will complete my study. I have changed a lot during these years, from undergraduate student to master student, from single to married, and now, I am ready to open a new chapter in my life!

I would like to thank my advisor, Professor Edward Roth, as well as the rest of my thesis committee, Dr. David Smith and Dr. Jennifer Fiore, for their guidance, patience, support, and help throughout my master’s thesis. I would also like to thank Meghan Elizabeth Feeman, who took the time to discuss perceptions, and Hindi Burkett, the Continuing Education Coordinator at the Certification Board for Music Therapists who provided the newest information. Of course, I cannot forget the help of the respondents who contributed to this research.

Finally, I would like to express my appreciation to my family and friends for their unlimited support and assistance. Special thanks to my parents, Li and Lin, without whose encouragement and support I could not have finished my study aboard journey in the United States.

Xueyan Hua
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CHAPTER I
INTRODUCTION

Academic programs in music therapy have continuously developed over several decades in the United States. The curriculum of these programs determines the quality of students who will eventually become professional music therapists. In 1944, Michigan State University established the first academic program in music therapy. Today, there are around 80 universities or colleges in the United States offering bachelors’ degrees or equivalency music therapy programs that are approved by the American Music Therapy Association (AMTA) (AMTA, 2015). All of the eligible programs in the United States aim to help these students develop and become professionals, as well as to provide a positive, professional, sufficient, and safe environment for the clients they will serve.

Statement of the Problem

The AMTA (The Education of Music Therapists, 2015) requires all approved institutions to use set curriculums, which include: music foundations (45%), clinical foundations (15%), music therapy (15%), general electives (20-25%), and electives (5%). Each program offers different courses based on the AMTA Standards for Education and Clinical Training. Since academic settings differ between each university, new graduates are increasingly required to strive to be innovative and accountable music therapy clinicians in contemporary society. Thus the academic settings, quality of teaching, clinical experiences, students’ abilities, which include music, professional, clinical, and other skills, should be presented at different levels than they were several decades ago. While the programs’ curriculum was developing, the existing abilities of students, the requirements from society, and professional requirements have also developed.
However, the skills and knowledge that the students believe are necessary to prepare for graduation may not be the same as what educators have previously thought. Thus, to both educators and students, good communication and improvement of curriculum is especially important.

Research has played an important role as the main communication method between professionals, educators, and students. Currently, researchers in music therapy are more focused on internship selection, clinical case studies with specific populations, and other topics. However, less of the research is focused on the perceived satisfaction level leading into entry of the professional world, or how to best prepare students before entering the professional world. Possible topics include the experiences about on-campus practice, the quality of teaching and the settings of courses, the overall undergraduate student’s satisfaction levels, as well as which aspects needs to improve for different professionals (e.g. professors, supervisors, students, clinical music therapists, and perhaps clients, etc.). With less research focusing on these aspects, professionals might be ignoring some basic training requirements. Without any academic developments or improvements over the last several decades, it may be difficult for teachers to notice the most basic issues before training students or for students learning to prepare for entry into the professional world.

The purpose of this study was to examine the satisfaction level of the undergraduate or equivalency students who have completed their degree program, with respect to their professional education and preparedness for practice in the United States.

Research question: How satisfied are music therapists with their undergraduate or equivalency curriculum as preparation for professional practice?
CHAPTER II
REVIEW OF LITERATURE

Music Therapy Historical Development

In 1919, the first music therapy course was offered at Columbia University in New York City under the title of “Musicotherapy.” This course was initially taught by Margaret Anderton and later taught by Isa Maud Ilsen. The purpose of this course was to teach the psychophysiological impact of music and to provide practical training for the application of music under medical control. However, the profession did not establish an official undergraduate curriculum during this era (de l'Etoile, 2000). During the 1940s, Columbia University was the only program that offered music therapy coursework. However, other universities were beginning to coordinate with various organizations in order to provide training. As the number of war veterans increased during the late 1940s, the need for trained musicians in the hospital increased as well. In order to meet this need, hospital officials began starting their own training programs. For instance, in 1949 the director of the University of Iowa program, Fredric D. Gingrich, established a 16-week training program, which included both lectures and practical work, at the State Hospital of Iowa (de l'Etoile, 2000). In 1951, Agnew’s State Hospital in Agnew, California started offering additional music therapy training, and this program provided structured curriculum with more of an academic focus than clinical practica.

Since hospitals were developing their own curricula, Roy Underwood, Music Department Chair at Michigan State University, established the first official curriculum for a bachelor of music therapy degree program in 1944. With the famous psychiatrist Dr. Ira Altshuler’s support and cooperation, Underwood also established the first music therapy internship that related to the university degree program at Wayne County Hospital in Eloise, Michigan (de l'Etoile, 2000).
the following year, the music therapy graduate degree program began to take a shape at the University of Kansas. This program was developed in 1946 at the Winter Veteran’s Administration Hospital in Topeka, Kansas, with clinical training preceding academic course development. This training was under the direction of Donald E. Michel, with E. Thayer Gaston as a consultant (de l'Etoile, 2000). Gaston earned his doctorate in educational psychology in 1940 from the University of Kansas. His knowledge, dedication to scholarship, and unquestioned integrity led to him being considered the “father of music therapy” (Johnson, 1981). Compared to Michigan State University, Gaston developed a degree at the graduate level as the Master of Music Education in Functional Music. During this era, other universities developed their own degree programs as well, such as the College of the Pacific and Alverno College (de l'Etoile, 2000).

**Early Stage Curriculum Surveys and Suggestions**

After that period of program development, music therapy curriculum still needed more time to develop. However, in order to assess the curriculum for a music therapy program, people should first ask: “What is a music therapist?” Then, the curriculum would be clearer to understand. In 1959, Charles Braswell at Loyola University established and later revised an outline of music therapy courses that were used as a training manual for students (de l'Etoile, 2000). Braswell qualifications included an undergraduate degree in piano performance from North Texas State University and a master's degree in piano performance from the American Conservatory of Music. The new curriculum that he developed included nine hours of philosophy and 12 hours of psychology, including an introductory course, child psychology, adolescent psychology, educational psychology, and abnormal psychology (Brooks, 2002).
Some universities still relate to Braswell’s observations and retain some of those early courses today. Upon re-examination, Braswell claimed that: first, “students will not enter music therapy training until the junior year;” and second, he suggested that students learn basic research principles with the techniques of scientific writing (de l'Etoile, 2000). In response to Braswell’s ideas, however, Dr. Clifford Madsen recommended three points for improving music therapy curriculum for a later era. First of all, “one year of music history is enough for the music therapists;” second, “the prospective music therapist should be required to study his applied major instrument only one year;” and third, “only one year of basic music theory should be required” (Madsen, 1965). These three points played an important role in the revolution of the music therapy curriculum.

In response to Dr. Madsen’s curricular recommendations, Galloway conducted a survey of 11 university music therapy programs to gather extensive curriculum information, which resulted in 13 major recommended changes. However, ten years later, Iley re-surveyed the same schools and found the curricula virtually unchanged. During the 1976 academic year, Florida State University (FSU) was the first school to adopt the 11 major revisions, and then performed a study in order to determine how their students were completing the FSU music therapy curriculum. The survey consisted of 58 questions and had a total of 24 respondents. The results showed several suggestions for curriculum that still needed to be revised (e.g. lack of uniformity in music therapy curricular or internship programs) (Alley, 1978). Since the curriculum still needed further developing, Ann Gault conducted another survey in 1978 about whether or not their collegiate music therapy clinical experience was adequate, qualitatively and quantitatively. Her survey was sent out to 918 people and had 529 respondents. The result indicated that 38%
believed their training during academic work was sufficient and 56% of respondents regarded the training as insufficient (Gault, 1978).

Because they too suspected deficiencies in music therapy programs, in 1979, three researchers, C. Braswell, C. D. Maranto, and A. Decuir, conducted a survey about music therapy clinical practice. Part of this research was focused on clinical practice, education, and clinical training. These authors wanted to know if these courses could be changed. The results showed that certified music therapists (Registered Music Therapist) suggested nine of 13 academic areas were sufficient and four areas should be improved (piano, recreational music, psychology, and music therapy). Music therapy students said six of eight academic areas were sufficient and two areas could be improved (percussion and elementary music education methods) (1979). Also, in 1980, Braswell, Decuir, and Maranot did a survey of a random sample of 25 training directors from the Great Lakes Region to list the subsections for four specific areas of knowledge, skills, and attributes to be considered when assessing an applicant for clinical training (Brookins, 1984). According to the results of this research, students during that era were lacking experience with group process, emotional maturity, and skills in piano, voice, and guitar, which would help them establish a repertoire of activities and resources. Considering these findings, it is evident that the music therapy curriculum during this period still required improvement.

As the music therapy curriculum developed and implemented these suggestions from past surveys, the music therapy curriculum started to change. In 1983, the Certification Board of Music Therapists (CBMT) surveyed educators, clinical training directors, and clinicians to determine the breadth and depth of courses being taught and learned: responsibilities for teaching various competencies, where the competencies are being learned, and materials and methods used to teach them. This indicated that three areas—music, clinical foundations, and music
therapy—were only perpetuating the existing requirement but ignored students strengths and weakness; in addition, music theory, music history, applied music, functional music skills, human development, psychotherapy, psychopharmacology, ethics, improvisation, movement, psychology of music, and music education (over 12 required courses) were agreed upon (Jensen & McKinney, 1990).

Certainly, evaluation was an important part of the development of these courses. After all, this process could determine whether or not these courses needed modifications or revisions. In 1987, Dr. Reuer conducted a study about music therapy curriculum by surveying practicing music therapists and music therapy educators to evaluate the music therapy curriculum. Of the 508 questionnaires sent out, 296 were completed. Three concerns were presented in the findings: first of all, the balance between four major components (music therapy, music, behavioral sciences, and general educations); second, the music therapist's tasks and responsibilities in healthcare facilities; and third, adequacy in preparing enough professionals to meet the standards and requirements for state and national facilities and agencies. The last point was to determine how to best help students prepare to become a professional, which is still a big concern for most music therapy programs today. Dr. Reuer believed that, because of these concerns, further examination and evaluation of the curriculum was needed to address all of these aspects. Moreover, the researcher found that behavioral science and music therapy components together totaled only 30% of the curriculum, areas that should be deemed more important than music and general education courses. Related to the outcomes of the study, Dr. Reuer provided three suggestions: identify the most important curricular components for preparing a professional music therapist; increase behavioral science and music therapy courses for students in order to prepare assessment, treatment methods, behavioral management and psychosocial competencies;
and use selecting criteria for advanced and formal music skills and functional music skills (Ruer, 1987).

**The Formal Professional Competencies**

After the National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT) passed a unification agreement in 1998 to form the American Music Therapy Association (AMTA), the AMTA competencies were established. The AMTA professional competencies were established in 1981 by Bruscia, Hesser, and Boxhill from AAMT, and then revised by NAMT in 1996. The final report of Commission on Education and Clinical Training of the recommendation was approved by the AMTA in November 1999, in order to ensure the quality of education and clinical training in the field of music therapy (AMTA Professional Competencies, 2015).

This list of competencies included three main aspects: music foundations, which is comprised of (a) music theory, (b) history, (c) composition and arranging skills, (d) major performance medium skills, (e) functional music skills, (f) conducting skills, and (g) movement skills; clinical foundations, which include (a) therapeutic applications, (b) therapeutic principles, and (c) the therapeutic relationship; and music therapy foundations and principles, with subcategories of (a) client assessment, (b) treatment planning, (c) therapy implementation, (d) therapy evaluation, (e) documentation, (f) termination/discharge planning, (g) professional role/ethics, (h) inter-professional collaboration, (i) supervision and administration, and (j) research methods (AMTA Professional Competencies, 2015).

There was a survey design by Groene and constructed by Pembrook to study issues related to AMTA competency. This research was focused on the following three questions: “Any concern about new knowledge or skills needed to be an effective music therapist in the next
decade?” “How is a possible move toward competency-based assessment viewed by collegiate music therapists?” and “What issues considering clinical training concern collegiate music therapists?” A total 92 surveys were sent out to music therapy faculty at 68 programs that offered music therapy degrees, with 58 surveys returned. Survey respondents agreed with several aspects: the technology training for music therapists, coursework additions and deletions, competency-based testing, clinical training changes, and greater flexibility in certain clinical practices. This was the most important suggestion that found out for music therapy curriculum from this survey (Groene & Pembrook, 2000).

**Current Music Therapy Curriculum and Related Researches**

Considering all of the research results and suggestions, the music therapy curriculum has continued to develop over the years. Today, the AMTA has approved music therapy degrees from over 70 colleges and universities. In order to meet the requirements of mental health, special education, and health care facilities, students are required to complete related clinical coursework and an extended internship (AMTA, 2015). Music therapy students can either start their study from an undergraduate or graduate level. In 1985, Professor Michel introduced an equivalency program for students who entered with a bachelor’s degree in music and wished to obtain their undergraduate equivalency in music therapy (Cohen & Behrens, 2000). For the undergraduate curriculum, the degree is four or more years in length and includes an internship with 1,200 hours of clinical training. Upon successful completion of the music therapy bachelor’s degree (or its equivalent) from an AMTA approved program, with a minimum of 1,200 supervised clinical hours through pre-internship training at an AMTA approved program, an individual is eligible to sit for the national certification exam to obtain the credential Music Therapist-Board Certified (MT-BC), which is necessary for professional practice (CBMT, 2015).
Recently, researchers have begun to investigate specific music therapy courses as online classes. In 2012, Professors Vega and Keith (2012) conducted the first in-depth study investigating the use of online learning in the music therapy curriculum. There were 150 music therapy educators surveyed about online music therapy courses. Of the 45% who participated in the study, researchers found that no universities offer online curriculum for undergraduate students and most courses were face-to-face. In addition, most online courses offered in these areas are music therapy theory and research. The researchers suggested that music therapy educators continue to investigate the addition of online courses for the music therapy curriculum. Today, some universities have started to offer online courses only for graduate degrees, (e.g. Colorado State University). Overall, the courses offered in a music therapy program have significant influence of music therapists’ career.

Since the music therapy curriculum was revised by NAMT in 1996, there have been fewer studies focused on the educational satisfaction related to the music therapy major. Dr. Michael Allen did a survey about educational satisfaction and academic achievement among music therapy majors in 1996 (Allen, 1996). His paper investigated the relationship of Holland’s constructs, from congruence, consistency, differentiation, and identity, to academic achievement and educational satisfaction among music therapy majors. Among the 45 respondents, both identity and congruence had a significant relationship with academic achievement. All four constructs were related to satisfaction and achievement. However, this research examined the relationship between Holland Theory and music therapy major educational satisfaction, but did not truly examine the level of satisfaction with the music therapy curriculum. In addition, the research without Holland theory can also be studied about educational satisfaction. One study in occupational therapy surveyed current students and graduates about professional education and
preparedness (Hodgetts et al., 2007). The study indicated that students and recent graduates from occupational therapy felt that they lacked technical and intervention skills, and both students and graduates were satisfied with their education. Compared with Dr. Allen’s study, this research was more focused on the educational satisfaction aspect and provided an idea of educational satisfaction level with music therapy curriculum.

In conclusion, some of these studies provide information about how the music therapy curriculum developed in the country and others show how students and professionals are satisfied with changes in music therapy curriculum. However, most of the previously published studies are over 20 years old and fewer recent research studies relate to the satisfaction of music therapy education after the curriculum was completed by AMTA. Since health care professionals and their corresponding educational programs are faced with the challenge of new and expanding practices in order to better provide services to all the human beings who need help, ongoing educational program evaluations are important.
CHAPTER III

METHOD

Participants

The inclusion criteria for participation in this study were: professional music therapists who completed their undergraduate degree or equivalency curriculum in the United States and currently hold the professional credential of Board-Certified Music Therapists (MT-BC).

With assistance from the Certification Board for Music Therapists (CBMT), the researcher purchased a list of e-mail addresses for music therapists who hold the MT-BC credential, current to the date when researcher purchased (October of 2017). A total of 7,183 participants met the inclusion criteria and were recruited to take this survey. Seven hundred and seventy-eight responses were received by the end of the survey completion period. However, one person did not complete the survey beyond the first question, so the number of valid responses was 777.

Development of the Survey Instrument

The Internet website SurveyMonkey was used for this research study. SurveyMonkey.com is a recognized website that guarantees user confidentiality and security. This survey contained one main research question with 20 sub-survey questions, which included four demographic questions. Seven questions prompted open-ended responses presented as short answers and 13 questions were closed responses including: yes or no questions, multiple choice, and Likert-scale rating format. The Likert-scale rating format included six levels: totally satisfied, mostly satisfied, somewhat satisfied, somewhat dissatisfied, mostly dissatisfied, and totally dissatisfied. Although the student researcher created the survey instrument, several
questions were modified from an earlier study conducted by Hodgetts et al. in 2007. The thesis committee approved the survey instrument as a whole before it was implemented.

Procedures

Following approval by WMU’s Human Subjects Institutional Review Board (see Appendix A), the student researcher contacted CBMT to request a contact list, which included the e-mail addresses for professional music therapists (MT-BCs).

Each participant received an e-mail invitation (See Appendix B) on October 16, 2017. The e-mail invitation contained an online survey link to SurveyMonkey, the purpose of the study, a description of inclusion criteria, and expected time commitment as the part of consent.

This survey link remained open for one month and closed on November 16, 2017. During the survey time, three messages were sent to each e-mail address, which included the initial invitation message and two reminder messages. The sending emails were on October 16, 26, and November 9, 2017. Data collection was anonymous; except for the confirmation e-mail to participants who entered wanted to be added into a drawing for the opportunity to win one of ten $10 Starbucks gift cards.

Data were initially stored in SurveyMonkey’s servers during the survey period. After the data collection period closed, the data was downloaded to the investigator’s laptop computer for subsequent analysis. Following the successful completion of the thesis project, the investigator transferred the data to a flash drive, deleted the data on the laptop computer, and placed the flash drive in a locked cabinet in a secure Western Michigan University office.
CHAPTER IV
RESULTS

A total of 7,138 e-mail invitations were sent to potential participants. For several reasons (i.e. invalid e-mail address, unable to open the web survey outside of the United States [China], etc.), there were 57 e-mail addresses that were not able to receive the e-mail invitation. Overall, 777 responses were counted as valid responses. Thus, the response rate resulted in 10.89%.

Most of the data collected in this survey were descriptive and were presented in tables and figures. Four questions (e.g. questions 4, 6, 7, and 15) required the use of statistical tests to determine if there was a statistically significant relationship between variables that influenced the results. The tests used to analyze these four questions were the Chi-square test and the Spearman Correlation test, which were used in consultation with the statistical consultant faculty of Graduate College from WMU Department of Statistics and computed through SPSS (Field, 2013). A decision was made to analyze and report only some of the data collected in this survey for alignment with typical expectations for a master’s thesis. The principal investigator or another graduate student may perform subsequent analyses in the future.

Demographics

Demographic question 1: In which AMTA region did you complete your undergraduate degree or equivalency curriculum?

The demographic breakdown of respondents’ region of education was 27.03% \((n=210)\) in the Great Lakes Region; 23.55% \((n=183)\) in the Mid-Atlantic Region; 16.09% \((n=125)\) in the Southeastern Region; 12.23% \((n=95)\) in the Midwestern Region; 8.24% \((n=64)\) in the Western

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Region; 7.46% (n=58) in the Southwestern Region; and 5.41% (n=42) in the New England Region (See Figure 1).

**Figure 1. Number of Music Therapists Who Graduated from Each AMTA Region**

Demographic question 2: How many hours per week do you work as a music therapist?

There were 52.91% (n=409) of respondents who identified working as a full-time (over 36 hours per week) music therapist (n=288, 36-40 hours per week; n=121, over 40 hours per week). The remaining respondents (47.91%) reported working part-time (fewer than 36 hours). The percentage of respondents who claimed that they worked less than 5 hours a week as a clinical music therapist was 15.39% (n=119), while 5.43% (n=42) reported working 6-10 hours per week; 4.79% (n=37) reported working 11-15 hours per week; 5.05% (n=39) reported working 16-20 hours per week; 6.34% (n=49) reported working 21-25 hours per week; and
5.05% ($n=39$) were sorted into two group of clinical hours, which were 26-30 hours per week and 31-35 hours per week (See Figure 2).

Demographic question 3: Beyond your bachelor’s degree, what other degrees have you earned?

There were 612 respondents who responded to this question. Of those who responded, 6.86% ($n=42$) reported holding a second bachelor’s degree other than a music therapy major; 55.23% ($n=338$) had earned a master’s degree; and 4.90% ($n=30$) had earned a Ph.D. degree. Another 33.01% ($n=202$) marked “other,” which may indicate that they are currently working toward a degree other than their first bachelor’s degree in music therapy ($n=51$), have only earned a bachelor’s degree in music therapy ($n=131$), or have earned more than two degrees in several areas ($n=22$).

Figure 2. Music Therapist Clinical Working Hours
Demographic question 4: In what year did you finish your undergraduate degree or equivalency curriculum in music therapy?

For survey question 4, most respondents (65.82%) earned their bachelor degree after 2007. There were 150 respondents who graduated in 2015 \((n=74)\) and 2016 \((n=76)\), equaling 19.2% of the total responses \((n=772)\). The first reported graduation year from all of the respondents was in 1971 \((n=1)\) (See Figure 3).

**Research Question (Includes Related Sub-Questions 5, 6, 7, 8, 9, 10, 15, 18, and 19)**

*How satisfied are music therapists with their undergraduate or equivalency curriculum as preparation for professional practice?*

Survey question 5: How would you best describe the theoretical orientation of your undergraduate/equivalency curriculum?

Results for survey question 5 (See Figure 4) indicated that 4.71% \((n=35)\) of respondents’ theoretical orientation was psychoanalytical; 3.50% \((n=26)\) indicated Nordoff-Robbins; 1.48% \((n=11)\) indicated medical; 6.86% \((n=51)\) indicated Neurologic Music Therapy; 30.28% \((n=225)\) selected eclectic; and the highest number of respondents, at 39.84% \((n=296)\), indicated behavioral as their theoretical orientation. In addition, other 13.32% \((n=99)\) selected “Other” and provided more detailed information, which included two or more theoretical orientations from the list or all of them.
Figure 3. Number of Music Therapists Per Graduation Year
Survey question 8: How many clinical practica were you required to complete prior to beginning your internship?

Survey question 8 was prepared in order to analyze the clinical practica numbers completed before starting the internship. As shown in Figure 5, 8.79% \((n=64)\) of respondents completed no more than two clinical practica before beginning the internship. Of that number, 2.61% \((n=19)\) completed only one practicum, and 6.18% \((n=45)\) finished two practicums. The percentage of 15.80% \((n=115)\) respondents finished three practicums; 31.46% \((n=229)\) completed four practica; 11.40% \((n=83)\) completed five practica; 14.42% \((n=105)\) completed 6; 5.08% \((n=37)\) completed 7 practica; respondents of 10.03% \((n=73)\) completed 8; of 0.96% \((n=7)\)
completed 9; and another 2.06% \((n=15)\) completed 10 practica before beginning the internship (See Figure 5).

Survey question 9: Was the number of clinical practica you were required to complete sufficient in preparation for your internship?

The number of 664 out of 728 respondents (88.46%) reported they were satisfied with their clinical practicum coursework, and 11.54% \((n=84)\) respondents reported that it was not sufficient. The number of respondents who reported that their number of clinical practica was insufficient was close to the number that completed one or two of the clinical practica \((n=64)\) before the internship.

Figure 5. Number of Clinical Practica Required
Survey question 10: How satisfied are you with the range of practicum experiences that were offered during your education?

*Figure 6* demonstrates that 658 out of 731 respondents were satisfied with the range of practicum experiences offered during their education. Their satisfaction was broken down to three levels: 38.58% (n=282) responses were totally satisfied; 38.30% (n=280) were mostly satisfied; and 13.13% (n=96) were somewhat satisfied. Also, 73 out of 731 (9.99%) respondents were in three different dissatisfied levels: 0.27% (n=2) of respondents were totally dissatisfied with their practicum range during their education period; 2.33% (n=17) reported that they were mostly dissatisfied; and 7.39% (n=54) reported that they were dissatisfied with their range of practicum experiences.

![Satisfaction Level-Range of Practicum Experiences](image)

*Figure 6.* Percentage of Satisfaction Level with Range of Practicum Experiences
Survey question 6: In relationship to your professional work, how satisfied are you with the relevance of your courses?

As shown in Figure 6, 742 respondents responded to this question. Overall, 92.72% (n=688) of respondents were satisfied at some level with their courses. The level of satisfaction was further divided into three different levels: 21.83% (n=162) were totally satisfied; 49.97% (n=370) were mostly satisfied; and 21.02% (n=156) were somewhat satisfied. Of the respondents, 7.28% (n=54) indicated some dissatisfaction with their courses. The level of dissatisfaction was further divided into three different levels: 4.85% (n=36) were somewhat dissatisfied; 1.89% (n=14) were dissatisfied; and 0.54% (n=4) reported being totally dissatisfied with their courses.

Figure 7. Percentage of Satisfaction Level with Relevance of Courses
Survey question 7: How satisfied are you with the quality of teaching in your program?

Seven hundred and forty-three people responded to survey question 7. Overall, 92.73% \((n=689)\) reported that they were satisfied with the quality of teaching in their program; 37.95% \((n=282)\) were totally satisfied; 40.51% \((n=301)\) were mostly satisfied; and 14.27% \((n=106)\) were somewhat satisfied. Respondents who indicated being dissatisfied with their program’s teaching quality \((n=54)\) were further divided into three different levels similar to survey question 6 with 4.98% \((n=37)\) being somewhat dissatisfied; 1.48% \((n=11)\) were mostly dissatisfied; and 0.81% \((n=6)\) were totally dissatisfied with the teaching quality (Figure 8).

![Satisfaction Level–Teaching Quality](image)

*Figure 8. Percentage of Satisfaction Level with Quality of Teaching*

Survey question 15 (qualitative data to be analyzed in the future): Taking as much into consideration as possible, including your course instruction, clinical supervision, quality and size
of facilities, overall, how satisfied are you with your undergraduate or equivalency curriculum in terms of your preparation for professional practice?

Out of the 777 surveyed, 632 people responded to question 15 (See Figure 9). Largely they were satisfied with their overall preparation for professional practice with 92.88% (n=587) feeling satisfied with their undergraduate training. Of those who were satisfied, 30.06% (n=190) felt totally satisfied; 49.53% (n=313) were mostly satisfied; and 13.29% (n=84) were somewhat satisfied. The percentage of respondents who reported not being satisfied came to 7.12% (n=45), with 5.06% (n=32) who were somewhat dissatisfied; 1.27% (n=8) were mostly dissatisfied; and 0.79% (n=5) were totally dissatisfied with their overall preparation for professional practice.

*Figure 9. Overall Satisfaction Level with Undergraduate or Equivalency Curriculum*
Responses related to the questions (survey questions 6 and 15) regarding the overall satisfaction level with the undergraduate or equivalency curriculum and the satisfaction level related to the relevancy of the courses are shown below (See Table 1). A Chi-square test (See Table 2) indicated there was a significant difference between the satisfaction levels with overall undergraduate or equivalency curriculum and relevance of the courses ($\chi^2 = 823.583$, $p < .001$). Thus, the satisfaction levels among undergraduate or equivalency curriculum and the satisfaction levels related to relevancy of the courses had a significant relationship.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Survey Respondents—Satisfaction Level with Undergraduate or Equivalency Curriculum Relative to Relevance of Courses</strong></td>
</tr>
<tr>
<td><strong>Number of Satisfaction Level with Undergraduate or Equivalency Curriculum</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Number of Satisfaction Level</td>
</tr>
<tr>
<td>Totally Satisfied</td>
</tr>
<tr>
<td>Mostly Satisfied</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
</tr>
<tr>
<td>Mostly Dissatisfied</td>
</tr>
<tr>
<td>Totally Dissatisfied</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Note:* *Horizontal data shows the detail response numbers of satisfaction level with Undergraduate or Equivalency Curriculum (Question 15)  
**Vertical data shows the detail response numbers of satisfaction level with Relevance of the Courses (Question 6)*

<table>
<thead>
<tr>
<th>Table 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Chi-Square Test—Satisfaction Level with Undergraduate or Equivalency Curriculum Relative to Relevance of Courses</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Pearson Chi-Square</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
</tr>
<tr>
<td>N of Valid Cases</td>
</tr>
</tbody>
</table>
Responses for the participants’ overall level of satisfaction regarding the quality of teaching in the undergraduate or equivalency curriculum related to survey questions 7 and 15 (See Table 3). A Chi-Square test (See Table 4) indicated that there was a significant difference among the satisfaction level with undergraduate or equivalency curriculum and the quality of teaching ($\chi^2 = 672.611, p < .001$); thus, the satisfaction levels between undergraduate or equivalency curriculum and the quality of teaching had a significant relationship.

Table 3
Survey Respondents—Satisfaction Level with Undergraduate or Equivalency Curriculum Relative to Quality of Teaching

<table>
<thead>
<tr>
<th>Number of Satisfaction Level with Undergraduate or Equivalency Curriculum</th>
<th>Totally Satisfied</th>
<th>Mostly Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Mostly Dissatisfied</th>
<th>Totally Dissatisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally Satisfied</td>
<td>145</td>
<td>87</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>239</td>
</tr>
<tr>
<td>Mostly Satisfied</td>
<td>37</td>
<td>188</td>
<td>22</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>253</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
<td>5</td>
<td>30</td>
<td>46</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
<td>0</td>
<td>8</td>
<td>11</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Mostly Dissatisfied</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Totally Dissatisfied</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>313</td>
<td>84</td>
<td>32</td>
<td>8</td>
<td>4</td>
<td>630</td>
</tr>
</tbody>
</table>

**Note:** *Horizontal data shows the detail response numbers of satisfaction level with Undergraduate or Equivalency Curriculum (Question 15)
**Vertical data shows the detail response numbers of satisfaction level with*

Table 4
Chi-Square Test—Satisfaction Level with Undergraduate or Equivalency Curriculum Relative to Quality of Teaching

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>672.611</td>
<td>25</td>
<td>.000</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>418.986</td>
<td>25</td>
<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>275.515</td>
<td>1</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td></td>
<td>630</td>
<td></td>
</tr>
</tbody>
</table>
Other than the statistical analysis in previous data, responses for the participants’ graduation year and satisfaction level regarding the relevance of the courses were related to survey questions 4 and 6. A Spearman Correlation test (See Table 5) gave the correlation coefficient between the two variables (-.041), the significance value of the coefficient was 0.135. The significance value for this correlation coefficient was greater than .01; therefore, there was no correlation between music therapists’ graduation years and the satisfaction level among the relevancy of the courses.

Table 5

<table>
<thead>
<tr>
<th></th>
<th>Q4</th>
<th>Q6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman's rho</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation Coefficient</td>
<td>1.000</td>
<td>-.041</td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td></td>
<td>.135</td>
</tr>
<tr>
<td>N</td>
<td>772</td>
<td>739</td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation Coefficient</td>
<td>-.041</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.135</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>739</td>
<td>742</td>
</tr>
</tbody>
</table>

Note: *Q4: In what year did you finish your undergraduate degree or equivalency curriculum in music therapy?**Q6: In relationship to your professional work, how satisfied are you with the relevance of your courses?

Table 6 shows the responses for the participants’ graduation year and satisfaction level among quality of teaching related to survey questions 4 and 7. A Spearman Correlation test indicated a correlation coefficient between the two variables (.038), the significance value of the coefficient was .151. The significance value for this correlation coefficient was greater than .01; therefore, there was no significant relationship between music therapists’ graduation years and the satisfaction level among the quality of teaching.
Table 6
*Spearman Correlation Test—Music Therapists’ Graduation Year Relative to Satisfaction Level of Quality of Teaching*

<table>
<thead>
<tr>
<th></th>
<th>Q4</th>
<th>Q7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman's rho</td>
<td>Correlation Coefficient</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>772</td>
</tr>
<tr>
<td>Q7</td>
<td>Correlation Coefficient</td>
<td>.038</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.151</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>740</td>
</tr>
</tbody>
</table>

Note: *Q4: In what year did you finish your undergraduate degree or equivalency curriculum in music therapy?*

**Q7: How satisfied are you with the quality of teaching in your program?**

A Spearman Correlation test (See Table 7) gave the correlation coefficient between the two variables (.070), above the significance value of the coefficient (.040). The significance value for this correlation coefficient was greater than .05; therefore, there was correlation between music therapists’ graduation years and the satisfaction level of the undergraduate or equivalency curriculum. The relationship was positive: the music therapists who graduated more recently had a higher satisfaction level with the undergraduate or equivalency curriculum training.

Survey question 18: If you could choose again, would you choose the same university/college music therapy program?

Of the 777 respondents, 617 responded to question 18 (See Figure 10). The responses showed that 78.58% (n=491) of professionals would choose the same university/college music therapy program again. However, 20.42% (n=126) indicated the opposite opinion.
Table 7
Spearman Correlation Test—Music Therapists’ Graduation Year Relative to Satisfaction Level with Undergraduate or Equivalency Curriculum

<table>
<thead>
<tr>
<th></th>
<th>Q4 Correlation Coefficient</th>
<th>Q5 Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman's rho</td>
<td>1.000</td>
<td>.070*</td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.</td>
<td>.040</td>
</tr>
<tr>
<td>N</td>
<td>772</td>
<td>629</td>
</tr>
</tbody>
</table>

Q15 Correlation Coefficient | .070* | 1.000 |
Sig. (1-tailed) | .040 | .    |
N | 629 | 632 |

Note: *Correlation is significant at the 0.05 level (1-tailed).

**Q4: In what year did you finish your undergraduate degree or equivalency curriculum in music therapy?

***Q15: Taking as much into consideration as possible, including your course instruction, clinical supervision, quality and size of facilities, overall, how satisfied are you with your undergraduate or equivalency curriculum in terms of your preparation for professional practice?

![Pie Chart](image)

Figure 10. Percentage of Music Therapists Who Would Choose Same University/College Music Therapy Program

29
Survey question 19: If you could choose again would you choose music therapy or another profession? If you would choose another profession, please specify the profession(s) you would choose to pursue?

The number of respondents who completed survey question 19 was 594 (See Figure 11). The results showed that 76.26% (n=453) would choose music therapy again, or, if possible, they would like to either be a double major in music therapy along with another discipline during their undergraduate training or earn a higher degree in another discipline. However, the other 23.74% (n=141) of respondents had different opinions. Since respondents specified their opinions, other professions the respondents would like to choose included (some respondents mentioned more than one career they are willing to chose): occupational therapy (n=28); speech therapy (n=8); business (n=11), social work (n=20); marriage and family therapy (n=3); community mental health counseling (n=4); art therapy (n=3); music performance (n=5); music education (n=9); speech language pathology (n=16); public health (n=9); elementary education (n=4); neuroscience (n=4); psychology (n=25); marketing (n=2); medicine (n=9); law (n=3); nursing (n=8); physical therapy (n=7); computer science (n=3); special education (n=4); and bioethics (n=1). According to the responses, the most common reasons respondents indicated a desire to choose another profession were related to low income (n=24), limited job availabilities (n=24), music therapist burn out (n=4), and constant advocacy efforts (n=3) (n equals how many times the respondents mentioned in the responses).
Figure 11. Percentage of Respondents Who Would Choose Music Therapy Again or Another Profession
CHAPTER V
DISCUSSION

The purpose of this study was to examine participants’ level of satisfaction regarding their undergraduate or equivalency curriculum, with respect to how their education prepared them for practicing music therapy in the United States. The areas analyzed in this study included basic demographic information, satisfaction levels related to pre-internship clinical practica, satisfaction levels regarding the quality of teaching and the relevancy of courses, and the overall satisfaction level with their undergraduate or equivalency training. Based on the survey results, most professional music therapists were satisfied with their undergraduate or equivalency curriculum training with regards to the quality of teaching, course relevancy, pre-internship clinical practicums setting, and overall training experience.

Demographic Information

Examining responses related to AMTA regions (survey demographics question 1), respondents from the two groups with the largest representation included the Great Lakes Region and the Mid-Atlantic Region. Based on the most recent database collected by the CBMT in February of 2018, there were 7,067 professional music therapists who hold the credential of Music Therapist-Board Certified (MT-BC). The two regions with the highest number of MT-BCs who completed the survey for this study included the Mid-Atlantic Region ($n=1,726, 24.42\%$) and the Great Lake Region ($n=1,567, 22.17\%$).

The next finding was that a total of 237 (30.66\%) respondents reported working as a music therapist for less than 20 hours per week. These part-time numbers could indicate that
30.66% of respondents have at least one more job other than music therapist and/or are currently working as a part-time music therapist.

Examining responses related to the participants’ reported graduation year, the mean score of the graduation year was 2006 but the median score of the graduation year was 2011. This result suggests that the number of the students who have graduated from music therapy programs has steadily increased from 1971 to 2017, with about half of professional music therapists who participated in this survey graduating after 2011. Thus, 59.45% of respondents enrolled in this survey held the MT-BC credential and were within the first five years of professional practice or had just re-certified their music therapist credentials and were between five and ten years of professional status (2009-2017). According to the 2017 “American Music Therapy Association Member Survey and Workforce Analysis” (2018), over half of the AMTA survey respondents (61.6%) have been working as music therapists for no more than 10 years. This information matched with this survey, which indicated that most professional music therapists graduated after 2011, have the MT-BC credential, and have been practicing from one to ten years professionally.

**Research Question Regarding Different Satisfaction Level Aspects**

Examining responses related to respondents’ level of satisfaction with pre-internship clinical practicum, most respondents were satisfied with their practicum training. However, 8.79% (n=64) of respondents mentioned completing no more than two clinical practicums before starting their internship. As the first professional competencies became established in 1981 from AAMT, there were only 10 respondents who graduated before 1981 who completed no more than two practica. This indicates that the other 54 respondents who graduated from those schools after 1981 might not meet the clinical training requirements by AMTA. Academic institutes are
now required to maintain the minimum number of pre-internship clinical training hours, which is 180 hours with children, adults, and older adults prior to internship (AMTA, 2015).

Several respondents ($n=43$) graduated prior to the music therapy curriculum first being established in 1981 (based on Braswell), so it is possible that the courses they took were not fully developed and may not have adequately prepared them for the professional world. Lastly, the populations with which some professional music therapists work may not have been part of their previous clinical experiences during undergraduate or equivalency training. Too few clinical experiences may require the music therapist to feel inadequately prepared as though they have to start over and spend more time, money, and energy to learn again to work with a new population. When professional music therapists have experiences that change the clinical population with whom they work without enough clinical experiences upon which to draw, and when they also do not feel prepared enough from undergraduate or equivalency training, the undergraduate or equivalency curriculum can lose its value.

Comparing the results from Hodgetts et al. study related to occupational therapy programs to the current study, overall the therapists from both professions were satisfied with the teaching provided during their undergraduate or equivalency curriculum. In addition, the sample related to the research of occupational therapists was much smaller ($n=244$) than this music therapy survey ($n=777$). The percentage of music therapy students satisfied with the teaching quality was lower (92.73%, $n=689$) than occupational therapy (98.77%, $n=241$). The respondents in the survey of occupational therapists graduated during a shorter range of years than the current music therapy survey. The potential reasons, other than sample size, that may affect the survey results were that the sample of music therapy professionals graduated during a wide range of years, from 1971 until 2017. The further out a student is from his/her academic years may also
impact memory recall related to his/her educational years and experiences. Many years of recommendations and developments have influenced the music therapy curriculum. Different professors, textbooks, classroom settings, classmates, and clinical settings may affect the responses of the respondents.

The respondents’ overall level of satisfaction with the undergraduate or equivalency training was 92.88%, which was close in comparison to the satisfaction level of teaching quality (92.73%) and relevancy of the courses (92.72%). Furthermore, related to the survey of Hodgetts et al. study, 97.95% (n=239) of respondents were satisfied with their undergraduate or equivalency training in occupational therapy. Beyond the different sample size and population, the survey of occupational therapists was only aimed at a sample that graduated from a single university, while the current study was open to professionals from multiple programs across the United States. In this study, most music therapists study independently, due to lack of communication related to each university’s course instruction, clinical supervision for undergraduate training, quality of teaching, and size of classrooms, lead to respondents would only considering their own study experiences when making the choice for the study. This situation results in different opinions among the respondents.

Limitations

The number of respondents who reported he/she would choose a different profession, instead of music therapy was 23.74% (n=141). This number is similar to the number of the respondents who indicated they would not choose the same university/college’s music therapy program (n=126, 20.42%). According to the 2017 AMTA Member Survey and Workforce Analysis (2018), the average salary related to years in profession decreased from 2016. The average salary for a professional working between 1-5 years dropped from $42,341 in 2016 to
$41,597 in 2017. Furthermore, the average salary rate for music therapists working more than 30 years declined from $71,171 to $70,283 from 2016 to 2017. In addition, the report from 2017 indicated there were five music therapy job cutbacks: one facility closed; three music therapy programs closed; and one respondent indicated “other” as a reason. The total positions eliminated in 2016 \((n=10)\) were increased compared with the number in 2015 \((n=5)\). The previous study evidenced part of the respondents’ ideas in some aspects. However, the limitation regarding the parallel comparison related to this aspect from AMTA’s study was surveyed all the AMTA members which included MT-BCs with other nationals register music therapists or members. In addition, limited literature was available related to 2017’s data. The data from AMTA’s annual report may not truly present the MT-BCs’ situations today, but may still provide some ideas for future researchers’ comparison and analysis related to this aspect.

Another limitation is the response rate. Compared with two other music therapy surveys that also invited Board-Certified Music Therapists, the response rate of this study was particularly low. A study from Dr. Jackson in 2008 randomly selected 2,000 MT-BCs to examine the issue of participation in supervision and how important they thought participation in supervision is for professionals. The response rate for this study was approximately 41%, which was 812 out of 2,000 (Jackson, 2008). Furthermore, another study from Register in 2002 also examined Board-Certified Music Therapists regarding their consultation and collaboration practices. The response rate was 42.8% or \(n=873\) (Register, 2002). All three studies surveyed Board-Certified Music Therapists, but extant literatures presented higher response rates than the current study (10.89%). The number of invited participants who never even opened the survey link was 42.9% \((n=3,078)\).
For this group of respondents, there are many potential reasons for low turnout. According to Yan and Fan’s study (2010), one main reason that a study is not more successful in number of respondents is that the topic might not have been attractive to them. Thus, participants may not have been interested or felt too sensitive about the topic to respond, or other possibilities might have impacted their engagement with the survey.

Furthermore, due to the vast data and limited amount of time available to analyze the data, the student researcher was not able to analyze all of the data collected from the respondents. Close-ended questions may have limited respondents’ true thoughts in some aspects, as some questions had a list of set response options. Therefore, the unanalyzed data could improve part of the perfectness of the survey results after analysis.

Since the extant literature on music therapy curriculum research is limited and outdated, parallels can be only drawn between music therapy and studies of other professions. Comparisons with early studies were limited to textbooks, professions, and curriculum requirements. Comparisons with other professions were also limited by the difference between professions. Thus, deep comparisons between early studies, current studies, and other professions are limited.

Finally, some survey question options may not have been clear enough. For instance, when respondents needed to explain what other degree(s) they have earned, some respondents filled in music therapy under the choice of ‘other’ instead of selecting “bachelor’s degree” and filling in an “earned degree” of music therapy. Also, regarding the question as to whether they would like to choose another profession or not, some respondents opted to choose music therapy instead of “Yes.” The unclear question options may have impacted the results.
Conclusions and Recommendations

In summary, this study found many interesting concerns, opinions, and perspectives related to music therapy professionals’ perceived level of preparation for the professional world. Since there were few studies focused on the satisfaction level of music therapy professional preparedness in the last several decades, this research may provide the American Music Therapy Association, music therapy educators, professional music therapists, music therapy clinical supervisors, and current music therapy students with some meaningful ideas. The information gathered from this survey may relate to how professional music therapists view their readiness for professional work after completing the undergraduate or equivalency curriculum, how to continue developing and improving music therapy curriculums, and how to help music therapy students prepare for entry into the professional world. Moreover, because there were few studies related to this topic, this research may provide guidance for future study and educational training changes, and may be used as an example to compare with future studies. This survey may also provide some information about current music therapy career tendencies and professional music therapists’ attitudes in the United States.

Recommendations for Further Study

For future study, researchers could continue with an analysis of the qualitative data (questions 11,12,13,14,16,17, and 20) of this survey, in order to more fully understand opinions from all the respondents.

In addition, even though there were over 770 responses for this survey, the response rate was still lower than other similar music therapy survey response rates; future studies may consider other methods to increase the response rate. For example, if a researcher could find funding support, they could offer more enticing prizes, or if they could extend the survey
duration, respondents would have more chances to open the survey.

For future survey questions and answer options, the researcher should re-modify the language in order to help respondents better understand the meaning of the question. For example, in survey question 19, use “Music Therapy” as an option instead of “Yes;” for survey question five, provide an explanation about “Eclectic.”

Also, future studies may want to design a survey that takes aim at a particular regional sample or looks more closely into each AMTA region; or they may want to focus on music therapists who hold the credential as Music Therapist-Board Certified (MT-BC) but earned the bachelor degree or equivalency curriculum outside of the United States.
REFERENCES


APPENDICES
Appendix A

HSIRB Approval Letter

Date: October 9, 2017

To: Edward Roth, Principal Investigator
Xueyan Hua, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 17-10-08

This letter will serve as confirmation that your research project titled “Professional Preparedness: Satisfaction Survey for Music Therapist in the United States” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study”). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: October 8, 2018
Appendix B

Consent Form

You are invited to participate in a research project entitled "PROFESSIONAL PREPAREDNESS: SATISFACTION SURVEY FOR MUSIC THERAPISTS IN THE UNITED STATES" designed to examine the satisfaction level of the graduated undergraduate or equivalency students’ professional education and preparedness for practice in the United States. The study is being conducted by Edward A. Roth and Xueyan Hua from Western Michigan University, Department of School of Music. This research is being conducted as part of the thesis requirements for Xueyan Hua.

This survey comprises 13 multiple choice and 7 open-response questions and will take approximately 10-15 minutes to complete. At the end, you will have an opportunity to enter into a raffle to WIN one of ten $10 GIFT CARDS to Starbucks. If you are willing to, please send your email to xueyan.hua@wmich.edu.

Your replies will be completely anonymous. When you begin the survey, you are consenting to participate in the study. If you do not agree to participate in this research project simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time. You may choose to not answer any question for any reason. If you have any questions prior to or during the study, you may contact Edward A. Roth at 269-387-5415, Xueyan Hua at 269-267-7114 Western Michigan University Department of School of Music, the Human Subjects Institutional Review Board (269-387-8293) or the vice president for research (269-387-8298).
This study was approved by the Western Michigan University Human Subjects Institutional Review Board (HSIRB) on 10/9/2017. Please do not participate in this study after 10/8/2018.

If you earned your degree in music therapy at a university/college outside of the United States, you are not eligible to take this survey.

Participating in this survey online indicates your consent for use of the answers you supply.

Thank you again for your time and input,
Xueyan Hua, Graduate Students in Music Therapy
Western Michigan University
School of Music
Appendix C

Survey

PROFESSIONAL PREPAREDNESS: SATISFACTION SURVEY FOR MUSIC THERAPISTS IN THE UNITED STATES

Demographic Questions

1. In which AMTA region did you complete your undergraduate degree or equivalency curriculum?
   - Great Lakes Region
   - Mid-Atlantic Region
   - Midwestern Region
   - New England Region
   - Southeastern Region
   - Southwestern Region
   - Western Region

2. How many hours per week do you work as a music therapist?

3. Beyond your bachelor’s degree, what other degrees have you earned?
   - Second bachelor degree in another discipline
   - Master’s degree
   - Doctoral degree
   - Other (please specify)

4. In what year did you finish your undergraduate degree or equivalency curriculum in music therapy?

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Research Question:
Please answer questions 5-20 as they relate to your UNDERGRADUATE DEGREE OR EQUIVALENCY CURRICULUM IN MUSIC THERAPY.

5. How would you best describe the theoretical orientation of your undergraduate/equivalency curriculum?
   - Psychoanalytical
   - Behavioral
   - Nordoff-Robbins
   - Neurologic Music Therapy
   - Medical
   - Eclectic
   - Other (please specify)

6. In relationship to your professional work, how satisfied are you with the relevance of your courses?

7. How satisfied are you with the quality of teaching in your program?

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8. How many clinical practica were you required to complete prior to beginning your internship?

9. Was the number of clinical practica you were required to complete sufficient in preparation for your internship?
   - Yes
   - No
10. How satisfied are you with the range of practicum experiences offered during your education?

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Research Questions

11. What was your best experience in your music therapy program?

12. What would you say is your strongest skill that you developed during your undergraduate/equivalency training, which supports your current organization and its clients/patients?

13. What would you say is your greatest learning need to better support your organization and its clients/patients?

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Research Question

14. What was not so good in your music therapy program?
15. Taking as much into consideration as possible, including your course instruction, clinical supervision, quality and size of facilities, overall, how satisfied are you with your undergraduate or equivalency curriculum in terms of your preparation for professional practice?

16. What are your recommendations to instructors who plan(ned) individual courses?

17. What are your recommendations to faculty who are involved with program planning?

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Research Question

18. If you could choose again, would you choose the same university/college music therapy program?
   - Yes
   - No

19. If you could choose again, would you choose music therapy or another profession? If you choose another profession, will you please specify the profession(s) you would choose to pursue?
   - Yes
   - Other

Please Specify Your Answer
20. Is there anything else you'd like to add regarding your undergraduate/equivalency training and how it prepared you for professional practice?