

A QUALITATIVE STUDY OF INTERDISCIPLINARY MUSIC SERVICES

Thomas Bonelli, Chad Christman, Sarah Tree

State University of New York at New Paltz

Author Note

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Signatures:

_____ (Advisor)

John F. Mahoney, PhD, MM, MA, LCAT, MT-BC

Maria Montserrat Gimeno, EdD., MT-BC, FAMI, LCAT

Daniel Kempton, Ph.D.

Date Approved

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Abstract

At present, there is little written about music therapy interdisciplinary models from the perspective of co-treating therapists. This manuscript serves to compare prewritten texts on the subject of music therapy collaborative methods with first-hand accounts of co-treating therapists. Five therapists from different fields were interviewed and the transcripts were analyzed for relevant and reoccurring themes. Themes include: (a) broader treatment options; (b) comfort; (c) communication; (d) attention redirection; and, (e) challenges. The findings of this study support the use of music therapy within interdisciplinary therapy treatment teams. Effective co-treatment methods utilize the collective knowledge and expertise of the treatment group in both the planning and execution stages of treatment.

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A Qualitative Study of Interdisciplinary Music Therapy Services

Introduction

Music is inherently rehabilitative. As therapy, music can offer a medium through which emotional expression, communication, and physical health can improve and even flourish. It encourages clients to push their potential to achieve goals that may not have been otherwise achieved. Based on our interviews and research, we have found that music therapists work with a variety of populations in several different environments. While performing their duties, some music therapists have found themselves with opportunities to co-treat alongside physical, occupational, and speech therapists. Our study shows that in conjunction with other therapeutic modalities, music therapy has been shown to increase the efficacy of treatments and yield greater results. Common goals facilitated by co-treatments with music therapists include but are not limited to the following: improving gait, coordination, expression, communication, strength, fine and gross motor function, and cognition. Until recently, music therapy's use in rehabilitative fields has been limited due to lack of research. This paper seeks to justify the use of music in the rehabilitative fields of occupational therapy, physical therapy, and speech-language pathology, by using the first-hand accounts of board-certified therapists who have participated in music therapy co-treatments.

The review of the literature will include a meta-analysis of studies conducted in the field of music therapy regarding collaboration with physical therapy, occupational therapy, and speech-language pathology in the past three decades.

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Music Therapy

Music therapists (MTs) work with a variety of groups and individuals including those with psychological illness, developmental delays, medical illness, and other health- or wellness-related diagnoses. Music therapists are often employed in many settings including schools, residential facilities, medical facilities, psychiatric facilities, and private music therapy agencies (Register, 2002). In order to practice, music therapists must have a bachelor's degree, complete a 1040-hour internship, and pass the national board-certification exam. MTs are often able to design their own music therapy sessions based on how they believe the client will most successfully respond (Wellman, Gustis, & Pyatt, 2009). Music therapy is currently used to address a wide array of goal areas, including but not limited to the following: (a) develop social and emotional skills; (b) improve communication skills; (c) increase cognition; (d) improve gross and fine motor skills; and, (e) increase motivation.

Music therapy can be increasingly found in conjunction with other therapies. Due to the music therapist's ability to augment the treatment efficacy of other therapists, they are often collaborators (Miller, 2006). The incorporation of music into sessions with occupational therapists or physical therapists can encourage clients to engage and perform movements which are otherwise taxing. Music can better unleash the full potential of clients in need of physical rehabilitation (Paul & Ramsey, 2000). It also offers a distraction, which can mask laborious movements, allowing physical therapists or occupational therapists to better meet their goals (Wellman et al., 2009).

Music therapists are not only responsible for learning the individual needs of each client, but also for choosing the most appropriate music to meet those needs. Music selection is

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important because music is the quintessence of the therapy sessions; music itself has been shown to cause involuntary physical effects in the human body such as heart rate and breathing rate fluctuations, as well as muscle tension (Steinberg, Guenther, Stiltz, & Rondot, 1992). Music can either entice or dissuade the client which is why making the proper selection is fundamental to the success of the session (Paul & Ramsey, 2000). The act of making music also plays a large role in music therapy techniques. Clients' participation in composition making and improvisational music making allows them to realize their potential, as well as their ability to contribute in a meaningful way. There are a number of new and emerging programs and devices used to make music in music therapy sessions, including, but not limited to, the following: MIDI (Musical Instrument Digital Information) instruments; Sound Beam device (Sound Beam Project, Norwich, UK); Wave Rider (Wave Access Inc., Sebastopol, CA, USA); electronic drums; and, Miburi (Yamaha Corporation, Buena Park, CA, USA; Paul & Ramsey, 2000).

Occupational Therapy

Occupational therapy is a science-driven profession that applies a breadth of evidence-based research to deliver treatment to a broad spectrum of individuals. Occupational therapists work in a wide array of settings that include hospitals, schools, private practice, outpatient clinics as well as other community based facilities (America's Occupational Therapy Association [AOTA], n.d.). Direct interventions are developed and used to assess and maintain treatment for an individual's performance skills (motor, process, social interaction); activity demands; performance patterns (habits, routines, rituals, roles); and contexts and environments (AOTA, n.d.). Evidence supports the effectiveness of adding occupational therapy to an individual's treatment plan. The AOTA Evidence-Based Practice Occupational Therapy Practice Guidelines

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(n.d.) show that occupational therapy interventions improve individual outcomes. These outcomes include the following: (a) customized treatment programs to improve one's ability to perform daily activities; (b) comprehensive home and job site evaluations with adaptation recommendations; (c) performance skills assessments and treatment; and, (d) guidance to family members and caregivers. All certified occupational therapists must receive a master's degree from an accredited institution and pass the necessary state licensure examination of their preferred state of employment in order to legally practice within the mandated AOTA guidelines and ethics (AOTA, n.d.).

Physical Therapy

The American Physical Therapy Association (APTA; 2013) offers a clear definition of the physical therapist's scope of practice. Physical therapists apply research and proven techniques to help people regain motion. All physical therapists are required to receive a graduate degree (either a master's degree or a clinical doctorate degree) from an accredited physical therapy program before taking the national licensure examination. State licensure is required in each state in which a physical therapist practices. They are trusted health care professionals with extensive clinical experience who examine, diagnose, and then prevent or treat conditions that limit the body's ability to move and function in daily life (American Physical Therapy Association, 2013). Physical therapists provide care for people in a variety of settings, including hospitals, private practices, outpatient clinics, home health agencies, schools, sports and fitness facilities, work settings, and nursing homes. They may consult and practice with other health professionals to help an individual improve mobility (APTA, 2013). Physical therapists generally work with their patients in the following capacities: (a) relieving of back,

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shoulder, and knee pain; (b) setting up fitness programs to avoid or reverse obesity; and, (c) rehabilitation following physical or brain injuries, strokes, and arthritis (APTA, 2013).

Speech-Language Pathology

“Speech-language pathology (SLP) is the scientific and professional study of the disorders of verbal communication, their assessment, and treatment,” (Hedge, 1991, p. 197). SLPs must first complete a graduate degree and clinical fellowship, before obtaining a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SP) from the American Speech-Language-Hearing Association (ASHA). SLPs work within a variety of clinical settings, including public and private schools, hospitals, special education institutions, and mental health institutions. Within these settings, SLPs meet the needs of children and adults with communication disorders. Disordered speech “deviates from the speech of other persons, calls attention to itself, interferes with communication, and often causes distress in both the speaker and the listener,” (Hedge, 1991, p. 199). Communication disorders may involve deficits in any or all of the five components of communication: voice, articulation, language, fluency, or hearing loss). Some common speech disorders include aphonia (loss of ability to speak due to disease of larynx or mouth), vocal paralysis, vocal nodules, phonological disorders, motor speech disorders, and telegraphic speech.

Communication disorders often affect individuals with physical disabilities, such as cerebral palsy, and individuals with neurological impairments, such as traumatic brain injury (TBI), cerebrovascular accident (CVA), Alzheimer’s disease, or vascular dementia. One disorder commonly treated by speech therapists is aphasia. Aphasia is a disorder of communication resulting from neurological injury or disease, which affects the ability of the patient to recall

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words. According to the ASHA's scope of practice (2007), "The overall objective of speech-language pathology (SLP) services is to optimize individuals' ability to communicate and swallow, thereby improving quality of life" (sec. 5, par. 6). Speech and communication disorders have a myriad of negative effects on individuals, impacting social, emotional, and educational domains. The individual may experience frustration, humiliation, or shame and may withdraw from social interactions. SLPs often assist individuals with communication disorders through augmentative communication devices. These devices include electronic communication devices such as iPods, dynavox, and physical communication aids such as PECS (Picture Exchange Communication System). Other methods of communication featured in the ASHA scope of practice may also be employed, such as American Sign Language (ASL).

Music Therapy as a Collaborative Service

Collaboration between professional disciplines results in many benefits for the patient. The collaborative process allows for a broader understanding and availability of treatment options, and the singular knowledge and skill of each professional (Hobson, 2006b). Co-treatments are therapy sessions in which therapists from more than one field collaborate to enhance their treatment of the client in a way that is more beneficial than a session conducted by a singular therapist. Music therapy is an inherently collaborative field. Its place in therapy is widespread and augmentative. In 2002, Register completed a survey of music therapists regarding collaboration and consultation with other related services to attempt to quantify music therapy's collaborative nature. Register (2002) collected data from 793 board-certified music therapists (MT-BC) regarding several parameters including populations served, and the nature of any collaborative or consultative relationships. Results indicated that 87.5% of responding

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therapists were involved in some form of collaborative relationships. These relationships were with many different types of people, including OT's (47.2%), PT's (40.3%), SLP's (44.6%), family members (55.8%), medical personnel (46.2%), educators (41.4%), clients (40.1%), other music therapists (31.2%), administration (30.6%), and other professionals (33.8%). Consultative relationships were reportedly less common, only recorded in 44% of respondents. These consultative relationships were with OT's (33.4%), PT's (29.1%), and SLP's (36.3), but also with educators (62%), family (59.7%), administration (40.6%), other music therapists (38.6%), medical personnel (36.6%), clients (32%), and other professionals (23.7%). These results are demonstrative of music therapy's interdisciplinary qualities. Collaborative percentages are fairly evenly spread across all disciplines, which is indicative of the augmentative results of music therapy paired across rehabilitative fields.

Hobson's (2006b) second article highlighted three different models of collaboration: multidisciplinary, interdisciplinary, and trans-disciplinary. In multidisciplinary collaborations, each professional approaches treatment from their own area of expertise, with little true collaboration between them. In this model, professionals establish and implement their own goals and objectives for treatment. While this approach allows for unique contributions from each discipline, inconsistency among treatment plans and lack of communication between professionals pose serious obstacles.

With an interdisciplinary approach, professionals collaborate on treatment goals following a formal assessment by each professional (Hobson, 2006b). Professionals are expected to have an understanding of each clinician's approach, and should frequently maintain

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communication and contact with each other. This approach is difficult to establish and maintain, due to limitations in coordination.

A trans-disciplinary approach involves the work of various professionals within the same therapeutic session (Hobson, 2006b). In this model, no specific therapeutic discipline is considered dominant, and professionals are encouraged to incorporate techniques from alternate therapies into their treatment. This approach may result in more continuity of treatment, but may also cause interpersonal difficulties.

Qualitatively, these three approaches to collaborative treatments are utilized on a case by case basis and have unique benefits— to be discussed in the analysis of the interviews.

Music therapy and occupational therapy. Many studies have been conducted to demonstrate the benefits of collaboration between music and occupational therapists in a variety of settings. Craig (2008) observed that music could be a strong modality to add to occupational therapy. However, Craig makes reference that there is little educational material about how music works in conjunction with occupational therapy. Thus, in his article, he conducted a review of research and organized the results into a guide for practitioners. There are a “myriad of possibilities for practitioners considering using music, providing a resource of research within and outside the field,” (Craig, 2008, p. 81). The study categorized applications around enhancement of occupational performance. First, music can accompany or assist with occupation. An example of this is listening to music while working to improve performance. Music can also prepare for an occupation. For example, listening to music before bed can help to induce sleep. Finally, music can also be used *as* occupation. For example, playing music in a group can help to augment the client’s social capacity.

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A study conducted by Gee, Devine, Werth, and Phan (2013) provides evidence-based support for the therapeutic use of music alongside occupational therapy for pediatric patients. Occupational therapists ($N=74$) completed surveys in order to convey their use of sound-based interventions with pediatric clients. Pediatric occupational therapists are found to be using sound-based interventions in a variety of settings, and these settings are often found to include children with a variety of medical and developmental conditions. The study concluded that sound-based interventions involving listening to psycho-acoustically modified music could create a new series of neurological connections. A variety of these sound-based interventions exist and are being used by healthcare professionals despite the lack of evidence supporting their efficacy. Due to the small sample size and an estimated response rate of only 14.7%, so generalization to occupational therapy practice in the United States is not possible. It was concluded that further research is needed to identify the internal and external influences on the selection of sound-based interventions as an occupational therapy intervention in pediatric practice.

Another study was designed to examine pediatric occupational therapists' use of sound-based interventions. Han et al. (2010) designed a study looking at the effects of a weekly structured music therapy and activity program (MAP) on behavioral and depressive symptoms in persons with dementia (PWD) in a naturalistic setting. The clients attended a weekly MAP group that was facilitated by a qualified music therapist and occupational therapist for eight weeks. The Apparent Emotion Scale (AES) and the Revised Memory and Behavioral Problems Checklist (RMBPC) were used to measure changes in mood and behavior. Twenty-eight subjects completed the intervention, while 15 wait-list subjects served as controls. The AES and RMBPC

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baseline scores did not significantly vary between the intervention and control groups. After the use of the co-led intervention, the RMBPC scores improved significantly more in the intervention group as compared to the control group. AES scores showed trends towards improvement in the intervention group, but it was shown by the research that this trend was of no clinical significance. The resulting evidence suggests that weekly MAP can improve behavioral and depressive symptoms in PWD.

A single-subject case study examined a five year-old child with pervasive developmental disorder NOS whose received sound-based interventions within the realm of the occupational therapy treatments (Nwora, & Gee, 2009). The case study analyzed the use of a sound-based intervention called “The Listening Program” (TLP), which focused on improving sensory processing and language function. Nwora and Gee (2009) provided the TLP intervention during a 20-week period and found it to be beneficial for the child. The data collection methods included both pre- and post-evaluations of video footage and questionnaires. Results of the study indicated an improvement of behavior and sensory tolerance, including active participation in singing and movement to songs. Data analysis also indicated significant improvements in sensory processing, receptive/expressive listening and language, motor skills, behavioral and social adjustments. The authors highlight the need for continued research of sound-based interventions by occupational therapists, especially larger-scale studies utilizing TLP to verify the efficacy of this treatment method.

Movement-to-music computer technology has been used with children with severe physical disabilities that lack the physical skills to explore their environment independently, including playing with toys or musical instruments (Tam et al., 2007). The movement-to-music

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system is a computer system that allows children with limited movements to play and create music. The study also provided insight into parents' experiences of using the movement-to-movement system with their children and how the use of technology can enhance therapeutic features for people with unique needs. Qualitative methods were employed, including in-depth interviews of six mothers and their children. The results showed that the movement-to-movement system expanded the potential for the child, and that movement-to-movement had a positive impact on environmental determinants of health for the clients. Tam et al. (2007) concluded that further research is needed, especially with a larger sample of children, that have restricted mobility, in order to obtain a better understanding of the impact of movement-to-movement technology on children's psychosocial development.

Music therapy and physical therapy. Staum (2000) completed a literature analysis of 235 studies on the role of music in physical rehabilitation covering the years between 1950 and 1999. Staum's analysis found that the most commonly named function of music in physical rehabilitation was to ease movement and coordination. However, only 23 (48%) of the 48 studies that used an experimental design yielded significant results. Her conclusion cites music as the motivating factor in clients' ability to perform repetitive motions and increase respiration capacity.

Most recently, a meta-analytical review of articles between the years 1999-2009 was published that details peer-reviewed studies dealing with the topic of interdisciplinary music therapy practices (Weller & Baker, 2011). The researcher's review of the literature yielded 79 articles, 15 of which showed valid results and were used for analysis. Many of the studies focused on patients with Parkinson's disease, stroke, and cerebral palsy. Weller's (2011) review

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addresses the use of music as a tool for motivation, an external timekeeper for movement, and a medium through which structured rehabilitation interventions can be achieved. Music as auditory stimulation can be employed either by the use of a metronome or a tempo adjusted music track. This technique is utilized to provide an external cue by which patients can organize their movements. These music therapy techniques are found, in most cases, to be employed for the improvement of patients' gait or fine and gross motor skills.

Of the 15 studies reviewed in the meta-analysis, the most common results showed significant gains in cadence, stride length, and velocity (Weller, 2011). Improvements were demonstrated in patients' ankle flexion while doing movements to music. Rhythmic auditory stimulation (RAS) was found to positively affect gait and cadence after repeated trials. Studies also focused on the use of music to assist in improving the gross motor skills of children with cerebral and Erb's palsy, as well as adults with Parkinson's disease and recovering from stroke. Thus, there is an increase in the use of music therapy alongside physical therapy in the past 15 years. Following their analysis, Weller and Baker (2011) concluded "the role of music in physical rehabilitation is to connect the physiological, psychological, cognitive and emotional functioning of physical therapy." (Weller, 2011, p. 52)

Music therapy and speech-language pathology. The similarities between structures found within music and those found within language support the use of music in the treatment of speech and language disorders (Hobson, 2006a, 2006b; Hurkmans et al., 2012). These shared characteristics include natural expression, frequency range, rhythm, intensity, and diction, (Hobson, 2006a, 2006b). Although music and speech share certain structural characteristics, recent studies show that music is processed differently from speech. While speech processes are

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predominantly associated with the left hemisphere of the brain, music has been shown to activate neural pathways throughout the brain, further supporting the use of music in speech rehabilitation (Hobson, 2006a). A wealth of studies exists that demonstrate the benefit of music therapy techniques for the treatment of aphasia, speech-fluency, speech production (Hurkmans et al., 2012). These techniques include Neurologic Music Therapy (NMT) techniques, such as Melodic Intonation Therapy (MIT), and Speech-Music Therapy for Aphasia (SMTA; Hurkmans et. al, 2012).

In 2012, Hurkmans et al. completed a systematic review 15 studies regarding the use of music therapy in the treatment of neurological language and speech disorders in 583 adult patients, ranging in age from 18 to 84. Included studies met the following requirements: (a) measurements before and after intervention; (b) musical elements were used as a form of therapy; (c) speech and language disorders were non-congenital neurological disorders (such as those caused by CVA and TBI); (d) with adults; and, (e) in English, French, German or Dutch. In 14 of these studies, CVA was the cause of the speech disorder. The remaining study described two patients with TBI. In 13 studies, patients had a diagnosis of non-fluent aphasia, and in two of these studies, patients also had apraxia of speech. Two articles studied the use of music for patients with dysarthria. Within the reviewed studies, MIT was the most common technique, evaluated in nine studies. It is important to note, however, that most of these studies gave less treatment time than the recommended frequency of 30 minutes twice daily, 5 days each week. In 12 of the 15 studies, patients received individual treatment. Overall the studies reviewed were given fairly low methodological quality ratings on a scale of zero to four, with nine studies rated between zero and two, and only six studies receiving a rating of three or four. Although all 15 of

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the studies reported positive results, more than half of the reviewed studies did not employ statistical outcomes.

Thaut's model of Neurologic Music Therapy (NMT) highlights the benefits of Therapeutic Singing (TS). Singing has been shown to enhance speech fluency, improve rate of speech, diction, intelligibility, intensity of voice, and breath/muscle control. Thaut's model includes other techniques, such as Vocal Intonation Therapy (VIT) and Oral Motor and Respiratory Exercises (OMREX), which have been shown to strengthen breath support in individuals. Melodic Intonation Therapy (MIT) has been shown to facilitate speech for patients with damage to the left hemisphere of the brain through incorporation of melodic elements to exaggerate natural speech intonation. (Thaut, 2005)

Challenges to collaboration. There are many challenges to collaboration that are cited in the literature. Chief among these obstacles are education, interpersonal relationships, and approach to therapy (Register, 2002). Educational differences between co-treatment therapists have been shown to contribute to new and innovative co-treatment sessions, as seen in the aforementioned benefits section. However, these same differences can also prove to be an obstacle for co-treating therapists in different fields. For co-relationships to develop successfully, members of the collaborative relationship must have a basic understanding of the therapy modalities with which they are collaborating. Training within alternate modalities may be most effective when it occurs prior to entering into a collaborative relationship (Register, 2002). Hobson expounds upon this point, stating that collaborations often go awry when the collaborators are using two different professional vocabularies. Without proper communication

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before sessions, the mixed vocabularies can contribute to a decrease in efficacy of treatment collaborations (Hobson, 2006b).

Need for Research. Being that there were only 15 studies chosen for the afore-mentioned meta-analysis (Weller & Baker, 2011), it can be inferred that there is a lack of evidence-based scientific research on interdisciplinary music therapy practices. There is much more than can be learned from the experiences of practicing professionals in the medical field concerning the process by which music therapists and music therapists, speech-language pathologists, and occupational therapists work together. Specifically, we were curious about how co-treatment scenarios are devised, what specific techniques have been used, what concerns or difficulties have been encountered, and among other things, how processing and planning happens after and prior to the therapy sessions.

In order to best address these research questions, interviews recounting the personal experiences of interdisciplinary work were obtained. There is a wealth of knowledge and experience to be found in the everyday workings of professionals in the field, much of which has not been published.

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Method

To address the lack of research supporting music therapy co-treatment, the writers sought out first-hand accounts of practicing non-music therapists who have participated in co-treatment methods with music therapists. To best address our research questions, a qualitative research methodology was used and data were collected by interviewing therapists. The research protocol was submitted to, and approved by, the Human Research Ethics Board (HREB) at SUNY New Paltz. An interpretive constructive approach was used to conduct the study (Rubin & Rubin 2005). This method was chosen because the writers believed they would get fuller and richer data from the interview subjects. This model of data collection was used instead of a positivist approach because the writers wished to have more in-depth and open-ended interviews. The transcripts were culled for relevant and reoccurring themes. Important and recurring phrases and ideas from the transcripts were highlighted, made into groups, and then interpreted within the framework of the interpretive constructive approach. Interview questions were created and chosen by the writers with the intention of gathering as much information about the process of co-treating with a music therapist. The writers also wished to gather personal accounts of the therapists' work with music therapists; highlighting the challenges and positive outcomes they experienced first-hand. The writers also intended to create a sense that more research was needed in this area, so that therapists of different modalities could better relate and communicate during co-treatment scenarios. While the interviews were framed by pre-determined questions, the interviews were conducted less as questionnaires and more as in depth conversations about the topic. Interviews were done in person at the workplaces of the therapists and recorded and then transcribed. Interviews will be kept on a secure hard drive for five years per HREB requirements.

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Each interview lasted between a range of forty-five and sixty minutes. Thomas Bonelli interviewed speech-language pathologist CK, Sarah Tree interviewed occupational therapist GB and physical therapist MK, and Chad Christman interviewed occupational therapist FE and occupational therapy assistant BL. A list of the predetermined questions can be found in Appendix A. The transcribed interviews are located in Appendix B.

Participants

We selected five practicing therapists in the fields of occupational therapy, physical therapy, and speech-language pathology who have had substantial experience co-treating patients alongside practicing music therapists. The participants were chosen based on their history of co-treating with music therapy services for ten or more years. Interviewees included the following participants: BL, CK, FE, GB, and MK. Interview questions (see Appendix A) were developed to best address the purpose of this study, which is to show how music therapy works in conjunction with other therapeutic models. We (Thomas Bonelli, Chad Christman and Sarah Tree) conducted the interviews. Thomas interviewed a speech-language pathologist; Chad interviewed an occupational therapist and occupational therapy assistant; and Sarah interviewed an occupational therapist and a physical therapist. The interviews were recorded via digital recorders and then transcribed into written text by each person that conducted the interview. The transcripts of each interview are provided in the appendix to this article.

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Results

The data demonstrated that the addition of music therapy to interdisciplinary therapy treatment teams could be exemplified by the following five themes: (a) broader treatment options; (b) comfort; (c) communication; (d) attention redirection; and, (e) challenges.

Theme 1: Broader Treatment Options

The first theme is broader treatment options. Participants spoke about the incorporation of music therapy into more common therapy disciplines, which gives patients more options when determining a treatment plan that works best. When treating patients who are not responding to typical therapy treatment options, such as physical therapy, occupational therapy, and speech-language pathology, therapists may turn to music therapy collaboration teams to give their patient a greater variety of treatment options.

Occupational therapist FE states that music therapists offer more expertise on “interpreting” patients than she can singularly offer. Music is a relatable tool that resonates in both the therapist and the patient. Aside from benefits to patients, co-treatments with music therapists can be equally beneficial to the co-treating therapist. When developing treatment goals for patients, FE states, “It is easy to not see, so more eyes and viewpoints can be helpful because one person might not get it.” Having a collaborator enables FE to increase the depth at which she analyzes each session.

Often music therapy co-treatments are unpredictable, which elevates the level of engagement and investment both therapists have in the patient’s progress. FE discusses her practice of re-grouping with her music therapist co-treatment partner and coworkers:

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I stayed back and talked with coworkers and did get a chance to process [the session] and it was so useful. Instead of leaving with a feeling of being out of sorts, I would leave with a feeling of empowerment about what it is that I do. And that validation is important to help sort it out.

In her experience working with a music-therapist collaborator, physical therapist MK states that she is able to learn and apply new techniques with patients that she has had the opportunity to see in action in co-treatment sessions:

When you collaborate you can think that you understand what the person means, but when you see them in action and you see their area of expertise in action, you pick up on strategies you would never in a million years have thought of. And then you can use it from then on, whenever you work with a kid.

She goes on to describe the physical benefits for the patient in music-therapy co-treatments in this regard:

I would do the weight shifting while she [MT] was doing the instruction for marching to the rhythm... or clapping the hands so that I could show her how to facilitate it in an appropriate way using good movement patterns.

The physical nature of music inspires action in the patients, which is unmatched by prototypical stimuli used in physical therapy sessions. In effect, music and physical motion has a symbiotic relationship, which augments the efficacy of both the physical therapist's and musical therapist's treatments. MK further expounds this point:

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I would let her [MT] know if they should lead with their right foot and why, or whether that student was also capable to doing something in a backward direction. Or how to facilitate reaching with an arm if that child happened to have cerebral palsy.

Even the simple notion of incorporating music into her solo physical therapy sessions had a profound effect on her work. MK describes her experience with a patient who enjoyed the music on *Barney & Friends*:

His calf muscles are definitely strong enough to start controlling, but he's very reluctant to do anything that involves balance.... Sometime during this last school year, I discovered that he liked *Barney*... His engagement went from about zero to a hundred... I noticed he liked to dance, and he also leaned some of the hand signs... he's doing some bilateral movements, which help him to balance in a more mature way... I had him on the tilt board... turned on the Barney tape, and he started doing a small shift of his shoulders like he was dancing... and he crouched down so he could see himself. That's a highly advanced balance skill. And he's just having the time of his life... We got to Mr. Sun, and he started doing the signs with both hands. It was unbelievable!

Theme 2: Comfort

The second theme found in the data is comfort. Music provides patients with a sense of familiarity, which results in more comfortable treatment sessions. Music is a relatable tool that has the capability of resonating in all parties—therapists and patients, alike. Occupational therapist FE states that music opens up her patients and makes them feel safe. The use of music in therapeutic sessions provides an even ground which helps to facilitate comfort and safety—

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and in turn, progress. Occupational therapy assistant BL shares her experience of music therapy's accessibility for a low-functioning patient:

We had a patient who was not organized enough to come to group. She was not able to physically get out of bed, and after a few one to one music sessions with the music therapy student, coming to group was enticing to this patient because she knew what was going to happen and eventually it got her to get out of bed and physically come to groups.

The interview data supported the literature, in that the use of music in physical therapy allows for the patient to experience decreased pain, elevated mood, and increased levels of control (Bradt, 2001) during painful procedures and rehabilitation.

Theme 3: Communication

The third theme is communication. Due to its melodic nature, music allows for non-verbal communication to take place within patient-therapist relations. This aspect of music is especially helpful to non-verbal patients who have difficulty expressing their selves. Similarly, music can also help the treating therapist communicate to the patient. The music therapist is able to use the rhythmic component of music to act as an external cue, giving the patient a reference to carry out specific movements non-verbally. Furthermore, the cues within music provide instant reinforcement to patients—encouraging participation.

Music enables the capability of non-verbal communication in sessions, such as body motion or musical instrumentation, which allows for the treatment of low-functioning and non-verbal patients. Occupational therapist, GB, also attests to this phenomenon: “You watch the

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cohesion of the group. Music facilitates that because they don't have to be able to talk. They can just move." of the treatment sessions.

SLP CK states that through the incorporation of music, her patients are able to "respond wholly—not just limited with whatever language they are capable of." Music offers CK the use of a universal language. This universal language imbues non-verbal and low-functioning patients with the confidence to communicate more freely. Not only does music provide an even ground between the patient and the professionals, but it also provides sessions with certain rhythmic and auditory devices that are difficult to reproduce in common language. One such device is communicatory anticipation: "[Anticipation] would help me to get the child to that point consistently when they would understand 'Oh, I'm supposed to make this next sound,' or elevating with their hand or head with the tone increase."

Another device that music offers in co-treatment sessions is instant reinforcement. CK attests to this phenomenon:

Auditory closure gave [patients] the understanding that basically there is another part and that the part is theirs to sing. And once they sing it, they get the reinforcement not just with a 'yay, good job!' but with reinforcement with the continuation of that music the therapist was playing. Something that I still can't replicate on my own very much.

Finally, one of the most essential devices of music is capability to connect patients emotionally to the world around them.

Just to make a connection with the world, really. It's not always a beautiful tone, but something that the child interacts with and relates to. Where you get a giggle where you never got a giggle before, and it's just that the sound struck the child in a perfect way that

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caused that emotion or smile or eyebrow raise whatever it was. And then they want to do it again because the sound they enjoy comes whenever they do that.

Theme 4: Attention Redirection

The fourth theme from the data is attention redirection. Especially useful within the physical therapy field, music's distractive qualities can divert attention away from the difficulty of certain physical motions. Music alleviates the punitive and strenuous aspects of OT and PT, OT GB states. Similarly, occupational therapy assistant BL states: "You are able to get them to participate more fully and work a little bit harder because they don't even know that they are doing the work." The role music plays in these co-treatments is invaluable to the progress of the patients. Music therapy, when coupled with occupational therapy, augments the treatment's efficacy. PT MK attests to a common thread found in all five interviews—the incorporation of music into therapy sessions often encourages patients to "forget that they're doing something challenging." This finding was discussed in the literature. A music therapist is able to use the rhythmic component of music to act as an external cue, giving the patient a reference to carry out specific movements (Paul & Ramsey, 2000).

Theme 5: Challenges

The final theme in the data regarded challenges and obstacles to co-treatment. Where there is an uneven distribution of knowledge among co-treating therapists, there is bound to be skepticism between therapists and their superiors. SLP attests to this: "The first MT in this facility had a hard road with helping everyone to understand what MT is all about and how it could be utilized and benefit the kids. There were a lot of people who were skeptical." Due to its infancy, music therapists are often asked to justify their work. Incidents such as these arouse

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further the need for more expansive research on music therapy co-treatments and the efficacy of such co-relationships.

Beyond differences in education, co-treating therapists may have varying philosophies on which treatment methods will work best for which patients. Such differences in theoretical orientation can lead to a competitive atmosphere, which can be detrimental to the patient's progress. OT GB speaks to this issue:

Because, while you would think, in an ideal world, that everybody would just get along, there also has to be a shared philosophy about what they are trying to accomplish, what the goals are... I may not always agree with [MT's] way to deliver instruction, but at the same time, she's my partner, I need to support her. And you have to have the respect for each other's position, and if you don't have respect for each other's position, I think... it can end up getting really competitive, and you don't really collaborate on things.

GB's account reveals respect to be an important component of collaboration. Interpersonal conflicts can spring from a lack of respect or support from therapy partners.

One of the major co-treatment issues found in multiple interviews is a systemic issue—that of reimbursement. Because there is such little research on co-treatments with music therapists, therapists commonly encounter difficulties finding a stable and reliable reimbursement method. Disruptions in co-treatment service due to payment difficulties can be harmful to patients who depend on the co-treatment sessions. OT GB states gaps in treatment can be detrimental to the psychosocial progress of the patients. Cancelled co-treatments appear to patients as though “my therapist doesn't care.”

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Conclusion

The data of this study supports the use of music therapy in interdisciplinary therapy treatment teams. Furthermore, treatment would be enhanced and more effectively utilized under the following evidence-based guidelines. First, each treating therapist must set aside their desire for professional self-preservation, which is often found in newly developing fields such as Music Therapy. Instead, the co-treatment team must function as a single entity, using their individual strengths to augment the efficacy of the therapy sessions. Second, communication among the collaborators is vital to their success. Where there is an uneven distribution of knowledge among co-treating therapists, there is bound to be skepticism between therapists and their superiors. Thus, communication of differing philosophies, treatment methods, and professional vocabularies must take place throughout the treatment collaboration.

As music therapists currently working in the field, the writers would add that it is most important that music therapists, in whatever environment they find themselves practicing, learn the languages and perspectives of the other treatment professionals in the workplace. In school, we are taught about the philosophies, techniques, and terminology associated with music therapy, however the reality of a real work situation can be much more complicated and varied. Music therapy does not exist in a vacuum. As stated in this paper, music therapists have many opportunities to co-treat with a wide variety of therapists from other modalities; it is very important, as a music therapist, to both educate co-workers about their processes as well as educating themselves about the processes of their co-workers. It is only when the therapists in a co-treatment relationship have a fuller understanding of each-other's language, techniques, methods will co-treatment relationships be truly fruitful.

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Further investigations would benefit by interviewing a larger sample size of therapists who co-treat alongside music therapists. There is a need for more expansive research on music therapy co-treatments and the efficacy of such co-relationships. Our results are limited by the number of subjects we interviewed— and therefore can only be analyzed qualitatively. For further study, we recommend drawing from the themes we found and exposing them to a larger survey group.

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Appendix A

Interview Questions

1. What population of clients do you serve? How many clients do you treat?
2. Do you currently treat some of the same clients with a practicing music therapist? And how many of your clients receive either group or individual music therapy sessions?
3. On a scale from 1-10, how would you rate your knowledge base of music therapy and the way that treatment goals are implemented?
4. Do you currently incorporate music into your sessions without the music therapist? And if you do, how have you done so and is it effective?
5. Do you do this for all of your clients, or only some? Why or why not, or is there a reason for this choice?
6. Have you experienced the effectiveness of MT interventions in the rehabilitation of clients? And why would you define them as effective?
7. What kind of role do you think music and/or rhythm play in the treatment of clients?
8. Have you found that music is more beneficial or successful with some protocols and not others? Please explain.
9. What type of treatment relationship do you share with this music therapist?
 - Co-treatment: Both clinicians are present and active within the same treatment session.
 - Collaboration: Clinician's work together to determine treatment goals and/or methods
 - Consultation: Clinician's discuss possible techniques
 - a. What is the working dynamic? Is there a "lead" therapist? How did this dynamic alter the way you and your patients responded to one another?

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- b. How are treatment goals selected? If sessions are separate, do both therapists use similar treatments/interventions for the same goal areas?
 - c. How do you measure whether these goals are met?
 - d. In an ideal environment, what kind of treatment relationship would you like to share with a music therapist?
 - e. What would you change about the working relationship with this music therapist?
What would you keep the same?
 - f. Does the type of co-relationship (co-treatment, collaboration, consultation) affect the overall satisfaction expressed by the OT/PT professional in Music Therapy services?
10. Did you debrief with the music therapist following any sessions?
 11. If yes, how did you proceed to move forward in the treatment relationship?
 12. Speak about 2-3 co-treatment cases that were especially inspiring or meaningful to you.

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Appendix B

Thesis Interview #1: Speech and Language Pathologist

Tom: So, would you say all in all it's been beneficial working with a music therapist?

CK: Definitely, most definitely. I've been working with MT's 7 or 8 years. The first MT in this facility had a hard road with helping everyone to understand what MT is all about and how it could be utilized and benefit the kids. There were a lot of people who were skeptical. All I could say is they were not wise to be skeptical when I was around. Because I sat next to that music therapist and saw firsthand how hard they worked and how difficult it was to walk down that road to get people to understand. And to be able to work with that MT side by side with a lot of the kids and be able to see first hand the benefits that that child was receiving. I as a therapist was receiving because my goals were being met much easier. It wasn't just my struggling to help this child to reach this goal, it was being reinforced by the music aspect. It was whole brain, so we are targeting all things at the same time.

Tom: What function does music and rhythm and rhythm play in your session with MT's?

CK: I think rhythm is good for me because of auditory closure. My singing is very limited so some of the kids prior to the music therapist just get three tones. I would sing the two sounds and they would have to fill in the other sound, and that was my limit. So to have the MT with the instrument and voice and that would help me to get that child to that point consistently whee

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they would understand “Oh, I’m supposed to make this next sound”, or elevating with their hand or head with the tone increase. It taught me a lot as far as how to manipulate that sound and get them to produce a little bit more.

Tom: What is important about them filling in that next done, or auditory closure, and lifting arms or head to the musical tones?

CK: It gets them to follow directions. Auditory closure gave them that understanding basically that there is another part and that the part is theirs to sing. And once they sing it they get the reinforcement not just with a “yay, good job!” but with a reinforcement with the continuation of that music the therapist was playing. Something that I still can’t replicate on my own very much. It’s nice to also ask the MT with help with that. Also, it helps with the memory triggers. They get used to certain music and rhythms and then it will key them into doing that part again. they get used to that.

Tom: I think they realize that they are part of something and that their part is important and propels the music forward,

CK: Yeah, their eyes just brighten, and they just know it’s their turn.

Tom: What roles does the MT play in rehab? You know your role but what is theirs?

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CK: For the most part, always there to support what I was doing and reinforce what the child is doing. Because once the child tok off in one direction, the MT was able to follow that and continue that line of what the child was leading down. Which is awesome. The other thing is, right you know that whole brain concept of music where language is not necessarily a whole brain thing but the music is, and can tie in other parts of the brain that are not as easily targeted and brings it together. Respond wholly not just limited with whatever language they are capable of. Can react with their whole body and produce their own things. We used to do the midi cart where we had two speakers aimed at the child and would set this sound for a movement and if the child would like elevate an arm they would hear the sound, which would cause them to produce the movement again. And we would have an orchestra with 2-3 kids in there. You can give them a direction and if they follow that direction you'd get a sound and that immediate feedback. I think it's that whole brain aspect of not just working with one area.

Tom: The immediate feedback is motivating too. When you say whole brain do you think emotion do you think emotion also ties in with this work?

CK: I would imagine emotion would play in there, sometimes you can't tell. Especially with emotion in particular is more with TBI clients. It's a great trigger for happiness or sadness and music helps them to go through all those different emotional states that they need to relearn. Like, singing songs that they would never have triggered without music. To relearn how to talk also.

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Tom: You mentioned the midi device that triggered sounds, and so what is the quality of music that music therapists have used working with you. I think when people think of music, they think it always has to be musical, but a lot of times MT's use music not to be musical but to serve some functional purpose, but not what some people would call music. So, what is the quality of music and its purpose in sessions?

CK: Just to make a connection with the world, really. It's not always a beautiful tone, but something that the child interacts with and relates to. Where you get a giggle where you never got a giggle before, and it's just that the sound struck the child in a perfect way that caused that emotion or smile or eyebrow raise whatever it was. And then they want to do it again because the sound they enjoy comes whenever they do that.

Tom: Have you found music is more beneficial in certain scenarios and not in others?

CK: No, I think music touches everything and can be altered to fit any situation. Yeah.

Tom: Did you convene with the MT prior to sessions? And if yes, what did that planning usually look like?

CK: Usually we did. Like I said, I always sat next to a MT just not recently. I feel starved too because I'm not longer able to talk about my kids and get advice from her and also give her advice as well. Um, but.

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Tom: What perspective did they get from you or you from them? Talking about your kids and cases?

CK: Well, I think each of us would probably walked away with a different perspective on how we would target different things. And sometimes I'd ask them "what did you get with this? And what happened? And how can I continue your goal and this is mine, so how did you target that? Yes, we talk all the time. before a session in particular we would say "this is what we are gonna d, right? Right!" so, we go in and we do it and during a session sometimes we look at each other and thing this isn't working so one of the other will tweak it, or then yeah afterwards we def discuss what could have gone better. If something should have lasted longer. But we communicate during the session to like...stretch that out and keep it going because it's really opening up doors...or it's not functional. A lot of times part of the MT's role was to reduce anxiety during a certain type of technique or a mode of stimulation. And if the child was still not capable of handling it we would try something different It was always tweaked when we needed it.

Tom: When you were cotreating, did it effect the way you worked with your kids even when a MT wasn't involved in a session?

CK: A lot of times, yeah. Of course because you learn different perspectives and you incorporate that. If it's working for that child, then definitely. And then sometimes with another

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child we did it we worked in this technique and that was pretty functional so let's try it with this one. You add it to your repertoire of things that are functional.

Tom: depending on whether the music used during a session was preferred I guess by the patient or child or not, did you notice more or less of an emotional response during sessions?

CK: Yes, definitely, certain kids have certain preferences to music. Which music or rhythms or tune whether higher frequency or low. You would notice either by heart rate or if the child is being more functional or smiling or grimacing. Stuff like that. As far as emotional, some of the kids like TBI, yes definitely more emotional. When you find the right instrument they liked they would get into it more or request that again. Of course, yeah if they didn't like it, that didn't negate whether we tried it again later because it may eventually open up something and it's it was a block or something that the children was producing to avoid progress, so yes we would try it again to see if it struck a chord. Mostly we would use what the child really enjoyed and then use that as another tool for opening a new door.

Tom: Did you find that having an MT made it easier to open those doors or "get deeper" as you said before.

CK: Yeah, I think so. A lot of times also after even if I didn't cotreat with the MT and they were doing therapy in the room, I would watch from a distance and see what the child's responses were when I wasn't involved and see what the quality of the responses were and whether or not

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they were trying out certain things I needed to work on as well since the door was being opened by the music. I would be able to go back and retarget as that possibility was opening up whereas maybe it hadn't been opening up before. You know, See that open door, stick my foot in there before it closes and massage it a little bit to see what we could draw out. So yeah pretty neat.

Tom: Having the music there in sessions, did it have an effect on you? Not just on who you're working with but did it effect you?

CK: I think my singing got better (laughter). Not a whole heck of a lot but definitely better I'm not. I was never really embarrassed about singing to a child, but after hanging out with a music therapist longer, I have no qualms about it. And if I need to get louder with my singing, I have no problem as well. I know that's benefitted me, hopefully the child as well (laughter). I used to partake in the Elizabeth Seton choir. At the hospital.

Tom: Before we talk about specific moments, tell me what population you work with, tell me what pop you work with, what you do, and acutonics. And any other sound you're involved with.

CK: Well, you know who I am. I am a speech language pathologist at elizabeth ann seton pediatric center. I work with this population which is skilled nursing facility long term care basically supposed to be birth to 21 but we never get that young. Earlier we get is 6 weeks, maybe. And definitely til 21. I have served with this type of floor where it's respiratory

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compromised vented unit or at least trached with respiratory problems pretty much the entire time I have been here which has been 8 years. Prior to that, I was in an early intervention clinic. We would sing songs and they were a lot higher functioning than the kids here. So, for here it's been challenging. More medically fragile.

Tom: Before you worked here, did you know what music therapy was?

CK: No. I first heard of it here. Acutonics was brought in by the same music therapist who showed me what music therapy was about. She brought in the teacher who came in to teach it to a few of us. I am the only one left here now that still know how to use here right now in the facility. I was trained up to the first level and I have used it for at least 6 years since I've been here. I think it's functional for a lot of kids. I have used it for constipation, pain reduction. I have used it with PTs and their work, say for passive range of motion and the child has high tone. The PT will tell me where to active. I will place the tuning fork to the belly and the muscle and they will quickly respond and the PT will get a greater stretch out of the child. They are always amazed. As far as my therapy sessions, I use it for kids with PVS or minimally conscious state diagnoses. Each child is different and they never respond the same. Some children don't respond at all. The instructor came back and suggested activating the tuning forks a foot away from the base of the feet which is an opening point. Acutonics uses pressure points and meridian lines just like acupuncture. The moment I active at the base of the feet a foot away, this child's whole system almost came back on line. There was a difference. You can see a lot of physiological changes.

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Thesis Interview #2-FE Occupational Therapist

Chad: What population of clients do you serve and how many clients do you have on an individual or group basis?

FE: As you know, I currently work with troubled teenagers in a program that generally has no more than 10 clients at a time in an acute day program. I have mostly worked with adults throughout my thirty years of working.

Chad: So you have mixed up the populations that you've worked with?

FE: Yes, it would seem so.

Chad: Do you currently treat the same clients with a practicing music therapist and if you do, how many of these clients receive individual or group music therapy sessions?

FE: I am currently working with a music therapy intern as I have in the past, and every client in our program is involved in music therapy group sessions when they are offered, and some have individual music therapy sessions.

Chad: What's your experience as far as working with music therapy?

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FE: I can think of two music therapists that I worked with, one was at Harlem Valley Hospital, which is no longer in existence. Then another, “Chuck,” worked in a continuing treatment center in Kingston for several years until he had to move for family purposes.

Chad: In your experience with them did you do any co-treatment? Or how did it work?

FE: Yeah in both cases we would share clients but generally did not work together. Although Chuck and I did run a group but music was not part of it. I tend to work in places that are not discipline specific, and music is one of those areas where that is not true because it is a special kind of discipline.

Chad: So your experience has more of an eclectic one? What do you mean by that?

FE: Well, I feel like we all do the same thing and nurses and music therapists and doctors know more in certain areas.

Chad: So it's less about the title per say and more about the work that is being done, is that what you are saying?

FE: Yes, yes.

Chad: Okay. Based on your experience, on a scale from 1-10, how would you rate knowledge

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of music therapy and the way that treatment goals are implemented?

FE: I would say a 6.

Chad: Okay. Now is that mainly the interventions or could you talk about the treatment goals too, how does that work exactly?

FE: I can see how the amazing power of music or even poetry especially working with the kids that I work with currently, and its great to work with them in that way because their emotions are right on the outside and they can speak in poetry easily. And with teenagers, music is a great way to pull them in. But I guess with anybody it works...for example, the music that you fall in love to, stays with you, like geriatric patients, they can remember those songs from the days of their youth. So it's certainly a great way to both connect with someone, and get them to open up. It is my understanding that music therapy, much more then my training, deals more with interpretation. We were busy trying to figure out moving arms and stuff like that, so interpretation wasn't a major component of our education.

Chad: Yeah, but maybe to draw a similarity, you still have to gauge where clients are at.

FE: Yes, the whole time...the whole time. It's almost like a dance. Even for people who aren't music therapists and ideally it happens without thinking about it and those times that we do have to think about it, that's when all the training comes in, with the theories and such. But mostly we

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have to rely on our intuition.

Chad: Yeah because at certain points in time, or so it seems, the training or preparedness takes a bit of back seat as to what is actually happening in front of you.

FE: Yeah.

Chad: Well I guess that answers my next question, as to how music has been incorporated music into sessions, seeing that you have done that as a way to open up with clients.

FE: Well I am a little inept when it comes to music, but I can see the power of it, but would like to have at the tip of my fingers the ability to play some music in the background while people are drawing or writing, but I don't have that awareness, but I do know from my work that background music can make a big difference in setting the tone.

Chad: Right. Has there ever been a point in time where you have been working with a music therapy intern and have done a co-led session, and you find that the music will take over or sit in the forefront of the session?

FE: I'm not sure that kind of flow happens throughout, and it certainly is not a problem if the music is in the forefront because hopefully the therapeutic goals are being taken care of.

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Chad: Okay. So it's more about putting it all together.

FE: Sure.

Chad: Earlier you mentioned that music can really help open people up whether it's the therapist or client, so could you talk a little but more about the effectiveness of music in sessions that you have seen?

Ellen: It certainly changes the mood, and it's really evocative. I think it may have to do with the vibrations and memories.

Chad: Do you ever feel that the best potential that comes out of a client is a little bit outside of the realm of understanding?

FE: Yeah I think that it happens all of the time. Maybe that's why I like this so much because it is almost magical or the fact that there are really no words to express what it is that happens that makes people go from feeling so desperate to feeling okay.

Chad: It seems like whenever you share that experience with another person, whether it's through music or being one to one with someone, it seems that the connection is an unseen force.

FE: Yeah, but something we need to do from the get go to have this work, is to have people feel

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safe or comfortable around us and that in and of itself is offering them something they might not often have or is something that they have forgotten. I think that music can be intimidating at times; you know to be involved in music other than in a listening experience.

Chad: I think even as listeners, it makes your character a part of the presence of the music, because music without a listener doesn't really mean anything.

FE: Yeah it seems that it's all about the shared experience, and I think it can be summed up to the fact that there is so much stuff that we don't have words for.

Chad: Yeah it seems like so much of our communication is based off of nonverbal content. So anyway, have you found that using music, as the intervention is more or less beneficial as opposed to other types of interventions?

FE: I think that of course it's very specific to the circumstance, but as we have already alluded to, music has a quality that other types of interventions don't, because of everything it can do... simultaneously.

Chad: On the flip side of that coin, do you think there are interventions that speak to patients more than music?

FE: It depends on who the patient is and it depends on where they are at in any given moment.

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Music is a good way to get in there for so many people, naturally due to how broad it is.

Chad: So no matter what it is, it's more about the individuals needs as opposed to the intervention.

FE: The intervention should be based on what is needed and any technique could be used. I guess it's all a matter of choice, or the comfort level of the therapist.

Chad: Perhaps the comfort level of the patient as well.

FE: Yes of course.

Chad: The next group of questions I am going to ask is more about the relationship that you have shared with the music therapists that you have worked with. As far as the type of relationship that you have had, there are three things specifically that I am looking at. The first one is a co-treatment relationship, so both clinicians would be present and active in the same session. Second is collaboration, which is working together to determine goals etc. Lastly, consultation is more along the lines of processing together.

FE: Well I have certainly been involved in all of them, I would say less involved in consultation because I am a fly by night therapist and I am not working as much lately.

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Chad: So you have participated in all of these types of relationships?

FE: Yes I have.

Chad: What has been your experience with a music therapist in session?

FE: There have been times when there has been a lead therapist, and there have also been times where it changes during the session, and that's good because there are many times when you make plans and they change based on what is going on and that's good because you're meeting the needs of the moment and not the plan.

Chad: So do you think that has an effect on what the patients are getting out of the session?

FE: I don't think it does or should because what the patients are getting out of it hopefully is some help with what they are dealing with, and that's what we are paying attention to and it doesn't matter who is in charge or what modality is being featured.

Chad: Okay. So let's talk a little bit more about treatment goals, when you are apart of a treatment team, what's the process of coming up with treatment goals?

FE: In some places that I have worked there has been a designated therapist who writes down goals, but I think that everyone on the treatment team is involved in identifying what the

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problems are and how to take care of them ideally.

Chad: Do you think that when it's more of a joint effort, it is more beneficial because there are so many more points of view?

FE: Yes I think it's true because it is easy to not see, so more eyes and viewpoints can be helpful and very much so to the patient because one person might not get it or there might be transference issues that happen with one person on the treatment team.

Chad: Okay so that brings me to my next question, on the flip side of that coin do you think that it could ever be a hindrance having "X" amount of people working together in a treatment team?

FE: I suppose so, if people are not working well together. I think though that it's a beneficial notion to have more than one persons input because I very much appreciate teamwork in my work and I have never wanted the whole responsibility of an individual practice.

Chad: I can wholeheartedly understand that. Okay, so within session when these goals were implemented how would you measure them or how would you know these goals were being met?

FE: Well because our goals were set in very measureable and clear ways so we could follow up and see if that percent of the time the goal was being achieved. I'm just kidding...patient report

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and observation is the most crucial. Also having family sessions and learning from their significant others what changes have been made.

Chad: Like you were saying earlier, it's less about interpretation of responses as opposed to a straight validation of improvement from the patient. I know that there are times when patient self-report isn't always the sole thing you can go on, but at least the patient is aware what is happening around them.

FE: Something that I need in the setting that I work, because I am there so rarely, is the morning meetings that we have, because that is how I know what people need on that given day. We have goals that we check in every two weeks, but the here and now is good to get from co workers, what is the milieu like and what does it need. It's good for us that aren't there serving all of the time.

Chad: So its safe to say that for you personally it is important to have all of these types of relationships all across the board so then you can ultimately keep treatment together and ultimately serve the needs of the patients.

FE: Yes, I always need to know the needs of the group or patient.

Chad: Is there anything that you would change as far as your experience and how would you work with therapists or music therapists?

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FE: I think I would like to be more open and feel like I have more time to have to process. That whole series of events can be very fulfilling.

Chad: Yeah I feel like the act of processing gives you a chance to come down from a session because so many things can happen, that you may not know specifically how to deal with these things as an individual.

FE: There were times long ago that I would be working and at the end of the day you felt like you had to get out of there on a hard day, but instead I stayed back and talked with coworkers and did get a chance to process and it was so useful. Instead of leaving with a feeling of being out of sorts, I would leave with a feeling of empowerment while good about what it is that I do, and that validation is important to help sort it out.

Chad: Plus it helps build rapport with fellow therapists.

FE: Right. We get a chance to be with good fellow therapists.

Chad: Okay. Well those are really all of the questions that I had, but maybe we could end this with you talking about a specific example of which you have taken something away from a music therapy type session.

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FE: I don't know about anything too specific but I am impressed with the way that music therapists can utilize percussion, although I am intimidated by it, but how it helps their patients to open up and make them more accessible to do other types of work. I also have sense memory of working with someone and feeling that you are on the same page with him or her and making something happen and come to life.

Chad: Great. Well let's leave it there and I appreciate your time and words of wisdom. This has been a pleasure to kind of pick your brain and get some insight into this whole therapy thing.

FE: Absolutely, and if you need anything more, feel free to ask any other questions when they come up.

Thesis Interview #3: L.B.-Certified Occupation Therapy Assistant

Chad: Starting with the first question...what population of clients do you serve and how many clients would you say you treat?

BL: The population is mental health and it could be a dual diagnosis from substance abuse to... there is always primary diagnosis of a mental health related disorder, and clients could also be MR...so there is a diverse population. As to how many clients that I treat...if my treatment team is full I have approximately 20 patients and during the day I can see anywhere from 1-20 depending on individual or group sessions.

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Chad: So it's a vast amount?

BL: Yeah a wide variety.

Chad: Do you currently treat some of the same clients with a practicing music therapist and how many of your clients receive either group or individual music therapy sessions?

BL: I would say that a majority of the patients are also seen by a music therapist, but its hard to say off the top of my head how many exactly. I would venture a guess as to half of the patients participate in music therapy.

Chad: Seeing that you work with a music therapist, on a scale of 1-10 how would rate your knowledge of the practice of music therapy and how you work together to implement treatment goals.

BL: I would say that I have about an 8 as far as understanding.

Chad: Okay could you explain a little bit, maybe a little further into your understanding.

BL: I would say that my understanding is that it is another way for patients to express feelings and emotions as well as explore on how to vent and explore what the feelings are bringing up with them in a nonthreatening way...almost as though they don't know that it is therapy that is

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going on, so it's not as intrusive.

Chad: So what you're saying is that it's geared towards letting the client express emotionally, but would you say that there is anything that it does for the mental illness side of things?

BL: I think that they have to organize around it and depending on what they are doing within the music therapy session, perhaps they are paying attention to the rhythm so there are cognitive things that are being addressed, depending on what's going on they have to be able to...on the appropriate level...cognitively participate. I also think that it provides structure so if they are having a hard time focusing on reality, the structure can come into the session.

Chad: Yeah that sounds good. Lets take a step away from that for a second. As far as your own sessions, do you incorporate music into them yourself without a music therapist there or how do you handle that?

BL: There are two groups that I routinely do that with. There is an open craft group and I find that the music allows patients to enjoy music in an open setting, and sometimes that's all the patient's do; listen to music. Then I also use music for relaxation as well, I do that twice a week and I find that when I do the relaxation without the music it doesn't capture the patients as much as when I do the relaxation with music.

Chad: I see. So like you said before it provides the patients with a structure or a container so to

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Speak?

BL: Yeah, absolutely.

Chad: Okay. Are there some clients that you would use music with as opposed to others in your sessions?

BL: Yeah and there are some patients that I would use music more, in fact that may be one of the only things that they would be able to tolerate. We have a couple of patients in which that is the way that they express themselves and where they find themselves most comfortable, so there are certain patients that when I am looking at a group, if I know that they are going to be in there, then I will put on music that they prefer because I know that is the one thing that they are going to take away from the group or at least enjoy.

Chad: Okay. A little bit earlier you mentioned something about the patients locking into something rhythmic to provide them with structure, you know as far as an intervention being effective. Can you talk a little bit more as to how rhythm plays a role in the implementation of therapy?

BL: Well I think it allows them to have structure, so they have to focus on a very structured task, which can base them back into reality. For people that have been depressed for a while just being able to follow something through with a protocol or steps to it in order to keep up a rhythm

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could actually be beneficial and could be one of the few things that they have been able to actually tolerate within a long time so I think the music again is a little less threatening than a talking group or discussion group and sometimes it can be the icebreaker that is used to in order to get them to facilitate more of a discussion group.

Chad: So again you're reiterating the fact that the music can hide or mask the therapeutic side of things.

BL: Yeah.

Chad: Okay. In your work, have you found that music is more beneficial with some treatment protocols than it is with others?

BL: Yeah, just because again it is that nonthreatening thing that is happening. Like DBT (Dialectical Behavior Therapy) coping skills, it's a useful group but some people find that it is work, so I think that when we are able to use music to introduce DBT or be the icebreaker or even just kind of have them relate to their emotions through music...as the way it's done, it's not looked as a therapeutic tool to the patient but that you are able to get them to participate more and fully and work a little bit harder because they don't even know that they are doing the work. So I think that especially for patients with borderline personality disorder who have a lot of work to do but they just don't want to do it, the music can kind of trick them that way. Also I think sometimes with cognitively delayed people they are able to relate to music much more as opposed to discussion groups or with say a paper and pencil...just something where they are not

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able to follow along in the discussion.

Chad: Let's talk a little bit about the relationship that you have with your co-therapists...I have broken it down to three types of ways to look at how you view the relationship with the music therapist. The first one I have is co-treatment, as both therapists are actively engaged together in the session to treat a patient. Then the second one is collaboration, more of like behind the scenes. Say you work with a patient and then you go to the music therapist and you say "This is what I have been working on with the patient, and if you go along with this, it would help them." Then lastly consultation is the most basic type of relationship breakdown. So what type of relationship would you say that you have with the work that you have done with music therapists in the past?

BL: I would say collaboration and consultation, not so much co-treatment at least for myself.

Chad: Is that because of the way that groups are set up?

BL: Yeah I think it was just the dynamic of what was going on.

Chad: So in that process when you are working together, how do you come to a conclusion as to how you are going to treat the patient's as far as goals are concerned?

BL: We have our goals designed by our social workers so we already know ahead of time of

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what the goals are so we can go on that. I think a lot of times that directs us as far as knowing the patient's goal and how the goal of the group will meet the patients needs. I think at that point the music therapist is the one figuring out what they can bring to the group and then I am there to help facilitate more.

Chad: Okay. So how would you say that you measure your treatment goals?

BL: I would say it's based on how the patient interacts within the group, were they active in the group, were they able to meet the criteria of what the leader set out to do, were they disruptive, were they able to follow along and give feedback, so its really about looking at how the patient interacts within the group when the material was presented to them.

Chad: Okay. Do you think that there are any other ways in which you represent how the patient is doing within their treatment like using a likert scale or something along those lines?

BL: I would say it is based more on patient response and observation. There are a lot of times for example that you will notice a patient before a group is agitated or labile and then will come to group, especially some sort of music group, and then get that energy or emotions out or redirect it, and then afterward they will be able to be on the unit and either take a nap or be able to interact more appropriately so I think it is more about observation of the patients.

Chad: Do you base that type of observation on more of a moment-to-moment type basis or do

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you compare it to their baseline?

BL: For me because I know the patients pretty well, I feel like I can utilize the baseline thing, but for other people that are not here as often and don't know the patients as well it's more about observing in the moment and how they are acting during their stay.

Chad: Okay. So a lot of it has to do with the relationship that you have with the patient as a therapist?

BL: Yeah.

Chad: Would you say that your relationship or the way that you work with the music therapist is ideal or would you have any suggestions as how to make that relationship different or stronger or better?

BL: I think for our environment it is pretty much ideal. I think that you have your groups but then if there is a person that needs a one to one we can always go to them and we can go provide a one to one, so the environment that we are in and the structure that we have, especially with the way that we work with other disciplines it works with this environment...including the way that we have it setup for groups and having the ability to say that such and such a patient could use a little bit more one to one time.

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Chad: Okay. Well I guess that answers my next question.

BL: Yeah I guess I wouldn't really change anything at this point in time.

Chad: Say you do a group on your own and then the music therapist does his or her own thing, how do you process after such said groups?

BL: I think we have ongoing processing. Some of it is pretty matter of fact. Every day we try to touch base and say, "hey this is what happened." Also we have notes that we write so we can check up on what happened in a group in a note, but I think just the way that our department is, we are pretty good at communicating with each other and that makes us pretty lucky because I'm not really sure how common that is with other co-discipline departments or departments of the same discipline for that matter.

Chad: Do you think that it's important for other staff to be involved in that level of communication like the doctors or nurses or do you think that they are even apart of that process?

BL: I think when we force them to be involved. We do have a communication log so that way if there is something that has happened we can make a note of it and our manager takes that to report to the nurses. I think as far as letting the doctor or treatment team know, there isn't a consistent way in letting the doctors know. I feel that it's lacking a little bit, but it's a bit of a two

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way street and we have to meet each other halfway.

Chad: But at least you're maintaining the relationship with other therapists.

BL: Yeah and I think our department does a really good job with being mindful about that and doing it on a regular basis.

Chad: Okay. Well to bring things to an end today, could you maybe talk about 2 or 3 situations or times working with a music therapist that was really meaningful or that you could see the patient taking something away from that type of work?

BL: When we had a music therapy student here, we had a patient who was not organized enough to come to group. She was not able to physically get out of bed, and after a few one to one music sessions with the music therapy student, coming to group was enticing to this patient because she knew what was going to happen and eventually it got her to get out of bed and physically come to groups. So I think that just a majority of the time, music groups are pretty powerful and we are surprised by patients in music groups because they are either active for a change, which in any other group they aren't active or refuse to come. I think again because the patient doesn't always realize that there is therapy going on, I think that the patient can be very genuine and honest. So I think on an ongoing basis it is very inspiring to me because it's one of the few groups besides crafts, which patients can be themselves, and not having to think, "someone is watching me or someone is documenting on me," I think they lose sight of all of that because the

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music is going on and it promotes a very genuine kind of interaction with the patients.

Chad: Yeah and at the same time underneath all of these layers its obvious that the music is doing something for them whether it's mentally, emotionally, physically.

BL: Right. It's able to give them a nonthreatening place to be able to vent and to explore what is going on and they don't even realize that is what they are doing so it allows them to get therapeutic things out of the group that they could get out of one of the direct therapy groups but find it more difficult to do it that way.

Chad: So it's direct and indirect all in the same.

BL: Yeah. I think it's direct on our part because we know what's going on but it indirect on the patient's part.

Chad: Great. Well Laura I want to thank you for your time this afternoon it helped greatly and I got some good insight as to what you do. Thanks again.

BL: Anytime. Glad to help out.

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Sarah: What population do you currently serve?

MK: Currently I serve the residential students at the Anderson center for autism. Primarily residential students. Most of the students that I treat have the diagnosis of autism, or autism spectrum disorder and the majority of the students I see range in age from 8 or 9 to about 16. So, I see a number of students who are a little older than that, but they typically have, on top of their diagnosis of autism, they also have a central nervous system diagnosis, such as cerebral palsy or some unknown neurologic disorder, that kind of thing, that causes a problem with their movement.

Sarah: Okay. Have you worked with any other populations?

MK: I've worked with just about every population you can think of. I have worked in hospital acute care. I have done rehabilitation, sort of a self-contained, working with spinal cord injuries of patients, amputee recovery, and I worked in a hand and upper extremity rehabilitation clinic, which was great because we all had different specialties, so there were two of us that just did hand and upper extremity, but there were other people there that specialized, one was in pain management, one was in spine... orthopedic management of the spine, mobilization, kind of like chiropractors do, and strengthening and that type of thing, a real diverse group of people, and you could collaborate and co-treat. So when I had someone who had a neck injury that went along with an injury to their hand, let's say they tried to pull away their hand out of a machine, and they injured their neck as well, I could consult with the guy who did mostly neck and upper back stuff, and he would either also do some of the treatment himself, and then when they got to a point where I was able to do it myself, you know, I would do a combination during the

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treatment of their neck as well as their hand and upper extremity. So it was really interesting

Sarah: Oh, neat!

MK: And then I started working in the school system part time while I continued doing the hand rehab, and that was from... I really didn't work in preschool, so it was kindergarten through graduation. It was anything from a mild learning disability all the way to, profoundly multiply handicapped. And then I worked at, I moved back east and I worked at Putnam northern Westchester BOCES. I worked with preschool on up. And primarily worked with the more profoundly involved students there, but I did work in some school districts where the kids were integrated into the, either regular classroom or self-contained classrooms.

Sarah: Sorry, just making sure I had pressed the play button

MK: Okay, so there were self-contained classrooms in the outlying schools as well. And then I had my kids. And then after that, I worked in a preschool setting, just 3 and 4-year-olds. And then I came here.

Sarah: You really have worked with everybody!

MK: Yep.

Sarah: So, I know...

MK: And I did early intervention, just part time, where I went into people's homes and provided services there, and worked primarily with the moms, sometimes the dads, to show them what I was seeing, and how they could play with their kids to help promote the development of their gross motor skills.

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Sarah: Awesome!

We used to co-treat and collaborate.

Sarah: Okay, so I know that currently the clients you work with receive music therapy, either individual or group services. In any of the other populations you previously worked with, did any of them work with music therapy?

MK: Um, yes. In the preschool there was a music therapist who also did, is it floor time? Is that an approach...

Sarah: Yeah.

MK: ...that you use with some folks. And she would occasionally invite me in during floor time, but also then to try and incorporate my strategies during the music session. So that was pretty, pretty neat. So we would, like I would do the weight shifting while she was doing the instruction for marching to the rhythm of the song, or clapping the hands so that I could show her how to facilitate it in an appropriate way using good movement patterns rather than substituting movements that they shouldn't use.

Sarah: Awesome!

MK: She would have things set up, like how to step over. She was really great, she really did try and incorporate all kinds of things. She would sometimes have small beams on the floor, and so I would let her know if they should lead with their right foot and why, or whether that student was also capable of doing something in a backward direction, or if she was shifting from a sitting position to crawling like animals, how to facilitate reaching with an arm if that child happened to

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have cerebral palsy or something like that.

Sarah: Awesome!

MK: So it was really neat.

Sarah: So in your current relationship with a music therapist, would you classify that as co-treatment, collaboration, or consultation?

MK: Primarily consultation. I did do one brief co-treatment with one of the students with J, and other than that, it's really consultation.

Sarah: And it sounds like with your previous relationship with the woman at the preschool, that might have been... would you still classify that as consultation, or did you get to collaborate on treatment goals?

MK: We didn't really talk about official goals or objectives, like on an IEP. But we would talk about, from my perspective, my short term goals for... you know 'right now we're focusing on shifting weight to the right. So if you could always place yourself to the right that would be great.' Those kinds of things. So we really didn't identify some specific objectives to happen during the session, and then it would happen periodically, probably no more than once a quarter. So, I don't know what you'd call that. I guess that's a more in depth consultation?

Sarah: Well, you're collaborating on... at least to the point where she understands what your objective is. And you're able to integrate that together.

MK: Right, and then we did some co-treatment cause I was actually in the music room during music therapy sessions.

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Sarah: That's great. Within the relationship between you and this previous music therapist, was one of you the lead therapist? Or was it a music therapy session, and you pushed in and assisted?

MK: I would follow her curriculum for the day, and determine from that how I could get my objectives met, so that if it was a sitting activity, that I would possibly weight shift... I think of some of my kids that had cerebral palsy, and typically they have one side which would be weaker than the other. So I would engage that one side, or I might bring a little cushion to sit on, so that they had to do a little more balance work, since I was right there. I might position their legs a little differently to either improve their flexibility, or challenge their balance. But it was the music therapist session, it wasn't mine.

Sarah: And from what you've described, it's been mainly consultation here (at Anderson). In the session that you were co-treating, was it again a music therapy session that you pushed into?

MK: Yes, it was an individual that J had with a student, and it occurred because he had a question for me about how a student was walking down the hall, so I followed him down, and he showed me what the student was doing, and then I was really thrilled to see what was happening, and it really evolved from there. So I ended up staying for most of the session, showed him some of the sitting positions I'd been using, and he demonstrated some of the bilateral movements that the student was doing that I'd never seen before. So it was really exciting.

Sarah: Wonderful! It sounds like you... did you ever get to discuss treatment goals for the client with a music therapist prior to a session?

MK: Not prior to that session, but we did talk about it afterwards. Now a couple times I did go in, we discussed another student, E, beforehand. When E was first starting at school here, and

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some of the challenges he was having with sitting and that kind of thing, and could I come in and see if there was anything I could suggest. And then, I went in a second time, and tried managing the situation myself while he was doing the class, to see if I could facilitate how he was moving, and how he was sitting, and what the demands were at the time. I wanted him to have more up and around movement, I thought that would be better for him than having to sit for the activity.

Sarah: Okay. With the music therapist at the preschool, did you ever discuss... I know you've said you discussed, you know, I want to shift weight. Did you ever have the opportunity to sit down with them and discuss treatment goals prior to sessions?

MK: How it usually occurred is she would say 'you know, I have so-and-so'... it would typically be a student within the school, and 'I'm having difficulty... it looks like they're having trouble walking evenly' or 'it looks like they're having difficulty walking evenly, and I'm not sure what to do during the sessions to promote better balance or better movement.' So she already knew that those were things that she wanted to do during the session, and could I come in and provide her with specifics of what I saw, and what she could try to do. So she was knowledgeable enough from her years of experience, but would need my input to determine some way of changing the movement to get what she wanted. Like if you're using rhythm sticks, instead of holding them both in the center, some of the kids, you want to give them one, have an opportunity to get them with both hands at the same time, sometimes you want them off to the side, sometimes you want them overhead, sometimes you want them to reach forward, so where you present them can really help with balance or flexibility or visual tracking. Those kinds of things. So that was really what I was providing during that time.

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Sarah: Yeah, I would find that really helpful. In fact, when we're finished, I've got a question for you about one of the boys I'm currently working with. Have you personally experienced the effectiveness of music therapy in working with clients.

MK: Absolutely. There seems to be something... you mean in general, or with this specific population.

Sarah: Either.

MK: I think in general, there is something about music that is universal. And that that rhythmical system allows the kids at some level to be comfortable in anticipating what's going to occur. I think also that music tends to be enjoyed by most kids, so that they are much more readily initiating and engaging in the activity, rather than having to do something hand-over-hand. I mean, sometimes you do when you're using instruments, but often times movement is involved, using my experience with the younger kids, and that's what they want to be doing anyway. And being able to incorporate all kinds of things: puppets and instruments, and some kind of back and forth exchange tends to get the kids really excited about doing something, and sometimes they forget that they're doing something challenging. You know what I mean? I mean, from my perspective as a physical therapist. So if they're really reluctant to shift their weight over a weaker leg, let's say to the right... if they're really... like that whole enthusiasm tends to increase their muscle tone, the trunk gets more muscle tone, their stability is actually enhanced, and they forget that they can't go to that side, they're thinking about something else, and they weight shift to that side without even noticing that it's happening. Those kinds of things. And it's much better for me to be doing skills within a fun functional activity than

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isolated in the PT room saying stand on one leg or walk to this side or something like that. For a lot of kids, that just isn't going to make them want to engage. But if they initiate it, the whole movement pattern that you see is different when it's spontaneous from them, versus something that I'm asking them to imitate, it is just totally different.

Sarah: Fantastic!

MK: The other thing, they've been looking at EMG's, you know electro-myo... I can't think of it, EMG's, the muscle activity... so they look at the sequence and speed of engagement of muscles. Let's say they want to see what's happening in the shoulder when you go to reach for something, and they compare what happens when you say to a person 'reach for the cup and put it down here,' versus when somebody unexpectedly knocks something over and you automatically go to grab for the item. The timing of the shoulder muscles which they have to engage before you can reach your arms. It happens much faster than you can even think about. So the timing is faster, but the way the muscles are recruited is different with a spontaneous reach, than when you're told to reach for something. It's fascinating.

Sarah: That's the word I was just thinking of.

MK: And they're finding the use of... can't think of the name of it... central program generators, CPG's. and we have, other than the basic reflex loops, like the doctor taps your tendon and you get the movement, there appear to be groups of reflex loops that work in units, so that the timing is much faster than if I have the intent to do a movement. So even before we're thinking I need to go and get that pencil, before you even begin the movement, there is a kick-in of the shoulder muscles from the intent, versus if I told you to go and get the pencil. So as soon

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as I get the idea, there's already an activation, and they're saying that it has to be, it's so fast that it has to be a reflex loop. It couldn't happen if it weren't. So, anyway, they're looking into that. They're looking into movement patterns and how they engage. So, if you're in with kids, and they're doing something that they're familiar with, and they like, using instruments or whatever, you're getting a whole different movement experience that's much more typical and functional than an isolated exercise or an isolated skill.

Sarah: So it sounds like you've definitely experienced music therapy as being effective. Did you use any measurements to define it's (music therapy's) efficacy?

MK: No. I think I have certainly recorded that, let's say the student was able to shift their weight over the right side, over the right hip, either more readily, or even at all. I tend to be descriptive about the change I notice, you know, "rather than substituting side bending of the trunk, the student actually shifted their weight over the right hip during the session." But I don't think I ever specifically measured the difference, like a range. It seems to me, it either occurs, or it doesn't occur. They're reluctant to shift weight over to one side, but during music, it was much more readily accomplished. That would be what I would put in my notes...

Sarah: So, more observational (qualitative) than quantitative?

MK: Right. But you probably could measure the amount of time of engagement. Let's say you had a kid who had Cerebral Palsy, who was reluctant to do very much walking. It would be a perfect thing to do, to then measure how much "up" time is there during the music session with a PT co-treating, versus an isolated PT session. So I think a lot of those things would be measurable, it's just... I've never done it.

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Sarah: Okay. What function does music and rhythm play in rehabilitation?

MK: Well, let me think before I answer. (pause) So, when you think about walking, typical walking has a cadence and a rhythm. And one of the things that throws that off is when someone can't take the same step length, so they have a short step length and a long. And hearing a rhythm... I'm thinking about my rehab days working with amputees, who had difficulty increasing... they would shorten the amount of time they would spend on the limb that was amputated once they got the prosthesis. That rhythm helped them to stay on that side longer. They were cognitively intact adults, who were able to understand the idea. And music would help them to increase the time they could spend on the stance phase, putting the weight on the new prosthesis. But I'm trying to think if I have any of the kids that I've worked with where that's really been... ask me the question again?

Sarah: What function does music and rhythm play in rehabilitation?

MK: Well, for a lot of the kids here, they either use one hand or the other. It's very classic for a lot of kids with autism. And the idea of clapping, or using rhythm sticks... it's a great activity because it has purpose. It's a functional activity that engages both hands, where you can get an outcome, versus if I asked them to throw a ball with two hands, they often times will let go, stabilize the ball against their chest with one hand, and then throw with just one hand. That's how they're used to doing it. But there's something instinctual about clapping in rhythm. Those kinds of things that get you engaging both sides once you get started. So that for me is a big, big thing for these guys. It engages their trunk in such a different way. They tend to turn to one side and the other side, they tend to use their peripheral vision. So when you're doing something

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together, you're getting activation of the trunk in a different way, you're getting both those hands to midline, which can help with visual tracking. It's amazing what that stuff can do. That, to me, would be a great way to use music.

Sarah: Have you found that music is more beneficial or successful with some protocols and not with others?

MK: To me, it almost is... does the individual like music, or don't they like music? If there's someone who enjoys music, you can do a lot with it and it can enhance the experience. If they really don't... if it doesn't do much for them. You know, especially in this population. There's either an acknowledgement that music is there, and you can see it. And there's something about the music that changes their level of attention and engagement. And if it doesn't, it doesn't. I tried using different music, like with E, and I haven't really found that there's anything... I haven't been able to pick up on any change using lots of different types of music.

Sarah: I haven't found a preference for him either. I've been struggling to find something that he likes. The only thing I've found that he's responded to, and I don't know if this is really a response you want in PT, but I played a Feng Shui album, kind of an Asian, ambient kind of sound. He fell asleep. Which for him was...

MK: Wonderful!

Sarah: Fantastic!

MK: He can't really regulate downward.

Sarah: Yeah, he's always up, up, up. When I saw him fall asleep, I was very surprised. They

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(the classroom staff) even asked me for a copy of the CD. So that's the only thing I can think of... but I don't really know how that would work for him for PT..

MK: It might be great.

Sarah: I'll get you a copy of the CD, so you can give it a try.

MK: It might bring him down a little bit. The other thing that I wonder about E is... because he likes to be up and around, and he likes that heavy proprioceptive input, I wonder if a very understated, quiet rhythm, drums or a heartbeat, something not in his face, but more as a background would let... (Phone rings)

Sarah: I'm going to pause while you take that phone call. (recording stops and starts again) In the times that you met with a music therapist, following a session where you consulted, collaborated, or cotreated, did you ever have the opportunity to debrief, or was there anything specific that you learned about?

MK: I think, for me, what's happened is that, it's more that they needed some input from me, rather than I was gaining input from them. Except that, for the kids that really responded well to music, I would then incorporate music into my session.

Sarah: You've actually touched on one of the questions I'm going to ask you in a little bit. In fact, why don't we skip to it right now. Do you incorporate music into any sessions in which a music therapist is not involved?

MK: Yes, I do. So P, his balance is definitely challenged. He has some weakness, and he has the leg braces, but really he's at a point where he doesn't need the braces that come up just below

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his knee. Cause his calf muscles have gotten strong enough that when he doesn't have his braces on, he can actually push up onto his toes. So his calf muscles are definitely strong enough to start controlling. But he's very reluctant to do anything that involves balance. So we have what's called a rocker board. It's got a u-shaped bottom, and then it's flat on top. So you stand on it, and you can either make side to side motions to keep it steady, or forward and backward motion to keep it steady. Can't remember when, it was sometime during this last school year, I discovered that he liked Barney. And I had an old Barney cassette tape at home that my kids used to use, and I brought it in. One of the teachers had a player, and I started playing it. His engagement went from about zero to a hundred. He loved listening to the music. I started with, "first this, then Barney", and then I would play Barney while he was practicing some of the stuff, but I found he was so focused on Barney that I couldn't have Barney playing, cause that's all he wanted to do. I noticed he liked to dance, and he also learned some of the hand signals for some of the songs. He'd do "day" and "sun". So he's doing some bilateral movements which help him to balance in a more mature way. If you have your hands out to the side and you're extending your back, that's an immature balance response. If you can get those hands closer to midline, then you're using more of your core muscles, and you get a more mature balance response. So, I had him up on the tilt board, and he likes the mirror, so I had him far enough back so he could see the mirror. I turned on the Barney tape, and he started doing a small shift of his shoulders like he was dancing. So I took my hands off, and he was perfectly balanced on the balance board. And he was looking at himself in the mirror, rocking a little bit, and he crouched down so he could see himself. So that's a highly advanced balance skill, to bend everything, his hips, his knees, and his ankles. And he's just having the time of his life, dancing with his feet on

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the rocker board. And we got to Mr. Sun, and he started doing the signs with both hands. It was unbelievable! So now, we use that for reinforcement. So now he tries more challenging things that he would never have started, because that is the most reinforcing thing. He wants the music, and to dance in front of the mirror.

Sarah: That's so cool!

MK: Unbelievable. So much difference in how he walks, how he gets up and down from the floor, and what he'll do. It's such a strong motivator. And so then, I had another student who was in there, S Well, he loves Barney, too. The other thing we've been doing though is, now he has to hold the tape with one hand, he used to use his thumb to press the button, which is less mature. Now we've gotten to where he uses the index finger of the opposite hand. He wants to just use his...

(space on recording device full. Once this was realized a moment later, a second data card was used to finish recording the remainder of the interview)

Sarah: So you were telling me about how he played the button with his index finger, and then he put it up on the hook above his head. I don't think we got any further than that, right?

MK: I don't think so.

Sarah: Okay, let's see where we've left off... Oh, I asked you if co-treatment altered the interactions between you and your clients.

MK: So, I think it was more that, often times it can be a more positive engagement, because the kid's perception... even for the most part, most kids like coming to PT because they get

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individual attention, and they get to move around. Often times PT is their highest preference. Because OT they still have to be doing some of the sitting and manipulating things that they don't necessarily have to do with me, although I do incorporate a lot of that stuff, because it's good to get those hands together. But, they weren't really thinking about it being a PT session, because it was actually music. So, it was perceived as more fun, less demand. So that if there was a challenging activity, they tended not to notice that it was as much of a challenge. But it was different, because I also had to work within whatever the confines of whatever the structure of the music class was. So, sometimes there were students that I would work with once a week during music for a couple of weeks, but then after that, it became not expansive enough. There wasn't enough movement going on, so then I'd shift back and schedule them back into my sessions. Much of the time that I was in the music session, it was because the music person needed some insight into... "how can I help the movement go better" versus me asking the music teacher, "have you found anything useful?". Then again, the music teacher would often tell me about someone who was really liking the particular unit. She used a lot of puppets, as part of the visual, get the engagement going, and they would sing songs related to whatever the puppets were doing. Then kids would have the opportunity to look under or wherever for the animal, so they could get down on hands and knees, get it, pick it up, and put it into something. I guess it could be a resource that I haven't tapped into, depending on the setting.

Sarah: You kind of already answered this question a little when we were talking before, but the question is: Depending upon whether the music used was preferred by the client or not, did you notice more emotional responses during those sessions?

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MK: Positive or negative?

Sarah: Either.

MK: I remember I started working here, it must have been H. The OT that had just left when I just started said that H. liked to do this one CD. So, I put it on, and she was just not having any of it. She wanted it off. And it turns out, she doesn't like "The Electric Slide" which was the first track, she liked number 3 or number 4. She didn't like the whole CD, she had a preferred song. So that took me a while to figure that out. But, the only thing I can think of is, kids that have favorite songs, I'm thinking of preschool, where they like the same songs, and they want to do it over and over and over again. You know, you sang "Row, Row, Row Your Boat" and they don't want to move on. So then you move on to another one anyway, that's not their preferred song, and you have to deal with the behavior. Versus the kind of kids who love it no matter what, and they're excited no matter what song comes on. So you have to keep that in mind if you're working with somebody. I know S. has a couple of songs that he prefers, and the amazing thing is that verbally I'm starting to understand, he persists in telling me, but I didn't realize at first that he was requesting one of the Barney songs on the tape. I thought he was just doing his typical, making some sounds. I realized "Oh my gosh, I think he's saying 'Row, Row, Row Your Boat'!" (unintelligible imitation of S requesting song) So I said, "Do you want 'Row, Row, Row Your Boat'?" and he said, "(unintelligible imitation of S requesting song)." So I said "Oh, let's find 'Row, Row, Row Your Boat'." Then I realized he was saying "Green Grass". But he said it so fast, "(unintelligible imitation of S requesting song)." He likes that one, he likes the rainbow song. (singing) "Oh, I've got red. It's the color of an apple." And P loves Mr. Sun. There's

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another one that he likes. I'd have to look at the tape. But he (S) verbally requests them.

Sarah: That I did not know. And that's impressive for him.

MK: Very impressive. He's becoming more verbal. It was sort of expanding anyway, and he's expanded with that. You really understand what he's saying. I had to start looking at the list. I was going to get a CD to make it much easier to play, cause I have to... although he's learning patience. Cause you have to wait while I rewind the tape and find it. "S, you're going to have to wait a while. Let's do something else while we're waiting." Oh, "Itsy Bitsy Spider", that's it!

Sarah: For P or for S?

MK: For S. "(unintelligible imitation of S requesting song)."

Sarah: Thank you for that information. I was planning on getting a Barney CD for them, cause I had found out last week that they liked Barney. Getting to my final questions. Getting back to the different types of relationships. In an ideal environment, where time wasn't a factor and funding wasn't a factor... If you had a choice of one of these three types of relationships to work in primarily, which would you choose?

MK: I would choose co-treatment.

Sarah: Is there a reason for that?

MK: Because I had the opportunity to co-treat in the past, and when you collaborate you can think that you understand what the person means, but when you see them in action and you see their area of expertise in action, I pick up on strategies I would never in a million years have thought of. And then I can use it from then on, whenever I work with a kid. So when I can

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really see it occurring during the co-treatment... So I used to frequently work with OT's, and they would be doing a tabletop activity, and I would be facilitating postural adjustments, weight shift, trunk position, all that kind of stuff, for kids that were having challenges. And it's like the perfect time, because the kids would be engaged in a functional activity, and the OT can't have a million hands. So they would be working on facilitating whatever, or even just the activity, making sure they were getting the right items, but I could really help with that weight shift, and sometimes I would work on a ball, sometimes I'd work on a bench, and challenge them a little bit, not too much to get them off of the task. And then I was able to see how they were using items in functional ways, and then I could say, "Well you know, maybe if you, instead of putting it on the table, maybe you could put it on the slant board. You'll engage the trunk a little more, and maybe engage some visual tracking by placing it here or there." Things that you don't necessarily think of when you're in the discrete activity where your goal is to complete this task. And speech I found to be... it was amazing how volume and repetition increased if the speech therapist was in there doing her thing while I was swinging the student, or giving them a little bit of resistance while they were crawling through a tunnel. That increased trunk engagement for those kids who couldn't get that much volume, their volume went up. It was just amazing! O, do you know O?

Sarah: Yeah.

MK: So I worked with O in the preschool, and she had an amazing speech therapist, and we used to cotreat. And the speech therapist could get an amazing amount of verbal stuff out of her during the PT session and at no other time. Because the trunk was engaged, the volume, she was

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moving, and she loves to move, so sitting is not a thing she wants to do. It was just amazing, and I learned so many things from the speech therapist. How to cue, or how long to wait. What was the focus? How could I cue her? All those things that when you see them in action it's so different from when it's not. You need to have a foundation of understanding what that person does, and what their session looks like, and that kind of thing. But generally speaking, once that's been covered, a co-treatment just goes fluidly. When you get two people who are really comfortable with what they do and who they are, and don't worry about what the other person might be thinking, cause that can get in the way of co-treatments. It really goes like... it's just amazing! Especially from my perspective. It gives me the opportunity to work on things that I could not otherwise do. Cause I can't keep them engaged in a physical activity, and have my hands where I might want to, and shift an item to make their balance different. Sometimes I just get a different idea, "Oh, I know what I want to do with them now!" that I never would have thought of. I really feel like co-treatment is wonderful.

Sarah: I agree. That's one of the reasons I was interested in it. It seems like there's such an opportunity here.

MK: My understanding is that the state does not allow co-treatment.

Sarah: Because of reimbursement issues.

MK: Right. It's too bad that there isn't more research in how much more effective treatments are when you allow a certain amount of co-treatment. My individual session becomes much more effective. I mean, that's the whole idea. To have everybody learn what everybody else does. But I think some of the things that have happened, I think there have been some abuses of

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those, and unfortunately it ends up that nobody can do it.

Sarah: Well, I think that's everything that I had for my questions. Thanks so much for your time!

MK: Thank you!

Thesis Interview Number Five: GB – Certified Occupational Therapist

Sarah: Can you please give me an idea of your professional history? The places you've worked, the populations you've worked with?

GB: Before I came to AC, I worked at Dominican College, so I have an academic background. I was a professor. I taught in a weekend program, I taught at a Master's program there. And before that, I worked at St. Francis Hospital, where I started out in the mental health unit. So I've worked in psychiatry for years, adolescent and pediatric mental health, and adult psychiatric. And then, while I was at St. Francis, I moved up professionally, until I ended up being the director of inpatient services for OT and PT. Which was a really big administrative position. Then I had children, so I changed my life around. And then I went and started teaching, and then came to Anderson. And I've been at Anderson for a while. When I first started at Anderson, I was hired as a consultant to see two kids twice a week. That was the Occupational Therapy services. In 1997, they didn't have OT. So all of the department, and all of the people, and all of that is what I created. Which is... scary.

Sarah: Impressive.

GB: Over all those years.

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Sarah: Yeah. So I know that I have consulted with you some for particular clients. You currently treat some of the kids at Anderson, am I correct?

GB: Yep. I have a very small caseload right now. I only have three kids over there. But there's been times when I've covered maternity leaves, and other things, and I've had full caseloads. The bulk of my caseload right now is in the adult services. So I have 30 people on my caseload here in the adult placement at this dayhab.

Sarah: Do you now coordinate OT for all of the dayhab and residential facilities?

GB: I don't have an administrative position, I have an unofficial supervisory position. You know how that happens. So yes. But not really. Not officially.

Sarah: The three clients you mentioned at the Education Center, I know that they get music therapy. Do any of your adult clients receive music therapy?

GB: No.

Sarah: In any of the previous populations you worked with... for instance, St. Francis, I know currently there is music therapy in the mental health unit...

GB: There is?

Sarah: Yeah.

GB: Good!

Sarah: There wasn't when you were there?

GB: No.

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Sarah: Are there any other locations where you've worked where there was a practicing music therapist?

GB: No.

Sarah: So just at AEC. How would you rate your personal knowledge of music therapy? What its goals and objectives are?

GB: I don't think I have a very good... I mean, I was J's supervisor at one point, so I learned from it, what I know is what I learned from him, and from studying the rags, that kind of thing, and helping him with early professional development once he graduated and since he's been in school. So that's all I know. But how I'd rate it... like on a one to ten? I'd say probably about a six.

Sarah: Okay. Better than some.

GB: Really?

Sarah: Yeah. I get asked all the time "what is music therapy?" It's the question I'm asked most often.

GB: Well, I had to do a lot of research, because I was his supervisor. So I had to figure out what the heck I was doing, or what he was supposed to be doing.

Sarah: Do you currently incorporate music into any of your sessions?

GB: Yes. Quite a bit. We will use it for our gross motor activities, like when we do hoops and the parachute. All kinds of gross motor, ball games, that kind of stuff. Using music for that. We also, I will use music as a reinforcement. So if somebody wants to work for music, or work

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for a youtube video, or whatever, that's how I use it. Those are the two primary...

Sarah: That's a great use of it. Have you found that music has been effective?

GB: Yes. Yeah. I mean, we had... last summer, we were covering, there was an empty position. So myself and C, who was my student at the time, were covering a lot of groups. And we came in, we had the same parachute activity, we had a... and we would bring in different music. And we would have guys who would, (classroom number), in different universes, and we'd bring the parachute, we'd use the same music over and over. We picked contemporary music. And we had... it pulled them together, so that I think over the course of the eight or six weeks of the summer program, we were doing the same thing every week, you really watched the cohesion of the group come together. And I think music facilitates that. Because they don't have to be able to talk, they can just move. Everybody's singing and dancing, and it's fun. And it engaged people in a way that, if you're just "yak-yak-yacking" at everybody it doesn't work as well. I think it kind of speeds it up. Speeds up the cohesion of the group.

Sarah: Do you use music for all of your clients, or only some?

GB: Not all of them. There are some... well, you know V?

Sarah: I do.

GB: V loves music, but at the same time, that can push her out of being in the just right place for engagement, and she can go over the top. She can get out of control very quickly. So something like music is something that you have to use in a very structured way with her. Otherwise...

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Sarah: Yeah, she gets very excited.

GB: And then she loses control. And that's not what you want. You want someone to be interested and engaged and aroused, but you don't want them to be too much.

Sarah: I agree completely, and that's one of the things we struggled with the most during my sessions with her, keeping her in that sweet spot. Have you... hold on, I'm going to come back to that question. What kind of role do you think music and rhythm can play in the treatment of clients?

GB: I think that it's a way that you can work with even the lowest functioning people. I know there are friends of mine who did a drum circle, at a Baptist home or somewhere, with the elderly, very demented patients, they did drumming. And I know that the idea of rhythm is something that on a very basic, core level, everybody can kind of relate to. So I think that you can use that to help anybody access what you're trying to pull them out of wherever they are. Bring them back to that human connection. And I do think rhythm is one of those, is one of the strengths. There's always the melody and the tune and all that, but if you have everybody relating to the rhythm, that's the connection.

Sarah: Have you had the opportunity to observe or participate in music sessions with a music therapist?

GB: Yeah, I think early on, with M, when M was at the school. She would have a group after mine, and so there would be some overlap, but I didn't really participate. Or else I was in a classroom, and I just stayed for music. But not formally.

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Sarah: Did you ever get to observe music therapy with a music therapist as being effective for the clients?

GB: No.

Sarah: So, with the three treatment types which we had briefly spoken about, co-treatment where both professionals are active and present, collaboration where both professionals work together on goals and objectives, and consultation where they just discuss possibly techniques, but don't collaborate on goals and objectives, have you had the opportunity to have one of those types of relationships with a music therapist?

GB: Collaboration and consultation. On some of the guys who have had, and this is mostly with J, who've had those individual goals, we would talk about how he tries to incorporate his knowledge of sensory components into the treatment. As part of the treatment team, collaboration, and then a lot of consultation.

Sarah: When you were able to collaborate on treatment goals, were both of you contributing to goal development, or was one person seen as more of the "expert"?

GB: I think, from the perspective that I was seen, I was viewed as the sensory expert, and then J would be the music piece of it. So it would really be from both sides of it, so that I learned the value or the contribution that the music would make, or the rhythm, or choicemaking in terms of what instrument kids were going to choose, things like that. And then there were kids that I could not even believe, like he was actually doing piano with, which was really amazing. So from that perspective he would be the expert, and then from my perspective, I was bringing in the sensory component, and maybe some of the psychosocial, too.

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Sarah: How did you select treatment goals with one another?

GB: I think we both came in with what we were thinking about, and then seeing... like, he would ask questions of me, how could he incorporate sensory components, or what were the sensory components, as he was thinking about treatment, or thinking about goals, what were the sensory components, and how did he need to understand that in relationship to the child. And then for me, it would be how could I use the power of the music to get to my goals.

Sarah: Did you use similar treatments or interventions with those clients that you shared?

GB: No.

Sarah: In an ideal environment, where time and funding was not a factor, which of those treatment relationships would you prefer to have with a music therapist?

GB: Definitely the co-treatment. Yeah. Altogether. I mean, cause that's where you really see each person in their element. Everybody has their own strengths and weaknesses, and in the reality of that moment is where you're going. You can talk and talk and talk, but in that moment is where you see the light bulb, or the "aha", or whatever it is, and I think that only comes with co-treatment. Unfortunately we see so little of it. One of the things that's happening over here in the adult world is that our funding source is totally switching over. We used to have an enhanced rate, to the Medicaid reimbursement which paid for speech and OT. So that went away, so now we are in the process of, we just opened an article 16 clinic, so we're re-evaluating. And the goal is to try to, I know it's not for music, but the goal is to try to re-create what we were doing in speech and OT, just with a different funding source, and I don't know if it can happen. But one of the things that had happened, as an example, is R was out on maternity leave, she was gone,

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and the absence of her with me in a group made a significant difference in the treatment. One of the things that we're seeing right now, we're in this time frame where we have to reevaluate everybody, and we have to write a new treatment plan, and the treatment plan needs to be approved by our new medical director. So the guys aren't getting treatment. We're seeing them for evaluations, but not for treatment. And what we're seeing is they're starting to just... not fall apart, but you can see the really subtle ways in which they depend upon the therapeutic relationships. So they'll be, out... like the whole thing that happened when you were coming in this morning (reference to an interaction with several clients, several of whom required prompting for appropriate social greeting behaviors), all that "HELLO!", you know, all of that is all about needing attention, needing connection, needing... and they're not getting it to the extent that they had been. And there are some days when they're standing at the door, lined up with some ridiculous question that has nothing to do with anything, other than the fact that, unless you can see it for what it is, they miss the connection, and they miss whatever it is we were doing. And I don't think that it's so much about speech and OT, I think it has so much more to do with the psychosocial component, and feeling competent and loved and accepted, and all of those things, which I don't know how you'd ever quantify that. And there's things like that... we're finagling the system so that the outside looks different, but we're trying to make it similar, and I don't know how that's going to work. So, as an example, before speech and OT, we would co-treat, and they would have two groups a week. But now, they get one speech group and one OT group a week. And they'll just bill separately, so hopefully the experience for them will be the same, and we'll just bill it differently. I don't know. I'm still not really clear that it's all going to be okay. Financially they say it's going to work, but...

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Sarah: Yeah, it could have unforeseen impact on the clients, and how they are able to make those connections.

GB: And as an example, when we see them, now when we see them in the article 16, now even though they're physically in this building, we have to sign them out from programming, so they're being removed from programming, and then sign them back in, even though we're still here in this building. It's bizarre. And, if they have another given appointment on a given day, say somebody needs to go the dentist, we can't see them on that day. Because you can't double bill. Actually, you can double bill, but Medicaid will only reimburse one and a half. If somebody has a medical appointment, that takes them out of therapy for the day. It's going to be a very interesting transition, and I think people anticipated that it was going to be a very simple kind of thing. I'm gonna get a drink. I don't feel very confident about it. (pause) and it's where you, it's the idea of a milieu. And when the milieu is intact, how everything flows. And when you pull a piece out of the milieu, even if it's like R on maternity leave, or whatever, or now this, things are starting to break down. You don't know what the impact is, in terms of the quality of what these guys are learning. But the power, we could run all the social skills groups in the world, we could run lots of them, but in that moment, in the context of that greeting, and the entry, that's the teachable moment right there, in the real world.

Sarah: With someone they don't usually get to interact with.

GB: Exactly! We could do role playing, we could pretend, but unless I'm there to facilitate that therapeutic interaction in that moment, that's where it has meaning. Otherwise, it doesn't. so then, how do these guys take what we're teaching them, and unless we're there with them, to

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apply it in different situations.

Sarah: They're not able to generalize the skill by themselves.

GB: No, so, I don't know what the answer is going to be. We'll have to see. (pause) so we were talking about co-treatment, and how I think that co-treatment is ideal. It's absolutely essential, but I don't know the reality of it as we move forward. The question is the reimbursement. So the way around that in the adult services, while they will be getting two services a week, one of the sessions will be billed as speech, and the other as OT.

Sarah: In those sessions, are both clinicians present?

GB: They will be. So for six people in the group, three of them will be getting speech, and three of them will be getting OT, then the second time, they swap. Meanwhile, they're getting the same thing.

Sarah: Well, it's good that the programming doesn't have to change significantly. Do you feel that the type of relationship between the therapists affects the overall satisfaction of both professionals?

GB: Yes. Absolutely. Because, while you would think, in an ideal world, that everybody would just get along, there also has to be a shared philosophy about what they are trying to accomplish, what the goals are. A shared comfort level with, you know, I may not always agree with R's way to deliver instruction, but at the same time, she's my partner, I need to support her. And you have to have the respect for each other's position, and if you don't have respect for each other's position, I think that that can get really, you know, it can end up getting really

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competitive, and you don't really collaborate on things. One person's got to be right, or whatever. I think there has to be that connection between the therapists, so that it can be therapeutic, otherwise, guys get caught in the middle. I mean, if everybody had to be the boss at a given moment, it causes problems. You have to have trust, and you have to have respect, and you have to be able to go back, not in the moment but later, and you have to be able to say "How do we think that went? What could we do differently?"

Sarah: Did you ever have the opportunity to have that type of conversation after either observing or collaborating in treatment with a music therapist?

GB: No.

Sarah: Can you give me a few specific examples where you saw that music was therapeutic for an individual client? Where you saw a big difference between the non-music and the music contingency?

GB: Last summer, or the spring, I was covering H's maternity leave, and I was seeing P (same client from interview 4 with KM). now P's got a lot of issues. He's got a lot of stuff going on. And in a lot of ways he's a very lower functioning guy. He loves Bob the Builder. So there were some things physically that we needed to do, I needed to get his AFO's off, I put him on a therapy ball doing some dynamic sitting, but I placed him at a desk, and I had choices for what videos he wanted to watch. So, he was sitting on the ball without his AFO's, his feet are on the floor, he's positioned, he's got nice dynamic sitting balance, and he had to reach to point to which video he wanted, which Bob the Builder one he wanted to watch, and point to the screen. So he was doing dynamic movement, but he was engaged because it was a very reinforcing

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activity for him. So it wasn't like I had to handle him. As long as I had the positioning and the environment set up in the right way, he was doing it himself. And he was motivated and engaged. I mean, I think those were very good sessions for him. And I see him in the hallway and he looks at me. I wonder if he even remembers me as that person who did that. I think that he does, but I don't know.

Sarah: I think that he would, based on what I've seen this summer with him.

GB: I got into a lot of trouble, because I wasn't supposed to be giving him Bob the Builder videos.

Sarah: What?!

GB: That was a weird thing from the staff in his classroom. What I was doing, my activities were too reinforcing for P, that somehow he has to suffer in some way. Isn't that weird?

Sarah: That just rubs me wrong.

GB: Isn't that terrible? I mean, he's a little kid with terrible things, he's got... make him happy in the world!

Sarah: That just irks me.

GB: I think he looks at me, and he's like "save me lady!" Why does it have to be so hard? So punitive?

Sarah: Why can't he have what makes him happy? That doesn't make any sense at all.

GB: So then we started out the first couple of sessions were all about that, and then I started to

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incorporate more work, more demands, and then he got to make his choices.

Sarah: After the classroom said you weren't allowed to use it anymore, did you notice any changes?

GB: Oh, I didn't stop!

Sarah: Good!

GB: No, it was working, it was totally working. And I was very comfortable with how I was presenting it, the work that I was presenting. He was making progress. I liked what I was seeing, and they were wrong. They're not telling me what to do.

Sarah: Do you have any other specific examples you can think of?

GB: No. Other than that cohesiveness of the group over the course of last summer.

Sarah: I would love to see that.

GB: You know that classroom, C's room. They had N, I don't know if you were there when he was there.

Sarah: Yeah, I know N.

GB: And they were all scattered. They would be physically in separate parts of the room, to get them to all just even come and relate to each other in any way. Of course, we acted like idiots and dancing, but it was fun. And even the staff got into it, which is no small feat.

Sarah: No, it isn't! Not with that room.

GB: Right. So then, you're also showing, you're engaging the staff, and showing that these

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guys can be engaged. That this can work.

Sarah: It sounds like it was all extremely positive, what happened in those sessions. Which is wonderful!

GB: It was a lot of fun. We had a lot of fun. Even with N.

Sarah: Yeah, I had a hard time with him. But most of the sessions when I had him, I had him when I was doing my internship, and they would not even bring him. It just seemed like... you know, at least give him a chance to try... if you have to remove him, you have to remove him. But at least give him the chance to try. Cause he actually...

GB: There was a lot inside of him. There was a lot inside of N. Is. He's not dead, but, he's somewhere.

Sarah: Are there any questions that you wish I had asked today? Or anything you feel I might have overlooked?

GB: No.

Sarah: Okay, then let me check my list of questions. (pause) I think I got all the questions that relate to you. Thank you so much!

GB: You're welcome!