The Use of the Music Therapist’s Principal Instrument in Clinical Practice

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The Use of the Music Therapist’s Principal Instrument in Clinical Practice

by Angela Voyajolu

A Master’s Thesis Submitted to the Faculty of Montclair State University

In Partial Fulfillment of the Requirements

For the Degree of

Master of Arts, Music Therapy

May 2009
Abstract

The purpose of this study is to determine the use of the music therapist’s primary instrument in clinical practice. Specifically, the interest lies in whether there is a relationship between the type of primary instrument reported and the degree to which it is used with clients. In the current study two-hundred and twenty-two therapists completed a survey concerning the use of their principal instrument in clinical practice. The use of the principal instrument was limited to the timeframe of one year so as to obtain results on current practices. Results suggest that many music therapists do use their principal instrument in clinical practice, although some instruments, such as the voice and guitar, may be used more often than others. It was also found that each instrument may contribute something unique to a session. Furthermore, results suggest the use of the principal instrument in clinical practice may be dependent on the setting one works in, the population one works with and the needs of the client. Implications are made for clinical practice as well as for training and education.
THE USE OF THE MUSIC THERAPIST'S PRINCIPAL INSTRUMENT
IN CLINICAL PRACTICE

A THESIS

Submitted in partial fulfillment of the requirements
for the degree of Master’s in Music Therapy

By
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Introduction

Many music therapists enter the profession with a background of study on a principal instrument which may include woodwind instruments, brass, string, and percussion as well as keyboard, guitar and voice. The American Music Therapy Association (AMTA) (2008) lists the skill of the music therapist's major performance medium as an essential component of the entry level competencies and studies have shown that music therapists have built upon the unique qualities of their primary instrument in clinical work (Alvin, 1976; Austin, 2003; Gonzalez & Salas, 1996; Kim, 1994; Priestley, 1975; Soshensky, 2005; Uhlig, 2006). Although literature exists that depicts how the major performance medium is used clinically, it is scarce. Furthermore, the main objective of these studies has not focused on how music therapists use their principal instrument with the clients they are working with. Rather, information on how the major performance medium is implemented clinically is derived through descriptive case studies and/or through a historical background given about the music therapist. This leads one to wonder if and how more music therapists use the competency of the major performance medium (principal instrument) in clinical practice.

The following literature review first covers the competency standards of the principal instrument according to the American Music Therapy Association (2008). The focus on this competency within the current study allows one to have a picture of how the use of the principal instrument is applicable to clinical practice as well as to the education of the music therapist. The literature review also looks at previous studies that have touched upon the applicability of the principal instrument in music therapy education. Furthermore, descriptive examples of how different principal instruments have been used in clinical practice are reviewed. This includes the use of string, brass and woodwind instruments, voice, piano, and guitar. An overall appreciation of the potential in using one's principal instrument in clinical practice is elicited.
The current study proposes to determine how music therapists are presently using their principal instrument in clinical practice. Interest in this topic came about because of the connection to my own principal instrument and new discoveries of how it could be used to a fuller extent clinically. In order to gather information on how music therapists are using their principal instrument in clinical practice a survey was created and sent to practicing music therapists in the United States. Through the use of this survey the following questions will be answered: 1) What do music therapists report as their principal instrument? 2) How often do music therapists use their principal instrument in clinical practice? 3) What interventions do music therapists employ when using their principal instrument? 5) What are the reasons given for using or not using the principal instrument in clinical practice? This study also proposes to understand if the type of principal instrument is related to its degree of use in clinical practice.

Literature Review

*AMTA Competencies: musical foundations and the major performance medium*

The American Music Therapy Association (2006) has set criteria for the entry level competencies of the music therapist, which includes musical foundations. Within this competency are the major performance medium skills as well as music history and theory, composition and arranging skills, keyboard skills, guitar skills, voice skills, non-symphonic instrument skills, and improvisation skills.

In detail the requirements for major performance medium, piano, guitar, voice and non-symphonic instrument skills are:
Major Performance Medium Skills: 3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice; 3.2 Perform in small and large ensembles.

Keyboard Skills: 4.1 Accompany self and ensembles proficiently. 4.2 Play basic chord progressions (I-IV-V-I) in several keys. 4.3 Sight-read simple compositions and song accompaniments. 4.4 Play a basic repertoire of traditional, folk, and popular songs with or without printed music. 4.5 Harmonize and transpose simple compositions.

Guitar Skills: 5.1 Accompany self and ensembles proficiently. 5.2 Employ simple strumming and finger picking techniques. 5.3 Tune guitar using standard and other tunings.

Voice Skills: 6.1 Lead group singing by voice. 6.2 Communicate vocally with adequate volume (loudness). 6.3 Sing a basic repertoire of traditional, folk, and popular songs in tune with a pleasing quality.

Non-symphonic Instrumental Skills: 7.1 Play percussion instruments alone or in ensemble. 7.2 Demonstrate basic knowledge of care and maintenance of non-symphonic and ethnic instruments. 7.3 Play autoharp or omnichord with same competence specified for guitar. 7.4 Demonstrate basic understanding of technologically advanced instruments (omnichord, MIDI, electronic keyboard). 7.5 Demonstrate basic skills (i.e. rudiments) on several standard percussion instruments sufficient to facilitate rhythm-based experiences for groups and individuals. (American Music Therapy Association, 2008, p. 29)
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Applicability of applied performance medium in music therapy. Research concerning the applicability of the applied performance medium in music therapy is scarce. However, Cohen, Hadsell and Williams (1997) conducted a study that focused on the “attitudes of music therapy clinicians and students towards the importance and applicability of their applied instrument requirements” (p. 67). The researchers found that the most frequently studied primary instrument of music therapy students at the time was voice while music therapy clinicians reported a ranking of keyboard, followed by voice, woodwind, strings, brass and percussion. Both music therapists and students felt that there was an “overall clinical importance of applied performance to success as a music therapist” (p. 71). However, Cohen et al. (1997) warn that this was not ranked against the importance of other competencies. The writers suggest that music therapists may be using secondary skills gained from study on their instrument in clinical practice such as “leadership, non-verbal interaction, musicianship and confidence “(p. 71). Cohen et al (1997) also commented that the type of applied instrument studied may influence the degree of applicability to a clinical setting. They state “it is possible that keyboard majors would transfer more of what they learned in lessons to a clinical setting than string majors would. However, this particular information is not provided in this study’s data” (p. 71).

The applicability of ones applied performance medium to music therapy clinical work was also touched upon by Braswell, Maranto and Decuir (1979a, 1979b). As part of a survey concerning clinical practice in music therapy the researchers included a section on university training, clinical training, and music therapy courses. Respondents ranked major instrument and performance among course requirements they felt should be lowered or removed from training. Respondents also felt that piano as a minor was among the requirements that should be raised in music therapy training. In terms of what instruments were reported as primary instruments by music therapists, piano was reported the most, followed by woodwinds, voice, double major, brass, strings, percussion and guitar. The instruments reported to be used most frequently in
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Clinical practice by music therapists were ranked from highest to lowest as guitar, followed by piano, autoharp, rhythm instruments, drums and voice; other various instruments were also included and ranked. In this study the primary instrument reported and the instrument most frequently used in practice do not correspond. Although the guitar is listed as the primary instrument studied by the least number of respondents it is listed as the instrument most often used in practice, followed by piano. Furthermore, although woodwinds were listed as the second primary instrument studied, woodwinds are not even listed among the instruments used in practice. This kind of inconsistency between the primary instrument and instruments used in practice can also be seen in a later study.

Byung-Cheul Choi (2008) conducted a study that provided information on music therapists’ major performing instrument in clinical practice. The information gathered was part of a survey which focused on music therapists’ awareness of theoretical approach in their work. She found that of 269 responses (500 surveys were sent) voice was reported as the major performing instrument of the majority of music therapists (32%). This was followed by piano (30%), guitar (14%), woodwinds (11%), string (6%), brass (5%), and other (2%) (p. 99). The instruments that were most used in clinical practice by these music therapists were guitar (55%), piano (21%), rhythm (16%) and other (8%). Although voice is the instrument that is reported to be the primary instrument of the majority of music therapists who responded to the survey, it is not listed as being used in practice. It is not clear from this study why this is so. Furthermore, guitar surpasses the use of the piano in practical work, even though piano was ranked as the second primary instrument studied after voice and only 14% of respondents listed the guitar as their primary instrument. Although this study is not geared toward the use of the applied instrument in clinical practice it does provide some information on the differences that are reported to exist between what one’s primary instrument is and what instrument is most frequently used in clinical practice.
Besides literature which reports the major performance medium competency in terms of applicability or ranking, descriptive studies can provide insight into how music therapists have used their major performance medium in clinical work. These studies show how one may build upon the unique qualities of a particular instrument in order to connect with a client. The following examples illustrate the use of string instruments, brass and woodwind, voice, piano, and guitar in music therapy.

Violin. The use of the violin in music therapy work can be seen in Gonzalez & Salas’s (1991) case study of four year old Gabriela, the piano and guitar are also used throughout. Gabriela is described as developmentally delayed, at a twelve to eighteen month year old level with “little spontaneous or purposeful speech” (p. 19). She is also severely blind and has formal diagnoses of osteoporosis and bilateral optic atrophy. Gonzalez & Salas, (1991) worked with Gabriela once a week in half hour sessions; this case study spans a four month time period. Within this study various instruments were used including guitar, voice, drum, cymbal, piano and violin. The two main instruments emphasized descriptively that were used by the music therapists were piano and violin. They explain, “David generally supplied the musical elements of rhythm, increased tempo and volume and vertical harmonies….Jo’s music (violin) was characteristically fluid, effecting changes through incremental modifications. She contributed linear rather then chordal harmonies” (p.26). In the descriptive summaries of Gabriela’s music therapy sessions it seems that the violin added an element of sound which encouraged vocalization and singing. Familiar children’s songs as well as improvisation were incorporated into the sessions. Gabriela is described as flourishing in the space that was created by the music, expressing herself and communicating musically. From this study it cannot be determined if the particular qualities of each instrument resulted in specific outcomes for Gabriela and one cannot know if the
outcomes would have been different had other instruments been used. However, the study illustrates that the music created had a positive effect and the individual instruments used added unique elements to the work. In particular Gonzalez & Salas, (1991) comment on the significance of the violin, stating, “We realized after these sessions were over that Gabriela, blind as she was, would not have been able to picture Jo playing the violin. To her this instrument was another animated presence in the room, to which she related with a particular affinity” (p. 26). In this example, the music therapist and her violin in particular seemed to communicate with the client.

Mary Priestley (1975, 1976), an accomplished violinist, used this instrument throughout her clinical work. She illustrates her use of the violin with an adult male psychiatric patient in his forties in the format of “therapeutic music teaching” (Priestley, 1975, p. 104). The patient is described as being in his forties, as having had minor brain surgery and was anxious and depressed. He also had experience playing the violin and loved music. Priestley (1975) explains that by combining verbal intervention, music and understanding she made the client’s “toleration, experience and expression of his feelings the main aim of work” (p. 104). She was able to effectively work with this patient so that he could transfer what he was learning on his instrument and about himself to life outside of therapy. For example, Priestley writes “In life, he became more adventurous, bought colored shirts, went out and played his violin to little gatherings, and his work prospered. He no longer felt the impossible gulf between music and work, feelings and duty” (Priestley, 1975, p. 105). In this case the patient’s previous experience on the violin may have made him well suited to working with a music therapist who shared knowledge of this instrument and worked within a music lesson format.

Priestley (1975) also writes about playing the violin for and with clients. In one example she describes a “rough impression of a typical session” on a locked male psychiatric ward. The session is run by two music therapists, Priestley (using the violin) and Mr. O (using the piano); percussion instruments are brought for the patients to play as well. The session starts as Mr. O...
plays a Schubert *Impromptu* on the piano while patients sit in a circle. Priestly explains, “It is expedient to start with some really good music in order to change the atmosphere of the ward and set the key for the session” (p. 70). This moves into a march played on the piano as Priestly passes out instruments to the patients who join in rhythmically, Priestly begins to play the violin along with the group and the music transitions into a collective improvisation based on a story/theme. Again, the patients are on percussive instruments while Priestley adds elements with her violin and Mr. O remains on the piano. Following this improvisation, Sibelius’s *Valse Triste* and Roussel’s *Aria* are played on piano and violin for the patients. The therapists and patients discuss what the story behind the music may have been. Furthermore, the solos by the music therapists provide an opportunity for the patients to express themselves musically through instrumental solos and singing. It is evident from the description of this session that both Priestley (1975) and “Mr. O” used their capabilities and musicianship on the piano and violin to effectively communicate and work with their clients, creating music for and with them.

*Celllo.* The use of the cello, as a primary instrument, in music therapy can be seen in studies by Juliette Alvin. Alvin (1976) was a concert cellist and used this instrument in her clinical work. She writes of providing music therapy in the context of a music lesson in the example of George, a ten year old boy who had an affinity for the cello after hearing it played in Swan Lake. George is described as being unhappy, with above average intelligence; is nervous, unstable, inattentive, and experiencing trouble in school. Alvin (1976) admits her reservations on using the cello because of its difficulty but George’s eagerness and willingness to learn were persuasive. Although learning the instrument was an aspect of each session, Alvin (1976) explains that for George the cello became a “means of rehabilitation” (p. 8). Cello lessons were used as an “occasion to make him evaluate himself and face his shortcomings…this relationship helped him to become stronger, more stable, to lose his indifference, and to regain his self-respect. At the same time the cello became to him a great source of emotional satisfaction and his
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love of music increased” (p. 8). George was able to take his progress outside of sessions and join the school orchestra, increasing his socialization and easing his transition from primary to secondary school.

Alvin (1976) also describes using the cello in music therapy for special needs children with an emphasis on listening. In these sessions the children responded to the sound of the instrument and the images that the music inspired. Alvin (1976) stresses the use of live performance and describes sessions in which she used the cello for developing “auditory, visual, and tactile perception” (p. 82). She explains that the therapist should provide music that the children can relate to and incorporate his/her imagination into when listening. Alvin’s (1976) sessions lasted fifteen minutes to a half an hour. The children listened to the cello, were given a presentation on the instrument and were able to try the instrument and handle objects related to it such as the bow or the resin, in order to increase their tactile experience. She explains how even the opening of the cello case became a ritual and a moment of excitement for the children. Effects of the instrument such as “tone, intensity, rhythm and speed” were manipulated for the children to distinguish and hear, sometimes in the form of guessing games. Alvin (1976) also explains how she related movement to the music, “Notes that can run, march, hop, bounce, skip, stop or start are produced by a visible bow movement corresponding to the effect”. (p. 86) Body movement to the music of the cello was sometimes incorporated, as well as singing. In these sessions the children were reported to improve in expressive communication through words and through the mediums of drawing, painting and movement. Within her descriptive writing one can see how Alvin (1976) used her primary instrument in clinical work. Photographs of Alvin, which depict her work with clients, are also valuable sources which show her use of the cello in practice.

Woodwinds and Brass. Woodwind and brass instruments have been shown to be effective instruments when used with children. An example concerning the use of the clarinet as one’s primary instrument in clinical practice can be seen in the video Music therapy for children
on the autistic spectrum (Anglia Polytechnic University, 1999). Music therapist Amelia Oldfield effectively uses the clarinet, among other instruments such as the piano, guitar, non-symphonic percussion instruments and voice. In her work with Matthew, a three year old boy on the autistic spectrum, she alternates playing phrases on the clarinet and singing, both of which Matthew responds to vocally. Later, Oldfield (1999) is seen using the clarinet in a children’s music therapy group. The children, seated in a circle, respond to the music of the clarinet by clapping rhythmically and take turns answering its sounds with reed horns. Oldfield’s use of the clarinet with clients appears natural and the children can be seen to readily respond.

Others have written about the benefits that wind and brass instruments may have. Although not written by music therapists the studies show how these instruments may be used by one whose principal instrument falls into this category. Rosene (1976) in his dissertation, conducted case studies on the instruction of wind instruments for children with special needs in primary school. Thirteen children, chronologically aged nine years and eleven months to twelve years, took part in the study, each learning a preferred instrument, which included flute, cornet, trumpet and trombone. The students were given weekly half hour individual instruction and group instruction for one full semester. The focus of the study was on the improvement of music skills, which included tone quality, intonation, technical facility, rhythmic accuracy, note-naming, sight reading, and general musicianship. Six of the thirteen students, after participating in the study, were accepted into the regular instrumental music program. Although the study focuses on music skills Rosene (1976) cites non-musical benefits that arose from the training, significant for goals and objectives that would be interesting to music therapists. For example, students in the study showed improvement in group cooperation and interaction, length of attention span, levels of self-control, peer interaction, socio-emotional maturity and self-awareness. This study shows that woodwind and/or brass instruments may have the potential to be effective when working with special needs children and illustrates how one may use these instruments in clinical practice.
Studies have also been carried out which look at the effect that playing woodwind and brass instruments may have on children with asthma. Lucia (1993) suggests that “playing a wind instrument has the potential of being a long-term therapeutic agent for asthmatics” (p. ii). His study compared teenage wind instrumentalists with teenage non-instrumentalists and looked at the effects of playing a wind instrument on asthmatic physical and emotional symptoms, specifically bronchoconstrictive symptoms, panic-fear response, and changes of mood and fatigue. A month long diary was kept by eight wind instrumentalists and ten non-instrumentalists who reported symptoms. His results found that although there were no differences in bronchoconstrictive symptoms or fatigue the panic-fear response and irritability (mood changes) were much higher in the non-instrumentalist group. Lucia (1993) also states that “A retrospective General Health Profile indicates that the wind instrumentalists have a significantly better health picture, with fewer asthma flare-ups, and fewer hospital visits than non-wind instrumentalists. Wind instrumentalists also perceived themselves better able to cope with the disease than non-wind players” (i).

The benefits of woodwind and brass instruments on asthmatic children was the focus of a four year project in England called Bronchial Boogie. This organization, made up of health and music services, consisted of music lessons as well as breathing exercises and respiratory health education for children from seven to eleven years of age. Andrew, Daniel and Pye (2007) in a 2006 report give statistics that were based on diaries written by forty five children and thirty seven questionnaires that were completed. The report found that when the children started the program 51% were compliant with medication, after the program 98% were compliant. Furthermore, 60% of children at the start had good inhaler technique, which improved to 98% at the end of the program. At the end of the first year all the children were reported to have obtained better self-management skills. The use of brass and woodwind instruments in helping children with asthma is an interesting topic which seems to have had little research in the music therapy
arena but may be a valuable area for study, perhaps especially by those whose primary instrument lies within the woodwind and brass family.

*Examples of applied instrumental use in clinical practice - voice, piano, and guitar*

The voice, guitar and piano are instruments that are listed separately under the musical foundation competencies by the AMTA, competencies which are mainly concerned with accompaniment skills by the music therapist (American Music Therapy Association, 2006). However, for those music therapists who come into the profession with a background of applied study on these instruments their knowledge and talents may also contribute something unique.

*Voice.* Some music therapists have written about how the voice, as a primary instrument, has influenced their work with clients. Diane Austin (2003) describes her development toward becoming a music therapist and the impact that her own singing and teaching of voice, among other influences such as her background in drama and personal experience with psychotherapy, had on her work. She writes about her use of the therapeutic music lesson and the natural transition she felt this had into music psychotherapy. In her dissertation *When words sing and music speaks* Austin (2003) reviews three improvisational vocal techniques she has developed in her practice of vocal psychotherapy. These are vocal holding, free associative singing, and psycho-dramatic singing. Vocal holding uses a simple accompaniment in order to help ground the client’s singing. Alternation between two chords is emphasized as is the use of the therapist’s voice. In free associative singing the therapist continues to use elements of vocal holding, such as playing repetitive chords, singing in unison, harmonizing and grounding. However, the client now sings words or phrases that are mirrored by the therapist. The client sings in a “musical stream of consciousness” (Austin, 2003, p. 220) with the idea that he or she will connect to unconscious thoughts and feelings. Psycho-dramatic singing maintains aspects of free associative singing and includes elements of the “double”, found in psychodrama (Austin, 2003, p. 223), which is said to
represent the client’s inner voice. Austin’s (2003) techniques are based on improvisation and involve singing by the music therapist and the client, as well as verbal intervention. Her studies show that the voice is an important element in her work.

Other music therapists have incorporated the voice, drawing on the specific characteristics that this instrument may contribute. Sylka Uhlig (2006) writes about the diversity of singing techniques throughout the world and the power of the voice as the main medium in a therapeutic context. She explains:

The voice as the therapeuticum is an instrument for self-healing, also vibrating and connecting body and mind. Influencing blood pressure, heartbeat and the formation reticularis, a network of the brain activating the limbic system, the voice can regulate emotions and primitive drives and instincts. Freeing up the energy through the voice can also create—beside emotional, social and spiritual effects—chemical, physical and neurological changes (p. 184).

Kate Richards Geller (N.D.) also focuses on the use of the voice as a main instrument in therapy, holding workshops on this topic such as one based on the use of chanting and lullaby. Cohen (1993, 1994, 1995) has written about the applicability of the voice in helping patients regain speech, for example for those with neurological disorders. She describes aspects of singing that are beneficial to clients such as breathing technique, expanding vocal range, vocal projection and diction. These music therapists focus on the specific use of the voice as a therapeutic tool in clinical practice and demonstrate the different ways in which one may use this instrument, specifically if it is their principal mode of study.

Piano. A prime example of one whose primary instrument of piano has been used in music therapy is reflected in the work of Paul Nordoff. Known as the Nordoff-Robbins technique, centered on concepts of music as accessible for all and built upon the use of improvisation, the purpose here is not to review the theories of Nordoff-Robbins work but to briefly look at how
Paul Nordoff developed his music therapy work with a strong basis in his own musical background of composition and piano. Kim (1994) provides some insight into the musical life of Paul Nordoff before his introduction to using music with special needs children. Nordoff began musical studies at the age of eight, majored in piano at the Philadelphia Conservatory of Music, and received a Bachelors and Masters in music. He further studied piano and composition at the Julliard School of Music and went on to become an Assistant Professor of music, composing various works including pieces for orchestra, opera, and song.

During a trip to Europe, Nordoff visited Sunfield Children’s Home in London, where music played a large part in the education of children with special needs. This is also where he met Clive Robbins, who would form a team with Nordoff, and both would pioneer the theories and techniques that continue to play a role in music therapy practice. Nordoff also visited an institution in Germany where he was impacted by his observation of a musician working with a young girl who had difficulty with speech but was able to improve through music. He went on to become a major figure in music therapy and used his musical background in piano, improvising, and composition to work with children. Kim (1994) writes,

Nordoff’s intuitive yet well-developed clinical musicianship resulted from his former music training and experiences. As an experienced composer and gifted pianist, Nordoff was able to offer new resources and techniques to meet the special needs of a wide range of disabled children. Most of his music was of a high artistic and aesthetic level (p. 330).

Nordoff’s musicality and effectiveness with clients can be heard in various recorded and documented sessions (Nordoff, P. & Robbins, C., 2007). It is clear that one who takes on the Nordoff-Robbins training and techniques must go beyond the basic piano competencies listed by the AMTA and would more likely be at the level of the major performance medium. This is only
one example of how one’s background and advanced piano skills had can be used and built upon when working with clients.

_Guitar._ Basic guitar skills are required in music therapy training, just as they are on voice and piano. As the previous examples have shown, one whose skills go beyond the minimum requirements are important in understanding how these instruments may be used to a fuller extent. Soshensky (2005) writes about how he adapted his principal instrument of the guitar and a background in rock, folk and blues within the Nordoff-Robbins approach. He explains that the guitar has both distinctive and versatile characteristics such as timbre, strumming, finger picking, single-string, percussive playing, and effects such as “vibrato, rapid picking tremolo effects, bending of notes, the use of harmonics, and altering tone quality by the style of picking” (p. 111) The instrument also allows the therapist to move freely and be in close proximity to the client while playing. Soshensky (2005) demonstrates how he used the guitar and his expertise with the instrument while working with Thomas, a two and a half year old boy diagnosed with pervasive developmental disorder, for a period of two years. He worked to help Thomas in areas such as motor planning, socialization, expressive verbal and non-verbal communication and in decreasing anxiety. Techniques such as improvisation, adapting songs from the piano to the guitar, using variety of styles such as funk and a Spanish idiom, and using both harmony and melody were effective. Soshensky (2005) used the talents he gained from previous study on his primary instrument and applied this to his music therapy clinical work. He wrote:

As only the third person to focus on guitar as my primary instrument during the certification training program at the New York Nordoff-Robbins Center, I felt as if I needed to integrate 40-plus years of Nordoff-Robbins history with my identity as a musician. Piano was firmly established as the definitive instrument of Nordoff-Robbins music therapy while I was a guitarist/singer with stylistic roots primarily in rock, folk, and blues. The extraordinary command (both technically and clinically) in Paul Nordoff's
classically influenced piano approach seemed to establish a legacy so formidable as to appear practically impossible for a primary therapist to play another instrument and still call it Nordoff-Robbins music therapy. (p. 111)

However, Soshensky (2005) in his writing illustrates that he was able to adapt the use of his principal instrument to this approach successfully. Although he describes this as a challenge, his work demonstrates to others that the unique aspects of the guitar, and one’s advanced skills on this instrument, are effective and extremely applicable to music therapy practice.

*The Applicability of one’s primary instrument in clinical practice*

One might speculate, as Cohen et al. (1997), whether certain instruments, such as the guitar and piano, lend themselves especially well to music therapy work. Priestley herself stated “Almost all music therapists play the piano and at least one other instrument. What instrument should a piano student, contemplating taking up music therapy, learn as his second study? I think that if I were not a violinist and in love with its repertoire and superb and challenging sensitivity, then I would learn to sing and play the guitar or flute” (p. 50). However she goes on to say “But each instrument has its advantages and disadvantages and the instrument to which a player is drawn is usually the one on which he expresses himself best” (p. 50). The previous examples of those music therapists who chose to use their principal instrument in clinical practice did so successfully. Perhaps it is not that a particular instrument is unsuited for music therapy clinical practice but that its use is situation and client specific.

There may also be instances of music therapists who have not used their primary instrument in clinical practice. One such example can be seen in Igari’s (2004) experience of separating his primary instrument from his clinical work. He writes that although the bass guitar was a large part of his life musically it “was rarely played during college and music therapy
practice years” (p. 4). He further explains that “I do play the piano and guitar to provide the accompaniment, but never practiced as hard as I did with the bass guitar. The bass guitar is probably the instrument that makes it possible for me to get in touch with my musicality. It also is the instrument that I am able to play freely enough to provide the strong musical experience with others” (p. 4). This raises the question of whether there are other music therapists who, although they are extremely competent on their applied instrument, do not use their skills in music therapy clinical practice.

In summary, music therapists in the United States are encouraged in training to be skilled musicians on a primary instrument as listed in the professional competencies. The literature review shows that some music therapists believe applied instrumental study is important to their work in the field (Cohen et al., 1997) and descriptive studies have given insight into how some music therapists have used their primary instrument in clinical work. However, the use of the primary instrument has not been the main concentration of these studies. Therefore, the study I propose will focus on the music therapist’s use of the primary instrument in clinical practice in order to gain a deeper understanding of how these skills are transferred into work with clients. This will be done through the use of a survey.

Purpose

The purpose of this study is to determine the use of the music therapist’s primary instrument in clinical practice. Specifically, I am interested to see if results will show a relationship between the type of primary instrument reported and the degree to which it is used with clients. The following questions will be answered: 1) What do music therapists report as their principal instrument? 2) How often do music therapists use their principal instrument in clinical practice? 3) What interventions do music therapists employ when using their principal
instrument? 5) What are the reasons given for using or not using the principal instrument in clinical practice?

For the purposes of this study a primary/principal or applied instrument will be defined as an instrument that one has had individual instruction on at the university level (undergraduate and/or graduate) as well as previous years of study on this instrument. Within this definition the music therapist must also be at the level of competence deemed necessary by the AMTA. The AMTA states that the music therapist: "(3.1) Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice" and "(3.2) Perform in small and large ensembles." (para 3).

Method

Subjects

The subjects in this study consisted of two hundred and forty-nine music therapists who replied to an electronic survey. Of the two hundred and forty-nine, the survey was completed fully by two hundred and twenty-two respondents. Surveys were sent by email to practicing music therapists listed in the American Music Therapy Association Sourcebook 2008. The original printed contact list consists of practicing music therapists, students, retirees, and affiliates. Within this list music therapists who were mailed the survey had to have the credential of MT-BC, in order to try and ensure that those answering the survey were registered and currently practicing. Therefore, those people listed as students (without MT-BC credentials), retired, affiliate, or professional without the credential of MT-BC were not included. A total of one thousand board certified music therapists were emailed a link to the survey within a cover letter, which explained the purpose of the study, assurance of anonymity for participants, and the option to withdraw from the study at any time. (See appendix A and B for cover letter and full
The Use of the Music Therapist's Principal Instrument

survey). Of the one thousand emails sent sixty emails were invalid and some of the music therapists were retired or not currently practicing.

Survey

Information for the study was gathered using a survey created by the researcher consisting of both closed and open ended questions. A new survey was created because an existing survey that specifically focused on how the primary instrument is used in music therapy clinical work could not be found. When devising the survey, questions were created which would answer the research questions stated in the purpose. After the initial draft of the questionnaire was designed it was given to three board-certified music therapists in order to test for clarity and design. Needed changes were made and ‘Survey Monkey’ was used to create the survey online. The survey is included here (see Appendix B) and includes questions related to and presented in the following order: background information focusing on the music therapists' education and practice (years of practice, setting, population), principal instrument and years of study on this instrument, use of the principal instrument in clinical practice, reasons for using or not using the principal instrument in clinical practice, and the frequency of the use of other instruments listed as professional competencies by the AMTA (voice, piano, guitar, non-symphonic instruments) in clinical practice. Before the final version was sent it was tested to ensure that the design of the survey worked properly online.

One of the objectives of the survey was to obtain information on how different principal instruments are used in clinical practice. Therefore, the survey was designed so that once the respondent reported his or her principal instrument (among the choices given) he or she would be directed to pages which focused only on his or her principal instrument of study. The survey was formatted in this manner so that descriptive answers given would be particular to each instrument, allowing for more specific information in the results. Questions which focused on the use of the
principal instrument in practice asked for brief descriptions of interventions used, as well as how often these interventions were used within the past year. Respondents were asked in terms of one year, rather than a general overview of how often these interventions were used, so as to provide a timeframe in which recalling events might be easier (Fink, 1995b). A six point scale (strongly agree, somewhat agree, agree, somewhat disagree, disagree, strongly disagree) was used for respondents to then rate the reasons why they use their principal instrument in clinical practice. Extra space was provided for a descriptive answer to this question if the respondent wanted to expand or clarify statements agreed or disagreed with on the scale. For each instrument the questions asked were the same. However, the survey was divided into sections based on each instrument to see if and how the answers would differ, due to the instrument used.

For those whose principal instrument was voice, piano, and guitar one extra question was included concerning the individual competency requirements for these three instruments listed by the AMTA. The purpose of this question was to find out how music therapists may use these instruments in a different way from the listed competencies due to advanced skills. Therefore, the specific competency for these instruments was presented and the respondent was asked how he or she used this instrument differently in practice, because it is their principal instrument.

In order to understand some of the reasons why music therapists may not currently be using their principal instrument in clinical work a section on this topic was included in the survey. If a respondent answered that they have not used the primary instrument in clinical practice within the past year, he or she was redirected to a new page of the survey. This page provided statements related to reasons why a music therapist may not be using his/her principal instrument of study, as well as if the principal instrument was used in the past, and if the respondent would like to use his/her principal instrument in the future. The respondent could agree or disagree with these statements according to the same six-point scale used previously. Additional space was
provided so that further descriptive information could be written by the respondent if chosen to do so.

Finally all respondents were directed to the same last page of the survey, which focused on the use of the four instruments listed as a separate competency by the AMTA. Surveyors were asked to rate how often they used the instruments of voice, piano, guitar, and non-symphonic percussion in clinical practice, again within the time frame of the past year. Although it was later realized that this should have read non-symphonic instruments rather than percussion, as this is how the competency is worded by the AMTA.

Overall, the survey attempted to present questions in a manner that would allow respondents to explain the use of the principal instrument in clinical practice in his/her own words. Questions that were presented in a quantitative format focused on background information and on timeframe. Those questions based on a scale were presented in this way in order to obtain standard information and for ease when taking the survey, so that not all questions had to be answered descriptively. However, space was provided if one wanted to include more information. In creating the survey an attempt was made so that one would be able to complete it in a short amount of time, while still providing substantial information.

Results

The results of this survey will be presented in the order of background information given by participants, followed by information on the use of the principal instrument in clinical practice. A general overview will be followed by a section on each individual instrument.

Background Information

The survey began with a number of questions based on background information concerning higher education, number of years in the field, the setting the respondents worked in,
and the population worked with. This information was included in the survey in order to gain a picture of the overall sample as well as to provide data that may be used in comparison with answers given later in the survey.

*Education.* Table 1 shows the higher education background of those music therapists who took the survey. The majority of respondents obtained a Bachelor’s in Music Therapy followed by a Master’s in Music Therapy. Among the responses some music therapists reported more than one area of training.

Table 1 *Degrees Held by Respondents*

<table>
<thead>
<tr>
<th>Education</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelors in Music Therapy</td>
<td>59.8%</td>
<td>149</td>
</tr>
<tr>
<td>Bachelors in Music Performance</td>
<td>5.2%</td>
<td>13</td>
</tr>
<tr>
<td>Bachelors in Music Education</td>
<td>8.0%</td>
<td>20</td>
</tr>
<tr>
<td>Education</td>
<td>2.4%</td>
<td>6</td>
</tr>
<tr>
<td>Bachelors/Other</td>
<td>5.6%</td>
<td>14</td>
</tr>
<tr>
<td>PostBac/Equivalency in Music Therapy</td>
<td>7.2%</td>
<td>18</td>
</tr>
<tr>
<td>Masters in Music Therapy</td>
<td>30.1%</td>
<td>75</td>
</tr>
<tr>
<td>Masters in Music Performance</td>
<td>1.2%</td>
<td>3</td>
</tr>
<tr>
<td>Masters in Music Education</td>
<td>3.2%</td>
<td>8</td>
</tr>
<tr>
<td>Masters in Special Education</td>
<td>3.6%</td>
<td>9</td>
</tr>
<tr>
<td>Masters in Counseling</td>
<td>3.6%</td>
<td>9</td>
</tr>
<tr>
<td>Masters/Other</td>
<td>9.2%</td>
<td>23</td>
</tr>
<tr>
<td>PhD in Music Therapy</td>
<td>4.0%</td>
<td>10</td>
</tr>
<tr>
<td>PhD/Other</td>
<td>2.4%</td>
<td>6</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

answered question 249

For those who answered “other”, additional education or degrees not listed in the choices given, were written by the respondents. These responses included:

- Business Administration-Management
- PhD in music education/therapy
- Masters of Healthcare Administration
- Special Education
- Bachelors in music theory (incomplete)
- Advanced Degree in Educational Administration and Leadership
- Elementary Education
- BS Recreational Therapy, BA Music
- Masters in Special Education
- Bachelor’s in "Music"; and also one in Medical Technology
- ABD in music therapy PhD program
- Bachelor of Arts in Applied Music, Music Therapy equivalency
- Music Education with certificate in Music Therapy
- Master of Arts, Expressive Therapy
- Bachelors social work, Masters Human Resources,
- Second Masters in Health Sciences
- Masters in Music
- 81 quarter hours Post-Graduate study in MusEd/Therapy
- MMT and MA in counseling student
- Advanced GIM Training
- Music Education/Cognition Music Therapy
- Masters in Education
- took MT classes and am board-certified but officially have a B. of Music
- PhD Arts & Human Development
- PhD in music education/therapy
- MA Music Theory
- Special Education
- MSW
- Advanced Degree in Educational Administration and Leadership
- BS Recreational Therapy, BA Music

**Number of Years in the Field.** Figure 2 shows the number of years the respondents have been working as a music therapist. Among those who answered this question and the survey overall, there is a range of work experience (between 0 and above 30 years).

<table>
<thead>
<tr>
<th>Number of Years</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>29.7%</td>
<td>74</td>
</tr>
<tr>
<td>5-10 years</td>
<td>23.7%</td>
<td>59</td>
</tr>
<tr>
<td>10-20 years</td>
<td>22.5%</td>
<td>56</td>
</tr>
<tr>
<td>20-30 years</td>
<td>16.9%</td>
<td>42</td>
</tr>
<tr>
<td>Over 30 years</td>
<td>7.2%</td>
<td>18</td>
</tr>
</tbody>
</table>

*answered question 249
skipped question 2*

**Setting.** Results for the reported settings in which the participating music therapist’s worked within the past year, are shown in Figure 3. Some of the music therapist’s who answered this question reported working in more than one setting. The settings most reported were school (78) followed by private practice (76) followed by “other” (71).
Table 3 *Settings Respondents Worked in Within the Past Year*

<table>
<thead>
<tr>
<th>Setting</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospital</td>
<td>15.2%</td>
<td>34</td>
</tr>
<tr>
<td>Psychiatric Facility</td>
<td>16.6%</td>
<td>37</td>
</tr>
<tr>
<td>Physical Rehabilitation</td>
<td>5.8%</td>
<td>13</td>
</tr>
<tr>
<td>Correctional facility</td>
<td>3.1%</td>
<td>7</td>
</tr>
<tr>
<td>Drug/Alcohol Rehab</td>
<td>4.9%</td>
<td>11</td>
</tr>
<tr>
<td>Veteran’s Affairs</td>
<td>3.6%</td>
<td>8</td>
</tr>
<tr>
<td>Children’s Day Care/Preschool</td>
<td>21.5%</td>
<td>48</td>
</tr>
<tr>
<td>School</td>
<td>35.0%</td>
<td>78</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>13.0%</td>
<td>29</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>21.5%</td>
<td>48</td>
</tr>
<tr>
<td>Hospice</td>
<td>11.7%</td>
<td>26</td>
</tr>
<tr>
<td>Community Center</td>
<td>8.5%</td>
<td>19</td>
</tr>
<tr>
<td>Private practice</td>
<td>34.1%</td>
<td>76</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

answered question **223**  
skipped question **28**

For those who selected “other” the settings reported were:

- Children’s Hospital/Pediatrics
- In home music therapy
- Outpatient adult mood disorders program
- University
- State developmental center
- State Residential Facility for Adults with Dev. Disabilities (ICF/MR)
- Well elderly, Adult Wellness
- Sheltered Workshops
- Residential Treatment Center
- Assisted Living and clinic for developmental disabilities
- Community based
- Assisted Living ; Senior Adults; Specialized Dementia Program
- Research
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- Hawaii Dept of Ed
- Adult Day Habilitation/Program for developmental, physical and other disorders
- Private facility government contracts kids with DD
- Group home
- In-home, private homes
- Early intervention
- CMSS
- Non-profit agency
- Forensic Psychiatric Hospital
- Orphan’s home
- State Office
- State institution for Developmentally Disabled
- MS Society day camp workshop leader
- Developmental-Behavioral Pediatrics Office
- Day Treatment Center and private schools
- Treatment Center/residential for children and adolescents

Population. Table 4 illustrates the population that respondents have reported to work with during the past year. Again, there is overlap as music therapists reported working with more than one population. It seems the majority of music therapist’s answering the survey have been working with children (70.1%), followed by adults (61.8%), special needs (55.6%), the geriatric population (41.5%), the multiply disabled (42.7%) and with the mental health population (36.1%). Data for more populations listed can be seen in the table.
Table 4 *Populations Respondents have Worked with within the Past Year*

<table>
<thead>
<tr>
<th>Population</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>20.7%</td>
<td>50</td>
</tr>
<tr>
<td>Children</td>
<td>70.1%</td>
<td>169</td>
</tr>
<tr>
<td>Adults</td>
<td>61.8%</td>
<td>149</td>
</tr>
<tr>
<td>Geriatric</td>
<td>41.5%</td>
<td>100</td>
</tr>
<tr>
<td>Special Needs</td>
<td>55.6%</td>
<td>134</td>
</tr>
<tr>
<td>Multiply Disabled</td>
<td>42.7%</td>
<td>103</td>
</tr>
<tr>
<td>Mental Health</td>
<td>36.1%</td>
<td>87</td>
</tr>
<tr>
<td>Drug/Alcohol Rehabilitation</td>
<td>10.4%</td>
<td>25</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>3.7%</td>
<td>9</td>
</tr>
<tr>
<td>Medical</td>
<td>24.9%</td>
<td>60</td>
</tr>
<tr>
<td>Oncology</td>
<td>19.1%</td>
<td>46</td>
</tr>
<tr>
<td>Stroke</td>
<td>17.4%</td>
<td>42</td>
</tr>
<tr>
<td>Neurological Disorder</td>
<td>27.4%</td>
<td>66</td>
</tr>
<tr>
<td>Alzheimer's/Dementia</td>
<td>31.1%</td>
<td>75</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

answered question 241

skipped question 10

For those who answered “other”, the specified populations listed by the respondents were:

- Learning Disabilities
- College students
- Developmental Disabilities
- Mental Retardation
- Adolescents
- ID/DD
- Terminally ill
- PTSD; Serious Mental Illness Life Enhancement (SMILE) Program
- MR
- Autistic
- Prater-Willis Syndrome
- Wellness
In order to answer the research question, *What do music therapists report as their principal instrument?*, respondents were asked to choose among a number of instrument choices given, which they considered to be their “principal instrument” during their music therapy education at a college/university? The distinction was made, in terms of focusing on the instrument studied during music therapy education, to see if the primary instrument studied at the time, was still used currently in clinical practice. Figure 1 demonstrates the respondents’ answers. Voice, piano and woodwind instruments were the three categories of principal instrument studied most by music therapists who responded to this survey. This coincides with Cohen’s (1997) study in which these three instruments were also ranked higher than others. However, it does not correspond with the results found by Byung-Cheul Choi (2008) in which voice (39%) was followed by piano (30%), guitar (14%) and then woodwinds (11%).
Years of Study. In terms of the years of study on one’s principal instrument this was divided into three questions. The first was “*How many years during your music therapy education in a university/college did you have individual lessons in your principal instrument*”? This question was presented in order to gage how extensive one-on-one training of the principal instrument may be during one’s music therapy training. The second question presented was "*If your music training was concentrated in a degree other than music therapy for how many years at the university level (undergraduate and/or graduate) did you take individual lessons*”? The purpose of asking this question was to target those respondents who in another degree, in a music related field or other subject, may have been building up skills on their principal instrument. Furthermore, if there are music therapists who responded that they did not have individual study
during their music therapy degree, this question would gage whether music instruction was taken elsewhere at the university level.

Finally the third question asked was, "For how many years did you take individual lessons prior to university studies"? In order to have an understanding of one’s previous study on his/her principal instrument this question was asked. Along with the other two questions it would also provide a picture of the overall years of individual instruction one has had on his/her principal instrument.

In all three of these questions the focus was on individual lessons/instruction so as to rule out group instrument classes such as those required in music therapy university programs, for example, voice, keyboard and guitar techniques. One’s individual instruction on his/her primary instrument may suggest more intense study. However, there were elements of instrumental instruction that were left out of these questions such as the frequency and length of lessons as well as the frequency and length of individual time spent practicing. Both are major elements when studying a principal instrument that may have provided more information in terms of the intensity of one’s study. The responses to these questions are presented in graph form in figures 2-4.

Figure 2 shows the response frequency in which respondents answered the number of years they had individual lessons on their principal instrument during music therapy education. The graph shows that for most respondents individual lessons were taken for three to four years (42.87%) during a music therapy degree.
Figure 2 Years of Individual Lessons Reported During Music Therapy Education

![Bar chart showing years of individual lessons reported during music therapy education.]

Figure 3 shows that for most respondents the questions concerning individual lessons in a degree besides music therapy was not applicable. However, among all instruments there are a percentage of respondents who studied their principal instrument during another degree, with a slight majority studying from 3-4 years.

Figure 3 Years of Individual Lessons Reported During Other Degree

![Bar chart showing years of individual lessons reported during other degree.]

1 In Figure 3 the term “not a requirement” refers to whether one was not required to have individual lessons on their principal instrument while in a music therapy degree program. See section on Limitations of the Study (p. 108) for further explanation.
The number of years respondents reported having individual lessons on their principal instrument prior to university studies is illustrated in Figure 4. A slight majority responded that they had individual lessons on their principal instrument for 5-10 years (37.5%) prior to university studies, followed by 1-5 years (24.63%). This indicates that for most respondents individual lessons were taken on their principal instrument for quite some time before studies in music therapy or another degree.  

Figure 4 Years of Individual Lessons Reported Prior to University Studies

The age of the respondents to this question may have had an effect on the number of years of study. For example, someone who came to university studies later in life may have had more years of previous instrumental study. There is a small percentage (16.7%) who studied their instrument 0-1 years before music therapy or university studies. Although it cannot be determined from this study, it may suggest there can be a wide range of musical ability on one’s principal instrument among those who enter music therapy degree programs. However, these respondents may have had group tuition or been part of their primary or high-school band/orchestra or choir programs. This was not indicated within the question as the focus was on individual instruction.

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2 In Figure 3 the term “not applicable” refers to whether this question does not apply because one was not enrolled in another degree or did not study a principal instrument while in another degree program. See Limitations of Study (p. 108)
Overall, it seems most respondents had private instruction on their principal instruments before their music therapy/university training and during their music therapy/university training, with the majority having three to four years of private instruction during their music therapy degree and five to ten, followed by one to five years of instruction prior to their music therapy or university degree.

The Principal Instrument in Clinical Practice

This next section focuses on the use of the primary instrument in clinical practice. First the question "Have you used your primary instrument in clinical practice within past year"? was asked to determine whether the music therapists in this survey have or have not used their principal instrument. A time frame of one year was given in order to focus on more current practices. This was followed by questions concerning how each instrument has been used in clinical practice.

Figure 5 shows the percentage of respondents overall who answered that they have used their principal instrument in clinic practice within the past year, the majority answering that they have.

*Figure 5 Use of the Principal Instrument in Clinical Practice within the Past Year*

A more detailed account for each instrument (of the percentage of respondents who answered that they have/have not used their principal instrument in clinical practice within the
The Use of the Music Therapist’s Principal Instrument

past year) is provided in figure 6. For those whose principal instrument is voice and guitar, all respondents answered that they have used their instruments in clinical work. There were 69 vocalists who answered this question and 18 guitarists. For those who studied piano there is a percentage who answered that they have not used their principal instrument in clinical practice within the past year. Within these responses it appears that the principal instruments of voice, guitar, percussion and piano have been used more in clinical practice than woodwinds, strings and brass.

Figure 6 Use of the Principal Instrument in Clinical Practice within the Past Year/Per Instrument

For those respondents who answered that they do use their instruments in clinical practice, the questions how, how often, and what reasons are given for using the principal instrument in practice will be explored. In order to address these issues the three research questions asked were 1) What interventions do music therapists employ when using their primary instrument? 2) How often do music therapists use their primary instrument in clinical practice? 3) What are the reasons given for using or not using the primary instrument in clinical practice?
The Use of the Music Therapist’s Principal Instrument

The answers to these research questions will be presented in the following sections covering each instrument individually.

**Voice in Clinical Practice** All of the respondents whose principal instrument was voice stated that they have used the voice in clinical practice within the past year. In order to address the question of how the voice, as one’s principal instrument, is used in clinical practice two issues were addressed. One is how the voice is used beyond the basic “voice skills” competency listed by the AMTA while the other is what type of vocal interventions are employed. The AMTA (2008) competency of “voice skills” under musical foundations are listed as: “Lead group singing by voice; communicate vocally with adequate volume (loudness); and sing a basic repertoire of traditional, folk, and popular songs in tune with a pleasing quality” (p. 29). As the voice is an instrument that may be one’s principal and that is also listed as a musical foundations competency, respondents were asked to write descriptive answers to the question “How do you use the voice differently from these competency requirements, in clinical practice, because it is your principal instrument?” This question was presented to inquire whether, and how, those who have a more extensive background on this instrument may go beyond the competency requirements while also incorporating the requirements for the major performance medium/principal instrument.

The responses to the question concerning competency varied, but among them there seemed to be some common themes that arose. For example, some respondents explained that they were able to use their knowledge of vocal technique with clients as well as for themselves when singing. The use of the voice and music theory, such as sight singing was mentioned as well. Other music therapists stated that the ability to sing classical repertoire was useful in some of their work. Another common answer was the use of vocal control and the ability to manipulate one’s own voice depending on the needs of the client, for example, in terms of dynamics, emotional expression, and vocal tone. Using various vocal sounds was also something that some
of the respondents agreed upon, for example, echoing the “sounds” of clients in for communication. Many respondents also commented on using improvisation, which goes beyond the voice skills competency but adheres to the musical foundations competency of improvisation as well. Some music therapists also agreed that they do not use the voice differently from the above competency requirements. Table 5 lists the written responses; because there were many responses the answers are grouped into the themes mentioned above.

In order to further understand how one uses the principal instrument in clinical practice, respondents were also asked to list and briefly describe interventions in which their principal instrument, voice, is used. As with the previous question there were some similarities among the answers that were given. These included the use of improvisation, the music therapist using the voice and singing for the client, group and solo performance oriented interventions, relaxation, toning, using the voice in a therapeutic lesson format, singing to aid in listening skills, the use of music history and theory centering around voice, singing to encourage change in certain skills or behaviors, the use of the voice by the music therapist to give directions/instructions, the use of singing and the voice to aid in communication, and singing/song-writing. These categories are listed in Table 6 with the respondents answers grouped accordingly so as to provide some order. Some of the interventions may fit in one or more category, but were placed in the grouping that seemed most appropriate.
Table 5 *Use of the Voice as a Principal Instrument in Comparison to Voice Skills Competency Requirements*

<table>
<thead>
<tr>
<th>Respondents Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vocal Technique</strong></td>
</tr>
<tr>
<td>• “Use knowledge base of vocal techniques and choral experience when I lead group or individual sessions. I can demonstrate &quot;pleasing&quot; quality specifically and help clients to adjust as well.”</td>
</tr>
<tr>
<td>• “Use of voice and technique during vocal improvisation, recitals, lessons etc.”</td>
</tr>
<tr>
<td>• “I use vocal warm-ups with groups and individuals, and talk about the benefits of them. I teach clients to use vocal singing techniques to improve his/her volume and clarity of speech.”</td>
</tr>
<tr>
<td>• “I am able to teach others to sing using proper technique.”</td>
</tr>
<tr>
<td>• “Because voice was my major instrument I feel I am more confident in my abilities than other MT’s may be.”</td>
</tr>
<tr>
<td>• “Vocal exercises, pneumonic phrases to assist aphasic stroke patients in diaphragmatic vocal strengthening.”</td>
</tr>
<tr>
<td>• “I have used voice to help stroke patients begin to vocalize.”</td>
</tr>
<tr>
<td>• “Voice lessons helped me understand how to use my voice in a way that is safe, by appropriately applying dynamics, accentuation, cadenzas, improvisations, different ranges, etc. When one works a full day, one must be able to use the voice in a therapeutic manner but also in a way that it will not cause the therapist harm (i.e., losing one’s voice).”</td>
</tr>
<tr>
<td>• “In addition to competency requirements, I vary the tone, and/or dynamic of my voice.”</td>
</tr>
<tr>
<td>• “Use singing to cue calming and/or relaxation.”</td>
</tr>
<tr>
<td><strong>Vocal Control</strong></td>
</tr>
<tr>
<td>• “Use different &quot;characters&quot; voices while telling a story, using Loud and quiet to explain Forte and Piano, using voice to differentiate all emotions”.</td>
</tr>
<tr>
<td>• “Volume control for babies. Using music therapy techniques (such as the iso principal) using the voice.”</td>
</tr>
<tr>
<td>• “I am able to use my singing voice more expressively to create greater meaning in the music. I am able to sing more than just a basic repertoire of music; furthermore, I am able to give songs from different genres, the appropriate sound and character they were meant to be performed with. I find, that as a trained singer, certain clients respond better to the way in which I use my voice, especially in a setting that demands more control and sensitivity, for example, hospice.”</td>
</tr>
<tr>
<td>• “In addition to competency requirements, I vary the tone, and/or dynamic of my voice.”</td>
</tr>
<tr>
<td>• “In addition to the competency requirements, I use the voice to work with individuals; varying tempo and dynamics to achieve desired results.”</td>
</tr>
<tr>
<td>• “Use singing to cue calming and/or relaxation.”</td>
</tr>
</tbody>
</table>
• "Occasionally and for therapeutic purposes I can emit an operatic vocal tone for attention securing purposes which I don't believe voice majors necessarily could do as well as sing quite differently (operatically) than most children are generally used to hearing. I find it really will intrude on some autistic type behaviors."

• "As a soothing quality to assist in relaxing clients, humming, chanting or toning, and singing at memorial services."

• "To use singing and speaking voice to accommodate need of the client (e.g. enthusiastic/energetic singing to stimulate versus soothing to alleviate distress)."

### Repertoire

- "Increased vocal repertoire."
- "Use classical and jazz repertoire as well."
- "I use my voice in the above ways, but can also provide classical vocal music such as opera, or art songs if my clientele enjoy that type of music."
- "Performing pieces of classical singing nature for instrument playing, movement or listening."
- "There are times when I just perform for the clients to hear good music. Sometimes I am asked to perform by the facility. I always make sure that the music I choose fits the therapeutic guidelines."
- "Have a wider range of repertoire."
- "Use the latest music."
- "Occasionally have to rap with the teens, not something I am great at but is useful to have an understanding of."
- "I am able to be freer with impromptu singing of songs that the client desires."
- "Vocal Improvisation, Free-styling (rap)."

### Vocal Sounds

- "Voice work is used to demonstrate loud and soft and other opposites with the children. I often utilize vocal call-response techniques where the child is the leader and I imitate whatever sound they make--not necessarily pleasing at all times but certainly more impactful for them."
- "With one non-verbal autistic boy, I echo his few constantly repeated vocal tones encouraging him to stretch and try new tones."
- "Echoing sounds that clients make to increase client awareness of sounds."

### Improvisation

- "Improvise vocally with clients create melodies and songs in the moment related to what the client is doing."
- "Improvising short melodies or lyrics based on client's emotional or physical response."

### Use of music theory and voice

- "Sing harmonies easily."
- "I also do some pitch matching type activities, and we teach a sight singing class here, another music therapist and myself."
### Table 6 Vocal Interventions

<table>
<thead>
<tr>
<th>Categories</th>
<th>Respondents Answers/Interventions</th>
</tr>
</thead>
</table>
| **Vocal Improvisation**         | • “Improvisate vocally with clients to establish interaction.”  
• “Improvising vocally on non-verbal client's sounds.”  
• “Improvisation - to mirror sounds or words that a client may be expressing or communicating.”  
• “Singing to improvise musical ideas.”  
• “Vocal Improvisation- imitating/initiating vocalizations presented by the client and expanding upon them.”  
• “Vocal and Instrumental Improvisations.”                                                                                                                   |
| **Singing by Therapist for client’s listening** | • “Perform classical voice pieces for psychiatric patients with developmental disabilities to expose them to the music and rehearse listening and concert-going behavior.”  
• “Singing songs that pt's have chosen.”  
• “Singing classical Italian pieces for an elderly man on a ventilator, who requested that genre.”                                                                 |
| **Patient Performance and Group Singing** | • “Group participation. Clients either singing, playing a rhythm instrument, movement to voice and guitar.”  
• “Vocal recitals of opera and musical theatre.”  
• “Provide choir group 1X per week.”  
• “Provide barbershop quartet group 1X per week.”  
• “Sing within/leading a group at hospital functions.”  
• “For performance/entertainment with patients in special events.”  
• “Singing to have a shared community experience.”  
• “Group singing for reminiscence.”  
• “Lead choral rehearsals/musicals/performances with DD clients.”  
• “Drum Circle chants/ Using simple African songs to accompany movement and drum circles.”                                                                      |
| **Singing for Relaxation**      | • “Facilitated relaxation through directed singing.”  
• “Softly singing a patient to sleep.”  
• “Passive Music Listening, singing patient selected songs at bedside to increase relaxation.”   
• “For relaxation talking in a soothing voice/humming.”  
• “Creating a relaxing atmosphere to help reduce anxieties through the use of voice and percussive instruments (ocean drum).”  
• “Vocal performance for relaxation - lullabies favorite songs etc.”  
• “Relaxation group-guided imagery and humming as a method of relaxation.”  
• “Relaxation: humming tunes or improvising at close proximity to bedbound residents.”                                                                       |
| **Toning**                      | • “Toning for relaxation.”  
• “Toning - to help decrease attention on pain.”  
• “Toning with infants in an intensive care unit.”  
• “Toning into chakras for cancer support group.”                                                                                                              |
Table 6 Continued

<table>
<thead>
<tr>
<th>Singing using the iso-principle and entrainment</th>
<th>Lesson Format/Use of Vocal Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Entrainment for pain, using iso-principles.”</td>
<td>• “I use vocal exercises I was taught, in music classes with students with special needs. I use strategies I learned from Orff workshops, as well.”</td>
</tr>
<tr>
<td>• “Treatment for anxiety using iso-principles.”</td>
<td>• “I can focus on vocal quality while singing individually and teach clients to do the same.”</td>
</tr>
<tr>
<td></td>
<td>• “Improve breath control and trunk posture through vocal exercises and singing strategies.”</td>
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<tr>
<td></td>
<td>• “Vocal warm-ups: Humming stable tones, ascending and descending lines, glissandos. &quot;Hello&quot; echoes: various spoken inflections, silly tones, singing repeated pitches, glissandos, intervals, short and sustained sounds.”</td>
</tr>
<tr>
<td></td>
<td>• “Speaking about benefits of vocal warm-ups and singing in general: Deepening breathing capacity, stress relief, mood enhancement, improve communication by increasing loudness of voice and breath control.”</td>
</tr>
<tr>
<td></td>
<td>• “With individuals having difficulty speaking due to stroke or Parkinson's disease: I use phrases like &quot;Before speaking, take a breath as if you're going to sing&quot;, &quot;breath deeply and let the sound come from your belly&quot;, etc.”</td>
</tr>
<tr>
<td></td>
<td>• “Breathing exercises.”</td>
</tr>
<tr>
<td></td>
<td>• “Working with a developmentally delayed teenager on her vocal abilities, in order to include her in the general chorus at school.”</td>
</tr>
<tr>
<td></td>
<td>• “Vocalizing with a patient in rehab to increase mobility of jaw and ease of speaking.”</td>
</tr>
<tr>
<td></td>
<td>• “Demonstration of good vocal production.”</td>
</tr>
<tr>
<td></td>
<td>• “Intonation exercises to increase the client's awareness and voice flexibility.”</td>
</tr>
<tr>
<td></td>
<td>• “Diaphragmatic strengthening.”</td>
</tr>
<tr>
<td></td>
<td>• “Singing for articulation- practicing certain sounds.”</td>
</tr>
<tr>
<td>Singing to aid in hearing/listening skills</td>
<td>• “Pitch matching.”</td>
</tr>
<tr>
<td></td>
<td>• “Sound discrimination”</td>
</tr>
<tr>
<td></td>
<td>• “High/low discrimination”</td>
</tr>
<tr>
<td>Music Theory/History</td>
<td>• “Provide sight singing 1x per week.”</td>
</tr>
<tr>
<td></td>
<td>• “Teaching the difference between beat, rhythm, and tone to retarded teens.”</td>
</tr>
<tr>
<td></td>
<td>• “I use active listening to vocal scores (ie; Hallelujah Chorus) noting vocal ranges, jazz artists to demonstrate i.e. skat singing.”</td>
</tr>
<tr>
<td></td>
<td>• “Provide a music history/music entertainment group 1x per week.”</td>
</tr>
<tr>
<td>Singing to encourage skills/changes in behavior</td>
<td>• “Having clients fill-in-the-blank and sing along w/ me to encourage language use.”</td>
</tr>
<tr>
<td></td>
<td>• “To increase attention span and staying on task/following directions.”</td>
</tr>
<tr>
<td></td>
<td>• “To support the learning of academic materials or social skills.”</td>
</tr>
</tbody>
</table>
Table 6 Continued

| The Use of the Music Therapist’s Principal Instrument | 49 |

<table>
<thead>
<tr>
<th><strong>Singing for Directives</strong></th>
<th><strong>Singing to Communicate</strong></th>
<th><strong>Song-Writing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Decrease anxiety or aggressive behaviors from a dementia client through the use of acapella (low volume, mid range, etc).”</td>
<td>• “Sing directions or during transitions to encourage on-task behavior.”</td>
<td>• “Create songs in the session that utilizes client material, singing songs that pt’s have written.”</td>
</tr>
<tr>
<td>• “Increase participation and energy levels in a group of elderly clients by using the appropriate volume, accents and style.”</td>
<td>• “Transition time between &quot;activities&quot;”</td>
<td>• “Making up songs with words that go with patient treatment.”</td>
</tr>
<tr>
<td>• “Practice social skills by rehearsing vocally appropriate question and response.”</td>
<td>• “To lead and direct movement interventions.”</td>
<td>• “Song writing - to help support the clients who desire to sing their own music.”</td>
</tr>
<tr>
<td>• “Using singing to give instructions and to keep the attention of children in a group or 1:1 setting.”</td>
<td>• “Provide directives for a large group of integrated children in a classroom. One specific melody for each directive provided acapella.”</td>
<td>• “Fill-in-the-blank song writing.”</td>
</tr>
<tr>
<td>• “Narration of session events.”</td>
<td>• “Narration of session events.”</td>
<td>• “Blues song writing.”</td>
</tr>
<tr>
<td>• “Providing feed back and/or instructions; encouraging residents to move, etc.”</td>
<td>• “Providing feed back and/or instructions; encouraging residents to move, etc.”</td>
<td>• “Fill-in-the-blank or piggybacking as an appropriate outlet for emotion.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Singing for Directives</strong></th>
<th><strong>Singing to Communicate</strong></th>
<th><strong>Song-Writing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Sing directions or during transitions to encourage on-task behavior.”</td>
<td>• “Opening song to state name.”</td>
<td>• “Create songs in the session that utilizes client material, singing songs that pt’s have written.”</td>
</tr>
<tr>
<td>• “Transition time between &quot;activities&quot;”</td>
<td>• “Question/Response using voice.”</td>
<td>• “Making up songs with words that go with patient treatment.”</td>
</tr>
<tr>
<td>• “To lead and direct movement interventions.”</td>
<td>• “Vocal Imitation of gestures or vocal responses by clients.”</td>
<td>• “Song writing - to help support the clients who desire to sing their own music.”</td>
</tr>
<tr>
<td>• “Using singing to give instructions and to keep the attention of children in a group or 1:1 setting.”</td>
<td>• “Use vocal syllables to &quot;communicate&quot; with a nonverbal woman with autism.”</td>
<td>• “Fill-in-the-blank song writing.”</td>
</tr>
<tr>
<td>• “Provide directives for a large group of integrated children in a classroom. One specific melody for each directive provided acapella.”</td>
<td>• “Call &amp; response by voice.”</td>
<td>• “Blues song writing.”</td>
</tr>
<tr>
<td>• “Narration of session events.”</td>
<td>• “To use differing vocal sounds indicating yes/no responses for communication purposes.”</td>
<td>• “Fill-in-the-blank or piggybacking as an appropriate outlet for emotion.”</td>
</tr>
<tr>
<td>• “Providing feed back and/or instructions; encouraging residents to move, etc.”</td>
<td>• “Singing for communication- recit type singing back and forth.”</td>
<td>---</td>
</tr>
</tbody>
</table>
The Use of the Music Therapist’s Principal Instrument

To obtain an idea of how often the type of interventions described are employed the respondents were asked to rate how often they have used the interventions listed within the past year (see figure 7). Although this will not indicate how often each individual intervention is used, it may give more than a general response than if the question asked was simply how often the voice/singing is used clinical practice. The responses suggest that for those whose principal instrument is voice, interventions in which this instrument can be employed are used often for many of the respondents in their practice (majority between 75-100% and 50-75%) Although unable to determine in these results, it would be interesting to note which interventions are employed more often than others. However, this may be dependent on the clients one is working with at the time.

*Figure 7 Percentages of Sessions Vocal Interventions Used within the Past Year*

In order to answer the research question “What are the reasons given for using or not using the principal instrument in clinical practice?”, statements were presented, which the respondents could agree with or disagree with based on a six point scale from strongly agree to strongly disagree. Respondents were also invited to write a descriptive response to provide more specific information on why they use their principal instrument in clinical practice.
The statements provided were:

- I feel that I am more effective with clients when using my principal instrument.
- I feel I have had adequate training in how to use my principal instrument in clinical practice.
- I feel my principal instrument is appropriate for my setting.
- I feel my principal instrument is appropriate for the population that I work with.
- I feel my principal instrument is accessible for clients to play.

The results for the level of agreement with these statements are shown in figures 8-12.

**Figure 8 Level of Agreement with Statement One/Principal Instrument Voice**
Figure 9 Level of Agreement with Statement 2/Principal Instrument Voice

"I feel I have had adequate training in how to use my principal instrument in clinical practice".

Figure 10 Level of Agreement with Statement 3/Principal Instrument Voice

"I feel my principal instrument is appropriate for my setting".
Figure 11 Level of Agreement with Statement 4/Principal Instrument Voice

"I feel my principal instrument is appropriate for the population I work with."

Figure 12 Level of Agreement with Statement 5/Principal Instrument Voice

"I feel my principal instrument is accessible for clients to play."

For the first statement the majority of the 54 respondents agreed that they feel more effective when using their voice. Respondents also agreed that they have had appropriate training in how to use the voice with clients, although, two responded that they strongly disagree with
this. Most respondents also agree that the voice is appropriate for both the setting and the population they are working with. In regards to the last statement, the wording of “I feel that my principal instrument is accessible for clients to play” was misleading. Twenty respondents strongly disagreed with this statement and in some of the descriptive responses given, it was indicated that the statement was read as if the client should play the voice of the music therapist, rather than sing with his/her own voice. The statement was meant to indicate that the client would use his/her own voice and should have been worded accordingly.

Respondents were also invited to provide answers in their own words about why they use the voice in clinical practice. The responses were as follows:

- “It works very well in conjunction with piano/keyboard which is my primary accompanying instrument”.
- “I feel that the voice is a major component in every session and most of my population has access to their own voice”.
- “Each student has their own “voice”, all pleasing and very satisfying in its own way. Self-expression becomes a very positive outlet”.
- “I also invested in additional years post-school to keep up my skill. This is very important”.
- “The voice is accessible to all, though patients are often reluctant to use it, especially older kids/teenagers”.
- “Everyone enjoys singing. The quality of the voice is not always as important as being encouraged to participate especially if they find their partner pleasing to listen to and sing with”.
- “I feel that the voice is a very personal instrument. It is more intimate receptively and expressively than using external instruments. It is, of course, extremely portable, as well
(a major advantage, when one is carrying all materials from place to place in one's practice!) (explanation for last standard question above: Not all of my clients have use of their voices, so to them "playing"; the instrument is not accessible. Some, though, have access to a singing voice but not a speaking voice.)"

- "I mostly use my voice, now, to help model basic communication for my clients".
- "Everyone can sing along, singing encourages participation by groups and individual clients. The qualities of voice can be easily adapted for the appropriate tonal quality needed".
- "I believe everyone can use their voice"!

A common thought among these responses is the ease and accessibility of the voice to all. This can be seen in the general agreement that the voice is appropriate for the population and setting among the respondents. However, one respondent rightly points out that some clients may not have use of the voice and may need another avenue for communication. The "personal" nature of the voice, as it is not an "external" instrument is also mentioned. This may tie in with the comment by another respondent that some clients may be reluctant to use the voice. In terms of the music therapists use of his/her own voice, one respondent suggests that it is important to keep up one's own skill after becoming a professional.

These answers may indicate some of the unique qualities the voice contributes to its use with clients. For example, it is an instrument within the body, related to speech (demonstrated in the interventions in which the voice is used for breathing and speech production). Perhaps for music therapists whose principal is voice, they are able to utilize their training, background and knowledge of the "mechanics" of singing for these interventions in particular. Furthermore, the voice's ease of accessibility (while not forgetting those clients who cannot use their voice) allows for the wide range of interventions that were listed and the many ways in which the voice can be used by both the music therapist and the client.
Piano in clinical practice. As with voice skills, keyboard skills are also listed separately as a music foundation competency by the AMTA. Therefore, respondents with the piano as a principal instrument were asked how it may be used differently from the competency requirements, in clinical practice. Keyboard skills competencies listed by the ATMA (2008) are “accompany self and ensembles proficiently, play basic chord progressions (I-IV-V-I) in several keys, sight-read simple compositions and song accompaniments, play a basic repertoire of traditional, folk, and popular songs with or without printed music and harmonize and transpose simple compositions” (p. 29).

These competencies were presented to respondents along with the question “How do you use the piano differently from these competency requirements, in clinical practice, because it is your principal instrument?” In the answers that were given, as with those who answered the same question concerning voice skills, there were some common themes. For piano, these were the use of teaching/pedagogy skills on the keyboard, improvisation, transposition and harmonization skills for more complex pieces, advanced accompaniment skills, the ability to play by ear, advanced playing skills/repertoire, as well as playing for relaxation and imagery. There were also those who commented that they do not use the keyboard differently from the above competency. However, one commented that although the instrument may not be used differently from the competencies listed, “these competencies came easier”. Table 7 lists the descriptive answers given by the respondents in detail within the categories suggested.

The issue of how the piano is used in clinical practice by those who stated it is their principal instrument was also addressed by focusing on the interventions used. Within the descriptions of piano interventions, there were similarities among some of the responses given. Therefore, again, the interventions are listed within categories that seemed to provide some order in presenting this information. Some of the interventions are applicable to more than one category but are only listed within the one that seemed most appropriate. Types of interventions that arose
by multiple respondents included “piano lessons” in which many mentioned the use of adapted methods, improvisation (therapist or client on piano or other instrument), the music therapist using the piano as an accompaniment instrument during sessions with use in various interventions, the music therapist playing the keyboard for clients (listening interventions), playing with the client, using the keyboard to facilitate relaxation and imagery, focusing on the client playing the keyboard, recording of keyboard music for clients, using the piano to accompany other modalities such as art or movement, using the piano in composition/song-writing, using the piano to facilitate the session-support music making, applying the piano to physical rehabilitation, and using the piano to improve cognitive skills and change behavior. The brief descriptions of these interventions are listed by category in Table 8.
<table>
<thead>
<tr>
<th>Teaching /therapeutic lessons/ adapted piano techniques</th>
<th>Respondents Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 'I use the piano as a teaching tool as it is the easiest instrument for a special needs child to successfully create a sound on.'</td>
<td></td>
</tr>
<tr>
<td>• “Offering adapted piano lessons for children with special needs.”</td>
<td></td>
</tr>
<tr>
<td>• “Often I teach clients to play the piano, if that is an objective towards their ultimate goal. So pedagogy training would have to be a competency. (I took piano pedagogy in college - 2 semesters).”</td>
<td></td>
</tr>
<tr>
<td>• “With a patient who was a concert pianist and had Left-sided hemiparesis, I played the left hand part of many classical music pieces while she played the right hand. This helped her learn new ways she could adapt her playing to still play favorite music; encouraged her to continue playing/teaching; and provided a milieu for her to continue using her right hand.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improvisation</th>
<th>Respondents Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Use the piano to improvise with special needs students to encourage vocalization.”</td>
<td></td>
</tr>
<tr>
<td>• “Improvisation in different styles.”</td>
<td></td>
</tr>
<tr>
<td>• “As well as the above I use the piano in improvisation with clients, either as support or to enhance their playing and creativity.”</td>
<td></td>
</tr>
<tr>
<td>• “Improvise music to accompany movements, feelings, etc.”</td>
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</tr>
<tr>
<td>• “Also, I do improvisation with children with autism, using the piano. Improvisational techniques (jazz styles) would have to be a competency.”</td>
<td></td>
</tr>
<tr>
<td>• “Improvisation, imitation of vocal sounds.”</td>
<td></td>
</tr>
<tr>
<td>• “Through modal improvisation, reading fake-books, bringing in classical music.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge of chord progressions/theory /Playing by Ear</th>
<th>Respondents Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “I do use piano with and without printed chords available of popular hip-hop, R&amp;B songs, and oldies when doing singing/performance groups with adolescents. I also often need to transpose songs to give the kids a better singing range and more successful experience. In addition to this, I use knowledge of chord progressions to facilitate songwriting and improvisation groups.”</td>
<td></td>
</tr>
<tr>
<td>• “My understanding and teaching background helps me confidently explain and illustrate correctly (i.e. chord progressions, following along to a recording or singing).”</td>
<td></td>
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<tr>
<td>• “I can play anything by ear so I use that skill frequently. If a client hums a tune, I will play it back to him/her.”</td>
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<tr>
<td>• “Sight-reading in JAM sessions.”</td>
<td></td>
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<tr>
<td>• “Transpose more difficult songs to match clients vocal range, song writing with melody line.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accompanying skills</th>
<th>Respondents Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Accompany voice lessons as therapy, and help accompany during recitals.”</td>
<td></td>
</tr>
<tr>
<td>• “I am able to play difficult accompaniments when working with nursing home residents; I also play classical music for them occasionally.”</td>
<td></td>
</tr>
</tbody>
</table>
| Accompanying Skills Cont’d | • “Play medium to complex accompaniments.”  
| | • “I rarely use it as an accompaniment instrument. I have clients play to their level and try to help them learn more.”  
| Advanced playing skills/Repertoire | • “Jazz jam sessions with clients”  
| | • “More comfortable to play in “Live instrumental Music Listening” Situations. Not as comfortable with guitar except when accompanying. I don't use it as much as guitar though because of availability in certain facilities.”  
| | • “Don’t use it differently, possibly just more frequently and with greater depth to my playing.”  
| | • “I have been challenged in the area of learning new repertoire for the older adult population and have improved my sight - reading skills as many of the big band hits that they enjoy incorporate ‘jazz chords’ or more complex progressions.”  
| | • “I also use classical piano music.”  
| Playing for relaxation | • “Performance for relaxation use.”  
| | • “I play entire piano pieces to help people relax, and I guide them through various exercises while they are listening. I also engage them in improvisation with me on the keyboard.”  
| | • “Music for Progressive Relaxation both recorded and live piano.”  
| | • “I play a variety of piano pieces for relaxation techniques, imagery with music (and art sometimes).”
<table>
<thead>
<tr>
<th>Categories</th>
<th>Respondents’ Answers/Interventions</th>
</tr>
</thead>
</table>
| **Teaching** | • “Teaching piano lessons to students with special needs.”  
• “To teach an elderly resident how to play scales and a simple song by ear.”  
• “To help teach basic accompanying skills to children in a group setting.”  
• “Therapeutic lessons focusing on correction and development of physical and cognitive functioning.”  
• “Piano Lessons: teaching piano as a catalyst for behavior change.”  
• “Teach piano lessons, using basic pedagogy techniques, in order to increase focus and attention in client.”  
• “Teach keyboard skills to those who are interested.”  
• “Teaching basic keyboard skills (last wish goals).”  
• “Teaching students to play some melodies and harmonies.”  
• “Teaching patients with paralysis how to adapt their playing to be able to continue playing the piano.”  
• “As a teaching tool, especially for kids who have earned a certain level in their program (highest level can receive music lessons).”  
• “Adapted methods (playing by pointing, color coded keys/music, EZ-Play (alphabet formats)).” |
| **Improvisation** | • “Improvising on the piano to develop vocal imitation skills with clients.”  
• “Piano music contingent upon the clients’ instrument playing and vocalizing...improvisation based upon clients’ music.”  
• “Supportive improvisation to help the client to succeed and continue in his/her musicing.”  
• “To facilitate improvisation”  
• “Improvising along with guitar, other percussion.”  
• “During improvisation with residents playing other percussion instruments.”  
• “Improv- we make up songs, engage in various types of play.”  
• “Improvisation both free and directed.”  
• “Improvisation to support creative outbursts from clients.”  
• “Improvisation-client and therapist both play piano, or client plays chosen instrument while therapist plays piano.”  
• “For improvisation especially with melody instruments such as xylophone.”  
• “Students move like a specific animal, I accompany (improvise).”  
• “Students move to illustrate a feeling, I accompany (improvise).”  
• “Improvisations on piano with children on autistic spectrum, in order to increase communication and turn-taking.”  
• “Improvisation - me on piano, clients vocalizing.”  
• “Improvisation (usually with a focus of interpersonal skills).”  
• “Improvisation to reflect the mood-expression of the client while s/he is engaged with another instrument or activity.”  
• “Pentatonic improvisation on black keys.”  
• “Improvisations on the Black Keys ; using Eb blues scale to accompany.”  
• “Improvisation (client is creating music extemporaneously with voice, instruments, or body).” |
| **Accompany** | “Accompanying students as they play the drums or other percussion instruments.”  
| | “Accompanying client’s vocal and instrumental songs.”  
| | “Accompaniment to encourage participation by singing.”  
| | “Voice lessons- I accompany a client who is receiving “voice lessons” as therapy. She chooses the music and I work with her on accuracy and confidence.”  
| | “To accompany a resident who was a singer.”  
| | “Accompaniment; Accompany myself or clients while singing or while they play piano.”  
| | “Accompaniment for various interventions.”  
| | “Accompanying singing/instruments during pre-composed pieces.”  
| | “Accompanying movement during rehabilitation.”  
| | “Accompaniment for individual or group singing, drums, simple rhythmic experiences.”  
| | “Accompaniment of Orff instrument improvisation (xylophones, metallophones).”  
| | “Accompany group songs with piano at schools and with groups.”  
| | “Accompanying a group during a sing-a-long session.”  
| | “Accompanying a group playing instruments.”  
| | “Accompanying myself singing songs.”  
| | “Support singing of new/unfamiliar songs, vocal exercises.”  
| | “One of my residents played the ‘drums’ when she was younger and enjoys having the keyboard set to ‘percussion’ while she plays.”  
| | “Make accompaniment CDs.”  
| **Playing for Client(s)** | “Play songs client likes to sing or listen to.”  
| | “Playing songs which encourage reminiscence/reflection.”  
| | “Receptive methods (client is listening and responding through imagery, movement, discussion, etc.).”  
| | “To provide novelty during sessions.”  
| | “Clients listen to me play and they possibly sing along.”  
| **Playing with Client(s)** | “Encouraging client to express mood on the piano (if he/she plays).”  
| | “Play duets with private client who was a pianist.”  
| | “Clients play with me or “teach” me to play something.”  
| | “Synchronizing with the client by joining him/her in their natural vocal range.”  
| | “Lullaby with parents.”  
| | “Synchronizing with the client by matching the natural tempo they demonstrate.”  
| **Client Playing Keyboard** | “A couple of my residents that are able to play by ear agreed to playing a duet in a Piano Recital held at the facility.”  
| | “I have researched simple songs/melodies that can be played using a pentatonic scale and instruct the residents to play using only the black keys.”  
| | “On occasion, when assessing pain, I will have a resident explore on the piano and try to express how they are feeling (loud vs. soft; high vs. low).”  

<table>
<thead>
<tr>
<th>Client Playing Keyboard Cont’d</th>
<th>Recording Live Music</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Recreational methods (client is playing/singing precomposed music).”</td>
<td>“Recording songs for special legacy related projects.”</td>
</tr>
<tr>
<td>“Allow veterans to play for their peers.”</td>
<td></td>
</tr>
<tr>
<td><strong>Relaxation/Imagery</strong></td>
<td></td>
</tr>
<tr>
<td>“Playing classical pieces or other appropriate compositions for relaxation therapy sessions.”</td>
<td></td>
</tr>
<tr>
<td>“Playing classical pieces for imagery work.”</td>
<td></td>
</tr>
<tr>
<td>“Relaxation techniques guided by piano music.”</td>
<td></td>
</tr>
<tr>
<td>“Guided imagery with piano music.”</td>
<td></td>
</tr>
<tr>
<td>“Listening; playing live piano for relaxation, client enjoyment, or as a reinforcer.”</td>
<td></td>
</tr>
<tr>
<td>“Musical entrainment.”</td>
<td></td>
</tr>
<tr>
<td>“Providing a keyboard for patients who play piano to help distract them and/or relax them while hospitalized.”</td>
<td></td>
</tr>
<tr>
<td>“Creating an environment for relaxation/pain management.”</td>
<td></td>
</tr>
<tr>
<td><strong>To accompany other modalities/art/movement</strong></td>
<td></td>
</tr>
<tr>
<td>“I play quiet, centering new age and classical selections while patients work on artwork.”</td>
<td>“Provide background music to movement/actions.”</td>
</tr>
<tr>
<td><strong>Composition/song-writing</strong></td>
<td></td>
</tr>
<tr>
<td>“Providing ideas for client's who are composing.”</td>
<td></td>
</tr>
<tr>
<td>“Spontaneous chord progressions when creating a spontaneous song in therapy for the client's needs.”</td>
<td></td>
</tr>
<tr>
<td>“Recording patients' compositions with my piano accompaniment.”</td>
<td></td>
</tr>
<tr>
<td>“To facilitate songwriting.”</td>
<td></td>
</tr>
<tr>
<td>“Write music with Alzheimer residents using notes they put on a staff.”</td>
<td></td>
</tr>
<tr>
<td>“Song writing-accompanying singing, providing chord structure.”</td>
<td></td>
</tr>
<tr>
<td>“Playing song as client composes it.”</td>
<td></td>
</tr>
<tr>
<td>“Song writing - finding melody line and adding chords.”</td>
<td></td>
</tr>
<tr>
<td>“Taping and recording and playback of songs composed by clients (and therapist).”</td>
<td></td>
</tr>
<tr>
<td>“Song writing and adapting of lyrics and then playing these songs as sing-alongs with hospice patients.”</td>
<td></td>
</tr>
<tr>
<td>“Compose my own keyboard songs to further client development (e.g. based on theme(s) which occurred in previous sessions).”</td>
<td></td>
</tr>
<tr>
<td>“Composition of music for client lyrics.”</td>
<td></td>
</tr>
<tr>
<td><strong>To facilitate/support music making/session</strong></td>
<td></td>
</tr>
<tr>
<td>“Playing melodies from different genres and decades for “Name That Tune””</td>
<td></td>
</tr>
<tr>
<td>“Playing blues progressions (or other styles) to serve as grounding while patients improvise on Orff instruments or rhythm instruments.”</td>
<td></td>
</tr>
<tr>
<td>“When leading a singing performance group, such as a small choir group, or to warm up the music therapy group.”</td>
<td></td>
</tr>
<tr>
<td>“In facilitating Orff activities and other structured activities with children”</td>
<td></td>
</tr>
<tr>
<td>“Active music making- I play piano and sing and encourage clients to play along with piano or other instruments.”</td>
<td></td>
</tr>
<tr>
<td>“Pentatonic client playing with therapist setting rhythms; change with client.”</td>
<td></td>
</tr>
<tr>
<td>“Adding to drum playing that they might be doing.”</td>
<td></td>
</tr>
</tbody>
</table>
Table 8 Continued

<table>
<thead>
<tr>
<th>The Use of the Music Therapist’s Principal Instrument</th>
<th>63</th>
</tr>
</thead>
</table>

| **For Physical Rehabilitation** | • “Jam sessions with abled musicians in transitional living situations.”  
| | • “Using it as a “transition” from one activity to another.”  
| | • “Opening/closing of session.”  
| | • “Fine motor development, individual finger exercises (fine motor coordination).”  
| | • “A motivation tool for a girl with severe physical disabilities to help her move and control her arms.”  
| | • “Having patients (in Rehab) play the keyboard to increase fine and gross motor skills.”  
| **To facilitate cognitive skills** | • “Letter/color/number matching (academic).”  
| | • “Rhythm skills, movement.”  
| | • “Cognitive Stimulation via lyrics recall.”  
| | • “To help teach basic leading skills to children in a group setting.”  
| | • “Use the piano as a PECS choice in teaching visual strategies.”  
| | • “Communication tasks.”  
| | • “Connecting via familiar melodies for dementia.”  
| **To facilitate changes in behavior** | • “Match client mood/Change client mood.”  
| | • “Assisting clients in tolerating someone sitting next to them (more purpose in using piano).”  

Respondents were also asked how often they use the described interventions in clinical practice within the past year. Figure 24 illustrates in graph form the provided answers. In comparison to the voice, there is not a large majority of respondents who chose one time frame over another. The respondents seemed to be divided quite equally among the choices given and this may have to do with the population or setting served.
The graphs in figures 14 to 18 show to what degree the fifty two respondents agreed with the statements given about why they use their principal instrument in clinical practice. In regards to the statement “I feel that I am more effective with clients when using my principal instrument” the responses are varied. However, a majority of the respondents agreed to some extent. More respondents felt that they had adequate training in how to use their principal instrument with clients. Concerning the appropriateness of the piano with population the majority of respondents agreed to some extent. Finally, in terms of whether the piano is appropriate for clients to play, the responses were more varied with a lower number strongly agreeing and more respondents somewhat disagreeing, in comparison to responses for voice.
Figure 14 Level of Agreement with Statement 1/Principal Instrument Piano

"I feel that I am more effective with clients when using my principal instrument."

Figure 15 Level of Agreement with Statement 2/Principal Instrument Piano

"I feel I have had adequate training in how to use my principal instrument in clinical practice."
The Use of the Music Therapist’s Principal Instrument

Figure 16 Level of Agreement with Statement 3/Principal Instrument Piano

"I feel my principal instrument is appropriate for my setting".

Figure 17 Level of Agreement with Statement 4/Principal Instrument Piano

"I feel my principal instrument is appropriate for the population that I work with".
Further information about why respondents use the piano in clinical practice was provided by a number of respondents who chose to add a brief written explanation. Among these responses the difficulty of transporting the keyboard to clients was mentioned, a practicality that may hinder the use of this instrument at times. One music therapist points out a further degree of comfort in playing the guitar rather than the piano. This brings up the issue that although one may have had a "principal instrument" during studies, one may be just as skilled or more so on another instrument that may be just as effective (or more depending on the situation), with clients. Another respondent highlights the ability to provide both melody and harmony when using the piano while another mentions the "range of sound" this instrument can give. There is one respondent who does stress that during music therapy studies he was not shown how to use the piano clinically in practice but has come to learn. This brings up the issue of how much one can be taught during formal studies/education and how much is learned "on the job".
Another key response that seems to arise in both the answers given for the piano (and voice previously) is the importance of considering the client and his/her needs. For example, concerning the piano, one respondent points out that some children have found the piano intimidating at times, while another finds the piano often inappropriate for hospice work. This brings up the case that although one may have a “principal instrument” the importance of the client’s needs may point to the importance of the music therapist to be flexible and skilled to some level, on a variety of instruments, such as those listed in the music foundation competencies (i.e. voice, guitar, keyboard, non-symphonic).

The descriptive answers given by the respondents were as follows:

- “A piano or keyboard is very difficult to travel with where I work, so I typically bring guitar; and I find the piano is often intimidating for kids to improvise on, especially if they are unfamiliar with the instrument”.

- “I work in various settings throughout the week. The piano is not available in all of those settings so I generally rely on the guitar which is more portable and allows me closer proximity to groups. I find the piano works best when I am seeing individual clients”.

- “Commuting from one classroom to another does not make transporting a keyboard easy or worthwhile at times”.

- “Using the piano elicits a greater response in the geriatric setting than using CDs”.

- “Piano is appropriate to accompany playing of rhythm instruments by clients, both individual and group”.

- “I work in numerous facilities, so at times I do not use the piano based on availability.”

- “Piano has been shown to be a very popular instrument with clients of all ages”.

• “My primary clinical work is in Hospice. I find it extremely cumbersome to use a keyboard in this setting. Additionally, I actually feel more comfortable using guitar (I have played that almost as long as I played piano but did not have as many private lessons”).
• “It is most effective for conveying both melody and harmony.”
• “I wasn't taught how to use the piano clinically in practice but over the years I have figured it out”!
• “I like the full range of sound I get from the piano. I also use keyboard sounds for fuller effect as appropriate”.
• “Difficult to carry around and set up for every session”.
• “I rarely use piano, but more frequently use keyboard. I would prefer piano but most facilities/client homes do not have piano”.
• “My principal instrument is the piano, so I strongly agree with all these questions”.
• “I use the piano because it allows me to meet a client need or address specific demands of the therapy session”.

**Guitar in Clinical Practice.** The use of the guitar in clinical practice also brings up the issue of a comparison to competency skills listed by the AMTA, as in the sections on voice and piano. The competency for guitar skills reads: “Accompany self and ensembles proficiently, employ simple strumming and finger picking techniques and tune guitar using standard and other tunings”. (American Music Therapy Association, 2008, p. 29) Again as with voice and piano, for those whose principal instrument is guitar, the question “How do you use the guitar differently from these competency requirements, in clinical practice, because it is your principal instrument?” was asked.
There were a total of eighteen respondents whose principal instrument was reported as guitar. All eighteen reported that they had used the guitar in clinical practice within the past year and eleven respondents answered this question. As with voice and piano there were some similarities among the answers. The responses to how the guitar is used differently from the competency requirements included the use of improvisation skills, adapting the use of guitar technique to other related instruments and using these in practice, the use of complex patterns, using the guitar in songwriting, using the guitar to provide melody and playing “background music”. Some respondents also commented that they do not use the guitar differently from what is listed in the AMTA competency. As there are not a large number of responses, rather than presenting the detailed responses in a table, they are listed as written in bullet form.

Respondents’ answers were as follows:

- “Guitar for improvisation”
- “In addition to the above I also improvise along with clients as they play marimba, etc. I also occasionally use the guitar while helping clients write songs, improvise lyrics, etc.”
- “Improvise while patients play other instruments. Provide “background” music prior to MT session.”
- “I use it to provide a temporal, time order rhythmic structure to interventions. I also use it to provide sensory stimulation - auditory and tactile. I also use complex patterns to illicit relaxation responses. I use a classical guitar; acoustic steel string and solid body electric and bass guitars, as well as mandolins, ukuleles, banjos and dulcimers.”
- “I have extended the techniques I learned on the guitar to other guitar-related instruments such as the 5-string banjo, the bass guitar and the ukulele. All of these instruments used basic guitar techniques and enrich the styles of music that I use in music therapy clinics.”
- “Teaching”
The Use of the Music Therapist’s Principal Instrument

- “Used when needed based on population”
- “Creative percussive practice collaborative w client in spontaneous expressive communication exercise”
- “Use it to play song melody to introduce the song”
- “Songwriting”
- “No difference”
- “The above summarizes how I use the guitar in practice”

Again, respondents were asked to provide a brief description of guitar interventions used with clients. Eleven music therapists provided responses, which are listed in Table 9. Similar responses are grouped into categories such as relaxation/imagery, song-writing, teaching, pain reduction, accompanying songs/singing/instrumental playing, improvisation, using the guitar to improve physical skills and cognition. An “other” category is provided for responses that did not seem to fit into the groups created but are still significant.

Eleven respondents also answered how often they have used the interventions described in clinical practice, within the past year, demonstrated in Figure 19. Of the eleven respondents, it seems that the guitar is used often as a principal instrument in clinical practice (between the ranges of 50-100%, similar to voice) and perhaps is a versatile instrument for use with clients.
### Table 9 Guitar Interventions

<table>
<thead>
<tr>
<th>Categories</th>
<th>Respondent’s Answers/Interventions</th>
</tr>
</thead>
</table>
| **Relaxation/Imagery**      | • “Calming down clients.”  
                              | • “Relaxation music - classical guitar.”  
                              | • “To provide live music for relaxation.”  
                              | • “Tension, anxiety reduction.”  
                              | • “To facilitate generative imagery.”  |
| **Song writing**            | • “Fill in the blank songs.”  |
| **Teaching**                | • “Teaching how to play to work on memory and self esteem.”  
                              | • “Teaching music therapy clients the guitar in individual lessons.”  
                              | • “Teaching people of Hispanic heritage music from the United States.”  
                              | • “Musical examples for music therapy majors in college classes.”  
                              | • “To teach a new or re-develop a prior leisure skill.”  
                              | • “Teaching listening skills, guitar or voice (match pitch, match rhythm).”  |
| **Pain reduction**          | • “To reduce perception of pain.”  |
| **Accompany songs/singing/instrumental** | • “Accompanying academic and popular songs.”  
                              | • “Singing songs with substance abuse groups for lyric analysis.”  
                              | • “Sing-alongs to teach English as a Second Language.”  
                              | • “Accompany/direct group instrument play.”  
                              | • “Tune identifier “name that tune”; instrument.”  
                              | • “Accompaniment to sing a longs.”  
                              | • “Group musical games.”  |
| **Improvisation**           | • “To accompany improvisations.”  |
| **Physical skills**         | • “Increase motor skills.”  
                              | • “NMT techniques: PSE, RAS.”  |
| **Skills/cognition**        | • “Working on selective and divided attention skills.”  
                              | • “Memory assessment through song melody playing.”  |
| **Other Responses**         | • “Provide opportunities for vocalizations.”  
                              | • “Opening/closing songs.”  
                              | • “Lyric interpretation.”  
                              | • “Talent shows.”  
                              | • “Increase creativity.”  
                              | • “Increase self awareness.”  
                              | • “Energize.”  
                              | • “Use for setting the atmosphere, environment; establish mood.”  |
Figure 19 Percentages of Sessions Guitar Interventions Used within the Past Year

Thirteen respondents rated the degree to which they agree/disagree with the statements based on why one might use his/her principal instrument (guitar) in clinical practice. These responses are shown in figures 20-24. Overall, most respondents agreed to some extent with each of the statements provided.

In terms of the instruments accessibility, one respondent explains descriptively that while a client may not be able to “play” the guitar, this instrument can provide opportunity for sensory stimulation through its vibrating surface. Within the descriptive answers given, another respondent pointed out that a variety of instruments are used in practice, beside the principal instrument, again suggesting the importance of flexibility by the music therapist. It was also stated that the guitar may be applicable to the styles of some clients’ musical preferences and that this instrument may not be intimidating for clients, particularly children and adolescents. This last statement is in agreement with one made in a description of the piano’s use in clinical practice, in which a respondent pointed out that the piano may be intimidating for some children, while the guitar may be less so. The written answers given for the guitar were as follows:

- “It is not easy for clients to play the guitar but it is easy for them to touch the vibrating surface to receive sensory input”.
"I also use piano, accordion, harp, drums and voice".

"I use music primarily as an engagement tool".

"I feel my instrument is indigenous to the styles of music that my clients prefer".

"Clients (children, adolescents) are less intimidated by guitar than piano as evidenced by statements, body language, and less time required to begin to participate".

Figure 20 Level of Agreement with Statement 1/Principal Instrument Guitar

![Graph showing level of agreement with statement 1](image)

Figure 21 Level of Agreement with Statement 2/Principal Instrument Guitar

![Graph showing level of agreement with statement 2](image)
Figure 22 Level of Agreement with Statement 3/Principal Instrument Guitar

"I feel my principal instrument is appropriate for my setting".

Figure 23 Level of Agreement with Statement 4/Principal Instrument Guitar

"I feel my principal instrument is appropriate for the population that I work with".
Woodwinds in clinical practice. Within this survey woodwinds were the principal instrument reported most after voice and piano and in this category one may study a number of instruments. For those who responded that their principal instrument was “woodwinds”, the following chart (Table 10) illustrates instruments within the woodwind family that respondents reported as their principal.

Table 10 Principal Instrument Woodwinds

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flute</td>
<td>50.8%</td>
<td>31</td>
</tr>
<tr>
<td>Clarinet</td>
<td>29.5%</td>
<td>18</td>
</tr>
<tr>
<td>Oboe</td>
<td>4.9%</td>
<td>3</td>
</tr>
<tr>
<td>Bassoon</td>
<td>6.6%</td>
<td>4</td>
</tr>
<tr>
<td>Saxophone</td>
<td>8.2%</td>
<td>5</td>
</tr>
</tbody>
</table>

Of the 62 respondents who answered that woodwinds was their primary instrument, 37.1% (23) reported that they do use it in clinical practice while 62.9% (39) answered that they do not. Unlike voice, piano, and guitar these respondents were not asked about a comparison with another competency because woodwinds are not listed separately within the competency.
requirements set by the AMTA. However, the same questions in terms of what interventions are used, how often these interventions had been used within the past year, and reasons given for using the principal instrument of "woodwinds" with clients were asked. Table 11 lists the interventions that these respondents briefly described. The table is divided into categories since among the responses there were some similarities that arose. These include improvisation, playing for clients/performing, using the instrument to aid in breathing/speech, communication, song-identification, reminiscence, environmental needs, emotional/spiritual well-being, sensory input, accompanying clients' music making, and as a novelty in sessions.
Table 11 *Woodwind Interventions*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Respondent's Answers/Interventions</th>
</tr>
</thead>
</table>
| Improvisation                  | • “Music improvisation with clients (playing recorders).”  
                                | • “Improvisation with clients with autism.”  
                                | • “Improvisation, creativity, composition for self esteem and life goal.”  
                                | • “Composition.”                                                                 |
| Playing for clients/            | • “For memorial services.”  
                                | • “Entertainment for the kids.”  
                                | • “Played flute in special events that were attended by patients, family members, and staff.”  
                                | • “Playing for special events and seasons.”  
                                | • “Used my flute for Christmas program especially helpful when I had laryngitis.”  
                                | • “Played flute for a Valentine's dinner.”  
                                | • “Performing / playing preferred music selections.”                                                                 |
| performance                    |                                                                                                   |
| Breathing/                      | • “Use with CI students to help link cognitive awareness of breath to speech/production of sound.”  
                                | • “Breathing entrainment.”  
                                | • “Improvisation to support optimal breathing on winds.”  
                                | • “Posture and breath support.”                                                                 |
| Speech                         |                                                                                                   |
| Communication                  | • “Music to support and lead a non-verbal group focused on receptive and expressive communication.”                                                                 |
| Relaxation                     | • “During relaxation exercises.”  
                                | • “Relaxation/healing music.”  
                                | • “Music as therapy intervention used to assist music relaxation techniques in group.”  
                                | • “Music Therapy Music Meditations.”  
                                | • “Music visualization with live music.”                                                                 |
| Song – Identification          | • “For 'name that tune' games with geriatric clients.”  
                                | • “Song identification: playing a song (without words) to help client identify song title/words in order to enhance speech or cognition.”  
                                | • “Used the flute for name that tune activities.”  
                                | • “Name that tune”; and familiar songs with pts with dementia/Alzheimer’s.”  
                                | • “Play melodies for memory recall by client/patient.”                                                                 |
| Reminiscence                   | • “Reminiscence and life review.”                                                                 |
| Environmental                  | • “Environmental Music Therapy.”                                                                 |
|                                |                                                                                                   |
| Emotional/Spiritual Well-being | “Promoting a sense of emotional and spiritual well being.”  
|                               | “Helping patient contact inner spiritual resources.”  
| Sensory                       | “Sensory stimulation: have the clients feel the bell of clarinet as I’m playing, or feel my fingers move.”  
|                               | “Use as a vibrotactile stimulus for visually impaired clients.”  
|                               | “Used to promote eye contact tracking responses from multiply disabled patients.”  
| Accompaniment/playing with clients | “Sing-a-long.”  
|                               | “Movement to music.”  
|                               | “Played flute with a pulmonary outpatient group - accomp. to their chimes and singing.”  
|                               | “Singing: accompanying singing during music therapy sessions.”  
|                               | “Support a client while they are singing.”  
|                               | “Provide melody line while clients are playing chimes.”  
|                               | “Duets with patients for therapeutic instrument performance.”  
|                               | “Played big band songs as clients sang along.”  
|                               | “Imitated melodies as played by client on a “play” saxophone.”  
|                               | “Ensemble listening skills and working together rhythmic accuracy and blend.”  
|                               | “Introduction of a new melody.”  
| As novelty                    | “ Exposure for the kids to something new.”  
|                               | “Instrument of the Month-Info on how to play it, demonstration of different types of music.”  
|                               | “Medium to promote discussion.”  

In regards to the question concerning how often these interventions are used, twenty-three respondents provided a response. Figure 39 shows that of the 23 respondents the majority have used these interventions, with their principal instrument, between 0-25 percent of the time.

In comparison to the other instruments reviewed so far (voice, piano and guitar) woodwind interventions are reported to be used the least in clinical practice. This is interesting when considering that after voice and piano woodwinds were reported by most respondents as their principal instrument. More insight can be provided as to why this may be so by looking at the reasons given for using or not using woodwind instruments in clinical practice.
Figures 26 to 30 illustrate the respondents level of agreement with the statements concerning why the principal instrument (woodwinds) is used in clinical practice. For the first statement “I feel that I am more effective with clients when using my principal instrument” the responses were varied. In regards to whether the respondents had adequate training in how to use their principal instrument in clinical practice, 7 agreed with this statement while six disagreed, the most disagreement thus far among instruments reviewed up to this point. However there are a number who do agree that they have had adequate training in how to use their principal instrument, which may imply that this is dependent upon the program/instructors as well as the interest of the students.

In terms of setting, the majority of respondents agreed to some extent that their principal instrument is appropriate. There was a similar response in terms of population. Finally when looking at the responses for whether or not one’s principal instrument is appropriate for clients to play, the majority disagreed.
Figure 26 Level of Agreement with Statement 1/Principal Instrument Woodwinds

"I feel that I am more effective with clients when using my principal instrument".

Figure 27 Level of Agreement with Statement 2/Principal Instrument Woodwinds

"I feel I have had adequate training in how to use my principal instrument in clinical practice".
Figure 28 Level of Agreement with Statement 3/Principal Instrument Woodwinds

"I feel my principal instrument is appropriate for my setting".

<table>
<thead>
<tr>
<th>Number of Respondents</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 29 Level of Agreement with Statement 4/Primary Instrument Woodwinds

"I feel my principal instrument is appropriate for the population that I work with".

<table>
<thead>
<tr>
<th>Number of Respondents</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The descriptive answers that were offered based on why woodwinds are used, or in some cases used less frequently in clinical practice, offer further insight. A common response on this subject was the impracticality of not being able to keep the instrument easily sanitized when working with different clients. A respondent whose principal instrument is the bassoon shared the impracticality of setting up this instrument and the awkwardness it brings when playing and leading a session simultaneously. However, it was also shared that at times the sound of the bassoon is a novelty for children and the vibrational qualities are effective. The soothing quality that can be created by the flute is mentioned by some of the respondents and one states that the ability to play to a more advanced level on the flute allows for effects that cannot be reached on other instruments for some clients. However, another response highlights the difficulty of using the flute and singing at the same time. One respondent suggested that woodwinds do have unique strengths in their connection to using the breath in terms of respiration and relaxation. Furthermore, another respondent points out that the flute has been an effective way to reach clients who are nonverbal.
The answers as written by respondents were as follows:

- "My instrument is impractical for home health, especially in Phoenix where I worked. I have no way to keep it protected from the elements unless I bring it to each session. This is impractical because I don't want to use it in every session and I was already carrying too many things in and out of my car every hour".

- "While I think playing my flute in a general medical setting helps individuals, I also have to worry about infection control issues and cannot sing while playing my flute, so at times the flute is not the best choice to use in this setting".

- "I am able to create a mood and effect with flute that I am otherwise unable to create. My musical skill on flute reaches a level that my musical skill on other instruments cannot touch. For some experiences, some situations, some clients, this can create a new mood, a new space for opening, a new attentiveness".

- "I feel that flute music is very soothing and appealing for clients to listen to. It has a calming effect.

- "My clients seem to really enjoy seeing and hearing the clarinet live, because they do not have the opportunity elsewhere".

- "It is very awkward to sit on a strap with a bassoon hanging across your body and a reed in your mouth while directing children with multiple impairments to follow therapeutic instructions. Using a neck strap makes the instrument hang at an odd angle and is still awkward. I do use my instrument on occasion as it introduces the kids to new sounds and has great vibrational qualities. It can also be played with a fibercane (plastic) reed that can be sanitized, which is nice. Many of my kids can't reach the finger holes to play notes, but can sit in a chair on the strap while I finger the notes. Overall, it is not the best
or most accessible instrument. I also worry about damage to the instrument as they can be very costly to fix”.

- “Geriatric population is very responsive as familiar melody stimulates memory. Kids with autism who are largely nonverbal have been more vocal with flute which closely resembles human voice”.
- “Winds have particular strengths that are unique, especially when working with the breath both for respiratory health as well as stress management and other clinical needs”.
- “I use my principal instrument in conjunction with other instruments, piano, autoharp, guitar, percussion, voice”

*Strings in Clinical Practice.* Among all respondents fourteen replied that their principal instrument was “strings”. Among these Table 12 shows the particular instrument studied by the respondents within the string family.

Table 12 *Principal Instrument Strings*

<table>
<thead>
<tr>
<th>Principal Instrument Within the String Family</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violin</td>
<td>42.9%</td>
<td>6</td>
</tr>
<tr>
<td>Viola</td>
<td>35.7%</td>
<td>5</td>
</tr>
<tr>
<td>Cello</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Bass</td>
<td>7.1%</td>
<td>1</td>
</tr>
<tr>
<td>Harp</td>
<td>14.3%</td>
<td>2</td>
</tr>
</tbody>
</table>

Six of the fourteen respondents reported that they had used their instrument in clinical practice within the past year. Table 13 illustrates the interventions that were described; again, the interventions have been grouped into categories. These include relaxation, improvisation, teaching, song-writing, hospice interventions, the therapist playing the instrument with clients, playing for clients, and the use of interventions targeted for cognitive needs. To this point, many of the type of interventions are similar among each instrument discussed thus far.
<table>
<thead>
<tr>
<th>Categories</th>
<th>Respondent’s Answers/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxation</td>
<td>• “Relaxation: improvised music to accompany breathing or imagery.”</td>
</tr>
<tr>
<td></td>
<td>• “Relaxation/spiritual groups.”</td>
</tr>
<tr>
<td>Improvisation</td>
<td>• “Duet improvisations (viola and guitar/drums/recorder).”</td>
</tr>
<tr>
<td></td>
<td>• “Sensory improvisation (visual and melodic prompts to vocalize and/or move in a certain way).”</td>
</tr>
<tr>
<td>Teaching</td>
<td>• “Violin lessons.”</td>
</tr>
<tr>
<td>Song-writing</td>
<td>• “Viola/violin accompaniment for song-writing (fiddling...”Train Song”).”</td>
</tr>
<tr>
<td>Hospice interventions</td>
<td>• “Transition music during dying process.”</td>
</tr>
<tr>
<td></td>
<td>• “One to one music therapy with hospice patients.”</td>
</tr>
<tr>
<td>Playing with clients</td>
<td>• “Accompanying client during performance.”</td>
</tr>
<tr>
<td></td>
<td>• “Accompanying singing during sing-a-longs.”</td>
</tr>
<tr>
<td></td>
<td>• “Playing with the clients during re-creative interventions or teaching clients simple parts to play in a group.”</td>
</tr>
<tr>
<td></td>
<td>• “Viola melody lead and accompaniment to Greeting/Goodbye Songs.”</td>
</tr>
<tr>
<td>Playing for clients</td>
<td>• “Active Listening.”</td>
</tr>
<tr>
<td></td>
<td>• “Leisure: performing for the clients as a leisure activity. (rarely).”</td>
</tr>
<tr>
<td></td>
<td>• “Solo performance for audience: listening/relax/stimulation.”</td>
</tr>
<tr>
<td>Interventions for Socialization/Cognition</td>
<td>• “One to one music therapy with geriatric patients: reminiscing, socialization, decreasing isolation.”</td>
</tr>
<tr>
<td></td>
<td>• “Group music therapy: socialization, reminiscing.”</td>
</tr>
<tr>
<td></td>
<td>• “Attention-to-task and opposites (following/identifying musical cues to play short, long, loud, quiet).”</td>
</tr>
<tr>
<td>Other</td>
<td>• “Exposure to new genres.”</td>
</tr>
</tbody>
</table>
Figure 31 illustrates how often the respondents answered that they use the above interventions in clinical practice. All six respondents who described interventions answered this question. None of the respondents chose the options of 75-100% of the time, 25-50% of the time or never. More so than woodwind instruments, strings seem to be used the least in clinical practice by the respondents, in comparison to the instruments reviewed thus far.

*Figure 31 Percentage of Sessions String Interventions used within the Past Year*

The reasons given concerning why the principal instrument is used in clinical practice may provide further insight into why strings were not reported to be used as often as piano, voice and guitar have been. This may also have to do with the low number of respondents who consider their principal instrument to be strings. Figures 32 to 36 illustrate the respondents’ level of agreement with the statements given. Of the six respondents who answered this question most agreed to some extent that they feel they are more effective when using their principal instrument. Most respondents agreed that they had adequate training in how to use their principal instrument in clinical practice and felt that their instrument is appropriate for their setting and the population worked with. Finally, similar to the response by those whose principal instrument was woodwinds, the majority of respondents disagreed that their principal instrument is accessible for clients to play, while one strongly agreed.
Figure 32 Level of Agreement with Statement 1/Principal Instrument Strings

"I feel that I am more effective with clients when using my principal instrument".

Figure 33 Level of Agreement with Statement 2/Principal Instrument Strings

"I feel I have had adequate training in how to use my principal instrument in clinical practice".
Figure 34 Level of Agreement with Statement 3/Principal Instrument Strings

"I feel my principal instrument is appropriate for my setting".

Figure 35 Level of Agreement with Statement 4/Principal Instrument Strings

"I feel my principal instrument is appropriate for the population that I work with".
If most of these respondents felt that their principal instrument (strings) is appropriate for their setting and population and that they are effective when using their principal instrument, perhaps an important factor in why these instruments are not used as often has to do with the agreement among respondents that the instruments are not accessible for the clients to play. This may suggest there is a lack of hands on approach for clients in terms of using string instruments in particular. Two of the respondents provided more information in describing why they may use their instrument less in clinical practice. One response was similar to that described in the woodwind section; this is the difficulty of playing while leading and singing. An interesting response here is also the negative effect years of learning and practicing one’s principal instrument to "perfection" may have on using one’s principal instrument in clinical practice. This would be an interesting topic in itself and points to the difference in attitude towards music in the education of a music therapist vs. learning to perform. The second response focuses on the positive boundaries clients may learn when the use of ones unique principal instrument is limited in practice. Therefore perhaps although these instruments are used less, they may be viewed as a special experience when introduced into a session.
The Use of the Music Therapist's Principal Instrument

The written responses were as follows:

- "It is hard to sing while playing violin. It is also hard to give verbal cues for stress management while playing. I also have hang ups on the violin due to years of feeling that I had to be perfect. Though less skilled, I am more comfortable on guitar since I don't feel pressured to be perfect or as good as I was when I practiced several hours per day".

- "My viola is the ONE instrument that my clients learn they are NOT to ever play themselves. Teaching boundaries and respect for another's things is important in attaining appropriate social interaction. Using the viola is “special” and the clients have all responded very favorably to its inclusion in therapy”.

*Brass in Clinical Practice.* Similar to strings, the number of respondents who answered that their principal instrument was “brass” was lower than voice, piano and woodwinds. Of the 13 respondents whose principal instrument was brass, the table in table 14 shows the respondents’ particular instrument of study.

Table 14 *Principal Instruments Brass*

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Frequency</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trumpet</td>
<td>30.8%</td>
<td>4</td>
</tr>
<tr>
<td>French horn</td>
<td>23.1%</td>
<td>3</td>
</tr>
<tr>
<td>Trombone</td>
<td>30.8%</td>
<td>4</td>
</tr>
<tr>
<td>Tuba</td>
<td>15.4%</td>
<td>2</td>
</tr>
</tbody>
</table>

Of these 13 respondents 23.1% (3) stated that they have used their principal instrument in practice within the past year, while 76.9% (10) stated that they have not. For those who stated that they have used their principal instrument in clinical practice, table 15 lists the interventions described by the respondents. As there were only six responses overall, the answers have not been grouped into categories but listed as written. Two similarities which did arise were the use
The Use of the Music Therapist’s Principal Instrument

of brass instruments for breath control, a similarity shared with woodwind instruments and the voice.

Table 15 Brass Interventions

<table>
<thead>
<tr>
<th>Respondent’s Answers/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “A resident who previously played trumpet—worked on breath control.”</td>
</tr>
<tr>
<td>• “Used with CP student to help strengthen arms, improve fine motor coordination, increase breath control.”</td>
</tr>
<tr>
<td>• “Lessons about wind instruments.”</td>
</tr>
<tr>
<td>• “Played mariachi music when class was studying Mexico.”</td>
</tr>
<tr>
<td>• “In recreational music groups—name that tune.”</td>
</tr>
<tr>
<td>• “Ensemble activity.”</td>
</tr>
</tbody>
</table>

The following pie chart (figure 37) illustrates how often the respondents reported to use the interventions they listed in clinical practice. There were only three responses to this question, 2 respondents (66.7%), answered between 0-25% of the time and one respondent (33.3%) answered that they have used the interventions listed between 25-50% of the time within the past year, a response similar to those who answered this question in the category of strings.

Figure 37 Percentage of Sessions Brass Interventions used within the Past Year

The responses related to why the principal instrument (brass) is used in clinical practice are demonstrated in table 16. From this table it can be seen that two of the respondents somewhat agreed that they were more effective with clients when using their principal instrument while one disagreed. This is in contrast to some of the responses about using other instruments reviewed so far, in which a majority strongly agreed or agreed. There were no further comments as to why a
principal instrument (brass) may be used in clinical practice, although some of the interventions listed may give hints to this. For example, its applicability towards breath control and fine motor control or its applicability to a certain style of music such as “mariachi”. Furthermore, as there were only three respondents it is difficult to know how the participation of more respondents would have altered the results and provided more information.

Table 16 Level of Agreement with Statements 1-5/Principal Instrument

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am more effective with clients when using my principal instrument.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel I have had adequate training in how to use my principal instrument in clinical practice.</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for my setting.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for the population that I work with.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel my principal instrument is accessible for clients to play.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Percussion in Clinical Practice. Percussion was last to be included as a choice of principal instrument within the survey. For those whose primary instrument was percussion, table 17 lists the interventions as described by respondents. Of the 8 respondents who stated that percussion was their primary instrument 7 responded that they have used their instrument in clinical practice within the past year. As with brass interventions, there were not a large number
of responses in this instrumental category, therefore the interventions are not divided into separate
groups. However, some similarities that do arise here are the use of drum circles, improvisation,
the use of percussion to accompany singing and other instrumental playing and the use of
percussion in the aiding of physical rehabilitation. The answers are listed as written by the
respondents.

Table 17 Percussion Interventions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Drum circles”</td>
<td>“Drum set lessons”</td>
<td>“Mallet ensembles”</td>
<td></td>
</tr>
<tr>
<td>“Drum circle with adolescents with Bx disorders”</td>
<td>“Percussion as part of “rock band” with Tweens”</td>
<td>“1:1 in private practice drum lesson to facilitate physical rehabilitation”</td>
<td></td>
</tr>
<tr>
<td>“Music Performance Groups”</td>
<td>“Music Improvisational Groups’”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Improvisation”</td>
<td>“Composition”</td>
<td>“Music reading”</td>
<td></td>
</tr>
<tr>
<td>“Drum Circles - Used for goals of socialization, attention, team-building, exercise”</td>
<td>“Improvisation with un-tuned percussion - To encourage verbalization, movement/ endurance, playfulness”</td>
<td>“Singing/chanting with frame drum - hospice to improve quality of life dementia to encourage response”</td>
<td></td>
</tr>
<tr>
<td>“Drumming to Poetry - to encourage creativity through cadence”</td>
<td>“Hand percussion to accompany piano - to encourage participation, socialization, and movement”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“As an accompaniment to my singing”</td>
<td>“For sensory stimulation”</td>
<td>“For motor skills/movement to increase level of alertness”</td>
<td></td>
</tr>
</tbody>
</table>

Figure 38 illustrates how often the respondents reported to use the interventions listed
within the past year. A more varied response is shown here in comparison to the responses in
terms of woodwinds, strings, and brass. The majority reported to use percussion interventions
between 25-50% of the time followed by 50-75%. This is less than voice and guitar but more than
woodwinds, strings and brass.
When looking at the statements of why the respondents feel that they use percussion in clinical practice, all respondents (7) who answered agreed with each statement to some degree. This is illustrated in figures 39 to 43. One statement that these respondents seem to agree with, more so than all the other instruments listed previously, is the accessibility of percussion for clients to play. This may implicate why percussion may be used more often than woodwinds, strings or bass. Other implications concerning why some instruments, such as percussion, voice, and guitar may be used more often than others may be practicalities such as the cost and maintenance of these instruments.
**Figure 40** Level of Agreement with Statement 2/Principal Instrument Percussion

"I feel I have had adequate training in how to use my principal instrument in clinical practice".

**Figure 41** Level of Agreement with Statement 3/Principal Instrument Percussion

"I feel my principal instrument is appropriate for my setting".
Figure 42 Level of Agreement with Statement 4/Principal Instrument Percussion

"I feel my principal instrument is appropriate for the population that I work with".

Figure 43 Level of Agreement with Statement 5/Principal Instrument Percussion

"I feel my principal instrument is accessible for clients to play".
In terms of further comments made by respondents about the use of percussion in clinical practice one respondent commented on the advantage of having a background in percussion which provided an increased ability to coordinate playing while also leading and assessing. A skill pointed out to be somewhat of a difficulty when using woodwind and string instruments. It was also commented that one's competency on another instrument is important so that instruments may change based on the needs of the client. The answers as written by respondents were:

- “Percussion is definitely an outlier in this kind of study. Oh well. Guitar, voice, and piano are to some extent, except that you can't apply classical training in any of those areas very directly to MT. Percussion, and specifically hand percussion, training is really rhythmic and coordination based which put me leaps ahead my classmates in playing, talking, and assessing all at the same time”.

- “While I listed percussion as my principle instrument during education, I feel nearly equally competent playing piano and do use that modality interchangeably based on assessment and needs of the population I work with”.

In summary, among the respondents who use their principal instrument in clinical practice there are similarities that can be discussed. For example, many respondents included related interventions such as improvisation, relaxation, song-writing/composition and using their instrument with clients in the context of a lesson. Although the interventions may be similar, reasons as to why the respondents use their principal instrument in clinical practice may give some insight into how different instruments can bring unique qualities to a session. For example, with voice, the ability of a trained vocalist to manipulate and use his/her voice in a range of ways as well as understand how the voice works physiologically were noted. The voice and its direct connection to the body is also something that is unique to this instrument. The connection of woodwind and brass instruments to breathing and respiration was also commented upon, a unique
trait not shared by keyboard, guitar, strings or percussion. Instruments in the family of woodwinds, strings, and brass may sometimes bring a degree of novelty to clients, adding something new that they do not often have access to hearing and experiencing live. The unique sound and timbral quality of each instrument may add to this novelty. Piano, as discussed previously, allows one the ability to use melody and harmony simultaneously, this can also be done on guitar by skilled players. Finally, percussion seems to be accessible for many clients to play themselves, while other instruments may have some limitations, some for practical reasons such as keeping the instrument clean etc. One common theme that also arose among many respondents is the importance of keeping the clients needs in mind. So, although one may be more skilled on a particular instrument, it may not be appropriate for a particular situation. This suggests that having the flexibility and skills to use varied instruments is important.

*Suggested reasons the principal instrument may not be used in clinical practice*

Among the two hundred and twenty two respondents who completed the survey, 27.6% (63) responded that they have not used their principal instrument in clinical practice within the past year. In order to understand the research question “What are the reasons given for not using one’s principal instrument in clinical practice?” respondents were asked to report to what degree they agree or disagree with statements relating to this topic as well as provide more information in a brief descriptive response. This question was answered by sixty-two respondents. Although a distinction was not made between each instrument, as done previously, some of the respondents gave more precise information regarding a particular instrument in the brief written statements that were given. Figures 44 – 48 show the statements and the respondents’ level of agreement with each.
Figure 44 Level of Agreement with Statement 1/All Principal Instruments

"I do not feel I have adequate training in how to use my principal instrument in clinical practice".

Figure 45 Level of Agreement with Statement 2/All Principal Instruments

"I do not feel there is enough information/research available that applies to using my principal instrument in clinical practice".
Figure 46 Level of Agreement with Statement 3/All Principal Instruments

"I do not feel my principal instrument is appropriate for the setting I work in".

Figure 47 Level of Agreement with Statement 4/All Principal Instruments

"I do not feel my principal instrument is appropriate for the population that I work with".
The results suggest that the majority of respondents who have not used their principal instrument within the past year felt that they have had adequate training in how to do so and that there is enough research/information available on how one may use his/her principal instrument in clinical practice. One interesting difference between the responses to these two statements is that while 10 respondents agreed to feeling that they have not had enough training in this topic 20
agreed that there is not enough research available. This may suggest that although, among those who took part in this survey, music therapists are adequately taught how to use their principal instrument in clinical practice during training or work, it is not as often written about. A majority of the respondents also felt that their principal instrument is inappropriate for the setting worked in. However, there is not a large difference between how many respondents felt their principal instrument to be appropriate or inappropriate for the population worked with. While thirty-three respondents felt their principal instrument was appropriate for their population, twenty-eight felt that it was not. From this data the specific instruments used are not known, which would have provided further information about which instruments may be thought to be more appropriate than others.

A large majority of the sixty two respondents who answered these questions felt that their instrument is not accessible for clients to play. Among those who do use their principal instrument (but not so often) such as woodwinds, strings, and brass and among those who do not use their principal instrument a relevant issue seems to be the inaccessibility of a hands on experience with the particular instrument, for the client. The last statement shows that for some respondents (31) the principal instrument studied in their music therapy education is no longer considered primary. This may be for various reasons, perhaps personal preference and skill on a range of instruments, because of the needs of the setting, population, or individual clients. If another instrument is more accessible to work with and used more often in practice it may take precedence over what was considered the “principal” instrument years ago.

Another statement presented to the respondents concerned whether they would like to use their principal instrument in clinical practice in the future, although they had not in the past year. Figure 50 shows that the respondents were divided in their response to this with a slight majority agreeing to some degree. In response to whether, although the principal instrument had not been used within the past year, it had been used previously, a majority of the sixty two respondents
agreed with this statement. These two statements suggest that whether one uses or does not use his/her principal instrument may depend somewhat on their current situation. There are those who have integrated their principal instrument in the past, are not doing so currently, but would like to again in the future.

*Figure 50 Level of Agreement with Statement 7/All Principal Instruments*

![Bar chart showing levels of agreement with the statement.]

*Figure 51 Use of Principal Instrument in the Past*

"Although I have not used my principal instrument in clinical practice within the past year I have used it in the past".
Written Responses. Respondents wrote of various reasons why the principal instrument may not be used in practice. Some of these reasons are practical, for example a facility that does not own/provide a piano or keyboard, or if it does the instrument may be old and out of tune. If the music therapist must travel from session to session or to different sites, some instruments, such as the keyboard, may not be easily transported. Respondents also mention that some instruments may not be appropriate for a "hands on" experience, especially if this is what is needed by the population one works with. Interestingly, there may be different opinions/or answers based on the same instrument. For instance, one respondent adds that the flute would not be suitable for the population worked with due to the need for a more hands on approach from the therapist; while another respondent answers that the flute has become her principal instrument and is used "frequently and consistently" in practice. However, this second respondent does not mention what population is being worked with. This again suggests that the use of a principal instrument may be highly dependent on the situation and the client's needs. Another comment focuses on the limitations of having to play an instrument that requires both one's hands and mouth when playing; in this case the saxophone is mentioned. This respondent also mentions that not playing the primary instrument in clinical work allows the instrument to be savored for one's own playing in terms of performance and self-care. This is an important implication when considering how the music therapist may connect on his/her own with music. The responses as written were as follows:

- "I have been waiting to receive one from my school. I will not use my own instrument at school for fear of being stolen, misused, or destroyed.
- "I want to add, with regard to population, that I work with people with very severe disabilities, which necessitates having "hands on"; most of the time. I often use recorded music, or just my voice. Flute would be about the worst instrument to use with these
The Use of the Music Therapist’s Principal Instrument

In order to engage them, I can’t just play for them either - I would not consider that therapy but rather background music”.

- “To add to “I do not consider the instrument I studied during my education to be my primary instrument any longer” I transitioned to flute and have used it consistently and frequently in my practice”.

- “I need my voice and hands to be able to interact with pre-school and school age children. Playing the flute doesn’t allow this type of interaction. I have used my flute for demonstrations or for listening activities but overall if I am playing I feel like it puts me in a performer/audience position and that is not what I view music therapy to be about”.

- “I have not used the piano in my practice because I am an itinerant/traveling therapist and the piano is not portable. Piano/keyboards are not available at the sites that I visit”.

- “Piano, organ”

- “Often in Nursing Homes there is not a tuned piano or it is placed in such a way that it is difficult to achieve maximum interaction with the residents while playing”.

- “I used portable instruments in a school setting where I moved from classroom to classroom every hour. Classrooms did not contain a piano”.

- “I cannot sing or speak while playing”.

- “I've 'acquired' braces in the past year, which make playing difficult and painful. Prior to braces, flute was an instrument that I used regularly in my music therapy services”.

- “I didn't get to use piano because the facility didn't have one”.

- “I worked in an administrative position for approximately 10 months while continuing to co-provide one hour of group therapy weekly. Upon returning to a fully clinical position, I have not had the opportunity to utilize my principal instrument”.

- "I'm afraid my clients would damage my flute. I need to use instruments that are more durable".
- "No piano on site"
- "Mostly I don't play bassoon anymore because I don't own one. When I graduated, I could have either bought a bassoon or bought a car. And I figured a car was the more practical choice".
- "I believe that the use of the guitar in my current setting better allows me to connect with my clients".
- "At this time, the patients' needs and the groups I offer do not accommodate flute music".
- "The saxophone is not an accessible instrument and it requires the use of my hands and my mouth, not allowing me to be available to a client in many ways. Also, part of it is because it is something that is "mine". I can save it for myself and think of it only on a performance level or as self care within music".
- "I use the guitar much more now".

Use of Other Instruments in Clinical Practice

The final question presented to all respondents concerned how often other instruments, meaning those listed in the professional competencies by the AMTA (voice, piano, guitar, non-symphonic percussion) are used in clinical practice. This question was asked in order to get an idea of what instruments are used in general and how often the competencies on these particular instruments may be employed. However, there is a limitation because of the instruments that were not presented in the survey. For example, there may be many who make use of Orff instruments in their setting or electronic/midi instruments, which were not included among the choices given. Table 18 shows the responses of the two hundred and twenty two music therapists
more varied interventions, this cannot be determined because it cannot be compared in this study to how others (for whom the instrument is not their principal) use the same instruments.

In terms of the number of respondents for each instrument presented in this survey, those with principal instruments of voice (69), piano (66) and woodwinds (62) was higher than those with guitar (18), strings (14), brass (13) and percussion (8). It may be worthy to note here that although guitar and percussion instruments were said to be used often in clinical practice, there are not as many music therapists within this survey who came into the profession with a background of principal study on these instruments. There may be several factors to this however, for example, a larger sample size may have reached a more varied pool of respondents. These instruments may also be secondary for many, still learned at a high skill but not considered “principal” when enrolled in a university program. This survey also was limited in that it required respondents to choose one principal instrument only. Perhaps also asking the level of skill on each instrument, principal and secondary, would have been advantageous.

In terms of particular instrument listed, it may have been more advantageous to have used the term “keyboard” rather than piano, as this might encompass music therapists who have focused on organ while studying, or use an electronic keyboard more often in clinical practice. Overall, the instruments suggested were of the Western Classical tradition, limiting for respondents who may be skilled on music and instruments outside of this. Furthermore, the study was limited to music therapists within the United States and therefore, may not be generalized to music therapists working in other parts of the world.

There was also a limitation concerning percussion skills within this study. While the survey included questions for piano, voice and guitar regarding a comparison to the competencies based on these individual instruments, this was not done so for percussion. Percussion is included as a competency by the AMTA (2008) within non-symphonic instrument skills, where it is stated that the music therapist “play percussion instruments alone or in ensemble and
demonstrate basic skills (i.e. rudiments) on several standard percussion instruments sufficient to facilitate rhythm based experiences for groups and individuals” (p. 29). It is noted that adding this question would have been valuable and provided more information for this study.

Within the survey some limitations are noted in terms of how some answer choices given for respondents may have been unclear. In the section on years of study on one’s principal instrument, when asked the question, “How many years during your music therapy education in a university/college did you have individual lessons in your principal instrument?” one answer choice given was “not a requirement” (See Figure 3). The term “not a requirement” referred to whether one was not required to take individual lessons on his/her principal instrument while in a music therapy university/college program. This was included in order to understand if there were any respondents who were part of a music therapy program that does not include the study of a principal instrument. Furthermore, for the question “If your music training was concentrated in a degree other than music therapy for how many years at the university level (undergraduate and/or graduate) did you take individual lessons”, one answer choice given was “not applicable” (See Figure 4). In this context “not applicable” referred to whether one did not take part in music training during a degree other than music therapy.

It is clear that the results suggest a majority of respondents studied a principal instrument during and before music therapy education. However, this study did not look at how respondents were taught to use their principal instrument in clinical practice. Although a majority, within the category of each instrument, agreed to some extent that they felt they had adequate training in how to use their principal instrument in clinical practice this statement did not specify where the training came from. It cannot be inferred then, whether respondents had adequate training during music therapy coursework, during practical training such as practicum and internship, on the job, or by teaching oneself. The question of how applicable music therapists view study on the primary instrument was also not touched upon in the current study.
who answered this question. Among the respondents it appears that voice and guitar are used most frequently, followed by non-symphonic percussion and the piano.

Table 18 *Use of Other Instruments in Clinical Practice*

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Between 75-100%</th>
<th>Between 50-75%</th>
<th>Between 25-50%</th>
<th>Between 0-25%</th>
<th>Never</th>
<th>Response Count</th>
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<tr>
<td>Voice</td>
<td>184</td>
<td>21</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>221</td>
</tr>
<tr>
<td>Piano</td>
<td>47</td>
<td>43</td>
<td>45</td>
<td>70</td>
<td>13</td>
<td>218</td>
</tr>
<tr>
<td>Guitar</td>
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<td>40</td>
<td>21</td>
<td>14</td>
<td>10</td>
<td>218</td>
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<td>90</td>
<td>64</td>
<td>42</td>
<td>17</td>
<td>4</td>
<td>217</td>
</tr>
</tbody>
</table>

answered question 222
skipped question 29

Discussion/Conclusion

*Limitations of the study*

Overall, the results in Table 18 suggest that the instruments of voice, guitar and percussion, followed by piano, have been used most often by respondents within the past year. The percentage of use of the four instruments listed (voice, guitar, piano, percussion) perhaps shows the importance of the competencies for these instruments as well as adherence to the competencies. However, this last question did not allow for detail on how these instruments are used, as the questions directed towards each principal instrument did. Although respondents were asked how they used their *principal* instrument in clinical practice (and for those who studied voice, piano and guitar how they used these instruments differently from the competencies) those who answered this last question (or who did not use their principal instrument in clinical practice) were not asked to provide the same detail. Furthermore, when asked how the principal instrument was used, the term “intervention” was not defined, which may have hindered receiving more specific information. Therefore, although it might be inferred from the results that perhaps more advanced skill on one’s principal instrument allows for more in depth playing during a session or
Implications for Clinical Practice

That being said some interesting information did arise in terms of the use of one’s principal instrument in clinical practice. The number of respondents who chose a particular instrument did not necessarily match if and how often these instruments are used in clinical practice/in terms of specific interventions. While the number of respondents for woodwinds (62) as a principal instrument was close to the number of respondents for voice (69) and piano (66), woodwinds were not reported to be used in clinical practice by as many respondents or if they were, were not reported to be used as often. However, instruments of guitar (18) and percussion (8) were note as principal instruments by a lower number of respondents but were reported to be used in clinical practice by more respondents and reported to be used more often than woodwinds and piano for that matter. In relationship to whether an instrument was used in clinical practice within the past year, if looking back at figure 6, brass, strings, and woodwinds show the highest response for not using the principal instrument in clinical practice within the past year.

These results correspond with some that were found by Braswell, Maranto and Decuir (1979b) in which the primary instruments most reported by music therapists were first piano followed by woodwinds, voice, double major, brass, strings, percussion and guitar. However, Braswell, Maranto and Decuir (1779b) found that the instruments reported to be used the most in clinical practice at the time were ranked from highest to lowest as guitar, followed by piano, autoharp, rhythm instruments, drums and voice. There is a similarity with the current study in that although guitar was not reported to be studied by the majority of respondents as a primary instrument, it was used often in clinical practice. The current study shows, as exemplified in Table 18, that voice was reported to be used most often in clinical practice, followed by guitar. Furthermore, woodwinds were also reported as the primary instrument at a higher number than others but in the case of Braswell, Maranto, and Decuir (1979a, 1979b) were not reported to be used at all in clinical work. Results of the current study show that woodwind instruments are
The Use of the Music Therapist’s Principal Instrument

used in clinical practice, just not to the same degree as others. Moreover, the voice appears to be used more in the current study, although to what depth cannot be specifically determined. Perhaps this implies as Cohen (1997) suggested, that certain instruments may be more applicable to clinical practice than others.

However, although instruments such as woodwinds, string and brass were reported to not be used as often in clinical practice, those respondents within these categories relayed useful information. As one respondent pointed out, the degree of skill which she was able to bring to playing the flute, when she did use it with clients, brought something special to certain sessions that she felt could not be reached when using other instruments. Another respondent whose principal instrument was viola suggested that the limited use of her instrument made it a novelty when presented. The issue of clients not being able to play the viola helped to work on goals of boundary setting. A respondent who used the clarinet also noted that clients enjoyed hearing the instrument because they do not have the chance to do so very often. The qualities of woodwind and brass instruments that made them applicable for working on respiration and fine motor control were also noted. Therefore, although the instruments in the woodwind, string and brass families were not reported to be used as often in this survey their unique qualities may still be important when they are applicable to work with a client. This may imply that it is not that a particular instrument is unsuited to music therapy work, but that how and when an instrument is used depends on the context in which the work is being done.

One might consider then how different instruments can be particularly suited to specific client needs. This can be seen in both the literature review and in the responses given and might be understood from two points of view. One is that interventions may be similar among instruments, which is suggested through the responses given, however, a particular instrument may bring out a greater response from one client over another. For example, in the case study of Gabriela (Gonzalez & Salas, 1991) the violin was noted to have an impact through improvised
and pre-composed music used to communicate with the client. It was also commented that the violin provided the use of “linear melody” within sessions (p. 26). Alvin (1976) wrote about the keenness of her client to study and work with the cello. Among the comments given by respondents, one mentioned that the sound of the flute closely resembles the voice and this has been effective in work with children with autism who are non-verbal. Another respondent mentions that the sound of the flute has a “calming effect”. The guitar was mentioned to lend itself well to the use of other instruments such as the banjo, mandolin, ukulele and dulcimer while percussion was noted to be very applicable for clients to have a hands-on experience. While many instruments might be used for the same interventions, a particular client might have a greater reaction (positive or negative) to one instrument over another.

In another way, results may also suggest that a particular instrument might indeed be suited for a specific need, one example being specific physiological or physical needs. For example, the voice, woodwinds, or brass instruments might be considered for work in speech, breathing, and respiration. For fine motor/gross motor control one might consider the keyboard, again woodwind and brass instruments, as well as guitar, strings and percussion. A number of respondents remarked, when listing interventions, that they used their principal instruments for physical rehabilitation purposes. Furthermore, the project noted in the literature review “Bronchial Boogie” (Andrew, Daniel, & Pye, 2007) is an example of a program that combines music and health related sources geared particularly for children with asthma. While in the mentioned project music teachers and health professionals were involved, perhaps it is feasible to consider similar programs in which music therapists and health professionals work together on such goals.

The results seem to suggest that all the instruments mentioned, although some may not be used as often as others, are applicable in some way. Perhaps in reasoning why some may be used more than others the context of a music therapy session may be considered. Respondents
commented on the use of one’s principal instrument based on the setting and population served, as well as an instrument’s applicability to a hands-on experience for clients. The information gathered in the section on “background” suggested a variety of settings and populations among the music therapists who took this survey. While one’s principal instrument may suit one setting or population it may not suit another. Some reasons given were practical and included the cost and value of an instrument, the difficulty or ease of transporting an instrument or the issue of whether a certain instrument might be intimidating for a client, or may not suit a particular need. Furthermore, respondents both with the primary instrument of woodwinds and strings commented on the difficulty at times of leading a session and interacting with a client while playing these instruments. Remarks were made about how one is not as free to use one’s voice or one’s hands at the same time because of how these instruments are played. The involvement of a co-therapist may allow more vocal or hands on interaction with the client, however, this is not always possible for many reasons which may include staffing, budget and available resources. Therefore, this infers that how often one’s principal instrument is used may be dependent on where one is working and whom one is working with at the time. This issue also raised the importance of having flexibility and skills on various instruments so that the client’s needs might be met.

**Implications for Education/Training**

Although a majority of respondents agreed that they received adequate training in how to use ones principal instrument in clinical practice, as mentioned earlier, the questions asked did not distinguish where the training came from. Improving one’s skill on a principal instrument, in terms of performance, is a component of music therapy training. Braswell, Maranto and Decuir (1979) found that respondents to their survey ranked major instrument and performance among the course requirements to be lessened to some degree or deleted. Cohen’s (1997) study found that music therapists reported positively that the applied instrument/performance requirements
were important to work as a music therapist, however, the importance was not ranked against other skills as it was by Braswell, Maranto and Decuir (1979). Cohen (1997) also writes about secondary skills that are applicable such as leadership and musicianship, rather than the actual use of the instrument. The question that arises then is what aspects of the performance medium, principal instrument, can be taught to be practically applied to clinical work? Although the current study cannot give a definitive answer some suggestions will be made from the results.

A number of respondents, within each category, wrote about the use of employing one’s principal instrument with clients in the form of a “therapeutic lesson”, drawing on performance medium skills as well as on pedagogy. Although, this type of intervention is used among participants, it is interesting that in the competency for one’s principal instrument, within “major performance medium skills” (American Music Therapy Association, 2008, p. 29) there is no mention of pedagogy skills. Although there is a difference between music teaching and music therapy, perhaps some of these skills may be transferred when working with clients. Among the responses, the use of a “lesson” for therapy incorporated various goals. For example, it was commented that teaching the voice can be used for voice production and breathing, for stress relief, to enhance mood, and to improve communication. In the context of a “piano lesson” goals mentioned were to improve cognitive functioning and increase focus and attention, adaptive methods of teaching were also noted such as the use of “playing by pointing, color coded keys/music, and EZ-Play (alphabet forms)”. Among responses for guitar interventions it was indicated that teaching may be used to work on “memory and self-esteem” and to “teach a new or re-develop a prior leisure skill”. Teaching listening skills by the use of matching pitch and rhythm was also noted. Other respondents mentioned using violin and drum-set lessons, although goals were not indicated those already mentioned may be applicable to these instruments as well. Some of the goals for physical rehabilitation needs may also be applicable in this context. Furthermore, in the literature review, Alvin and Priestly were noted to combine verbal processing within the
context of a music lesson to work on social and emotional goals. The use of a “therapeutic lesson” in these contexts might use learning and playing an instrument in order to work on these goals and objectives. Learning an instrument or the voice in this way might lead to further socialization in a school or community music ensemble or choir, if one goal is to carry what is done within a session to one’s life outside therapy.

Perhaps the importance here is that applying pedagogy skills to music therapy differs from a typical music lesson in that the goals are not focused on fine-tuning the music or one’s musicianship (although this may still occur) but on the cognitive, physical, emotional, or social needs of the client. Perhaps it would be applicable then to include within the major performance medium competency, the application of pedagogy skills to the needs of the client. This might help to infer that pedagogy training as well as performance on one’s principal instrument may be advantageous within music therapy education.

Other interventions that seemed to be shared among a number of respondents were the use of improvisation, relaxation, and song-writing. As improvisation is a key component of music therapy education, it would be interesting to note how many programs employ courses specifically based on using one’s principal instrument in the context of improvisation with clients. Although the AMTA lists improvisation skills as a separate competency, applying improvisation skills to one’s primary instrument is not mentioned. However, it can be inferred in the statement “Compose and develop original melodies, accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally. Improvise in small ensembles” (American Music Therapy Association, 2008, p. 29). Improvisation might also be mentioned within the major performance medium skills with an emphasis on the principal instrument.

Within music therapy education it might be also interesting to look at how much of the time spent in music therapy technique classes are geared toward using one’s principal instrument in interventions that do employ, for example, improvisation, relaxation, song-writing/arranging,
and adaptive methods for playing. Perhaps it is simply that the techniques learned on one instrument are transferable to a number of instruments. There is also the issue of how much can be taught within the timeframe of a music therapy degree. However, these techniques did seem to arise by many respondents within this study. This implies that as well as stressing performance skills on one’s principal instrument within competencies or education/training, stressing the transfer of the applied performance medium/principal instrument to music therapy techniques may also be important.

Finally, in terms of education and training it may be interesting to look at whether the lack of stress on applying one’s principal instrument to clinical work detracts from students coming into the field who study instruments that do not seem to be employed as often, such as woodwinds, strings, and brass. For example, how many students do not continue their education in music therapy training because they may be struggling to improve skills on required instruments such as piano or guitar, even though they may be advanced on another instrument that is not deemed as applicable?

In summary implications for training and education are; the applicability of pedagogy skills on one’s principal instrument to music therapy work, learning to transfer the use of one’s principal instrument to music therapy techniques and interventions, looking at how music therapy programs include applying the principal instrument to clinical work, and understanding if placing more stress on applying the principal instrument to clinical work would attract or maintain a more diverse range of instrumentalists who come into and remain in the field.

Implications for Future Research

With regards to clinical practice and future research the current study did not result in detailed accounts of how each principal instrument listed was used in clinical practice, but rather a general overview was obtained. A follow up study might focus on how one uses his/her
principal instrument in clinical practice, with the focus on one instrument. This might be done in the form of a detailed case study to allow for more particular information in terms of clinical work and the instrument used. One respondent wrote of the use of the flute and its positive effect on children with autism. An in depth case study of such work might provide rich information of how the flute is used with children in clinical practice.

An in depth qualitative study may also provide interesting information in terms of how the music therapist and clients respond to the use of a particular instrument. For example, music therapists who studied and use a particular instrument in clinical practice may be targeted and interviewed to understand how this instrument affected their work with a particular client or clients. Information such as this may be gathered from both the perspective of the music therapist and the client. Finally, the importance of other factors in music therapy work such as the therapeutic relationship, therapeutic skills, music therapy skills and verbal skills (among others) were not considered in this study and also play a large part in one's work with clients. Future study might consider how the principal instrument is used in relation to these other skills.

Implications for future study may also be applicable to education and training. As noted previously, one might look at education programs and determine how students are taught specifically to apply their principal instrument to clinical work within each training program. While previous studies have inferred that the performance medium is not as applicable as other competencies/requirements one might look at which aspects specifically are applicable, which are not and what may be done to make them more so.

The music therapist's relationship to his her principal instrument may also be an area of future research. A respondent in this survey brought up the issue of how one's years of intense study on a principal instrument may have a negative impact on the use of this instrument when working with clients, in the sense that one has been taught in terms of product and perfection, rather than process. Another respondent pointed out the positive aspects of using the principal
The relationship one has with his/her principal instrument may correspond with how one identifies him or herself as a musician as well as a music therapist. Maranto (1969) briefly explores the identity of the music therapist; although studies of this kind seem to be more common in terms of music educators/education students (Isbell, 2008; Roberts, 2004) it is a topic that may warrant interesting research in terms of music therapy.

The current study provided a general overview of how the principal instrument may be used in clinical practice. It aimed to understand a bit more of how one's individual background and relationship to a particular instrument might add something unique to clinical practice. Results suggested that although some principal instruments may have been reported to be used more often than others (voice, guitar, percussion and piano in comparison to woodwinds, strings and brass) each instrument was reported to add value to practice when it was used. Furthermore, the use of the principal instrument in clinical practice often seemed to be determined by the setting and needs of the client. Future research might help to understand how various instruments can be used in a particular context and to address certain needs as well as understand how music therapy training makes use of applying the principal instrument/applied performance medium to clinical practice.
References


Dear Colleague,

I am a Master’s student in the music therapy program at Montclair State University. As part of my thesis I am conducting a survey to research the use of the music therapist’s principal instrument in clinical practice. My fascination with this topic came about because of the connection to my own principal instrument and new discoveries of how it could be used to a fuller extent clinically. I am very interested in looking at how music therapists employ the use of their principal instrument in clinical work. I would also like to understand why music therapists may or may not use their principal instrument when working with clients.

You are listed in American Music Therapy Association Sourcebook as a practicing music therapist and I am writing to ask if you would take part in this study. The survey will take approximately fifteen to twenty minutes to complete and your participation will be anonymous. If you click on the link below, it will take you directly to the survey. You may choose not to participate or withdraw from the study at any time.

http://www.surveymonkey.com/s.aspx?sm=jn5ggdcRE_2bRN0pbksv7xB_A_3d_3d

If you have any questions or would like results of the survey you are welcome to contact me by email at avoyajolu@gmail.com. After completion the thesis will also be available through the Montclair State University library.

Thank you for your participation it will be a great help in this research!

King Regards,

Angela Voyajolu, MT-BC
Music Therapy Research Survey

Thank you for choosing to take part in the following survey. This survey is part of a Master's thesis research project, which focuses on the music therapist's use of his/her principal instrument in clinical practice.

The survey includes questions in multiple choice format as well as questions to be answered by brief description. For multiple choice answers, please click on the circle next to each option provided. Questions are formatted so that you will be directed to provide answers based on the principal instrument you report.

Sections of the survey focus on demographic information such as setting and population, musical background, the use of the principal instrument in clinical practice and other instruments used in clinical practice. The survey should take approximately fifteen to twenty minutes to complete. Your participation in this survey will be anonymous.

To move forward within the sections of the survey please click on the "next" button at the bottom of each page. Because of the survey's design, in which you are directed to questions based only on your principal instrument, it is not possible to go back to previous pages for review. For example, if you choose voice as your principal instrument, the survey will skip over the pages based on piano etc. The questions for each instrument are the same. However, I have designed the survey this way in order to collect more specific information, especially through the descriptive responses, for each instrument. Thank you for your understanding. I look forward to learning more about the richness and diversity of instruments and sound used in music therapy work.

References used in this survey are cited on the last page.

Please click on the "next" button to begin.
EDUCATION/PROFESSIONAL INFORMATION

What level of education have you completed? Please check all that apply.

☐ Bachelors in Music Therapy  ☐ Masters in Music Therapy
☐ Bachelors in Music Performance  ☐ Masters in Music Performance
☐ Bachelors in Music Education  ☐ Masters in Music Education
☐ Bachelors in Psychology  ☐ Masters in Special Education
☐ Bachelors/Other  ☐ Masters in Counseling
☐ PostBac/Equivalency in Music Therapy  ☐ Masters/Other
☐ Masters in Music Therapy  ☐ PhD/Other
☐ Other (please specify) __________________________

How many years have you worked as a music therapist? Please check one.

☐ 0-5 years
☐ 5-10 years
☐ 10-20 years
☐ 20-30 years
☐ over 30 years

What setting have you worked in during the past year? Please check all that apply.

☐ General Hospital  ☐ School
☐ Adult Day Care  ☐ Psychiatric Facility
☐ Physical Rehabilitation  ☐ Nursing Home
☐ Correctional facility  ☐ Hospice
☐ Drug/Alcohol Rehab  ☐ Community Center
☐ Veteran’s Affairs  ☐ Private practice
☐ Children’s Day Care/Preschool  ☐ Other (please specify) __________________________

What population have you worked with during the past year? Please check all that apply.

☐ Infants  ☐ Drug/Alcohol Rehabilitation
☐ Children  ☐ Eating Disorder
☐ Adults  ☐ Medical
☐ Geriatric  ☐ Oncology
☐ Special Needs  ☐ Stroke
☐ Multiply Disabled  ☐ Neurological Disorder
☐ Mental Health  ☐ Alzheimer’s/Dementia
☐ Other (please specify) __________________________
MUSIC FOUNDATIONS/PRINCIPAL INSTRUMENT

The context of one’s principal instrument here is based on the major performance medium skills of the music foundation competencies of the American Music Therapy Association. These are listed as: “perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice. Perform in small and large ensembles” (American Music Therapy Association, 2008, p. 29).

What was your principal instrument during your music therapy education at a college/university? If you studied more than one instrument please only check ONE that you consider to have been primary. (Please provide a response. You will be led to more specific questions based on your chosen principal instrument.)

☐ Voice
☐ Piano
☐ Guitar
☐ Strings (violin, viola, cello, bass, harp)
☐ Woodwinds (flute, clarinet, oboe, bassoon, saxophone)
☐ Brass (trumpet, trombone, French horn, tuba)
☐ Percussion
The Use of the Music Therapist’s Principal Instrument

VOICE/YEARS OF STUDY

How many years during your music therapy education in a university/college did you have individual voice lessons?

☐ 0-1 years  
☐ 1-2 years  
☐ 2-3 years  
☐ 3-4 years  
☐ more than 4 years  
☐ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual voice lessons?

☐ 0-1 years  
☐ 1-2 years  
☐ 2-3 years  
☐ 3-4 years  
☐ more than 4 years  
☐ not applicable

For how many years did you take individual voice lessons prior to university studies?

☐ 0-1 years  
☐ 1-5 years  
☐ 5-10 years  
☐ 10-20 years  
☐ over 20 years

Have you used the voice in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

☐ Yes  
☐ No
VOICE IN CLINICAL PRACTICE

The AMTA (2008) also lists voice skills as a separate competency under musical foundations. These are: "Lead group singing by voice; communicate vocally with adequate volume (loudness); and sing a basic repertoire of traditional, folk, and popular songs in tune with a pleasing quality" (p. 29).

How do you use the voice differently from these competency requirements, in clinical practice, because it is your principal instrument?

Please list and briefly describe specific interventions in which you use your principal instrument of voice with clients.

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________

In what percentage of sessions have you used the above listed vocal interventions in clinical practice within the past year? Please check one.

☐ Between 75-100%
☐ Between 50-75%
☐ Between 25-50%
☐ Between 0-25%
☐ Never
The Use of the Music Therapist's Principal Instrument

Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am more effective with clients when using my principal instrument.</td>
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<tr>
<td>I feel I have had adequate training in how to use my principal instrument in clinical practice.</td>
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<tr>
<td>I feel my principal instrument is appropriate for my setting.</td>
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<tr>
<td>I feel my principal instrument is appropriate for the population that I work with.</td>
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<tr>
<td>I feel my principal instrument is accessible for clients to play.</td>
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</table>

Other (please explain)

__________________________________________________________________________
PIANO/YEARS OF STUDY

How many years during your music therapy education in a university/college did you have individual piano lessons?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual piano lessons?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not applicable

For how many years did you take individual piano lessons prior to university studies?

☐ 0-1 years
☐ 1-5 years
☐ 5-10 years
☐ 10-20 years
☐ over 20 years

Have you used the piano in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

☐ Yes
☐ No
PIANO IN CLINICAL PRACTICE

The AMTA (2008) also lists keyboard skills as a separate competency under musical foundations. These are: "Accompany self and ensembles proficiently; play basic chord progressions (I-IV-V-I) in several keys; sight-read simple compositions and song accompaniments; play a basic repertoire of traditional, folk, and popular songs with or without printed music; and harmonize and transpose simple compositions" (p. 29).

How do you use the piano differently from these competency requirements, in clinical practice, because it is your principal instrument?

Please list and briefly describe specific interventions in which you use your principal instrument of piano with clients.

1. _________________________________________________________________________________________________________
2. ___________________________________________________________________________________________________________________________
3. _____________________________________________________________________
4. _____________________________________________________________________
5. _____________________________________________________________________

In what percentage of sessions have you used the above listed piano interventions in clinical practice within the past year? Please check one.

□ Between 75-100%
□ Between 50-75%
□ Between 25-50%
□ Between 0-25%
□ Never
Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am more effective with clients when using my principal instrument.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tr>
<tr>
<td>I feel I have had adequate training in how to use my principal instrument in clinical practice.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for my setting.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for the population that I work with.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is accessible for clients to play.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Other (please explain)</td>
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</tbody>
</table>
**GUITAR/YEARS OF STUDY**

How many years during your music therapy education in a university/college did you have individual guitar lessons?

- □ 0-1 years
- □ 1-2 years
- □ 2-3 years
- □ 3-4 years
- □ more than 4 years
- □ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual guitar lessons?

- □ 0-1 years
- □ 1-2 years
- □ 2-3 years
- □ 3-4 years
- □ more than 4 years
- □ not applicable

For how many years did you take individual guitar lessons prior to university studies?

- □ 0-1 years
- □ 1-5 years
- □ 5-10 years
- □ 10-20 years
- □ over 20 years

Have you used the guitar in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

- □ Yes
- □ No
The AMTA (2008) also lists guitar skills as a separate competency under musical foundations. These are: "Accompany self and ensembles proficiently; employ simple strumming and finger picking techniques, tune guitar using standard and other tunings; perform a basic repertoire of traditional, folk, and popular songs with or without printed music; Harmonize and transpose simple compositions in several keys" (p. 29).

**How do you use the guitar differently from these competency requirements, in clinical practice, because it is your principal instrument?**

Please list and briefly describe specific interventions in which you use your principal instrument of guitar with clients.

1. _______________________________________________________________________________________
2. _________________________________________________________________________________________________________
3. _____________________________________________________________________
4. _____________________________________________________________________
5. _________________________

In what percentage of sessions have you used the above listed guitar interventions in clinical practice within the past year? Please check one.

- □ Between 75-100%
- □ Between 50-75%
- □ Between 25-50%
- □ Between 0-25%
- □ Never
Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
</table>
I feel that I am more effective with clients when using my principal instrument. | □     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
I feel I have had adequate training in how to use my principal instrument in clinical practice. | □     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
I feel my principal instrument is appropriate for my setting. | □     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
I feel my principal instrument is appropriate for the population that I work with. | □     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
I feel my principal instrument is accessible for clients to play. | □     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
Other (please explain) | ☐     | ☐              | ☐                 | ☐       | ☐                 | ☐   |
The Use of the Music Therapist’s Principal Instrument

**STRINGS/YEARS OF STUDY**

**What is your principal instrument of study within the string family?**

- □ Violin
- □ Viola
- □ Cello
- □ Bass
- □ Harp

**How many years during your music therapy education in a university/college did you take individual lessons in this principal instrument?**

- □ 0-1 years
- □ 1-2 years
- □ 2-3 years
- □ 3-4 years
- □ more than 4 years
- □ not a requirement

**If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual lessons in your principal instrument?**

- □ 0-1 years
- □ 1-2 years
- □ 2-3 years
- □ 3-4 years
- □ more than 4 years
- □ not applicable

**For how many years did you take individual lessons in your principal instrument prior to university studies?**

- □ 0-1 years
- □ 1-5 years
- □ 5-10 years
- □ 10-20 years
- □ over 20 years

**Have you used this principal instrument in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)**

- □ Yes
- □ No
### STRINGS IN CLINICAL PRACTICE

Please list and briefly describe specific interventions in which you use your principal instrument (strings) with clients.

1. 
2. 
3. 
4. 
5. 

In what percentage of sessions have you used the above interventions, using your principal instrument, in clinical practice within the past year? Please check one.

- [ ] Between 75-100%
- [ ] Between 50-75%
- [ ] Between 25-50%
- [ ] Between 0-25%
- [ ] Never

Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

**I use my principal instrument in clinical practice because:**

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</tbody>
</table>

I feel that I am more effective with clients when using my principal instrument.

I feel I have had adequate training in how to use my principal instrument in clinical practice.

I feel my principal instrument is appropriate for my setting.

I feel my principal instrument is appropriate for the population that I work with.

I feel my principal instrument is accessible for clients to play.

Other (please explain) ____________________________________________
WOODWINDS/YEARS OF STUDY

What is your principal instrument of study within the woodwind family?

☐ flute ☐ bassoon
☐ clarinet ☐ saxophone
☐ oboe

How many years during your music therapy education in a university/college did you take individual lessons in this principal instrument?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual lessons in your principal instrument?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not applicable

For how many years did you take individual lessons in your principal instrument prior to university studies?

☐ 0-1 years
☐ 1-5 years
☐ 5-10 years
☐ 10-20 years
☐ over 20 years

Have you used this principal instrument in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

☐ Yes
☐ No
WOODWINDS IN CLINICAL PRACTICE

Please list and briefly describe specific interventions in which you use your principal instrument (woodwinds) with clients.

1. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________
5. ____________________________________________________________________________

In what percentage of sessions have you used the above interventions, using your principal instrument, in clinical practice within the past year? Please check one.

☐ Between 75-100%  ☐ Between 50-75%  ☐ Between 25-50%  ☐ Between 0-25%
☐ Never

Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
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<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am more effective with clients when using my principal instrument.</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>I feel I have had adequate training in how to use my principal instrument in clinical practice.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for my setting.</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for the population that I work with.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>I feel my principal instrument is accessible for clients to play.</td>
<td>☐</td>
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</table>

Other -please explain
BRASS/YEARS OF STUDY

What is your principal instrument of study within the brass family?

☐ Trumpet  ☐ Trombone
☐ French horn  ☐ Tuba

How many years during your music therapy education in a university/college did you take individual lessons in this principal instrument?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual lessons in your principal instrument?

☐ 0-1 years
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ more than 4 years
☐ not applicable

For how many years did you take individual lessons in your principal instrument prior to university studies?

☐ 0-1 years
☐ 1-5 years
☐ 5-10 years
☐ 10-20 years
☐ over 20 years

Have you used this principal instrument in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

☐ Yes
☐ No
BRASS IN CLINICAL PRACTICE

Please list and briefly describe specific interventions in which you use your principal instrument (brass) with clients.

1. _______________________________________________________________________
2. _______________________________________________________________________
3. _______________________________________________________________________
4. _______________________________________________________________________
5. _______________________________________________________________________

In what percentage of sessions have you used the above interventions, using your principal instrument, in clinical practice within the past year? Please check one.

☐ Between 75-100%  ☐ Between 50-75%  ☐ Between 25-50%  ☐ Between 0-25%
☐ Never

Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th>I feel that I am more effective with clients when using my principal instrument.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel I have had adequate training in how to use my principal instrument in clinical practice.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<table>
<thead>
<tr>
<th>I feel my principal instrument is appropriate for my setting.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</table>

<table>
<thead>
<tr>
<th>I feel my principal instrument is appropriate for the population that I work with.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel my principal instrument is accessible for clients to play.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
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</tbody>
</table>

Other - please explain _____________________________________________________________________
PERCUSSION/YEARS OF STUDY

How many years during your music therapy education in a university/college did you take individual lessons in percussion?

□ 0-1 years  
□ 1-2 years  
□ 2-3 years  
□ 3-4 years  
□ more than 4 years  
□ not a requirement

If your music training was concentrated in a degree other than music therapy, for how many years at the university level (undergraduate and/or graduate) did you take individual lessons in percussion?

□ 0-1 years  
□ 1-2 years  
□ 2-3 years  
□ 3-4 years  
□ more than 4 years  
□ not applicable

For how many years did you take individual lessons in percussion prior to university studies?

□ 0-1 years  
□ 1-5 years  
□ 5-10 years  
□ 10-20 years  
□ over 20 years

Have you used this principal instrument in clinical practice within the past year? (Please provide a response. The following questions will be based on the chosen answer.)

□ Yes  
□ No
PERCUSSION IN CLINICAL PRACTICE

Please list and briefly describe specific interventions in which you use your principal instrument of percussion with clients.

1. ____________________________________________________________________________

2. ____________________________________________________________________________

3. ____________________________________________________________________________

4. ____________________________________________________________________________

5. ____________________________________________________________________________

In what percentage of sessions have you used the above interventions, using your principal instrument, in clinical practice within the past year? Please check one.

□ Between 75-100%  □ Between 50-75%  □ Between 25-50%  □ Between 0-25%
□ Never

Please indicate the extent to which you agree with the following statement. Please also use the space provided to further explain why you use your principal instrument in clinical practice.

I use my principal instrument in clinical practice because:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am more effective with clients when using my principal instrument.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel I have had adequate training in how to use my principal instrument in clinical practice.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for my setting.</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is appropriate for the population that I work with.</td>
<td>□</td>
<td>□</td>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I feel my principal instrument is accessible for clients to play.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other - please explain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Use of the Music Therapist’s Principal Instrument

**PRINCIPAL INSTRUMENT IN CLINICAL PRACTICE**
The following questions are based on the previous answer given, that you have not used your principal instrument in clinical practice within the past year.

**Please indicate the extent to which you agree with each of the following statements. Please also use the space provided to give any further information that is not listed.**

**I have not used my principal instrument in clinical practice within the past year because:**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not feel I have adequate training in how to use my principal instrument in clinical practice.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I do not feel there is enough information/research available that applies to using my principal instrument in clinical practice.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I do not feel my principal instrument is appropriate for the setting I work in.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I do not feel my principal instrument is appropriate for the population that I work with.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I do not feel my principal instrument is accessible for clients to play.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I do not consider the instrument I studied during my education to be my primary instrument any longer.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Other -please explain ________________________________________________________________
Although I have not used my principal instrument in clinical practice during this past year:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Other -please explain

Although I have not used my principal instrument in clinical practice within the past year I have used it in the past.

□ Yes
□ No
**OTHER INSTRUMENTS IN CLINICAL PRACTICE**

Music therapists are also taught to refine skills in voice, guitar, piano and non-symphonic percussion instruments. The following question focuses on the use of these instruments in clinical practice.

Please estimate in what percentage of sessions you have used each of the listed instruments in your clinical work within the past year.

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Between 75-100%</th>
<th>Between 50-75%</th>
<th>Between 25-50%</th>
<th>Between 0-25%</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Piano</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Guitar</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Non-symphonic percussion</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>