

THE USE OF TOUCH WITH OLDER ADULTS IN MUSIC THERAPY SESSIONS

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by

Marcus James Hughes

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APPROVED:

Karen Miller, MM, MT-BC  
Thesis Director

Carolyn Dachinger, PhD, MT-BC  
Committee Member

Lilibeth Al-Kofahy, PhD, RN  
Committee Member

Ronald Shields, PhD  
Dean, College of Fine Arts and Mass  
Communication

## ABSTRACT

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The purpose of this study was to explore how board-certified music therapists are currently using touch with older adults in clinical music therapy settings, what factors influence the use of touch, and which, if any, trainings are being implemented. Three forms of touch were defined and used in this study including: simple touch, protracted touch, and dynamic touch. Previous research within the music therapy and related fields suggest that touch is an important variable for consideration within a therapeutic context, and that there is potential for benefit by older adult clients.

The independent variables analyzed were gender, race/ ethnicity, personality type, region, age, years of experience, philosophical/ theoretical orientation, diagnoses served, settings served, caseload, functions of touch, reasons for restriction of touch, and training received. A survey was created and sent using emails for 973 board-certified music therapists who identified as working with the geriatric population that were purchased from the Certification Board for Music Therapist. Of those individuals, 186 people completed the survey and met the inclusion criteria.

Several findings were generated from this study. First, participants indicated using simple touch more frequently than protracted touch. Few participants indicated using dynamic touch on a frequent basis, and no participants indicated being most likely to use dynamic touch compared to simple or protracted touch. Second, the results provide support for the conclusion that diagnosis, setting, functions of touch, restrictions for

touch, gender, personality type, region, philosophical orientation, and personal beliefs are all factors that may potentially influence a music therapists use of touch.

Finally, the majority of participants who indicated providing massage or more advanced forms of therapeutic touch to clients indicated having received some form of advanced training or supervision from a qualified professional. As a result of this study, it can be concluded that touch is an important factor for consideration by music therapists working with older adults, that touch can have potential for benefit and harm to older adults, and that more training and education is needed in order to better prepare music therapists for appropriate use of touch within a therapeutic context.

**KEY WORDS:** Music therapy, Touch, Geriatrics, Older adults, Physical interaction, Massage

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## **CHAPTER I**

### **Introduction**

#### **Statement of the Problem**

Adults ages 65 and older represent a rapidly growing population receiving services within the health care system of the United States. According the U.S. Census Bureau (2014), adults ages 65 and older make up approximately 15% of the total U.S. population. It is projected in the same report that by 2030 older adults will grow to 74,107,000 and by 2050 will grow to 87,996,000. According to the Centers for Disease Control and Prevention (CDC) (2013), there has been a shift within healthcare from treatment of infectious diseases and acute illnesses to chronic diseases and degenerative illnesses as a result of medical advances and changing circumstances. In the same analysis, two out of every three “older Americans” are reported to have multiple chronic conditions and care for these “older Americans” make up 66% of the United States’ health care budget.

Within this budget, music therapy is a service commonly provided to older adults, and treatment of older adults accounts for a significant area of work for music therapists. According to the American Music Therapy Association’s (AMTA) 2016 workforce analysis, 8% of participating music therapists identified as working with “elderly and Alzheimer’s” as a population type, which could be served in a variety of settings. According to the same survey, 15% of participating music therapists identified as working in “geriatric facilities” as a setting, and 15% identified as working with “seniors” as an age group (AMTA, 2016).

As a treatment modality, researchers have examined music therapy's various effects on older adults. In their 2014 study, Solé, Mercadal-Brotons, Galati, and De Castro found that older adults with dementia were more easily engaged through the use of music therapy, increasing their participation, and also improving their overall affect. Solé, Mercadal-Brotons, Gallego, and Riera (2010) found that older adults receiving music therapy perceived an improvement in overall quality of life and felt they were able to broaden their social network in music therapy groups. In a different study, Hamburg and Clair (2003) found that music therapy aided in improving one-foot stance balance, gait speed, and functional reach in healthy older adults working on gait and balance. Within this larger context of research over the relationship between music therapy services and older adults, there has been research examining more specific techniques used with this and related populations.

In 2016, Clements-Cortés published an article listing music therapy techniques that are found to have efficacy in the palliative population. While palliative music therapy is not directly connected to the older adult population, many of the techniques found within palliative music therapy are also appropriate in geriatric music therapy. Clements-Cortés classifies all of the techniques into four main categories: receptive, creative, recreative, and combined. Under the receptive category are techniques focused on passive listening and reaction to music such as music listening or lyric analysis. Under the creative category are techniques based on newly created pieces of music through music experiences such as songwriting or improvisation. Under the recreative category are techniques focused on replaying already created pieces of music such as singing pre-composed songs. Finally, techniques that combine music with other experiences, such as

music and movement are discussed. Important to note is that, among all of the listed techniques, touch is not explicitly mentioned anywhere as a therapeutic tool.

However, touch and massage as a technique can be found in other existing experimental research. Demmer (2004); Groen (2007); and Horowitz (2009) all conducted studies that explored the frequency of the use of therapeutic touch, massage, and music therapy in the context of complimentary therapies for end-of-life care. The effects of music therapy on interaction between client and caregiver are also analyzed in several studies (Baker, Grocke, & Pachana, 2012; Clair & Ebberts, 1997). In an article more relevant to the present study, Belgrave (2009) explored the use of “expressive touch” compared to “instrumental touch” in the context of music therapy for individuals with late-stage dementia. However, in general, little research exists regarding the use of touch in music therapy, including frequency and methodology of the use of touch by music therapists in clinical settings.

According to Mammarella, Fairfield, and Di Domenico (2012), positive tactile experiences can lead to improvement in both cognitive and emotional skills. Through this study involving 45 older adults, the authors illustrated that positive forms of tactile experiences, in this case different textures of material, lead to a difference in functioning. Velvet, the softest of all the materials, resulted in the most significant benefits. This study was one of the first of its kind to analyze the benefits of tactile experiences, and can have some direct transfers for validating why physical interaction with another person or the environment can be a beneficial and important experience to have. Thus, it is important for there to be research in the context of music therapy specifically analyzing how tactile experiences such as touch are being used in current practice.

## **Need for the Study**

From a theoretical standpoint, this study was aimed to identify the frequency and descriptive characteristics of the use of touch by music therapists in sessions with older adults, possibly leading to the suggestion of some type of relationship bearing further study in future research. This study was designed to explore any trends in the training of music therapists related to the use of touch. This could lead to the possible suggestion of the need to explore, develop, or promote a specific technical training process for implementation of touch into music therapy sessions both with older adults specifically, and potentially on a more generalized manner across the field of music therapy. On a practical level, this study was aimed to develop a description of the nature of how music therapists are currently using touch within their sessions with older adults, so as to clarify and encourage the use of appropriate forms of touch with older adults in the context of music therapy sessions.

## **Purpose of the Study**

For the reasons mentioned above, the purpose of this study was to explore how board-certified music therapists are currently using touch (as defined) with older adults in a clinical music therapy setting. Specifically, this study explored how commonly touch is being used by music therapists, the ways in which touch is used by music therapists, what specific types of techniques are being implemented, and what (if any) types of training relating to the implementation of touch music therapists have received prior to use in sessions.

## **Research Questions**

This study's three main research questions are as follows:

- 1) How frequently and in what forms do music therapists implement touch in sessions with older adults?
- 2) What factors influence the use of touch by music therapists in sessions with older adults?
- 3) What forms of training relating to the use of touch, if any, are applied by music therapists in sessions when using touch with older adults?

### **Definitions**

**Touch.** For the purposes of this study, touch is being defined in three categories as explained in a study by Morrison, Löken, & Olausson (2010). Categories include simple touch, protracted touch, and dynamic touch. Simple touch is defined as involving “brief intentional contact to a relatively restricted location on the surface of the receiver during a social interaction” (Morrison et al., 2010, p. 306). Protracted touch is defined as involving “longer and often mutual skin-to-skin contact between individuals, and usually includes a component of pressure” (Morrison, et al., 2010, p. 306). Dynamic touch is defined as involving “continuous movement over the skin from one point to another, and can often be repetitive, as in stroking, rubbing, and caressing” (Morrison, et al., 2010, p. 306).

## **CHAPTER II**

### **Literature Review**

In this chapter, research related to the use of touch in music therapy will be presented. In the first section, the researcher will provide a conceptual framework for defining touch as it is presented in the context of psychological and neuroscience research providing evidence for its influence as a social behavior. In the second section, the researcher will summarize how touch has been defined and analyzed in research related to other health care professions. Following this, the researcher will look at how touch is referenced and regulated in the professional documents created by professional music therapy associations. Finally, the researcher will present a summarization of research that specifically looks at the use of touch in music therapy with older adults.

#### **Conceptual Framework for Defining Touch**

There has been a variety of research published in the fields of psychology and neuroscience analyzing touch in its different forms and influences on neurology, human behavior, and psychological functioning. Within this research, attempts have been made to categorize, define, and conceptualize what touch is and how it is implemented.

An article entitled “Observations on active touch”, published by Gibson (1962) in the *Psychological Review*, stands out as a foundational publication within the study of haptics (touch). The first important distinction that this article makes is to differentiate between active and passive touch. Gibson describes active touch as the act of touching or initiating touch, while he describes passive touch as the act of receiving touch or being touched. Gibson also classifies active touch as being an exploratory process rather than a receptive process, like passive touch. He goes further by then stating that active touch

could be referred to as “tactile scanning”, similar to the concept of “ocular scanning” or visual scanning (Gibson, 1962, p. 477).

Gibson implies that active touch is a process by which we explore and perceive our environment. It is not only a source of interaction with others, but also viable form of interaction and process of learning about our environment. Gibson states that, prior to his research, psychologists viewed active touch as a combination of the “feeling of movement” and the “feeling of contact” or kinesthesia and “touch proper” (Gibson, 1962, p. 478). He objects to this with the point that active touch constitutes an effort to “search for stimulation”. This describes a concept now known as gaining feedback.

Another distinction that Gibson (1962) makes between active and passive touch is that passive touch only involves the excitation of receptors in the skin and its underlying tissue. In contrast, active touch, according to Gibson, involves the “concomitant excitation of receptors in the joints and tendons along with new and changing patterns in the skin” (Gibson, 1962, p. 479). The idea that active touch involves the excitement of more receptors provides implications for the use of touch in therapy. Active touch, such as might be seen in a therapeutic setting, activates more awareness. As a result, touch provides an added stimulus, when appropriate and necessary, to the therapeutic environment.

Gibson (1962) seems to make a case for the idea of levels of touch, which is then reinforced later in the same article in a discussion of mechanical events that stimulate the skin. Gibson gives three types, inferring, to some degree, different levels. The first he describes as brief events, including examples such as apply pressure to, tapping, or patting of skin. Second is what he calls prolonged events without displacement, including

vibrating, stretching, or needing. Finally, he describes prolonged events with displacement, including scratching, scrapping, or rubbing (Gibson, 1962, p. 480).

Related to this article by Gibson, is an article published in 2016 by Wagner *in History of Psychology*. In this article, Wagner gives Gibson's study historical context for its significant in this subfield of study in psychology, and then provides a review of other overlooked literature on the subject of active touch in psychology. Wagner states that Gibson's article served as a departure point from the classical theory at the time, which largely focused on the subject of passive touch. It was with Gibson's article that active touch began to take more of a significant role in the psychological research.

Wagner (2016) also states that beyond this article, little more research was done relating to active touch that held as much significance, and as a result, this study served as a milestone for this research in haptics for several decades to come. This article simply serves to illustrate how, since 1962, touch within the area of psychology has been researched in limited quantities, resulting in few articles of significance. Of that research, the few significant articles other than Gibson are reviewed and summarized by Wagner.

Going beyond touch within a psychological context, one major article in the field of neuroscience provides the categorization and definitions of touch that will be adopted by the present study in order to analyze how music therapists use touch with older adults. Morrison, Löken, and Olausson, in 2010, wrote an article that takes a neuroscientific approach to the analyzation of touch specifically though the skin. The researcher starts the article with a statement of the fact that most social neuroscience research focuses on visual and auditory means of gaining social information. However, he goes on to justify that "because the skin is the site of events and processes crucial to the way we think

about, feel about, and interact with one another, touch can mediate social perceptions in various ways” (Morrison, et al., 2010, p. 305). The researchers also set up the article for discussion of how touch can have implications for exchange of social information.

In the early parts of the article, Morrison et al. (2010) defines three important roles that touch has for transmission and processing of social information. First, is how touch serves the role of facilitating affiliative behavior and communication. Affiliative behavior, according to the article, is defined as “that which reflects or increases the disposition of one or more members in an interaction to seek close contact with another member” (Morrison, et al., 2010, p. 306). In other words, touch serves as a means of promoting group cohesion.

Second, according to Morrison et al. (2010), touch serves the role of facilitating affective processing through skin to brain pathways. Affective processing refers to the processing of emotions, feelings, and affects among other things. In this case, touch can be important to the communication and understanding of others on an emotional level. Finally, touch serves to facilitate the role of intersubjective representation or the psychological relation between multiple individuals.

Following these points based on research of how touch facilitates social behavior, Morrison et al. (2010) argues that one crucial point is left out, which is the fact that touch can be pleasant. The researchers then explain that positive hedonic tactile experiences such as a pat on the back or a caress from a loved one are at “the heart of the social domain” (Morrison, et al., 2010, p. 305). The researchers support hedonically positive touch with a statement of how this form of social interaction is ubiquitous in spite of any

differences from culture in how it might be regulated or the varying roles it might play in human relationships.

On another stream of support regarding touch as a social behavior, Morrison et al. (2010) state that touch influences certain developmental pathways. Examples in the article include how parent animal behavior, like licking, can influence the offspring behavior as an adult or how the deprivation of contact with a mother can cause infant humans or animals to become stressed. The idea of developmental pathways is an area of importance to a music therapist seeking to influence behavior in an individual with some kind of developmental delay for example, both in how they have been positively or negatively impacted by either the presence or lack of tactile stimulation.

Morrison et al. (2010) continues to provide numerous examples of how touch has been proven to lead to positive social behavioral changes. This includes but is not limited to: providing a mechanism for the formation and maintenance of social bonds, a nonverbal means of communication of emotions, thoughts and feelings, and an increased desire to seek more tactile interaction. Also included are positive effects of touch such as: increasing the liking of a person or place, facilitating trust and compliance, increasing prosocial behavior, reducing anxiety posed by an impending threat, and benefits for premature infants (Morrison, et al., 2010, p. 306). With the exception of the benefits for premature infants, all of these benefits of positive touch can be addressed across different age groups and populations including older adults.

Finally, within the context of this article by Morrison et al., (2010) three categories of touch are provided that will serve as the definitions of touch for the purposes of this study. The three categories are simple touch, protracted touch, and

dynamic touch. The first category, simple touch, is defined as involving “brief intentional contact to a relatively restricted location on the surface of the receiver during a social interaction” (Morrison, et al., 2010, p. 306).

The second category, protracted touch, is defined as involving “longer and often mutual skin-to-skin contact between individuals, and usually includes a component of pressure” (Morrison, et al., 2010, p. 306). Finally, the third category, dynamic touch, is defined as involving “continuous movement over the skin from one point to another, and can often be repetitious, as in stroking, rubbing, and caressing” (Morrison et al., 2010, p. 306). These three categories and their respective definitions are used in the present study to explore the ways in which music therapists implement touch as well as the intentions behind the implementation of touch.

### **Touch in Health Care**

Transitioning from the idea of touch as a social construct, touch is a concept that has also been explored, researched, and defined in a variety of ways within the health care industry. Given the necessity of the use of touch for health care professionals when interacting with their patients or clients, there has been an array of research looking into touch as a concept within a practical setting. The researchers go into how touch is being implemented, and what effects it has on the health care industry and its clients. In some cases, the researchers evaluate the state of research on touch as it pertains to a certain field within healthcare. In order to explore how touch has been researched in the health care industry, the current researcher has reviewed recent and previous literature on touch within the profession of nursing specifically.

The nursing profession has some of the most concentrated research regarding touch. Touch, in its variety of uses and functions, is one of the most necessary parts of a nurse's practice. This review of literature will serve as a basis for which to compare the current state of literature in the field of music therapy, and serve as a model for developing the critical ideas to be explored in the current study.

In 2001, Chang conducted an in depth review of literature as well as a series of interviews of South Korean adults who were likely to be involved in caring situations regarding physical touch from a nurse or an allied health professional. Chang sought to delineate a working definition of touch as well as meanings, characteristics, and aspects of physical touch through the two phases of study described above. As a result of the literature review and interview process, a working definition of physical touch in caring was developed. Chang described physical touch as a behavioral process of "promoting: physical and emotional comfort, appropriate social role function in caring, and sharing spirituality between people in caring situations based on humanism" (Chang, 2001, p. 821).

This working definition sets up some of the primary functions that touch can serve in a healthcare setting. These functions match some of the functions of touch as a social characteristic in the previous section, and will also be reflected in part in the music therapy literature. In addition to this working definition, Chang (2001) discovered physical touch to have five aspects that related to some need provided the patients. First, the act of physical touch is related to promoting physical comfort and pain relief. Second, the act of physical touch is related to promoting emotional comfort by conveying an empathetic understanding and making the patient aware that he/she is not alone in the

process of disease. Third, the act of physical touch is related to promoting mind-body comfort through the assumption that providing bodily comfort is related closely to the mind.

Fourth, the act of physical touch is concerned with sharing spirituality. This type tends to be focused on helping the recipients find meaning or enlightenment related to their illness and beliefs. Finally, the act of physical touch is carried out to be a part of a specific social role. Touch, as a behavioral process, is oriented to addressing various emotional and physical needs through the way we structure our role as a provider for our clients. According to Chang (2001), physical and emotional comfort as well as spirituality are promoted by nurses through touch. These five aspects also are compatible with the research discussed earlier in the literature review on touch as a social role.

In contrast to the previous study, which sought to define touch and how it functions, Benner (2004) discussed some of the ethical considerations for the use of touch in nursing practice. Specifically, Benner discussed three primary threats to nursing practice relating to the use of touch and comfort measures. According to Benner, the first threat is that the use of touch is invisible due to the fact that it is rarely charted, and almost never suggested in nursing care plans. This concept is perhaps why so little research exists regarding the use of touch in healthcare in general comparative to other research concepts. It is an assumed concept that rarely ever gets explained in detail in formal plans and documentation.

Second, Benner (2004) states that there often exists cultural confusion and other barriers to comforting touch that can lead to boundaries being crossed. The idea of

cultural competence is a topic that is very prevalent in the field of music therapy today. The most recent committee created by the American Music Therapy Association is a diversity and multiculturalism committee, which is committed to serving the diversity cultural differences within the field of music therapy and its client population. The third threat to the use of touch in nursing care is the provision of more technical interventions such as medication to address the same needs that touch is often used to address. This is not an uncommon trend in healthcare. As more technical interventions continue to develop, less emphasis is put on the use of more traditional means of comfort such as through touch.

Benner (2004) also discusses how comforting a patient can still provide social, emotional, physical, and spiritual support for the patient. According to Benner providing comfort requires a certain amount of judgment and skill level. As a result, the use of touch can be life saving for fragile patients, when used intentionally and dutifully. In the case of infants who need to learn to be comforted by human touch and physical comfort, the absence of this soothing type of touch can cause sensory deprivation once they are old enough to tolerate it. The absence of soothing touch, among other stimuli, can also inappropriately increase the need for pain and sedative medications. In conclusion, Benner states that “intrusive, boundary-crossing, inappropriate, and unwanted touch must be avoided, but the dangers of inappropriate touch must not prevent comforting touch and human comfort measures” (Benner, 2004, p. 349).

Transitioning into experimental research conducted in the field of nursing, several studies have been conducted on the use of touch with nurses. The first article, in an earlier study conducted in 1999, Kim and Buschmann explored the effect of expressive

physical touch with verbalization (ept/v) on anxiety and dysfunctional behavior in patients with dementia. Through a one group repeated measures design the researchers found several results. First, anxiety was rated lower immediately following the implementation of ept/v. Second, ept/v caused decreasing episodes of dysfunctional behavior. The implications of these results are that this form of treatment is cost-effective, simple to learn, and effective in improving a patient's quality of life.

In a more recent study by Leonard and Kalman (2015), the experience of being touched was explored with cancer patients undergoing chemotherapy. The study was primarily qualitative and was conducted in both New York and northern Pennsylvania. There were 11 Caucasian, adult participants who spoke English. Each participant was interviewed via a series of open-ended questions to explore the meaning of being touched. Themes were then formulated from the concepts and views expressed in all of the interviews. The primary findings were consolidated down to three primary themes: to build rapport with the healthcare setting, adjusting to changing patterns of touch with family and friends, and intentionally incorporating the therapeutic use of touch.

As a result of all three of these themes, it was concluded that the perceived quality of being touched was dependent upon the established relationship between the patient and provider. It was also noted that for touch to be regarded as positive, patients must be regarded as "inherently whole and equal" (Leonard & Kalman, 2015, p. 517). Previous research that divided touch into two categories of comforting touch and touch necessary for providing care were also not supported by the interviews of the patients in this study. The focus is almost entirely on the connection between touch and therapeutic relationship.

In 2015, Whiteside and Butcher explored and critically reviewed the factors that influence the perception and use of touch by male nursing staff in contemporary healthcare settings. They found that there was an overall perceived fear of touch misinterpretation in the context of what is considered gender appropriate. This is a theme that can be easily reflected in the music therapy field, given a similar disproportion of male to female therapists as it also exists in the field of nursing. Also in 2015, Pedrazza, Minuzzo, Berlanda, and Trifiletti conducted a study to examine how comfortable nurses are with the concept of touch in their own practice. The interesting finding in this study was that touch providing emotional containment was directly related the nurse's perception of emotional exhaustion and negatively related to job satisfaction.

In summarization, there is research in the nursing profession that examines the phenomenon of touch from all aspects and viewpoints. Both qualitative and quantitative studies have been conducted, and the subjective perceptions of both the patients and nurses have been evaluated. There appears to be a majority consensus among the body of researchers in this field that touch as a phenomenon is viewed as a positive experience, but that it directly relates to the perceptions of all parties involved and must be carefully implemented. Aspects such as gender, culture, age, and setting all play into how touch is evaluated, and touch in nursing practice has been defined in a variety of ways relating primarily to its function. The insight gained from this review of nursing literature will serve to guide the structure of the current study moving forward, as the research seeks to gain insight from the perceptions of music therapists working directly with older adults.

## **Touch in Clinical Music Therapy**

While touch has been researched within the health care industry, touch has also been regulated specifically within the field of music therapy. The American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT) are the two autonomous but collaborative authorities on the education and regulation of music therapy within the United States. Each organization respectively has created and regularly updates a set of professional documents that contribute to the definition, education, and implementation of music therapy. Within those documents, certain items make direct or indirect references to the use of touch in music therapy.

AMTA's Scope of Music Therapy Practice (2015) document, which "defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification", makes several references to the idea of implementing touch or physical contact into music therapy sessions. The most direct reference happens under the potential for harm section, where it lists two specific references to physical. In the context of this document, safety is a primary concern for the use of touch or physical interaction in a music therapy session. It is the duty of the therapist to ensure that all physical contact or transport is implemented with appropriate training, and in a way that does not bring harm to the client.

Following the scope of practice, AMTA provides a Code of Ethics (2014) that applies to board-certified music therapists who are also professional members of AMTA. This code of ethics was created in order to "establish and maintain high standards in public service, and require of ourselves the utmost in ethical conduct" (AMTA, 2014).

References in this document to touch or physical contact exist, but are not as direct as those described in the Scope of Music Therapy Practice.

Under section 3.0 for Relationships with Clients/Students/Research Subjects, point 3.4 references a music therapist's obligation to not exploit clients in a number of ways, including physically. Under section 8.0 for Research, point 8.3 points to a music therapist's obligation to protect the welfare of research subjects, including physically as well (AMTA, 2014). The references to physical interaction with a client follow the same context ensuring the physical safety of clients and preventing any physical harm.

Also along the lines of cautionary guidelines, CBMT has put out a Code of Professional Practice (2011). Under section II for application and certification standards, the code states that CBMT may revoke certification or take action against a board-certified music therapist in the case of gross negligence, malpractice resulting in sexual relationships or physical or otherwise exploitation of a client. Like the AMTA documents, the reference is made in the context of protecting and preventing harm to clients. The difference in this case, is that it specifically classifies it as a form of negligence or malpractice.

The next set of references made by AMTA or CBMT professional documents are made in the context of the use of touch or physical interaction as is appropriate or necessary for the music therapist to facilitate the session. Some of these references are also less direct, where another term may imply that touch is or can be used within that context. AMTA's standards of Clinical Practice (2015) make reference indirectly through a point under section 2.0 for assessment. In this section, point 2.3 mentions verbal and

nonverbal. This reference of nonverbal interventions might imply the use of physical touch or interaction as a means of intervening on client behaviors.

As a part of education and clinical training of music therapy students, two separate sets of competencies have been created to declare exactly what types of skills, techniques, and knowledge a music therapist should have in order to practice at the professional, or entry level, and at an advanced level. Under the AMTA professional competencies (2013), which regulates the expected education and training of undergraduate students leading to board certification, section 13 for therapy implementation lists a competency mentioning providing nonverbal directions and cues. In this case, physical interaction could be an implied means of cueing or prompting clients in the context of a music therapy session.

Along with this, the AMTA advanced competencies (2015) make two indirect references to the use of touch. First, under section 2.0, clinical supervision of section B for clinical practice, references nonverbal interventions. The second reference in the AMTA advanced competencies (2015), is under section 4.0 for advanced clinical skills. Point 4.10 references nonverbal interpersonal skills. In either case, interventions or interpersonal skills implies interacting with clients in a nonverbal manner, possibly implying physical interaction as a result.

The document, which makes the most references to the potential use of touch or physical interaction by a music therapist, is within the CBMT's Board Certification Domains (2015), accessible to the public. Within this document, under section A. Implementation under section II, for treatment implementation and termination, a music therapist can provide music therapy experiences to address client's: "(w) interactive

response”, “ac) nonverbal expression”, “av) social skills and interactions”, “ax) spontaneous communication/interactions”, and “ba) verbal and nonverbal communication” (CBMT, 2015). A later section of the same document states that a music therapist may provide verbal and nonverbal guidance in order to achieve therapeutic goals.

Within each of these points either the word “nonverbal” or “interaction” is used, which all possibly imply a music therapist’s ability to use touch or physical interaction as a possible intervention technique or component. Very similar to previously discussed AMTA documents, the CBMT Board Certifications Domains (2015), makes several references to recognizing potential for harm of physical interventions and interacting with clients in way that is respectful. These statements directly and indirectly imply that board-certified music therapists and music therapy students may use touch or physical interaction as a means of assessing, cueing, prompting, guiding, transferring, or intervening on a client. As a result, music therapists, according to these documents, must also be aware of and careful not to bring any potential harm through the exploitation of physical interaction with clients.

In summary, both AMTA and CBMT have created a series of documents that regulate the field of music therapy, and within these documents there are specific and more indirect references to the use of touch in therapy. According to these documents, a music therapist should not in any way implement touch and/or physical interaction in a way that brings harm to any client or seek to exploit them. In contrast, touch is something, through more general references, that may be incorporated in therapy sessions for a variety of purposes including but not limited to physical prompting and transferring.

Beyond those areas, there is not as much explicit detail regarding the exact boundaries of when touch can and cannot be used. This leaves room for interpretation by the therapist, educators, and internship supervisors to decide for themselves how touch should be taught and incorporated into therapy. This provides a need for research regarding the use of touch in clinical practice to further clarify the effects of touch of a variety of populations, which in turn will hopefully lead to further clarification of how it should be regulated and implemented. In the context of this study, the researcher will look a research on touch in music therapy specifically relating to older adults.

### **Touch in Music Therapy with Older Adults**

A variety of research exists analyzing the use of touch in various capacities in the context of music therapy. Belgrave conducted one of the primary studies on the effects of different types of touch in music therapy with older adults in 2009. The researcher examined to find what effect music therapy interventions using two primary types of touch (expressive touch and instrumental touch) had on the behaviors of older adults with late-stage dementia. The researcher also hoped to analyze the perceived effectiveness of music therapy when touch was used. Participants included nine participants, who each received three sessions in each of three conditions (including the two forms of touch and a control condition).

Belgrave (2009) found that expressive touch (i.e., touch conveying feelings of support, comfort, and care applied to the shoulder, arm, or hand) was significantly more effective in eliciting and maintaining alertness in the initial session than instrumental touch (i.e., touch used to assist in a completion of a musical task applied to the appropriate part of the body that was needed to play the instrument) or no touch.

However, the researcher also found there were no significant differences during the first and second session between the experimental and control conditions, meaning that within the context of an initial music therapy session, touch in any form may not have any relative impact until rapport has been established with the client. In addition, rapport ratings were found to be higher during both touch conditions than during the control condition. The researcher indicates that touch is an important technique to be used in music therapy sessions with older adults because touch is proven to have an established impact on both the development of rapport and elicitation of alertness with older adults.

In addition to expressive and instrumental touch, several music therapy studies make reference to caregiver interaction, which could include touch. In 2003, Brotons and Marti analyzed the applications of music therapy and measured its effects on people with Alzheimer's disease and their family caregivers. The study included a satisfaction questionnaire in which caregivers perceived an improvement in the social and emotional areas of their patients. The researchers also found that the patients needed progressively less prompts to initiate spontaneous social interactions with other group members. An interesting finding of this study was that caregivers initiated touch more frequently than patients, however, patients had a greater response to touch from the other than the caregivers did. This shows the discrepancy for how different parties within a therapeutic context related to interaction, and as a result have a need to be reinforced for interaction with client and caregiver in a music therapy context. Continued from this study, several other music therapy studies were conducted to analyze caregiver interaction.

In 2012, Baker, Grocke, and Pachana studied 5 couples living at home where one partner had dementia. The authors sought to discover the impact of stimulating

meaningful interaction between spouses on the quality of the relationship, caregiver satisfaction, and caregiver wellbeing. This study was a mixed methods experimental design, in which 6 weeks of caregiver-facilitated music was implemented for the purpose of stimulating interaction including touch. Touch was involved in several forms including: gentle movement to music with the caregiver, and caregiver initiated physical touch.

The sample size was small, so the results were not tested for significance (Baker, Grocke, & Pachana, 2012). In addition to this, the results revealed limited changes in scale measured for spousal/caregiver depression, spousal caregiver anxiety, quality of caregiver/patient relationship, and caregiver satisfaction. However, several qualitative themes came through the diaries and interviews of caregivers including: engaging in music enhanced enjoyment and relaxation, enhanced quality of spousal relationship, strengthened reciprocity, and increased satisfaction with care-giver role. Baker, Grocke, and Pachana (2012) found, while there are definite indications for there to be a relationship between touch and older adults in the context of music therapy, there is also inconsistency in the reported relationship between touch and music therapy with older adults. In this case, touch is included in a larger context of caregiver interaction, and not direct touch from the music therapist.

Finally, in a series of three studies, Clair with other researchers also analyzed interactions between caregiver and client including physical touch primarily in the form of dancing. In 1993 Clair, Tebb, and Bernstein completed a small study with 4 caregivers (one male and three females) and their spouses with dementia ages 65 years and older. This study was conducted in a group setting with 2 main purposes: to determine if

caregivers who had no prior musical experiences could be trained to use music with their care recipients, and to determine if caregivers' participation with other care giving and care receiving couples in a social gathering with music therapy programming would affect changes in their measure of loneliness and self-esteem. Ballroom dancing was the primary form of touch implemented. The statistical results were not significant, but approached the 0.05 level. Three out of four caregivers indicated improvement in self-esteem. However, none of the spouses had significant changes in loneliness. One couple did indicate that they continued to dance after the conclusion of the study, showing signs for transferability of the increase in touch to everyday.

Clair and Ebbers, in a second study in 1997, examined how singing, dancing, and rhythm playing affected participation and engagement of individuals with late-stage dementia and their caregivers. In this study physical contact was described as including kisses, hugs, caresses, arms about one another, and snuggling. Negative touch was described as including pushing away or grabbing. Like the study done by Brotons and Marti, this study also found that caregivers initiated touch more frequently than their care receivers, but that care receivers were more responsive to touch than were their caregivers.

Clair alone, in a third study in 2002, examined how a music program implemented by caregivers affected engagement with their care receivers. Eight couples over the age of 65, in which the care receiver's disease had progressed to an inability to communicate through conversation, participated in eight sessions once per week at the care receiver's residence. Three forms of engagement were defined including:

participation together in the music application designed for the couple, verbal or vocal interactions between the two members of the couple, and physical touching.

Clair (2002) proved in this study that music therapy was effective in increasing mutual engagement. Claire also found transfer of the engagement outside of the initial study as well. Like the other two studies, Claire analyzed touch in caregivers and not directly from music therapists. Claire also looked at touch in a larger context of engagement. For this reason, further research is needed to analyze more specifically the use of touch by itself and how it is used in current clinical practice by music therapists with older adults.

In summary, music therapy researchers have explored the use of touch both as a primary variable and as a part of some larger context. Touch has been analyzed as it has been implemented both directly between therapist and client and as encouraged between client and caregivers. Overall, generally positive results have been found regarding how touch has impacted clients in a variety of contexts. However, there is a general lack of research that specifically focuses on touch as its own separate variable. Beyond this, with the exception of a few definitions of touch, little research, if at all, has conducted more in depth examination of exactly how touch is currently being implemented by current therapists working with older adult clients. This is intended purpose for the current study, to begin filling the gap in research on this subject.

### **Summary of the Literature Review**

Throughout the course of the literature for the current study, several areas of key research relating to touch have been identified and reviewed. First, neurological and psychological research was reviewed relating to touch and the multiple ways in which

touch acts as a social construct for interaction and communication amongst individuals. In addition to this, the primary classifications of touch derived from this research, which will be used for the purposes of this study were including: simple touch, protracted touch, and dynamic touch. Next, when looking at the research conducted within the nursing profession, touch was identified as being used frequently due to the necessity of the types of care provided. Issues such as gender, setting, and population can affect the way that touch is perceived and implemented by nurses and their patients.

Third, touch was looked at in the context of regulation in clinical practice through the American Music Therapy Association and the Certification Board for Music Therapists. Several general findings were noted relating to the regulation of touch including: 1) music therapists should not bring physical harm to or in any way exploit their clients 2) touch or physical interaction is directly and indirectly noted as an appropriate form of interaction and prompting within a music therapy session and 3) touch or physical interaction is both directly and indirectly referenced in the competencies expected of entry level music therapists. Finally, a literature review was conducted on music therapy specific research relating to the use of touch by music therapist with older adults. Results suggest that there is an overall positive relationship between touch and music therapy with older adults, but that more research is needed regarding use in clinical practice.

## **CHAPTER III**

### **Methodology**

In this chapter, this study's methodological details are presented, including information regarding participants, study components, and measurement tools. Data collection and statistical analysis procedures are also included.

#### **Research Design**

This study used a survey based research design for the purpose of analyzing various dependent factors related to music therapists' use of touch in music therapy sessions with older adults. The dependent variable was the use of touch in music therapy with older adults, as further categorized into three types of touch: simple touch, protracted touch, and dynamic touch. The independent variables analyzed included demographic variables, music therapy practice characteristics, and restrictions/functions of touch. Table 1 includes a complete list of the study's independent variables.

Table 1

*Independent Variables Investigated in this Study*


---

Independent Variables
Demographics including: age, gender, ethnicity, and region
Theoretical/philosophical approach to music therapy
Type of geriatric facility/setting served by the music therapists
Clients' conditions/diagnoses
Types of specialized training/ certifications acquired/implemented
Presence of co-treatment with other allied health professionals
Years of experience
Music therapy caseload characteristics
Personality type
Restrictions relating to the use of touch
Functions of the use of touch within music therapy
Assumptions made by the music therapist relating to the use of touch

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**Participants**

Participants ( $N = 186$ ) were board-certified music therapists (MT-BC) who identified as currently working with adults ages 65 years and older and who provide services within a geriatric or hospice focused company or setting. More specifically, the participating music therapists fit the following criteria: 1) had a current music therapy board certification through the Certification Board for Music Therapists at the time of the study; 2) identified as currently working with adults ages 65 and older; and 3) identified as providing services either through a geriatric community in which the client is a resident or through a company providing services to older adults in home or at alternative

facilities. This survey was developed with the intent of identifying relationship(s) that may or may not generalize to all music therapists working with older adults.

### **Instrumentation**

Given the unique nature of the variables being analyzed, the researcher could not locate an existing, published survey appropriate for in the present study. Thus, the survey used in this study was a researcher-developed instrument created to answer this study's research questions. The survey included questions asking about the following: years of experience in the field, gender, ethnicity, current geriatric settings/facility types serving, percentage of clinical practice dedicated to working with older adults, alternative certifications/trainings acquired relating to touch, functions for which touch is used actively in sessions for older adults, inhibitive reasons for restricting use of touch, and opportunities for co-treatment involving touch. Questions were also included at the beginning of the survey relating to the inclusion criteria in order to filter out unqualified participants. The survey was vetted for clarity, spelling, and grammar by all three members of the thesis committee as well as two non-qualifying board-certified music therapists.

### **Procedural Details**

This study was reviewed and received exempt status from Sam Houston State University's Institutional Review Board (Protocol #33125). Following IRB review, the researcher purchased a list of music therapists' emails through The Certification Board for Music Therapists (CBMT); these individuals identified as working with older adults or end of life care. In order to vet the survey for grammar, spelling, clarity of content, and determine projected time-length for completion prior to sending out the survey to official

participants, the survey was reviewed by two music therapists who did not qualify to participate in the survey.

Upon completion and approval of the final survey, the researcher distributed the survey to the participants using the Qualtrics survey platform via email with two follow up reminders sent at two weeks and three weeks following the initial distribution. The music therapist sent the emails using the email script included in Appendix D.

Participants viewed the informed consent cover letter included in Appendix C and agreed to participate before being allowed to proceed to the survey. Finally, the researcher input the data collected from the survey and analyzed it for trends and themes amongst the responses. All data was stored in a password protected file on a password protected computer that was only accessed by the researcher and other research personnel.

### **Data Analysis**

Upon completion of the survey, the results were analyzed through the Qualtrics analytical tools in combination with the Statistical Package for the Social Sciences (SPSS) program for frequencies, distribution of certain variables, cross tabulations, and common themes presented among therapists. Each variable has been organized and presented according to demographics and research question in order to best draw conclusions from the survey results.

## CHAPTER IV

### Results

The purpose of this study was to explore how board-certified music therapists are currently using touch with older adults in a clinical music therapy setting. Nine hundred and seventy-three emails were purchased from the Certification Board for Music Therapist (CBMT). The purchased emails from CBMT were for board-certified music therapists who identified as working with the geriatric population and who agreed to have their information released by CBMT for research purposes.

An initial email inviting individuals to take part in the survey was sent out to all 973 potential participants. Nine emails bounced back as being invalid email addresses, leaving 964 invited participants. Two follow up reminder emails were sent to participants who had not completed the survey one and two weeks after the initial invitation email. The poll was closed 37 days after the original invitation email was sent out. Out of the 964 potential participants who received the initial invitation, 232 participants started the survey. Of those who started the survey, 202 individuals completed the survey. Out of those 202 participants, 186 met the inclusion criteria and as a result their data was included in the final data analysis.

In this study, the independent variables included gender, race/ethnicity, personality type, region, age, years of experience, philosophical/theoretical orientation, diagnoses served, settings served, caseload, functions of touch, reasons for restriction of touch, and training received. The dependent variables included type and frequency of touch implemented. In this chapter, the researcher will present the descriptive statistics and participants' responses analyzed for themes, organized by research question.

## Demographic Information

**Gender, race, ethnicity, and age.** The total number of participants finishing the survey included 12 males (9.45%) and 174 females (93.55%). One hundred and seventy-two (92.47%) of the participants indicated being white/Caucasian. Five (2.69%) of the participants indicated being multiracial. Three participants (1.61%) indicated being Asian/Asian American. Two (1.08%) participants indicated being Hispanic/Latino/Spanish Origin, two (1.08%) participants indicated being Black/African American, and two (1.08%) participants indicated other. Out of the 181 participants who indicated an exact number when asked about their age, the average age given was 41.77-years-old with a range of ages from 23-years-old to 74-years-old.

**Regional representation.** The two regions with the largest number of survey participants were the Great Lakes region ( $n = 50$ , 26.88%) and Mid-Atlantic region ( $n = 46$ , 24.73%). The next three regions most represented were the Southeastern region ( $n = 25$ , 13.44%), the Western region ( $n = 23$ , 12.37%), and the Midwestern region ( $n = 20$ , 10.75%). The two regions with the smallest number of survey participants were the New England region ( $n = 10$ , 5.38%) and the Southwestern region ( $n = 9$ , 4.84%), with three participants (1.61%) indicating the international option. Two out of the three international participants indicated being from Canada. The third participant did not specify their location. Table 2 presents the demographic information.

Table 2

*Demographic Information of Participants*

Demographic Variable		
<b>Gender</b>	Number Reporting	Percentage
Female	174.00	93.55
Male	12.00	9.45
<b>Race and Ethnicity</b>		
White/Caucasian	172.00	92.47
Multiracial	5.00	2.69
Asian/Asian American	3.00	1.61
Hispanic/Latino/Spanish origin	2.00	1.08
Black/African American	2.00	1.08
Other	2.00	1.08
<b>Age</b>	Number (in years)	
Mean age	41.77	
Lowest reported age	23.00	
Highest report age	74.00	
<b>Region</b>	Number Reporting	Percentage
Great Lakes	50.00	26.88
Mid-Atlantic	46.00	24.73
Southeastern	25.00	13.44
Western	23.00	12.37
Midwestern	20.00	10.75
New England	10.00	5.38
Southwestern	9.00	4.84
International	3.00	1.61

*Note.* Five participants did not indicate an exact number when asked their age, so their responses could not be calculated into the mean age.

**Diagnoses served.** Participants were asked which types of diagnoses they worked with. All listed diagnoses were represented by at least one participant. The top five indicated diagnoses were dementia ( $n = 184$ , 98.92%), Alzheimer's ( $n = 183$ , 98.39%), stroke ( $n = 149$ , 80.11%), Parkinson's ( $n = 144$ , 77.42%), and depression ( $n = 133$ , 71.51%). The following are the most common additional diagnoses or conditions listed by participants: heart disease or heart failure ( $n = 8$ ), Lou Gehrig's disease ( $n = 4$ ), renal disease or renal failure ( $n = 4$ ), and finally psychiatric related diagnoses ( $n = 6$ ) including anxiety, depression, psychosis, and schizo-affective disorder. Figure 1 displays results from diagnoses served by music therapists.

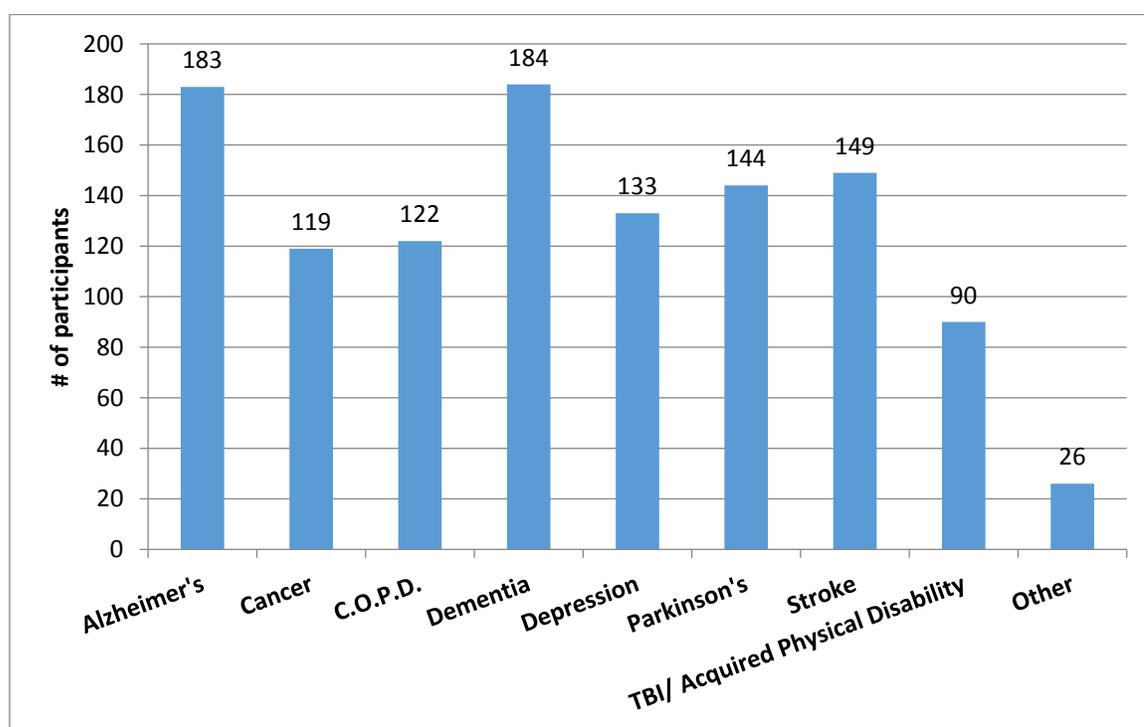
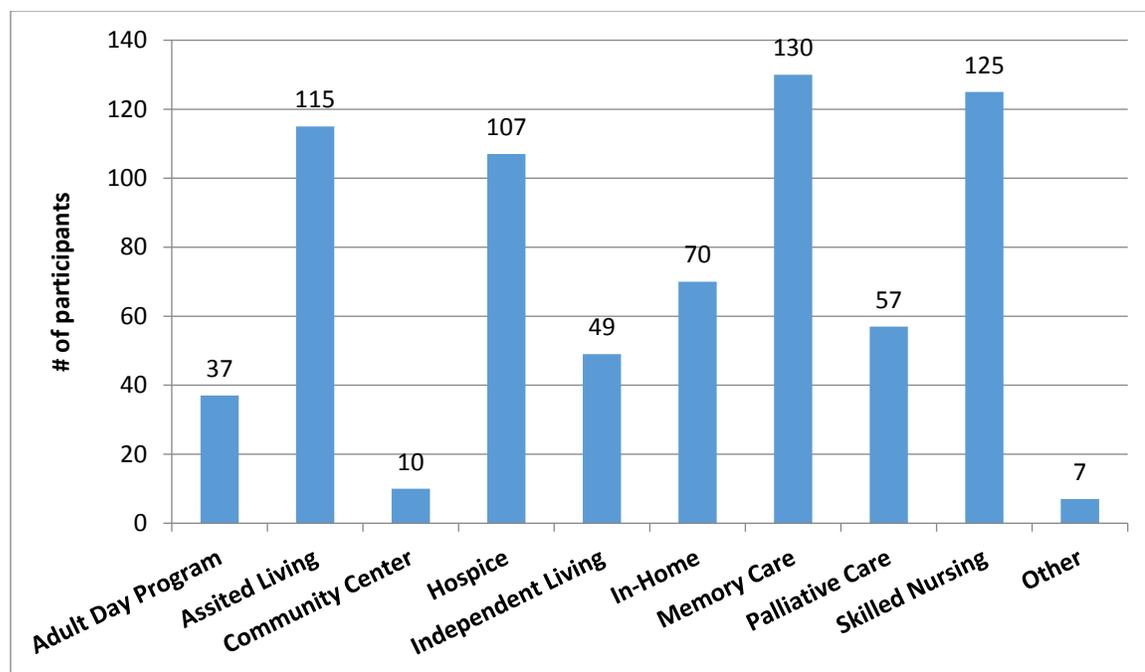


Figure 1. Diagnoses served by participating music therapists.

**Settings served.** Participants were asked about which types of setting they provide services in. All settings were represented by at least one participant. The top five

indicated settings were memory care ( $n = 130, 69.89\%$ ), skilled nursing ( $n = 125, 67.20\%$ ), assisted living ( $n = 115, 61.83\%$ ), hospice ( $n = 107, 57.53\%$ ), and in-home ( $n = 70, 37.63\%$ ). Additional settings noted by participants included a psychiatric unit ( $n = 2$ ), a hospital ( $n = 1$ ), behavioral health ( $n = 1$ ), long term care ( $n = 1$ ), and rehab ( $n = 1$ ).

Figure 2 includes results about settings in which the music therapists serve.

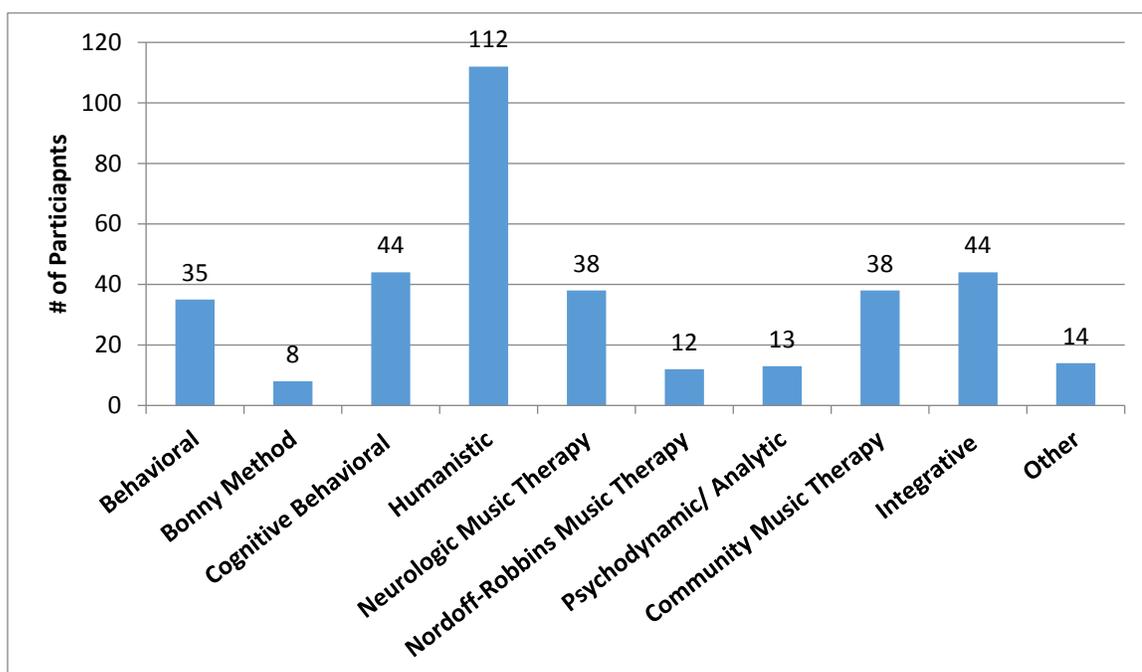


*Figure 2.* Settings served by participating music therapists. Participants were allowed to select more than one philosophy.

**Years of experience.** All participants were asked to indicate the number of years of experience they have as a board-certified music therapist. One hundred and eighty-four participants indicated an exact number. The average number of years of experience indicated was 12.22. The range of years of experience given was one year to 46 years of experience.

**Philosophical/theoretical orientation.** Participants were asked to choose which philosophical or theoretical orientations they identify with. All of the

theoretical/philosophical orientation options provided in the survey were endorsed by at least one participant. However, the top five theoretical orientations indicated were humanistic music therapy ( $n = 112$ , 60.22%), cognitive behavioral music therapy ( $n = 44$ , 23.66%), integrative music therapy ( $n = 44$ , 23.66%), neurologic music therapy ( $n = 38$ , 20.43%), and community music therapy ( $n = 38$ , 20.43%). Figure 3 includes a full representation of indicated theoretical orientations.



*Figure 3.* Philosophical/theoretical orientation of participating music therapists. Participants were allowed to select more than one philosophy.

**Personality type.** Each participant was provided with definitions of the terms introversion and extroversion, including self-statements common to each personality type. Each participant was then asked to choose whether they identified with introversion or extroversion as it relates to their own personality. Seventy-one participants (38.17%) identified with extroversion, while 115 participants (61.83%) identified with introversion.

**Caseload.** Participants were asked a series of questions related to their current caseload. The participants indicated having an average of 85.11 percent of their caseload dedicated to older adults, with a range of seven percent to 100 percent. Participating music therapists indicated visiting an average of 6.55 geriatric facilities per week with a range of one facility per week to 60 facilities per week. Only 177 out of the 186 responses were calculated due to response error or the participant not indicating an exact number. In addition to the number of facilities per week, participants indicated seeing an average of 51.75 older adults per week with a range of two to 300 individuals seen per week. Only 166 out of the 186 responses were calculated due to response error or the participant not indicating an exact number.

### **Results Organized by Research Question**

**Research question #1.** The first research question investigated how frequently and in what forms music therapists implement touch in sessions with older adults. The three forms of touch being investigated in this study are simple touch, protracted touch, and dynamic touch. Simple touch is defined as involving “brief intentional contact to a relatively restricted location on the surface of the receiver during a social interaction” (Morrison, Löken, & Olausson, 2010, p. 306). Protracted touch is defined as involving “longer and often mutual skin-to-skin contact between individuals, and usually includes a component of pressure” (Morrison, et al., 2010, p. 306). Dynamic touch is defined as involving “continuous movement over the skin from one point to another, and can often be repetitive, as in stroking, rubbing, and caressing” (Morrison, et al., 2010, p. 306). The descriptive and thematic results are presented below.

**Simple touch.** When asked how frequently they use simple touch, the largest number of participants indicated implementing simple touch “frequently” ( $n = 82$ , 44.09%). The next two most frequent answers were “very frequently” ( $n = 49$ , 26.34%) and “sometimes” ( $n = 48$ , 25.81%), followed by “rarely” ( $n = 6$ , 3.23%) and “never” ( $n = 1$ , 0.54%). The participants were also asked to give examples of how they use simple touch in their current practice. The most common example given included touching or patting the hand, fore arm, upper arm, shoulder, knee, or leg of the client. Some participants also listed functions for the use of touch (e.g., described why they implement touch), which closely corresponded with a later question, including the use of simple touch for prompting, waking up a client, directing attention, or comfort.

**Protracted touch.** When asked how frequently they use protracted touch, the largest number of participants indicated implementing protracted touch “sometimes” ( $n = 79$ , 42.47%). The next most frequent answer was “frequently” ( $n = 60$ , 32.26%) followed by “rarely” ( $n = 27$ , 14.52%), “very frequently” ( $n = 17$ , 9.14%) and “never” ( $n = 3$ , 1.61%). The examples most commonly given by participants about how they use protracted touch in their current practice include: holding or shaking hands, holding/grasping the clients shoulder, touch through dance or movement to music including physical guidance, and hugging. Similar functions were also listed relating to the use of protracted touch including: for hand-over-hand assistance or hand-under-hand assistance, for greeting or saying goodbye to a client, and for comfort.

**Dynamic touch.** When asked how frequently they use dynamic touch, the largest number of participants indicated implementing touch “rarely” ( $n = 75$ , 40.76%). The next two most frequent answers were “sometimes” ( $n = 52$ , 28.26%) and “never” ( $n = 44$ ,

23.91%), followed by “frequently” ( $n = 12$ , 6.52%), and “very frequently” ( $n = 1$ , 0.54%). The examples most commonly given for dynamic touch as they use it in their practice were: rubbing the client’s hand, fore arm, upper arm, or shoulders, patting or rubbing the client while providing a hug, and providing gentle massage to hands or arms. Comfort, empathy, relief of emotion and tactile or sensory stimulation were the most common functions listed for dynamic touch.

***Comparison between types of touch.*** When asked which form of touch they are most likely to use, 82 participants (44.09%) indicated using simple touch most frequently, while 57 participants (30.65%) indicated that it depends on the goals addressed. Following that, 25 participants (13.44%) indicated protracted touch, 18 participants (9.68%) indicated all of the above, four participants indicated that they are not likely to use touch, and no one indicated dynamic touch. Table 3 displays results forms and frequency of the use of touch.

Table 3

*Frequency and Form of Touch Implementation*

Demographic Variable	Number Reporting	Percentage
<b>Simple Touch</b>		
Never	1.00	0.54
Rarely	6.00	3.23
Sometimes	48.00	25.81
Frequently	82.00	44.09
Very frequently	49.00	26.34
<b>Protracted Touch</b>		
Never	3.00	1.61
Rarely	27.00	14.52
Sometimes	79.00	42.47

(continued)

Demographic Variable	Number Reporting	Percentage
Frequently	60.00	32.26
Very frequently	17.00	9.14
<b>Dynamic Touch</b>		
Never	44.00	23.91
Rarely	75.00	40.76
Sometimes	52.00	28.26
Frequently	12.00	6.52
Very frequently	1.00	0.54
<b>Most Common Form</b>		
Simple touch	82.00	44.09
Protracted touch	25.00	13.44
Dynamic touch	0.00	0.00
All of the above	18.00	9.68
It depends on the goal	57.00	30.65
I am not likely to use touch	4.00	2.15

**Research question #2.** The second research question focused on factors that may influence the use of touch by music therapists in sessions with older adults. The factors investigated for their influence were: diagnosis, setting, function of touch, reason for restriction, gender, race, region, philosophy, personality type, and subjective views based upon education, training, and personal beliefs. The descriptive, inferential, and thematic results are presented below.

*Use of touch according to diagnosis.* Participants were asked to identify with which diagnoses that they were most likely to use touch. Participants were given the option of selecting more than one diagnosis. The top two diagnoses selected were Alzheimer's ( $n = 175$ ) and Dementia ( $n = 169$ ). The next three most common diagnoses were depression ( $n = 90$ ), stroke ( $n = 75$ ), and Parkinson's ( $n = 65$ ). Additional diagnoses

noted by participants include: heart disease or heart failure ( $n = 3$ ), terminal illness ( $n = 2$ ), adult failure to thrive ( $n = 1$ ), anxiety ( $n = 1$ ), multiple sclerosis ( $n = 1$ ), and renal disease ( $n = 1$ ). One person indicated it is dependent upon the individual needs and not the diagnosis. Figure 4 displays the data for use of touch according to diagnosis.

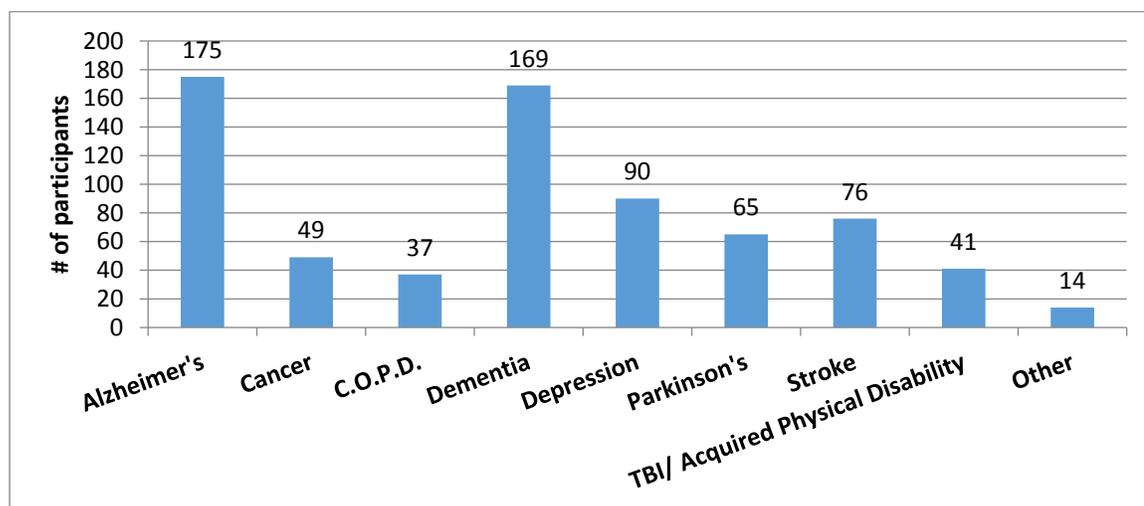
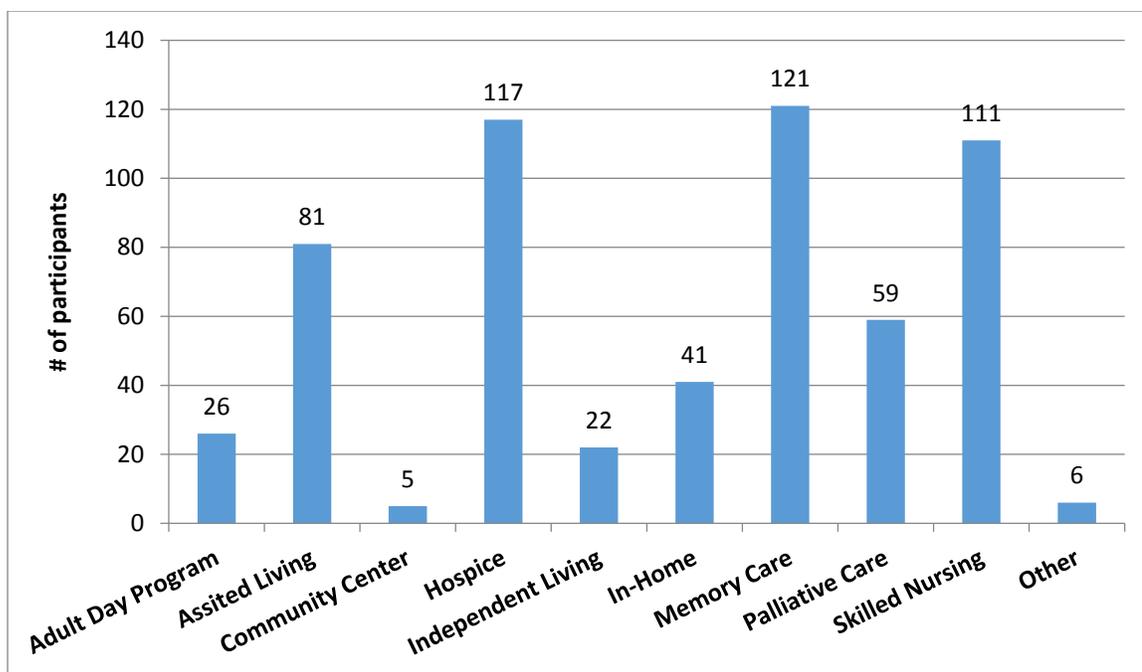


Figure 4. Diagnoses with which participating music therapists are most likely to use touch.

**Use of touch according to setting.** The participants were next asked to identify within which of the following settings they were most likely to use touch. Participants were given the option of selecting more than one setting. The top three settings indicated were memory care ( $n = 121$ ), hospice ( $n = 117$ ), and skilled nursing ( $n = 111$ ). The next two most common settings indicated were assisted living ( $n = 81$ ) and palliative care ( $n = 59$ ). Additional settings noted by participants included: rehab ( $n = 1$ ), hospital ( $n = 1$ ), and individual sessions ( $n = 1$ ). One person stated that it is dependent on the individual needs not the location. Figure 5 displays use of touch according to setting.

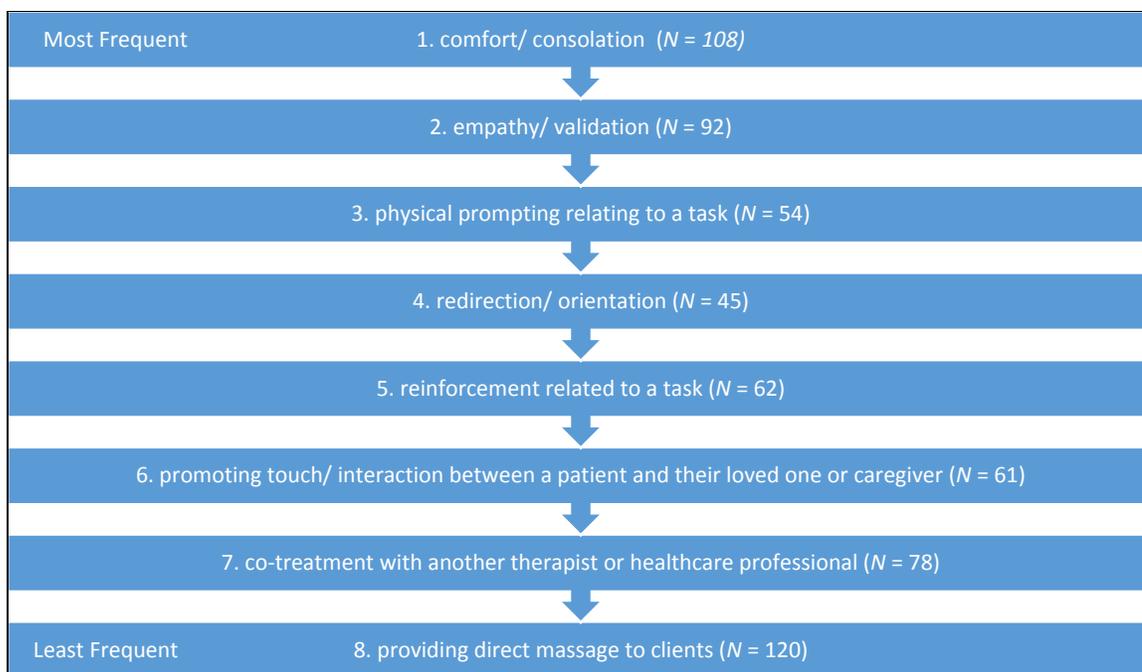


*Figure 5.* Settings within which participating music therapists are most likely to use touch.

***Use of touch according to function.*** Participants were asked to rank eight different functions of touch in order from most common reason to least common reason. When ranked according to the mean rank and total number across all participants, comfort/consolation was the number one function indicated followed by empathy/validation and physical prompting relating to a task. Providing direct massage was the least common function indicated. The following are additional functions of touch indicated by participants including touch for: greetings and/or goodbyes ( $n = 8$ ), providing sensory or tactile stimulation ( $n = 2$ ), closure ( $n = 1$ ), fostering human connection ( $n = 1$ ), dance ( $n = 1$ ), decreasing isolation ( $n = 1$ ), positioning the client ( $n = 1$ ), promoting a therapeutic relationship ( $n = 1$ ), resolving unmet emotional and spiritual needs ( $n = 1$ ), initiating sessions ( $n = 1$ ).

Participants who indicated co-treatment with another health care professional as a common function for the use of touch were given the option to indicate which types of professional they most commonly co-treat with. The following are the seven most common answers: massage therapists and/or bodywork professionals ( $n = 13$ ), occupational therapists ( $n = 10$ ), chaplains ( $n = 8$ ), nurses ( $n = 8$ ), physical therapists ( $n = 8$ ), certified nursing assistants ( $n = 6$ ), and social workers ( $n = 4$ ).

When asked how or why any particular function of touch is important to their practice, two major themes emerged. First, creating human connection was a theme expressed by 10 participants. Individuals felt that touch is an effective way of establishing basic human connection. One participant stated, *“a sense of connection is valuable for those who may be disoriented or are feeling lost in memory care”*. Another participant stated, *“...touch is a natural, human way for me to be present and offer care and connection to them without words or sound”*. The second theme expressed was a general awareness of older adults longing for touch. Ten participants contributed to a general sentiment that older adults often lack positive or loving touch in their everyday environment. One participant stated, *“touch is an important form of validation for geriatric residents who are sensory deprived”*. Emphasis added to participant quotes was added by the researcher for visual clarity and not by participants. Figure 6 displays the rank each function was most frequently given by participants



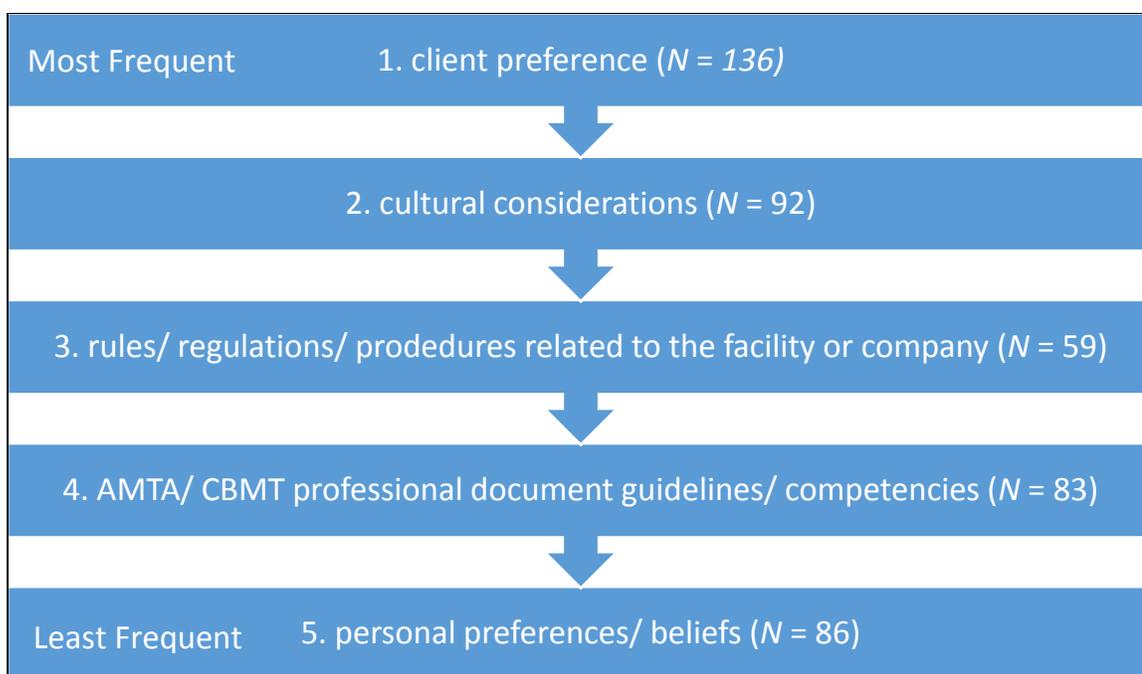
*Figure 6.* Participant Prioritized Ranking of Each Function of Touch from 1 to 8. The N for each function of touch represents the number of participants that ranked that function at that level.

***Use of touch according to restriction.*** Next, participants were asked to rank five different reasons for the restricted use of touch. According to mean rank and total number, client preference was the number one reason indicated followed by cultural considerations. The therapist's personal preferences or beliefs was the least common reason indicated. In addition to this, the following are the most common additional functions of touch indicated by participants including restriction due to: contact precautions or inflectional control ( $n = 25$ ), contraindication related to pain, client condition, or diagnosis ( $n = 6$ ), uncertainty related to lack of knowledge or training ( $n = 4$ ), potential for misinterpretation of the therapist's intentions ( $n = 3$ ), physical distance or barriers ( $n = 2$ ), safety concerns ( $n = 2$ ), and client sensitivity to touch ( $n = 2$ ).

When asked why any particular reason for restriction is important relating to their use of touch, two themes showed up the most frequently. First, client comfort was a theme expressed by four participants. In relation to this theme one participant expressed, “*the client’s comfort and assurance is primary. Touch is very personal and emotionally invasive*”. Second, the potential for a dual relationship was a theme expressed by three participants. One participant expressed,

The concept of dual relationships is very important to consider when using touch. If a client interprets the touch as an intimate experience, they may become confused. It is important to use touch that benefits without misleading the client and or the client's family.

Figure 7 displays the rank each restriction was most frequently given by participants.



*Figure 7.* Participant Prioritized Ranking of Each Restriction of Touch from 1 to 5. The *N* for each restriction of touch represents the number of participants that ranked that restriction at that level.

*Use of touch according to gender.* Participants' gender was cross tabulated with their choice for most likely form of touch to determine if there was potential for any trends. When comparing both gender to each other and to the total, simple touch was the most common for all three calculations. The next most common choice was "it depends on the goal" across all three calculations. Males indicated a slightly lower percentage (8.33%) compared to females (13.79%) and the total (13.44%) that would most likely use protracted touch and a higher percentage (8.33%) compared to females (1.72%) and the total (2.15%) that would not likely use touch in sessions. All other combinations were similarly represented across genders.

Table 4

*Cross tabulation of Gender and Most Likely Form of Touch*

Most Likely Form of Touch	Gender		N
	Male	Female	
Simple touch	6.00	76.00	82.00
	50.00%	43.68%	44.09%
Protracted touch	1.00	24.00	25.00
	8.33%	13.79%	13.44%
Dynamic touch	0.00	0.00	0.00
	0.00%	0.00%	0.00%
All of the above	1.00	17.00	18.00
	8.33%	9.77%	9.68%
It depends on the goals addressed	3.00	54.00	57.00
	25.00%	31.03%	30.65%
I am not likely to use touch	1.00	3.00	4.00
	8.33%	1.72%	2.15%
N	12.00	174.00	186.00
	100.00%	100.00%	100.00%

*Use of touch according to personality type.* The personality type of each participant was cross tabulated with their choice for most likely form of touch. Out of the different forms of touch, 49.3% of extroverted participants were most likely to use simple touch, compared to 40.87% of introverted participants. In addition to that, 7.04% of extroverted participants were most likely to use protracted touch, compared to 17.39% of introverted participants. Finally, 12.68% of extroverted participants indicated all of the above, compared to 7.83% of introverted participants. All other combinations were similarly represented across both personality types.

Table 5

*Cross tabulation of Personality Type and Most Likely Form of Touch.*

Most Likely Form of Touch	Personality Type		N
	Extroversion	Introversion	
Simple touch	35.00	47.00	82.00
	49.30%	40.87%	44.09%
Protracted touch	5.00	20.00	25.00
	7.04%	17.39%	13.44%
Dynamic touch	0.00	0.00	0.00
	0.00%	0.00%	0.00%
All of the above	9.00	9.00	18.00
	12.68%	7.83%	9.68%
It depends on the goals addressed	21.00	36.00	57.00
	29.58%	31.3%	30.65%
I am not likely to use touch	1.00	3.00	4.00
	1.41%	2.61%	2.15%
N	71.00	115.00	186.00
	100.00%	100.00%	100.00%

*Use of touch according to region.* Each participant's region was cross tabulated with their most likely form of touch. The participants from the Midwestern and Great Lakes regions indicated using simple touch proportionately more frequently than any other region. However, the participants from the Western, Southeastern, and New England regions were proportionately least likely to use simple touch. The participants from the Western and Southeastern regions indicated using protracted touch proportionately more frequently than the average, while participants from the Southwestern, New England, and Midwestern regions were indicated using protracted touch proportionately less frequently than the average. Finally, participants from the New England, Southeastern, and Western regions were proportionately most likely to use touch dependent upon the goals addressed. All other combinations did not vary significantly from the totals across all regions. Table 6 displays all cross tabulations for region and most likely form of touch.

Table 6

*Cross tabulation of Region and Most Likely Form of Touch.*

Region	Most Likely Form of Touch						N
	Simple touch	Protracted touch	Dynamic touch	All of the above	It depends on the goals addressed	I am not likely to use touch	
Great Lakes	26.00	6.00	0.00	7.00	11.00	0.00	50.00
	52.00%	12.00%	0.00%	14.00%	22.00%	0.00%	100.00%
Mid-Atlantic	21.00	7.00	0.00	5.00	13.00	0.00	46.00
	45.65%	15.22%	0.00%	10.87%	28.26%	0.00%	100%
Midwestern	11.00	1.00	0.00	2.00	5.00	1.00	20.00
	55.00%	5.00%	0.00%	10.00%	25.00%	5.00%	100.00%
New England	3.00	0.00	0.00	1.00	6.00	0.00	10.00
	30.00%	0.00%	0.00%	10.00%	60.00%	0.00%	100.00%

(continued)

Region	Most Likely Form of Touch						N
Southeastern	8.00	5.00	0.00	1.00	10.00	1.00	25.00
	32.00%	20.00%	0.00%	4.00%	40.00%	4.00%	100.00%
Southwestern	4.00	0.00	0.00	1.00	3.00	1.00	9.00
	44.44%	0.00%	0.00%	11.11%	33.33%	11.11%	100.00%
Western	7.00	6.00	0.00	1.00	9.00	0.00	23.00
	30.43%	26.09%	0.00%	4.35%	39.13%	0.00%	100.00%
N	82.00	25.00	0.00	18.00	57.00	4.00	186.00
	44.09%	13.44%	0.00%	9.68%	30.65%	2.15%	100%

*Use of touch according to philosophy.* Each participant's philosophical or theoretical orientation was cross tabulated with their most likely form of touch. Participants who identified with the Bonny Method of Guided Imagery and Music indicated using simple touch proportionately more frequently than the average, while participants who identified with Nordoff Robbins music therapy were proportionately least likely to use simple touch. Participants who identified with cognitive behavioral therapy were proportionately most likely to use protracted touch, while participants who identified with the Bonny Method of Guided Imagery and Music were proportionately least likely to use protracted touch. Nobody indicated using dynamic touch.

Participants who identified with integrative music therapy were proportionately most likely to indicate "all of the above", while participants who identified with cognitive behavioral therapy and psychodynamic/ analytical music therapy were proportionately least likely to indicate "all of the above". Participants who identified with Nordoff Robbins music therapy were proportionately most likely to use touch depending on the goals addressed, while participants who identified with community music therapy were least likely to use touch depending upon the goals addressed. Finally, music therapists

who identified with Nordoff Robbins music therapy were proportionately most likely to not use touch in sessions. All other combinations did not vary significantly from the totals across all philosophies. Table 7 displays all cross tabulations for philosophy/theoretical orientation and most likely form of touch.

Table 7

*Cross tabulation of Philosophy and Most Likely Form of Touch.*

Philosophy	Most Likely Form of Touch						N
	Simple touch	Protracted touch	Dynamic touch	All of the above	It depends on the goals addressed	I am not likely to use touch	
Behavioral	14.00	3.00	0.00	3.00	13.00	2.00	35.00
	40.00%	8.57%	0.00%	8.57%	37.14%	5.71%	100.00%
Bonny Method	5.00	0.00	0.00	1.00	2.00	0.00	8.00
	62.50%	0.00%	0.00%	12.50%	25.00%	0.00%	100.00%
CBT	15.00	8.00	0.00	3.00	17.00	1.00	44.00
	34.09%	18.18%	0.00%	6.82%	38.64%	2.27%	100.00%
Humanistic	48.00	17.00	0.00	10.00	36.00	1.00	112.00
	42.86%	15.18%	0.00%	8.93%	32.14%	0.89%	100.00%
NMT	14.00	6.00	0.00	4.00	12.00	2.00	38.00
	36.84%	15.79%	0.00%	10.53%	31.58%	5.26%	100.00%
NRMT	2.00	2.00	0.00	2.00	5.00	1.00	12.00
	16.67%	16.67%	0.00%	16.67%	41.67%	8.33%	100.00%
Psychodynamic	5.00	2.00	0.00	1.00	5.00	0.00	13.00

(continued)

Philosophy	Most Likely Form of Touch						<i>N</i>
	38.46%	15.38%	0.00%	7.69%	38.46%	0.00%	100.00%
Community	15.00	6.00	0.00	6.00	9.00	2.00	38.00
	39.47%	15.79%	0.00%	15.79%	23.68%	5.26%	100.00%
Integrative	14.00	4.00	0.00	8.00	16.00	2.00	44.00
	31.82%	9.09%	0.00%	18.18%	36.36%	4.55%	100.00%
Other:	7.00	1.00	0.00	2.00	4.00	0.00	14.00
	50.00%	7.14%	0.00%	14.29%	28.57%	0.00%	100.00%
<i>N</i>	82.00	25.00	0.00	18.00	57.00	4.00	186.00
	44.09%	13.44%	0.00%	9.68%	30.65%	2.15%	100.00%

*Use of touch according to education, training, and personal beliefs.* At the end of the survey, participants were given the opportunity to provide an open ended response stating what their understanding about how or why touch can or cannot be used in music therapy with older adults based upon their own education, training, and personal beliefs. The following are the top twelve factors expressed by participants as influencing how or why they do or do not use touch with older adult. The first theme expressed was the idea that patient preference and/or patient consent influences their use of touch ( $n = 38$ ). The second theme expressed was that touch provides the ability or opportunity to create a connection with the client/patient ( $n = 29$ ). The third theme expressed was that touch provided the ability or opportunity to provide comfort and/or empathy for the patient/client ( $n = 27$ ). The fourth theme expressed was the overall promotion of the use of touch as a positive or powerful tool within the therapeutic setting ( $n = 26$ ).

The fifth theme expressed was the consideration for professional or ethical boundaries when implementing touch ( $n = 20$ ). The sixth theme expressed was that older adults tend to have or express a perceived lack of touch or need for contact with others ( $n = 18$ ). The seventh theme expressed was consideration for the goals, treatment plan, and/or benefit for client when implementing touch ( $n = 16$ ). The eighth theme expressed was consideration for potential misinterpretation by the client when implementing touch ( $n = 13$ ). The ninth theme expressed was consideration for potential stimulation and/or overstimulation of the client/patient as a result of touch ( $n = 13$ ). The tenth theme expressed was consideration for the patient/client's diagnosis, condition, and/or medical status when implementing touch ( $n = 12$ ). The eleventh theme expressed was the opportunity for building rapport through the use of touch ( $n = 12$ ). Finally, the last theme

expressed was consideration for cognitive level and/or orientation when implementing touch ( $n = 11$ ).

**Research question #3.** The third research question investigated what forms of training, if any, are applied by music therapists in sessions when using touch or massage with older adults. Participants were asked to list or describe any type of training (outside of their music therapy training) they implement if they use touch or massage with older adult clients. Fifteen participants specifically mentioned that they have not received any touch or massage training, and do not use touch or limit their use of touch as a result. Nine participants indicated that they have received one or more in-services in massage and/or aromatherapy from a massage therapist.

Five participants indicated receiving supervision or training directly from a massage therapist, occupational therapist, or other staff within their place of work. One participant indicated being a licensed massage therapist, and one individual indicated having a master's in occupational therapy. In addition, participants indicated various specific massage or touch related trainings they have taken including: benevolent touch training ( $n = 1$ ), compassionate touch training ( $n = 1$ ), healing touch level one ( $n = 1$ ), John Barnes myofascial release training ( $n = 1$ ), reiki master certification ( $n = 1$ ), and specific human emotional nexus (shen) emotional healing therapy training level one ( $n = 1$ ). Finally, one participant indicated using information on anatomy and physiology gathered from research journals.

## CHAPTER V

### Discussion

The purpose of this study was to explore how board-certified music therapists are currently using touch with older adults in a clinical music therapy setting. Nine hundred and seventy-three emails were purchased from the Certification Board for Music Therapist (CBMT). The purchased emails from CBMT were for board-certified music therapists who identified as working with the geriatric population and who agreed to have information released for research purposes.

An initial email, inviting individuals to take part in the survey was sent out to all 973 potential participants. Nine emails bounced back as being invalid email addresses, leaving 964 invited participants. Two follow up reminder emails were sent to participants who had not completed the survey one and two weeks after the initial invitation email. The poll was closed 37 days after the original invitation email was sent out. Out of the 964 potential participants who received the initial invitation, 232 participants started the survey. Out of those 202 participants, 186 met the inclusion criteria and as a result their data was included in the final data analysis.

In this study, the independent variables included gender, race/ethnicity, personality type, region, age, years of experience, philosophical/theoretical orientation, diagnoses served, settings served, caseload, functions of touch, reasons for restriction of touch, and training received. The dependent variables included type and frequency of touch implemented. In this chapter, the results will be discussed in detail. The researcher will discuss the study limitations and identify recommendations for future research. Finally, the study's theoretical and practical implications will be presented.

## **Discussion Organized by Research Question**

**Research question #1 .** The first research question investigated how frequently and in what forms music therapists implement touch in sessions with older adults. Participants were asked to rate categorically how frequently they use each of the three defined forms of touch (simple touch, protracted touch, and dynamic touch) from never to very frequently. Participants were then asked to decide which form of touch they were most likely to use. Results indicated that participants would most frequently use simple touch compared to the other two forms. The second largest percentage of participants indicated that the form of touch they would use depends on the goal.

In addition to this, on a non-comparative scale, the largest percentage of participants indicated using simple touch “frequently” followed by “very frequently”, while participants most frequently indicated using protracted touch “sometimes” and dynamic touch “rarely”. This suggests a trend that the more invasive or prolonged the form of touch gets, the less frequently participants indicated using it with clients. Furthermore, this interpretation is qualified by the fact that more than a quarter of participants (30.65%) felt the form of touch used depends on what goal they are addressing. This reinforces the conclusion that there are factors, either internal or external, that may have influence on how music therapists use touch with their older adult clients. The conclusion that form of touch may make a difference in how frequently touch is implemented is also supported.

**Research question #2.** The second research question focused on factors that may influence the use of touch by music therapists in sessions with older adults. The factors investigated for their influence were: diagnosis, setting, function of touch, reason for

restriction, gender, race, region, philosophy, personality type, and subjective views based upon education, training, and personal beliefs. The discussion of the results for each factor is presented below.

*Use of touch according to diagnoses.* This survey's participants are most likely to use touch with Alzheimer's and dementia. There is a large gap between these two diagnoses and the next most frequent diagnosis of depression. When asked which diagnoses participants serve, Alzheimer's and dementia were the most commonly indicated in that question as well. However, the gap between these two diagnoses and the next most common (stroke) was larger when touch was factored in. One possible reason for this is the fact that participants use touch most commonly with Alzheimer's and dementia because they are the most commonly served, while participants use touch with the other diagnoses less often because they are less commonly served as a whole.

The gap change between the two outcomes, however, suggests a possible outside influencing factor. One possible explanation could be that, as result of being the most commonly served diagnoses, therapists feel the most comfortable using touch with those diagnoses due to familiarity. However, the number of participants indicating the use of touch with Parkinson's disease is lower than the number of participants indicating that they work with individuals with Parkinson's in general. This could suggest that a diagnosis that more commonly presents with physical symptoms can lead to increased hesitancy in use of touch by the therapist. Overall, the results contribute towards the conclusion that diagnosis may have an influence on how touch is implemented within music therapy sessions.

***Use of touch according to setting.*** Hospice, memory care, and skilled nursing are the three settings in which participants indicated they most frequently used touch. As with diagnosis these three settings are similarly three of the four most frequently served settings before touch is factored in. In addition to this, there is a notable increased gap between the top three settings and the next most frequent setting when touch is factored in. One possible explanation for this is that these three settings are most commonly served and therefore are likely to lead to increased opportunities for the use of touch. Also, being the most frequently served settings, hospice, memory care, and skilled nursing may lead to increased use of touch due to increased familiarity with the circumstances of the setting types rather than purely due to increased opportunities alone.

Assisted living was indicated as the third most frequent setting served, but when touch is factored in, it drops in frequency. This could provide support for the conclusion that there are factors related to setting that may have influence on how touch is being implemented outside of familiarity. One possible explanation could be that, of all setting options, hospice, memory care, and skilled nursing may present the most severe cognitive or physical limitations requiring more direct physical interaction as opposed to verbal or less direct social cues. However, overall the results provide support for the conclusion that setting may have influence on how touch is implemented in sessions with older adults.

***Use of touch according to function.*** Participants indicated that comfort/ consolation and empathy/ validation were the two most common functions for which touch was used by music therapists. Within each rank position, one particular function of touch stands out as the function most frequently ranked at that level. This clear

distinction between function and rank shows support for the idea that the function of touch may be an influencing factor on how touch is used. In particular, the two highest ranked functions listed above could possibly correlate to common goal areas addressed within the geriatric population. This provides support for the conclusion that socio-emotional needs may have the most influence over the use of touch within the geriatric population.

It is notable that providing direct massage is the least common function indicated. This could suggest that therapists are aware of the difference between touch and massage, and do not provide massage unless they have adequate training. One participant even stated, "*I do not provide direct massage to clients as I do not have any training in this domain*". In further support of this conclusion, participants most commonly indicated co-treating with massage therapists or body work professionals related to the use of touch. This provides support for the conclusion that beyond knowing their own scope of practice, the participants within this survey likely defer to qualified professionals (also including occupational therapists and physical therapists) for providing more direct touch or massage.

***Use of touch according to restrictions.*** Participants indicated that client preference and cultural considerations were the two most frequent reasons leading to their restricted use of touch. Also, within each rank there is a clear distinction between the first and second most common restriction listed at that rank level among participants. This suggests the possibility that reasons for restriction may possibly have an impact on the use of touch with older adults. More specifically, it suggests that certain reasons for restriction may take precedence over others. The fact that client preference most

commonly ranked first and personal beliefs or preferences of the therapist ranked last supports that conclusion that the client is the most central factor in determining how touch should be integrated into their individualized care.

Another important note is the fact that the American Music Therapy Association (AMTA)/ Certification Board for Music Therapists (CBMT) professional document guidelines and competencies is listed as the second least likely reason for restriction. There are several possible reasons for this. One reason is that, as stated in the literature review, there is a general lack of direct references to the use of touch outside of prevention of harm or exploitation to clients. This leaves room for interpretation of how touch and physical contact should be approached as a music therapist. In addition to this, another reason could be a general lack of in depth knowledge or awareness of competencies or guidelines within these documents that refer to the use of touch. Finally, the fact that cultural considerations was ranked as the second most common reason for restriction supports findings from Benner's study in 2004 which mentioned that cultural confusion can serve as a barrier to the use of touch.

*Use of touch according to gender.* Participants across both genders indicated simple touch as being the most common form of touch used. This supports the general conclusion drawn thus far that music therapists tend to use less invasive and less prolonged forms of touch more often. However, the slight variation between the use of protracted touch and the indication of not likely to use touch at all between males and females supports the conclusion that gender may possibly have influence over the use of touch. More specifically, it could be concluded that males indicated using more invasive or prolonged forms of touch less frequently than females. Another gender specific theme

expressed by multiple female participants was the idea of reducing use of touch with specific patients so as not to suggest misleading and/or inappropriate intentions. This is illustrated in one participant's response who said, "*being a female, I am cautious in using touch with males, especially those with dementia who may not understand the nature or purpose of my touch*".

There are several possible explanations for why gender may influence the use of touch. The first possible explanation is that perceived gender roles as it relates to interacting with other people may influence how likely a participant of a particular gender uses touch in their practice. Another possible explanation is reflected in the comments stated above. The client's perception of the intention of touch related to the gender of the participant may impact how touch is used in sessions. As a further clarifier, perception of intention or gender roles may further influence not only if or how frequently touch is used, but what forms of touch are considered more or less appropriate. Overall though, data seems to suggest that gender may be an influencing factor.

The results of this part of the survey create an interesting contrast to the results found in 2015 by Whiteside and Butcher. In their study they specifically explored touch as it relates to male nurses. These researchers found that there was an overall perceived fear of touch misinterpretation in the context of what is considered gender appropriate. It was hypothesized during the literature review for this study that this might be similarly reflected in the results of this study. However, the same ideas of misinterpretation were expressed by female participants rather than male participants. In spite of this, there is some evidence to support the possibility of male participants having similar hesitations

since male participants indicated using more invasive forms of touch proportionately less frequently than female participants.

*Use of touch according to personality type.* Introverted participants indicated using protracted touch proportionately more frequently, while extroverted participants indicated using simple touch or indicating all of the above proportionately more frequently. While there is not a consistent trend for whether introverts versus extroverts use more or less invasive forms of touch or use touch more or less frequently overall, personality type does seem to be a potential influencing factor. One possible explanation for the difference between use of touch amongst personality types lies in the fact that extroverted participants more frequently choose all of the above. Extroverted participants may employ any or every form of touch more frequently while introverted participants might choose a specific form of touch they use most often.

One likely explanation for this may be that an individual's comfort level with use of a more varying range of forms of touch could be influenced by their perception or relation to the environment based upon their personality. Based upon the self-identifying statements provided for each personality type in the survey, extroverted participants may engage in the environment or people around them more frequently. This could potentially lead to the increase in frequency and variation in use of touch. By contrast, introverted participants may be more inclined to be conservative in their use of touch or to limit themselves to specific forms of touch. Overall though, data suggests that personality type may be an influence on the use of touch.

*Use of touch according to region.* According to the cross tabulation of touch and region, there are some minor differences between forms of touch used across different

regions. The New England region deviated most from the average use of touch. Fewer participants from this region indicated using a specific form of touch most often, while more participants from this region indicated that it depends on the goals addressed. The participants from the Midwestern region indicated using less invasive touch like simple touch more frequently than the average rather than more invasive touch such as protracted touch. By contrast, participants from the Western and Southeastern regions showed the opposite trend. They indicated using protracted touch more frequently than the average and indicated using simple touch less frequently than the average. Other deviations from normal existed, but none pointed towards a consistent trend with a particular region.

There are several possible explanations for this difference. First, cultural or social norms within each region may influence how touch is used within a therapeutic context. This could be related to expectations of the therapist, the client, the facility/setting, or all three. Another possible explanation is that philosophical differences within each region influence how touch is used within a therapeutic context. None the less, while it is hard to draw conclusions about regional differences without a bigger and more equally representative sample, there is evidence to support the general conclusion that region may play a factor in how touch is used within a therapeutic context.

*Use of touch according to philosophy.* There are also some notable differences in the use of touch by participants subscribing to different philosophical orientations. Participant who chose behavioral music therapy indicated using simple touch and protracted touch specifically less frequently than the average, but indicated using touch dependent upon the goal more frequently than the average. Related to behavioral music

therapy, participants who selected cognitive behavioral music therapy indicated using simple touch less frequently than the average and indicated using protracted or selected that they would use touch dependent upon the goals more frequently than the average. Participants who selected community music therapy indicated using simple touch or using touch depend upon the goals less frequently than the average, but indicated all of the above in reference to all three types of touch more frequently than the average. Finally, participants who selected integrative touch indicated using simple touch or protracted touch specifically less frequently than the average, but indicated all of the above in reference to all three forms or selected using touch dependent upon the goals more frequently than the average.

There are several possible explanations for these differences. First, as with region, there may be external explanations (not intrinsically connected to music therapy) related to the participants who indicate a particular philosophy or set of philosophical orientations that influence the way they use touch. For example, a participant who prescribes to a certain one or more philosophical orientations may also, because of core beliefs or principles, choose to use touch as informed by those core beliefs. As an alternative possible explanation, music therapists who prescribe to certain philosophies may choose to use touch as a direct influence of the protocols or theoretical foundations of the philosophical orientation itself rather than their own personal beliefs outside of the music therapy orientation. Either way, the data supports the conclusion that philosophical orientation may be an influencing factor on the use of touch.

*Use of touch according to education, training, and personal beliefs.* When asked to discuss what their understanding of the use of touch within music therapy is

based upon their own education, training, and beliefs, 12 themes or ideas were commonly expressed by participants in their open-ended responses as being factors or concerns related to their own personal view of how touch should be used in music therapy. The most common factor expressed by therapists was the need to consider patient preference and/or gain consent. This was related to a variety of factors including: ability to provide consent, obtaining consent, cultural beliefs, family comfort level and consent, and analysis of the client's tolerance, mood, and state of mind. One participant stated, "*I believe touch can be very important for people's well-being, but only once the therapist knows it is ok with the client. I always ask before touching*".

The second most common factor influencing therapists' use of touch was the perceived ability to create a connection with the client. In particular, this was related to several sub factors including reducing isolation, initiating social contact, building a therapeutic relationship, acknowledging the client, creating a sense of belonging, and establishing non-verbal communication. One participant expressed, "*using touch can be useful to make social interactions with isolated individuals... allows clients to feel a connection with another individual and allows clients to trust their healthcare professional*".

The next factor expressed by participants as influencing their own use of touch in sessions was the idea that touch can create or convey a sense of empathy or comfort. As older adults experience a state of decline either through natural aging processes or through disease or injury, older adults (according to participants) tend to receive or experience less empathy. As a result, participants expressed that a more direct form of interaction such as touch can be a way to express empathy or foster a sense of comfort in

the client. One participant expressed that, *“human touch is necessary for older adults to feel valued as human beings”*. Another participant also supported this idea by stating, *“touch can be an important sense for comfort measures, and to emphasize presence for a patient in hospice care who is dying”*.

The fourth most common idea expressed by participants was less specific. Twenty-six participants expressed a general sense of support for touch being an important and/or powerful or effective tool that can be used within the music therapy session. This was used in most cases in connection with ideas from other themes found within participant responses. Some participants qualified this general statement of support by saying it depends on the client, the situation, the diagnosis, needs or contraindications of client, or training. One participant expressed this sense of support for the use of touch by saying, *“I feel appropriate touch is therapeutic when done with good intentions and the client is receptive”*. Another participant related this support to outcomes generated within a music therapy session by saying, *“touch has proven in my work to be beneficial and necessary for greatest possible response when appropriate”*.

The next most common factor expressed by participants is the concern for maintaining boundaries while engaging with older adults in a music therapy setting. This took several different forms within the responses including maintaining professional boundaries, not invading or crossing the personal boundaries of the client, minding physical boundaries within the environment, or comments related to staying within the scope of practice as a music therapist.

One participant expressed this idea when they said, *“I think touch can be used appropriately but one needs to maintain professional boundaries and provide services*

*within their scope of practice*". Some participants expressed a general sense of fear of potentially crossing boundaries through the use of touch. One participant stated, "*...it is a fine line with touch and professionalism that many are afraid to cross*". This theme supports findings from Benner (2004) who stated that "intrusive, boundary-crossing, inappropriate, and unwanted touch must be avoided..." (Benner, 2004, p. 349). However, Benner contrasts this by going on to posit that concerns of potential consequences of inappropriate touch must not prevent "comforting touch and human comfort measures" (Benner, 2004, p. 349).

The sixth most common factor expressed by participants that influences their view of the use of touch in music therapy is the perceived lack of touch that older adults experience. Participants that expressed this theme noted that they use touch as a means of filling a need for human contact created by a perceived or reported lack of positive touch or human interaction by older adults. This is concisely expressed by one participant who said, "*older adults tend to be sensory deprived, and a gentle touch or hug provides a needed connection*". Another participant related this preventative measures stating, "*older adults tend to be sensory deprived, and a gentle touch or hug provides a needed connection*".

The next theme expressed by participants was the idea that touch should be related to or used according to the client's goals/treatment plan. In most cases, the participants emphasized that touch should only be used as it is effective in addressing their goals or according to the structure of their treatment plan. This was most directly expressed by a participant who stated, "*touch should be utilized if it relates directly to the client's goals and if it can be effective in enhancing therapeutic outcomes*". Another

participant added to this by discussing how touch can be, “*an additional adjunctive technique during MT interventions with a therapeutic goal in mind*”.

Some participants expressed hesitation for the use of touch due to the possibility for misinterpretation by the family or patient. Some participants related this to the client’s misinterpretation of the intentions behind the use of touch by the therapist. One participant stated, “*sometimes, if used too much or inappropriately, the patient may confuse the touch and the meaning behind it as being more personal than it is meant to be- and in that confusion, respond inappropriately*”. A few participants even related it to gender, stating that there is concern that a male client may misinterpret the actions of a female therapist. Other participants related the misinterpretation to non-verbal clients stating things such as, “*if a resident is nonverbal you have to be careful about touch*”.

The next theme expressed by participants was that touch may provide stimulation for the client as it is needed for alertness or sensory purposes. Participants stated that either clients (related to the previous theme of lack of touch) have a deprivation of sensory input, or that due to a decline in other senses, touch can often be used to stimulation awareness or even engagement in clients. One participant stated, “*touch stimulates another sense, so it seems to help them engage and participate more. Many older adults also don't get touched like they used to so many times this helps elevate mood*”. Several participants, however, cautioned against the use of touch in certain circumstances due to a therapist’s ability to over stimulate the client if too much touch is used.

This theme supports findings by several of the researchers discussed in the literature review. First, Gibson (1962) postulated similarly that more active forms of

touch constitute an effort to seek out stimulation and can activate more awareness as is reflected in the participants' responses related to touch for stimulative purposes. This theme also supports Belgrave's (2009) findings that expressive touch was significantly more effective in eliciting and maintaining alertness in the initial session than instrumental or no touch. While the results in this study are not quantitative or experimental, the fact that participants in this study validate their use of touch by citing stimulative reasons shows practical applications that reflect the findings in these two studies.

Another cautionary theme expressed by participants was that touch should be used with consideration for the medical conditions and diagnoses of each client. According to participants, contraindications such as those related to pain or sensitive medical conditions may prevent the participant from using touch. In addition, participants expressed caution for use of touch with clients with Alzheimer's or depending on the stage they are in. Another theme expressed by participants related to this was the idea that cognitive functioning should be considered when using touch. One participant stated, "*someone who has dementia or is otherwise confused may not want a perceived stranger to touch them*". On the other hand, some participants stated that, due to cognitive functioning level, touch may be necessary. This was expressed by one participant who said, "*in the case of Alzheimer's and dementia, touch is often necessary to make a connection*".

The final theme expressed by participants was the idea that touch can be a means of building rapport with older adults. This was often connected with other themes. Due to some clients lack of cognitive functioning or particular diagnosis, it may be difficult to

build rapport in less direct ways. In addition to that, because some older adults have a perceived lack of touch or sensory stimulation, meeting that need through the use of touch can contribute to that increased sense of rapport.

When used in positive ways, the natural positive reinforcement that touch can provide and the connection it can establish may also contribute to the increased sense of rapport. This theme supports findings discovered by Belgrave in 2009. When evaluating expressive touch compared to instrumental touch and no touch, Belgrave found that rapport ratings were higher during both touch conditions than during the control condition. This theme also supported Leonard and Kalman (2015) who found touch was beneficial for building rapport within the healthcare setting.

In addition to the above mentioned researchers whose findings are supported or contrasted to the findings in this study, two of the five themes discovered by Chang (2001), on how touch is beneficial or important to the therapeutic process are reflected in this study. Touch for comfort and pain relief, and for promoting emotional comfort and empathy both were ideas mentioned by participants. However, the other three themes of touch for spirituality, for filling a certain role, and for providing physical comfort and consequently mind comfort through the mind-body connection were ideas not as directly reflected in this study.

**Research question #3.** The third research question investigated what forms of training, if any, are applied by music therapists in sessions when using touch or massage with older adults. The conclusion supported by participant responses is that the participants in general were aware of the difference between types of touch, and accordingly are cautious in using touch beyond what they perceived as non-therapeutic

touch without additional training or supervision by a qualified professional. While none of the trainings listed by participants were evaluated by the researcher for their credibility or the quality of their training content, the idea that participants who are using more invasive or therapeutic forms of touch or massage are seeking out training beyond their existing music therapy education is still supported.

### **Study Limitations and Recommendations for Future Research**

The current study's results indicate that there are many factors that may have potential for influencing a music therapist's use of touch with older adults. However, there are several limitations that should be considered when interpreting and applying the results of this study including the lack of directly related prior research, participant characteristics, the self-reported nature of the data collection, and the construction of the instrumentation.

The first limitation of this study was the lack of directly related research. Having a firm basis of directly related research often helps lay a foundation for understanding the research problem being investigating and contributes to the development and construction of the study design. In this case of this study, few prior studies were directly related to the questions being posed by the research, and as such an exploratory design rather than an explanatory or experimental design was used. Most studies evaluated within the literature review were either from related fields such as nursing or addressed the use of touch as a part of a larger or more broad variable or in a less direct or less defined manner. In addition to this, only nine of the evaluated studies were conducted in the last five years, and only two of those studies were music therapy studies.

The next limitations of this study are the participant characteristics. In several cases there was a lack of diversity in representation of certain aspects of the population being sampled including gender, race/ethnicity, and region. In all three instances, there is evidence to suggest that the field of music therapy as a whole may have a general lack of representation of diversity. However, without definitive and reliable norms to compare the current study's sample to, it cannot be conclusively stated that the representation within this study's sample is truly reflective of the diversity or lack of diversity within the population at large. The lack of diversity within this study weakens the analysis of trends within each variable and potential for generalizability. Future research should strive to seek or establish more definitive norms for demographic representation within the field of music therapy and/or also strive for more equal representation of diversity across various demographic variables.

The next limitation of this study is the self-reported nature of the data collection procedure. Because an exploratory-based survey design was used, all data collected was done so through self-report of the participants rather than through direct data collection. As a result, this creates room for several types of bias including selective memory, exaggeration, and false attribution. Another implication of this type of data collection is that results have to be taken at face value and cannot be verified for accuracy or validity. Future research should strive to use more exact and verifiable forms of data collection such as through an experimental design in which variables can be directly examined for effect using quantitative measurement tools.

Another limitation of this study was the construction of the instrumentation. Because a survey was constructed by the researcher for use in this study, there are several

possible implications. First, after going through several rounds of vetting by the researcher, the thesis committee, and non-qualifying music therapists, there were several minor grammatical and spelling errors detected in the final version survey that was sent out to the participants. This could have impacted the participants' understanding of the questions. In addition to this, there is potential for bias in the construction of the questions that could have potentially influenced the manner in which participants answered questions.

Length or clarity of the survey may have contributed to participant mortality, causing some participants to not complete the survey. In addition, the lack of definition of some terms within the survey may have influenced the participants understand of the survey. For example, providing exact definitions for the difference between touch and massage may have aided the participant in their completion of the survey. All of these factors combined may have skewed the results of the survey. Future research should seek to further vet the construction of the instrumentation for clarity, spelling, grammar, and length. If possible, future research should seek to use established and validated instrumentation so as to generate more reliable data.

Future research should also employ more mixed methods research designs including both quantitative experimental methods paired with more direct qualitative methods such as interviews. This would serve to explore touch and related variables more in depth and to generate more correlational or causational results that can be supported or contrasted by the qualitative results. In addition to this, future research should also examine how touch is used by music therapists in other populations so as to compare and contrast how touch is used consistently or differently from population to population.

Finally, future research should analyze the differences between positive and negative touch. This study primarily focused on touch used positively by therapists. However, analyzing client perception of touch and the proportion of touch being perceived positively versus negatively may generate more insight into how touch should or should not be incorporated in sessions.

### **Study Implications**

The current study's findings contribute to both theoretical and practical implications regarding the use of touch by music therapists with older adults. Theoretically, the results provide information regarding the frequency and types of touch currently being used by music therapists with older adults, as well as factors that may influence their use of touch and types of training being implemented. Practically, results from the study can guide music therapists in the use of touch within their own practice.

**Theoretical implications.** This study explored the nature of the use of touch by music therapists with older adults including: the frequency and types of touch used, factors that may influence the use of touch, and types of training being implemented by therapists who use therapeutic touch or massage. It was discovered that the form of touch is relevant to how touch is implemented. Less invasive forms of touch such as simple touch were used more frequently by participants than more invasive forms of touch such as protracted or dynamic touch. In addition to this, most of the factors evaluated in this study showed some potential for influence on the use of touch including: gender, region, philosophical orientation, personality type, setting, diagnosis, personal beliefs, reasons for restriction, and functions of touch.

While no strong or conclusive correlations can be drawn from the results, this study serves as a starting point for the understand of how touch is used by music therapists within this population in current practice. It also provides evidence for that fact that touch has potential for benefit and harm for clients relating to various factors within the therapeutic environment. Further research should be conducted to further delineate the relationship between touch and music as well as the effects of touch on geriatric clients within a music therapy context. Most prior research conducted on touch was done so in an experimental research environment, so this study fills a gap in the literature by seeking to make direct connections to practical and clinical settings.

**Practical implications.** This study contains results that provide several practical implications. First, music therapists who are unfamiliar with the use of touch can use the results of this study to inform and guide their own use of touch in their practice. The definitions of touch provided as well as all factors and themes analyzed can directly correlate to points of consideration for therapists who are seeking to further evaluate or structure their own use of touch. The evidence supports the idea that touch can be beneficial to older adults, but that caution should be taken when using touch. The use of more advanced or invasive forms of touch should only be implemented after seeking additional training or supervision by qualified professionals, and massage should only be used by licensed massage therapists.

In addition to this, the results of this study combined with the general lack of direct reference to regulation of the use of touch within professional documents created by both the American Music Therapy Association and the Certification Board for Music Therapists, suggest that touch is an important concept that is necessary for music

therapists to address. The results also suggest that further support and clarification should be made within these professional documents so as to foster more direct delineations, training, and protocols for the appropriate use of touch within the scope of practice as a music therapist.

### **Summary and Conclusion**

The purpose of this study was to explore how board-certified music therapists are currently using touch with older adults in a clinical music therapy setting, what factors influence the participants use of touch, and which, if any, trainings are being implemented. Three forms of touch were defined and used as part of the survey including: simple touch, protracted touch, and dynamic touch. A survey was created by the researcher to evaluate the participants' frequency and form of touch used and independent variables that influence their use of touch.

The independent variables included gender, race/ ethnicity, personality type, region, age, years of experience, philosophical/ theoretical orientation, diagnoses served, settings served, caseload, functions of touch, reasons for restriction of touch, and training received. A survey was created and sent using emails for 973 board-certified music therapists who identified as working with the geriatric population that were purchased from the Certification Board for Music Therapist (CBMT). Of those individuals, 186 people completed the survey and met the inclusion criteria and as a result their data was included in the final data analysis.

Several findings were generated from this study. First, participating music therapists indicated using simple touch more frequently than protracted touch. Few music therapists indicated using dynamic touch on a regular basis, and no music therapists

indicated being most likely to use dynamic touch compared to simple or protracted touch. Second, the results provide support for the conclusion that diagnosis, setting, functions of touch, restrictions for touch, gender, personality type, region, philosophical orientation, and personal beliefs are all factors that may potentially influence a music therapist's use of touch. Each factor led to different types of suggested influence on the use of touch, some with more clear or consistent trends than others.

Finally, the majority of participating music therapists who indicated providing massage or more advanced forms of therapeutic touch to clients indicated having received some form of advanced training or supervision from a qualified professional. In addition, several music therapists who indicated not using massage in their sessions clarified that they do not do so due to the limit of the scope of practice of a music therapist and their lack of appropriate training and credentials. As a result of this study, it can be concluded that touch is an important factor for consideration by music therapists working with older adults, that touch can have potential for benefit and harm to older adults, and that more training and education is needed in order to better prepare music therapists for appropriate use of touch within a therapeutic context.

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## APPENDIX A: Questionnaire for Participants of the Survey

Do you currently work with adults ages 65-years or older?

- Yes
- No

Do you provide music therapy services either in a geriatric community/facility or hospice or geriatric focused company?

- Yes
- No

Please indicate your gender.

- a. Male
- b. Female
- c. Transgender
- Other: \_\_\_\_\_

Please indicate your ethnicity or race.

- Hispanic/Latino/Spanish Origin
- American Indian/Alaskan Native
- Asian/Asian American
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White/Caucasian
- Multiracial
- Other: \_\_\_\_\_

What is your age?

Read the following statements regarding extroversion and introversion and answer the following question.

Extrovert: I like getting my energy from active involvement in events and having a lot of different activities. I'm excited when I'm around people and I like to energize other people. I like moving into action and making things happen. I generally feel at home in the world. I often understand a problem better when I can talk out loud about it and hear what others have to say.

Introvert: I like getting my energy from dealing with the ideas, pictures, memories, and reactions that are inside my head, in my inner world. I often prefer doing things alone or with one or two people I feel comfortable with. I take time to reflect so that I have a clear idea of what I'll be doing when I decide to act. Ideas are almost solid things for me. Sometimes I like the idea of something better than the real thing.

Given the above statements, which personality trait do you most identify with on a personal level?

- Extroversion
- Introversion

How many years of clinical experience do you have as a board-certified music therapist?

\_\_\_\_\_

Within which region do you currently practice as a music therapist?

- Great Lakes Region
- Mid-Atlantic Region
- Midwestern Region
- New England Region
- Southeastern Region
- Southwestern Region
- Western Region
- International: \_\_\_\_\_

What is/are your primary theoretical or philosophical approach(es) to music therapy?  
(Mark all that apply)

- Behavioral Music Therapy
- Bonny Method of Guided Imagery and Music
- Cognitive Behavioral Music Therapy
- Humanistic Music Therapy
- Neurologic Music Therapy
- Nordoff-Robbins Music Therapy
- Psychodynamic/Analytical Music Therapy
- Community Music Therapy
- Integrative Music Therapy
- Other: \_\_\_\_\_

Click and slide the slider below to indicate approximately what percentage of your case load is currently dedicated to working with older adults.

\_\_\_\_\_ Percentage

For which type(s) of diagnoses do you provide services? (Mark all that apply)

- Alzheimer's
- Cancer
- Chronic Obstructive Pulmonary Disease
- Dementia
- Depression
- Parkinson's
- Stroke
- TBI/Acquired Physical Disability
- Other: \_\_\_\_\_

Within which type(s) of settings do you provide services? (Mark all that apply)

- Adult Day Program
- Assisted Living
- Community Center

- Hospice
- Independent Living
- In-Home
- Memory Care
- Palliative Care
- Skilled Nursing
- Other: \_\_\_\_\_

On a weekly average, in how many individual facilities, related to older adults, did you provide services within the past year?

On a weekly average, with how many older adult clients did you provide services within the past year?

Read the following definitions of touch and answer the questions that follow:

**Simple Touch:** Brief intentional contact to a relatively restricted location on the surface of the receiver during a social interaction. Examples of Simple Touch: brief physical prompting of a client to complete a task, a pat on the should or upper arm, a high five, etc.

Approximately how frequently do you implement simple touch with your client(s) over the course of an average session?

- Never
- Rarely
- Sometimes
- Frequently
- Very Frequently

(Optional) Please provide an example of how you currently use simple touch with your geriatric clients:

**Protracted touch:** Longer and often mutual skin-to-skin contact between individuals, and usually includes a component of pressure. Examples of protracted touch: grabbing/ holding another person's hand, embracing a person's shoulder, prolonged hand-over-hand prompting, etc...

Approximately how often do you implement protracted touch with your client(s) over the course of an average session?

- Never
- Rarely
- Sometimes
- Frequently
- Very Frequently

(Optional) Please provide an example of how you currently use protracted touch with your geriatric clients:

Dynamic touch: Touch involving continuous movement over the skin from one point to another, and can often be repetitious, as in stroking, rubbing, and caressing. Examples of dynamic touch: providing sensory stimulation to a child with autism through a “feathering motion” with fingers down the client’s arms, rubbing a person’s back, shoulders, or upper arm for an extended period of time, etc...

Approximately how often do you implement dynamic touch with your client(s) over the course of an average session?

- Never
- Rarely
- Sometimes
- Frequently
- Very Frequently

(Optional) Please provide an example of how you currently use dynamic touch with your geriatric clients:

Which form of touch are you most likely to use?

- Simple touch
- Protracted touch
- Dynamic touch
- All of the above
- It depends on the goals addressed
- I am not likely to use touch

With which of the following type(s) of diagnoses are you most likely to use touch? (Mark all that apply)

- Alzheimer’s
- Cancer
- Chronic Obstructive Pulmonary Disease
- Dementia
- Depression
- Parkinson’s
- Stroke
- TBI/Acquired Physical Disability
- Other: \_\_\_\_\_

In which of the following type(s) of settings are you most likely to use touch? (Mark all that apply)

- Adult Day Program
- Assisted Living
- Community Center

- Hospice
- Independent Living
- In-Home
- Memory Care
- Palliative Care
- Skilled Nursing
- Other: \_\_\_\_\_

Click and drag the following functions of touch in order from 1 to 8 according which function is the most common reason for the use of touch in your own practice. 1 indicates the function that most commonly leads to the use of touch, and 8 indicates the function that least commonly leads to the use of touch in your own practice.

- \_\_\_\_\_ Comfort/consolation
- \_\_\_\_\_ Co-treatment with another therapist or healthcare professional
- \_\_\_\_\_ Empathy/validation
- \_\_\_\_\_ Physical prompting relating to a task
- \_\_\_\_\_ Promoting touch/interaction between a patient and their loved one or caregiver
- \_\_\_\_\_ Providing direct massage to clients
- \_\_\_\_\_ Redirection/orientation
- \_\_\_\_\_ Reinforcement related to a task

(Optional) List any other functions of touch not listed above that are common reasons for using touch in your own practice:

If you indicated in question 23 that you provide direct massage to clients in your sessions as a common function of touch, what type of training/certification/licensure have you received?

If you indicated in question 23 that you provide co-treatment with other therapists or healthcare professionals in your sessions as a common function of touch, please provide additional information about what types of professionals or situations you commonly co-treat in or with:

(Optional) Please provide additional information for how or why any of these functions play a significant role in the use of touch in your practice:

Click and drag the following reasons from 1 to 5 according to which reason most commonly leads to restriction of the use of touch in your own practice. 1 indicates the reason that most commonly leads to restrict of the use of touch, and 5 indicates the reasons that least commonly leads to the restriction of the use of touch.

- \_\_\_\_\_ Client preference
- \_\_\_\_\_ Rules/regulations/procedures related to the facility or company
- \_\_\_\_\_ AMTA/CBMT professional document guidelines/ competencies
- \_\_\_\_\_ Personal preference/beliefs
- \_\_\_\_\_ Cultural considerations

(Optional) List any other reasons not listed above that commonly lead to restriction of touch in your own practice.

(Optional) Please provide additional information for how or why any of these factors lead to the restriction of the use of touch in your practice:

Based upon your experience, education, training, and personal beliefs, what is your understanding about how/why touch can or cannot be used in music therapy sessions with older adults?

Additional comments:

## **APPENDIX B: Music Therapy Professional Documents Touch References**

### **AMTA Scope of Practice**

- Potential for Harm
  - Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices.
  - To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:
    - Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
    - Comply with safety protocols with regard to transport and physical support of clients.

### **American Music Therapy Association Code of Ethics**

- 3.0 Relationships with Clients/Students/Research Subjects
  - 3.4 The MT will not exploit clients/students/research subjects sexually, physically, financially or emotionally.
- 8.0 Research
  - 8.3 The MT is ultimately responsible for protecting the welfare of the research subjects, both during and after the study, in the event of aftereffects, and will take all precautions to avoid injurious psychological, physical, or social effects to the subjects.

### **American Music Therapy Association Standards of Clinical Practice**

- 2.0 Standard II - Assessment
  - 2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

### **American Music Therapy Association Professional Competencies**

- 13. Therapy Implementation

- 13.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.

### **American Music Therapy Association Advanced Competencies**

#### B. Clinical Practice

- 2.0 Clinical Supervision
  - 2.5 Analyze the supervisee's music therapy sessions in terms of both the effects of musical, verbal, and nonverbal interventions and the musical and interpersonal dynamics and processes of the client(s)-therapist relationship.
- 4.0 Advanced Clinical Skills
  - 4.10 Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.

### **CBMT Code of Professional Practice**

#### II. APPLICATION AND CERTIFICATION STANDARDS

- H. Gross or repeated negligence or malpractice in professional practice, including sexual relationships with clients, and sexual, physical, social, or financial exploitation;

### **CBMT Board Certification Domains**

#### II. Treatment Implementation and Termination: 70 items

##### A. Implementation

- 2. Provide music therapy experiences to address client's:
  - w) interactive response.
  - ac) nonverbal expression.
  - av) social skills and interactions.
  - ax) spontaneous communication/interactions.
  - ba) verbal and nonverbal communication.
- 5. To achieve therapeutic goals:
  - t) provide verbal and nonverbal guidance.

##### B. Safety

- 3. Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- 6. Comply with safety protocols with regard to transport and physical support of clients.

#### IV. Professional Development and Responsibilities: 10 items

##### B. Professional Responsibilities

- 4. Interact with the client in an authentic, ethical, and culturally competent manner that respects privacy, dignity, and human rights

**APPENDIX C: Cover Letter/ Informed Consent****Subject Information Sheet**

My name is Marcus Hughes, MT-BC, LMT, and I am a graduate student of the music therapy department at Sam Houston State University. I would like to take this opportunity to invite you to participate in a research study of the use of touch in music therapy sessions within the geriatric population. I am conducting this research under the direction of Karen Miller, M.M., MT-BC. I hope that data from this research will identify how music therapists are currently implementing touch as a technique with geriatric clients. You have been asked to participate in the research because you have been identified through CBMT as a music therapist currently working within the geriatric population.

The research is relatively straightforward, and we do not expect the research to pose any risk to any of the volunteer participants. If you elect to participate in this research, you will be asked to complete a survey indicating your current use and views relating to the use of touch with geriatric clients. Any data obtained from you will only be used for the purpose of this study and will be kept in a secure file only accessible by the primary investigator and thesis advisor. Under no circumstances will you or any other participants who participated in this research be identified. In addition, your data will remain confidential. Your survey responses will be kept confidential to the extent of the technology being used. Qualtrics collects IP addresses for respondents to surveys they host; however, the ability to connect your survey responses to your IP address has been

disabled for this survey. That means that I will not be able to identify your responses. You should, however, keep in mind that answers to specific questions may make you more easily identifiable. The security and privacy policy for Qualtrics can be viewed at <https://www.qualtrics.com/security-statement/>.

This research will require about 10 minutes of your time. Participants will not be paid or otherwise compensated for their participation in this project.

Participation is voluntary. If you decide to not participate in this research, your decision will not affect your future relations with Sam Houston State University. Also, if at any point during the research you decide to withdraw, or do not wish to, participate in the remainder of the research you are free to withdraw your permission and to discontinue participation at any time without affecting that relationship. If you have any questions, please feel free to ask me using the contact information below. If you are interested, the results of this study will be available at the conclusion of the project.

If you have any questions about this research, please feel free to contact me, Marcus Hughes, MT-BC, LMT or Karen Miller, M.M., MT-BC, using our contact information below:

\*Contact information removed for privacy reasons. \*

- I understand the above and consent to participate.
- I do not wish to participate in the current study.

## APPENDIX D: Email Script

(Initial invitation)

Hello fellow music therapist,

You are invited to participate in a research study to examine how music therapists are using touch as a therapeutic tool within the geriatric population. You were selected as a possible survey participant because you are a board-certified music therapist designated as working within the geriatric population, and have authorized CBMT to release your email address.

The survey will take approximately 10 minutes and may be revisited until complete. Please visit the survey by clicking the link below to further read about the research and document your potential participation. Your identity will be kept confidential and will not be reflected in the results of the survey. Survey results can be made available to you upon completion of the study if desired. Your time is greatly appreciated. Have a wonderful day.

Follow this link to the Survey: [\\${1://SurveyLink?d=Take the survey}](#)

Or copy and paste the URL below into your internet browser:

[\\${1://SurveyURL}](#)

Follow the link to opt out of future emails:

[\\${1://OptOutLink?d=Click here to unsubscribe}](#)

Sincerely,

Marcus Hughes, MT-BC, LMT

Principle Investigator

Sam Houston State University

(First reminder to unfinished participants)

Hello fellow music therapist,

You are invited to participate in a research study to examine how music therapists are using touch as a therapeutic tool within the geriatric population. You were selected as a possible survey participant because you are a board-certified music therapist designated as working within the geriatric population, and have authorized CBMT to release your email address.

The survey will take approximately 10 minutes and may be revisited until complete. Please visit the survey by clicking the link below to further read about the research and document your potential participation. Your identity will be kept confidential and will not be reflected in the results of the survey. Survey results can be made available to you upon completion of the study if desired. Your time is greatly appreciated. Have a wonderful day.

Follow this link to the Survey:

[\\${1://SurveyLink?d=Take the survey}](#)

Or copy and paste the URL below into your internet browser:

[\\${1://SurveyURL}](#)

Follow the link to opt out of future emails:

[\\${1://OptOutLink?d=Click here to unsubscribe}](#)

Sincerely,

Marcus Hughes, MT-BC, LMT

Principle Investigator

Sam Houston State University

(Final reminder to unfinished participants)

Hello fellow music therapist,

This is the final reminder regarding your participation in a research study to examine how music therapists are using touch as a therapeutic tool within the geriatric population. The survey will take approximately 10 minutes and may be revisited until complete. The survey will be open for one more week before the results are analyzed, and your participation would be very much appreciated.

Please visit the survey by clicking the link below to further read about the research and document your potential participation. Thank you for your time and consideration.

Follow this link to the Survey:

[\\${1://SurveyLink?d=Take the survey}](#)

Or copy and paste the URL below into your internet browser:

[\\${1://SurveyURL}](#)

Follow the link to opt out of future emails:

[\\${1://OptOutLink?d=Click here to unsubscribe}](#)

Sincerely,

Marcus Hughes, MT-BC, LMT

Principle Investigator

Sam Houston State University

## VITA

**Marcus Hughes, MT-BC, LMT**

### **Education:**

#### **Sam Houston State University**

Master of Music in Music Therapy, (May 2017). Thesis Title: “The Use of Touch in Music Therapy with Older Adults.” Huntsville, TX.

Bachelor of Music in Music Therapy, Minor in Psychology. (December 2013).  
Summa Cum Laude/ With Honors-Honors College. Huntsville, TX.

#### **Laurel School of Massage**

Massage therapy training, 500 hours (November 2014). Spring TX.

### **Academic Awards:**

Outstanding Music Therapy Senior, Department of Music Therapy, Sam Houston State University, May 2013.

Dean’s List, Sam Houston State University, Eight Consecutive Semesters. Fall 2009- Spring 2013.

President’s List, Sam Houston State University, Seven Non-Consecutive Semesters. Fall 2009- Spring 2013.

### **Work/Clinical Experience:**

#### **Graduate Teaching Assistant**

Sam Houston State University, Music Therapy Department. August 2015- May 2017

Duties: teaching, clinical supervision, administration, coordination of services at the on-campus clinic

#### **Lone Star Therapies**

Owner, Clinician| February 2014- Present

Populations Served: geriatric groups and individuals; in-home therapy for individuals with developmental delays, neurologic disorders, special needs, physical disabilities and other related diagnoses; private massage therapy clients

#### **Heart and Harmony Music Therapy**

Intern| July 2013 – December 2013

A music therapy private practice serving a variety of ages and diagnoses including: geriatrics, neurologic disorders, developmental delays, and physical disabilities.

#### **Huntsville Health Care Center**

Assistant Activities Director| December 2011- May 2013

**SHSU Music Therapy Program**

Student Music Therapist| September 2011- May 2013

Practicum Experiences: early childhood intervention, individual with a cochlear implant, hospice, adult special needs group

**Organizational Involvement:**

American Music Therapy Association- Professional Member

Positions held: Master's Level Entry Subcommittee Member, Assembly of Delegate Alternate

Association of Bodywork & Massage Professionals- Professional Member

**Credentials/Advanced Training:**

Music Therapist- Board Certified: January 2014

The Certification Board for Music Therapists| Certification #: 11121

Licensed Massage Therapist: November 2014

Texas Department of State Health Services| LMT #: 121267

Neurologic Music Therapy Advanced Training: February 2015

The Robert F. Unkefer Academy of Neurologic Music Therapy

**Professional Presentations:**

Wylie, M.E., Borling, J., Cynthia Briggs, C., Creagan, J., Furman, A., Hughes, M. J., Hunter, B., Kaplan, R., Neugebauer, C., & Snell, A. (2013, November). Voices of the MLE A 2013 Review. Concurrent session presented at the annual conference of American Music Therapy Association. Jacksonville, Fl.

Wylie, M.E., Borczon, R., Borling, J., Cynthia Briggs, C., Creagan, J., Furman, A., Hairston, M., Hughes, M. J., Hunter, B., Kahler, E., Kaplan, R., Montague, E., Neugebauer, C., & Snell, A. (2014, November). Master's Level Entry Subcommittee Update for Educators and Clinical Training Directors. Concurrent session presented at the annual conference of American Music Therapy Association. Louisville, Ky.

Wylie, M.E., Borczon, R., Borling, J., Cynthia Briggs, C., Creagan, J., Furman, A., Hairston, M., Hughes, M. J., Hunter, B., Kahler, E., Kaplan, R., Montague, E., Neugebauer, C., & Snell, A. (2014, November). Master's Level Entry Subcommittee Presents a Progress Report. Concurrent session presented at the annual conference of American Music Therapy Association. Louisville, Ky.

- Fleming, K., Fitch, K., Hughes, M. J., Enser, K., Goldschmidt, D., Craven, E., & Neugebauer, C. (2014, November). The INTERNAL Struggle: A Panel Discussion of Common Challenges Faced by Interns and Tips for Coping. Concurrent session presented at the annual conference of American Music Therapy Association. Louisville, Ky.
- Neugebauer, C. & Hughes, M. J. (2015, March). Spring 2015 Report from the Master's Level Entry (MLE) Subcommittee MLE National conference. Concurrent session presented at the annual conference of the Southwestern American Music Therapy Association. Oklahoma City, Ok.
- Wylie, M.E., Borczon, R., Borling, J., Cynthia Briggs, C., Creagan, J., Furman, A., Hairston, M., Hughes, M. J., Hunter, B., Kahler, E., Kaplan, R., Montague, E., Neugebauer, C., Snell, A. (2015, November). 2015 Master's Level Entry Subcommittee Update. Concurrent session presented at the annual conference of American Music Therapy Association. Kansas City, Missouri.
- Neugebauer, C., Hughes, M. J., Kahler, E. (2016, March). Master's Level Entry 2016 Survey: A Preliminary Report. Concurrent session presented at the annual conference of the Southwestern American Music Therapy Association. Austin, TX.
- Dachinger, C. D., Miller, K. E., Hughes, M.J., & Way, M. A Music Therapist's Guide to a Master's Degree. Concurrent session presented at the annual conference of the Southwestern American Music Therapy Association. Austin, TX.
- Wylie, M.E., Borczon, R., Borling, J., Cynthia Briggs, C., Creagan, J., Furman, A., Hairston, M., Hughes, M. J., Hunter, B., Kahler, E., Kaplan, R., Montague, E., Neugebauer, C., Snell, A. (2016, November). 2016 Master's Level Entry Subcommittee Presentation. Concurrent session presented at the annual conference of American Music Therapy Association. Sandusky, Oh.
- Hughes, M.J. (2017, March). The Use of Touch in Music Therapy Sessions with Older Adults: A Thesis Presentation. Concurrent session presented at the annual conference of the Southwestern American Music Therapy Association. Fort Worth, TX.
- Kahler, E., Hughes, M. J, & Neugebauer C. (2017, March). Sharing What We Have Learned: Report of the MLE Subcommittee. Concurrent session presented at the annual conference of the Southwestern American Music Therapy Association. Fort Worth, TX.