SURVEYING MUSIC THERAPISTS WHO WORK WITH AT-RISK FAMILIES

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DEDICATION

This thesis is dedicated to my godparents who have supported and encouraged me throughout my college career. For the unconditional love and invaluable wisdom that has helped me to achieve this goal.

ABSTRACT

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At-risk families remain to be a population in need of many services that most do not realize exist. Few studies have examined the practice and challenges faced when serving this specific population. In addition to that, there is little research that exists discussing how music therapy is implemented and how families are addressed during a session. The primary purpose of this study was to survey music therapists working with at-risk families regarding (1) educational and training characteristics, (2) clinical practices, and (3) challenges and limitations when serving this population. Participants included board-certified music therapists in the United States who reported currently working with or having worked with at-risk families in the past. The survey contained 27 questions about demographics, session structure, goals addressed, interventions utilized, challenges and limitations, as well as perceptions of effectiveness of music therapy practice. The most common setting for music therapy practice with at-risk families was private practice. The most commonly utilized interventions during assessment included interviews with the family, consultation with other providers, chart review, and re-creative music. The most commonly utilized interventions during regular reoccurring sessions included re-creative music and improvisation. The most common goal areas included communication, establishing rules, roles, and expectations, and behavioral issues.

KEY WORDS: At-risk, At-risk families, Music therapy

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CHAPTER I

Introduction

The term “at-risk” is often used broadly to describe a person or group of people that belong to a particular type of community, face a variety of challenges, experience traumatic events such as abuse, or those who are economically disadvantaged, among other criteria. Oftentimes, professionals designate individuals as at-risk without knowing exactly what the standard or reference point for at-risk is.

Before considering the standard or reference point for those who are considered at-risk, it is necessary to explain who exactly is at risk. Pasiali (2016) believes that children who are considered at-risk may be affected by individual factors such as a diagnosed disability, socio-emotional problems, or genetic predispositions. Other researchers describe that children who are emotionally neglected and abused have an increased risk of diminished cortisol response that can lead to anxiety, stress, and depression later in life (Jacobsen & McKinney, 2015). Conversely, others posit that the environments in which children develop have the most impact on the child (Pasiali, 2016). For example, early exposure to poverty or neighborhood disadvantage can create risks for a child’s emotional and behavioral adjustment (Flouri, Midouhas, Joshi, 2014). Thus, for those deemed at risk, a number of personal, interpersonal, biological, and environmental risk factors ultimately interact.

In addition to individuals, families may be considered at risk if they are unable to provide stability and proper care for their children; these at risk families may include those with incarcerated family members, single or teen parents, parental mental health issues, poverty, and low parental education levels. Additional family risk factors could

include lack of housing, low language proficiency, unemployment or family disorganization. Oftentimes, more than one factor is present within the family, which further decreases the likelihood of family resiliency (Pasiali, 2012). However, research indicates that parental nurturing can mitigate many effects of factors associated with at-risk families. Specifically, a healthy relationship between the parent and child has been found to offset the effects of neighborhood disadvantage and family poverty on children's emotional and behavioral functioning (Flouri, Midouhas, Joshi, 2014).

Children who are considered at-risk are affected by many factors that often result in negative outcomes. Pasiali (2016) proposes that the term at-risk when referring to child, suggests that a child who has faced crises that may hinder healthy socio-emotional adaptation across the child's lifespan. Instead of specifying what the child is at risk of, many times at-risk is used to describe general adverse outcomes for that child. The most common outcomes that are noted by many professionals are observable developmental delays and; challenges with regulating behavior, including symptoms of insecure attachment and trauma (Teggelove, 2017).

Family is a key context in the process of human development (Santos & Alberto, 2016When referring to a parent or family, the term at-risk suggests that when faced with significant life situations, the parent or guardian may be unable to assume the role of a responsible adult who can identify and prioritize problems, and seek community resources to address them (Pasiali, 2016). The parents of a child are responsible for providing everything that their child needs while growing up. Parents with limited resources such as money and support typically do not have the additional time to devote

to homemaking and nurturing. These parents face many challenges such as lower salaries and longer working hours which result in fatigue and emotional distress (Pasiali, 2016).

According to Killam and Weber (2013), brief strategic family therapy is effective with at-risk youth.. The authors note that the most significant factor in brief strategic family therapy is the inclusion of family in treatment, allowing the counselors to help the parents make changes and reinforce behaviors (Killam & Weber, 2013). In this study, African-American youth and their families received treatment for 12 weeks, and the authors noted a positive change in behavior over the 12-week period. Thus, involving the entire family in therapy may quickly affect important change throughout the family unit. This particular model may have applications to different therapy modalities, such as music therapy.

Theoretical Perspectives

Several recent studies show that music therapy is becoming more prevalent in the field of family therapy. Family therapy is a field that has been studied and proven effective throughout history. Music therapists who currently work with families have reported using multiple traditions based in the field of family therapy to better understand working with the family, while other music therapists chose a specific tradition as the main approach to music therapy. The approach of these music therapists is the integration of a resource-oriented and family-centered belief system. The integration of these systems includes elements such as a focus on adaptation to the needs of individual members of the family, empowering, supporting and helping the parents and other family members to cope (Jacobsen & Thompson, 2017). A common focus of family therapy is family resilience. According to Pasiali (2012), resilience is defined as the ability to

endure and overcome hostile environmental stressors. Patterson believes that one way of determining whether a family is resilient is assessing the degree to which each family member is able to fulfill their function. With that being said, supporting an obligation to maintain the family unit by solving marital issues or an existing disconnect between the parent and child is said to be an example of competence in fulfilling the overall function of the family (Patterson 2002).

Many music therapists describe their work with families as having a focus on supporting family members to interact together with increased positivity, without restrictions, frequently, and with increased sensitivity for one another. It has been reported that music therapy methods can provide a nonjudgmental space for parents to be playful and sensitively attuned to their children. Music therapists in family settings are said to step back in the role of facilitator, moving more into the role of a coach or collaborator, to support family members to be as autonomous in the initiations of interaction with each other as possible. Within this role, the music therapist gently models various aspects of interaction and participation in the session. Many goals described by music therapist who work with families are focused on enhancing parental/caregiver sensitivity, empowering the parent/caregiver, and improving the quality of communication and interaction between family members (Jacobsen & Thompson, 2017). Within the last decade, there has been an increased interest in working with families in music therapy in various settings. However, very little research has been conducted within the specialized area of working with at-risk families. In order to provide effective treatment for these families, we need to know how and why it would be beneficial for them.

Definition of Terms

At-risk. The term at-risk has been applied by mental health professionals to refer to children who face crises that may hinder healthy socio-emotional adaption across the lifespan. Children who are considered at-risk are affected by a combination of individual, family, and societal factors that are linked to poorer life outcomes (Pasiali, 2017). The absence of affection between the parent and child, and angry, irritable interactions have been noted as contributing to the early onset of emotional and behavioral problems and later development of issues with conduct and depression (Abad & Williams, 2007). Circumstances can place families at heightened risk of being unable to provide adequate conditions for optimal child development, and links have been made between the identified risk factors and poorer academic outcomes, criminality, family breakdown, poverty, and health problems for affected children in later life (Teggelove, 2017).

Family-centered therapy. Family-centered therapy can be seen as aligned with community music therapy qualities due to a focus on family resources, emphasis on the system or community of the family, and taking an active and reflective stance where the therapist partners with a family member in trying to help find meaningful pathways to meet their goals. All families have their own core values and beliefs, and the aim is to assist them to find their own inner resources and to help them to find ways to cope (Jacobsen & Thompson, 2017).

Family-centered music therapy. Family-centered music therapy encompasses the children of the family in terms of the family system of which the children are a part. The focus is on the process involved in bringing changes towards more optimal directions in family relationships (Pasiali, 2017). In working with families, many music therapists

base their approach on theories of communicative musicality and nonverbal communication (Jacobsen & Thompson, 2017).

Statement of the Problem

Several recent studies show that music therapy facilitated in a family therapy model is becoming more prevalent. Participation in music therapy has resulted in increased satisfaction with the parenting process, increased levels of positive engagement between the parent and child, and child social and developmental skills, parent's improved understanding and overall enjoyment of their children, and the child's increased feelings of social support (Abad & Williams, 2007). Still, not much research has been conducted from those music therapists who serve those families who are considered at-risk, in the same way that there is no standard or reference point for what at-risk means. Music therapists currently serving this population can best provide the information needed to understand the various facets of providing family-centered music therapy for at-risk populations.

Theoretical relevance. A notable lack of research has been conducted on therapeutic theories and approaches for working with at-risk families. Also, the term at-risk is used broadly to categorize many families, with no clear definition of the term. In order to best serve these families, information should be collected regarding the educational and training characteristics for professionals who effectively serve this population, as well as any existing challenges and limitations that these music therapists face while working with families. This information provides a starting point for understanding the full scope of music therapy with at-risk families, which may elucidate other areas in need of investigation.

Practical relevance. Information from this study may encourage music therapists who work with at-risk families to contribute to current research by narrowing the focus of various studies to at-risk families. Additionally, this information will provide music therapists with information about the current state of music therapy with this population. If music therapists have an understanding of education and training necessary to serve families, they may be encouraged to seek higher education or seek feedback from those with expertise to serve the population. Furthermore, knowledge of challenges and limitations when working with at-risk families will allow music therapists to prepare for such events and plan for ways to combat them.

Purpose of the Study

The purpose of this survey was to examine music therapy clinical practices with families considered by music therapists to be at-risk, challenges and limitations that arise with these families, and educational and training characteristics of music therapists who serve at-risk families. It is believed that results that arise from this study might be of interest to other music therapists working with families.

CHAPTER II

Review of Literature

Introduction

Over the past 10 years, research into working with families in music therapy in various settings has expanded significantly. It is important to note that designs of these studies and methodologies vary across settings and approaches. These research studies provide us with insights into how and why working with families in music therapy works.

Family-Centered Therapy

Family dynamics and the traditional view of families has significantly changed over the years. This is something that professionals must take into consideration when working with families. There are now blended families, dual income families where both parents work full-time jobs, single-parent families, stepfamilies, domestic partners, or families with parents who are of the same gender (Pasiali, 2016). Therapists who have worked with families in the past suggest that there are some essential elements that should be included, such as, adapting to the individual needs of the family, empowering and supporting, and helping the parents and other family members to cope (Jacobsen, 2017).

Another commonality in family therapy is a strong focus on resilience and flexibility of the family. The basis of resilience is that some families fare well in the face of risk and adversity while others do not. Family resilience is quite similar to individual resilience. The difference is that the family acts as a social system, wherein all of its parts must work together. Patterson (2002) suggests that a family system is two or more individuals and the patterns of relationship between them. Cohesiveness, flexibility,

affective communication, and behavioral control are just a few of the characteristics that are telling of how well the family functions. Pasiali (2012) infers that an indicator of resilience, when referring to a child within the family, is the ability to meet age-appropriate developmental milestones, in spite of exposure to environmental stressors. Although these findings have been presented by those who work with families, it is important to remember that each family presents with different dynamics, resulting in varying levels of family resilience.

Exposure to family poverty or neighborhood disadvantage can mean risks for the child's emotional and behavioral adjustment. Nevertheless, all children are not affected by factors such as neighborhood disadvantage, family poverty, or adverse life events. Some children continue on a typical trajectory (Flouri, Midouhas, Joshi, & Tzavidis, 2014). The quality of children's social interactions with their caregivers during the infant and toddler years, is considerably important to healthy child development, especially when faced with adversity. Children require positive interactional skills such as: parental responsiveness, warmth and sensitivity, combined with the absence of angry, irritable parental affect to reach development outcomes. These factors have a tremendous influence on a child's behavioral, social and communication skills (Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008). Finding effective interventions for parents of children who are at risk of developing mental health issues remains to be a significant challenge for those who work with this population (Abad & Williams, 2007). Not only are effective treatments needed, but early intervention is the key to interruption or prevention of negative outcomes.

In an article written by Broderick & Weston (2009), various forms of family therapy are explored by using the example of an adolescent who is experiencing depression. The different forms of family therapy outlined include psychodynamic, structural, strategic, and cognitive-behavioral. These schools of thought are similar, if not parallel, to existing models in music therapy, thus supporting the idea that music therapy can be incorporated with the entire family to provide treatment.

Music Therapy with At-Risk Populations

Music therapy has a variety of potential therapeutic benefits for families. It provides opportunities for a family to engage in intergenerational music making where each family member's developmental stage is respected. Furthermore, the collective process of making music may provide more immediate access to family processes than words. Often, the issues an individual faces and seeks treatment for in individual therapy can be addressed more effectively in the family setting. It is important to note that family-centered music therapy does not replace the need for individual music therapy, rather it adds another perspective, providing understanding of the ways family processes influence family members. The issues surrounding some family systems are often complex, and words may fail to express the depth of a family member's emotions. Little research has been conducted on music therapy with families but the potential benefits are supported by studies of children and adolescents in individual and group therapy (McIntyre, 2009). Music therapy is particularly relevant in assessing parent–child interaction due to its ability to reveal emotional communication, power struggles and levels of autonomy, symptoms of dysfunction, cooperation, turn-taking, and other components of interaction.

Music therapy can assess parents and their capacity to meet their children's needs, to communicate and interact with them (Jacobsen & McKinney, 2015).

Family-Centered Music Therapy. Music therapists serve a wide variety of families with varying dynamics. Some music therapists focus on early intervention and parenting skills, while other studies involve families of children who have been diagnosed with autism spectrum disorder, young parents or those who are in child and family psychiatry.

According to a study by Jacobsen, McKinney, and Holck, music therapists who worked with families with emotionally neglected children found that nonverbal engagement and mutual attunement improved as a result of music therapy. In the same study, it was noted that parents who participate in music therapy with their children reported feeling less stressed by the mood of the child, as well as improved communication and understanding of their children (Jacobsen, Mckinney, & Holck, 2014). Music therapists who describe having worked with families who are considered at-risk suggest that music therapy presents a nonthreatening environment, focusing and building on family strengths rather than deficits (Abad & Williams, 2007). Nemesh proposes that family-centered music therapy can serves as an effective and accurate family clinical assessment, and an intervention addressing a variety of family objectives (Nemesh, 2016).

Summary of the Literature Review

Although the findings of these studies provide a basic understanding of the benefits of working with families, there is no evidence of a framework, assessment process, goals typically addressed, or challenges and limitations. Furthermore, there is

very little to no research providing information about educational level, additional certifications or licenses that could be useful when working with this particular population.

Research Questions

This study addressed the following research questions:

1. What are the educational and training characteristics of music therapist who serve “at risk” families?
2. What are the music therapy clinical practices that these music therapists use when serving “at risk” families?
3. What challenges and limitations exist for music therapists serving “at risk” families?

CHAPTER III

Design of the Study

Research Design

The purpose of this research was to gather information from board-certified music therapists across the country in order to establish common practices and methods when providing music therapy services to at-risk families.

Sample

Survey participants were board-certified music therapists, who identified themselves as working with at-risk families. Only those music therapists who were actively practicing participated. These music therapists were recruited using social media and e-mail.

Instrumentation

A 27-question survey was developed and approved by the Institutional Review Board to survey subjects. The survey was conducted via Qualtrics. The survey link, included informed consent, which informed participants of the purpose of the study and potential risks and benefits, demographic questions, the number of year practicing music therapy, as well as the number of years serving at-risk families, level of education, and credentials. The survey also asked questions relating to the structure of music therapy sessions, goals, interventions, assessment practices, and challenges and limitations. The responses from the returned surveys were compiled for analysis.

Procedural Details

A survey link was either posted on social media or emailed to the music therapists. Participants that did not agree to the terms in the consent form were

disqualified from completing the survey. Music therapists who received the survey but had no prior experience working with at-risk families were also disqualified. This process ensured meaningful results from those with experience within the population.

CHAPTER IV

Results

A total of 20 responses were received from music therapists residing in various regions. Out of the 20 responses, 10 participants completed the survey in its entirety. Data from these survey responses were compiled utilizing the Qualtrics program. A brief interview was also conducted with a music therapist who specializes in work with at-risk families. The responses from that interview were transcribed and will be shown in a table below.

Demographic Data

Participants' ages ranged from 25 to 58 years with an average of 37 years old (n = 13). Around 91% (n = 11) of respondents identified themselves as female, with a total of 11 females and 1 male. All of the regions in the United States were represented in the survey except for the New England region. The Southwestern Region had the highest level of participation at 58% (n = 7), followed by the remaining regions each having one participant including the Great Lakes Region (n = 1), Western Region (n = 1), Southeastern Region (n = 1), Mid-Atlantic Region (n = 1), and Midwestern Region (n = 1).

The education level reported was primarily Bachelor's level with 66% (*n = 8)* indicating Bachelor's degree as highest level of music therapy education obtained and an additional 33% (*n = 4)* reporting either a Master's degree or Master's equivalency degree as highest level of music therapy education. Zero participants reported having a doctoral degree in music therapy.

Years of experience in working with at-risk families varied from 1 to 25 years with an average of about 8 years of experience. Most professionals surveyed (46% or *n = 6)* indicated that they hold an additional music therapy certification in neurologic music therapy (NMT). The remainder of professionals either indicated zero additional music therapy certifications (*n = 5)*, Neonatal Intensive Care Unit Music Therapy (*n = 1),* or Bonnie Method of Guided Imagery and Music (*n = 1)*.

Theoretical orientations were reported with an exact even number of respondents indicating behavioral with 22% (*n = 7)* and cognitive with 22% *(n = 7).* Humanistic and existential were also even with each accounting for 16% (*n = 10)*, followed by an even report of holistic and psychodynamic each having 9% (*n = 6).* In addition, there was a typed text response of trauma informed from one respondent. Information regarding participants' reported theoretical orientations is displayed in Table 1.

Lastly, when asked about additional licenses or certifications relevant to healthcare, a majority of respondents (91% or *n = 11)* reported that they did not hold any additional licenses or certifications. There was one typed text response of certified special education teacher.

Table 1

Reported Theoretical Orientations

Theoretical Orientations	**Percentage**	**Count**
Behavioral	22.58%	7
Cognitive	22.58%	7
Holistic	9.68%	3
Humanistic/Existential	**16.13%**	**5**
Neuroscience	**16.13%**	**5**
Psychodynamic		

Other, please specify	**9.68%**	**3**
	3.23%	**1**

Note. Respondents were asked to identify the theoretical orientations that most closely aligned with their current music therapy practice and were able to select multiple responses.

Professional Characteristics

Respondents reported having a minimum of 1 year and a maximum of 25 years of experience working with at-risk families as a music therapist. The average number of years working with this population was 8.75 years. In the past 12 months, 7 respondents identified the percentage of their music therapy work that involved at-risk families was 50% or more, while the remaining 5 respondents indicated less than 50% of their work involved at-risk families. In addition, 61% of respondents indicated private practice as the most common setting for music therapy with at-risk families. Followed by community groups with 13.75%, outpatient/hybrid programs with 10%, and inpatient long term treatment facility with 6.67%. There was also a typed text response indicating "non-profit". Table 2 displays information regarding participants' percentage of work in the past 12 months in various work settings.

Table 2

Percentage of work in the past 12 months

	Minimum	Maximum	Average	Standard Deviation
Private Practice (e.g., in home or your own clinic)	0.00	100.00	61.25	44.54
Inpatient Long-Term Treatment Facility (Child(ren) typically there for longer than a few weeks and family/guardian comes to visit for family sessions)	0.00	80.00	6.67	22.11

Outpatient/Hybrid programs such as Partial Hospitalization Programs (PHP)	0.00	100.00	10.00	27.69
Medical Hospital	0.00	0.00	0.00	0.00
Residential Treatment Center (RTC) (e.g., facility run by child protective services or a similar department/program)	0.00	0.00	0.00	0.00
Community Groups (e.g., mommy and me)	0.00	100.00	13.75	28.22

Note. Percentage of music therapy work in the past 12 months in each of the following.

Assessment Practices

When asked specific questions about how families are referred to music therapy services, respondents typed several responses including “Medicaid waiver programs,” “autism support organization,” “family respite program,” “social media,” “physicians,” and “word of mouth.”

In reference to the initial assessment, respondents indicated they personally perform the initial assessment 79% of the time. When asked about methods used during assessment, a majority of respondents (*n = 9)* reported conducting an interview with the child/family as the initial assessment. Followed closely by consultation with other providers with 19%, chart review with 12%, and re-creative music with 12%. The remainder of responses included improvisation with 9%, composition/songwriting with 4%, as well as listening, and music games/recreation with 4%. The typed text responses included “movement to music,” “play-manipulatives,” and “site specific assessment.” Table 3 displays common methods used during assessment.

Table 3

Percentage of methods used during assessment

	%	Count
Improvisation (e.g., instrumental, vocal, etc.)	9.76%	4
Re-Creative Music (e.g., instrumental song re-creation, group sining, hand bell choir, etc.)	12.20%	5
Composition/Songwriting	4.88%	2
Listening (lyric analysis, relaxation, etc.)	4.88%	2
Music games/recreation (e.g., name that tune, music bingo, etc.)	4.88%	2
Interview with child, children, and/or family/guardian	21.95%	9
Chart review	12.20%	5
Consultation with other providers (e.g., therapists, doctors)	19.51%	8
Something else, please specify:	9.76%	4

Goals

In an attempt to identify common goal areas, the researcher asked participants to indicate goals commonly addressed while providing music therapy to at-risk families. Communication was the highest reported goal with 21% (*n = 10)*, with an even report of establishing rules, roles, and expectations (*n = 8)* and behavioral problems (*n = 8).* Improving family interactions was reported by 12% of respondents, mental health with 8%, an even report of psycho-education, conflict resolution, and family grief all with 6% and lastly parenting issues with 2%. Typed text responses included “anxiety,” “self-esteem,” “suicidal ideation/self-harm,” “trauma,” and “anger management.” Figure 1 indicates the goals commonly addressed during sessions.

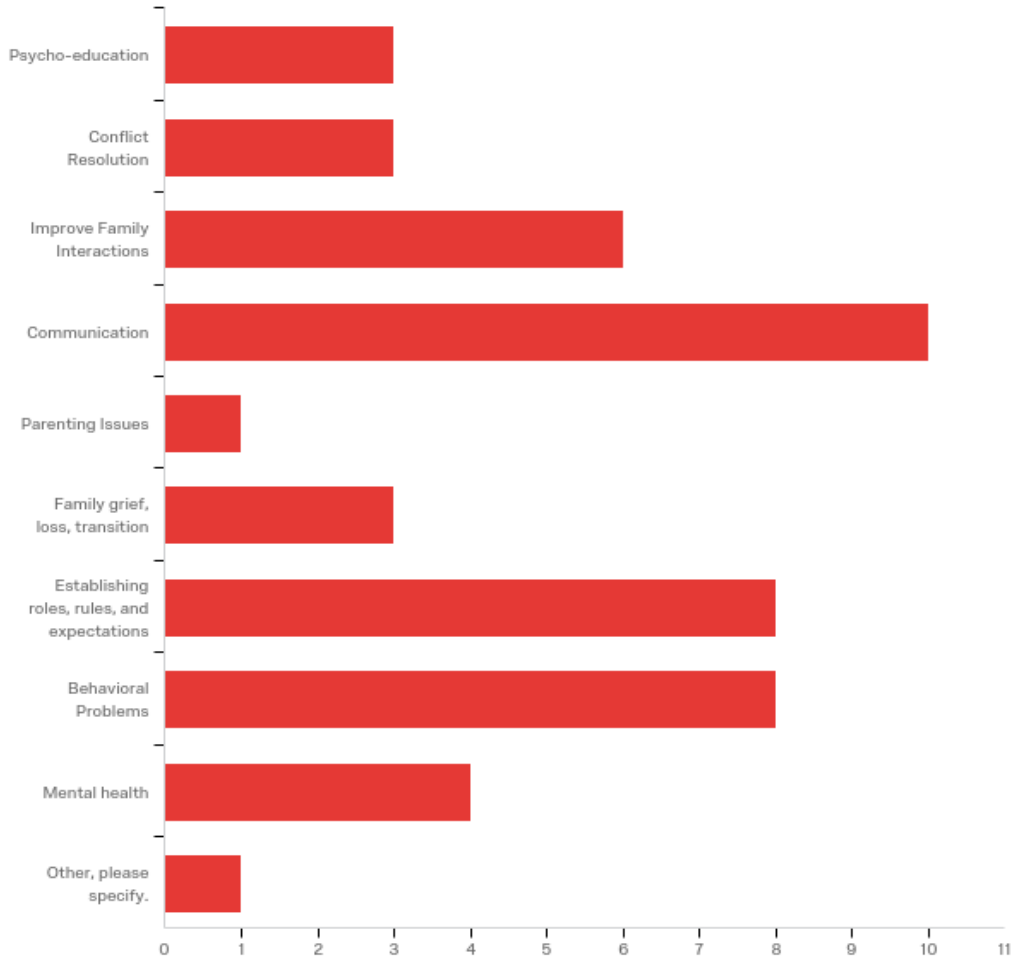

Figure 1. Goals commonly addressed during sessions.

Interventions/Methods Utilized

Participants were asked to identify the method or methods that they use to treat at-risk families. Re-creative music, including instrumental song re-creation, group singing, and drumming, was the method that most respondents (*n = 4)* indicated they use with this population, followed by improvisation both vocal and instrumental (*n = 2)*, and music listening (*n = 1).* Typed text responses (*n = 3)* included "neurological music therapy techniques" and "stories." Some respondents indicated that they use a variety or combination of methods. Figure 2 displays these interventions/methods.

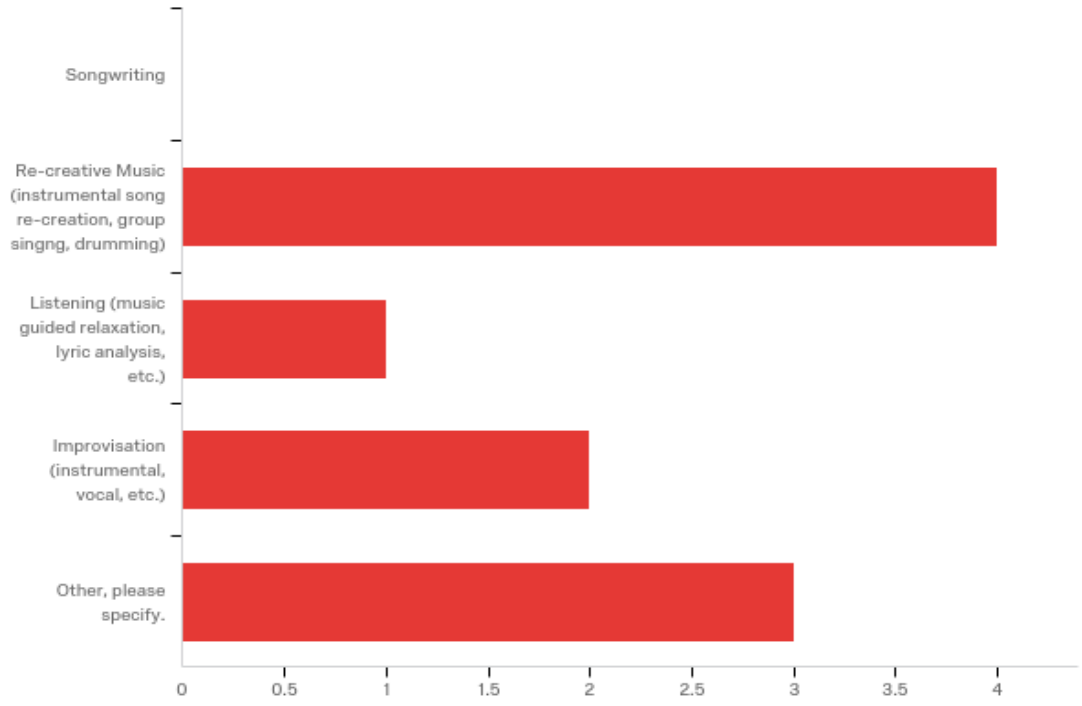

Figure 2. Types of interventions utilized during music therapy sessions.

Challenges/Limitations

Respondents were asked about common challenges and limitations faced when serving at-risk families in order to inform music therapists who have a possible interest in working with the population. The highest recorded challenge (*n = 3)* was child/children's guardian is/are not the parents. A majority of respondents chose to type text responses including "scheduling", "unexpected presence of additional family members", "difficulty affording private-pay services," "single parent families," "low socioeconomic status," "low engagement from parents during session," "transportation," "language barrier," "limited education," and "overbearing parents."

Personal Perceptions

For the final question of the survey, music therapists were asked to share their personal opinion regarding music therapy education, effectiveness of treatment, and need

for research. The questions addressed feelings of preparedness from the respondent's music therapy education to provide effective treatment to at-risk families, the level of effectiveness perceived when working with at-risk families, and the belief or lack thereof that more research is needed in the area of music therapy with at-risk families.

In response to the statement "I feel that my music therapy education and training prepared me to provide treatment for at-risk families" a majority of respondents answered "Somewhat Agree" (*n = 4),* while others responded with either "Somewhat Disagree" (*n = 3)* and "Strongly Agree" (*n = 2)*. In response to the statement "I feel that music therapy has the potential to be effective for at-risk families" a majority of respondents answered "Strongly Agree" (*n = 9)*. Lastly, in response to the statement "I feel that the topic of music therapy practices with at-risk families should be further researched" a majority of respondents answered "Strongly Agree" (*n = 8)*.

CHAPTER V

Discussion

Summary

The data collected were made up of responses from 10 music therapists from various regions throughout the United States, with varying levels of experience and a variety of theoretical backgrounds. Despite the small sample size, the respondents' backgrounds and practices were diverse and unique, with an average of eight years of experience, demonstrating a wide representation of the field of music therapy. In addition to the survey questions posed in the survey, an interview was conducted with a music therapist with 25 years of experience working with at-risk families. Each of the research questions will be further discussed and answered with the data collected from the survey and interview.

What are the educational and training characteristics of music therapist who serve at risk families? Respondents were surveyed on their level of education, years of experience in music therapy, years of experience working with at-risk families, and additional certifications. Results showed that a majority of respondents were bachelor's level music therapists, while 33% of respondents held a master's degree in music therapy. When asked about total years of experience as a practicing music therapist, respondents ranged from 2 years of experience up to 28 years, demonstrating a wide representation of music therapists with varying levels of experience. In addition, a majority of respondents held an additional certification in Neurologic Music Therapy.

During a brief interview with an expert music therapist in the field of music therapy with at-risk families, the participant was asked to discuss which, if any,

additional trainings or certifications are necessary to increase effectiveness of practice with at-risk families. The respondent noted that additional training in the field of trauma informed care would be helpful to music therapists serving this population. Also, obtaining continuing education units (CEU), in topics related to this population can assist in staying up to date with current trends. The respondent further noted that master's level is common among those who serve the at-risk population.

What are the music therapy clinical practices that these music therapists use when serving at-risk families? Music therapists surveyed indicated that oftentimes during the initial assessment a non-musical form of an assessment is used to determine goals and objectives. This finding is interesting due to the fact that engagement in music is the most prominent and unique feature of music therapy. The lack of music-based assessment measures could be due to the fact that music therapists serving this population may have a heavy caseload of clients, allowing for a limited amount of time to conduct the initial assessment. Besides that, music therapists working at various facilities may have a generic site specific assessment used across disciplines that does not allow for the introduction of music interventions within the initial assessment.

When asked about assessment practices during the interview, the respondent noted that the assessment is typically geared towards the reason for referral. For instance, in the case of child abuse, the assessment is used to assess trauma symptoms. In addition the respondent stated that assessment tools sometimes take a while to get used to because every family is unique. In order to increase comfortability with using an assessment, it should be used multiple times with varying family dynamics. Oftentimes, music therapists are asked to conduct assessments with Spanish speaking families. This poses a

challenge to music therapists who do not speak Spanish. In this instance, it may be more appropriate to conduct a strictly musical assessment, because of the benefits of music as a non-verbal form of communication.

What challenges and limitations exist for music therapists serving at-risk families? Music therapists were asked about challenges and limitations faced while providing services to at-risk families. This particular survey question yielded a wide variety of responses including transportation, scheduling, single parent families, lack of engagement from parents during the session, as well as overbearing parents. During the interview, the music therapist stated that because of these challenges, oftentimes the result is inconsistency in treatment and ultimately a discontinuation of treatment because of the many burdens that accompany the stressors of an at-risk family. The interviewee mentioned that reminder calls about reoccurring sessions are a viable solution for at-risk families who have difficulty managing a busy schedule with limited resources and numerous stressors. Future research concerning solutions to these issues would be helpful to music therapists who work with this population.

Study Limitations

Although the sample surveyed consisted of a diverse group of music therapists with a wide variety of backgrounds, one of the limitations that existed in this survey was the small sample size used. Although there are many music therapists who work with at-risk families, it is the researcher's belief that those providing services do not always consider the clients to be at-risk. The researcher was asked by prospective participants on numerous occasions to define the term "at-risk", which was telling in that a majority of music therapists lack understanding of who is considered to be at-risk. This study points

to the need for a uniform set of characteristics or definitions to identify who is considered at-risk, so that professionals can collaborate to better serve the population.

An additional limitation during the research process for this subject is the lack of previous research and literature on the subject of music therapy with at-risk families. This study's findings demonstrates the need and desire for more research within this population by music therapists.

Recommendations for Further Research

In the future, the sample size should be broadened to promote a large snapshot of current characteristics of music therapists working with at-risk families and their clinical practices. To achieve this goal, it may be necessary to dedicate an entire study to the pursuit of defining the term at-risk by allowing music therapists to list characteristics of who they consider at-risk families. This type of study may encourage music therapists to collaborate in research and practice, increasing the effectiveness of treatment within this population. Further research involving access to and awareness of services for families who are considered at-risk is also suggested. Many at-risk families remain to be unaware of music therapy and its many benefits. Lastly, further research could improve inconsistencies and discontinuation of treatment within the population and possible solutions to combat these issues. This could increase length of treatment and overall improvement of results and achievement of goals when working with at-risk families.

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