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# A Critical Review of the Literature on the Accessibility of Music Therapy in Rural Areas in the USA for Families with Children with Special Needs

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A Critical Review of the Literature on the Accessibility of Music Therapy in Rural Areas in the  
USA for Families with Children with Special Needs

Capstone Thesis

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Music Therapy

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### **Abstract**

This capstone thesis explores the topic of the accessibility of music therapy in rural areas of the United States for families with children with special needs. Through a critical review of the literature on this topic, it was found that the small body of knowledge on music therapy in rural parts of the USA focused on populations other than families with children with special needs (Brotons & Marti, 2003; Leist, 2011; Levy, Spooner, Lee, Sonke, Myers, & Snow, 2018; Sisk, 2016). Literature from music therapy journals as well as related health professions were analyzed and synthesized to further understand why access to music therapy is limited for families with children with special needs living in rural areas. From the literature, ways of increasing accessibility and developing music therapy practices in rural parts of the country for this population included family-centered music therapy (Forrest, 2014; Gutierrez-Jiménez & Franco, 2018; Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008; Thompson, 2017), home-based music therapy (Forrest, 2014; Schmid & Ostermann, 2010), community music therapy (Bolger, 2015), resource-oriented music therapy (Pasiali, 2012; Rolvsjord, 2004), and culturally competent music therapy (Bolger, 2015; Forrest, 2014; Whitehead-Pleaux, Brink, & Tan, 2017). From these approaches, a model is developed that incorporates the approaches and findings highlighted above for increasing the accessibility of music therapy in rural areas for families with children with special needs.

*Keywords:* music therapy, accessibility, rural, families

A Critical Review of the Literature on the Accessibility of Music Therapy in Rural Areas in the  
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### **Introduction**

Music therapy in rural areas of the USA is a topic that has been largely unexamined, with the few scholarly journal articles published on the topic focusing on populations other than families with children with special needs (Brotons & Marti, 2003; Leist, 2011; Levy, Spooner, Lee, Sonke, Myers, & Snow, 2018; Sisk, 2016). This small body of literature reveals a major gap in knowledge on the topic. As of 2017 (America Counts Staff), 60 million people, or 1 in 5 Americans, lived in rural areas of the United States. It was found that more children in rural areas were uninsured compared to those living in urban areas ("New Census Data", 2016). Those living in rural areas were also less likely to have obtained a bachelor's degree or higher than those living in urban areas ("New Census Data", 2016). Rural households were also found to have lower median household incomes ("New Census Data", 2016). In 2018 ("Rural People with Disabilities"), it was found that approximately 15.1 percent of the rural population in the US had disabilities, however, that services and resources in these parts of the country were limited and scarce:

Access to adequate housing, transportation, employment, educational programs, and specialized healthcare may be limited in many parts of rural America. Community organizations, healthcare facilities, local governments, and other rural entities can help people with disabilities by collaborating and creatively using limited resources to provide needed services. ("Rural People with Disabilities", 2018)

While little data exists on children with disabilities in rural America, in 2007 (Waldman & Perlman) almost 610,000 rural families had a child with a disability, and almost 20 percent of

those families were living in poverty (Waldman & Perlman, 2007). More than 25 percent of children living in rural areas had Medicaid for their healthcare needs (Waldman & Perlman, 2007). It was also found that families living in rural America with a family member with a disability had lower incomes, had a greater likelihood of receiving income from Social Security and other types of public assistance, and had higher incidences of family householders who were unemployed (Waldman & Perlman, 2007). Such data highlight a need for accessibility of music therapy in rural areas for families with children with special needs in the USA.

A critical review of the literature will be analyzed and synthesized to further understand why access to music therapy is limited for families with children with special needs living in rural areas. This will be done by first reviewing the literature on general mental health and medical services and their accessibility in rural areas. This information will then be compared to data on music therapy in rural areas. Barriers to service delivery in rural parts of the country, such as lack of health insurance coverage, funding, and large geographic catchment areas will also be discussed (Cristancho, Garces, Peters, & Mueller, 2008). These barriers to service delivery will be discussed from a music therapy lens, including how music therapists navigate these barriers as well as current potential risks for burnout when working in these areas (Kenmore, 2018).

When researching music therapy in rural areas of the USA it is necessary to have a sense of cultural humility and seek to understand the values, norms, and rituals within these areas (Bolger, 2015). An exploration into culturally responsive music therapy, and how other countries have incorporated culture in their music therapy practice will be discussed. A look into the culture of rural areas in different parts of the USA, and how this may interplay with perceptions of music therapy, will also be examined (Forrest, 2014).

As this thesis is focused on families with children with special needs, a general overview of the benefits of family-centered music therapy (Thompson, 2017) for families living in rural areas will be discussed. Home-based music therapy will also be explored as a type of therapy that has the potential to increase access and to be effective for meeting family's needs (Schmid & Ostermann, 2010).

Along with family-centered and home-based music therapy, other approaches in the field of music therapy have emerged as having certain characteristics or guiding principles that lend themselves to work in rural areas. Those approaches are community music therapy (Bolger, 2015) and resource-oriented music therapy (Rolvsjord, 2014). These approaches and their focus on empowerment and utilizing strengths that are already present within individuals and communities (Rolvsjord, 2004) will be explored as a way of building music therapy practices in rural areas.

### **Defining Terms**

According to the United States Census Bureau (2018), there are two types of urban areas: Urbanized Areas and Urban Clusters. Urbanized Areas consist of 50,000 or more people, and Urban Clusters consist of at least 2,500 people and less than 50,000 people (Urban and Rural, 2018). The United States Census Bureau states that rural “encompasses all population, housing, and territory not included within an urban area” (Urban and Rural, 2018).

Merriam-Webster's (Family, 2018) dictionary has several definitions for the word ‘family.’ The first definition listed is “the basic unit in society traditionally consisting of two parents rearing their children” (Family, 2018). As many families do not consist of two parents, and children may be raised by people other than parents, the term ‘caregiver’ will be used to recognize that not all families include parents. When defining the term ‘family’ it is also

important to recognize that every family is different, and honor what the family defines as their family (Forrest, 2014). Using the Culturally Competent Music Therapy Assessment (Whitehead-Pleaux, Brink, & Tan, 2017) can assist with understanding the family roles, dynamics, and norms within each family (Whitehead-Pleaux et al., 2017).

Through critically reviewing the literature related to the accessibility of music therapy for families with children with special needs in rural areas in the USA, it is hoped that new knowledge, ideas, and insights will be generated that will be integrated into clinical practice. Furthermore, from reading this thesis it is hoped that an awareness and understanding of intersections of culture within rural areas will occur, as well as how music therapy can intersect and work within these cultures. Readers will also develop an understanding of the resources and services that are currently available for families with children with special needs living in rural areas. Understanding the accessibility of the resources already in place could potentially inform and assist in developing music therapy programs within rural communities. As this topic is currently a gap not only in the research but in service delivery as well (Kenmore, 2018), it is hoped that ultimately this capstone thesis inspires others to consider working with this population to address this gap in accessibility.

### **Literature Review**

A critical review of the literature has been chosen as the format for this capstone thesis. This capstone thesis option was chosen as there is a gap in the current body of knowledge in the field about the accessibility of music therapy in rural areas, specifically for the population families with children with special needs.

### **Accessibility of Mental Health and Medical Services in Rural Areas**

While little research exists on the accessibility of music therapy in rural areas of the USA, information can be gleaned from researching other types of mental health and medical services and their accessibility in rural areas. Through doing this, issues that those living in rural areas face can be recognized and understood. For many people living in rural areas, these issues include "...poverty, growing incidents of drugs and violence, inadequate medical and dental personnel, limited health insurance, and a greater prevalence of children with special health care needs than in urban areas" (Waldman & Perlman, 2007, p. 81). Another consideration for children with special needs in rural areas is children who are part of migrant farm-working families (Waldman & Perlman, 2007). As this type of work is often associated with frequent moving depending on agricultural seasons, it can be especially difficult for these families to have continuous services (Waldman & Perlman, 2007).

Although 20 percent of the population live in rural parts of the country, only 9 percent of physicians practice in these rural areas, with very few being specialists (Waldman & Perlman, 2007).

Despite considerable efforts by federal and state governments over the past decades to address these problems, rural provider distribution and shortage issues have continued to plague efforts to meet the health requirements of the general rural population and, in particular, the requirements of children with special health needs. (Waldman & Perlman, 2007, p. 82)

Furthermore, in 2007 (Waldman & Perlman) it was found that there was half the supply of dentists in rural areas to those in urban areas.

**Alternative Medicine.** Bodner et al. (2018) identified the prevalence and types of integrative medicine in pediatric pain clinics throughout the country. Fifty-three pediatric pain

clinics were identified throughout the country, with 8 clinics located in rural areas, and the other 45 located in urban areas (Bodner et al., 2018). Out of these 8 clinics in rural areas, 6 offered integrative medicine (Bodner et al., 2018). Integrative medicine services that were offered included acupuncture, mind-body strategies, massage, aromatherapy, nutrition counseling, yoga, and art/music therapy (Bodner et al., 2018).

Cahill, Aycock, Cuellar, and Ford (2003) studied if there was a difference in the use of complementary and alternative medicine (CAM) between African American older adults and Caucasian American older adults living in rural areas, as well as self-reported satisfaction with CAM. No differences existed between satisfaction with CAM use among African Americans and Caucasian Americans (Cahill et al., 2003). Caucasian Americans used more CAM than African Americans, with Caucasian Americans using an average of 4 types of CAM and African Americans using an average of 3 types of CAM (Cahill et al., 2003). It was found that the most commonly used complementary and alternative medicine among adults living in rural areas were prayer, vitamins, exercise, meditation, herbs, chiropractic medicine, glucosamine, and music therapy (Cahill et al., 2003).

Cahill et al. (2003) and Bodner's et al. (2018) studies show that CAM and IM are being used, and that those using them are satisfied, but that there is an increasing need for access to these services as well as others in rural areas across the USA. Cristancho et al., (2008) found in their study of Hispanic immigrants living in Illinois that there were several barriers to accessing and utilizing health care services. These included lack of health insurance, high costs of healthcare, communication issues, transportation, legal status/lack of documentation, and discrimination (Cristancho et al., 2008). In another study, veterans living in rural areas reported that they were not able to receive the medical care they needed due to travel time, disability, and

transportation costs (Levy et al., 2018). Based on this evidence, it is clear that those living in rural areas face certain disadvantages to receiving the care they need that those living in other parts of the country do not have to face (Cristancho et al., 2008; Levy et al., 2018).

**Nursing.** One profession that has been able to serve those living in rural areas is nursing. Due to changes in acute medical care and limited availability of hospital beds, there has been an increase in home-based nursing services (Barrett, Terry, Lê, & Hoang, 2016). This shift has created a significant workload pressure for community-based nurses, who already face many of the barriers of working in rural community settings as discussed previously (Barrett et al., 2016). “When combined with additional factors associated with working in rural community settings, community nurses can potentially become dissatisfied. These additional factors may include limited access to education, isolation of the role and additional geographic challenges” (Barrett et al., 2016, p. 120). Similar to findings related to music therapists in rural areas, nurses working in rural areas are most often generalists due to lower population densities and the broad range of medical conditions that they may encounter (Barrett et al., 2016). “...they may be required to administer trauma care, provide mental health care, stabilise the critically ill, while providing comfort to the dying all within one shift” (Barrett et al., 2016, p. 122). Due to rising rates of chronic illness in rural areas, nurses have become responsible for a large number of long-term patients who require ongoing nursing needs (Barrett et al., 2016). However, while more healthcare has been transferred to these community-based settings, community nurses have at the same time become responsible for more intensive, rapid discharge patients (Barrett et al., 2016). Similar to music therapists in rural areas, this has contributed to community based nurses working within a large scope of practice with a variety of skills required on a daily basis. Nurses working in rural areas have also had to deal with a lack of resources, equipment, and facilities, in

underfunded areas (Barrett et al., 2016). This shift has created additional stress for nurses in both rural and urban areas and has led to burnout and some leaving the profession altogether (Barrett et al., 2016).

Due to the shift in healthcare that has a greater emphasis on community based nursing, Australia, the US, and the UK have developed policy initiatives aimed at reducing costs, ensuring quality, and improving access (Barrett et al., 2016). An emphasis on less structure and more autonomy for nurses working in community-based settings has been highlighted for benefits of the job (Barrett et al., 2016).

Nurses were shown to benefit from the autonomy and creativity that is an intrinsic part of practicing in rural communities. As autonomy, skill variety, task significance and the levels of social support increased, the level of satisfaction increased while burn out decreased. (Barrett et al., 2016, p. 125)

The skills that community-based nurses require, such as competency and flexibility, need to be more greatly appreciated and expanded, according to Barrett et al. (2016). Because of this, Barrett et al. (2016) encouraged community nurses to take on more of a leadership role within the profession, and incorporate this type of setting more into academic settings. It was also recommended that nurses partner with other organizations, colleagues, and clients to implement and enhance services within rural communities. Through this, nurses were able to be actively involved in decision-making and program implementation, rather than adhering to the hierarchy within healthcare systems (Barrett et al., 2016). While nursing has implemented several steps for ensuring those living in rural areas receive needed medical care, Barrett et al. (2016) stated that more research is needed on understanding what factors impact rural community nursing practices, and that advocacy around this is still needed.

**Telehealth and Reliable Internet.** One of the disadvantages for Americans living in rural parts of the country is a lack of reliable internet (Segan, 2018). This impacts access to mental health services, as telehealth and video conferencing has the potential to reach those living in rural areas that do not have access to face to face services (Levy et al., 2018). 5G, the latest in wireless technology, is said to be able to provide faster and more reliable internet than ever before (“Is 5G the Magic Bullet, 2018). However, while those in the industry are promising that it will provide improved access in rural areas, the rollout of this is expected to require special equipment and extended time (“Is 5G the Magic Bullet”, 2018). A current lack of data on where broadband internet already exists and where it does not throughout the country is negatively impacting those seeking services in rural areas. In order to address this ‘digital divide’ (“Is 5G the Magic Bullet”, 2018) data collection on where reliable internet already exists, and where there are gaps, is needed. Furthermore, it has been found that the technology used for 5G is efficient for densely populated urban areas, however, is not well suited for sparsely populated, large geographic regions (“Is 5G the Magic Bullet”, 2018). Some have concluded that only government subsidies would turn 5G into a real solution for rural home broadband issues (Segan, 2018).

Despite the concerns around the technology used and slow timeframes, if 5G is made accessible, it has the potential to create resources and services for those living in rural areas through video conferencing and other online mediums (Segan, 2018). Having a reliable form of internet could also make supervision and peer support more accessible to those working in rural areas, which could reduce burnout rates. Another possibility for providing reliable internet access, and therefore increasing access to services, is RS Fiber (Carlson & Mitchell, 2016). RS Fiber is striving to bring high-speed internet to those living in rural Minnesota and was

spearheaded by local leaders and volunteers (Carlson & Mitchell, 2016). In order for this to occur, 10 city councils from rural, conservative parts of Minnesota came together, used tax dollars, and worked on implementation for 7 years (Carlson & Mitchell, 2016). “RS Fiber is a promising model for the vast majority of rural communities stuck with slow and unreliable internet access. Without that access, they have fewer prospects for economic development, educational advancement and health care” (Carlson & Mitchell, 2016). That being said, it could also be argued that reliance on telehealth could limit the number of job opportunities and economic growth in these rural areas (Segan, 2018).

Perhaps a similar approach is needed when considering music therapy in rural areas. As will be discussed further on in the cultural section, the need for music therapy must be recognized by locals from rural communities who are willing to work together and reach out to others to help educate and spread awareness of music therapy and the many benefits.

### **Music Therapy in Rural Areas**

Studies specific to music therapy in rural areas have focused on those living with Alzheimer’s (Brotons & Marti, 2003), adults struggling with substance abuse (Sisk, 2016), veterans (Levy et al., 2018), and adults with coronary heart disease (Leist, 2011). While these are all topics in need of further research, little to no research has been conducted on the accessibility of music therapy in rural areas specifically for families with children with special needs.

**Payment and Health Insurance.** Music therapy in rural areas is often only available to clients if they are able to pay privately (Kenmore, 2018). In some cases, funding is available through various grants and programs, such as Levy et al.’s, (2018) study of telehealth-based creative arts therapy for rural veterans that was funded through the Veteran’s Health Administration’s Office of Rural Health. According to Healthcare.com (Pak, 2018), some health

insurance providers may cover music or art therapists depending on the therapist's credentials. If the music or art therapist is also a licensed psychologist or psychiatrist, the service may be covered through the client's health insurance (Pak, 2018). In order for this to occur, a "Medically Necessary Referral" (Pak, 2018) has to be made, which typically comes from a physician or mental health specialist. Health insurance companies review these on a case by case basis (Pak, 2018). Another way clients may have music therapy covered by their health insurance is if they have Medicare Part B (Pak, 2018). As Medicare Part B includes outpatient care for mental health needs (Pak, 2018), Medicare Part B can reimburse music therapists if they are providing the service in the context of outpatient mental health care with a referral from a doctor (Pak, 2018). It should be noted that music therapists currently are out of network providers with insurance companies, which means there may be an out of network deductible (Pak, 2018). For music therapists working in rural areas of the country, it is important to understand the state requirements around reimbursement for music therapy, as this will affect the accessibility of music therapy and who will be able to receive the service.

**Risk Factors for Music Therapists in Rural Areas.** When researching music therapy in rural areas of the USA, it was found that music therapists working in rural areas were often the only music therapist in their geographic region (Kenmore, 2018). Music therapists in rural areas also had a large scope of practice that included working with different populations in different settings (Kenmore, 2018) to try to ensure that music therapy was as accessible as possible for the geographic region. This has the potential for music therapists to be working outside of their competence area, and could also lead to an increased risk of burnout (Kenmore, 2018). Working in rural areas could also mean that there is an increase in travel time to meet clients throughout the region (Kenmore, 2018). In one study, "urban and suburban music therapists reported higher

job satisfaction than did therapists working in rural areas” (Vega, 2010, p. 156). Additionally, it was found that being the only music therapist in a large geographic region could be isolating, which could impact available supervision and peer support (Vega, 2010). These risk factors have been found to be true not only for music therapists but in other health professions as well, which leads to the problem of limited access. With no incentives, however great challenges to face when working in these rural areas, the amount of people seeking to work in these areas is limited. “No solutions for the future of rural healthcare for youngsters with special needs can come to fruition if they do not promote stable, rewarding, and fulfilling professional and personal lives for rural health workers” (Waldman & Perlman, 2007, p. 82).

**State Licensure.** One way that the music therapy profession is trying to increase the legitimacy of the field is through the State Recognition Operational Plan (State Advocacy, n.d.). The American Music Therapy Association (AMTA) and Certification Board for Music Therapists (CBMT) are working jointly on this “national initiative to achieve official state recognition of the music therapy profession and the MT-BC credential required for competent practice” (State Advocacy, n.d.). Through this plan, state-based public protection programs would ensure that music therapy was established by those who met established training qualification (State Advocacy, n.d.). State recognition and licensing could also have the potential to improve employment and funding opportunities for music therapists (State Advocacy, n.d.). Current states that are recognized for either having a music therapy license, or title protection, meaning practitioners must hold the MT-BC credential, are Connecticut, Georgia, Nevada, North Dakota, Oklahoma, Oregon, Rhode Island, and Utah (State Advocacy, n.d.). Other states have also introduced or are planning to introduce legislation to recognize clinical training, education, and credentialing requirements (State Advocacy, n.d.). These states are Illinois (license), Iowa

(title certification), Michigan(license) Minnesota (license), Missouri (title protection), New Jersey (license), New York(license), North Carolina (license), Ohio(license), Pennsylvania(license), and Utah (license) (State Advocacy, n.d.).

State recognition and licensure could allow for music therapy regulations and requirements to be specific for the unique needs and cultural considerations of each state (Moore, 2012). This is important to consider for states with large amounts of rural areas, as it could allow each state to consider their geographic and cultural climate and tailor the music therapy regulations to fit these individual state characteristics, creating more opportunities for success.

**Awareness and Advocacy.** An important aspect when considering the accessibility of music therapy in rural areas is people's awareness and perceptions of music therapy in these rural areas. While there are many barriers to effective service delivery, a factor may be that those living in rural areas are unaware that music therapy exists or how to receive the service. Therefore, music therapists marketing themselves and their business can help to advocate for the field and spread awareness. Furthermore, connecting with other service providers within the community and making the music therapy service known to businesses can also help to create connections and receive referrals (Crowell, 2018).

### **Family-Centered Music Therapy**

There are many benefits for both children and families when engaging in family-centered music therapy. Including family members in sessions can provide an opportunity for support to be given to caregivers and siblings during what may be a challenging time caring for their child (Thompson, 2017). Music therapy can also provide family members with opportunities for enjoyment and positive engagement with their child, which is critical for families when going through stressful times related to their child's well-being (Thompson, 2017). For many of these

families, their lives can feel isolated as they devote all their time and energy to their child (Thompson, 2017). This isolation from others that caregivers and family members may feel often occurs in conjunction with the lack of social support and resources that exist in rural areas, and is something that music therapy can address. Finally, music therapy has the potential for children living in rural areas to promote the development of meaningful relationships with family members, as for young children the family is typically their primary social context and can inform how they interact with others later in life (Thompson, 2017).

Music therapy can be effective especially for those that have nonverbal family members, as it can assist with communication and expression of feelings in a nonverbal manner (Gutierrez-Jiménez & Franco, 2018). Through this, communication and relationships can be enhanced, and the family system can become more connected (Gutierrez-Jiménez & Franco, 2018). This can also occur for infants and caregivers for bonding and increasing attachment (Nicholson et. al., 2008). As singing is one of the earliest forms of interaction between a caregiver and child, it can also be used therapeutically to soothe an infant or child in distress (Nicholson et al., 2008). Lastly, music therapy can also be a way to nonverbally connect and establish a relationship if any language barriers are present (Gutierrez-Jiménez & Franco, 2018).

In one study, mothers of young children with Autism found long-term benefits to creating positive social relationships within the family through music therapy (Thompson, 2017). Additionally, it was found that these positive relationships early in life had the potential to relate to other social systems later in life for children with Autism (Thompson, 2017). These benefits in social relationships within the family have the potential to improve the quality of life for not only the child, but also the family after music therapy sessions (Thompson, 2017).

From Thompson's (2017), Gutierrez-Jiménez & Franco's (2018), and Nicholson et al.'s (2008) studies it can be seen that family-centered music therapy benefits not only the child but the entire family system, and can have lasting effects throughout a child's life (Gutierrez-Jiménez & Franco, 2018; Thompson, 2017). However, for families in rural areas, opportunities to engage in music therapy are often limited, which can lead to further isolation and loss of hope for their child. Through home-based music therapy, music therapists are able to increase access to music therapy in rural areas and also are more likely to be able to work with the whole family system.

### **Home-Based Music Therapy**

Home-based music therapy has been used by music therapists and other health professionals to reduce barriers and increase accessibility (Schmid & Ostermann, 2010). The use of home-based music therapy specifically in rural areas is one way that could improve access specifically for families living in rural areas. Moreover, there are additional therapeutic benefits to providing home-based music therapy that will be outlined here (Forrest, 2014). For those living in rural areas, increased travel time to receive mental health and medical services is often a barrier for treatment and has been found to be true for music therapy services as well (Kenmore, 2018). Lack of public transportation in rural areas also contributes to this, leaving those without a car often unable to receive needed treatment and services. For families with no car, or with a car but managing both the caregivers and children's schedules, it can be challenging to maintain consistent therapy times that are not a major disruption to the family. Through the music therapist traveling to the client's home and conducting sessions in their home, the music therapist is able to provide this service more consistently. Providing music therapy in the home has the potential to increase accessibility while reducing stress for families as they do not have to worry about transportation and travel times.

There are many benefits to home-based music therapy that go beyond transportation (Forrest, 2014; Schmid & Ostermann, 2010). Music therapy conducted in the family's natural environment improves outcomes for not only the child, but can also support caregivers and siblings (Gutierrez-Jiménez & Franco, 2018). Through providing music therapy in the home, there is the chance that more family members may be home and available to join in during music therapy sessions if the family wishes. This provides families with increased opportunities for enjoyment and positive engagement (Gutierrez-Jiménez & Franco, 2018). This is especially critical for families when going through stressful times related to their child's well-being (Thompson, 2017). In one study, it was found that music therapy helped to reduce stress and increased the use of coping skills for families with children in pediatric palliative care that received home-based music therapy (Forrest, 2014). It was also found that music therapy provided opportunities for fun, improved quality of life, and created a space for bonding to take place between the caregiver and child (Forrest, 2014). Other additional benefits of music therapy included that it provided opportunities for choice and control, and facilitated stimulation and relaxation (Forrest, 2014).

Home-based music therapy could be argued to be a humanistic approach, as it meets people where they are at both physically and emotionally (Schmid & Ostermann, 2010). It minimizes disruption to family life when provided at home, and provides the client and family with more control over the environment (Forrest, 2014). As a result, inherent power differentials within the therapeutic relationship can be lessened, which is important for the music therapist to consider (Forrest, 2014). Another benefit of home-based music therapy with families is that through musical interventions taking place directly in the home, it is easy to have family members continue the musical play activities and have these transferred into their everyday

routines (Thompson, 2017). Ultimately, by providing music therapy in the home, the music therapist has the opportunity to gain a fuller understanding of the client and family (Forrest, 2014) through being in their environment and witnessing family dynamics, roles, and norms (Thompson, 2017).

### **Cultural Considerations**

There are many cultural aspects to consider for music therapy in rural areas. As discussed earlier, home-based music therapy has the potential to be effective for increasing accessibility for those living in rural areas and has also been found to be effective for children and families (Forrest, 2014). There are certain cultural considerations a music therapist must be aware of when entering a client's home. First of all, it is important that the music therapist recognizes that they are entering the private world of the client and their family, which may make the family feel vulnerable (Forrest, 2014). This act of stepping into the client's culture and world for therapeutic purposes requires both respect and cultural humility (Forrest, 2014; Whitehead-Pleaux et. al., 2017). It is also important that through developing the therapeutic relationship the music therapist takes time to learn about the family's culture and their family dynamics, including roles, traditions, and rituals (Forrest, 2014). Ultimately, the music therapist must understand that each family is different and has its own unique culture (Whitehead-Pleaux et. al., 2017). While a music therapist can look at someone's ethnocultural background to gain some understanding of what to expect in relation to customs, beliefs, and traditions, it is important to not assume, and understand that cultural diversity occurs at the micro and macro levels (Forrest, 2014).

These cultural considerations when doing home-based music therapy may also bring up ethical dilemmas and concerns. For example, it may be easier for boundaries to be crossed when working in the client's home. Families may offer food or give gifts, or see the music therapist as

more of a guest in their home rather than a therapist. Other scenarios include neighbors or friends stopping by unannounced, or family conducting business as usual when you are there, including eating, cleaning, doing the dishes, or other daily tasks done at home. It is important that the music therapist is aware of this, and also has a flexible plan for how they will handle these situations as they arise while being mindful of the family's culture.

Cultural considerations specific to rural areas must also be kept in mind, with the acknowledgment that the culture of rural areas throughout the United States will vary. Therefore, music therapists working in rural areas throughout the USA should familiarize themselves with the culture specific to their area. Generally speaking, music therapists must be prepared to take on not only the therapist role but also the advocate and educator role in rural areas, as it is likely that music therapy will not be as well known. People may have hesitations around trying a type of therapy they have never heard of or may have misconceptions around what music therapy actually is. This lack of knowledge, education, and misconceptions may be impacting the accessibility of music therapy in these parts of the country. A study of the knowledge and perceptions of music therapy in rural parts of the country is encouraged, as this will help the profession further understand the culture in these areas, how these cultures and the music therapy profession intersect, and how to best work within these rural areas.

Without this research though, ultimately it is important for the music therapist to understand how music fits into each family's culture, and the role music has played in the family's lives (Forrest, 2014). For example, a family may say they are not musical at all and therefore music therapy is not a good fit for them (Forrest, 2014). In these situations, it is the responsibility of the music therapist to provide education on what music therapy is and what it is not and to discuss how music therapy will be provided within the context of the family's culture.

It is important for a music therapist to not only develop an understanding of their client's culture, but to also have an understanding of their own cultural background, and what their values and beliefs are (Forrest, 2014). A music therapist working from this level of perspective can comprehend how they respond to being placed in a different cultural context, and where their judgments and biases might lie (Forrest, 2014).

### **Community Music Therapy**

Through researching the literature, community music therapy has been identified as a possible approach that could be used and incorporated into addressing the accessibility of music therapy for families with children with special needs in rural areas in the USA. In one study, Bolger (2015) used an ecological approach that prioritized collaboration and used participatory decision-making with marginalized youth. A similar approach could be applied to music therapy with families in rural areas. Using an ecological approach that encompasses collaboration has the potential to promote the development of meaningful relationships within the rural community (Bolger, 2015). Through providing this community music therapy approach in public spaces where locals already frequent such as churches, libraries, and schools, there could be greater opportunities for spreading awareness about music therapy that involves community members. This approach could also be used to establish trust and understanding for both the music therapist and members of the community (Bolger, 2015).

### **Resource-Oriented Music Therapy**

Resource-oriented music therapy is an approach that focuses largely on empowerment and utilizing one's strengths (Rolvjord, 2014). On a macro scale, this approach has the potential to be effective in rural areas through working with community members and using the strengths that already exist within these rural areas. Using this as a basis, it is likely that music therapy

would more likely be embedded into the community and would serve clients in a way that fit their needs and their culture (Rolvjord, 2014).

Therapy as empowerment has to do with collaborating with the client in the development of their ability to act and to participate in the community. This ability has to do with individual strengths as well as the social, cultural, and economic resources available and the use of such resources. (Rolvjord, 2014, p. 103)

Resource-oriented music therapy can also be used on an individual level with clients in these rural areas. While clients, specifically families with children with special needs, might be feeling isolated or with nowhere to turn due to lack of services in these parts of the country, through resource-oriented music therapy families have the opportunity to feel empowered, have ownership in treatment (Rolvjord, 2014), and have joy and other positive experiences with family members (Thompson, 2017).

When considering resource-oriented music therapy for families, the music can be seen as an opportunity for families to engage in creative expression together and to experience a feeling of connectedness (Pasiali, 2012). Through this, families are able to recognize their own strengths and learn to understand themselves and their family members in their environment (Pasiali, 2012). This can have therapeutic benefits for not only caregivers and siblings, but for the child with special needs as well. “Structured and guided opportunities to make music with others have the inherent potential to become a resource in a child’s life, especially when parents are directly involved in music therapy sessions” (Pasiali, 2012, p. 46). For many families living in rural areas, it is likely that caregivers were born and grew up in the same area, and have intergenerational connections and possibly intergenerational trauma (“New Census Data”, 2016; Pasiali, 2012). While it may be that for some of these families there is a pattern of ‘dysfunction’

that cycles and continues with each generation (Pasiali, 2012), through music therapy the focus can shift to uncovering family strengths and resources, rather than focusing on deficits (Pasiali, 2012). This deficit-focused pattern of thinking can often occur when working with a child with special needs, however, through using a resource-oriented approach, this shift to utilizing strengths can occur. In addition, “music therapy experiences become an external support and resource for fostering resilience in family ecosystems” (Pasiali, 2012, p. 42). This is especially true in rural areas, where the family may be one’s main social circle and may be the only source of support nearby (“New Census Data”, 2016).

### **Discussion**

A critical review of the literature on the accessibility of music therapy in rural areas, specifically for the population families with children with special needs was chosen by this writer due to the gap in literature about this topic. Furthermore, the literature on the topic of increasing access to music therapy in rural areas as well as the importance of music therapy in rural areas was limited (Brotons & Marti, 2003; Kenmore, 2018; Leist, 2011; Levy et. al, 2018). From this critical review of the literature, it is apparent that research on these topics needs to occur to improve the validity of the field and to increase the accessibility for those not only in urban areas but for those living in rural areas who may already have limited resources. This writer recommends ethnographic research on this topic as it is important for researchers, and the whole field, to interact with and hear from those living in rural areas. It is also recommended that this ethnographic research takes place in multiple rural locations throughout the country to gain an understanding of perceptions and awareness of music therapy throughout different parts of the country, as well as how access is different in various rural locations. Ultimately, without their voices, it cannot be known whether or not those living in rural areas have knowledge of what

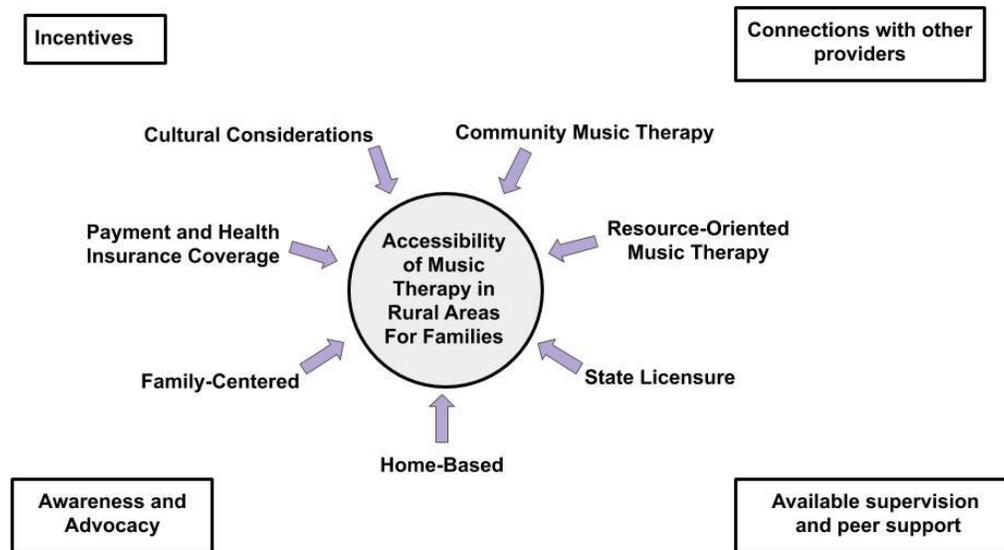
music therapy is or have an interest in it being available in their community (Bolger, 2015; Whitehead-Pleaux et. al., 2017).

Other voices that need to be heard from are the music therapists already working in rural areas. While few articles have been published related to this (Kenmore, 2018; Leist, 2011), further information from those already in the field will inform practice and create connections amongst the field. Lack of resources within these communities and isolation from the rest of the field may contribute to why they are not heard from as frequently. Furthermore, as most universities are located in urban areas, the research being conducted may be limited due to the geographic region where it is being conducted. This being said, having opportunities for music therapists working in rural areas to share and publish their work experiences and findings could provide much-needed insight for the field. This would also create more opportunities for music therapists working in rural areas to connect with other music therapists and reduce feelings of isolation music therapists may be feeling, which could, in turn, reduce burnout rates (Vega, 2010).

### **Transferring Findings into a Clinical Framework**

The following model is recommended for use for music therapists seeking to increase the accessibility of music therapy in rural areas for families with children with special needs. There are many approaches and considerations that will affect building relationships with communities, families, and clients. These are placed next to the inward arrows, as they will directly affect relationships with clients, the community, and with other professionals. The four topics placed in boxes: incentives, connections with other providers, awareness and advocacy, and available supervision and peer support, are important for the music therapy profession to consider for reducing burnout and making change that do not directly relate to client care. While all rural

communities are different, this model is recommended as a starting point for engaging rural communities in the conversation around music therapy.



While steps have been taken in other health professions to combat the challenges of working in rural areas, no literature could be found on similar steps taken in the music therapy field. Examples of what has been done to mitigate these challenges in other professions include loan forgiveness, financial incentives, educational programs, and exchange arrangements, where practitioners rotated working in rural areas (Waldman & Perlman, 2007). It is recommended that music therapists look into and discuss with those working in rural areas, and those who are not, possible ways to make working in rural areas more appealing so that more populations can be served throughout the country.

### **Incentives for Working in Rural Areas**

One important consideration is whether or not music therapists working in rural areas also live in rural areas, as this can involve major changes for daily living. Rural housing options offer the lowest prices compared to suburban and urban living. (“The differences between city, suburban, and rural living, 2018”). However, there are other costs that come with living in rural

areas. For example, the closest grocery store, mall, or opportunities for employment may be 30 minutes to an hour away. This may make those living in rural areas more reliant on owning cars rather than using public transportation, adding additional costs (“The differences between city, suburban, and rural living, 2018”). One possible incentive for those interested in working and living in rural areas is the quiet and reflective atmosphere that is associated with rural living. For those who may be at risk of burnout from living and working in cities due to the fast-paced, aggressive nature of the city, the peacefulness and solace of living in rural areas may appeal to some music therapists (“The differences between city, suburban, and rural living, 2018”).

In one study, those who remained in their hometown into adulthood tended to be less educated, less wealthy, and less hopeful (Chang, 2018). These people also tended to be more conservative. However, for some, the decision to remain in their hometown was based solely on the fact that they wanted to stay close to their family and friends, and valued those relationships (Chang, 2018).

Staying in one’s hometown tends to reflect certain ideologies, and can lead to one having narrow points of view (Chang, 2018). “Staying in your hometown makes you insular. You aren’t exposed to other people, other cultures, other experiences — and that otherness scares you” (Chang, 2018). However, some argue that this is a gross generalization, and that there may be many factors for why one does not leave their hometown, such as caring for loved ones, or those who lack financial means to leave (Chang, 2018).

Carr and Kefalas (2009) found that there are four basic groups for those growing up in rural areas. These are the stayer - who does not leave home, the returner - who leaves home but comes back, the seeker - who wants to leave but lacks money or grades, and the achiever - who shows abilities early and is nurtured from young age to leave home. Carr and Kefalas (2009)

found that rural communities spent lots of time and resources on those who they perceived to be the achievers, who were encouraged to leave their towns when they grew up to reach their full potentials. From this, a cycle of rural areas losing their brightest kids left the rural areas with gaps in resources and services (Carr & Kefalas, 2009). This left those in the other three categories with less resources, opportunities, and were often left to find low-skill jobs with less benefits, such as health insurance, and lower incomes (Carr & Kefalas, 2009).

How do rural communities continue to support those in the achiever's category if all that is left are those from the other three categories? Through 'return migration' - those who leave rural towns to develop life experiences and gain an education, and then return to implement what they have learned in their rural community (Chang, 2018). For many, the decision to return home is based on familial ties and the need to give back to the community that raised them. Returnees also felt that bringing back new perspectives and viewpoints were well received as they were shared by someone from the community. This type of return migration has been found to be the most common type of migration and flow of populations for rural towns (Chang, 2018).

Rural leaders must better understand how to incentivize returners. Most young people who move to rural areas grew up there. They return because of family ties and the desire to raise children in a small-town environment, surrounded by family. In fact, most returnees' parents still live in the family home. The migration decision to return also hinges on school quality. Lastly, the access to outdoor recreation and tranquil rustic environments pulls young adults back to rural environments. ("Rural America Is Losing Young People", 2018)

Encouraging young people to move to rural areas is key for rural areas not being left behind compared to urban areas. As discussed earlier, in order for this to occur, there need to be

incentives in place. This would entail both the state and federal government providing resources that are already in place for those who return. One way this is already occurring is through wealthier states subsidizing less wealthy states through taxes (“Rural America Is Losing Young People”, 2018).

As discussed earlier, it is unclear what current knowledge and awareness of music therapy exist in rural parts of the United States. A study of the knowledge and perceptions of music therapy in rural parts of the country is encouraged. This could also be an opportunity to advocate and spread awareness of music therapy to those who may be unfamiliar with it. It is also recommended that advocacy for the accessibility of music therapy in rural areas takes place at the local, state, and federal levels.

While the literature on the accessibility of music therapy in rural parts of the USA for families with children with special needs is limited, several findings did emerge from analyzing research from related fields and various approaches to music therapy. The first major finding was that access is limited for this population not only for music therapy but for most mental health and medical services as well (Waldman & Perlman, 2007). This is due to a variety of barriers, such as lack of public transportation, long distances to offices, high costs of healthcare, lack of insurance coverage, and lack of funding (Cristancho et. al., 2008). Despite these many barriers, there are ways for music therapists to work with families within rural areas that reduce these barriers and provide quality music therapy at the same time. These include using a family-centered (Thompson, 2017), home-based approach that is inclusive of all family members (Forrest, 2014). Along with this, it is also recommended that the music therapist has a sense of cultural humility and recognizes that each family’s culture is unique and different (Bolger, 2015). Lastly, community music therapy (Bolger, 2015) and resource-oriented music therapy

(Rolvjord, 2004) are also both recommended for both building the music therapy practice within communities as well as for empowering and utilizing the strengths of each family (Rolvjord, 2004). As the literature has shown that this is a gap in both research and service delivery, it is this writer's hope that this capstone thesis inspires others to consider both researching and working with this population within rural areas, and will find the content provided informative and useful.

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***THESIS APPROVAL FORM***

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**Student's Name: Carolyn Artesani**

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**Title: A Critical Review of the Literature on the Accessibility of Music Therapy in Rural Areas in the USA for Families with Children with Special Needs**

**Date of Graduation: May 18, 2019**

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

**Thesis Advisor: Rebecca Zarate**