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The Experience of Music Therapists in Delivering Telehealth During the COVID-19 Pandemic

Nicole Gelfand

THE EXPERIENCE OF MUSIC THERAPISTS IN DELIVERING TELEHEALTH DURING
THE COVID-19 PANDEMIC

A THESIS

Submitted in partial fulfillment of the requirements

For the degree of Master of Science

In Music Therapy

By

Nicole Gelfand

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Thesis Committee:

_____   05|03|21
Dr. John Carpente   Date
Faculty Advisor

_____   05 / 03 / 2021
Nick Farr   Date
Thesis Committee Member

_____   May 3, 2021
Dr. Suzanne Sorel   Date
Director of Graduate Music Therapy

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Abstract

This study explored the experience of the music therapist in delivering music therapy via telehealth during the COVID-19 pandemic. In semi-structured interviews, three music therapists explored their transition from in-person to telehealth clinical services during the COVID-19 pandemic. Data was analyzed using interpretive phenomenological analysis (IPA) and organized into group themes and individual themes. Group themes included 1) role of therapist changing 2) technology considerations in the home office 3) career reflection and future practice. Individual themes included 1) adapting to change, 2) learning curve of telehealth and burnout, 3) work-life boundaries and authentic therapeutic presence. Participants experienced an expansion of their role as a music therapist and each music therapist reflected on how telehealth and the pandemic influenced their career moving forward. Study findings offer implications for music therapy practice in telehealth and future research exploring music therapy in telehealth and music technology.

Keywords:

music therapy, therapist experience, telehealth, pandemic, COVID-19, music technology

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Introduction

This study explored the experience of music therapists in delivering music therapy via telehealth. Three music therapists who transitioned their practice from in-person to telehealth during the COVID-19 pandemic were interviewed in a semi-structured manner. The data was analyzed using interpretive phenomenological analysis (IPA) (Creswell, 2007; Smith, 2008).

The world has dealt with epidemics throughout history, but the SARS-Cov-2 (COVID-19) global pandemic is the first to test modern society. A pandemic is **"**an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population" (Pandemic, 2020, p.1). After initial outbreaks of COVID-19 in China quickly spread to other nations in late 2019, the World Health Organization deemed COVID-19 a worldwide pandemic in March of 2020 (CDC, 2020).

The beginning of this pandemic was elusive and confusing. Scientists had not seen this strain of SARS before which meant its rate of transmission or its ability to mutate could not be predicted (CDC, 2020; Haleem et al., 2020). As new information became available, there were significant shifts in daily life including social life practices, healthcare protocols, and brick and mortar shops closing doors (Haleem et al., 2020). The United Nations (2020) issued a response to the COVID-19 pandemic saying that while the pandemic can affect everyone, certain populations like the elderly, low-income and indigenous people are more at risk. As a result, the pandemic was likely to "increase inequality, exclusion, discrimination, and global unemployment in the medium and long term" (United Nations, 2020, p.1).

In the United States of America, daily life amidst a contagious and uncontained virus required new daily protocols (e.g., social distancing, extreme hygiene measures, and wearing masks) (Haleem et al., 2020). Since several of these restrictions limited in-person contact, the

delivery of most in-person healthcare moved towards remote delivery via telehealth. Telehealth provides care and clinical support across geographical barriers to connect users and providers who are in different physical locations (World Health Organization, 2010). While this modality of treatment can increase access to healthcare resources, delivering telehealth specifically in a pandemic can be stressful for providers (Maunder, 2008).

Music therapists in many clinical settings also shifted to working remotely through telehealth (Gaddy et al., 2020). This shift presented music therapists with many challenges, including following new safety and security protocols and adjusting treatment plans to telehealth. Additionally, clear boundaries needed to be drawn by music therapists between work and personal time while working from home. Further, clients and music therapists had limited access to instruments such as drums and percussion while at home.

This study will address multiple gaps in literature surrounding how the music therapist responded to transitioning to telehealth during COVID-19 so that music therapists may reflect on strengths and challenges in the process. Understanding strengths, challenges, and areas of growth in the transition to telehealth required a reevaluation of the delivery of treatment in music therapy via telehealth. This includes determining (a) resources necessary and available for clients and music therapists to engage in music therapy, (b) how music therapists adapt their approach to music making and music interventions, and (c) how music therapists delineate professional boundaries while attending to their personal needs.

For this study, three music therapists who transitioned their practice from in-person therapy to telehealth during the COVID-19 pandemic were interviewed. Data were analyzed using IPA to explore the music therapists' experiences. This study explored similarities and differences

between how the music therapists responded to the COVID-19 pandemic and the steps they took to pivot their practice or personal music making to accommodate this new adjustment.

Epistemology and Methodology

My epistemology aligns with the interpretivist approach which maintains that life is highly situational, humans vary day-to-day, and each individual's unique lived experience holds meaning (Creswell, 2007). This extends to the belief that humans can best express their lived experience through a conversation that allows for space, dialogue, and stream of consciousness. It would be impossible for me to suggest I know about the music therapist's experience if I were to observe their work without their input or ask them to rate their experience on a limited scale. Similarly, it would be reductive to assume my experience delivering telehealth music therapy was similar to other music therapists'. Because the experience of a global pandemic can be felt differently across cultures, hearing firsthand experiences of the participants in this study was determined the best way to paint the portrait of their experience in delivering telehealth during the pandemic. Conducting interviews with dialogue helped the participants recount what they underwent, witnessed, and discovered in the transition from in-person to virtual musicking.

IPA was employed for this study for several reasons. First, IPA was a methodology born within the field of psychology, equipping it to handle this study which straddles the fields of music and psychology (Alase, 2017). Second, the IPA research design affords the researcher the opportunity to explore the participant's personal experience based on the participant's own account (Smith, 2008). Each participant in this study experienced the COVID-19 pandemic, however, it is in the recollection of this event that the participant formulates an awareness of their experience (Smith, 2008). It is the participant's awareness of their experience, that IPA seeks to engage with and interpret (Smith, 2008). Third, IPA does not seek to find objective

answers to questions, but to uncover the participant's perspective surrounding a specific topic and the meaning that each participant makes of that topic (Smith, 2008). This research design inherently pursues a small sample of subjects because it is committed to uncovering the specific details of each participant's experience and may also investigate the similarities and differences between each participant (Smith, 2008).

By interviewing a sample of music therapists who delivered telehealth services during this pandemic, a greater understanding can be gained of the strengths and barriers each clinician experienced because the participant plays a large part in what topics are discussed. "At its heart, the topic of phenomenology does, or should, connect with our everyday experience" (Smith, 2008, p.32). Exploring the experience of music therapists delivering telehealth in a pandemic can contribute to the development of the music therapy profession in several ways including but not limited to the potential to 1) evaluate where certain benefits or difficulties may lie in delivering remote telehealth services for certain populations and providers, 2) evaluate best practices in delivering quality sounding music, and 3) understand how the music therapy profession can further develop if telehealth continues to be a popular modality of treatment.

Review of Literature

The literature review will include topics like the trauma and effects of a global pandemic; how a practitioner might navigate the uses and considerations of telehealth; case studies on creative arts therapy and music therapy in telehealth; and the use of music technology and development of the therapeutic relationship through telehealth. The studies compiled in this literature evaluate telehealth delivery primarily conducted through pilot studies and small sample sizes before the COVID-19 outbreak.

Trauma and the Effects of a Global Pandemic

  A global pandemic is not a foreign concept in our history books. The 1918 influenza pandemic was the most recent pandemic in modern history (Martini, 2019). The 1918 pandemic arose at the end of World War I when army bases around the world reported the flu breaking out in their crowded barracks (Ashton, 2020; Martini, 2019). At that time, however, general knowledge about the flu was unknown and unresearched; similarly, illness and mortality rates are speculative due to incomplete reporting (Martini, 2019). Despite efforts across the past century to address pandemic prevention and treatment, the COVID-19 outbreak still managed to shock infrastructures and healthcare systems in 2020. From governments that delayed acknowledging its severity to the lack of resources for testing kits and personal protection, people found themselves scrambling to keep themselves and their loved ones safe (Ashton, 2020; Sheraton, 2020).

  A hallmark feature of the COVID-19 pandemic has been the worldwide grief over losses of lives, jobs, freedoms, and routines (McNeely et al., 2020; Sheraton, 2020; Wilner et al., 2020; Wu et al., 2020). Bereavement-related depression in response to traumatic events can result in feelings of blame and shame and, in some cases, ultimately result in post-traumatic stress disorder (PTSD) (Loewy, 2007). From the general public to frontline workers to those with COVID-19, the pandemic exacted a psychological toll. The COVID-19 pandemic is a prolonged, chronic event. On December 10th, 2020 the official COVID-19 daily death total in the U.S. reached over 3,000 and remained above 3,000 daily through mid-February of 2021. For comparison, just under 3,000 people died on 9/11 (Crist, 2020; CDC, 2021; The New York Times, 2020). This means the United States experienced the death toll of 9/11 for days, weeks, and months in a row (CDC, 2021). This parallel is not to diminish the traumatic impact that 9/11

had and still has on Americans, but rather to illustrate how a globally tragic event may incur chronic stress and trauma within the human race.

For those who contracted COVID-19, depression, anxiety and poor sleep quality can take hold of their recovery experience (Vindegaard, 2020). The general public also experienced its share of fear and anxiety. People were panic-buying household essentials leaving store shelves empty for weeks; racist attacks against Asians increased with correlation to when President Donald Trump labeled COVID-19 the "Chinese virus"; and mass food shortages were experienced in places never before (Breuninger, 2021; Miller, 2020, Tavernise, 2020; Usher, 2020). Additionally, typical visiting hours for family members in hospitals was stopped to prevent further spread of COVID-19 resulting in additional loneliness and isolation for all parties (Miller, 2020). In many instances, COVID-19 patients were unable to say goodbye to their loved ones or hold burial services.

An important cornerstone of the COVID-19 pandemic are the frontline workers who worked overtime, and at times, without proper personal protective equipment (PPE) in order to serve the public (Wu et al., 2020; Miller, 2020). Healthcare workers experience heightened anxiety, fear, and stress with national or global events (Wu et al., 2020). An early systematic review of the psychological effects of COVID-19 for both healthcare workers (HCWs) and nonhealthcare workers (NHCWs) showed that both experienced the same amount and "effect of anxiety depression, PTSD, and occupational stress" (Sheraton, 2020, p.5). The difference lied in the HCWs increased level of fear related to contracting the virus (Sheraton, 2020). Since the included studies were cross-sectional, there is little validity of causation, and a majority of the studies reviewed had conducted "online surveys, which introduce an element of selection bias" (Sheraton, 2020, p. 6).

Most significantly, this pandemic has revealed that the planning and preventative infrastructures in place to treat the indirect chronic mental health effects of a pandemic requires improvement (Miller, 2020; Vindegaard, 2020). HCWs disrupted sleep patterns, fear, and discomfort takes its toll due to the pandemic having no set end point (Wu et al., 2020). These effects are especially apparent for HCWs who need to quarantine and self-isolate from their support systems and loved ones as they continue to work on the front lines. Clear and regular communication as well as strong leadership in the hospital setting has been shown to mitigate psychological stress of the healthcare workers is (Wu et al., 2020).

Uses and Considerations of Healthcare Through Telehealth

When music therapists transitioned to telehealth, they had limited resources at their disposal to inform that transition. As of March 2020, a majority of literature about telehealth practice was not specific to music therapy or creative arts therapy. Some modalities of treatment like cognitive-behavioral therapy (CBT), relapse prevention, and exposure therapy have shown to be effective over telehealth for certain populations (Gros et al., 2013). Additionally, certain populations like those who actively avoid human interaction, need to travel long distance for therapy, or live with certain health conditions (e.g., anxiety disorders) may benefit from telehealth (Gros et al., 2013). Telehealth can also offer privacy to receive treatment, more convenience for the patient, and "decreased burden of stigma" (Gros et al., 2013, p. 5). In certain contexts, telehealth has shown no treatment attrition as well as a significant reduction in targeted symptoms (Stewart et. al., 2017). Telehealth can be a cost-effective treatment approach, but this form of treatment may only appeal to clients who are less symptomatic (Myers, 2017).

It is currently difficult to compare the effectiveness of therapy via telehealth to in-person treatment when there are few direct comparison studies. The studies that do support the efficacy

of telehealth to in-person treatment, typically lack a strong sample size or randomization (Gros et al., 2013). When the effectiveness of delivering group voice therapy via telehealth was compared to delivering group voice therapy in-person, both groups demonstrated "positive outcome measures" with no significant differences between groups (Mashima et al., 2003, p. 432). However, some clients resisted the change to a new method of treatment delivery (telehealth) and clients with "severe cognitive impairments or attention deficits may have difficulty with the distance interaction mode" (Mashima et al., 2003, p. 438).

Clinicians are faced with unique challenges and considerations when working through a different modality of healthcare like telehealth (Gaddy, 2020; Knott, 2020). There are several clinical and ethical considerations for practitioners and clients when delivering telehealth (Wrape & McGinn, 2018). Practitioners may (a) have difficulty collecting data for assessments including physical body language and facial expressions, (b) struggle to develop a robust therapeutic alliance, and (c) be unable to deescalate outbursts between family members or couples (Wrape & McGinn, 2018). Clients may feel (a) ill-equipped to utilize technology, (b) unsafe if there's no mediator in the room, or (c) there is no privacy or separation between home life and therapy (Wrape & McGinn, 2018).

Gaddy and colleagues (2020) surveyed music therapists on topics exploring employment, service delivery, income, and feelings of hope for music therapists living and practicing in the United States during the COVID-19 pandemic. Around 70% of 1196 respondents reported changing their service delivery methods, with telehealth being the most widely adopted (Gaddy et al., 2020). The questionnaire also revealed that 87% of music therapists felt hope for the profession of music therapy in this time, referencing the creativity and adaptability that is required of music therapists daily (Gaddy et al., 2020). In the open-response section of the

questionnaire, music therapists explained in more depth their perception of telehealth. Some reported gratitude to be able to continue practice, while others noted the technology learning curve, potential contraindication for clients, and potential cost issues for clients (Gaddy et al., 2020). Most music therapists also noted their mental health status during the pandemic citing increased stress, anxiety, and burnout (Gaddy et al., 2020).

Creative Arts Therapy and Music Therapy in Telehealth

Spooner and colleagues (2019) examined the use of telehealth in delivering creative arts therapy to veterans through three case studies that used either art therapy, dance/movement therapy or music therapy. Like Baker and Krout (2009), this article emphasizes that access to services in rural areas are disparate and how telehealth can benefit those who usually need to travel hours to receive treatment (Spooner et. al., 2019). In this study, each client received 6-8 weeks of individual therapy through telehealth. Each case documented assessment protocols and provided participants with psychoeducation related to wellness. Clients ultimately benefitted by feeling a sense of connection when experiencing loneliness and feeling secure and relaxed in their home environment. Unfortunately, details about the methods and modalities of specific treatment plans or intervention went unreported.

An approach for virtual music therapy services was developed, which outlines a three-tiered model: curating online resources, creating original content, and implementing telehealth (Knott, 2020). The method broadly explained how to complete each tier with the third tier, implementation of telehealth, being the primary focus. While this method is objectively useful for those adopting telehealth moving forward, those who had to switch to telehealth in the peak of the COVID-19 lockdown had little guidance on these points from the American Music Therapy Association and may have reached the same conclusions as this paper by the time it was

published in late 2020 (Gaddy, 2020; Bates, 2014). Similarly, this article does not address how to cultivate a therapeutic relationship when the treatment room is no longer in-person.

In a study with an adolescent diagnosed with Asperger's syndrome, in-person and Skype sessions were compared (Baker & Krout, 2009). Findings displayed that the client engaged more readily with Skype treatment including increased eye contact and "[confidence] to offer disagreeing statements" (Baker & Krout, 2009, p.3). The researchers suggest that telehealth is a viable treatment, but that further trials delivering music therapy online are needed to assess the use and effectiveness of different music therapy approaches (Baker & Krout, 2009, p 3). While this article found results that seem to verify the efficacy of telehealth, the outcome measurements used – like eye contact – may not be a signifier of engagement in treatment across all populations especially considering direct human-to-human eye contact is impossible through video conferencing. Another consideration is that technology has significantly improved since 2009 as it related to virtual meetings.

It appears that telehealth may benefit certain populations and potentially be more successful than in-person treatment (Baker & Krout, 2009; Mashima et al., 2003; Stewart et al., 2017). However, it is unclear if these same conclusions can be drawn while the client and therapist were experiencing a global pandemic with limited social and physical resources. The American Music Therapy Association (AMTA, 2020a) released a statement about telehealth stating they "support the use of telehealth/therapy as a means to provide music therapy interventions when beneficial to clients" (p. 1) offering therapists to use discretion in their decision making to determine appropriate services for clients. This statement, however, is vague and provides limited direction towards resources that may help therapists discern the most ethical considerations for clients.

Telehealth has shown that virtual therapy is indeed different than in-person therapy. The client may have difficulty with accessing the virtual room, the therapist may have trouble assessing body language and facial expressions, and the potential lack of privacy at home may not create a safe space for the client (Wrape & McGinn, 2018). The additional layer that music therapy practice is typically based on the use of live instruments in vivo poses questions as to how clients participate in music making over telehealth and how the music making relationship between client and therapist develops. Music Technology such as Digital Audio Workstations (DAWs), Musical Instrument Digital Interface (MIDI) devices, and audio editing software could be an avenue to deliver care both in-person and remotely that addresses the inaccessibility of traditional instruments used in music therapy.

Music Technology in Music Therapy Treatment

One format of innovation in music therapy is incorporating music technology into clinical practice. Music technology plays a role in the ability to make music on electronic devices like computers, tablets, and phones, which are necessitated to conduct telehealth sessions. Music technology in music therapy has been used in various capacities including MIDI devices programmed to be readily interactive in sessions in hospice, school, and rehabilitation settings (Burland, 2014; Hahna et al., 2012; Knight & Krout, 2017). These studies have reported on the impact of technology in different cultural contexts as well as the development of the therapeutic relationship through client empowerment and independence. However, there is a scarcity of literature regarding "the benefits and risks of technology" as well as a lack of guidelines provided by the AMTA Code of Ethics in conducting music therapy using technology (Bates, 2014, p. 136). Roughly 71% of music therapists have used music technology in some capacity in the clinical setting (Hahna et al., 2012). However, more than half of music therapists do not use

music technology, don't have access to music technology equipment, and lack clinical training with music technology (Hahna et al., 2012; Knight & Krout, 2017). Future use of music technology in music therapy could include the increased availability of music technology and music technology education in clinical and educational settings (Hahna et al., 2012).

Knight and Krout (2017) discussed how a stand-alone music technology product requires little physical movement and interaction by the client with the product to create intentional musical sounds (Knight & Krout, 2017). This product, however, requires it to be used in-person (Knight & Krout, 2017). Other music technology devices exist including those on web-based platforms; however, there has been little to no research on the use of these platforms through distance therapy or the ability for two people to interact on the same technology from two separate devices.

Notably, the telehealth studies discussed thus far were not conducted in the context of the COVID-19 pandemic; As such, the extremes of this context demand a new look at existing evidence. The researchers had time and resources to control for factors involving required technology, treatment planning, and proper protection of health information whereas music therapists during the COVID-19 pandemic may not have had the initial resources to facilitate a seamless transition to telehealth. Additionally, these studies all controlled for and measured different variables, which may or may not be reliable indicators of the effects of telehealth. For example, using eye contact as a metric for engagement may not necessarily be generalizable for patients who do not typically engage with others through eye contact.

This study sought to understand music therapists' experiences in delivering in-person therapy delivery to telehealth during the COVID-19 pandemic. The study is looking to assess 1) how participants modulated their in-person practice to telehealth, 2) the participant's experience

in this transition, 3) considerations for music interventions, treatment planning, and musicing over telehealth, 4) how they felt the effects of the global pandemic in their practice, and 5) what they have learned about their practice over telehealth.

Method

Research Objectives and Purpose

This research is aimed at exploring how music therapists experienced delivering music therapy through telehealth during the COVID-19 pandemic. The study contributes to the knowledge base of how music therapists can understand the practice of music therapy through telehealth during times of global crisis.

Participants

IPA studies use a small homogenous sample size so as to "examine convergence and divergence in some detail" (Smith, 2008, p. 3). As such, three participants (Table 1) were recruited using a purposive sampling method based on recommendations offered by music therapy educators. The inclusion criteria for participants were:

1) Board-certified music therapist

2) Provided telehealth music therapy sessions for at least six months between March 2020 and December 2020 during the COVID-19 pandemic

3) Transitioned their practice from in-person to telehealth between March 2020 and December 2020 during the COVID-19 pandemic as a result of the COVID-19 pandemic

4) Worked in music therapy for at least five years or more prior to COVID-19

5) Minimum graduate degree in music therapy

This study sought participants with at least 5 years experience and a graduate degree because the nature of conducting interviews in the frame of IPA takes an in-depth look into the individual's experience of delivering music therapy and their ability to reflect on that experience with depth, breadth, and reflexivity. Per AMTA's (2020b) explanation of standards for a master's degree: "Credentialed Music Therapists who obtain a master's degree in music therapy further expand the depth and breadth of their clinical skills. These skills added to professional practice in music therapy of sufficient duration and depth, allow the music therapist to gain a comprehensive understanding of the clinical process of the client and the therapist's impact on that process" (p. 5).

Table 1

Participant Descriptions.

Participant	Theoretical Orientation	Work/Population
Participant A	Trauma-informed and psychodynamic	Private practice with adults with mental illness and substance abuse
Participant B	Humanistic and psychodynamic	Home-based work with neurodivergent and medically fragile children
Participant C	Person-centered, psychodynamic and behavioral	Day treatment for adults with severe mental health conditions; Private practice

Recruitment

After this study received IRB (Institutional Review Board) approval, participants were recruited through purposive sampling by contacting colleagues who referred participants that were willing to share their email to learn more about this study. An email invitation (Appendix D) was sent to potential participants that included information about the purpose and method of this study, the possible risks and the benefits of the study, and methods of confidentiality. Potential participants were asked to reply to the email if they were interested in participating in

the study. Before the interviews began, all participants provided their informed consent and permission to have their interview audio and video recorded. The informed consent (Appendix B) was exchanged through email prior to the start of the study. All participants were allowed to withdraw from the study at any time.

Data Collection Procedures

Interviews were conducted over Zoom at the participants' convenience. Each interview lasted between 45-60 minutes. All interviews were audio and video recorded through Zoom directly on to a password-protected computer. Additional audio was recorded on the iPhone Voice Memo app as a backup. Signed consent for recording each interview was obtained from each participant. Interview questions addressed a few topics including but not limited to 1) how participants modulated their in-person practice to telehealth, 2) the participant's experience in this transition, 3) considerations for music interventions, treatment planning, and musicing over telehealth, 4) how they felt the effects of the global pandemic in their practice, and 5) what they have learned about their practice over telehealth. Each interview was transcribed and member-checked with participants.

Data Protection Procedures

The completed audio and video files from Zoom and the iPhone voice memo app for each interview were stored on a password-protected external hard drive securely stowed in a lockbox in my home office. This hard drive did not leave the office. Data will be kept for up to one year through May 2022 after the completion of this study. Only my thesis adviser and I had access to this data. If a participant chose to withdraw from the study, their data was immediately destroyed. Participant identities remain nameless (e.g., participant A, B and C) and any potential identifying features within the interview answers were revised to maintain anonymity.

Materials

For this study, the built-in recording device on the video conference software of Zoom was used to record the interviews and each interview was saved directly to my computer, which is password protected. A secondary audio collection was used through the digital voice recording iPhone app "Voice Memos" on a password protected iPhone as the backup audio device. The audio was transferred to the password protected computer and then subsequently transferred to the password protected external hard drive. After each interview, and once all audio and video files are transferred to a secure external hard drive, they were subsequently deleted from the original recording devices.

Data Analysis

Throughout data analysis for this research design, I committed to maintaining the participant's unique perspective and recollection (Smith, 2008). While I took care not to color the participants' perspective, this method of research is inherently co-constructed as I interpret the participant's experience (Smith, 2008). This means I have a dual role in both experiencing and exploring the same phenomenon and as the participant (Alase, 2017; Smith, 2008). Because of this dual role, the themes that emerge in this study's results section will reflect my own lens.

Each recorded interview was transcribed and member checked. The member-checking procedure involved sending the transcribed interview back to the interviewee for them to look over and insure that the contents of the transcription are true to the interviewee's words and intentions. Following member checking, I read through each interview three times, noting the participant's reflections after each reading. Once all three interviews were completed, they were coded into themes using a mixture of in vivo coding and descriptive codes (Creswell, 2007; Alase, 2017). In vivo coding creates codes directly from the participant's spoken words. This

method of coding highlights and honors the participant's voice in the process of data analysis and researcher interpretation (Manning, 2017). Descriptive coding summarizes the topic of the data and was used for instances where an experience was discussed several times, but different words were used to describe that experience (Creswell, 2007). From the in vivo and descriptive codes, pattern coding was used to further understand larger themes within each data set (Creswell, 2007).

Each interview's codes were compared across-interviews to analyze any similarities, differences, or overlap between individual participant's experiences. This was done to assess if there are any shared experiences between participants. I elaborated on findings and described potential themes of the music therapist's experience delivering telehealth during COVID-19. Additionally, I included any reflections that arose as a result of interacting with the data. These reflections were subsequently written down in a personal journal.

Epoché

Based on my personal experience with transitioning from in-person to telehealth services, I strived to practice reflexivity when conducting interviews and throughout data collection. In order to limit the influence of my personal bias, I member-checked each interview. Additionally, it should be noted that one participant was my past supervisor at the time of the transition from in-person to telehealth in March of 2020. I believe that this is a unique situation and our two perspectives of the same situation could offer novel awareness and information. This fact, though, may have biased me in interpreting their data. For this reason, I worked with the faculty advisor to review the data. Lastly, my personal experience having undergone the transition from in-person music therapy to telehealth is itself a bias. My curiosity about the pandemic's influence

on music therapists was born from self-reflection on the impact of the pandemic on my own practice and personal life.

Being a native New Yorker and residing in New York for the entirety of the pandemic has had a resounding impact on me. New York was the epicenter of COVID-19 in March 2020, and everyday through May I woke up and fell asleep to the unyielding sound of sirens and ambulances until the curve flattened. Earlier I drew a parallel between 9/11 and COVID-19; while I was young in 2001, living in the epicenter of a pandemic marks a novel, traumatic event that my generation and my fellow New Yorkers now share. For these reasons, I sought to understand how others felt this shared experience as well.

Results

Three main themes emerged across all three participants: 1) Role of Therapist Changing, 2) Technology Considerations in the Home Office, and 3) Career Reflection and Future Practice. There were additional personal themes specific to each individual participant that emerged. Participant A spoke about the need to adapt to change, Participant B emphasized the initial learning curve of telehealth as well as burnout, and Participant C discussed creating work-life boundaries and maintaining authentic therapeutic presence.

Theme 1: Role of Therapist Changing

The music therapist's role in telehealth proved to be different than conducting therapy in person. Participant A was the only therapist to have previously utilized telehealth, both personally and professionally. As a result, Participant A was more primed to understand the basic functions of how a therapeutic relationship is cultivated over telehealth. This potentially allowed Participant A to be more receptive to this mandatory change in work and lifestyle. Participant A

also discussed how the music therapist's role has always been multi-faceted and transitioning to telehealth required utilizing the adaptability and flexibility required of music therapists.

Example 1– Participant A: I had definitely dipped my toe in [to telehealth] at that point which I think was mostly helpful in the sense of getting over the initial hump and resistance of "it's gonna be weird, different and watered down."

Example 2– Participant A: My role already wasn't always musical partner. It often is container, or music therapist as producer, which is kind of this other role that isn't always talked about; I'm here to facilitate a musical experience.

All participants noted that they stepped into the role of tech support for their clients, which included all tasks typically present in a therapy session as well as helping troubleshoot video conferencing software and sound or video problems for the client. This role emerged even before their initial telehealth sessions since the therapists needed to consider which video conferencing platform is easiest to access for the population with which they work.

Example 1 – Participant B: I use FaceTime for some clients because they're older and they're not really sure about how to use technology or Zoom.

Example 1 – Participant C: Zoom was the platform that I chose knowing it was extremely accessible, user friendly, and free for participants to download.

Example 2 – Participant C: In some instances, you become technology support as well; helping somebody try to figure out what's going on with their computer.

Participants A and C also noted how their role grew into establishing their authentic, selves in the telehealth setting, where they might not have brought as much of their authentic selves prior to the pandemic. Participant A explained their role as a music therapist widened to include their humanity in experiencing the pandemic, acting not just as a music therapist but as a

participant in the therapeutic relationship. Participant A provided responses to the client such as "I don't have an answer for you" and "I can't make the pandemic okay," which they felt brought authenticity into the therapeutic relationship. Participant C experienced this humanization as a result of conducting therapy in their bedroom with their personal effects on display or pets walking into frame.

> Example 3- Participant A: I think it's forced me as a clinician to bring more of myself into the work, which maybe should've happened without a global pandemic.

> Example 3 – Participant C: There would be times when clients would ask, "Oh are those records in your background?" or they just start to know things about you that it's not bad that they know, but there are things that you didn't anticipate coming into the therapeutic relationship.

Participant B recognized how they stepped into a more psychodynamic role through telehealth with some clients who are more verbal. Participant B expressed some insecurity in their ability to utilize verbal techniques based on the little education their music therapy training provided on this topic. They saw this as an opportunity to grow their practice and expertise.

> Example 2 – Participant B: I've always been wary of using verbal techniques. I've also felt not as experienced in verbal techniques; I think this has been a good opportunity to practice those and ways to utilize them.

Theme 2: Technology Considerations in the Home Office

Each participant took a different approach in using technology to supplement their telehealth sessions in their home office. Participant A used a high-quality external microphone, an audio interface to run sound, Ableton (a Digital Audio Workstation) and a software program called Loopback 2 to digitally wire various input and output sources (e.g., microphone, Spotify,

YouTube) through the video conferencing software. While Participant A did not have enough space to create a home office in their apartment, they were able to use a vacant space nearby in which to run their telehealth sessions. Participant A utilized their technology to add to their clinical techniques and experience, creating a new music therapy experience called Referential Sound-scaping in which the client's voice is recorded and the client can sing with themselves. Referential Sound-Scaping was a response to the challenge of synchronously musicing over telehealth.

> Example 1– Participant A: If I can't sing in time with my client, maybe we can record something and they can music in time with themselves in the recording.

At the onset of telehealth, Participant B used what resources and technology they had on-hand to practice, like the built-in camera and microphone on their laptop. Participant B didn't heavily invest in any extra equipment or new materials and kept it minimal because they did not see themself continuing to practice telehealth once the pandemic is over; however, they noted that the quality of sound and recordings could have been better. Participant B incorporated software programs into their treatment, utilizing Microsoft Word for songwriting and Audacity for audio recording lyrics and music.

> Example 1– Participant B: I made what I needed out of necessity, learning as I go, and I think I've been successful.

> Example 2– Participant B: I didn't want to invest in a better laptop…the camera is not the best, but it works.

> Example 3 – Participant B: I recorded [my client's] voice through my speakers; it wasn't the best quality, but it was still successful.

Participant C upgraded their at-home Wi-Fi for a stronger and faster connection so that their sessions would not be interrupted by a poor signal. Participant C found that if they are preoccupied with how their internet will perform, they are less likely to be present in the therapy session. Additionally, Participant C upgraded the equipment at their day treatment center office for hybrid (in-person and telehealth) group sessions once it was deemed safe. Participant C ordered conference room microphones that had a large radius pickup pattern, long USB ethernet cables to hardwire Wi-Fi for optimal speed and connection, and USB cameras for higher quality picture.

> Example 1 – Participant C: It's important to know that I'm going to have a really solid [internet] connection so I can have what feels like authentic presence with the clients.
>
> Example 2– Participant C: I noticed a quality issue of the calls with our telehealth groups. We were using laptop cameras, which are sometimes good, often not; laptop microphones tend to be tinny and for someone who's calling into the group and doesn't have a smartphone like many of our participants that's not a very good quality of group.

Theme 3: Career Reflection and Future Practice

All three participants reflected on the significance that the pandemic had on their work and lifestyle choices. Participant A plans to continue offering telehealth to their distance-therapy clients once the pandemic is over just as they did before the pandemic. Participant B acknowledged that telehealth as a treatment platform will likely continue after the pandemic is over but prefers to return to working in-person. However, Participant B recognized their own limiting beliefs about their clients and the effectiveness of telehealth. Participant B also noted in their interview that the nature of being interviewed about their experience brought up thoughts that they hadn't had before.

Example 1 – Participant B: I don't see myself personally continuing [with telehealth] so I didn't feel like I wanted to invest in a better laptop.

Example 2 – Participant B: I felt a lot of surprise when I didn't think a client would be able to benefit from virtual and ended up that they did benefit.

Example 3- Participant B: Talking to you in this way is like processing it in a different framework than in my therapy sessions. I'm actually thinking about a lot of things that I haven't really thought about before.

Participant C at the time of the interview was transitioning exclusively to telehealth for their individual private practice clients but believes resuming in-person group work at their day treatment center is best. At the beginning of the pandemic, Participant C conducted telehealth in their bedroom for several months. Since then, Participant C was able to upgrade their space to include a separate at home-office. This influenced Participant C's choice in continuing to offer telehealth services post-pandemic.

Example 1 – Participant C: It's weird to do therapy in a place where you sleep.

Example 2 – Participant C: I do not intend to return to in-person services [in private practice] because not having to go to an office is of value to me. I found with the clients that I see in private practice, they respond really well to telehealth. It doesn't feel different to me.

Individual Themes

Participant A: Adaptation and Letting Go

Participant A reflected on the importance of responding to the medium – telehealth – to adapt treatment plans and music therapy modalities. Participant A incorporated intermodal techniques from their training in Guided Imagery and Music (GIM) as well as Music and

Imagery (MI) to utilize visual and art-based techniques using the zoom box itself as a tool to explore boundaries. Participant A also modified their screen so that the client could have remote control over their music making software.

Example 1: Everything was about adapting to change, and the setting was as much a metaphor for what was going on as it was a thing to do adapt to in and of itself.

Example 2: You can't play the way you did before [the pandemic].

Example 3: Movement has become more of a focus, even playing with the screen; what's it like if I pass something to you through the screen?

Example 4: Modalities have changed, there's more of a focus on using the tools we have [in telehealth] instead of trying to replicate the tools we have [in person].

Another form of adaptation that Participant A experienced was in the client-therapist relationship. Participant A became a consistent figure in a client's life during the pandemic, which meant that Participant A was one of the few people the client was interacting with socially. Continuing to see clients over telehealth allowed for consistency and reliability throughout the pandemic for both Participant A and their clients. The clients also experienced how Participant A is "committed to staying with them" by flexibly moving over to telehealth to continue treatment. In contrast, Participant A had to adapt their technique for clients who experience attachment issues and had a challenging time engaging with Participant A as a real person. This led to feeling like the client struggled to acknowledge Participant A as "actually there" at the other end of the video camera.

Example 5: Clients have recognized that I'm committed to staying with them. With some clients when it's been appropriate, also being real like, hey its really nice to have something constant for me too.

Example 6: I've had people who have had breakthroughs where now I'm in their home and that's all the more real than going to some building that was a sheltered little time capsule away from reality.

Example 7: Some people with certain kinds of attachment difficulties really struggled to experience me as real more so than they did before.

Participant A originally did not have the privacy or space in their home to create a home office. However, they were able to use a vacant space lent to them during the pandemic to set up their telehealth office. While there was separation between home and work life for Participant A, there also grew a musical and personal separation, since Participant A's instruments were now at a separate location. Similarly, Participant A had few to no opportunities to perform their main instrument in a group or band as they were used to pre-pandemic.

Example 8: To be able to get out of the house everyday was nice. But at the same time, I didn't have any of my stuff at home. It was strange that I couldn't just play guitar after dinner in the comfort of my home.

Example 9: I had sort of two separate lives for a little while. At the same time, I had an office I could go to and didn't have to worry about someone needing me while at home.

This work-life separation taught Participant A to work on letting go of conceptions that were potentially unhelpful to them. Accepting and acknowledging this adjustment allowed Participant A to recognize new territory to explore, like fixing up an old instrument and exploring new tunes on that instrument. Multitracking their voice – the process of recording on multiple tracks – was another outlet that allowed Participant A to feel like they weren't "quite so alone."

Example 10: It shifted my identity of myself as a musician and also forced me to let go of things that I was holding on to that weren't as helpful.

Example 12: I remember coping a lot with multi-tracking my voice improvisationally. Putting sounds out and hearing them back and that was powerful…I felt like I wasn't quite so alone, in being able to layer and layer and layer [my voice].

When Participant A was asked if any music artifacts come to mind (i.e., song lyrics or a musical experience) that reflect their journey through the pandemic, they cited the song "When It Don't Come Easy" by Patty Griffin (Appendix E) and sang the lyric:

"If you get lost drive out and find you if you forget my love, I'll try to remind you, stand by you, but it don't come easy."

This song also repeats the lyric: "I wonder if we're gonna ever get home" several times throughout the song. This struck the researcher as a significant lyric for Participant A surrounding their experience of "having two separate lives". Participant A's choice of this song as an artifact can also be representative of how life halted during the pandemic. There were feelings of loss and starting a new course "don't come easy."

Example 13: All of a sudden, it's really hard to be with people and I guess maybe that's the metaphor of transition to teletherapy: how do we figure out how to be together when all the ways we knew how are not there anymore?

Participant B: Learning Curve and Slowing Down

There is a level of adaptability that is required of all therapists regardless of their setting, client, or amount of experience in the field as seen with Participant A. Several times throughout Participant B's interview, they mentioned the learning curve they felt during their transition. However, in reflecting on the pandemic almost a year later, they noted:

Example 1: I don't remember what it was like before [telehealth] and it was a big learning

curve of course but honestly it feels second nature to me now.

Example 2: After a month I was just in it and completely virtual

Participant B attributed a few things to their ability to overcome the learning curve in

transitioning to telehealth: 1) practicing in the field for more than half a decade, 2) working in

their present role as a contractor for three years, and 3) the pre-existing relationships established

with their clients. Additionally, the change in lifestyle forced by the pandemic afforded time for

Participant B to slow down and rejuvenate.

Example 3: I have a lot of long-term clients and I think because I have a good rapport

with the client and their caregivers, they had more patience with me, and I had more

patience with them to work things out.

Example 4: I personally thrived in the pandemic because of being forced to slow down.

Burnout is a big issue for me but this past year I feel like having just virtual clients was

really good for me.

Despite their ability to adapt to the learning curve, Participant B noted their tendency

towards career burnout rise again with the unique situation of moving towards a hybrid-model. A

few months into the pandemic when it was safer to practice in-person, Participant B serviced the

same population of neurodivergent and medically fragile children both in-person and over

telehealth. Participant B noted that having both a virtual and in-person caseload took a physical

toll to adjust not only to the type of therapy either modality requires, but also to adjust switching

the work setting and materials throughout one day.

Example 5: I think the burnout came from going back in person. I need a longer buffer to

switch from in person to virtual.

Example 6: I don't really like doing half and half. If it was all virtual, I think I would like

it but doing half and half…There's a big physical toll on myself.

Participant B recognized they prefer to connect with clients in-person and stressed that

most of the clients they serviced throughout the beginning of the pandemic were long-term

clients with established relationships, which made switching to telehealth more fluid. Still,

Participant B mentioned how a new client of theirs, one who they have never seen in person,

could greatly benefit from the continuation of telehealth even after the pandemic is over.

Participant B also emphasized the importance of having guidance from their boss to supplement

the learning curve. Despite being a contractor where the boss is not required to provide direction

on conducting business, Participant B's boss regularly answered HIPPA compliance questions

with telehealth, offered to supplement PPE for the contractors if they see in-person clients, and

held monthly group check-in meetings for extra support.

Example 7: I do see that there's a big opportunity for growth virtually. Even if the

pandemic ended and I was back in person I feel like virtual would still be excellent for

[my client].

Example 8: I think that a big reason I was able to be successful was because [my boss]

was always supportive.

Example 9: Having a boss that cares about you is honestly pretty rare. I think that was a

big part of me feeling like [work] was sustainable.

Participant B was unable to identify any music artifacts that reflected their journey

through the pandemic. However, they further reflected on their own process of receiving

personal virtual therapy during that time, which increased their compassion and understanding

for the virtual therapy process for their client.

Example 10: I have found it like a parallel process of working through becoming

completely virtual… giving my clients the same grace that I am trying to give myself I

think is an important role too.

Participant C: Boundaries and Therapeutic Presence

Participant C experienced tempering the balance between a clear client-therapist

relationship while also bringing their authentic therapeutic presence. Moving to a larger home

with a home office separate from their bedroom aided in Participant C's ability to show up for

their clients in an authentic manner. Additionally, Participant C's home office provided a quieter

space than their work office, which has distracting and loud construction outside.

Example 1: I moved [to a two-bedroom] so that I could have more of a mental separation,

and I think that's been really good for both my therapeutic presence and my own self-

care.

Example 2: In this new space I feel like I have more control over what comes into the

therapeutic relationship and I appreciate that.

Participant C also accounted for how they set up their virtual therapy space and what

personal objects or background details would be in their video frame. Like Participant A,

Participant C wanted to ensure their clients experienced a real human on the other side of the

screen particularly with their mental health focused clients. While a virtual background can be

interesting, Participant C felt like it doesn't portray their personal authenticity.

Example 4: I still wanted greenery behind me because in my office at work I have a lot of

plants and I wanted it to be a real person in a real space as much as possible.

Example 5*:* There's nothing wrong with using a Zoom background but if you're the

person receiving the therapy you are thinking, "I can see they're using a background, I

wonder if they have a green screen… what's their house like… why aren't they showing me their house?"

Example 6: I feel more authentic sitting in my space that reflects me and my presence in the relationship.

Drawing from their person-centered approach, Participant C found it helpful to humanize the unplanned or distracting moments – like a cat walking into frame – in order to maintain engagement and continue strengthening rapport. Additionally, Participant C experienced varying behaviors and levels of engagement from their clients over telehealth, understanding that there could be many reasons why a client may not participate as readily in their therapy as they did in person. The client "may not want you to see how they're living [and] may not have other options" to set up their own therapeutic space. As a result, Participant C changed the way they viewed the telehealth interactions from in-person interactions, recognizing that we were all humans trying to navigate this new space. Participant C also noted that there are things you do not anticipate coming into the therapeutic relationship. Often times, distractions ended up influencing the content of their therapy sessions.

Example 7: When I lived in a much smaller apartment it would be difficult to mediate what's going on in the background; suddenly we were all in each other's living rooms, which is not something that any textbook prepares you for.

Example 8: We are all humans in a weird space (telehealth) that nobody really knew how to navigate but again being person-centered, I tend to default at the end of the day to *we're all humans on earth trying to figure these things out.*

When Participant C was asked to identify any music artifacts that reflected their journey through the pandemic, they noted how they started listening to more chart-topping contemporary

pop music. This is significant for Participant C because they typically spend time listening to more obscure, indie music that mirrors their typical taste and attitude. Participant C attributed this to a subconscious desire to feel connected with more people who are listening to the same genre and the same songs.

> Example 9: I'm saying Top 40 hits, like I had to Google who some of these new artists were…They're putting out some good music that I really enjoyed just existing to.
>
> Example 10: I tend to really marinate in the indie folk type of music; that has always brought me comfort and felt authentic to me, and my subconscious craved something more communal.
>
> Example 11: The fact that I sought out a new genre was big. It opened my mind in a way that it really needed to be opened…like my new window to look out of, instead of always listening to this music that mirrored myself.
>
> While Participant C's theme emerged to be one of personal authenticity, their inclination

to listen to more broad-reaching, generic music may speak to the isolation experienced in the pandemic and the need to feel connected beyond oneself. As Participant A framed it: "How do we figure out how to be together when all the ways we knew how are not there anymore?"

Discussion

The purpose of this study is to understand the music therapist's experience in delivering telehealth during the COVID-19 pandemic and contribute to the growing body of literature surrounding this topic. The current available literature on the implications of music therapy via telehealth is limited and to date, few studies look in-depth at the music therapist's experience in delivering music therapy during the COVID-19 pandemic. The study sought to uncover 1) how participants modulated their in-person practice to telehealth, 2) the participant's experience in

this transition, 3) considerations for music interventions, treatment planning, and musicing over telehealth, 4) how they felt the effects of the global pandemic in their practice, and 5) what they have learned about their practice over telehealth.

From this study's exploration, the following group themes emerged: 1) Role of Therapist Changing, 2) Technology Considerations in the Home Office, and 3) Career Reflection and Future Practice. The following individual themes emerged: Participant A worked on adapting to change, Participant B experienced the learning curve of telehealth as well as burnout, and Participant C focused on delineating work-life boundaries while maintaining an authentic therapeutic presence.

During the COVID-19 pandemic, music therapists needed to find a videoconferencing platform, learn that software and how to troubleshoot it, and also act as tech support for the client when they encounter connection, video, or audio issues (Sasangohar, 2020). The participants in this study all noted how their journey in utilizing telehealth started with learning how to problem solve their own technology issues and how they grew to "serve a dual role" as therapist and technician (Sasangohar, 2020, p. 9).

Previous examples of music therapy over telehealth discuss how the music therapist can augment live musicing experiences to account for lag as well as techniques they can use to most closely resemble musicing in-time together (Glover, 2020). Participant A discovered a way for them both to hear the client's recorded voice in live time: the client simultaneously harmonizes or sings along with their pre-recorded voice. Participant A saw the bounds of telehealth through the lens of "What can we do differently than we did before" instead of "How can I recreate what we used to do in-person?" This shift in perspective can be helpful to any music therapy practice

as therapists should strive to be reflexive in collaboration with their clients and adaptable to the medium in which they work (Bruscia, 2013).

The therapist's role also shone through in each participants' clinical approach. Participants A and B noted how they augmented their typical clinical approach and session structure when delivering telehealth, while Participant C's approach and session structures remained mostly same as they did in-person. This contrast could be reflective of the setting in which Participant C practices. A structured day program consisting of various classes throughout the day requires predictability and familiarity that the client can rely on and show up for (Sasangohar, 2020).

For Participant C, creating experiences in group work may also require more long-term planning that builds on previous weeks to meet the overall group goals so the group may progress. Previous accounts of music therapists delivering telehealth reported how their clinical approach remained primarily the same from in-person to telehealth, which aligns most with Participant C's approach (Glover, 2020). The global pandemic and their work with individuals might explain why Participants A and B deviated from Glover's (2020) findings. Since the global pandemic exacted a psychological toll and impacted daily life, working with an individual allows for more flexibility in spontaneously changing or adapting the session to the individual's needs.

Participant B's role expanded by incorporating more non-musical aspects into their music therapy when it came to delivering telehealth despite receiving minimal training in this area. Participant B's experience and acknowledgement that they initially felt uncomfortable and untrained in utilizing verbal skills adds to the larger conversation in the music therapy profession about the role of verbal language in music therapy. The type of work and theoretical framework

under which the therapist practices informs the degree to which they may use verbalizations and music in their practice (Loewy, 2005; Aigen, 2014). Beyond that, Schwartz (2019) emphasizes that music therapists should also understand their scope of practice and what level of therapy they can practice at within their state's regulations. Music-centered experiences, like synchronous improvisation, were replaced with more verbal instruction and discussion in telehealth for Participant B.

Aigen (2014) described how verbalizations assist in creating or "increasing awareness about internal thoughts and feelings as well as external events within music and interpersonal relationships – it is essential in linking nonverbal and verbal realms of experience" (p. 103). It is a particularly interesting parallel that Participant B was the sole participant to note how the process of being interviewed brought up undiscovered material within, and they were the sole participant to express their increased use of verbalizations this past year through telehealth.

Telehealth sessions often encounter video and audio interruptions or lags. Because of this, Participants A and C found that utilizing the medium of virtual therapy itself can be a part of the therapeutic process instead of an uncomfortable hinderance, corroborating earlier findings (Glover, 2020). An unexpected technological difficulty – or even an animal walking into frame – can create material for therapeutic fodder rather than allowing it to go unaddressed and developing into frustration and discomfort.

When videoconferencing, users have the ability to see their video reflections as well as the video of the person they are viewing. This feature was seen as a strength, particularly with Participants A and B who described using their "video box" as a physical boundary in creative ways. Glover (2020) offers how this unique aspect of telehealth can aid in further establishing a therapeutic relationship.

While the participants found ways to use the situation to their advantage, they also needed to consider how to play music over video conference including accounting for lag. Kaplan (2008) suggests these added considerations can influence how the client perceives the clinician, changing the relationship between the client and clinician. Each participant utilized their adaptability to learn the software and eventually use its features to enhance the therapeutic material and therapeutic process. Because of this, most participants noted how their established relationships continued to stay strong. Similarly, creating rapport with new clients did not seem to be hindered by the quality of connection.

Participants A and C noted, however, that some clients struggle to experience virtual therapy as "real". There are complex and intersecting interactions happening on the virtual screen that alter spatial and visual dynamics (Nadler, 2020). For clients who struggle with reality orientation or experience severe mental health issues, seeing humans "flattened" or two-dimensional in the virtual therapy room could disengage the client from experiencing the therapist as "real" (Nadler, 2020; Mashima et al., 2003; Kaplan, 2008). Similarly, technical difficulties, audio lag or unexpected audio feedback can all contribute to a triggering environment for the client if they struggle with interpersonal relating in daily life. For these reasons, high quality sound was important for both Participants A and C in order to counteract the potential harm in telehealth especially with their mental health clients. Participant A incorporated concepts of vocal psychotherapy into their practice, which meant utilizing high quality gear to record and hear-back the client's audio. Participant C not only upgraded their at-home Wi-Fi to ensure a stable and strong connection with their clients, but also upgraded their office's microphone and camera gear to improve the client's experience of receiving telehealth,

which helps the client continue engaging in their treatment (Kaplan, 2008; Wrape &McGinn, 2018).

Participant C acknowledged their privilege in being able to set up their new home office as well as upgrade to high-speed internet. Participant C also recognized that while these upgrades helped on their end, the client end does not always have access to such upgrades to receive higher quality telehealth. Other music therapists also found how access to technology and technological literacy "exacerbated disparities for lower-income patients" (Sasangohar, 2020, p. 9) amidst the transition to telehealth in the pandemic.

Each participant experienced the transition to telehealth differently since they each have their own perspective and experiences unique to them. As such, their outlook on the future of their practice varies from participant to participant. Participant A was the sole participant to have already utilized telehealth personally and professionally, so the continuation of these services was a given for them. Participant B looks to fully resume in-person services as soon as possible, as that is their preference. Participant B recognized how important touch and nonverbal communication is in their practice, which aid in client participation and engagement (Loewy, 2005). Kaplan (2008) discusses how "clinicians may miss important visual cues" and "they may miss offering comfort by touching the person they are treating" (p. 410). Physical touch has an entirely new association in a pandemic with the distancing and sanitary regulations. It will be interesting to see how or when therapists like participant B integrate physical closeness and intentional physical touch back into their practices when it is safe to resume in-person treatment.

Participant C plans to incorporate a hybrid approach into their practice moving forward. Once it's safe, they prefer to run their therapy groups in-person at the day treatment center. For their private practice, Participant C plans to keep seeing their individual clients over telehealth;

64% of music therapists are in agreement as they responded they were at least somewhat likely to continue delivering telehealth once the COVID-19 pandemic is over (Brunick, 2021). All three participants noted that their therapeutic alliance was minimally disrupted or changed, which can potentially be attributed to the technological development that allows for fast and smooth connection (Glover, 2020).

Participant A – Adapting and Letting Go

Music therapists should strive towards growth and development in their profession, and each participant displayed a level of adaptation to the new virtual lifestyle of delivering telehealth (Decuir, 2010). Participant A highlighted how the nature of adaptation itself became a cornerstone of the way in which they delivered telehealth. Taking a here-and-now approach, Yalom (2005) noted that "if something important…is being actively avoided, then nothing else of import gets talked about either" (p. 34). For participant A, adaptation directly addressed the avoidance of change that they experienced. Participant A recognized that adaptation was tied to letting go of past conceptions of who they should be in the therapy room. Out of this adaptation. Participant A moved to bring more of their authentic self when conducting their therapy sessions, acknowledging that they are also a human experiencing the pandemic.

Participant B – Burnout and Career Reflection

Throughout their interview, Participant B mentioned how switching to telehealth was a "learning curve." They correlated this learning curve to their tendency towards burnout and how they experienced a new form of burnout in increasing their workload during the COVID-19 pandemic. Burnout is a common experience among music therapists who have been in the field for more than 5 years, and personal counseling is one avenue among ways to reduce burnout and gain self-awareness (Chikhani, 2015; Oppenheim, 1987). Participant B mentioned how they've

used their personal therapy as a space to allow themselves to rest more. Resting and slowing down also brought up reflections for Participant B in figuring out the kinds of jobs they want to take in the future since they used to take any job that came their way. Glover (2020) explains how a therapist should understand their own limits so they may set a clear boundary with who they choose to work with in telehealth and in-person.

Participant B also explained how they chose not to upgrade any of their hardware (microphones, laptop, speakers) because they didn't see themselves practicing telehealth post-pandemic, but also because they felt under-educated in the use of music technology in music therapy. While more research is emerging on the various uses of music technology in music therapy, there is limited literature surrounding clinical training and use of music technology for music therapy students (Hahna et al., 2012).

Participant C – Boundaries and therapeutic presence

Even when Participant C's workplace started to open back up, the construction outside the building did not afford a quiet and peaceful teletherapy space. This inclined Participant C to work from home more, which also allowed them to feel more present in session while attending to their personal needs at that time. Additionally, working from home provided reliable and strong internet which allowed for a more authentic therapeutic presence (Glover, 2020). Further, upgrading space was necessary for Participant C since they needed more separation between work and home life. This upgrade also influenced how Participant C sees the future of their practice. Participant C emphasized their need to ensure their work and personal lives are separate when conducting therapy. This could be a result of the therapist knowing their boundaries and their populations as well (Glover, 2020; Sasangohar, 2020). Working in mental health often requires licensure or extra training and self-reflection.

Transforming Approaches Personally and Professionally

Each participant in this study experienced a shift in their work personally, professionally or a mix of both. The shift seen in these three participants might prompt the greater population of music therapists to revisit and redefine their theoretical approach in delivering telehealth since it requires different resources than in-person therapy. Bruscia (1987) suggests the importance in considering the method and model of music therapy you practice under depending on your population and setting. Bruscia (1987) posits that using an improvisational model – of which there are many types – is relatively flexible and adaptable across settings and populations. In improvisation, there can be both active and receptive music making. In active music making, "the client improvises (with or without another person) and listens to his/her own improvisation as it unfolds" (Bruscia, 1987, p.10). It is not explicitly stated whether Bruscia is talking about in-person or virtual sessions; however, one can infer from the 1987 copyright that the music making he discusses is happening in-person. Technology has since advanced, and therefore the likelihood of technological difficulties like latency or microphone issues are not discussed and may compromise the ability to synchronously improvise with the same quality and character.

More recently, Bruscia proposed a new style of thinking that can be applied to an increasingly diverse and connected world (Hyung, 2015). Integral thinking in music therapy welcomes any model of music therapy like Nordoff-Robbins Music Therapy, Neurologic Music Therapy, or Guided Imagery in Music, and posits that not just one approach, but the use or combination of any approach is valid if it means the client is being better served (Hyung, 2015). Integral thinking in music therapy discusses how "music itself is integral" and no one particular

setting or clientele is more or less suited for integral thinking (Hyung, 2015, p. 72). As a general basis for thinking in music therapy, it is widely accepted that there are three main forces at play: the therapist, the client, and the music (Amir, 1996, p.47). This extends to how the aesthetics of the therapy room, the client's relationship with the therapist, and the client's inner world directly influence the client's experience (Amir, 1996). Projections, identifications, and boundaries are always being negotiated within the physical environment (Bruscia, 1998).

With these dynamic forces at play in music therapy, the telehealth music therapist may glean a novel perspective from the integral model when practicing virtually. Incorporating knowledge from a spread of models within all therapeutic realms can equip the music therapist to remain reflexive despite practicing over a new medium like telehealth. Participant A borrowed from several of their advanced clinical trainings to inform their virtual practice; Participant B reached towards other forms of creative arts therapy to facilitate their personal and professional development; Participant C utilized cognitive and behavioral therapy models to enhance their sessions. Music therapists encountering barriers in their telehealth practice might consider taking a creative and innovative approach by expanding and incorporating tenets of integral thinking for their virtual sessions.

Conclusion

This study looked at the music therapist's experience in delivering telehealth during the COVID-19 pandemic through analyzing and interpreting interviews with three music therapists. The results indicate that the role of the music therapist, the way they use technology, and their career reflections all played a part in their unique response and adaptation to telehealth.

Limitations and Recommendations for Future Studies

While this study produced important data on how music therapists experienced telehealth during COVID-19, the study focused on music therapists with master's degrees, so there may be limited transferability to music therapists who practice with solely an undergraduate degree. Interviewing a diverse sample with varying philosophical frameworks, or both masters and bachelor's music therapy degrees could shed more light on the diversity of music therapist experiences during COVID-19, and more largely, in telehealth delivery. Similarly, this study was limited to music therapists in the U.S. Since each country addressed the pandemic in different ways, the transferability of this study to other countries who practice music therapy may be limited.

Despite studying the effects of the COVID-19 pandemic, this study was conducted while in the midst of the pandemic. A potential limitation of this could be that the participants may not have a clear picture of their experience since they were still undergoing telehealth while the world was still experiencing the pandemic. Participant B noted how the interview for this study itself was the first time they were reflecting about their work in-depth. Future studies could look into the same research question of how music therapists experienced telehealth during the pandemic two, three or five years from its advent.

The use of music technology beyond recording the client's music was limited. While synchronous musicing is hard to achieve over telehealth, I suggest that future studies focus on the impact of music technology in telehealth including the use of remote screen control for web-based platforms and software-based platforms like Digital Audio Workstations such as Ableton, Garageband, and Pro Tools to co-create music. Additionally, future studies could investigate

how music therapists experience delivering a hybrid of telehealth and in-person services since Participants B and C were already transitioning into that structure at the time of this study.

Based on Participant B's experience, music therapists and music therapy institutions may benefit from becoming more familiar and confident in their use and teaching of verbal skills in music therapy sessions especially over telehealth where nonverbal cues may be lost (Sasangohar, 2020). If music therapy programs or academic research considers this direction, they can explore how or if the use of verbalizations should be taught and utilized differently for in-person and telehealth sessions.

Implications for the field

This study was one of the first to explore how music therapists experienced delivering telehealth during the COVID-19 pandemic. A greater understanding of the strengths, challenges, and barriers each clinician experienced during this time was revealed. If a music therapist finds themselves reflecting on their practice in the pandemic, they can turn to this study to reveal any similarities or differences while processing their experience. This study also provides a foundation for future research based on this study's limitations and suggestions for future research. The future of music therapy may look towards more online work to increase access to clients and this study can inform music therapists about the experience of transitioning or expanding their practice from in-person to telehealth.

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Appendix A

Molloy College IRB Approval
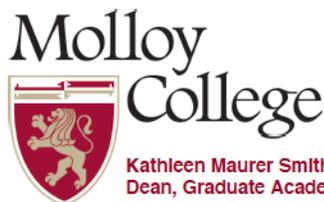
Molloy College

1000 Hempstead Ave., PO Box 5002, Rockville Center, NY 11571-5002
www.molloy.edu

Kathleen Maurer Smith, Ph.D.
Dean, Graduate Academic Affairs
T: 516.323.3801
F: 516.323.3398
E: ksmith@molloy.edu

DATE:	November 30, 2020
TO:	Nicole Gelfand
FROM:	Molloy College IRB
PROJECT TITLE:	[1689203-1] The Experience of Music Therapists in Delivering Telehealth During the COVID-19 Pandemic
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
DECISION DATE:	November 30, 2020
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of New Project materials for this project. The Molloy College IRB has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations. However, exempt research activities are subject to the same human subject protections and ethical standards as outlined in the Belmont Report.

This acknowledgement expires within three years- unless there is a change to the protocol.

Though this protocol does not require annual IRB review, the IRB requires an annual report of your exempt protocol (Expedited and Exempt Research Protocol Annual Report Form) which is available on the IRB webpage.

If there is a proposed change to the protocol, it is the responsibility of the Principal Investigator to inform the Molloy College IRB of any requested changes before implementation. A change in the research may change the project from EXEMPT status and requires prior communication with the IRB.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Patricia Eckardt at 516-323-3711 or peckardt@molloy.edu. Please include your project title and reference number in all correspondence with this committee.

Sincerely,

Patricia Eckardt, Ph.D., RN, FAAN
Chair, Molloy College Institutional Review Board

This letter has been issued in accordance with all applicable regulations, and a copy is retained within Molloy College IRB's records.

Appendix B

Informed Consent

Molloy Music Therapy Department/ School of Arts and Sciences
1000 Hempstead Ave
Rockville Centre, NY 11570
(516) 323-3000

Title of Study: The Experience of Music Therapists in Delivering Telehealth During the
COVID-19 Pandemic

This study is being conducted by:
Graduate student - Nicole Gelfand: ngelfand@lions.molloy.edu
Faculty advisor - John Carpente: jcarpente@molloy.edu

Key Information about this study:
This consent form is designed to inform you about the study you are being asked to
participate in. Here you will find a brief summary about the study; however you can find
more detailed information later on in the form.
        This research is aimed at exploring how music therapists experienced delivering music
therapy through telehealth during the COVID-19 pandemic. Each subject will partake in a forty-
five to sixty-minute interview over video conference that will be recorded on both audio and
video. The study seeks to contribute to the minimal knowledge base of how music therapists can
understand the practice of music therapy through telehealth during times of global crisis. The
inclusion criteria for participants are as follows:
6) Board-Certified Music Therapist (MT-BC)
7) Minimum graduate degree
8) Provided telehealth music therapy sessions for at least six months during the COVID-
19 pandemic
9) Transitioned their practice from in-person to telehealth during the COVID-19
pandemic as a result of the COVID-19 pandemic
10) Has worked in music therapy for at least five years or more

You will need access to a quiet space, as well as a computer with video and audio capabilities,
and a stable internet connection. Interview questions will surround a few topics including but not
limited to: 1) how participants modulated their in-person practice to telehealth 2) the
participant's experience in this transition 3) considerations for music interventions, treatment
planning, and musicing over telehealth 4) what participants have and have not found useful 5)
how they felt the effects of the global pandemic in their practice and 6) what they have learned
about their practice over telehealth. Following the, the researcher will transcribe the interview.
The time commitment for this study includes the allotted forty-five minute to sixty minute
interview time. Additionally, each interview will be transcribed and sent to you, the subject, to
read through and confirm the information is accurate – this should take forty-five minutes to
sixty minutes. Therefore, the total commitment time is around two hours. Interview data
including audio and video recordings will be securely stored on a password protected external

hard drive located in and not to leave the researcher's home office lockbox. Any identifiable personal information will be disguised or stricken from the final research product. There will be no compensation provided to research subjects for participation. There are minimal to no risks for participating in this study; however, talking in a reflective manner of one's self and experiences may bring up strong feelings. In this case, the national crisis hotline is provided to you: call 800-273-8255 or text HOME to 741741 for help. You may opt out of participating at any point throughout this study.

Why am I being asked to take part in this study?
This study seeks to enhance the current knowledge base of how the COVID-19 pandemic affected the profession of music therapy. Due to stay-at-home procedures, music therapists needed to modulate their practice from delivering care in-person to telehealth. This change influenced the way in which music therapy can be delivered and poses questions about ethics, confidentiality, quality of care, and personal experiences of the therapists. You are being asked to take part in this study because you fit the inclusion criteria. By being interviewed about your experience switching from in-person music therapy to music therapy through telehealth, you will help contribute to a larger understanding of the music therapist's experience of delivering telehealth curing a global pandemic. Potential themes across various music therapist's experiences may arise from this study and inform the profession on how to best practice music therapy through telehealth.

What will I be asked to do?
You will be asked
- to participate in an interview ranging from forty-five minutes to sixty minutes over a video conferencing app
- a series of questions about your practice and your experience of delivering music therapy through a pandemic.
- to read through the final interview transcript after the interview and provide any notes or amendments to the transcript

During the interview, your answers may be personal and reflective depending on the nature of the question. For example, how you created an at-home therapy space, how you planned for sessions, and how you felt about the experience of providing telehealth.

Where is the study going to take place, and how long will it take?
The video-conference interview for this study will take place in a quiet, private location of your choosing. The interview will be between forty-five minutes to sixty minutes. Reviewing the interview transcript will take around forty-five minutes to sixty minutes. In total, this study should take no more than two hours.
What are the risks and discomforts?
There are no anticipated risks of participating in this study. However, talking in a reflective manner of one's self and experiences may bring up strong feelings. In this case, the national crisis hotline is provided to you: call 800-273-8255 or text HOME to 741741 for help. You may opt out of participating at any point throughout this study. It is not possible to identify all potential risks in research; however, reasonable safeguards have been taken to minimize known

risks. If new findings develop during the course of the research which may change your willingness to participate, we will tell you about these findings.

What are the expected benefits of this research?
>   **Individual Benefits: Greater clarity on one's experience of delivering telehealth music therapy through a pandemic.**

Do I have to take part in this study?
Your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.
Will it cost me anything to participate?
There is no cost to participants for participating in this study.
What are the alternatives to being in this study?
Instead of being in this research, you may choose not to participate.
Who will have access to my information?
Only the primary investigator and the faculty advisor will have access to your information. Some identifiable information like place of work, population with which you work, and length of time you've been working at this location or with this population may be collected. Your information will be held on a password-protected external hard drive in the primary investigator's home office lockbox and this hard drive will not leave the home office lockbox. Research results will be presented anonymously after being coded into thematic groups. No data will be available to anyone outside the research team at any time until all information is coded and made anonymous.

How will my information be used?
Your interview responses will be coded into themes that emerge between each interview as it pertains to the music therapist's experience in delivering telehealth during COVID-19. Subsequently, these codes will be used in a thematic analysis to explore or uncover any larger themes across other music therapists delivering telehealth curing COVID-19. Identifiers might be removed from the identifiable private information and that, after such removal, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility.

To ensure that this research activity is being conducted properly, Molloy College's Institutional Review Board (IRB), whose members are responsible for the protection of human subjects' rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.

Can my participation in the study end early?

If at any point you would like to terminate your participation in this study, you may contact the researcher noting your termination without any reason. Any of your data will be destroyed upon termination

Will I receive any compensation for participating in the study?
There is no compensation for participating in this study

What if I have questions?
Before you decide whether you'd like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact

Nicole Gelfand **at** ngelfand@lions.molloy.edu **or**
John Carpente **at** jcarpente@molloy.edu

What are my rights as a research participant?
You have rights as a research participant. All research with human participants is reviewed by a committee called the *Institutional Review Board (IRB)* which works to protect your rights and welfare.
If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB contact the Molloy IRB office at irb@molloy.edu or call 516 323 3000.

Documentation of Informed Consent*:

You are freely making a decision whether to be in this research study. Signing this form means that
1.   you have read and understood this consent form
2.   you have had your questions answered, and
3.   after sufficient time to make your choice, you have decided to be in the study.

You will be given a copy of this consent form to keep.

Your signature	Date

Your printed name	Date

I agree to being video and audio recorded.

Your signature	Date

Your printed name   Date

_____   _____
Signature of researcher explaining study   Date

_____   _____
Printed name of researcher explaining study   Date

Appendix C

Semi-structured Interview Questions

- How long have you been practicing as a board-certified music therapist?

- Do you have any advanced clinical training?

- In the past year, what populations have you serviced?

- Have you had experience with telehealth prior to the pandemic?

- What steps did you take to modulate your practice from in-person to telehealth?

- How did you feel about your ability to navigate technology in telehealth when transitioning your practice online?

- What were your considerations when setting up your home office?

- How did you experience your role as a therapist in telehealth?

- What methods, techniques or modalities did you employ in telehealth?

- Do you see yourself continuing to practice telehealth once the pandemic is declared over?

- Do you have any music artifacts such as journals, notes, reflections, lyrics or songs that you found important in your transition or in answering these questions?

Appendix D

Dear _____,

My name is Nicki Gelfand and I'm a Music Therapy graduate student at Molloy College. I'm conducting research for my thesis about how music therapists experienced switching their practice from in-person to telehealth during the COVID-19 pandemic. You were referred to me by [a fellow colleague] to be a participant since you fall into the inclusion criteria of this study. I plan to conduct a 45-minute interview with my participants including (but not limited to) topics such as: 1) how participants modulated their in-person practice to telehealth 2) the participant's experience in this transition 3) considerations for music interventions, treatment planning, and musicing over telehealth 4) what participants have and have not found useful 5) how they felt the effects of the global pandemic in their practice and 6) what they have learned about their practice over telehealth.

In seeking to explore themes of music therapists delivering telehealth in a pandemic, we can better reflect on the development of the music therapy profession in several ways including but not limited to the potential to 1) evaluate where certain benefits or difficulties may lie in delivering remote telehealth services for certain populations 2) evaluate best practices in delivering quality sounding music through technology 3) understand how the music therapy profession can grow if telehealth continues to be a popular and effective modality of treatment.

Please let me know if you're interested in participating or if you know someone who would like to participate as well.

Regards,
Nicki Gelfand

Appendix E

When It Don't Come Easy – Patty Griffin

Red lights are flashing on the highway
I wonder if we're gonna ever get home
I wonder if we're gonna ever get home tonight
Everywhere the waters getting rough
Your best intentions may not be enough
I wonder if we're gonna ever get home tonight

But if you break down
I'll drive out and find you
If you forget my love
I'll try to remind you
And stay by you when it don't come easy

I don't know nothing except change will come
Year after year what we do is undone
Time keeps moving from a crawl to a run
I wonder if we're gonna ever get home

You're out there walking down a highway
And all of the signs got blown away
Sometimes you wonder if you're walking in the wrong direction

But if you break down
I'll drive out and find you
If you forget my love
I'll try to remind you
And stay by you when it don't come easy

So many things that I had before
That don't matter to me now
Tonight I cry for the love that I've lost
And the love I've never found
When the last bird falls
And the last siren sounds
Someone will say what's been said before
Its only love we were looking for

But if you break down
I'll drive out and find you
If you forget my love
I'll try to remind you
And stay by you when it don't come easy