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**The Experience of Music Therapists Working with the Parents of Premature Infants
in the Neonatal Intensive Care Unit (NICU)**

A Thesis Submitted to Molloy College
Music Department, Rockville Centre, NY

In Partial Fulfillment
of the Requirements for the Degree

Master of Science
in
Music Therapy

by

Harria Kim, MT-BC

May 2022

Molloy College

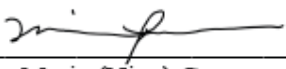
A thesis committee of the undersigned has examined the thesis titled

**The Experience of Music Therapists Working with the Parents of Premature Infants in the
Neonatal Intensive Care Unit (NICU)**

Presented by Harria Kim, MT-BC

A candidate for the degree of Master of Science in Music Therapy

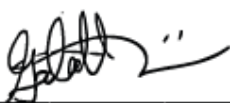
And hereby certify that the thesis was read and approved by the committee.



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2022

Abstract

This study explored the lived experience of music therapists working with parents of premature infants in the neonatal intensive care unit (NICU). While there are many studies regarding the effects of music therapy on parents and premature infants in the NICU, few in-depth qualitative studies focus on the experiences and perspectives of music therapists working in the NICU. The present study aims to explore music therapists' experiences of working with the parents of premature infants in the NICU and their perspectives on how music therapy can meet the needs of these parents. Data were collected through audio-video recording and transcription of semi-structured interviews. The data were analyzed using Moustakas' (1994) modification of van Kaam's method of Interpretative Phenomenological Analysis (IPA). The findings consisted of six common themes across participants: (a) witnessing parents' difficulties and providing support, (b) music therapy advocacy, (c) serving as a bridge between parents and their babies, (d) utilizing various interventions, (e) mediating between parents and medical staff, and (f) setting boundaries. These common themes explored music therapists' experiences and supported the need to recognize the roles and challenges of music therapists working in the NICU.

Keywords: music therapy, therapist experience, parents, premature infants, neonatal intensive care unit (NICU)

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누구보다 저의 새로운 도전과 출발에 사랑과 지지를 보내준 가족과 친구들에게 감사인사를 전합니다. 또한 몰로이 대학에서의 여정을 이끌어 주신 모든 교수님들, 선생님들과 선후배님들에게 감사인사를 드리고 그간의 여정을 함께한 친구들에게도 감사와 축하를 보냅니다. 이 논문이 진행될 수 있도록 인터뷰에 응해주신 음악치료사분들께 깊은 감사를 드리며 마지막으로 저를 여기까지 인도해준 그동안의 모든 경험에 감사합니다.

Contents

Abstract	iv
Acknowledgments.....	v
Contents	vi
Introduction.....	1
Review of Literature	6
Parents' Experiences During Their Infant's Hospitalization in the NICU	6
Music Therapy in the NICU.....	9
Music Therapy Interventions in the NICU	10
Family-Centered Music Therapy	14
Music Therapists' Experience in the NICU	15
Method	17
Results.....	25
Discussion	39
Discussion of Common Themes	39
Limitations	47
Implications for Music Therapy Practice	47
Recommendations for Future Research	47
Conclusion	49
References	50
Appendix A: IRB Approval Letter	56
Appendix B: Letter of Informed Consent	57

Introduction

The World Health Organization (WHO) defines preterm birth as a live birth before the completion of 37 weeks of pregnancy (WHO, 2018). The incidence of preterm births in the United States has been rising for the past 5 years. In 2019, the preterm birth rate in the United States was 10.23%, a 2% increase from 2018 (10.02%; Martin et al., 2021). Preterm birth complications are the leading cause of neonates' death, resulting in approximately one million deaths each year (Liu et al., 2016). Survivors may have lifelong cognitive and developmental impairments (WHO, 2018).

Mothers who give birth to a premature infant can perceive their labor and delivery experiences as traumatic. Beck and Woynar (2017) explained traumatic stress as “either directly experiencing or witnessing a traumatic event that can be life-threatening like preterm birth” (p. 338). Premature infants’ neonatal intensive care unit (NICU) hospitalization induces stress for the infants, their parents, and their families as a whole. Separation from their mother in the NICU initiates a stress response in infants and is also related to maternal depression and posttraumatic stress disorder (PTSD; Coughlin, 2014). Therefore, it is essential to recognize parents’ needs during their infant’s NICU hospitalization (Cockcroft, 2012).

Music Therapists Working in the NICU

According to Standley and Gutierrez (2020), “Neonatal intensive care music therapy (NICU-MT) is an evidence-based, specialized training in music therapy, neurodevelopmental, and family care intervention for premature infants” (p. 40). Music therapy can improve the well-being of premature infants, reduce parents’ anxiety perception during NICU stays, and enhance mother-infant bonding (Loewy, 2015; Palazzi et al., 2020). Music therapists with NICU specialized training are interdisciplinary team members in a NICU and work in-depth with both

premature infants and their parents (Standley & Gutierrez, 2020). Many studies address the effects of music therapy on premature infants and parents in the NICU, but few studies address music therapists' experiences of working with parents in the NICU.

NICU Training at Louis Armstrong Center for Music and Medicine

As a music therapy graduate student, I wrote several literature reviews of music therapy case studies in my first semester. In one of the case studies at a NICU, Nöcker-Ribaupierre (2011) played a recording of a mother's voice in an incubator for her baby to hear, and the baby turned their head toward the sound. I was drawn to this case study and became interested in the effects of music therapy on premature infants and their parents in the NICU.

During my internship at the Louis Armstrong Center for Music and Medicine (LACMM) in New York, I worked at the NICU and received First Sounds RBL (rhythm, breath, and lullaby) training, which was developed by Dr. Joanne Loewy, the director of LACMM, and the LACMM team. First Sounds RBL is a music psychotherapy-based training which consists of re-creating a womb-like environment through sound and music for premature babies (The Louis Armstrong Department of Music Therapy, 2019). In the NICU, the units were divided into two sections: private rooms for higher-risk infants and shared rooms for lower-risk infants. Also, depending on the infants' postmenstrual age (a sum of gestational age and chronological age; American Academy of Pediatrics Committee on Fetus and Newborn, 2004), they were placed either on a bed or in an incubator. Many parents and family members spent long periods of time next to the babies, sitting or standing at the bedside. Many of them appeared to be anxious, tired, and sensitive to external stimuli such as sounds from the machines and the fast-paced environment, with people continuously coming in and out of the unit.

As a music therapy intern, I held music therapy sessions with infants, sometimes including their parents, and occasionally with the parents alone. Given the tense atmosphere in the unit and the parents' high level of anxiety, one of my concerns was "What if the parents have a negative impression of music therapy due to my non-fluent English and limited professional experience?" Nevertheless, I endeavored to create a comfortable atmosphere and offer support to parents through what I could provide for them, which was music therapy. Over time, I became accustomed to the NICU environment of care and developed an increased mutual understanding with several of the parents. I had more opportunities to meet and converse with them, especially the parents of infants with long-term hospital stays. Most parents tried to maintain hope for their babies and remain positive. Meanwhile, they sobbed as they shared how frustrated and tired they felt, discussed conflicts they had experienced with medical staff, and complained about the hospital's restrictive visiting policy during the COVID-19 pandemic. From these experiences, I perceived the need for music therapy not only for the infants but also for their parents.

I had several chances to observe my supervisors' and internship cohort's sessions in the NICU. Even though we had the same NICU training, each of the other interns applied the therapeutic approach and interventions in their own way. I wondered about their unique experiences of working in the NICU. While communicating with my internship cohort, I realized that other interns were also facing difficulties in getting accustomed to the internship experience and talking to parents, as I had encountered. I also noticed that different interns had varying experiences with parents and infants in the NICU during their internships, while undergoing similar difficulties and accomplishments. These observations and reflections led me to wonder how other music therapists may perceive their experiences of working with parents of premature infants in the NICU.

Purpose of Study

While there are many studies regarding the effects of music therapy on parents and premature infants in the NICU (Ettenberger & Ardila, 2018; Loewy, 2015; Palazzi et al., 2017), there are few in-depth qualitative studies focusing on the experiences and perspectives of music therapists working in the NICU. As the scope of music therapy services expands, a greater understanding of music therapists' experiences is needed, as they are ultimately connected to the quality of patient care. The present study aims to explore music therapists' experiences of working with the parents of premature infants in the NICU, and their perspectives on the ways that music therapy can meet the needs of these parents. The findings of this study may generate insight into music therapists' subjective experiences of their clinical work, especially in the NICU environment, and thus support the delivery of high-quality clinical care.

Epistemology

My epistemological framework reflects an interpretive approach, which emphasizes each individual's unique interpretation of the world depending on their circumstances. I originally came from South Korea. Ever since living in the United States, I have met people from many different cultural backgrounds and have observed that their experiences and perspectives vary widely. I have become aware of ways in which cultural context may influence one's view of the world. Based on the premise that different individuals have different understandings of a given situation, I was curious to study the ways in which music therapists interpret their experiences, such as the challenges and learning lessons of clinical work. Thus, this qualitative study employs a phenomenological design, which investigates how each individual perceives, feels, thinks, and derives meaning from a lived phenomenon that they have experienced (Wheeler & Bruscia, 2016).

Methodology and Research Questions

Two board-certified music therapists experienced in working with parents of premature infants in the NICU participated in individual interviews. Data were collected through audio-video recording and transcription of the interviews. The data were analyzed using Moustakas' (1994) modification of van Kaam's method of Interpretative Phenomenological Analysis (IPA). The study addressed the following research question: What are music therapists' experiences of working with parents of premature infants in the NICU? The interview explored such topics as (a) participants' experiences as a music therapist working in the NICU, (b) participants' experiences with the parents of premature infants in the NICU, and (c) participants' experiences with the medical staff in the NICU.

Review of Literature

This review of literature related to the present study will cover the following topic areas:

(a) parents' experiences during their infant's hospitalization in the NICU, (b) music therapy in the NICU, and (c) music therapists' experiences in the NICU.

Parents' Experiences During Their Infant's Hospitalization in the NICU

The birth and hospitalization of premature infants may lead mothers to perceive their labor and delivery as traumatic and may present challenges to parent-infant bonding. When premature infants require care in a NICU, parents may suffer guilt and psychological distress and may go on to develop PTSD (Beck & Woynar, 2017). Parents may face environmental stressors such as distressing sights and sounds in the environment and difficult communication with the staff (Heermann et al., 2005). NICU visitor restrictions caused by the current coronavirus disease pandemic (COVID-19) have added challenging and dysphoric psychological impact on parental experience (Bembich et al., 2021).

Heermann et al. (2005) interviewed 15 mothers whose infants were in a Level III NICU unit, which provides the highest level of NICU care for premature and critically ill neonates, to explore mothers' experience of motherhood during their infants' hospitalization. The study revealed that mothers developed relationships with the infant across four domains, including (a) focus, (b) ownership, (c) caregiving, and (d) voice. Initially, the mothers' attention was not focused on their babies, until the mothers became accustomed to the environment of the NICU, including the complex technology of the unit and the specialized expertise of the nurses. Once mothers became familiar with the unit, they grew to recognize and focus on their baby's individuality. As an initial reaction to the NICU, mothers perceived that their baby "belonged" to

the nurses and felt a barrier to taking ownership of the baby. As mothers became more comfortable in the NICU and as their baby developed, they claimed ownership of the baby.

The study found that active maternal caregiving, including soothing, holding, and touching, could be present from the beginning of the NICU experience or might develop over time (Heermann et al., 2005). Mothers were found to differ in their readiness to take responsibility for infant care. Some mothers stayed in the silent observer role during their whole NICU stays, while other mothers engaged in advocacy for themselves and their infants. The study indicated that the next step in the development of the maternal role was the establishment of partnering relationships between the nurse and mother, but this was observed in only a few mothers. Most mothers expressed that a lack of continuity of care disrupted the development of their partnership with the nurses (Heermann et al., 2005).

Beck and Woynar (2017) studied mothers' posttraumatic stress related to the NICU experience through a mixed research synthesis of 37 studies. The 10 qualitative and two mixed methods studies on mothers' NICU experiences revealed five themes:

- (a) stark contrast to images of joyous early motherhood; (b) a cultural overlay to mothers' NICU experience; (c) issues of ownership and control; (d) four essential prongs of perceived support; and (e) learning to be a NICU mother. (p. 350)

Mothers experienced traumatic, shocking, and anxiety-provoking feelings when they first saw babies in the NICU. The sights and sounds of the NICU, with babies connected by multiple wires to equipment producing a range of mechanical sounds, contrasted sharply with what mothers had expected. Mothers' cultural background also influenced their experiences in the NICU. For example, some Taiwanese mothers had to follow the cultural ritual of rest during the first month after birth while their babies were in the NICU. Mothers' relationship with the nurses

affected their sense of ownership and control of their preterm infants. Beck and Woynar's (2017) findings of mothers' experiences in the NICU were similar to those of Heermann et al. (2005). Some mothers shared that they felt deprived of parenting during their premature infants' NICU stay. Beck and Woynar (2017) identified four sources of essential support for mothers during NICU stays: "health professionals, family members, other parents in the NICU, and religious or spiritual beliefs" (p. 351). Mothers learned to be "nursery mothers" (p. 351) during their infants' NICU stays and eventually bonded and connected with their infants. However, the researchers indicated that the frequent staffing changes and inconsistent rules among nurses were a challenge to mothers while in the NICU (Beck & Woynar, 2017).

Cleveland (2008) conducted a systematic review of 60 qualitative and quantitative studies to explore the needs of parents of premature infants in the NICU and potential sources of support for these parents. Six parent needs were identified:

- (a) the need for accurate and understandable information, inclusion in the decision-making process, and active involvement in the care of their infants; (b) the need to watch over their infants, which was demonstrated by parents' frequent phone calls to the NICU and presence at the infants' bedside; (c) the need for contact with the infant, which included providing breast milk; (d) the desire to be positively perceived by the nursery staff, in the hope of better care for their infants; (e) the need for individualized care, considering different needs between mothers and fathers; and (f) the need for a therapeutic relationship with the nursing staff, as opposed to a power struggle. (pp. 672, 680, 685)

Four behavioral supports were identified to assist parents in meeting these needs:

(a) emotional support; (b) empowerment of parents; (c) a welcoming unit environment with a supportive and engaging nursing approach; and (d) parent education, with opportunities for guided participation to improve parenting with their preterm infants. (pp. 686-687)

The death of a premature infant is another experience parents might face during their babies' NICU hospitalization. According to Levick et al. (2017), there is increased demand for formalized bereavement care programs, follow-up emotional support for bereaved parents, and staff education and support during and after the death event in the NICU setting. Levick et al. (2017) surveyed bereaved parents and staff who experienced the Helen DeVos children's hospital bereavement care program, which provided care to the parents and family before and after an infant's death. For example, it offered parents the opportunity to hold and bathe their infant and offered a keepsake box. The program also emphasized the need to take care of the infant's siblings. Follow-up care to the parent and family included reaching out with condolence cards, comforting words, and ongoing telephone follow-ups. The parent survey indicated that most parents were satisfied with the NICU and post-NICU follow-up care. The study also found that the sharing of grief during hospitalization and the individualized follow-up care provided "a collective healing between families and staff" (Levick et al., 2017, p. 460).

Music Therapy in the NICU

This section considers past research exploring specific music therapy interventions in the NICU, as well as research pertaining to the family-centered model of music therapy, which is widely implemented in NICU settings.

Music Therapy Interventions in the NICU

Music therapy in the NICU requires an understanding of the biological, physiological, neurological, and behavioral development of premature infants, as well as an understanding of parent-infant bonding (Shoemark & Hanson-Abromeit, 2015). Music therapy interventions in the NICU consist of evidence-based, individualized music activities such as singing, playing, and music listening (Yakobson et al., 2020). Board-certified music therapists, qualified music therapy faculty, and graduate and advanced music therapy students are eligible to complete specialized training in NICU music therapy (Standley, 2003).

Loewy et al. (2013) examined the effects of live music intervention on premature infants' physiological and developmental functions. A randomized trial was carried out with 272 premature infants aged over 32 weeks, with common NICU admitting diagnoses of respiratory distress syndrome, small size for gestational age, and clinical sepsis, who served as their own controls in the study. Three live musical elements were provided in the intervention: (a) the ocean disc, which simulated womb sounds and was played in a manner that reflected the infant's breath pattern; (b) the gato box, which was played in synchrony with the infant's heartbeat sounds; and (c) parent-preferred lullabies, or "Twinkle, Twinkle Little Star" when parent-preferred lullabies could not be identified. Live music interventions were delivered through the portholes of the incubators or isolettes, or at the bassinet side, and infants received these interventions twice per week over a 2-week period. The results indicated that live instrumental sounds and live singing of lullabies might affect premature infants' vital signs, sustaining their quiet-alert state (indicated by decreased heart rate and increased activity level) along with their sucking patterns. The music was also associated with a significant decrease in parents' stress perception. Loewy et al. (2013) recommended encouraging parents to use their voice, providing

“a soothing vibratory experience” (p. 910) which could enhance parent-infant bonding and confidence in parenting.

Loewy (2015) compared the effects of the *song of kin* intervention, which “employs parent-selected songs” (p. 178), with standard pre-composed music such as “Twinkle, Twinkle Little Star,” on premature infants. Maternal and paternal singing of parent-selected songs, especially when the parent was attuned to the infant, enhanced infants’ positive quiet-alert states and strengthened attachment between the infant and parent. A song of kin provided by a certified music therapist who had received First Sounds RBL (rhythm, breath, and lullaby) training specifically showed effects on the sleeping patterns and sucking rate of infants with a sepsis diagnosis. Overall, the results showed that premature infants might benefit from the song of kin intervention when feeding and developing bonding and trust with their parents (Loewy, 2015).

According to Standley (2003), stimulation techniques including skin-to-skin contact and non-nutritive sucking (NNS) for premature infants may support weight gain and increased motor development. Standley (1998) explored the benefits of lullaby singing and multimodal stimulation (MMS) on premature infants in the NICU. Participants in the study were 40 premature infants who were over 32 weeks of corrected gestational age (the number of weeks since the date of birth minus the number of weeks the baby was preterm), over 10 days of age after birth, and over 1700 g in weight. Twenty infants in the experimental group received the experimental treatment combining a sung lullaby and the adapted multimodal (auditory, tactile, visual, and vestibular, or ATVV) stimulation. Initially, the infants were held in a cuddling position and given humming without other stimulation. Afterward, depending on the infants’ stress response, Brahms’ “Lullaby” was hummed without words while rocking, and then tactile stimulation and eye contact were sequentially added. The stimulation was provided for a

minimum of 3 days across 2-3 weeks. The results demonstrated that music and multimodal stimulation benefited infants' daily weight gain and tolerance for stimulation, which showed a steady increase across the stimulation intervals. Female infants showed a more rapid increase in tolerance than males, along with earlier discharge from the hospital. According to Standley (1998), these results indicate that gender affects responses to music during medical treatment from the earliest stages of premature birth.

Whipple (2000) explored the effects of parent training in music and multimodal stimulation on parent-premature infant interactions. Parents who were trained and encouraged to use music and massage with their infants demonstrated more appropriate interaction skills, and their infants showed fewer stress behaviors. These parents also spent more time visiting the NICU, and their infants showed an increase in daily weight gain and shorter length of hospitalization (Whipple, 2000).

Haslbeck (2014) examined the effect of creative music therapy (CMT) on premature infants and their parents. According to Haslbeck, "CMT with premature infants and their parents is an interactive, resource- and needs-oriented music therapy approach" (2014, p. 38). CMT is derived from Nordoff-Robbins music therapy, which emphasizes clinical improvisation and builds relationships through musical interaction. The study analyzed the "music" (p. 38) of premature infants, such as their breathing patterns, facial expressions, gestures, and sucking behaviors, along with the musical interventions. Based on parents' availability and willingness, the therapist individually joined the parents in singing to their infant to improve parent-infant bonding. The findings indicated that CMT may empower both parents and infants to self-regulate and to engage in interactions through communicative musicality, such as via smiles which function as a sign of well-being. According to Trevarthen (2008), communicative musicality is

a theory of how human vitality acts, regulates itself, forms intimate relationships and grows in friendships, and also how it defends itself when the physical or social environment is threatening, and how it can be undermined by illness. (p. 37)

In addition to enhancing parent-infant bonding, CMT may also support parents in their own well-being and self-confidence.

Palazzi et al. (2020) studied the contributions of a *Music Therapy Intervention for the Mother-Preterm Infant Dyad* (MUSIP) to mother-preterm infant interactions. They described MUSIP as “a music therapy intervention aimed at sensitizing and supporting the mother to sing to her preterm baby when in a NICU,” based on research in “NICU family-centered music therapy, early vocal contact with preterm infants, infant-directed singing and communicative musicality” (Palazzi et al., p. 339). The protocol educates mothers about their baby’s early skills and the benefits of maternal singing for babies (Palazzi et al., 2019). Participants in the study were a mother and her preterm son who were hospitalized in a Brazilian NICU. The dyad participated in nine sessions of MUSIP, which focused on maternal singing and mother-infant interaction. Four months after discharge, the mother was interviewed, and the mother-infant interaction was observed during two interactional contexts: while breastfeeding and during free interaction with singing. The findings indicated that MUSIP contributed to the mother’s and the infant’s empowerment and mother-infant bonding by using maternal singing as a way to calm the infant during hospitalization and after discharge. Palazzi et al. (2020) speculated that these outcomes might have long-term benefits to the infant's development and parent-infant attachment.

Family-Centered Music Therapy

According to Gooding et al. (2011), family-centered care (FCC) has been widely recognized as an essential part of neonatal intensive care. FCC emphasizes the role of patients' family members in providing emotional, social, and developmental support. Family-centered music therapy not only integrates parents into the therapy, but endeavors to balance the needs of babies, parents, and their relationship (Ettenberger, 2017). Ettenberger (2017) studied the effects of family-centered music therapy on premature infants and their parents. The study was conducted at a family-centered music therapy program in the NICU at a hospital in Bogotá, Colombia. Music therapy was offered daily in the NICU, using an approach based on the RBL model. Findings of the study suggested that family-centered music therapy can help not only to improve the infant's health but also to identify and work with the needs of parents and to support the family system.

Roa and Ettenberger (2018) found that family-centered care supports both infants' and parents' well-being. They studied a music therapy self-care group designed to help parents develop new ways to cope with potential stressors and mental health risks. The group took place twice a week for 30 sessions, with 122 parent participants, in the NICU's breast milk extraction room. The group began with a short verbal introduction and assessed parents' current moods and stressors. Live music therapy was offered, along with musical games, verbal relaxation, and movements. At the end of the session, the music therapist discussed music-assisted self-care techniques that participants could use on their own, including breathing techniques and listening to recorded music. The participating parents highly valued the self-care group, and showed a decrease in perceived levels of anxiety and stress and an improvement in mood, restfulness, and motivation levels.

Yakobson et al. (2021) studied the effects of a combination of family-centered music therapy and skin-to-skin care (SSC) upon premature infants and their parents. In SSC, the “parent holds the infant upright, chest-to-chest, and skin-to-skin” (Yakobson et al., 2020, p. 221). The study used a live music intervention based on the RBL model, within the context of the Newborn Individualized Developmental Care and Assessment Program (NIDCAP), which assesses “premature infants’ developmental status and ability to withstand stress in the NICU before, during, and after caregiving procedures” (Yakobson et al., 2020, p. 221). The results showed improved autonomic stability of premature infants, which may influence neuro-behavioral and psycho-emotional development; and decreased parental anxiety.

Music Therapists’ Experience in the NICU

Although research on the effects of music therapy and family-centered care in the NICU is well developed, limited information exists on music therapists’ experience of working with parents in the NICU (Gooding & Trainor, 2018). Gooding and Trainor (2018) surveyed 54 board-certified music therapists with experience working in the NICU in the United States, exploring the ways that they addressed parents’ needs. The study investigated training factors, work factors, treatment practices, and barriers. Most of the music therapists had had National Institute for Infant & Child Medical Music Therapy (NICU-MT) training or RBL training. Parental anxiety was the most common reason for referral to the parent service, and anxiety reduction was the primary parent goal. When working with parents, 85% of the survey respondents provided educational materials, such as recommended song lists. In parent-only sessions, respondents used parent recordings, parent counseling, and music-assisted relaxation interventions; in sessions with parent and infant together, they used infant-directed singing, developmental music play, and multimodal stimulation. Most respondents stated that the greatest

barriers to service were parents' work schedules and families' inability to visit regularly due to living long distances away. Another barrier was the lack of alignment between music therapists' working hours and parents' visiting hours. The researchers recommended the use of technology, including telehealth and written communication, to address these barriers. Most respondents (77.55%) felt competently trained to work in the NICU, but many felt the need for additional training regarding grief and general counseling skills, parent-specific interventions, and cultural sensitivity, in order to improve parent-therapist interactions (Gooding & Trainor, 2018).

Summary and Rationale for the Study

The hospitalization of infants affects not only the infants but also their parents and family members. Considering the increasing number of premature births and the importance of parent-infant attachment at an early age, there are growing demands to recognize parents' needs and support both parents and infants. Music therapists often communicate and work with parents of infants in the NICU, just as other health care professionals do. There are already many studies addressing the effects of music therapy on premature infants and their parents. However, only a small number of studies have specifically addressed music therapists' experience in the NICU, especially in working with parents. By exploring participants' experiences of working with parents in the NICU, including their challenges and accomplishments, the present study offers insights to other music therapists and interdisciplinary teams and may enhance the quality and safety of the care they provide in the NICU.

Method

Research Design

This qualitative study employed a phenomenological research strategy to identify “the essence of human experience about the phenomenon as described by participants” (Creswell, 2009, p. 13), conducting semi-structured interviews with the participants and extracting themes from their responses through an Interpretative Phenomenological Analysis (IPA). According to Jackson (2016), “phenomenology provides a means of systematically studying...non-qualifiable experiences in order to bring depth and breadth to the human understanding of self, other, and music” (p. 885). This study explored the lived experiences of music therapists working with parents of premature infants in the NICU, which are unique to each music therapist.

The participants were selected through purposive sampling. The selection pool consisted of board-certified music therapists (MT-BCs) who have practiced in a NICU in the United States for at least 2 years. Each participant took part in a virtual semi-structured interview with the researcher. The researcher applied Moustakas’ (1994) modification of van Kaam’s method of IPA to explore common themes reflecting the essence of participants’ lived experience of working with parents in the NICU.

Recruitment

Following approval by the Institutional Review Board (IRB) at Molloy College, the researcher recruited participants through purposive sampling by contacting colleagues who could refer potential participants. An email invitation was sent to potential participants that included information about the purpose and protocols of the study, participants’ right to withdraw from the study at any time without penalty, possible benefits and risks involved in the study, and measures taken to protect participants’ rights. Potential participants were asked to reply to the

email if they were interested in participating. Before the study began, participants provided written informed consent to take part in the study, along with specific permission to have their interview audio- and video-recorded and transcribed for analysis. They were given the opportunity to ask questions or express concerns about the study. They were informed that participation in the study was voluntary, that they could omit any questions during the interview that they preferred not to answer, and that they could end the interview at any time or request to reschedule it.

Participants

The participants were two female music therapists, who were assigned the pseudonyms Diane and Kate to protect their privacy and identity. The inclusion criteria for participants were as follows:

1. Board-Certified Music Therapist (MT-BC)
2. Graduate degree in music therapy
3. Minimum of 2 years of professional working experience as a music therapist in a NICU setting in the United States
4. Experience in working with parents of premature infants in the NICU

Below are brief descriptions of each participant.

Participant #1: Diane

Diane obtained a bachelor's degree in social work and was employed as a social worker for a few years before becoming a music therapist. She has studied singing and voice development and is a credentialed yoga instructor. While working as a social worker, her desire for additional therapeutic training led her to study music therapy; she completed master's and doctoral degrees in music therapy. Diane received RBL training and served as a trainer and

research fellow at the Louis Armstrong Center for Music and Medicine in New York. She now works in a NICU in her native country in the Middle East. In total, she has worked as a music therapist in NICU settings for over 5 years. Diane's primary therapeutic approaches are humanistic music therapy and music psychotherapy. Her experience of practicing music therapy in different sociocultural contexts, and in particular, her role as a pioneer of NICU music therapy research and practice in her home country, informed her perspective on working with the parents of premature infants in the NICU.

Participant #2: Kate

Prior to becoming a music therapist, Kate explored the possibilities of studying psychology, music performance, or theater. She found music therapy by chance and felt that it suited her interests and skills. She obtained a master's degree in music therapy. Initially, she wished to work with veterans from the armed services, but she took an internship at a children's hospital due to circumstances at the time. She discovered that she loved her work there and has been working in children's hospital settings in the United States for over 6 years, serving both children in the pediatric units and premature infants in the NICU. Kate received NICU music therapy training from Jayne Standley, emphasizing neurologic music therapy; however, she also draws upon other approaches, including the RBL model.

Data Collection Procedures

An in-depth, semi-structured individual interview, approximately 45 minutes in duration, was conducted virtually with each participant. The interviews were audio- and video-recorded using the Zoom video conference platform, with additional audio recording on a separate device as a backup. They consisted of open-ended questions based on the main research question: What were the participants' experiences of working with parents in the NICU? Interview questions

included the following: Why and how did they become music therapists and come to work in the NICU? How have they felt about their experiences of working in the NICU, as compared with what they expected at the outset? How did they introduce music therapy to parents in the NICU? What challenges and opportunities did they encounter when working with parents in the NICU? What kinds of music therapy interventions have they used in the NICU? How did they feel, overall, about facilitating music therapy sessions in this setting?

The researcher transcribed each interview. Each participant had an opportunity to check their interview transcript for accuracy and completeness and provide feedback to the researcher during a follow-up meeting which lasted approximately 30 minutes. Follow-up questions or comments based on the interview were also brought up during this meeting. All video files, audio files, and transcriptions were kept on a personal password-protected computer in the sole possession of the researcher.

Data Analysis

To conduct an IPA, the researcher followed the guidelines of Moustakas' (1994) modification of van Kaam's method of phenomenological data analysis, consisting of the following steps:

1. Horizontalization. After completing and transcribing the interviews, the researcher followed this first step of the analysis. Horizontalization is defined as "listing every expression relevant to the experience" (Moustakas, 1994, p. 136). The researcher read each participant's transcript several times and listed each statement that appeared meaningful, following Moustakas' (1994) principle: "Each statement holds equal value and contributes to an understanding of the nature and meaning" of the experience (pp. 137-138). In the process of horizontalization, a total of 225 participant statements were listed.

2. *Reduction and Elimination.* In this second step, the researcher asked two questions regarding each statement listed, as required by Moustakas' (1994) method: "(a) Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?; and (b) Is it possible to abstract and label it?" (p. 136). If the answer was no, the researcher eliminated the statement. Repeated statements were also deleted. After this process of reduction and elimination, 146 statements remained, which were considered "invariant constituents" (p. 136).

3. *Clustering and Thematizing the Invariant Constituents.* The third step was to cluster the invariant constituents and identify the themes that expressed each participant's experience of working with the parents of premature infants in the NICU. The researcher used a color-coding strategy to organize statements into categories by similarity. Significant words and phrases were highlighted through bold text. Through this process, collective themes were identified.

4. *Final Identification of the Invariant Constituents and Themes by Application.* After generating themes, the researcher compared them with the interview transcripts to check whether those themes were representative of the participants' experiences. After this procedure was applied, six common themes remained, including (a) witnessing parents' difficulties and providing support, (b) music therapy advocacy, (c) serving as a bridge between parents and their babies, (d) utilizing various interventions, (e) mediating between parents and medical staff, and (f) setting boundaries.

5. *Create Individual Textural Descriptions.* The researcher re-read each transcript with a focus on the bolded text, which highlighted significant words or statements of each participant. The researcher selected verbatim excerpts from the transcripts to develop individual textural descriptions of "what" was experienced by each participant in connection with each theme.

6. *Create Individual Structural Descriptions.* The researcher created individual structural descriptions in relation to each theme, which focused on aspects of the context or setting that influenced “how” each participant perceived and experienced their work with parents in the NICU.

7. *Create Textural-Structural Descriptions.* In this step, the researcher combined the textural and structural descriptions for each participant in relation to the emergent themes, creating a narrative of each participant’s perceptions and experiences in the specific context of their work with parents in the NICU.

8. *Composite Descriptions.* In the final step of analysis, the researcher integrated the textural-structural descriptions across participants to generate “a synthesis of the meanings and essences of the experience” (Moustakas, 1994, p. 159).

Materials

For this study, the built-in recording function within the Zoom video conference software was used to record the interviews and follow-up meetings with the participants. The digital voice recording application Voice Memos on the researcher’s iPhone was used for backup audio recording. Each video recording was saved to the researcher’s password-protected computer, and each audio recording was saved to the Voice Memos application on the researcher’s password-protected iPhone.

Data Protection Procedures

Each participant was given a private link to attend their virtual interview via Zoom. The researcher used the waiting room function of Zoom in order to control the entry of participants into the interview. Interviews were scheduled at each participant’s convenience, at a time when both the participant and the researcher were able to attend from private locations with minimal

disturbance. The audio and video files from each interview, the interview transcripts, all information disclosed by participants during the informed consent process, and all materials generated during data analysis were stored on the researcher's password-protected computer, in the sole possession of the researcher. The researcher, her thesis committee, and the Molloy College IRB had sole access to the data. Once transcription and member-checking were completed, the audio and video files from each interview as well as follow-up meeting were electronically destroyed. All other data will be kept in secure storage for at least 3 years following the completion of this study. Participants' anonymity was maintained through the use of pseudonyms throughout the transcription of interviews, analysis of data, and preparation of findings. Any potentially identifying information within the interview responses was adjusted to preserve participant anonymity.

Trustworthiness

The researcher utilized member checking, peer debriefing, and bracketing to support the trustworthiness of the study (Creswell, 2009; Moustakas, 1994).

Member Checking

Member checking was used to verify the accuracy and completeness of the interview transcriptions and to invite participants' open-ended feedback on the researcher's analysis and specific descriptions of themes emerging from the interviews (Creswell, 2009). The researcher held a virtual follow-up meeting with each participant to share interview transcriptions for participants to review, invite participants' feedback, and ask follow-up questions based upon the initial interview.

Peer Debriefing

Peer debriefing was used to strengthen the credibility of the researcher's analysis of the interviews and description of themes (Creswell, 2009). A peer music therapist who had no connection with the study reviewed the data analysis and had the opportunity to ask questions and provide feedback to the researcher.

Bracketing

Moustakas (1994) described bracketing as a strategy to promote trustworthiness: "The focus of the research is placed in brackets; everything else is set aside so that the entire research process is rooted solely on the topic and question" (p. 111). Throughout the research process, the researcher kept a research journal to aid in bracketing by acknowledging and articulating her own thoughts, feelings, and interpretations, as distinct from the participants' experiences which constituted the subject of investigation.

Results

The purpose of this study was to explore music therapists' experiences of working with the parents of premature infants in the NICU and their perceptions of how music therapy could meet the needs of these parents. Two female music therapists, who were assigned the pseudonyms Diane and Kate, participated in the study. One-time individual interviews were conducted with each of them, consisting of questions ranging from general experience in the NICU to specific experiences of working with the parents of premature infants. Each interview was transcribed and confirmed with the participants in a follow-up meeting. This chapter briefly describes the participants' histories and presents findings from the data gathered through the semi-structured interviews and follow-up meetings. The analysis was guided by Moustakas' (1994) modification of van Kaam's method of phenomenological data analysis. A summary of the common themes across participants is provided.

As outlined above, Moustakas' (1994) modification of van Kaam's method of phenomenological data analysis consists of the following steps: horizontalization, reduction and elimination, clustering and thematizing, checking the themes against the data, textural description, structural description, textural-structural synthesis, and composite description of the meanings and essences of the experiences (Moustakas, 1994). According to the principles of phenomenological research, "understanding of a phenomenon relies on interpretations of the individual experiencing the phenomenon" (Jackson, 2016, p. 885). The findings consist of participants' experiences with the parents of premature infants in the NICU.

Each participant had unique experiences in working with parents of premature infants in the NICU. However, a comparison of their experiences revealed notable commonalities. Finding the essences across these participants' experiences was the final step of phenomenological

analysis, which required synthesizing all individual textural-structural descriptions to “develop a composite description of the meanings and essences of the experience, representing the group as a whole” (Moustakas, 1994, p. 136). Common themes found across the participants’ experiences included (a) witnessing parents’ difficulties and providing support, (b) music therapy advocacy, (c) serving as a bridge between parents and their babies, (d) utilizing various interventions, (e) mediating between parents and medical staff, and (f) setting boundaries. (See Table 1.)

Table 1*Themes Across Participants*

Themes	Participants’ statements and examples
Witnessing parents’ difficulties and providing support	<p>“[We] witness and sometimes go through patients’ procedures together.” (Diane)</p> <p>“Parents describe NICU experiences as one of the most stressful events in their life.” (Kate)</p>
Music therapy advocacy	<p>Introducing music therapy to parents and professionals (Diane & Kate)</p> <p>Sharing helpful information regarding music and babies’ development (Diane & Kate)</p>
Serving as a bridge between parents and their babies	<p>Family-centered care (Diane & Kate)</p> <p>Skin-to-skin care (Diane & Kate)</p>
Utilizing various interventions	<p>RBL & NIDCAP models (Diane)</p> <p>MMS & RBL models (Kate)</p>
Mediating between parents and medical staff	<p>“When you help explain parents’ stories to the staff, it’s helpful for them and the mother.” (Diane)</p> <p>“Parents are willing to share more with me. They’re willing to open up more [than to medical staff].” (Kate)</p>
Setting boundaries	<p>The need to set boundaries between work and personal life (Diane & Kate)</p> <p>Setting boundaries between previous work as a social worker and current work as a music therapist (Diane)</p> <p>Setting emotions aside (Diane & Kate):</p>

“I compartmentalize because I understand my role is to be there as a professional.” (Kate)

Common Theme #1: Witnessing Parents’ Difficulties and Providing Support

The participants agreed that even though there were differences in degree, the parents’ experiences of dealing with their babies’ hospitalization were intensely challenging. As music therapists, the participants witnessed and underwent many of those experiences together with the parents, as other NICU staff did. When asked about her overall experience of working in the NICU, Diane described the NICU as a highly sensitive environment involving complex challenges: “It’s working with people in a very sensitive stage. So, there can be difficulties, whether [the parents] have difficulties – finding it hard to express – or just viewing and *containing this heaviness*.” When asked about the specific meaning of *heaviness*, Diane responded, “Now you say *heaviness*, I also think about the *heaven-ness*, like from heaven. It’s like a very complex situation.” She described the experience of working with parents in the NICU as moving between heavy and heavenly moments. The pervasive heavy moments included hearing babies crying from pain, seeing parents in anguish, and working with exhausted and burned-out staff. Diane stated, “You contain...a lot of other people’s frustrations and worries. ... There were some infants born in severe condition. So, it was known that they wouldn’t survive. Maybe there was a rise of hope that something will get better and eventually did not.” She shared that she had experienced working with infants who survived for only a month or so, stating, “When you work in the NICU, eventually, it happens. You come across it.” The contrasting “heavenly” moments were characterized by such experiences as inspiring music, parents holding their baby, and shared feelings of intimacy, happiness, and love. Diane described these moments as heaven: “You would have moments of really pure love, or happiness – *heaven-ness*.”

The specific work experience of Kate, and her efforts to acknowledge and reduce parents' hardships, informed her perspective on working with parents of premature infants in the NICU. Kate discussed her efforts to assist parents in overcoming barriers to accessing services during their infants' hospitalization, including language barriers, difficulties in scheduling sessions, and financial barriers. There was a very high concentration of families who spoke only Spanish receiving services at her workplace, and Kate shared, "I spent a year and a half working an hour a day with a private tutor to learn Spanish to work with them." She also faced challenges in scheduling sessions with the parents due to the limited number of music therapists working in the NICU and the requirements of parents' work schedules. In regard to parents' financial challenges, Kate explained that most parents in the NICU where she worked were not documented citizens, so they did not qualify for any public insurance and usually did not have private insurance. However, she was funded through a health foundation, so she did not charge for music therapy services in the hospital. She stated, "When I started the program, that was important to me, because I did not want *not* to provide [music therapy] to someone because their insurance doesn't cover it." Kate systematically considered possible challenges for parents and tried to work things out so that more parents and babies could receive music therapy services.

Kate also observed that parents' response to the challenges of their babies' hospitalization depended on how well the baby did and whether parents acknowledged the need for their baby's hospitalization beforehand and could prepare for it. Even though the experience was different for every parent, many parents later expressed to Kate that it was one of their most stressful times. She described the annual reunion for previous graduates and their families at the NICU where she worked. At the reunion, parents always expressed gratitude to the whole staff and said that being in the NICU was just "difficult." Kate shared, "I think, as most people do in difficult

situations, they do what they need to do when they rise to it. But it ends up being a tough experience.” She acknowledged that some days were extremely challenging. When she witnessed the death of many patients, especially those she had worked with for a long time, she stated, “It is super hard.”

Common Theme #2: Music Therapy Advocacy

The common theme of music therapy advocacy consisted of two subthemes: *Music Therapy Advocacy to Parents*, and *Music Therapy Advocacy to Other Professionals*.

Music Therapy Advocacy to Parents

Both participants found that most parents in the NICU did not appear to be familiar with music therapy. When asked how she introduced music therapy to parents, Diane shared that she began her work with parents by introducing music therapy “in a nutshell,” then proceeded to describe music therapy in the hospital context, and then specifically explained music therapy in the NICU. She emphasized, “In the NICU, I say that we work with babies, parents, and the environment all together. And we use music to work either on pain or to support medical procedures, but also to work on everything related to interaction, human attachment, and bonding.” Many parents asked questions about topics such as the relationship of music to cognitive stimulation and brain development. In reply, she “explained to them how it is important for their babies to hear their voices.”

Diane said that she tried to leave the conversation open when explaining music therapy interventions to the parents. She might discuss with them different types of music, songs of kin, and their musical preferences or heritage. She shared specific examples of barriers to providing music therapy services to some families, such as religious restrictions that only allowed the use of music for specific religious purposes or prohibited females from singing. After sharing these

examples, Diane expressed the view that hospitals could be “a bridge above all of this religious discourse” because they dealt with health: “In [my country], hospitals are the best example of how people [of different religious and cultural backgrounds] can work together equally. ... This situation of the NICU, most of the time, passes all other circumstances.”

Kate shared the script that she used when introducing music therapy to parents. The script included appropriate interventions for the infant’s developmental stage, such as infant massage, recording songs for the infant to listen to, or providing live music while parents held their infant. She said she tried to keep her explanation casual so that parents did not find it intimidating. When asked about parents' responses to her introduction of music therapy, Kate replied, “Some parents ask questions such as ‘How does that help?’, and others don’t care as much about the science behind it. They don’t need to understand the science if they can see its value.”

Kate put considerable effort into educating parents in the NICU, trying to address barriers to music therapy and their fear of taking care of their babies. She shared that many parents were afraid of singing to their babies and thought they needed musical talent to engage in music therapy with their babies. She stated, “I think that’s a music therapy challenge in general, not just in the NICU – but that’ll be a big thing.” Kate explained that music therapists take on the role of an educator who shares helpful information with parents regarding music therapy and infant development “because it’s so different than what they know; everybody thinks classical music is what premature babies need, and that is not true.” She gave examples of parent education through music therapy:

[Music therapy] also teaches the parents...what their babies’ overstimulation signs are, and how their babies are communicating with them. ... Music therapy is one of the only disciplines that does that type of teaching ... [giving] examples and doing live music

while they're holding, so they can hear what types of songs are appropriate, what types of volumes are appropriate, and what's going to be helpful for their babies in terms of music.”

Kate shared that most parents were very open to music therapy, but sometimes parents declined further sessions after receiving one or two. She felt that this was because the parents were comfortable continuing musical interventions with their infant on their own, and not because they disliked music therapy. She stated, “By that point, I've already educated them: ‘Okay, so you'll do it for 20 minutes at a time.’ Or, ‘If you notice your baby's overstimulation signs, just pull it back.’”

Kate also shared that the parents in the NICU could be terrified of touching or holding their baby, especially when the baby was the firstborn child. She identified possible reasons: parents did not want to hurt their babies, and they were uncomfortable with touching their babies. She noted that the hospital where she was employed focused on family-integrated care, and they encouraged parents to do everything they could do on their own; thus, parents did not stay scared for long. She stated, “If I could give [parents] the confidence to feel like they could be an active member of the care team – thumbs up [thumbs up gesture].” However, Kate also emphasized that parents could feel challenged by the large volume of information they were receiving. She pointed out the need to assure parents that offering them education and suggestions did not imply that they were doing anything wrong.

Music Therapy Advocacy to Other Professionals

Diane explored her role as a music therapy pioneer in the NICU in her home country, following her specialized NICU training in the United States. After a few years of working as a music therapist in the United States, Diane returned to her home country and established music

therapy services in a NICU, which involved advocacy of music therapy to interdisciplinary medical staff. She shared that music therapy was well developed in her home country in the areas of special education, psychiatry, and geriatrics, but was not commonly practiced in hospital settings. She added that in the hospital care of younger patients, at the time of her return, music therapists worked only in pediatrics and pediatric specialties, and not in neonatal care. They were employed through the ministry of education, which takes care of children above the age of 3. Babies under 3 and preterm infants were “falling between the chairs.” Diane described her experience of pioneering music therapy in the NICU:

When I came back, I started a collaboration with a neonatologist who was the vice-manager of the NICU at that time. He conducted several music medicine studies on the use of music for preterm infants and their parents. This is how we initiated my PhD study with the final aim of implementing a music therapy service at the NICU. So, this was the first time that we had music therapy in a NICU [in my home country].

Diane was also involved in conducting other music therapy studies, including a multi-site longitudinal study on music therapy for preterm infants and their parents in the NICU. She shared that music therapy services were expanded as a result of those studies; hospitals employed additional music therapists and began taking music therapy interns in the NICU.

Kate’s experiences of working in the NICU demonstrated the importance of continuous advocacy to other healthcare staff for music therapy services to preterm infants and their parents. She described advocating for herself and music therapy as one of the significant challenges in her work experience. Kate had not expected that she would need to continually explain herself and music therapy to staff: “Even after being here for 6 years, there are nurses I’ve worked with for 6 years who will be like, wait a minute, what? Or why? ... So, always advocating.” In the case

of the families of preterm infants, Kate understood the need to advocate, since many of them did not know about music therapy. However, she said she had not realized how much of her day would be spent explaining what music therapy was to her colleagues as well as to the families.

Common Theme #3: Serving as a Bridge Between Parents and Their Babies

Both participants utilized family-centered care in the NICU and felt that having sessions with infants and parents together was essential. They offered music therapy with skin-to-skin care, an intervention that provides live music while parents hold their babies skin-to-skin or touch their babies in the incubator. Diane reflected on the meaning of skin-to-skin care in music therapy and the music therapist's role during the session: "When doing music therapy in the skin-to-skin, for example, the parents put their hands on the infants, which is in an incubator; and you help them, you support them through music to interact with their baby. I think it's beneficial for each one on their own."

In the hospital where Kate was employed, each mother and her baby stayed together in a private room, so they usually received music therapy sessions together. She stated, "Almost all my interventions I do *with* the parents, so we add live music to skin-to-skin holding. ... We push that a lot in our hospital. We are very developmentally based, and we don't just focus on the medical aspect." Kate regarded parents' involvement in their infants' music therapy as essential for both parents and infants. She found that parents tended to respond well and enjoy music therapy because it gave them a chance to feel close to their babies. She shared, "I've had many parents tell me that it's the first time they felt like they could really do something in a situation where they can't do quite as much right yet." She valued music activities that supported babies' attainment of developmental milestones, as these helped parents use music to continue enhancing their babies' development even when they returned home. This bolstered parents' confidence and

enhanced their knowledge about their baby's development and communication, leading them to "spend more time appropriately interacting with their baby and less overstimulating them. ... I think music therapy would be very effective. ... It's therapeutic for the parents as well, like they have power, feeling like they can be helpful in a situation where otherwise there's sometimes not a lot they can do."

The participants recognized the need for parental care in the NICU but did not feel the need for individual music therapy sessions with parents alone. Diane felt that parents came to the NICU to be with their baby as much as possible, so that each part of the dyad in parent-infant care could "heal from the preterm birth and the hospitalization." Diane stated, "When [the parents] are in such a sensitive period, whatever happens to them, it's about the baby." Kate acknowledged that there was a vast need for parental support. Still, she was unsure whether individual music therapy for parents fit into the NICU's services, since a counselor had been hired to work with the parents, and the social worker also provided parents with therapy and support. Kate said, "Parents themselves, like, separate from their babies... I don't do as much with music therapy; [instead, more] empathetic listening or offering emotional support. But I'm not actively using music through those interventions. More as... just in the sense of rapport building, and things like that."

Common Theme #4: Utilizing Various Interventions

Both participants applied a range of music therapy interventions and developmental models to their work. Diane shared two models of practice that she used in the NICU. First, she discussed the RBL model she had studied in New York. Diane compared her work with mothers of premature infants in the NICU in New York 5 years earlier and her present work in her home country. She stated, "I *grew* [with emphasis, using a forward hand movement] as a therapist and

person. ... But still, it's the same principles." Within the RBL model, she used the song of kin and ocean disc interventions many times with parents, infants, and staff. The second model of practice Diane discussed was the interdisciplinary Newborn Individualized Developmental Care and Assessment Program (NIDCAP) model, which was developed by a neuropsychologist. She explained that this model is the gold standard for developmental care in treating infants and their parents. The various members of her interdisciplinary team at the NICU collaboratively implemented this model and valued the role of music therapy within it. Diane stated, "This is why it's such a special place that opens their hands to music therapy, because of understanding the importance of supporting preterm infants and parents." She added that the RBL and NIDCAP models shared common family-centered care and sensory regulation principles and provided music interventions according to the needs of the infants, parents, and the environment.

When asked about her music therapy interventions in the NICU, Kate replied that her NICU training was based on neurologic music therapy. However, she said, "I don't just follow one 'type' [using finger quotes] of music therapy." She considered it more important to understand "all of them and use what's going to be most effective with the patient or family." One method she used was Jane Standley's Multimodal Neurological Enhancement (MNE), which combines singing, rocking, and baby massage. She explained that this method was supposed to help babies learn to deal with multiple types of stimulation and also taught parents about their babies' overstimulation signs. Since occupational therapists, physical therapists, and speech therapists provided a different type of baby massage for physical alignment, Kate offered MNE as a uniquely integrative intervention. When parents were not present, she took the baby out of the incubator, held them, and sang. Another intervention she used was to provide recorded

music, including lullabies, that babies could hear when their parents were not present or while their parents were holding them. She also applied the RBL model and song of kin in sessions.

Common Theme #5: Mediating Between Parents and Medical Staff

The participants' interview responses indicated that music therapists could connect parents and medical staff by helping to share each side's positions in order to view the situation from a broader perspective. Diane stated that parents shared with her their primary challenges in their parental role. She said, "Having the baby being taken away, and the responsibility is on the medical staff ... I've heard many parents deal with this process. It takes time to filter their own need to ask for permission to take the baby out of the incubator; or how do you negotiate medical procedures or the way this nurse handled my baby, or the other nurse is gentler?" Diane viewed the music therapist as a "moderator between patients and medical staff," and also – along with other therapists, psychologists, and social workers – as a place to ventilate, for both staff and parents. Diane said, "You can explain emotional dynamics or psychological causes, bring the patient's voice or see other abilities ... so that staff could be more empathetic and understand the situation, because the staff sees the baby's needs." She emphasized, "When you take care of the parents, you take care of the infants, and vice versa."

Kate also perceived the therapist's role as a bridge, "almost like a liaison, because a lot of times, [parents] will say things to me; they might not talk to 'medical staff' [with finger quotes several times]. This is very important." She elaborated:

Parents have a good relationship with the medical staff. But I do think, in many ways, that they are more comfortable with me as the music therapist because they don't quite view me as much [of] a medical professional. Like I don't give them bad news, I don't tell them if their baby is doing well or poorly. ... This can be good and bad. Because they

are willing to share a lot more with me, but then sometimes they don't take me quite as seriously.

Common Theme #6: Setting Boundaries

Both participants consciously tried to set boundaries between their work and personal life and put their emotions aside in the session. Diane described her experience in the NICU as “tough,” stating, “I tried to contain the happenings and to work on myself, not burying it with me and taking it from work” [using hand gestures toward herself]. Prior to becoming a music therapist, Diane had been employed as a social worker. When asked how her social work experience affected her current work as a music therapist, she shared that she found it helpful to take a holistic approach and see each situation as a whole, based on all of her professional experience. At the same time, she tried to maintain her professional boundaries and avoid doing anything related to social work in her position as a music therapist. In regard to her personal well-being, Diane shared that she took care of herself and her family by making music for herself and communicating with family, friends, and colleagues. She stated, “We help a lot each other. I vent a lot to my colleagues, and the social worker calls me every day.” Also, she belonged to an “emotional team” at work, including a psychologist and social worker who recently started a support group for the staff.

In regard to setting emotional boundaries, Kate stated, “If it's a bereavement, I compartmentalize because I understand my role is to be there as a professional and execute my job as a music therapist. Even in difficult situations, I'm able to push that aside. And when I'm not at work, I do many things that just bring me joy.” She shared that she did not give out personal contact information to the parents; she gave them only her work email, so that she could

set boundaries and not be constantly immersed in work. When asked how she dealt with difficult times, Kate shared an example from her experience of working in a hospice setting:

We would put on the funeral if the families wanted us to, and probably sang at two or three funerals a week. When I'm in the front of the church, singing for these people's loved ones, there's so much emotion in the room. If I couldn't set it aside, then I couldn't sing the songs I needed to sing.

Kate added that she had to learn quickly how to deal with and focus on intensely emotional sessions in that setting. She also shared her thoughts on the need for each music therapist to find a suitable setting in which to work:

That is something to consider ... not every setting is ideal for every person, even as a professional. You do see people who make it, and [it's] too hard for some people. And if that's too hard, then that's okay. You don't have to figure it out. ... You just be a good professional in a different setting where you may not have to deal with those things. ... It is just finding your boundaries, how you can deal with them; and if you can't deal with it, then find the setting where you can be more nurturing to yourself.

Discussion

This phenomenological study explored music therapists' experiences and perceptions of their work with the parents of premature infants in the NICU and various ways that music therapy can meet the needs of these parents. Interpretative Phenomenological Analysis using Moustakas's modified van Kaam Method (1994) yielded six common themes across the participants' responses: (a) witnessing parents' difficulties and providing support, (b) music therapy advocacy, (c) serving as a bridge between parents and their babies, (d) utilizing various interventions, (e) mediating between parents and medical staff, and (f) setting boundaries. This chapter offers a discussion of these findings and their relationship to the findings of previous studies. It also presents the limitations of the study, followed by its implications for music therapy practice and recommendations for future research.

Discussion of Common Themes

This section will compare and contrast the findings of this study with prior research related to each of the common themes listed above.

Witnessing Parents' Difficulties and Providing Support

While working in the NICU, music therapists observe and engage with clients in many different circumstances; for example, they often accompany premature infants during procedures, together with medical staff, and sometimes care for premature infants and their families not only during hospitalization but also after discharge. Diane described working in the NICU as containing *heaviness*, in the sense of working in a highly sensitive environment and working with highly sensitive premature infants and parents. Music therapists, along with other NICU staff, witness a wide range of critical events and interventions during the hospital stays of premature infants and their families, and this could lead to burnout (Gooding, 2019; Profit et al.,

2014). Profit et al. (2014) explained that in health care, stress results from frequent intense interactions with clients with complex problems. According to Gooding (2019), music therapists have high levels of compassion for others and may experience more burnout than other mental health workers due to emotional exhaustion.

Alongside *heaviness*, Diane also experienced contrasting moments of “*heaven-ness*” in music therapy, characterized by shared feelings of happiness and love. The spiritual quality of this experience, which appeared to be rooted in Diane’s holistic worldview, aligns with Marom’s (2004) findings that music therapists may play “a key role in spiritual moments in music therapy, regardless of whether or not they were in the center of experience” (p. 65).

Kate observed that parents experienced many challenges during their baby’s hospitalization, including language issues, lack of insurance, and barriers to scheduling music therapy sessions. Similar challenges were reported by music therapists in the study of Gooding and Trainor (2018) cited above. The majority of their survey participants identified parents’ inability to visit the NICU regularly due to living long distances away, along with lack of alignment between parent visitation hours and music therapists’ working hours, as barriers to service (Gooding & Trainor, 2018). In the present study, Kate recognized barriers to service and tried to support the parents in overcoming them, for instance, by learning Spanish to communicate with Spanish-speaking families.

Both participants observed that parents’ experience during their baby’s hospitalization appeared to be overwhelmingly difficult and stressful. After the baby’s discharge, parents occasionally kept in touch with them to share their baby’s growth and reflect on the multiple challenges they had faced during hospitalization. This finding is consistent with the findings of previous studies addressing parental needs in the NICU (Beck & Woynar, 2017; Cleveland,

2008; Gooding & Trainor, 2018; Heermann et al., 2005). Gooding and Trainor (2018) addressed multiple parental concerns, including (a) non-musical concerns, such as coping with the stressful environment and limited and confusing information; and (b) musical concerns, such as parent singing ability, appropriate musical selections and volume level, and the possibility of overstimulation. Cleveland (2008) also described a variety parental needs and behavioral supports to assist parents in meeting these needs.

Both participants affirmed the need for parental care in the NICU and applied family-centered music therapy by including infants and parents together in music therapy sessions. These findings are supported by Loewy's findings (2013, 2015) regarding the beneficial effects of parents' singing to their babies. Participants in the present study also regularly applied skin-to-skin care in their music therapy sessions. This is directly aligned with previous findings by Standley (1998, 2003) and Whipple (2000) regarding the beneficial effects of stimulation techniques such as using music to support skin-to-skin contact and parent massage for infants.

By contrast, Roa and Ettenberger's approach (2018) applied family-centered music therapy by addressing parents' needs separately from their babies' treatment, with culturally sensitive interventions aimed at improving parental mental health. In the current study, the participants perceived that the parents visit the NICU mainly to spend as much time with their babies as possible, and that there were already other health professionals working with the parents to address their personal needs. Depending on arrangements within the hospital and therapists' rationales for intervention, thus, it appears that family-centered music therapy can be applied in different ways but with the consistent goal of supporting infants and parents.

Music Therapy Advocacy

Both participants explored their experiences of music therapy advocacy to parents and other professionals.

Music Therapy Advocacy to Parents. Music therapy advocacy in the NICU involved educating parents on music therapy interventions and the potential benefits of those interventions for the development of their babies. The participants introduced music therapy to parents and offered developmentally appropriate interventions considering their infant's age. Similarly, in the study of Gooding and Trainor (2018), music therapists provided educational materials for parents related to music therapy and music therapy interventions. Whipple (2000) demonstrated the importance of educating parents about appropriate music techniques. Participants in the present study supported parents who were not familiar with the role of parenting – including many who were afraid of touching their baby – by providing suitable interventions and enabling parents to understand and apply these interventions themselves.

Music Therapy Advocacy to Other Professionals. Kate shared that the need to advocate continuously for music therapy in her dealings with colleagues was one of her primary challenges at work. Even after they had worked together for several years, there were still many staff members who did not understand what music therapy was or how it worked. Similarly, Gooding and Trainor (2018) reported that one of the barriers to music therapists' service was a lack of staff understanding regarding the impact of music therapy on parent needs. Chang (2014) also found that the need for ongoing advocacy and education regarding music therapy in professional settings, due to widespread lack of understanding, was a challenge for music therapists that could cause feelings of frustration and lead to burnout.

Although many studies have demonstrated the effects of music therapy on premature infants and families (Gooding et al., 2011; Haslbeck, 2014; Loewy et al., 2013; Palazzi et al.,

2020; Shoemark & Hanson-Abromeit, 2015; Standley, 2003; Whipple, 2000), there are still many hospitals and communities in which NICU music therapy is not available. Diane acted as a music therapy pioneer and established the first music therapy program in a NICU in her home country. Moreover, she continually expanded her work both locally and internationally with other music therapists and professionals from other disciplines, and began to take music therapy interns in the NICU. According to the Certification Board for Music Therapists (CBMT, n.d.), one of the music therapist's roles is continuous public advocacy, so that more people acknowledge the benefits of music therapy to various populations, including premature infants, and more people have access to services. More widespread recognition of music therapy's benefits by professionals of various disciplines, as well as the general public, will lead to increased availability of funding for music therapy services and employment opportunities (CBMT, n.d.)

Serving as a Bridge Between Parents and Their Babies

Music therapists assist and support parents in interacting with their babies in and out of the music therapy session. One of the struggles faced by parents in the NICU is establishing parent-infant bonding, especially with the firstborn child. Both participants in the present study practiced family-centered music therapy, which directly involved parents in each session. They facilitated music therapy with skin-to-skin care, giving parents an opportunity to hold or touch their babies skin-to-skin while using music to support their increased interaction with their babies. The experiences of the participants support previous research findings that music therapy with skin-to-skin care promotes parent-infant bonding (Standley, 2013; Whipple, 2000; Yakobson et al., 2020).

The participants also encouraged parents by educating them on developmentally appropriate interventions that they could continue using with their babies after returning home. Learning such interventions gives parents confidence and enables them to provide more appropriate care for their babies. Findings of this study support previous research findings regarding the importance of addressing parents' needs during their babies' NICU stays (Beck & Woynar, 2017; Cleveland, 2008; Heermann et al., 2005), including the need for accurate medical and developmental information, enhanced confidence in taking care of their babies, and cultivation of a healthy bond with their babies.

Utilizing Various Interventions

In the NICU setting, music therapists may select from a variety of interventions according to the NICU training they received, their treatment rationale, or other factors. Participants in this study had received different NICU trainings, but they were similarly flexible in incorporating various methodological approaches in their sessions. Diane incorporated the RBL music therapy model, skin-to-skin care, and the interdisciplinary NIDCAP developmental model in her sessions. According to Yakobson et al. (2021), in a NIDCAP-certified NICU, music therapy may be integrated with skin-to-skin care within multi-sensory family-centered care. In her pioneering interdisciplinary collaborations, Diane not only communicated with other medical staff but also advocated for music therapy in her discussions with them. Her work demonstrated that the more professionals collaborate in developing and implementing methods and models of practice, the more fully they can understand each other's work.

Kate incorporated the MMS and RBL models in her work, depending on the session. By trying to select appropriate interventions in each session, she came to know the most effective approach for each premature infant and parent. Benefits of music therapy to premature infants

have been found for both the MMS and RBL models (Loewy, 2013, 2015; Standley, 1998). As earlier discussed, Standley (1998) found that lullaby singing and multimodal stimulation with music (MMS) benefited premature infants' daily weight gain and tolerance for stimulation. Loewy (2013, 2015) indicated that song of kin might improve infants' vital signs and bonding within infant-parent dyads and triads.

Mediating Between Parents and Medical Staff

Since medical staff are usually more focused on the premature infants' needs, music therapists can help to illuminate different perspectives and possibilities by communicating with the parents and sharing parents' concerns with the staff, thereby promoting integrated care for both parents and babies. This role of music therapists in the NICU was identified as a common theme of *mediating between parents and medical staff*. The participants expressed that mothers are often intimidated by nurses and the NICU environment and require some time to familiarize themselves with their newborn baby. Similarly, Heermann et al. (2005) found that it was challenging for mothers to adjust to the NICU environment, with its pervasive noise and lack of privacy; to develop a sense of ownership of their baby; and to negotiate with nurses to take control of caregiving. Fenwick et al. (2001) indicated that mothers "struggled to mother" (p. 49) due to power struggles with nurses, and thus tended to feel unimportant and unempowered to care for their babies.

Participants in the present study shared that the parents appeared less intimidated by music therapists than medical staff, and more willing to express their concerns and feelings to music therapists. Parents possibly felt more comfortable with music therapists because music therapists do not deliver bad or critical news as medical staff members do. On the other hand, as Kate observed, parents at times did not take music therapists as seriously as medical staff or give

them adequate credit for their professional expertise. Therefore, a deeper understanding of the role and position of music therapists in the hospital is needed.

Setting Boundaries

As a witness, advocate and educator, bridge, and mediator, a music therapist may play several roles in the NICU. The common theme of *setting boundaries* emerged through exploring ways in which music therapists take care of themselves amidst the demands of these multiple roles. The study participants shared that although they enjoyed their job, they faced significant stress. Similarly, Gooding (2019) found that music therapists are typically satisfied with their jobs but may experience more burnout than other mental health workers, specifically related to emotional exhaustion. Occupational stressors, according to Gooding (2019), result in stress-related physical and mental health outcomes for music therapists, such as burnout. Self-care strategies may promote resilience in the face of stress, allowing music therapists to continue their careers despite challenges (Gooding, 2019). In the present study, participants used peer and family support, musicing, and the setting of boundaries as means of self-care. They described their efforts to set boundaries between their work and life, as well as between their previous and current occupations. Since Diane had been employed as a social worker before becoming a music therapist, she understood the perspectives of both professions and valued her ability to see her job in a broader, more holistic context, but she made a conscious effort not to take on the tasks of a social worker in her current work. Both participants tried to avoid carrying emotions into and out of sessions, which involved (a) not bringing emotions from a session out of the session; and (b) remaining focused upon and attuned to the client's emotions during a session, while being mindful of their own personal emotional reactions which could influence the session.

Limitations

One limitation of the study was the inherent lack of diversity due to the inclusion of only two participants. Both participants were females; the inclusion of male music therapists in the study would have expanded the scope of its findings. Also, the inclusion of additional participants could have enhanced diversity in regard to participants' NICU trainings, therapy approaches, and choice of interventions. The participants had different NICU trainings but were similar in their choice of interventions, especially skin-to-skin care. Increased diversity in music therapy practice among participants would have broadened the range of their experiences, perceptions, and rationales in working with parents in the NICU.

Implications for Music Therapy Practice

This study afforded opportunities for music therapists to share their experiences of working with parents of premature infants in the NICU. Common themes were extracted to describe the essence of the music therapists' lived experiences. Many previous studies have presented the effects of music therapy on premature infants and parents in the NICU (Loewy, 2015; Palazzi et al., 2020; Shoemark & Hanson-Abromeit, 2015; Standley, 2003). The present study adds to the relatively limited past research examining music therapists' experiences in the NICU. By examining music therapists' experience of working with parents in the NICU and exploring parents' experiences in the NICU as perceived by the music therapists, this study contributes to a more integrated understanding of music therapy in the NICU.

Recommendations for Future Research

Considering that music therapists' experiences are closely related to patient and family care, the findings of this study yield a recommendation for future research into staff needs as well as patient/family needs in order to provide high-quality clinical care in the NICU. Future

studies may include a larger sample size to gain a more comprehensive understanding of music therapists' experiences in the NICU, along with parents' experiences as perceived by music therapists. A larger sample would permit greater diversity with respect to such factors as gender, race, and ethnicity; NICU training and therapy approach; and socioeconomic and cultural contexts of practice. Studies could be designed to examine in depth the role and position of music therapists in the hospital setting. Future research could incorporate mixed methods, including survey investigations, to create a fuller picture of music therapists' perspectives on working in the NICU, which directly influences clinical care.

According to Aleksiene and Lesinskiene (2017), as more health professionals understand and express the need for diverse interdisciplinary collaborations, the possibility of using music therapy as an innovative service in various medical settings expands. From this point of view, by exploring participants' experiences in the interdisciplinary environment of the NICU, the present study helps to lay a foundation for future research regarding interdisciplinary collaboration between music therapy and other disciplines in a hospital setting.

Conclusion

While previous research on music therapy in the NICU largely focused on music therapy's effects on premature infants and parents, this study investigated the lived experience of music therapists in their work with parents in the NICU. The themes that emerged from the investigation convey music therapists' perspectives on the needs and experiences of parents and the role and position of music therapists in the NICU. The study found that music therapists witness and accompany premature infants' and parents' journey in the NICU, engage in music therapy advocacy to parents and other professionals, facilitate the connection between premature infants and their parents, utilize various interventions, and mediate between parents and medical staff. Lastly, the findings highlighted the importance of self-care for clinicians in order to recognize and ameliorate stressors. Taken together, the themes found in this study illustrate the need to understand music therapists' perspectives in order to promote high-quality clinical care for parents and infants in the NICU.

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Appendix A: IRB Approval Letter



1000 Hempstead Ave., PO Box 5002, Rockville Center, NY 11571-5002
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Kathleen Maurer Smith, Ph.D.
 Dean, Graduate Academic Affairs
 T: 516.323.3801
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 E: ksmith@molloy.edu

DATE: January 21, 2022

TO: Harria Kim
FROM: Molloy College IRB

PROJECT TITLE: [1854580-1] The Experience of Music Therapists Working with the Parents of Premature Infants in the Neonatal Intensive Care Unit (NICU)

REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: January 21, 2022

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.

You may proceed with your project.

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: Letter of Informed Consent

Molloy College IRB
Approval Date: January 21, 2022
Expiration Date: January 20, 2025



Letter of Informed Consent

Music Therapy Graduate Program
1000 Hempstead Ave
Rockville Centre, NY 11570
516-323-3000

Title of Study:

Music Therapists' Experiences of Working with Parents of Premature Infants in the Neonatal Intensive Care Unit (NICU)

This study is being conducted by:

Harria Kim (Student Researcher; Primary Investigator)
929-507-4725, hkim3@lions.molloy.edu

Maria C. "Nina" Guerrero, PhD, MT-BC (Faculty Advisor; Co-Investigator)
646-262-7711, mguerrero@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.

- **Purpose of study:** This study aims to explore music therapists' experiences of working with parents of premature infants in the neonatal intensive care unit (NICU). Participants will be interviewed virtually, and the interviews will be recorded, transcribed, and analyzed. This study is being conducted as part of my graduation requirements.
- **Inclusion criteria:** You have been contacted and considered eligible for the study because you meet the following criteria:
 1. You are a board-certified music therapist (MT-BC).
 2. You hold a graduate degree in music therapy.
 3. You have a minimum of 2 years of professional work experience as a music therapist

Molloy College IRB
 Approval Date: January 21, 2022
 Expiration Date: January 20, 2025

in the NICU.

4. You have experience in working with parents of premature infants in the NICU.

- **Time commitment:** Participation in the study will include a maximum of 45-minute virtual interview and a maximum of 15-minute virtual follow-up meeting for the purpose of member checking. The virtual interview and a follow-up meeting will take place via Zoom.
- **Compensation:** There is no compensation for this study.
- **Privacy concerns:** You will be given private, password-protected links to join the virtual interview and virtual follow-up meeting, both of which will be scheduled at your convenience, during times that will allow privacy for both you and the researcher. The audio and video recordings and transcription of the interview will be securely stored on a password-protected personal computer in the sole possession of the researcher. Access to the data will be limited to the researcher, her thesis committee, and the Molloy College IRB. The audio and video recordings of the interview will be electronically destroyed as soon as the interview has been transcribed and you have had the opportunity to check the transcript to verify its accuracy and completeness. If you choose to withdraw from the study, your data will immediately be destroyed.

Your identity will be protected. Anonymity will be maintained through the use of a pseudonym in place of your name throughout the transcription of the interview, analysis of data, and presentation of findings. Any potentially identifying information within the interview responses will be adjusted to preserve anonymity. Your name, your place of work, and any other identifying factors will be omitted. Findings of the study may be reported in future publications or presentations, but your identity will always remain anonymous.

Why am I being asked to take part in this study?

You are being invited to take part in this study because you meet the inclusion criteria listed above.

What will I be asked to do?

The interview will consist of questions related to your overall experience in the NICU, your experience of working with parents of premature infants in the NICU, your experience with the medical staff in the NICU, and meaningful or challenging moments you have experienced while working with parents in the NICU. With your permission, the interview will be audio and video recorded and transcribed. You will have an opportunity to review the transcript and to provide

Molloy College IRB
Approval Date: January 21, 2022
Expiration Date: January 20, 2025

any corrections or feedback to the researcher at the follow-up meeting. The researcher will analyze the transcript using Interpretative Phenomenological Analysis to identify salient themes.

Where is the study going to take place, and how long will it take?

The study will be conducted virtually through Zoom. It will involve a maximum of 45-minute virtual interview and a maximum of 15-minute virtual follow-up meeting for member checking. These will take place within the period from January through May 2022.

What are the risks and discomforts?

There are no known risks of the study beyond those of daily life. In the event that you experience uncomfortable or unpleasant feelings arising from the interview, the researcher will offer emotional support and will provide you with a list of mental health resources if needed or desired.

What are the expected benefits of this research?

You will not benefit directly from this research, although the study is intended to contribute to qualitative research on music therapists' subjective experiences of working with parents of premature infants in the NICU.

Do I have to take part in this study?

Your participation in the study is entirely voluntary. You may decide at any point to stop participating in the study, at which time you may choose to withdraw with no negative consequences. You may omit any questions during the interview which you would prefer not to answer. You may choose to end the interview process at any time, and you will have the option to reschedule the interview.

What are the alternatives to being in this study?

Instead of being involved in this research, you may choose not to participate.

Who will have access to my information?

Your anonymity will be maintained through the use of a pseudonym throughout the interview transcription, data analysis, and discussion of findings. All data will be securely stored on a password-protected personal computer in the sole possession of the primary researcher. Access to the data will be limited to the primary researcher, her thesis committee, and the Molloy College IRB.

How will my information be used?

Data gathered during the interview will be analyzed to identify themes related to music therapists' experiences of working with the parents of premature infants in the NICU. The audio and video recordings of the interview will be electronically destroyed after the interview has been transcribed and you have had the opportunity to check the transcript and provide feedback.

Molloy College IRB
Approval Date: January 21, 2022
Expiration Date: January 20, 2025

to the researcher. The data will not be used in future studies.

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, has the right to review study records, but confidentiality will be maintained as allowed by law.

Can my participation in the study end early?

You can withdraw from this study at any time without penalty.

Will I receive any compensation for participating in the study?

You will not receive any monetary or any other form of compensation for participating in this study.

What if I have questions?

Before you decide whether you would 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 **Harria Kim** at (929) 507-4725 or hkim3@lions.molloy.edu , or **Maria "Nina" Guerrero** at (646) 262-7711 or mguerrero@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, or a concern or complaint about this research, you may contact the Molloy IRB office at irb@molloy.edu or call (516) 323-3000.

Molloy College IRB
Approval Date: January 21, 2022
Expiration Date: January 20, 2025

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

Signature of researcher explaining study

Date

Printed name of researcher explaining study

Date

Consent to Record

Check all statements you agree to:

___ I give permission to Harria Kim to audio and video record my interview.

___ I give permission to Harria Kim to use a transcription of the recording for educational purposes related to this study.

Your signature

Date

Molloy College IRB
Approval Date: January 21, 2022
Expiration Date: January 20, 2025

Researcher's signature

Date