Community Engagement in Music Therapy: Reflections From the Field

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ABSTRACT

This paper reflects on a music therapy community engagement project that incorporates clinical training, service learning, and community music therapy. Two faculty members and a practicum student in a Midwestern university engaged community members connected to Parkinson's disease to create a music-based program. We offer a conceptual framework that connects approaches situated within community music therapy (CoMT) qualities and community-based participatory research (CBPR) principles. We share project processes, findings, and recommendations, emphasizing all as equal stakeholders.

Keywords: clinical training, service learning, community music therapy, community based participatory research, Parkinson's disease

COMMUNITY ENGAGEMENT IN MUSIC THERAPY: REFLECTIONS FROM THE FIELD

The music therapy profession is inherently community based and designed to provide a public service that acknowledges the dignity and worth of every person (American Music Therapy Association, 2019). Clinical training opportunities represent a significant portion of music therapy degree programs (American Music Therapy Association, 2021). Instructional opportunities are often developed by faculty without extensive collaboration with community partners (Kwoun, 2019). This may be due to focusing on student learning rather than community-based outcomes. Given this, there may be limited to no interaction with the community members who will receive and participate in the music therapy services before service delivery. In these cases, faculty serve as arbiters who set out to develop community-based learning opportunities and projects, often in their areas of clinical interest, expertise, research, or out of convenience, making community partners a secondary consideration.

As a faculty member, I, (Rushing) am a practicum supervisor interested in exploring the role of community engagement and service learning in relation to music therapy clinical training. In developing clinical training opportunities, my goal is to move from the historically "gown and town" division (Bruning et al., 2006; Carolan & Withers, 2018, p.4) to a mutually beneficial, two-way collaboration with a community partner. An opportunity to take such an approach arose when our department discovered a small pot of donor funding specifically designated for a Parkinson's Clinic. Charged with determining how to use the money, I engaged a music therapy practicum student and a colleague in the College of Education from the University

of Louisville (second author, Cumberland) to help explore approaches to using these funds. As a team, we integrated clinical training with service learning and a community-based participatory research (CBPR) approach to identify what types of services would best support the needs and desires of the Parkinson's disease (PD) community in our city.

A Proposed Framework for Achieving Community-Engaged Scholarship (CES)

Music therapy students engage in multiple forms of clinical training. In addition to shadowing, clinical training typically involves completing multiple semester-long practicum placements across the degree program. During practicums, students observe, plan, co-lead, lead, and receive feedback on the treatment process under an approved board-certified music therapist (MT-BC) supervisor (American Music Therapy Association, 2021). In some instances, clinical training for music therapy students may have elements of service learning, an "educational approach that strives to connect knowledge and action for the common good" (Deegan, 2017, p. 51). Historically, service learning strives to unite human needs with educational growth (Shumer et al., 2017). This approach, however, has been criticized for focusing on students learning instead of achieving community goals (Stoecker & Tryon, 2009). Given this criticism, service-learning advocates have started to rethink community engagement, arguing for a more reciprocal or community-focused design as opposed to student learning being the primary driver (Bruning et al., 2006; Carolan & Withers, 2018; Kwoun, 2019; Wollschleger et al., 2020).

Wollschleger et al. (2020) provided a service-learning model through a senior sociology course that embraced a needs assessment process conducted by the students. These students reported that from their needs assessment, they identified the critical needs in the community and were able to provide, with confidence, recommendations to the organization. A highlight of this project was that all activities were geared toward listening to the community and understanding what would benefit it, thus achieving the goal of redirecting the flow of resources not from the community to the students but from the students to the community. Similarly, the power dynamics of the student-faculty relationship flipped, emphasizing student leadership.

While clinical training in music therapy is not synonymous with service learning, it is suggested that equal emphasis be given to addressing community needs and student learning (Kwoun, 2019). This type of partnership is evident in Kwoun's (2019) example of a music therapy service-learning project. During their project, students and faculty partnered with a local symphony and a nonprofit (Arc) serving people with intellectual and developmental disabilities (IDD). The project emphasized equality in identities for all involved. The stance on musical identity for all three groups (symphony members, students, and Arc participants) allowed for outcomes such as shifts in attitudes about persons with IDD in both personal identity and perception of persons with IDD. This was seen through reported pride, joy, sense of accomplishment, and reward in observing and participating in *Creative Music Making.* Specifically for the students, this experiential-learning approach (service-learning) provided opportunities to develop skills for future clinical work, gain insight into the field, foster leadership development, and reflect on civic engagement. This case suggests that such service learning combined with community music therapy can foster social responsibility and student learning through positive community engagement.

Community music therapy (CoMT) is an international movement seeking to work toward "the restructuring and revisioning of health and social care service" within music therapy service delivery (Ansdell & Stige,

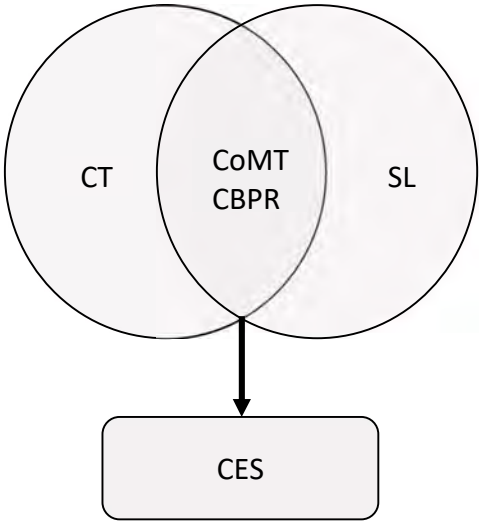
2015, p. 595). Kwoun (2019) posits that CoMT can serve as a conceptual framework for developing and implementing music therapy service learning. The acronym PREPARE is provided for music therapists to work reflexively within the CoMT paradigm (Ansdell & Stige, 2015). PREPARE is an acronym for participatory, resource-oriented, ecological, performative, activist, reflective, and ethics-driven. In this illustrative case of a music therapy project, we focused on the CoMT qualities of participation, resource-oriented, and activism to promote the redistribution of power and work toward developing critical service-learning practices.

Furthermore, we embraced a CBPR orientation. In CBPR, the awareness of power is central and integrated mutually with the researcher's expertise and community member knowledge and experiences (Wallerstein et al., 2017). The CBPR guiding principles (Wallerstein et al., 2017, pp. 32–34) informing this music therapy project are listed below, followed by ways each principle was represented in this illustrative case:

- Build on strengths and resources within the community.
    - Used a PD social network that the community had in place to recruit focus group members and workshop participants.
    - Accessed donations of harmonicas for all to use from a community member in the focus group.
- Facilitate collaborative, equitable partnership in all phases in an empowering and power-sharing process that attends to social inequities.
    - Involved community members from inception through program envisioning and development.
- Promote co-learning and capacity building among all partners.
    - Used didactic elements based on community-identified needs and interests with the goal of having access to resulting knowledge and engagement opportunities beyond this project.
    - Partnered with additional community-based experts based on the above to aid in the learning and capacity-building process.
    - Built an online resource hub with a collection of resources from the workshops to support learning and increase access to continued engagement.
- Disseminate findings and knowledge gained to all partners involved in the process.
    - Created a resource hub.
    - Expected to publish in an open-source journal for others to access findings and knowledge gained.
- Acceptance of a long-term process and commitment to sustainability.
    - Evaluated the project to allow for the continued evolution of the offerings by disseminating findings and resources, enabling others to replicate.

To aid in understating the layers of our community-based music therapy initiative, we developed a conceptual framework illustrating a connection between university-driven clinical training and service-learning opportunities with CBPR principles and CoMT qualities (Figure 1). We posit that CES tenets of faculty activity aligned with addressing social issues and community needs collectively can be actualized to benefit all stakeholders mutually. Furthermore, this aligns with Carolan and Withers' (2018) definition of engaged scholarship as an "intentional effort to connect knowledge generated through faculty activity directly to the public in ways that collaboratively address social issues and community needs" (p. 1).

Figure 1
Conceptual Framework for Achieving Community-Engaged Scholarship With Music Therapy



Note. CT = Clinical Training; CoMT = Community Music Therapy; CBPR = Community-Based Participatory Research; SL = Service Learning; CES = Community-Engaged Scholarship

BACKGROUND OF PROJECT

In the presented illustrative case, a small amount of funding to support a Parkinson's Clinic was donated to the University Music Therapy Clinic (MTC). At the service site, the MTC functions largely as a private practice. However, it is partially funded by the university and serves as a hub for student clinical training. It was determined that the best use of these funds would be to collaborate with the community, specifically those affected by Parkinson's disease. This aligns with the values and vested interest of a land grant higher education institution. Additionally, this approach addresses the suggestion by Stoecker and Tryon (2009) that those in higher education use a service-learning approach to become "true partners, rather than inappropriate leaders of the project" (p. 283). The first author began work on this project late in the fall of 2020 (during COVID-19), with the programming concluding in May of 2021.

Consistent with a social action model in CBPR, a needs assessment was carried out. A needs assessment process has been used successfully in previous participatory health research (Salsberg et al., 2012). For example, Salsberg et al. (2012) used a needs assessment process to develop workshops for medical faculty aimed at increasing their capacity for participatory health research. The authors began by surveying current users of participatory health research and conducting focus groups of current and interested users. The resulting information was thematically coded and used to design a needs survey that was then distributed to the wider faculty. Based on survey results, a half-day workshop was created and piloted. Authors report that most workshop participants (30/32) were satisfied and that several had taken steps to begin participatory health research within nine months. Workshop success credit was given to the use of the needs assessment process.

Table 1 provides the steps and timeline of our needs assessment, program development phase, and execution. The steps included pre-assessment, which was focused on 1) relationship building and market research; 2) the needs assessment inquiry, which included two focus groups; 3) the development of the workshop program; 4) the execution of the workshop; and 5) the evaluation and reflection of the music program.

Table 1

5-Step Process and Timeline

1. Relationship Building and Market Research	**3. Workshop Development**	**4. Conducting Workshops**
~ 4 months	~ 2 months	~ 3 weeks
Discussions with local stakeholders, including a PD organization, music therapists offering PD services, persons with PD, PD care partners, and fund managers Review of research Development of invitation letter Commitment from practicum student Recruitment of faculty mentor	Participant recruitment Identification of community resources Local music therapists Faculty experts Business owners Musicians Development and distribution of evaluation paperwork and workshop materials Barcelona Reward in Music Questionnaire Social Isolation and Ability to Participate in Social Roles and Activities Questionnaires (pre and post) Workshop evaluation survey Harmonicas – donated by a community member Development of resources Resource web hub Infographic Vocal exercise practice videos Playlists, music resources, and more	Curate resource hub Workshop 1 – Music as and in Therapy Workshop 2 – All About the Voice Workshop 3 – Music as a Health Resource
2. Needs Assessment		**5. Evaluation and Reflection**
~ 1 month		~ 2 years
Focus group 1 Review of discussion Focus group 2 Refinement of pitched workshop idea and content selection		Receipt of evaluations Descriptive analysis Reflection Manuscript

~ = approximate length of time spent on the respective stage of the project; PD = Parkinson's disease

METHODS

Participants and Data Collection

Bob, the first author's initial community contact with PD, was instrumental in locating interested people who had Parkinson's, were care partners, or were local musicians. The eight participants recruited included persons with Parkinson's, spouses and care partners, and musicians. The lead clinician from the university clinic, the

practicum student, and the first and second authors attended the focus groups and workshops. As relationship building was critical, the practicum student and first author assumed the role of the communication conduit, mailing packets, emailing reminders, and touching base with participants periodically to check in. For some workshops, community expert guest presenters and a music therapy student intern also attended. Six to eight participants attended each of the three workshops. Finally, seven participants returned the evaluation paperwork.

Before the workshops began, participants were mailed a packet with a harmonica, media consent form, the Barcelona Reward in Music Questionnaire (BRMQ) (Mas-Herrero et al., 2013), and pre- and post-surveys of the Social Isolation and the Ability to Participate in Social Roles and Activities Scales domain (short form) (Cyranowski et al., 2013), evaluation questions to gauge participant perceptions of the program, and a stamped return envelope. Participants were instructed when to complete forms. At the conclusion of the program, participants returned all paperwork in the included envelope. Outlined below are the specific survey tools used.

To understand sensitivity toward music, participants answered the Barcelona Reward in Music Questionnaire (BRMQ) (Mas-Herrero et al., 2013). This 20-item questionnaire evaluates five facets of music reward on a 5-point scale ranging from 1 (completely disagree) to 5 (completely agree). Examples of items include: "When I share music with someone, I feel a special connection with that person," "I can't help humming or singing along to music that I like," and "Music comforts me." The five factors are seen later in Table 2. Each factor has a mean value of 50 with a standard deviation of 10. Thus, standard scores range from 40–60 for each factor as well as the global sensitivity to music score. Values outside of this range are considered low or high, respectively.

For program evaluation purposes, participants responded to two surveys. Pre-post scales on Social Isolation and the Ability to Participate in Social Roles were selected to assess the program's impact on PD patients during the COVID-19 pandemic. These were completed prior to and following the workshops. Participants were asked to rate their response on a 5-point scale, with 1 being never and 5 being always. Examples of items include: "I feel left out," "I am able to socialize with my friend," and "I am able to participate in leisure activities." Finally, in the post-survey, participants' overall reactions to the program were captured through a series of questions. Items included thoughts on workshop benefits or lack thereof, interest in future programming and type, and general comments.

FINDINGS FROM FOCUS GROUPS AND SURVEYS

Focus Groups

Discussions from the first focus group, during the needs assessment phase, indicated that PD patients were interested in connecting with others with Parkinson's in a social way. Several participants spoke about the role of music in modulating mood and fostering social connection. Some were interested in designing a specific and recurring (annual) community event. Overall, those involved were interested in knowledge (science) and programming (experiences) that would let them explore music-related information and ideas as a health resource. They were interested in access to resources—for example, ongoing communication about happenings from the local university. One participant was particularly interested in support for vocal prosody and volume. It was discovered that there was a saturation of current offerings in the Parkinson's community related to exercise but with limited to no use of music.

With results from the first focus group, the idea of a workshop series emerged and was

presented during the second focus group meeting. The group aligned on a three-part workshop series to address a variety of the presenting needs. Multiple participants noted an interest in learning to make music during this focus group. One participant offered a connection to harmonica donations. It was determined that the workshops would focus on connecting, learning, engaging, and emphasizing knowledge building (science and music), collective experiential opportunities, and access to resources. The workshop series was named *Music and Parkinson's 3 (MP3): Connect, Learn, and Engage*.

Surveys

As noted earlier, to determine the participants' music sensitivity, participants completed the BRMQ. Six of seven participants fell within the standard range on the global sensitivity to music reward on the BRMQ, with one being below the standard range. Of the five factors of music reward, two participants scored high in the music-seeking and social areas, and one additional participant scored high for mood regulation. Single low scores in each factor can be seen except for mood regulation. Scores are documented in Table 2.

Table 2

Barcelona Reward in Music Questionnaire Scores

Participant	1	2	3	4*	5	6	7
Music Seeking	61	62	48	34	40	59	47
Emotion Evocation	47	49	25	45	48	43	60
Mood Regulation	65	57	50	47	46	51	46
Sensori-motor	38	50	18	55	44	42	58
Social	44	50	41	28	58	68	66
Music Reward	**52**	**55**	**30**	**40**	**46**	**52**	**57**

*Missing one-item response; standard scores range from 40-60 (M = 50, SD =10).

Results from the pre-post measures of Social Isolation and Ability to Participate in Social Roles and Activities Scales had minimal to no changes from pre- to post-workshops, with no participant showing any remarkable concern at baseline. In other words, no one indicated particularly low feelings of isolation or the inability to participate in social roles and activities prior to or following the workshops. This may explain why the program had no significant impact on these measures.

When asked what benefits participants received from the experience, respondents highlighted learning something new (i.e., the harmonica), meeting new people, understanding resources, and having fun. The only comment under the heading *possible improvements* was an interest in doing larger-scale promotion. Three responses consisted of appreciation, noting high levels of professionalism, interest in doing it again in person, enjoyment of working with our team, a new understanding of how music can be used in new ways, and a comment on already participating in a drumming group. When asked what type of group they would be interested in for future endeavors, four participants chose a music therapy group with various activities and a harmonica group. Two participants wrote about an interest in being in a band. A singular interest was in a rehabilitative specific group, individual music therapy, and a drum circle.

Based on learning from the focus groups, the program *Music and Parkinson's 3 (MP3): Connect, Learn, and Engage* emerged. The BRMQ provided the facilitator with a

more nuanced understanding of each participant's music sensitivity. While neither the measures for Social Isolation nor the Ability to Participate in Social Roles and Activities changed, the participants' overall reaction to the music program was positive.

REFLECTION

In the project presented here as a case illustration, we integrated clinical training, service learning, and community music therapy with a community-based participatory action research design resulting in community-engaged scholarship. Through this process, we worked to promote shared power and the development of service-learning practices for a practicum experience. From a clinical training perspective, the student collaborated in all aspects from program inception through implementation. This differs from traditional practicum placements, where students are only involved in direct client service provision. Furthermore, considering a service-learning framework, we were able to function with equality, avoiding the risk of emphasizing the student experience over the community goals (Stoecker & Tryon, 2009) and facilitating a focus on the connection of knowledge and action for the common good through experiential learning (Deegan, 2017).

We intentionally invited a practicum student to participate not just in service provision but also in the conceptualization of possible services through service evaluation. The student participated in reviewing the literature, developing resources (infographic), facilitating focus groups with community members, leading correspondence, relationship-building efforts, and partnering with faculty in preparing for and reviewing happenings. Thus, this student worked on leadership development, community collaboration, program development, community needs assessment, program evaluation, and many sub-parts that go into each task. This gave the student a more robust look at the professional world, particularly from a private practice lens in which one has to develop their own services. At times, the student took the lead over the faculty member in communications and was an equal partner with the community members and faculty in program development, including community needs assessment and focus groups. These approaches provided reciprocity in the flow of resources between the community, student, and university. Additionally, the student had the opportunity to build skills in areas outside of and including direct clinical services. This differs from many music therapy practicum placements, which only include service provision (direct clinical service).

Our process emphasized CoMT qualities of participation, resource-oriented, and activism (Ansdell & Stige, 2015). Our CoMT approach included a needs assessment process to foster equal participation in providing music-making and health learning opportunities with a focus on capacity building. We also utilized a CBPR orientation to shift from "community-place" to "community-based." In other words, it is a shift from "doing good stuff" to co-learning, and from emphasis on developing revenue-generating services to building community capacity. This program incorporated relationship building, pooling of resources, collective decision-making, resource development, evaluation, and dissemination.

Relationship building was a key theme in our process, as well as critical service learning and higher education community engagement initiatives. Power et al. (2004) reflected on "the importance of building and sustaining these relationships over time, and in a way that shares power and ownership with communities" (p. 54). While we completed this project (except the dissemination portion) in approximately seven months, it is worth noting that relationships with all workshop partners and our champion community members had been fostered prior to the project's inception. Additionally, relationship-building work was made a priority through

timely communications, calls, follow-ups, and reviews of happenings prior to decision-making. It is important to note the time required for these activities.

Participants did not have any outstanding low or high scores on formal assessments. This information could serve as a comparison for future offerings or possibly further evaluation of people who might be particularly responsive to such offerings given a sense of reward in music (BRMQ). For the social scales, these were selected due to the interest in connecting and the COVID-19 pandemic world status at the time. These scales may no longer be best to use for future related offerings. Though social constructs might still be of interest, researchers might also consider enjoyment and learning-based tools. Subjectively, participants in the workshops enjoyed the experience and valued both learning about and engaging with music as a health resource.

A final element of the project is the community-engaged scholarship we have presented here. Everyone involved helped define the "critical problem," and all of us as community members were valued as experts across the project (Carolan & Withers, 2018). Because of these dynamics, the group was more inclusive and had access to more resources than if a single music therapist had designed a group for people with Parkinson's. This project incorporated musicians, care partners, students, clinicians, faculty, business owners, and people with Parkinson's. This illustrative case disseminates our efforts, hoping to encourage similar endeavors, specifically the collaborative processes. Throughout the process, we curated original and existing resources onto a web-based hub available to the public and workshop participants.

RECOMMENDATIONS AND CONCLUSION

The process outlined here led to a unique and community-centered music therapy offering (a workshop series). The focus groups brought a depth of community engagement and resources that might have been otherwise ignored. The overall process resulted in building capacity for music as a health resource that had not previously existed in the community through workshops and resource hub development (website). Furthermore, this process expanded the student clinical training experience. A large amount of time was required and resulted in a level of investment from all who could support sustainability. Recommendations include:

- Commit to increased time and a long-term process to result in a higher level of commitment by all, and to foster sustainability.
- Provide structure (drafts of timelines, roles, expert knowledge, and information) but avoid predetermined ideas of outcomes that would create barriers to being open, present in shared power dynamics, and recognizing everyone's strengths, needs, and resources.
- Optimize the practicum student's experience. While the first author invested extensive one-on-one time per all happenings to process with the student, no specific assignments were given tied to self-reflection. We recommend providing a reflective structure for students before, during, and after service-learning experiences (Power et al., 2004).

We hope this project served as a bridge from community engagement and outreach to community-based equal partnerships and community-engaged scholarship. Similarly, from clinical training to service learning, it can serve as a model of "community-based" work, moving institutions away from "community placed."

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