The influence of religion and spirituality on clinical practice amongst Registered Music Therapists in Australia

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In plain language:

Despite an increasing awareness of spirituality in healthcare, little is known in regards to the spiritual or religious beliefs of music therapists and how these beliefs may impact clinical practice. Australian music therapists responded to a web-based survey designed to ascertain information that would increase understanding of how spiritual or religious beliefs of music therapists may influence their clinical work with patients and clients. The majority of Australian music therapists who responded to the survey identified as currently affiliated with an organized religion or spiritual practice. The religious or spiritual beliefs of music therapists were found to impact clinical practice in a variety of ways, with increased likelihood of a positive rather than negative influence. Participants described the complex and personal nature of the topic, and suggested the need for reflective practice in relation to the influence of personal spiritual or religious beliefs.
The influence of religion and spirituality on clinical practice amongst Registered Music Therapists in Australia

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Abstract
Despite an increasing awareness of spirituality in healthcare, there is little known in regards to the spiritual or religious beliefs of music therapists and how these beliefs may impact clinical practice. Australian music therapists (n=73) responded to a web-based survey designed to address this gap in the literature. Quantitative and qualitative data were collected. The majority of Australian music therapists who responded to the survey identified themselves as currently affiliated with an organized religion or spiritual practice (67%). The religious or spiritual beliefs of music therapists were found to impact clinical practice in a variety of ways, with increased likelihood of a positive rather than negative influence. Participants described the complex and personal nature of the topic, and suggested the need for reflective practice. Recommendations are made for further research in this area.

Keywords: religion and spirituality, clinical practice, reflexive practice, web-based survey, music therapists

Introduction

Religion and spirituality in healthcare

Over the past 15 years there has been a rise in interest surrounding spirituality and religion in healthcare and clinical settings (Connelly & Light, 2003; Kidwell, 2014; Sulmasy, 2009; Tanyi, 2002). Researchers and practitioners have begun to appreciate the spiritual aspects of coping with illness, moving towards a more holistic approach and recognising patients as “living unities with medical, moral, spiritual, and psychological concerns” (Cohen, Wheeler, Scott, and The Anglican Working Group in Bioethics, 2001, p. 30). Patients have indicated spirituality as an important factor contributing to quality of care (McCord et al., 2004), and it is now considered an ethical obligation for healthcare professionals to address the spiritual concerns of patients, with this information being obtained during routine clinical assessments (Astrow, Puchalski & Sulmasy, 2001; Post, Puchalski & Larson, 2000; Sulmalsy, 2009; Tanyi, 2002).

Clinicians also indicated the need to acknowledge and understand their own spirituality and biases, in order to readily assist patients and provide general spiritual care if necessary (Astrow et al., 2001; Connelly & Light, 2003; Tanyi, 2002). Astrow et al. (2001) highlighted the importance of healthcare professionals examining the sources of meaning and value in their work, stating that “healthcare professionals may find it helpful to grapple with these (spiritual) issues in their own lives, if for no other reason than for the sake of their patients, whose struggles with these spiritual questions are central to the nature of illness and healing” (Astrow et al., 2001, p. 286). This changing attitude towards spirituality in healthcare is seen in the music therapy profession, with Forinash (2009) identifying that music therapists are increasingly open to discussing their spirituality and how it may influence practice.
Religion and spirituality in music therapy

Spiritual qualities are recognised as heightened during interventions that involve the arts, such as poetry, visual arts, and music (Connelly & Light, 2003), and music remains an essential part of worship practices in various religious traditions (Lipe, 2002). In regards to healthcare, Cook & Silverman (2013) suggested music therapists as being uniquely equipped to address spiritual wellbeing using non-verbal and non-threatening techniques. The discourse surrounding an inextricable link between music, religion and spirituality therefore requires examination within music therapy practice prior to investigating any influence of religion and spirituality on the music therapist and their clinical work.

The majority of literature on spirituality and religion in music therapy has been written in regards to end-of-life care, a time when spiritual elements of experience assist most in rising above suffering, and allow one to find purpose, hope and meaning (Aldridge, 2003). Aldridge (2003) therefore argues that integrity and hope can be maintained through music therapy, as the creative acts allow for transcendence to occur; transcendence being when one ‘goes beyond’ a current awareness to another level of understanding through the process of questioning and the search for meaning (Aldridge, 1995).

Like Aldridge, Magill (2006) argued that music allows for transcendence, the promotion of faith and hope, the sense of meaning and purpose, and fostering connectedness. Magill identified four recurring spiritual themes in music therapy – relationship, remembrance, prayer, and peace. She proposed that it was through music’s ability to evoke memory and enhance life review that patients had an opportunity to gain perspective of inner values and achievements in life, and allowed music to promote connectedness through fostering meaningful interaction between patients and their loved ones (Magill, 2006).

Salmon (2001) identified music therapy in palliative care as psychospiritual, with music therapy able to facilitate “quick movement beyond ordinary awareness, where disease is prominent, into the realm of spirit and psyche” (Salmon, 2001, p. 142). Salmon identified music as a means of accessing the ‘realm of depth’ without the usual habitual defences, through evoking memory, imagery, and resonating with feeling, thereby transporting one beyond ordinary awareness (Salmon, 2001).

A number of studies have empirically investigated the relationship between music therapy and spirituality within palliative and oncology settings. Wlodarczych (2007) conducted an ABAB design study where residents at a hospice unit were assigned to a music therapy session or a nonmusical visit. Participant responses to a spiritual well-being questionnaire after each session indicated that music therapy visits encouraged more participant-initiated discussions regarding issues related to spirituality. Through naturalistic inquiry, Magill (2009) found that memories of joy and empowerment, and finding meaning through transcendence during pre-loss music therapy had the potential to offer spiritual support to bereaved caregivers of advanced cancer patients. A retrospective, cross-sectional analysis of electronic medical records conducted by Burns, Perkins, Tong, Hilliard, & Cripe (2015) however, found that music therapy was associated with family perceptions of increased spiritual support in hospice care for cancer patients.

A randomised-control trial (RCT) investigating the effects of music therapy on spirituality with patients on a medical oncology ward found participants in the music therapy condition had higher posttest means in the peace and faith subscales (Functional Assessment of Chronic Illness Therapy-Spiritual Well Being Scale; FACIT 12) than participants in a standard care control group (Cook & Silverman, 2013). Qualitative data supported the importance of music therapy in meeting spiritual needs, as participants reported music therapy helped them feel closer to God and elevated their moods. Using grounded theory to explore the
healing and spiritual experience of a one-off group music therapy session, McClean, Bunt, & Daykin (2012) found that the spiritual experience of patients with cancer supported and drew upon Magill’s four spiritual themes of transcendence, connectedness, search for meaning, and faith and hope.

The FACIT scale was also used by Grocke et al (2014) in a study of quality of life, self esteem and spirituality in people with severe mental illness engaged in group songwriting. The RCT demonstrated that spirituality and quality of life improved when compared with the control condition, and spirituality was maintained at 12 weeks follow up.

The increasing evidence concerning the link between music and spirituality within music therapy indicates that there is a need for music therapists to address their own spirituality and biases in order to readily assist and provide patients with spiritual care. Kidwell (2014) identified that acknowledging a patient’s spirituality can present the music therapist with unique challenges, including examination of one’s own beliefs, practices and awareness of the possible impact on the therapeutic relationship.

Lipe (2002) reviewed the literature to evaluate how musical and spiritual aspects of human experience might work together to influence wellbeing. Out of the 58 authors represented in the review, 30 were music therapists, indicating music therapists were addressing issues of spirituality surrounding clinical practice (Lipe, 2002). At this time however little was known regarding the spiritual or religious involvement of music therapists who use music to address spiritual needs of their clients, and Lipe (2002) called for further research in this area.

More recently, Potvin (2013) also surveyed a random sample of American music therapists to investigate whether spiritual beliefs functioned as a predictor for theoretical orientation in music therapy practice in the United States. Results indicated that spiritual beliefs were not predictors, however the study raised the need for continued exploration of music therapists’ self-awareness of spiritual issues and theoretical development. Theoretical orientation was surveyed in Australian music therapists as part of a study on supervision (Kennelly, Baker, Morgan, & Daveson, 2012). Of a total sample of 71 responses, the most common theoretical orientation was humanistic (44%; n=28) followed by behavioural (14% n =9) and creative music therapy (9%; n=6). Further exploration is therefore warranted to capture the importance of spiritual beliefs, self-awareness and reflective practice in Australian music therapy practice.

Despite the increasing literature on spirituality within music therapy, little is known regarding the spiritual or religious values of music therapists in Australia, and how a music therapist’s religious or spiritual orientation may influence clinical practice. Given the call for healthcare professionals to acknowledge their own spirituality in relation to patient care, and research indicating the spiritual nature to music therapy, it is necessary to address this gap in the literature. Therefore the purpose of this study is to investigate the influence of religious background and spirituality among Registered Music Therapists (RMTs) and clinical practice in Australia.

Method

Design

This study adopted a survey methods approach, which included the collection and analysis of both qualitative and quantitative data. The study was not a true mixed-methods study in that the two forms of data were not merged and integrated according to Creswell & Plano-Clarke’s (2007) definition of mixed-method research. It was not the intention of the researcher to
merger the data. The purpose in obtaining qualitative
data was to allow for richer descriptions to further
support responses of survey questions, and therefore
develop a more extensive understanding of religion
and spirituality among music therapists in Australia
and its influence on clinical practice.

A web-based survey (See Appendix) was used,
as it presented the most effective tool to obtain a
general overview of the influence of religious or
spiritual involvement among RMTs in Australia.
Ethics approval was obtained through the University
of Melbourne (HREC 1135925). The invitation to
complete the survey was embedded in a weekly email
distributed by the Australian Music Therapy
Association (AMTA) to the sample of Australian
RMTs. Email recipients who clicked on the link
thereby confirmed their consent to participate in the
study. An email reminder was distributed two weeks
prior to the survey closing.

The anonymity of the survey was considered
beneficial as the nature of the study related to personal
views of RMTs. The survey hosted by ‘Survey
Monkey’ was open from 1st June 2011 until 31st July
2011. The survey consisted of ten questions that
addressed religious and spiritual affiliation, possible
influences of religion or spirituality on clinical
practice, the client populations involved, and music
therapists’ attitudes towards spirituality and religion in
clinical practice. Thirty percent of questions were
closed, 30% were open-ended, and 40% were two-part
questions, demanding a closed answer followed by the
option to elaborate with an open-ended response.
These questions therefore collected quantitative and
qualitative data. The survey was piloted with a group
of peers in a Research Methods class at University of
XXX (withheld for blind review), and was revised
based on peer feedback. Once the survey was closed,
the data was collated using ‘Survey Monkey’.

Analysis of quantitative data

‘Survey Monkey’ generated graphs and figures
for the quantitative data which were analysed
deductively, and compared and presented as
descriptive statistics. Standard deviations were not
calculated, as the study did not intend to compare
groups. Given the focus of the study was to understand
religion and spirituality among music therapists in
Australia, general demographic data was not sought
e.g., age, gender, state or territory etc.

Analysis of qualitative data

Many of the open-ended survey questions
generated rich descriptions that required processes to
ensure the depth of those descriptions was retained.
Qualitative data was analysed inductively, and was
informed by the principles of thematic analysis
(Braun and Clark, 2006). Thematic analysis was
defined as “a method for identifying, analysing, and
reporting patterns (themes) within data” (Braun &
Clark, 2006, p.79). The first five phases of analysis as
identified by Braun and Clark (2006) were followed
and subsequently verified by the co-author.

Phase 1: Getting familiarised with the data
initially consisted the removal of any redundant
information or information not directly relevant to
the question. For example, “Well, I suppose
sometimes” was reduced to “sometimes”.

The researchers were careful to retain the
words of the original description.

Phase 2: Generating initial codes involved the
systematic categorizing of statements into
categories or codes. Statements of similar
descriptive words were grouped together using
colour codes. When words were unclear in
meaning, the researcher interpreted the words.

Phase 3: Searching for themes required the
researcher to ‘sit with’ the codes and the data to allow
the themes to emerge.

Phase 4: Reviewing themes

Phase 5: Defining and naming themes involved
giving grouped codes a thematic tag or heading.

The following example illustrates how the five
phases of analysis were used to obtain and code data
extracts. The question (Question 3) asked if
participants believed their religious or spiritual beliefs had an influence on their decision to become a music therapist. Below are six data extracts, which were identified from participants 6, 7, 10, 11, 15 and 16 (in the right-hand column), the participants’ responses were identified as a code Influence of being brought up with religious values. This code subsequently fell under Theme 1. Influence of religious values on the desire to help or care for others.

Findings & Discussion

Seventy-three participants responded to the survey, which was a response rate of 18.7%. Given the nature of the survey, where some questions were quantitative and qualitative, the results are presented in the sequence of the survey.

Table 1 Example of thematic coding

<table>
<thead>
<tr>
<th>Coded for</th>
<th>Data extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence of being brought up with religious values</td>
<td>Grew up in a close family environment where good deeds and philanthropy were emphasized</td>
</tr>
<tr>
<td></td>
<td>Growing up with religious values and morals</td>
</tr>
<tr>
<td></td>
<td>The religious values I learnt may have contributed to my desire to help others</td>
</tr>
<tr>
<td></td>
<td>My values of everyone being equal and having the same opportunities was influenced by my religious upbringing, and led to me wanting to work in a helping profession</td>
</tr>
<tr>
<td></td>
<td>The values of creating community where all people are valued and supported are important to me and implicit and explicit in my work as an RMT in community settings; these values trace back to my experience in a catholic parish as a child</td>
</tr>
<tr>
<td></td>
<td>Upbringing based on Christian values has helped shape me to be a compassionate person</td>
</tr>
</tbody>
</table>

Theme 1. Influence of religious values on the desire to help or care for others

- Influence of being brought up with religious values
- Influenced the desire to help or care for others
- Conditioned to care for others
- Called as a Christian to serve others

Prevalence of religion or spirituality

Question 1 asked participants about spiritual or religious affiliation (n=73). The largest group response (37.0%) identified with an organised religion, while 30.1% identified as spiritual or spiritually aware, but not belonging to a religious group. A smaller number of participants (23.3%) identified themselves as previously affiliated with an organised religion and 9.6% did not affiliate with spirituality or religion.

Question 2 asked which organised religion people were affiliated or previously affiliated with. Out of 71 responses, 24 identified as Christian and 15 previously identified as Christian, while 22 considered themselves as spiritual or spiritually aware. Given that in 2001 approximately 64% of Australians identified as Christian and only 5.5% identified with non-
Christian religions (Australian Bureau of Statistics, 2006), it is unsurprising that the majority of respondents identified themselves with a form of Christianity. Participants who identified as spiritual indicated a variety of responses, reflecting the complex and highly personal nature of spirituality (Aldridge, 1995; Aldridge, 2003; Connelly & Light, 2003; Tanyi; 2002). Various spiritual groups were listed, for example Pagan, New Age, Agnostic, and those who did not follow a particular spiritual group, who described their spiritual beliefs, as for example, a “belief in the spirituality of human beings” (Participant #8).

Influence of religion or spirituality on clinical practice

Question 3 asked participants about their decision to become a music therapist in relation to religious or spiritual beliefs. The majority of participants (58.3%) believed their decision to become a music therapist had nothing to do with their religious or spiritual beliefs, although the difference (16.6%) was marginal. Participants who believed their religiosity or spirituality influenced their career choice indicated a variety of ways in which this occurred. The following themes emerged from their open-ended responses.

Theme 1. Influence of religious values on the desire to help or care for others
Theme 2. Attribution of decision to an entity greater than oneself
Theme 3. Religious and spiritual beliefs inform one’s entire being
Theme 4. Influence of belief in relationship between music and spirituality
Theme 5. Influence of spiritual mentor

Question 4 asked participants about the extent to which religious or spiritual beliefs influence clinical practice. The following themes emerged.

Theme 1. Beliefs overtly influence interaction with the client
Theme 2. Beliefs indirectly inform approach to clinical work
Theme 3. Beliefs influence therapist’s motivation and resilience
Theme 4. Beliefs are overtly related to clinical work but kept private
Theme 5. Beliefs overtly influence client selection
Theme 6. Would like to believe religious beliefs have no influence
Theme 7. Influence of religious context
Theme 8. Influence the desire to help others

The majority of participants indicated that religious or spiritual beliefs influenced clinical practice to varying degrees. Some participants had indicated that although their beliefs were related to clinical work they were kept private, while others stated they would like to believe their religious beliefs had no influence on their clinical work. Such responses demonstrate an awareness of the ethical issues and dangers that may impact on integrating one’s religious beliefs in the clinical setting (Astrow et al., 2001; Miller & Thoresen, 2003; Sulmalsy, 2009). However, one response indicated that client selection was based on client’s religious beliefs, as priority would be taken with clients who held similar beliefs to the therapist. This is an interesting finding given such conduct is not advocated within the Australian Music Therapy Association (AMTA) Code of Ethics. This response (although the exception) indicates that religious and spiritual beliefs of the music therapist may impact clinical practice.

Question 5 asked participants about how religious or spiritual beliefs influence or do not influence clinical work. Out of 70 responses, 15 participants replied with ‘N/A’. The following themes emerged from the remaining responses (n=55).

Theme 1. Does not influence clinical work
Theme 2. Do not discuss beliefs with patients
Theme 3. Influences clinical work in a practical way
Theme 4. Influences resilience and provides support
Theme 5. Indirectly effects clinical work through influence on RMT as a person
Theme 6. Client’s beliefs are priority
Theme 7. Unable to integrate own beliefs with clinical context or client

Where beliefs did not influence their work, participants indicated their work was grounded in psychology and that their beliefs were not relevant to music therapy practice, a belief in line with the common and previously held notion of religion as largely irrelevant and sometimes harmful to quality clinical care (Sulmalsy, 2009). Other participants stated they do not discuss their beliefs with clients, and that the client’s beliefs are priority. Certain participants who stated their beliefs influenced practiced indicated that it allowed for better service to the client, such as having better knowledge of religious repertoire or being better able to support or relate to spiritual or religious clients. This increased ability to support spiritual or religious clients may be attributed to a sense of understanding around spiritual concerns displayed by the therapist, an understanding often desired by patients (McCord et al., 2004). Beliefs were also found to have ‘direct influence’ on clinical practice such as having preference not to work in Christian-based contexts, or influencing clinical methods and goals. Interestingly one participant indicated the inability to integrate their beliefs within the clinical context or with the client, leading to withdrawal from practice.

Despite music therapy literature demonstrating religion and spirituality as most prevalent in palliative care (Aldridge, 1995, 2003; Magill, 2006; Salmon, 2001) it is interesting to note that responses in this study had a much higher incidence in aged care, dementia and older adults. This may indicate spirituality as more evident in these settings, or that more RMTs work in these areas than elsewhere.

Table 2.

<table>
<thead>
<tr>
<th>Population/Clinical Setting</th>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care/Dementia/ Older Adults</td>
<td>21</td>
</tr>
<tr>
<td>Disabilities</td>
<td>12</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>11</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10</td>
</tr>
<tr>
<td>Children with special needs</td>
<td>6</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>6</td>
</tr>
<tr>
<td>Acquired Brain Injury (ABI)</td>
<td>5</td>
</tr>
<tr>
<td>All populations*</td>
<td>5</td>
</tr>
<tr>
<td>When MT services provided by religious organisation</td>
<td>4</td>
</tr>
<tr>
<td>Community setting (Adults and Children)</td>
<td>3</td>
</tr>
<tr>
<td>Adults with special needs</td>
<td>3</td>
</tr>
<tr>
<td>Learning disabilities/Autism</td>
<td>2</td>
</tr>
<tr>
<td>Special Education</td>
<td>2</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2</td>
</tr>
<tr>
<td>Cancer patients (Adult &amp; Children)</td>
<td>2</td>
</tr>
<tr>
<td>General population</td>
<td>2</td>
</tr>
<tr>
<td>Academic Staff</td>
<td>1</td>
</tr>
<tr>
<td>Adult medical setting</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Illness</td>
<td>1</td>
</tr>
<tr>
<td>Drug and Alcohol Rehab</td>
<td>1</td>
</tr>
<tr>
<td>GIM</td>
<td>1</td>
</tr>
<tr>
<td>Teenagers with special needs</td>
<td>1</td>
</tr>
<tr>
<td>Aged Physical Rehabilitation</td>
<td>1</td>
</tr>
<tr>
<td>Adult rehabilitation</td>
<td>1</td>
</tr>
</tbody>
</table>

*There were 5 responses for “All populations” as follows:
1. Every population I have worked with
2. Really it applies to all the client groups I work with
3. My beliefs are part of my being, it does’t really matter what population I am working with. However, the subject is more relevant in music therapy services provided by religious organisations and in palliative care
4. They don’t influence my clinical work but influence my attitude the way I conduct myself and the person I am (in general)
5. I would say the influence of my beliefs is there with all of them

When RMT’s beliefs have ‘clashed’ with contexts or patient’s beliefs in clinical practice

Question 7 asked participants about situations where their beliefs about religion or spirituality have clashed within clinical practice. The majority of
participants (66.7%) indicated they had not come across a situation where their beliefs about religion or spirituality had clashed within clinical practice as a music therapist. The coding of open-ended responses from participants who answered ‘yes’ (n=26) were divided into two tables of codes due to the way participants presented their survey responses: Description of Clinical Situation and Response to Clinical Situation

The following themes emerged from the analysis of coded statements for Description of Clinical Situations.

Theme 1. Differing spiritual or religious views with other staff
Theme 2. Confronted by clients with strong differing beliefs
Theme 3. General differences in beliefs not specific to particular incident or client

The following themes emerged from the analysis of coded statements for Responses to Clinical Situation.

Theme 1. Respect and accept the client’s beliefs
Theme 2. Conscious of differences with the client and its possible impact on the clinical relationship
Theme 3. Direct session to common ground
Theme 4. Discuss issue with co-worker involved
Theme 5. Impart alternative views to the client
Theme 6. Follow moral code and organisation’s policies
Theme 7. Respond by debrief and prayer

The responses to difficult clinical situations varied. However, most themes implied that it was up to the therapist as a clinician to take responsibility and not let spiritual or religious differences damage therapeutic goals or professional relationships. The only theme to indicate otherwise was Theme 5. Impart alternative views to the client, in which the participant explained that they tried to expand the client’s “area of understanding (which they actually appreciated)”.

Despite client appreciation, the question remains whether such influence is appropriate in a therapeutic relationship where the RMT holds a position of power. Such actions of imparting views to a client is not supported in the literature, as it is stated that clinicians must take extreme precaution regarding proselytizing beliefs, particularly given the power imbalance between clinicians and patients (Astrow et al., 2001; Miller & Thoresen, 2003; Sulmalsy, 2009). It is also suggested that any religious advocacy, no matter how well intended, threatens patient autonomy (Astrow, et al., 2001).

When RMT’s religious or spiritual beliefs have enhanced clinical practice

Question 8 asked participants about situations where their beliefs about religion or spirituality have enhanced clinical practice (n=68). About one third of the respondents (36.8%), indicated they had not experienced enhanced practice from spiritual or religious beliefs, while the majority of participants (63.2%) indicated that they had come across a situation where their beliefs about religion or spirituality had enhanced their clinical practice. The following themes emerged from the open-ended responses of these participants.

Theme 1. Enhances work and therapeutic relationship with spiritual client
Theme 2. Enhances ability to readily offer religious repertoire
Theme 3. Assists RMT with resilience
Theme 4. Constantly enhances clinical practice
Theme 6. Miscellaneous

- Only approach spiritual issues when directed by clients
- Working as an RMT, I feel spiritually fulfilled
- Yes, but viewed more as ‘special connection’ than a shared spiritual experience
- Feel comfortable attending church funeral
- When hearing about how client and caregiver’s faith journey gives comfort
These results suggested that religious and spiritual beliefs of music therapists were inclined to have a positive influence on clinical practice rather than a negative one. The experiences of enhanced practice due to spiritual or religious beliefs when working with spiritual clients are consistent with the model proposed by Sulmalsy (2009). This model suggested the dyad in which both clinician and client share religiosity has the most potential for concordance. Sulmalsy (2009) stated that in this case both should have the means to talk about religion in regards to healing, and theoretically problems would only arise over differences in denomination and strength of belief.

Religious and spiritual beliefs were also stated to enhance practice in regards to increasing the therapist’s resilience. This is supported by Ablett and Jones (2006) who found that awareness of own mortality and spirituality allowed palliative care staff to perceive difficult aspects of their work as comprehensible, thereby contributing to reducing psychological distress and burn-out.

Separating religious and spiritual beliefs from clinical practice

Question 9 asked participants about the separation of religious and spiritual beliefs when working in a clinical context (n=70). The majority of participants (60%) indicated that religious and spiritual beliefs should be kept separate from clinical practice, while 40% indicated they should not. All participants were asked to elaborate on their answers through open-ended responses. The following themes emerged.

Theme 1. It may be appropriate to integrate spirituality or religion at times
Theme 2. If spiritual or religious beliefs are internal to the therapist, boundaries are necessary
Theme 3. The client’s needs and beliefs are priority, and must be respected
Theme 4. Spiritual or religious beliefs do not belong in professional setting
Theme 5. The relationship between spirituality and music therapy as mutually enriching
Theme 6. Therapist must be mindful about how beliefs may impact work
Theme 7. Spiritual health should be addressed as it is of equal importance to physical and mental health
Theme 8. Our beliefs inform who we are and how we treat others

Many of the open-ended responses indicated that this was not a question that could be answered in a simple ‘yes/no’ manner. Despite the ambivalence about certain situations where it would be appropriate to integrate spiritual or religious beliefs, there was a strong indication that therapists should never impose such beliefs on a client. This view was consistent with literature that stated clinicians should never engage in religious advocacy, spiritual coercion, or impose their own religious orientations on patients, despite the notion that religious practice and spirituality is associated with good health outcomes (Astrow et al., 2001; Cohen et al., 2001; Miller & Thoresen, 2003; Post et al., 2000; Sulmalsy, 2009). Participants also suggested the client’s needs and beliefs are of priority and must always be respected. This is supported by the statement that health professionals “must remember that spirituality is about a relationship of mutuality and freedom” (Sulmalsy, 2009, p. 1639).

Participants who stated that spiritual or religious beliefs did not belong in the professional setting indicated that personal beliefs in general should remain separate, and that sharing religious beliefs had potential to complicate professional relationships. These views not only appeared to be in line with the previously held notion of religion as largely irrelevant to clinical care (Sulmalsy, 2009), but they also appeared to support the claim that many physicians remain worried that addressing spiritual or religious concerns will be intrusive, difficult, or embarrassing.
(Cohen et al., 2001), leading to the assumption that avoiding the discussion of spirituality is the safest course (Sulmalsy, 2009).

However, other participants viewed spiritual health as equally important to physical and mental health, which is consistent with the move towards a holistic approach to healthcare which recognises patients as “living unities with medical, moral, spiritual, and psychological concerns” (Cohen, Wheeler, Scott, and The Anglican Working Group in Bioethics, 2001, p.30).

Participants also identified that therapists must be more aware of how beliefs may impact their work. This issue of self-reflective practice re-emerged in responses to the final survey question regarding the experience of completing the survey.

**Experience of Completing the Survey**

Question 10 asked participants to comment on their experience of completing the survey (n=68). The following themes emerged.

*Theme 1. Participants enjoyed and identified interest in this topic*

*Theme 2. The process was informative and encouraged reflection*

*Theme 3. Survey was biased to those with spiritual or religious affiliation*

*Theme 4. Participants viewed survey questions as insufficient to address such a complex issue*

*Theme 5. Participants commented on question style and wording*

*Theme 6. Miscellaneous*

An unexpected finding was that many participants raised the importance of reflective practice and being mindful in order to work effectively and meet the needs of the client in relation to religion and spirituality. This is supported by the statement that “reflection and reflective practice… are increasingly described as essential attributes of competent healthcare professionals” (Mann, Gordon & MacLeod, 2009, p.596). The support and interest for this topic identified by participants indicated that the growing interest surrounding spirituality and religion in healthcare (Connelly & Light, 2003; Sulmalsy, 2009; Tanyi, 2002) also extends to clinicians in the music therapy profession. Comments that the survey itself was biased to those with spiritual or religious affiliation were likely made due to the way questions were constructed to obtain more detailed responses from participants who did identify as religious or spiritual. Others viewed the survey questions as insufficient to address the complexity of these issues, indicating questions often required more complicated answers.

**Methodological Problems**

Methodological problems encountered by the researcher included low response rate, and limitations of the survey questions. The invitation to participate in the survey was sent to 391 RMTs in Australia. Seventy three participants responded giving a response rate of 18.7%, which is low according to Wigram (2005) who states that a response rate of 20-25% is considered low. It is interesting to consider whether people did not want to participate given they would be disclosing privately held views surrounding religion and spirituality.

It is also possible that the results of this study were biased, as the RMTs most likely to participate in the survey could have been those with religious or spiritual affiliations given that the topic may be of increased interest to them.

As mentioned by some participants, the method of survey itself proved limiting in terms of obtaining rich responses given that the survey questions were insufficient in addressing the complexities of these issues.

**Recommendations for further study**

The purpose of this study was to gain a general overview of the prevalence of religious and spiritual involvement among RMTs in Australia, and how this
involvement may influence further practice. Therefore, further study in this area would be beneficial. The use of semi-structured interviews would allow for richer participant responses and also decrease ambiguity experienced by some respondents given that an interviewer would be present to clarify any uncertainty regarding questions. It would also be of benefit for an improved version of this survey to be conducted in the future to document how the prevalence of and opinions on religion and spirituality within Australian music therapy may have changed over time. It would also be valuable to extend the scope of the survey to gain an overview of religion and spirituality amongst music therapists and clinical practice at an international level.

Conclusion

The results indicated that the majority of music therapists represented in this study are currently affiliated with an organised religion or identify themselves as spiritual. Although the majority of participants reported that spiritual and religious beliefs should ideally be kept separate from clinical practice, it was evident that the complex and personal nature of this topic meant that in practice, integration of the therapist’s beliefs would be inevitable or in some situations appropriate or beneficial. The spiritual and religious beliefs of music therapists were found to have an impact on clinical work in a variety of ways, with results indicating beliefs were more inclined to have a positive influence. Perhaps the most significant point to emerge from this study was the suggestion of reflective practice, and the importance of being mindful in regards to how spiritual or religious beliefs may impact one’s clinical practice.

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References


Appendix

Survey

RELIGIOUS AND SPIRITUAL BELIEFS AMONG AUSTRALIAN RMTS & INFLUENCE ON CLINICAL PRACTICE (formatting removed)

There are many elements that influence our reasons for becoming music therapists. Factors that come to mind include one’s personality, previous personal experiences, a belief in the power of music, and the desire to help other people. For some, music therapy may have been the perfect marriage between a professional interest in psychology and in music. For others, it may have been the perfect marriage between a love for music and the desire to help others. During a conversation with a music therapist who was my clinical supervisor at the time, an apparent trend was brought to my attention. It seemed that many music therapists and music therapy students in our immediate circle held various religious or spiritual beliefs. This led me to question the possible role of religion and spirituality among music therapists, and form the basis for this study. What is the prevalence of religious background and spirituality among Registered Music Therapists in Australia and how might this influence one's work as a music therapist? The following survey aims to address these questions.

1) Please select the description that best suits you:
   a. I am currently affiliated with an organised religion (eg. Protestant, Catholic, Buddhist, Muslim, Jewish, etc.)
   b. I consider myself as spiritual or spiritually aware, but do not belong to an organised religious group
   c. I am none of the above

2) Which organized religion are you affiliated with? OR if you consider yourself spiritual, please elaborate on your spiritual beliefs. OR Please tick if N/A

3) Do you believe your religious or spiritual beliefs had an influence on your decision to become a music therapist? If yes, how?

4) To what extent do your religious or spiritual beliefs influence your clinical work as a music therapist? OR Please tick if N/A

5) Please explain how your religious or spiritual beliefs influence or do not influence your work.

6) If your religious or spiritual beliefs have influenced your clinical work, what client population(s) were you working with at the time? OR Please tick if N/A

7) Have you come across a situation where your beliefs about religion or spirituality have clashed within your clinical practice as a music therapist? (eg. with a client, client’s family, colleague etc.) If yes, please elaborate and give an example of how you responded.

8) Have you come across a situation where your beliefs on religion or spirituality have enhanced your clinical practice as a music therapist? (eg. client, client’s family, colleague etc.) If yes, please elaborate and give an example of how you responded.

9) Do you believe religious and spiritual beliefs should be kept separate when working with clients in a clinical context? If yes, why? If no, why not?

10) Please comment on your experience of completing this survey. Was it easy, difficult or other?

You have reached the end of the survey. Thank you.