THE EFFECTIVENESS OF MUSIC THERAPY INTERVENTIONS WITH PERSONS OF CONCERN: AN INTEGRATIVE REVIEW

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THE EFFECTIVENESS OF MUSIC THERAPY INTERVENTIONS WITH PERSONS OF CONCERN: AN INTEGRATIVE REVIEW

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Music in the College of Fine Arts at the University of Kentucky

By

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2019

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ABSTRACT OF THESIS

THE EFFECTIVENESS OF MUSIC THERAPY INTERVENTIONS WITH PERSONS OF CONCERN: AN INTEGRATIVE REVIEW

Immigrants, refugees, asylum seekers, internally displaced persons, and stateless persons, collectively known as “persons of concern,” often have unmet mental health and wellness needs as a result of trauma. With a diverse variety of interventions and approaches, the use of music therapy has the potential to meet the needs of persons of concern. In the present study, the researcher conducted an integrative review to examine the use of music therapy with persons of concern. After conducting a hand-search of music therapy journals and an advanced keyword search through internet databases, the researcher found 17 studies that met inclusion criteria. There were ten studies in which participants were immigrants, six studies in which participants were refugees or asylum seekers, and one study in which participants were displaced persons. Refugees’ countries of origin were: Azerbaijan, Cambodia, Chile, Democratic Republic of Congo, Ethiopia, Iran, Liberia, North Korea, Rwanda, Sierra Leone, Sudan, and Vietnam. Immigrants’ countries of origin were: China, Haiti, India, Korea, Latin America, Malaysia, Mexico, Romania, Russia, and Vietnam. Interventions used in the studies were (in order of frequency) singing, songwriting, instrument play, improvisation, lyric analysis, music listening, music imagery, and music-based relaxation. The needs of persons of concern, music therapy interventions, the rigor and quality of music therapy research, and implications for future clinical practice are discussed.

KEYWORDS: Music Therapy, Persons of Concern, Immigrants, Refugees, Integrative Review

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4/17/2019
THE EFFECTIVENESS OF MUSIC THERAPY INTERVENTIONS WITH PERSONS OF CONCERN: AN INTEGRATIVE REVIEW

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“Yesterday I was clever, so I wanted to change the world.
Today I am wise, so I am changing myself.”

-Rumi
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CHAPTER ONE

Introduction

Definitions of Terms

Since 2014, forced displacement of individuals around the globe has risen to an all-time high (Edwards, 2016). There are groups and sub-groups of people who find themselves in a new country or living environment whether or not it is their choice. The United Nations High Commissioner for Refugees, or UNHCR, has defined and categorized these groups as persons of concern in need of protection, shelter, health, and education: immigrants, refugees, asylum seekers, internally displaced persons, and stateless persons (UNHCR, n.d., para 1).

An “immigrant” is defined as someone who chooses to resettle in another country, for which there are various legal processes worldwide (United Nations, 2013). Immigrants often have the choice to move in order to pursue improved quality of life, employment and economic wealth, or educational opportunities. A “refugee” is someone who has been forced to leave their home country due to armed conflict or persecution and is therefore required to prove there is imminent danger to them in their home country in order to procure an official refugee status. Within the “refugee” category, there are also “asylum seekers,” or individuals claiming to be refugees whose claims have not yet been evaluated. All refugees begin as asylum seekers while awaiting lengthy and complicated legal application results, but not all seeking asylum are granted refugee status (Habitat for Humanity Great Britain, n.d.).
There are also those who are unable to cross international borders, “internally displaced persons” (IDP). IDPs do not cross international borders to seek help and often remain under the protection of their own government, even if the government is the reason for their displacement. These individuals are considered especially vulnerable due to their displaced locations where humanitarian aid is difficult to deliver. According to the Internal Displacement Monitoring Centre, approximately 40.3 million people were considered internally displaced in 2017 as a result of armed conflict, human rights violations, or generalized violence (UNHCR, n.d.).

Similarly, someone who is “stateless” is fluidly defined as someone who is not considered a national citizen by any country under the operation of its law. Statelessness may occur in migration and non-migration situations, and the legal definition varies from nation to nation; for example, a refugee could be described as stateless if they have left their country due to persecution (The International Observatory on Statelessness, n.d.).

**Population Statistics**

A Global Trends report by UNHCR found that in 2015, approximately 65.3 million individuals were displaced from their homes by conflict and persecution. Of those 65 million, approximately 22.5 million were considered refugees (people who fled to a foreign country or power to escape danger or persecution), of which only 189,300 were re-homed in 2016 (UNHCR, 2016). In addition, the UNHCR estimated that, of the total number of persons of concern in 2016, there were 3.1 million asylum seekers (UNHCR, 2016).
According to a 2018 report from U.S. News, foreign-born residents now make up approximately 13% of the U.S. population, with 25.5% of immigrants coming from Mexico (Zong and Batalova, 2018). In 2017, the top three countries of origin for refugees in the U.S. were the Democratic Republic of Congo, Iraq, and Syria (UNHCR, 2017). Of the 16.5 million refugees documented worldwide in 2016, the U.S. set its 2017 refugee resettlement limit at 57,000 people via executive order from President Trump (Immigration Forum, 2018), and later at 45,000 in 2018, the lowest number since the Refugee Act of 1980 was passed. According to Refugee Council USA, in order to reach a cap of 45,000 refugee resettlements per year, approximately 3,750 refugees must be resettled each month (Refugee Council USA, 2018). If the total number of refugees are not quickly and appropriately resettled, this could jeopardize the safety of people of concern, many of whom are minors, and prevent families or groups from remaining together.

Persons of concern face several barriers in ensuring assimilation into a country. Interpersonal communication, societal roles, and standards of interaction can greatly impact how people adjust to a new culture and its inhabitants. Spoken language is only one facet of communication, which varies from society to society. Language can also determine societal perceptions of foreign-born citizens and the ease with which they are resettled. Using Schumann’s Acculturation Model, which defines acculturation as “social and psychological integration of the Learner with the Target Language Group” (Schumann, 1978, p. 379), researchers have hypothesized that the acquisition of a second language can directly relate to or influence a person’s adaptation to a new culture.
Connections to others, family separation, and disabilities as a result of injury can contribute to future risks of mental health issues, such as drug addiction, suicide, depression, anxiety, and PTSD for persons of concern (Kirmeyer et al., 2011). The United States Refugee Admissions Program (USRAP) states that, on average, a length of two years is needed to screen a single adult applying for refugee status after they are referred by the United Nations High Commissioner for Refugees (Immigration Forum, 2018). Refugees who are approved by the USRAP are provided with limited currency, basic housing, some food from their native country, and cultural training to help prepare them for the U.S. state in which they will eventually be settled. There are at least two ways refugees can apply for asylum, but the process can take between six months and several years (Immigration Forum, 2018).

A report from the National Immigration Forum stated that in 2018, there were over 733,000 pending cases of immigration with an average hearing delay of 721 days (National Immigration Forum, 2018). As a result of budget cuts and administrative changes to immigration judgement policies, the backlog of active deportation cases is expected to increase and contribute to present challenges judges face, like having access to an applicant’s documentation from their home country, which may or not be unstable (Los Angeles Times, 2018).
In addition to the legal challenges an immigrant, refugee, or asylum-seeker faces for simply gaining safe entry into the United States, other difficulties may include physical and mental health, language and communication, disabilities, financial support, and acculturation. Koya and Egede (2007) found that immigrants develop higher risks of cardiovascular disease due to issues of mental health related to acculturation based on their length of stay in the United States. Leclere, Jensen, and Biddlecom (1994) found that, compared to native-born U.S. residents or immigrant residents of up to 10 years, newly immigrated individuals were less likely to receive timely healthcare access. Additional evidence from an analysis by Singh and Siahpush (2002) provided information linking foreign-born U.S. residents’ length of stay in the United States with increased risk factors and prevalence of obesity, smoking, hypertension, and chronic health conditions. It is estimated that refugee children are five times more likely to be out of school than their non-refugee peers (UNHCR, 2016), and a vast number of refugees are left with disabilities as a result of cultural conflict and war (UNHCR, 2016). The needs of persons of concern are becoming more urgent and complex.

**Resources to Address Challenges**

The type and availability of resources for persons of concern vary from country to country, as well as region to region. According to the UNHCR, there are currently nine resettlement agencies in the U.S.: Church World Service, Ethiopian Community Development Council, Episcopal Migration Ministries, Hebrew Immigrant Aid Society, International Rescue Committee, Lutheran Immigration and Refugee Service, U.S. Committee for Refugees and Immigrants, United States Conference of Catholic Bishops/Migration and Refugee Services, and World Relief (UNHCR, US Resettlement
Agencies, n.d.). The UNHCR is an international agency that assists other resettlement agencies in placing and vetting persons of concern. Refugees in the U.S. are resettled through these agencies’ affiliate offices throughout the country.

These offices help to provide refugees with employment and language proficiency classes, as well as immigration information to assist them in becoming permanent residents, which could take one year or longer after the initial two year vetting and clearance period. Refugees may also apply for U.S. citizenship after five years of residency. Figure 1 displays the top countries of origin of refugees for the year 2017. Figure 2 displays the most common resettlement areas of refugees in 2017.

*Figure 1. Where America’s refugees come from (Source: Refugee Processing Center, 2017a).*
Whereas national agencies are more focused on checking backgrounds of migrants or refugees and conducting legal procedures for entry, regional organizations are able to further connect immigrants and refugees with legal aid during times of resettlement, as well as assistance in housing, transportation, adult education (academic, mental and physical health, community groups, interpreters, and job opportunities), childcare, and citizenship classes (UNHCR, 2018). Despite the variety of resources made available at the national and international level, there is little mention of services devoted to mental health, which could be an underlying issue that would affect a major life event such as immigrating or seeking refuge, or mental health concerns could come to fruition as a result of the refuge-seeking process. In times of uncertainty or distress, locating a resource to offer personalized assistance can be challenging. Of these possible resources, music can be found as an integral part of societies throughout the world, with places in rituals, performing arts, cultural identity, historical preservation, religion, and spirituality (Braithwaite, 1998).

*Figure 2.* Where refugees in America live (Source: Refugee Processing Center, 2017b).
The Role of Music

Music and musical properties can have a powerful role within the context of life transitions, such as bereavement (Amir, 1998). Music in a multicultural context can be used for preserving history, artifacts, rituals, expressing and transforming identity, and musicking by singing, listening, or performing in any way (Lidskog, 2017). Cultures original to and new to the United States (e.g., slaves and immigrants) have contributed to musical knowledge, instruments, styles, uses (plays or dramas), and expression (Library of Congress, n.d.).

In spite of the artistic impact foreign-born citizens have made, there is increasing evidence illustrating the struggles and vulnerabilities of these populations. Those working in relief efforts have begun incorporating more diverse methods of meeting the needs of these individuals, such as culturally-related components like music. With a lack of access to music-related services due to unreliable transportation, a shortage of clinicians, high program costs, or inaccessibility of effective communication and language, the genesis of service programs can seem daunting (Nöcker-Ribaupierre, 2009). Board-certified music therapists can work with communities to bridge the gap in service access by implementing appropriate services based on the needs of facilities, programs, and the community in culturally-relevant ways.
Music Therapy

Music therapy is an evidence-based profession in which a credentialed music therapist uses carefully selected music-based interventions to address physical, psychological, social, and emotional needs (AMTA, 2006, para. 1). According to an overview of research from the American Music Therapy Association, trauma-informed music therapy interventions have produced evidence of positive changes in the following outcomes: muscle tension and anxiety, relaxation, verbalization, interpersonal relationships, and group cohesiveness (AMTA, n.d.).

However, the music-based research concerning international populations who have experienced trauma is limited. With the growing number of immigrants and refugees worldwide, there is a shortage of information outlining or addressing the needs of those individuals. The purpose of this integrative review is to investigate and analyze existing music-based interventions or music-based approaches that address the needs of immigrants and refugees, as well as explore any gaps in the literature.
CHAPTER TWO

Review of Literature

Global Statistics of Persons of Concern

According to World Vision, the top five countries of origin that account for the majority of refugees are: Syria (6.3 million), Afghanistan (2.6 million), South Sudan (2.4 million), Myanmar (1.2 million), and Somalia (986,400) (World Vision, 2018). The top ten countries that took in the most migrant individuals in 2016 were: the United States (accepted 1,183,500), Germany (accepted 1,051,000), the United Kingdom (accepted 350,100), Canada (accepted 296,400), France (accepted 258,900), Australia (accepted 223,500), Spain (accepted 215,000), Italy (accepted 212,100), the Netherlands (accepted 138,500), and Sweden (accepted 132,800) (U.S. News, 2018). However, many of these numbers account for permanent lawful entry and not migration or asylum by any other means (such as entry by boat, which Australia prohibits) (U.S. News, 2018).

Barriers and Challenges

Economic gain, educational opportunities, and family connections are some reasons why an individual or family may choose to immigrate. For those whose lives are directly threatened, the reasons seem more imminent; violence, terrorism, discrimination, and inhumane living circumstances can create complex difficulties that are exacerbated when attempting to seek refuge. Regardless of a person’s circumstances, a major move to a new country can come with challenges that impact people similarly.
Approximately 15% of individuals in the U.S. immigration system have a mental illness (ACLU, 2018), which could be pre-existing or arise as a result of the immigration or asylum process. This can sometimes determine whether they are viewed as adaptable or able to fit in or contribute to their new home country. Similarly, individuals with physical disabilities are more likely to be deported than those without. The United States is said to be lenient with mental health concerns and individuals are only deported if they “pose a threat to others,” but there are stricter appeal procedures concerning physical disability (Council of Canadians with Disabilities, 2018, para 1).

Another difficulty within immigration and seeking refuge is the use of varying, inconsistent terminology that can affect how immigrants and refugees see themselves, or how others see them. Language of immigration law still uses “public charge” language from the early 20th century when foreign-born citizens were viewed as potential threats. This use of potentially discriminatory language is reflected in, stating that For example, individuals applying for entry into U.S. will be excluded from becoming a U.S. citizen if they may become a public charge or exhibit mental and physical behaviors that would be harmful to others, according to a source from the National Coalition for Latinx with Disabilities (2018) (as cited in Dept. of Homeland Security, 2018). Unfortunately, with stringent consequences for failing to be viewed as non-threatening, there is a lack of safeguards in the arrests, hearings, deportations, and removal of immigrants with mental health issues that potentially cause further psychosocial harm (ACLU, 2018).
According to the Women’s Refugee Commission (2018), among 66 million displaced people, over 13 million are presented with disabilities. These individuals are often overlooked or excluded from receiving resettlement services, and women and children with disabilities face a higher risk of experiencing gender-based violence. Disabilities may be a direct result of disease, war, or violence in a person’s home country due to explosive weapons or as a result of older age (UNHCR, 2017). Aside from age and gender, groups of people with disabilities are often overlooked when attempting to enter a new country, reflected in the lack of appropriate normative language in international mandates (UN, 2018) even though there are articles and acts that call for change in The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN, n.d.).

**Multicultural Music Therapy**

Because the roles of music are central and unique to each culture, music therapy can be implemented and adapted to assist individuals in reaching specific goals. Properties of music such as tempo, dynamics, lyrics, and instrumentation can evoke changes in emotional expression, verbal and nonverbal interaction, physiological changes (heart rate, respiration rate, oxygen saturation, sleep quality), cultural sharing, and social/emotional/cognitive engagement (Orth, Doorschodt, Verburgt, & Drožděk, 2004). Music therapy literature centered in multicultural music therapy offers invaluable insight to cultural identity, breadth of musical knowledge, cultural complexities, and experiences of music therapists who have worked with immigrants and refugees.
Whitehead-Pleux and Tan (2017), Jin (2016), and Swamy (2014) have all described the intricacies of working with individuals from differing cultures and backgrounds, concluding that a comprehensive framework of culture is difficult to build. However, in order to be effective, music therapists must understand how their identities differ from their clients while remembering which aspects of music can be universally understood? (Swamy, 2014). Comte (2016) has also articulated that music therapists might be influenced by their own assumptions about refugee populations. These assumptions from Comte’s critical interpretive synthesis were the homogeneity of refugees and the view that musical improvisation is a universal language. Privileging a person’s refugee status over other aspects of their identity, like religion or ethnicity, can contribute to culturally un-centered practice in music therapy, as well as making judgements of a person’s musical improvisation from a Western European aesthetic perspective rather than from the culture of the individual.

In the confines of music therapy, it is also possible to experience vicarious traumatization when using reflective and reflexive techniques. Resources for handling this type of burnout might be limited for music therapists (Jin, 2016). Aside from empathetic responsibility, music therapists must also be prepared to facilitate the most effective treatment sessions with authentic, patient-preferred music (Yeung, Baker, & Shoemark 2014). Musical components such as language, lyrics, genre, and instrumentation are geographically different, and a patient’s subculture may also play a part in musical choices (Ansdell, 2004). In spite of the potential for multicultural music therapy to benefit foreign-born citizens, there is a need for additional research in this
area, as well as a need to summarize the existing information through an integrative review.

**Integrative Reviews**

Due to the variance of information concerning the use of multicultural music therapy and persons of concern, there is a lack of comprehensive information to better inform clinicians. The use of integrative review frameworks can be helpful in casting a wide net while synthesizing specific aspects of data. Through integrative reviews, information has been gleaned on the impact music can have on a person’s quality of life.

In the realm of music education, an integrative review by Gooding and Yinger revealed that performance-based options for students with disabilities lack optimal pathways of inclusivity and ease of participation (2014). Another integrative review of music psychology and emotion by Juslin and Sloboda showed that when listening to music, emotions can be influenced either passively or actively (2001). Within music medicine, integrative reviews revealed that music can decrease cancer patients’ perceptions of pain in a diverse, non-invasive manner (Keenan & Keithley, 2015) and that can have a positive impact on decreasing pre-operative anxiety (Pittman & Kridli, 2011). Lastly, an integrative review on music therapy in the neonatal intensive care unit found that music therapy contributed to positive effects in pacification and stabilization of pre-term infants (Haslbeck, 2011).

Little is known regarding the past and present work of board-certified music therapists with immigrant and refugee populations. In the 2017 AMTA Workforce Analysis, no specific information was divulged about music therapists working directly...
with these populations (2017 AMTA Workforce Analysis, pg. 14). However, immigrant and refugee populations might be seen within the confines of certain diagnoses or target populations such as those experiencing post-traumatic stress disorder, school aged people, or the physically disabled. Due to the wide parameters and scopes of practice within music therapy, well-established goals related to cognition, behavior, emotion, physical and physiologic function, and identity may be applied to populations of immigrants and refugees. What is still unknown is the number and types of settings in which music therapists have accessed populations of immigrants and refugees the specific interventions used to accommodate cultural needs, and if the current work of music therapists is reflective of migrant and refugee circumstances and any needs they develop. With the addition of culturally-informed research, the benefits of music therapy may become even more accessible and integral in the lives of persons of concern.

**Problem Identification and Purpose**

Despite increased awareness of the needs of immigrants and refugees, there is little comprehensive evidence of directives that have been made within the music therapy field in order to address the needs of these populations. With annually increasing numbers of persons of concern in the United States, mental health issues and obstacles with resettlement are becoming more prevalent (ACLU, 2018). The purpose of this integrative review was to investigate and analyze existing music-based interventions or music-based approaches that address the needs of immigrants and refugees, as well as explore any gaps in the literature.
Research Questions

The researcher addressed the following research questions:

1. What are the characteristics of research that currently exists about music therapy services for immigrants and refugees?
2. Which music therapy interventions have been used for immigrant and refugee populations, and what is the quality of intervention reporting in research with these populations?
3. How effective are music therapy interventions with immigrant and refugee populations?

It is the hope of the researcher to use the results of these research questions to provide further implications for current and future music therapists based on past and current practices with immigrants and refugees. It is also the aim of the researcher to discover any gaps between current statistics relating to persons of concern, approaches to research, and methods being used to counteract or mediate obstacles. Suggestions for music therapists are made in the discussion section.
CHAPTER THREE

Methodology

Due to the wide range of potential settings, treatment methods, population demographics and needs, the researcher used an integrative review approach in order to synthesize the literature in the most effective and comprehensive manner. An integrative review is a broad, comprehensive research method that allows for the inclusion of quantitative and qualitative (experimental and non-experimental) literature, which is useful when analyzing diverse types of research (Haslbeck, 2012). The review was modeled after a framework developed by Whittemore and Knafl (2005) in order to decrease the potential of developing a researcher bias or error. The review process was conducted in five stages: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis, and (e) presentation of findings.

Research Procedures

The researcher used a search strategy in a method similar to other integrative reviews by Burns (2012), Gooding and Yinger (2014), and Whittemore and Knafl (2005). The search included the use of these keywords: music therapy, immigrant, migrant, refugee, asylum seeker, stateless person, internally displaced person, alien, foreigner, permanent resident. Although the term “alien” is recognized as a controversial and culturally insensitive way to describe immigrants and/or refugees, this term was included in the search in order to account for past research in which the term was more commonly used (NPR, 2015).
**Literature Search**

The researcher performed two methods of literature search and collection: obtaining articles from an online database search and obtaining articles from a hand search of music therapy journals. The researcher searched the following selected databases for literature: PsychINFO, JSTOR, PubMed, ERIC, ProQuest, and Google Scholar. The researcher also conducted hand searches through the following peer-reviewed journals: *Journal of Music Therapy, Music Therapy Perspectives, Music Therapy, Australian Journal of Music Therapy, British Journal of Music Therapy, Canadian Journal of Music Therapy, Nordic Journal of Music Therapy, Qualitative Inquiries in Music Therapy*, and *Voices*.

The researcher used these sets of keywords in searching databases and in hand-searching music therapy journals:

1. Music, music therapy, immigrant
2. Music, music therapy, migrant
3. Music, music therapy, refugee
4. Music, music therapy, asylum seeker
5. Music, music therapy, internally displaced person
6. Music, music therapy, stateless person
7. Music, music therapy, alien

The researcher evaluated all studies based on the inclusion and exclusion criteria.
The researcher’s final inclusion criteria for literature were as follows. Included articles:

a) involved the use of music therapy as the primary modality,

b) involved immigrants or refugees as the primary participants or subjects,

c) were scholarly articles or unpublished theses or dissertations, and

d) were published in English.

Exclusion criteria for literature were as follows. Articles were excluded if they:

a) did not include the use of music therapy as the primary treatment for participants,

b) did not include immigrants or refugees as primary participants, or

c) were not initially published in English.

Analysis

For all included studies, the researcher extracted and represented the following characteristics of the literature: author(s) and year of publication, country of origin, design, participants (age, gender, nationality/ethnicity, number of participants), outcome measures, and study results. The researcher then assessed the level of evidence for each study and synthesized the results. For both search methods, if the inclusion criteria were met based on an initial review of the title and abstract of the articles, then the articles were included in this work. Duplicate articles, articles not meeting inclusion criteria, and articles not relevant to the purpose of the integrative literature review were discarded. The remaining articles were then reviewed and findings were categorized.
In order to further assess the rigor and quality of each included study, the researcher listed and defined each study’s design format and theoretical or philosophical framework (see Figures 4 and 5). To further assess the quality of music therapy intervention reporting, the researcher used Robb’s guidelines for reporting music-based interventions (Robb, 2011) (see Table 3). Limitations of the literature search and analysis were the exclusion of material not published in English, potentially incomplete reporting of intervention qualities by the included studies’ authors, and missing studies due to a difference of key terms within the abstract or title.
CHAPTER FOUR

Results

Research Question 1

What are the characteristics of research that currently exists about music therapy services for immigrants and refugees?

The results of the literature search yielded 17 studies that met inclusion criteria, with 103 studies being excluded for either being a duplicate article or not being relevant to the study (see Figure 3). Certain keywords used in the search strategy yielded very few or no results, including: stateless person, internally displaced person, alien, asylum-seeker. Studies were grouped into tables by age of participants: families and children under 18 years of age, and adults aged 18 years and older (see Tables 1 and 2). The rationale for this grouping was to facilitate investigation of the diverse study characteristics and to search for any potential patterns related to study settings and participant life experiences.
Resource 1: Music Therapy Journals ($n = 41$)

Hand search of each volume available, screened by title and/or abstract:

- Australian Journal of Music Therapy ($n = 5$)
- Nordic Journal of Music Therapy ($n = 9$)
- Canadian Journal of Music Therapy ($n = 1$)
- British Journal of Music Therapy ($n = 1$)
- Music Therapy Perspectives ($n = 6$)
- Music Therapy ($n = 0$)
- Journal of Music Therapy ($n = 2$)
- New Zealand Music Therapy Journal ($n = 1$)
- Voices ($n = 15$)
- Qualitative Inquiries into Music Therapy ($n = 1$)

Resource 2: Online Databases ($n = 72$)

- ERIC: $n = 4$
- JSTOR: $n = 4$
- PsycInfo: $n = 0$
- ProQuest: $n = 37$
- PubMed: $n = 0$
- Google Scholar: $n = 27$

Articles meeting inclusion and exclusion criteria

- NO ($n = 100$)
  - a. duplicate article, already found in hand search
  - b. duplicate article, already found in first keyword search
  - c. not relevant to study

YES, articles selected ($n = 17$)

Figure 3. Flowchart of literature search process
### Table 1

**Studies Including Children under 18 years and Families**

<table>
<thead>
<tr>
<th>First Author, Year, Country of Study and Setting</th>
<th>Design/ Theory or Framework</th>
<th>Participants</th>
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<tbody>
<tr>
<td><strong>Baker (2005)</strong> Australia, high school English-language reception center</td>
<td>Cross-Over Design</td>
<td>$N = 31$</td>
<td>Refugees from Sudan ($n = 20$), Iran ($n = 5$), Liberia ($n = 2$), Rwanda ($n = 2$), Ethiopia ($n = 1$), Democratic Republic of Congo ($n = 1$)</td>
<td>Behavior Assessment Scale for Children (BASC) conducted by teachers, Multiple Analysis of Covariance (MANCOVA)</td>
<td>Instrumental improvisation, song sharing, songwriting, dancing, singing.</td>
<td>Two groups received two 10-week terms of alternating 30-40 minute group music therapy treatment and baseline education. Results yielded a significant difference between treatment effects, as well as a significant decrease in hyperactivity over time by treatment condition. No significant changes in other behaviors were noted. Brief increases of negative behaviors were observed in the middle of the treatment phases, suggesting that the participants were re-experiencing crises that improve with time. Long-term treatment effects approached significance for the BSI. Cultural differences in behavior should be noted as influencing factors in BASC assessment, as well as misinterpretations due to lack of English-speaking skills as difficulty with emotional expression. Lack of English competency can contribute to frustration.</td>
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<tr>
<td>Cominardi, (2014) Italy, main play area of two kindergarten schools in Brescia</td>
<td>Qualitative Observation</td>
<td>$N = 65$ (including 14 immigrants)</td>
<td>The author did not specify the ethnicities of the participants who were immigrants but did mention that most immigrants in Brescia are from Morocco, Albania, Ghana, India, Moldova, Pakistan, Romania, Senegal, and Ukraine.</td>
<td>Creative improvisation based on Orff-Schulwerk approach with Orff and ethnic instruments including maracas, cabasas, rainsticks, bongos, etc.</td>
<td>Sound-musical improvisation, graphic-pictoral improvisation, motor-environmental improvisation within an Orff Schulwerk context.</td>
<td>Researchers observed an increase in expressive autonomy, decreased prejudice against immigrants from natives, and reduced anxiety among extroverted and introverted individuals due to equalization in participation opportunities without competition or expectations. It is unknown if these results generalized outside of the study site and school setting.</td>
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<td>Eren (2017) Turkey, public school of Romani children</td>
<td>Qualitative Observation</td>
<td>N = 35</td>
<td>Romani immigrants from Turkey</td>
<td>Audio and video transcriptions, observational field notes, semi-structured interview with the teacher</td>
<td>Multicultural Orff Schulwerk-based activities: rhythm, singing, instrument play, and movement to music to varying music genres and styles.</td>
<td>Researchers observed an increase in participant school attendance, along with positive changes in both musical abilities and social, emotional, motor, and cognitive skills. Behaviors were speculated to improve due to the facilitator’s behavioral approach.</td>
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Two groups received 45-minute treatments each Friday throughout the school year.

During the first 4 months of treatment, the following behaviors were observed: exaggerated attachment to family members/siblings in school, inability to follow directions, gender-based friendship, verbally abusive language directed at one another, gang-based grouping, displays of street culture, and a preference of Romani music.
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<tbody>
<tr>
<td>Felsenstein, (2012) Israel; preschool setting developed by community</td>
<td>Case study; UP model (Uprooting to rePlanting), BASIC Ph model of coping and resiliency (Belief, Affect, Social, Imagination, Cognitive, Physical) to address posttraumatic symptoms</td>
<td>$N = 21$</td>
<td>Jewish displaced families from the Gaza Strip</td>
<td>Observable indicators of post-traumatic growth: intrusions, avoidance, hyper arousal</td>
<td>Use of live music (instrument play, singing) and recorded music (karaoke, music listening, songwriting) paired with other elements of play such as role playing, movement to music, and the creation of art. Genres of music used included Israeli music, children’s songs, international musicals, and classical music. Participants received once-weekly group sessions for five months.</td>
<td>The study yielded mixed results with verbal and non-verbal activities. Participants were more likely to engage in non-verbal activities due to language deficits. Issues that researchers observed were: absenteeism due to illness or posttraumatic attachment to parents, low tolerance of frustration, short attention deficit, suppression of emotion, regressive behavior, and loss of value for material possessions. One particular intervention, guided imagery, had an adverse effect on participants as the sounds and cues the therapist asked children to associate experiences with triggered emotional distress.</td>
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</thead>
<tbody>
<tr>
<td>Jones (2004) Australia; school for recently resettled students with no English-speaking skills</td>
<td>Multiple Case Study</td>
<td>$N = 6$</td>
<td>Refugees from Sudan</td>
<td>Observable indicators of social interaction and emotional expression with peers and adults.</td>
<td>Complementary instrument play, singing, body movement, use of participant-preferred current hip-hop and rap from America. Interventions were adapted to suit the interests and needs of participants.</td>
<td>Interventions improved rapport and communication between participants who initially displayed aloofness and anger issues. However, there might have been misinterpretations of participants’ behavior due to cultural differences between researchers and social norms of participants. Western-based client-centered music therapy and the social roles of music and certain musical instruments were reflected upon based on the participants’ manner of engagement in sessions, as well as their interactions with each other and the music therapist.</td>
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<tr>
<td>Kennedy (2008) United States; kindergarten ESL (English as a Second Language) classes</td>
<td>Pre-post/Quasi-Experimental</td>
<td>N = 18</td>
<td>Latino immigrants</td>
<td>LAB-R (Language Assessment Battery Revised test), Literacy Assessment of Second Language Learners, English Speaking Checklist, Story Retelling Inventory</td>
<td>Chanting, use of rhythm sticks, singing, movement to music, music listening, and lyric analysis to target receptive and expressive language skills.</td>
<td>English-speaking and storytelling skills improved in both groups, with the after-group performing slightly better in both categories due to a more relaxed environment and less pressure to make mistakes when using their second language. Two groups received treatment, with one receiving music therapy during intact class time, and another after school in a community-based setting.</td>
</tr>
<tr>
<td>Mondanaro (2016) United States; Mount Sinai Beth Israel Hospital</td>
<td>Case Study</td>
<td>N = 5</td>
<td>Immigrants from Romania (A), Germany (B), Haitian-African community (C), China (D), and Latin America (E)</td>
<td>Observed indicators of self-affirmation and cultural identity.</td>
<td>Interventions varying from patient to patient were: procedural support, music-based discussion, singing songs of kin, instrument play, spiritual support, and recreating preferred music.</td>
<td>Not all individuals facing medical emergencies have the preference or cognitive ability to turn to their cultural heritage in the same manner to process the event. Music therapists must use flexibility and reflexivity in musical and non-musical domains; including family members in sessions can sometimes have a positive influence on the family unit as well as the individual patient.</td>
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### Table 2

**Studies Including Adults (18+ years)**

<table>
<thead>
<tr>
<th>First Author, Year, Country of Study and Setting</th>
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<tbody>
<tr>
<td>Ahonen (2014) Canada; community health center</td>
<td>Qualitative Paradigm, Phenomenology</td>
<td>$N = 6$</td>
<td>Refugees (countries of origin not specified)</td>
<td>Audio tape and transcribed sessions, interviews in hermeneutic method based on subjective interpretation.</td>
<td>Participants received 8 weekly sessions, each session lasting 1.5 hours (with an interpreter provided if needed).</td>
<td>The aim of the study was to document shared feelings between participants. Shared feelings were: self-defining a trauma story (helplessness, fear, pain and anxiety), transition story (acceptance, dealing with loss and guilt), and re-authored survivor story (validation, feeling content, liberation). Participants felt meaning in giving and receiving support after surviving trauma.</td>
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Age: 30–60 years
Table 2 (continued)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Choi (2010) South Korea CAC-MT based program (CARING at Columbia Music Therapy) in a school setting</td>
<td>Multiple case study</td>
<td>$N = 9$</td>
<td>Refugees from North Korea recruited from an alternative school</td>
<td>Field notes and anecdotal reports</td>
<td>Participants received a total of 25 group sessions made up of two 45-minute sessions during the school day.</td>
<td>Participants perceived a reduction in psychological distress and behavior issues based on the following themes that emerged during the study:</td>
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<td></td>
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<td>Male: $n = 5$ Female: $n = 4$</td>
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<td></td>
<td>1. Avoidance</td>
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<td>Age: 18–24 years</td>
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<td>2. Distrust</td>
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<td>3. Loneliness</td>
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<td>4. Feelings of Loss</td>
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<td>5. Fear</td>
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<td>Units addressed issues in this order: feelings about self, problem solving, feelings about our friends, feelings about our community, and feelings of loss, healing, and “goodbye.”</td>
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<td>Forrest (2000) Australia, hospital palliative care setting</td>
<td>Case Study</td>
<td>$N = 1$</td>
<td>Immigrant from Russia Semi-structured interview, observed indicators of cultural identity and self-affirmation</td>
<td>Singing patient-preferred classical, Western, and Russian songs (accompanied by family members), music-based discussion in an effort to address and resolve conflicts of self-identity near death.</td>
<td>Participant experienced improved affirmation of personal identity and exploration of family issues with family members present during the participant’s progression toward death and life review.</td>
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<tr>
<td>Kim (2013) United States; New York community center</td>
<td>Multiple Case Study</td>
<td>$N = 6$</td>
<td>Immigrants from Korea (unspecified if from North or South Korea) Culturally-Informed Music Therapy</td>
<td>Participants received six months of once-weekly, 60-minute group music therapy framed by the Feminist Theory and Social Justice Theory. Researchers used a musical assessment based on heritage, English-speaking skills, and family history, singing, song discussion, relaxation, and improvisation.</td>
<td>Goals of the sessions were to bring attention to awareness to participants’ acculturation-related stress and to remove acculturation conflicts within the context of the participants’ families. Participants eventually benefitted from feminist theory with improved sense of empowerment and knowledge of rights, but initially displayed difficulty with initializing instrument-play and group participation without offering apologies.</td>
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<td>Lauw (2016) Australia; Chinese residential care facility for older adults</td>
<td>Qualitative Observation</td>
<td>$N = 17$</td>
<td>Immigrants from China, Malaysia, Vietnam</td>
<td>Observed indicators of social interaction.</td>
<td>Participants received two music therapy and movement group sessions per month for 3 months conducted in Mandarin by a Chinese-Singaporean music therapist who spoke Mandarin but was most comfortable with English.</td>
<td>The music therapist was a third-generation Chinese-Singaporean person who reflected on guanxi (interpersonal relationships) and mianzi (social self-worth) after facilitating the music therapy sessions. Higher attendance of participants in group sessions was observed after revision of song selections to accommodate accurate participant preferences and dialects, and participants became more social outside of group sessions despite strong, unspoken social rules.</td>
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<tr>
<td>Schwantes (2011) United States; group home</td>
<td>Multiple Case Study</td>
<td>N = 14</td>
<td>Immigrants from Mexico who had experienced an auto accident and the death of one of their friends</td>
<td>Participants’ contributions to writing a corrido narrative ballad.</td>
<td>Participants received four sessions of group songwriting and lyric analysis, as well as time to record a final product of the written song.</td>
<td>Three healthcare providers were also present during group sessions. One healthcare provider served as an interpreter. Researchers observed and increased level of participation over the course of the study with culturally-centered interventions, along with improved group cohesion. A few participants engaged more than others due to previous musical training and lack of music performance opportunities after moving to the U.S. until the start of music therapy sessions.</td>
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<tr>
<td>Schwantes (2010) United States; group home</td>
<td>Mixed Methods</td>
<td>N = 5</td>
<td>Immigrants from Mexico</td>
<td>CES-D (Center for Epidemiological Studies Depression Scale), BSI 18 (Brief Symptom Inventory 18), semi-structured interviews</td>
<td>Five weekly group music therapy sessions with music-making, music instruction, and lyric analysis</td>
<td>Though the researcher spoke Spanish, a male interpreter was used in order to accommodate the participants’ perceptions of female group leaders. No significant differences were found in the BSI 18 inventory, but significant differences in mean level of depression were recorded as measured by the CES-D. Familism and machismo (male dominance and responsibility) are two themes specific to Mexican and Latinx culture explored in this study. Participants described music therapy sessions as a diversion from regular post-work activities, decreasing their perception of stress. They also stated that they would listen to music with more intention after having received music instruction for the guitar, and that there was no difficulty in learning from a female therapist.</td>
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<tbody>
<tr>
<td>Swamy (2018) United States; homes of participants and the researcher</td>
<td>Qualitative Paradigm, phenomenology, ethnography</td>
<td>$N = 5$</td>
<td>Indian-American immigrants (cisgender) with Hindu backgrounds. Two participants also identified as gay.</td>
<td>Semi-structured interviews, qualitative paradigm (portraiture), researcher observations of participants’ body language, behavior, and physical characteristic.</td>
<td>Portraiture developed by Sarah Lawrence-Lightfoot, CCMI (culturally-centered music and imagery) adapted from the Bonny Method of Guided Imagery and Music (GIM) in order to expand on the analysis of non-Western music and the culturally-specific uses of music.</td>
<td>Participants reflected on their parents’ and their own cultural heritage and made new discoveries of ethnic identities. CCMI is not useful or appropriate for all populations due to the GIM methods and participants’ abilities to follow prompts. Themes of Indian identity discussed by participants: core, aesthetic, philosophical, ancestral, mythological, and spiritual. Within American identity, participants described conflicting identities of freedom and liberation, an oppression and discrimination.</td>
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<tr>
<td>Orth (2005) Netherlands</td>
<td>Expert Opinion, Case Studies</td>
<td>$N = 3$ Age: 18 years, 21 years, and 35 years included in vignettes</td>
<td>Refugees and asylum-seekers from Azerbaijan, Cambodia, Chile, Iran, Liberia, Sierra Leone, Somalia, and Vietnam.</td>
<td>Vocal holding, singing and discussion, guided imagery and music (GIM).</td>
<td>Composition of relaxation music, instrument play, improvisation, and creating a musical product.</td>
<td>Individual music therapy can offer greater access to immediate needs following trauma (culture and safety). However, while individual or group therapy sessions might allow for shared feelings and validation to emerge, ease of participation may be hindered by residual effects of trauma. Interventions may require adaptation and the music therapist should be reflexive to their clients’ immediate needs. Four interventions used by the researcher are: 1. Compose your own relaxation music 2. Music learning and instrument play with another person 3. Making your own musical product 4. Improvising to express thoughts and feelings Guided imagery and music may not be feasible when working with clients of varying backgrounds. The researcher explains that it is difficult to find suitable music that reflects the emotional state of a client who has experienced trauma, and also corresponds with the client’s value and perception of music.</td>
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</table>
The research designs for each study were listed and defined in Figure 4, and specific theoretical models that directly influenced music therapy interventions were listed and defined in Figure 5.

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<thead>
<tr>
<th><strong>Study Design</strong></th>
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<tr>
<td>Case Study</td>
<td>In-depth investigation of an individual, group, or event phenomenon in real-life context (Creswell, 2013).</td>
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<tr>
<td>Cross-Case Analysis/Collective Case Study</td>
<td>Comparison of commonalities and differences in events, activities, and processes (Creswell, 2013).</td>
</tr>
<tr>
<td>Qualitative Paradigm</td>
<td>Research within the basis of a single worldview of beliefs, values, and methods (Creswell, 2013).</td>
</tr>
<tr>
<td>Cross-Over/True Experimental</td>
<td>Longitudinal study in which subjects receive a sequence of varying treatments (Phillips, 2008).</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>Empirical interventional study used to estimate the causal impact of an intervention on a target population without random assignment (Phillips, 2008).</td>
</tr>
<tr>
<td>Qualitative Observation</td>
<td>Observation of data observed with our senses, with no involvement of measurement or numbers (Phillips, 2008).</td>
</tr>
<tr>
<td>Descriptive</td>
<td>Used to describe a situation, subject, behavior, or phenomenon in a study in the most accurate manner possible (Phillips, 2008).</td>
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</table>

*Figure 4. Study designs and definitions.*
<table>
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<th>Model</th>
<th>Definition</th>
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<tr>
<td>“BASIC Ph” Model</td>
<td>“Belief, Affect, Social, Imagination, Cognitive, Physical” based on six characteristics at the core of a child’s coping style (Lahad &amp; Avalon, 2013).</td>
</tr>
<tr>
<td>“CARING” at Columbia University Music Therapy</td>
<td>“Children at Risk: Intervention for the New Generation;” a music therapy program adapted by Columbia University in order to teach at-risk multicultural students coping skills including social skills, communication skills, and emotional expression (Kestenbaum &amp; Canino, 1988).</td>
</tr>
<tr>
<td>Cross-Cultural Music Therapy/Culturally-Informed Music Therapy</td>
<td>The occurrence of music therapy within a therapeutic relationship that involves at least two cultures, or with a client who has experienced living within at least two cultures (Stige, 2002).</td>
</tr>
<tr>
<td>Feminist Theory</td>
<td>A form of psychology centered on social structures and gender, oriented on the values and principles of feminism (Creswell, 2013).</td>
</tr>
<tr>
<td>Group Analytic Theory</td>
<td>An approach in which individual experiences (cultural, societal, linguistic) converge and are affected by group dynamics (interactions and relationships) (Foulkes, 1986).</td>
</tr>
<tr>
<td>Medical Music Psychotherapy</td>
<td>A music therapy approach informed by self-affirmation theory and family systems in which cultural identity is affirmed for individuals experiencing illness-related threats (Mondanaro, 2012).</td>
</tr>
<tr>
<td>Narrative Theory</td>
<td>Assumes that narrative (the manner in which a person shapes a personal story) is a basic human strategy for coming to terms with time, process, and change (Creswell, 2013).</td>
</tr>
<tr>
<td>Orff Schulwerk</td>
<td>A developmental approach to music education involving music, movement, drama, and speech into lessons that are similar to child’s play (American Orff-Schulwerk Association, 2018).</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>The study of structures of consciousness and self-awareness as experienced from a first-person point of view (Creswell, 2013).</td>
</tr>
<tr>
<td>Self-Affirmation Theory</td>
<td>A psychological theory that posits people are motivated to maintain an adequate sense of self-integrity or self-concept when their self-image is threatened by experiences (Steele, 1988).</td>
</tr>
<tr>
<td>Social Justice Theory</td>
<td>A form of psychology with an aim to decrease human suffering and to promote human values of equality, equity, and justice (Creswell, 2013).</td>
</tr>
<tr>
<td>Trauma-Informed Therapy</td>
<td>An approach to care that recognizes the impact of trauma and pathways to recovery, recognizes the signs and symptoms of trauma in anyone affected by it, and responds by fully integrating information about trauma into policies, procedures, and practices (SAMHSA, 2014).</td>
</tr>
<tr>
<td>“UP” Model</td>
<td>“Uprooting to replanting;” a short-term expressive therapy tool developed as a model of dealing with PTSD within contexts of (1) adapting to a new reality, (2) coping with trauma, and (3) working through loss and mourning (Porat et al., 2006).</td>
</tr>
</tbody>
</table>

Figure 5. Theoretical framework and model definitions.
Participants

Participant sizes of studies including children and adolescents ranged from five to 65. Four of the six studies including children and adolescents did not specify demographic information such as participant genders and/or age ranges, but the results indicated the youngest participant age(s) to be five years old and the oldest to be 18 years old, with the majority of participants being five to ten years old (see Figure 9).

Participant sizes of studies including adults were relatively smaller compared to studies with children and adolescents. Participant sizes ranged from one to 17, with one study not specifying. Four studies did not specify either participant sizes or age ranges, but the age ranges specified in other studies indicated a range of 18–84 years, with the majority of age ranges per study from 20–40 years (see Figure 10).

Participants’ Countries of Origin

Of the 17 studies, six studies included participants who were refugees or asylum-seekers, 10 studies contained participants who were immigrants, and one study included displaced persons from the Gaza Strip. Two studies did not specify participants’ countries of origin. Refugees’ counties of origin included: Azerbaijan, Cambodia, Chile, Democratic Republic of Congo, Ethiopia, Iran, Liberia, North Korea, Rwanda, Sierra Leone, Sudan, and Vietnam. Immigrants’ countries of origin were: China, Haiti, India, Korea, Latin America, Malaysia, Mexico, Romania, Russia, and Vietnam.
Country of Study

Of the 17 studies, the majority were conducted in the United States (n = 6) and Australia (n = 4). The results also revealed that one study was conducted in each of the following countries: Canada, Germany, Israel, Italy, the Netherlands, South Korea, and Turkey (see Figure 4). The results of the studies presented in this review are mostly reflective of findings from previous research concerning external and internal resettlement obstacles. Of the studies conducted in the United States that were included in this review, the majority of participants were from Mexico or Latin America, which is reflective of the more than 25% of Mexican immigrants in the U.S. (U.S. News, 2018). However, with regards to the countries of origin of refugees, the ethnicities of the top percentage groups in the U.S. are not represented.

Design

Results indicated that study designs were case studies (n = 8), quasi-experimental (n = 2), mixed methods (n = 1), cross-over (n = 1), qualitative paradigm (n = 2), and qualitative observation (n = 3). This indicates that approximately 62% of the included studies were qualitative while 38% were quantitative in design. See Figure 4 for a description and definition of each design.

The researcher further analyzed the rigor of the included study designs by using a model developed by Phillips and Merrill (2015) (see Table 1). The rationale for using this model was to reflect the advanced nature of both qualitative and quantitative studies and to encompass the complexity of the research conducted with persons of concern. Of
the included studies, one study received a low value of rigor, ten studies received a mid-
level value of rigor, and six studies received a high level of rigor.

**Outcome Measures**

The majority of the studies used more than one outcome measure to interpret results. Three of the 17 studies used one or more scales or inventories in measuring study outcomes. These were the Behavior Assessment Scale for Children (Baker, 2005), the LAB-R (Language Assessment Battery Revised test), Literacy Assessment of Second Language Learners, English Speaking Checklist, and Story Retelling Inventory (Kennedy, 2008), the CES-D (Center for Epidemiological Studies Depression Scale), and BSI 18 (Brief Symptom Inventory 18) (Schwantes, 2010).

Of the 17 studies, six studies used a combination of field notes, observations, and semi-structured interviews. Results also indicated that six of the 17 studies relied on a model or theory, including: UP (Uprooting to rePlanting), BASIC Ph (Belief, Affect, Social, Imagination, Cognitive, and Physical), cross-cultural music therapy, feminist theory, social justice theory, phenomenology, self-affirmation theory, medical music psychotherapy, and CARING (Children at Risk: Intervention for the New Generation) at Columbia University. One study used the intervention itself as a way to measure outcomes, which was the Mexican corrido songwriting method (Schwantes, 2011). Corrido is a Mexican form of narrative poetry in ballad songwriting dating back to the 19th century. Songs written in “corrido” style often aim to celebrate the lives of individuals who show courage in the face of tragedy, violence, and death (Corrido Songwriting Project, n.d., para 1).
Research Question 2

Which music therapy interventions have been used for immigrant and refugee populations, and what is the quality of intervention reporting in research with these populations?

Interventions used in the studies included: singing ($n = 8$), instrument play ($n = 7$), improvisation ($n = 7$), movement ($n = 5$), songwriting ($n = 4$), music listening ($n = 3$), music-based relaxation or imagery ($n = 4$), and lyric analysis or song discussion ($n = 6$).

Results indicated that 15 studies used more than one intervention while two studies only used one intervention (see Figures 9 and 10). Artwork was also paired with music-based activities in three of the studies that met inclusion criteria, allowing for participants to have a physical product as a result of music therapy that was also culturally relevant to them. Interventions were culturally-centered, using musical components and models that were relevant to participants. Tables 1 and 2 provide more detail about each combination and application of the aforementioned interventions, including additional details of culturally-specific instruments and songs that were mentioned by the researchers.

Researchers usually addressed multiple goals related to the settings of the studies. For example, musical art-making (Cominardi, 2014) involved the use of Westernized music-making experiences to welcome others, open communication and sharing, the integration of participants’ knowledge and experiences, and to foster peer and teacher relationships. Shared goals of studies with participants who were 18 years and older included cultural integration/acculturation, quality of life, self-esteem, decreasing self-prejudice, and to gain the benefit of and integrative language using music as a form of non-verbal expression.
In order to assess the quality of music therapy interventions used in the included studies, the researcher re-created Robb’s checklist of music therapy intervention criteria reporting in Figures 6 and 7 to specify which studies reported 11 different criteria for music-based interventions in whole or partially and identified the complete number of studies reporting these criteria in Table 3. Of the studies including children and families, one study reported 11 criteria, three studies reported 10 criteria, two studies reported nine criteria, one study reported eight criteria, and one unfinished study (Nöcker-Ribaupierre, 2010) reported three criteria (see Figure 6). Of studies including adults, one study reported 11 criteria, five studies reported 10 criteria, one study reported nine criteria, and two studies reported eight criteria (see Figure 7). Eren (2012) and Schwantes (2011) were the only included studies to report all 11 music-based intervention criteria, while no studies other than Nöcker-Ribaupierre’s incomplete pilot study reported fewer than eight intervention criteria.
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention Theory</th>
<th>Person Selecting the Music</th>
<th>Music</th>
<th>Music Delivery (Live or Recorded)</th>
<th>Intervention Materials</th>
<th>Intervention Strategies</th>
<th>Intervention Delivery Schedule</th>
<th>Intervention Delivery</th>
<th>Interventionist</th>
<th>Treatment Fidelity</th>
<th>Setting</th>
<th>Unit of Delivery</th>
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<td>Mondanaro (2016)</td>
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<td>Nöcker-Ribaupierre (2010)</td>
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</tbody>
</table>

Figure 6. *Intervention quality: Studies including children under 18 years and families*

* Ø denotes partial criteria reporting, ✓ denotes full criteria reporting*
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention Theory</th>
<th>Person Selecting the Music</th>
<th>Music</th>
<th>Music Delivery (Live or Recorded)</th>
<th>Intervention Materials</th>
<th>Intervention Strategies</th>
<th>Intervention Delivery Schedule</th>
<th>Interventionist</th>
<th>Treatment Fidelity</th>
<th>Setting</th>
<th>Unit of Delivery</th>
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<tr>
<td>Choi (2010)</td>
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<td>Schwantes (2011)</td>
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<tr>
<td>Swamy (2018)</td>
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<tr>
<td>Orth (2005)</td>
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</tr>
</tbody>
</table>

Figure 7. Intervention quality: Studies with adults (18+ years)

* ○ denotes partial criteria reporting, ✓ denotes full criteria reporting
Table 3

*Quality of Music Therapy Interventions (from Robb, 2011)*

<table>
<thead>
<tr>
<th>Intervention Quality</th>
<th>N of Studies Reporting this Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Theory</td>
<td>17</td>
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<td>Person Selecting the Music</td>
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<tr>
<td>Music</td>
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<td>Music Delivery (Live or Recorded)</td>
<td>16</td>
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<tr>
<td>Intervention Materials</td>
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<tr>
<td>Intervention Strategies</td>
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<td>Intervention Delivery Schedule</td>
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<td>Treatment Fidelity</td>
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<td>Setting</td>
<td>16</td>
</tr>
<tr>
<td>Unit of Delivery</td>
<td>17</td>
</tr>
</tbody>
</table>

Research Question 3

*How effective are music therapy interventions with immigrant and refugee populations?*

While there may have been a high rigor of study design and intervention quality reporting among both quantitative and qualitative study designs, the effectiveness of music therapy interventions was difficult to assess due to the small number of randomized controlled trials which used tools to measure direct effects of treatment conditions over time. Additionally, generalizing results and study conditions from qualitative designs may be problematic because of the context in which the treatments are presented.
Although two randomized controlled trials were included in this integrative review (Baker, 2005; Schwantes, 2010), only one study had both a control and experimental group and differing treatment conditions (Baker, 2005). Results from Baker’s 2005 cross-over study with adolescent refugee participants yielded a significant difference in participant engagement and behavior between treatment effects of music therapy versus no music therapy, as well as a significant decrease in hyperactivity over time in participants who received music therapy. Interestingly, brief periods of increased negative behaviors were observed between treatment phases, suggesting that the participants were re-experiencing crises that improve with both time and the treatment condition of music therapy.
CHAPTER FIVE

DISCUSSION

Research Question 1

*What are the characteristics of research that currently exists about music therapy services for immigrants and refugees?*

The authors’ goals for participants found across studies included cultural identity, behavior change, and psychological distress, which framed the culture-centered approaches used by the researchers in the study designs and interventions used with participants (see Table 1). To address cultural identity, the authors developed their studies around these participant details that were documented and analyzed: gender, age, country of origin, culturally significant music, and societal roles. When addressing goals of behavior modification with younger participants, behaviors appeared to be the results of negative or inconsistent experiences that occurred prior to immigration or resettlement, such as family separation or trauma. The authors’ objectives of addressing psychological distress involved assessments of participants’ anxiety, depression, and post-traumatic stress disorder, which were further impacted by gender-based violence. Some authors, though not all, demonstrated reflexivity by re-designing interventions and music therapy techniques based on the engagement and reactions of participants. In one instance, participants’ perceptions of their own safety following a traumatic event became tantamount before any therapeutic goals could be effectively addressed. Upon reflection and evaluation of the study designs and intervention quality reporting for all included studies, it appears that, while the authors desired to address commonly assessed goals of
immigrants and refugees with evidence-based music therapy treatment, the fidelity of
treatment may not have been accomplished in the authors’ desired manner due to
misconceptions of participants’ cultures and behaviors.

**Country of Study**

The majority of studies were completed in the United States ($n = 6$) and Australia
($n = 4$), two predominantly English-speaking countries with participants from non-
English-speaking countries. Two studies were conducted in countries geographically
adjacent and linguistically similar to the participants: Choi’s 2010 study in South Korea
with North Korean refugees, and Felsenstein’s 2012 study in Israel with Jewish refugees
from the Gaza strip (see Figure 8). Though two researchers from the U.S. used an
interpreter in their studies and one researcher from Turkey sought advice from a cultural
council, there is scant information about the languages in which music therapy sessions
were facilitated. Of the top 10 countries that accept persons of concern, only four of
them (U.S., Germany, Canada, and Australia) are represented in Figure 8. One major
determining factor for this result could be that the researcher only included studies
published in the English language. Even though Germany and Canada take in more
persons of concern (U.S. News, 2018), results of this study indicated that Australia
produced the second-highest percentage of music therapy studies with immigrants and
refugees. It is also uncertain if the amount of studies originating from Australia is due to
the increased presence of music therapy work being facilitated there compared to other
countries.
Figure 8. Country of study

Setting of Study

The settings of completed studies including participants 18 years and younger were primarily school settings \( (n = 7) \), either schools created out of need by a community or pre-existing schools. This could provide context for the sample sizes due to convenience, as well as music therapists’ accessibility to therapy spaces. Other settings were a hospital \( (n = 1) \) for Mondanaro’s 2016 study. The settings of studies including participants 18 years and older took place in community centers \( (n = 2) \), group homes \( (n = 2) \), individual’s homes \( (n = 1) \), nursing centers \( (n = 1) \), palliative care facilities \( (n = 1) \), and
alternative schools ($n = 1$). One study did not specify the exact setting in which therapy sessions took place (Orth, 2005), but the researcher suspects that sessions were facilitated in a trauma-based care center due to the study’s trauma-informed framework. The researcher also hypothesizes that studies conducted in schools were planned in order to facilitate access to refugee populations within a relatively controlled and stable environment. It is suspected that this setting would also likely lead to an increase in expected sample sizes of participants, improving the validity of results. A possible explanation for the small sample sizes found in studies with adults could be the fact that they took place in either a healthcare setting or a home environment, in which a music therapist may typically only work with one patient at a time.

**Participant Ages and Genders**

In studies of participants aged 18 years and younger, three researchers did not specify the age of participants. The highest number of participants in studies with participants aged 18 years and younger were four to six years old ($n = 50$), with the second-highest amount being 15–18 years old ($n = 31$). The smallest number of participants were 11–13 years old ($n = 6$). Only two studies contained participants in the infant and toddler ages of three to five years, with one study containing an infant participant with an unspecified age (see Figure 9). With specific ages being reported in studies with children and adolescents but less so with adults, it is difficult to accurately assess or document details that could further impact the effectiveness of music therapy interventions. There is also a noticeable gap in music therapy interventions being administered to adolescents aged 11 to 13 years during a critical transition period of psychological and social development.
Figure 9. Specified ages of participants 18 years and under. Studies with no specified age of participants 18 years and under: $n = 3$ (Cominardi, 2014, Nocker-Ribaupierre, 2009, and Mondonaro, 2016).

In studies of participants aged 18 years and younger, two authors did not specify the age of participants (Cominardi, 2014 and Nocker-Ribaupierre, 2009) and one author specified the ages of all but one participant, an infant (Mondonaro, 2016). In studies with participants aged 18 years and older, four authors only provided a wide age range for the total number of participants in their studies: Ahonen (2014) had six participants aged 30 – 60 years, Choi (2010) had nine participants aged 18 – 24 years, Schwantes (2010) had five participants aged 21 – 53 years, and Schwantes (2011) had 14 participants aged 20 – 50 years. Three authors specified each participants’ ages: Forrest (2000) had one participant aged 84, Orth (2005) had three participants aged 18 years, 21 years, and 35 years, and Swamy (2018) had five participants aged 29 years, 34 years, 36 years, 37
years, and 41 years. Accurate data representation is difficult to produce based on the overlap of ages and ranges provided by the authors. Again, with more specific ages or smaller age ranges being reported in studies with children but not in studies with adults, there is a gap in the amount of data and detail of participant information that could contribute to music therapy’s evidence-based practice.

The designs of studies in which the ages of the participants were specified were case studies with a small sample size of participants, which may have made age reporting easier compared to studies with a greater number of participants. However, all sample sizes of the included studies were relatively small in nature with the largest sample being 20 participants in Schwantes’s 2011 study. Any reasons for the omission of participant ages or limitations in accessing this information are not mentioned, so there is potentially vital information or context missing in order to inform future researchers. In studies with groups of adults with a large age gap, it is also possible that not all participant’s needs are being met due to differences in musical preferences and lived experiences. The reasons for the lack of information are not apparent, but the omission of such information is startling. These differences in participants’ ages could impact factors of music therapy such as music preference, life experience, and physical and mental health status. It is also unclear of the exact number of participants in each age range, which could provide better context for their psychological, medical, or social needs.
In studies of immigrants 18 years and younger, 16 participants were specified as male and 26 participants were specified as female. In studies of immigrants 18 years and older, 25 participants were specified as male and 14 were specified as female. The majority of younger immigrant participants were girls, while the majority of older immigrant participants were men (see Figure 10). Genders of participants were not specified in four studies. With immigrant and refugee women more likely to have experienced gender-based violence and discrimination, there is a dissonance in the amount of women included in music therapy studies versus the number of men.

**Figure 10.** Specified gender identity of immigrants. Studies with no specified gender identity of immigrants: n = 4.
In studies of refugees 18 years and younger, 17 participants were specified as male and 20 participants were specified as female. In studies of refugees 18 years and older, five participants were specified as male and 10 were specified as women. The majority of refugee participants were girls aged 18 years and younger (see Figure 11). The connection between a fewer amount of women or girls who are immigrants and a greater amount of women or girls who are refugees raises some questions. Is there a greater number of children, regardless of reported gender, with more complex psychological and emotional needs than we originally thought? Could early intervention with music therapy provide a positive impact on longitudinal development? In every age group of included studies, there was missing demographic information that could answer the questions of the researcher.

*Figure 11.* Specified gender identity of refugees. Studies with no specified gender of refugees: $n = 2$. 

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While the vast majority of participants were assumed or specified to be heterosexual, two participants in Swamy’s 2018 study self-identified as gay or queer. Not only is this information pertinent to migrant and refugee populations within the LGBTQ community, but to researchers or readers who naturally assume heterosexuality in study participants and engage in heterosexual bias. This unconscious method of assuming participant information could potentially be harmful for any future music therapy participants who are persons of concern (American Psychological Association, 1991).

**Participant Ethnicities of Immigrants and Refugees**

In studies of immigrants, six studies contained homogenous groups with participants from a single country of origin, which were: India, Mexico, North Korea, Russia, and Turkey. Four studies contained participants from multiple countries of origin, which were: China, Germany, Haitian-African community, Latin America, Malaysia, Romania, and Vietnam. In one study, the researcher did not specify the ethnicities of immigrant participants. In studies of refugees, asylum seekers, or displaced persons, three studies contained homogenous groups of participants from a single country of origin, which were: the Gaza strip (displaced persons), North Korea, and Sudan. Two studies contained non-homogenous groups of participants from multiple countries of origin, which were: Azerbaijan, Cambodia, Chile, Democratic Republic of Congo, Ethiopia, Iran, Liberia, Rwanda, Sierra Leone, Somalia, Sudan, and Vietnam. The authors of two studies did not specify the ethnicities of refugee participants.
Though one study’s reporting of Latin America may provide some basic context for the culture and language of participants, Latin America refers to a broad range of territories in the South American continent and Central America (Encyclopedia Britannica, 2019), each with its own unique music history and usage. If the reason for this is due to privacy concerns or participants, the author’s reporting skills, or the legal dissemination of information, the lack of detail is still not specified. Inclusion of limitations along with musical details would be just as helpful to readers hoping to understand or recreate the music therapy interventions in particular settings.

Based on the demographic information from Figure 1 (Refugee Processing Center), none of the top ten refugee ethnicities of those admitted to the U.S. are represented in the analyzed studies from the U.S. Because several participant groups were varied an unspecified number of individuals from the different countries of origin, it is difficult to know if all participant groups are reflective of current refugee statistics per country of resettlement. This lack of background information could also prevent music therapists from delivering the most effective culturally-informed services.

**Participant Life Experiences**

Life experiences and pre-existing issues varied between participants of different ages and countries of origin. Some children were reported to have a deceased or missing mother, both parents deceased or missing, or other family members missing. Experiences of children and adults also differed based on the length of stay in the country in which the study took place, with some researchers noting that persons of concern had difficulty interacting with non-migrant peers or staff members.
In qualitative studies, many participants described feeling exclusion, marginalization, and/or discrimination based on their ethnicity or culture. This is reflective of the information disseminated in the review of literature which describes the frequency of discrimination persons of concern encounter either during or after the immigration and asylum-seeking process.

One such population that was investigated thoroughly was the community of Romani gypsies in Eren’s 2017 study. After meeting with a council of Romani individuals to frame the study, researchers learned that Romani students often experience a precedent of educational failure set by parents and elders, leading to discrimination by peers. There is a generational cycle of a lack of scholastic and occupational education for Romani individuals, early entry into the workforce, and early marriage, further contributing to a cycle of discrimination which decreases desire to remain in an education system.

Disabilities and Old Age

None of the authors of included studies specified that participants had physical, cognitive, or neurologic diagnoses. However, the studies with participants of old age were set within a context of medical intervention for an illness-related threat or in end-of-life care. Not all older participants communicated in the language used in the country in which the study took place, further complicating music therapy treatment. Many participants presented with symptoms of PTSD that required long-term care and, while symptoms were able to become manageable or better understood by clinicians, they were unresolved after a short-term music therapy treatment.
Theoretical Frameworks and Methodologies

A combination of frameworks and models were used to approach these music therapy studies. Researchers used models that were developed to address coping skills, resilience, illness-related threats, and self-preservation. Researchers chose frameworks regarding oppression, justice, discrimination, self-perception, intersectionality, and individual and group experiences based on the population characteristics of study participants, specifically with adult participants, to further investigate and address the impact of their collective life experiences. One researcher, Swamy (2018), created an original method (Culturally Centered Music and Imagery) based on cultural factors she shared with the Indian-American immigrant participants in her study. Some reasons behind the reported success of the study could have been not only the shared (but not identical) perspectives and identities of the author and the participants, but the author’s specific training in the Bonny Method of Guided Imagery and Music and her reliance on the participant to describe their responses to music. Not only was the prescribed music aligned with pillars of Indian-American and Hindu culture, but the participants were able to engage in therapy in a way that was more easily understood by the author. There may have been a difference of execution and analysis based on another author’s familiarity with the needs of the participants.

Goals of Studies

Most of the studies, if not all, began music therapy treatment with one goal in mind but researchers adapted the goals to address emerging issues the participants were experiencing along the course of treatment. Internal and external factors both played a part in the effectiveness of treatment. In studies with participants aged 18 years and
younger, researchers sought to contribute positively to the development of young participants, provide a pathway of cultural integration into a new community, improve their social skills, and decrease prejudice that may exist between foreign and native peers. Studies with participants aged 18 years and older addressed needs more related to mental health, intersectional cultural identity, self-worth, and social connection with others in multiple communities. However, most participants were in the process of integrating into a new culture while still developing based on their own society’s norms. Were the authors of these studies basing the participants’ integration and success on their own cultural context? Were the authors making assumptions of the function of music and the participants’ responses to selected music therapy interventions? In at least four studies this appeared to be the case, as evidenced by the authors stating a change in approach and intervention design. Also, because there was a lack of explanation for the protocols of the most-used interventions (such as instrument play and musical improvisation) it is not clear which exact portions or qualities of the music and facilitation the participants responded to positively or adversely.

**Research Question 2**

Which music therapy interventions have been used for immigrant and refugee populations, and what is the quality of intervention reporting in research with these populations?

**Music Therapy Interventions Used**

Several researchers noted that originally planned interventions needed to be adapted or tailored to meet needs of participants or to respond to changes within the
study. In school settings, the interventions used in reaching proficiency of the English language changed to culture sharing, understanding self-identity, improving social skills, and regulating impulse control. During the progression of studies involving younger participants, interventions used by the music therapist transitioned from objective goal-reaching to discussion of subjective matters such as anti-racism, acculturation, adjustment, and feelings of failure that emerged during music therapy sessions across several studies. Within a therapeutic environment, reaching a level of participant-perceived comfort and trustworthiness is often a goal of therapists in order to foster authentic expression and progress toward goals.

In some cases, participants were more skilled than the researchers with certain interventions and musical techniques. Students in Jones’s 2004 study displayed a greater sense of mastery and agency in African drum rhythms than the music therapist as evidenced by their knowledge and familiarity with drumming. Jones used the students’ abilities as an opportunity to provide them with autonomy, feeling a sense of freedom and safety during a time in their life when there may have been little to none. By learning from the participants and following their lead, the author’s change in intervention protocols allowed for the participants to make their own music the way they wanted to and were familiar with, making the process more enjoyable and effective.

At times, a non-musical approach was necessary to facilitate musical participation. A behavioral approach with younger participants in several studies was observed to be successful but took the entire course of the study to yield noticeable results. With this behavioral approach, it was hypothesized that students wished to gain their teacher’s approval and attention as evidenced by followed directions more readily
and performing tasks with improved accuracy. It is, however, unknown if these interventions and approaches were able to transition to other settings due to a potential difference in cultural perspectives of behavior modification between the authors of the studies and the participants (or their guardians at home). Inconsistent expectations of behavior could cause problems in development in the long-term. See Figures 13 and 14 for a complete list of interventions.

Perceptions of Natives, Immigrants, and Refugees

Although the goals of the literature included in this review may not have originally been changing perceptions of others toward persons of concern, this change was noted in four of the 17 studies. In Cominardi’s 2014 study in Italy, which included native schoolchildren and immigrants from various countries, a noticeable decrease in prejudice against the immigrants by their school peers was observed through group work involving musical ability. In Lauw’s 2016 study with Asian immigrants living in an assisted living facility, a generalization of group interaction in other activities outside of music therapy sessions occurred when participants became more social with each other and native residents at the conclusion of the study.

In two of the studies included in this integrative review, there was an indication of the social and personal impact of perceptions concerning native residents and immigrants. In Kennedy’s 2008 study with Latinx children in a school setting, literacy, English-speaking, and story-retelling results improved but were not significantly different between the school group and after-school group. Both groups appeared to benefit from sessions based on observations of the researcher and teachers. The researcher observed that Latinx children learning English as a second language were less anxious and more
willing to make mistakes with their English literacy activities in the after-school group due to a more relaxed, non-scholastic atmosphere. In the music therapy group during normal school hours, the Latinx children would only interact with themselves in Spanish rather than with their English-speaking peers. The results from this study are in agreement with other studies on children such as Cominardi (2014) and Eren (2017), in which internalized feelings can greatly impact performance of a task and relationships with others outside their culture.

The relationship between self-image and societal perceptions was also reflected in studies with adults. Indian-American adults from Hindu backgrounds in Swamy’s 2018 study expressed that among native peers there was more pressure to conform and acculturate in order to be accepted. Swamy’s 2018 study also illuminated immigrants’ perceptions of their own heritage, with participants stating embarrassment or shame because of their parents’ antiquated cultural aspects. Intersectionality of multiple aspects of heritage also became a primary discussion point, in which participants reflected on their gender and sexual identity and how they affect their American and Hindu personas.

**Evaluation of Quality of Service**

A number of formal assessment tools and inventories were used to address outcomes of music therapy studies. Assessment measures of youth were: hyperactivity, aggression, depression, somatization, attention and learning problems, atypicality, withdrawal, social skills, leadership, and study skills. One assessment tool was used in a study with adult participants to measure self-reported symptoms of depression. In some studies set in schools, evaluations were completed by teachers or non-therapists as a means of maintaining reliability and validity. Qualitative means of assessing
effectiveness of sessions were the use of triangulated data (field notes, observations, and interview transcriptions).

Aside from communicating with researchers, language barriers also affected how outcomes were evaluated. A lack of English skills was, at times, misinterpreted as a participant having issues expressing anxiety and depression. This was observed to be frustrating for misunderstood clients, creating less helpful environments. Societal roles of leaders and music and also affected music therapists’ effectiveness as clinicians with people from certain patriarchal cultures. Some clinicians designed treatment plans based on assumptions of the role of music and musical activities for certain cultures. A number of clients displayed or indicated a preference in music different from the music therapists’ perceptions.

Music therapists needed to remain reflexive and be reminded that not all people respond to or are motivated by certain music-based activities. Some might have no musical background, meaning that outcome expectations for musical engagement should be lowered. One important question to music therapists is this: Is westernized client-centered music therapy even possible when the roles of music for participants are removed from Western customs (Baker, 2005)? This not only includes the uses and functions of music, but also a person’s expectations of working with a male vs. female therapist, or with a therapist who is younger than they are.

No discussion regarding longitudinal effects were mentioned in the studies. In order to develop reliable and impactful music therapy treatment methods for immigrants and refugees, it is imperative to assess the generalization of interventions and approaches from one setting to another. Complementary education and services through a
continuation of a music therapy program or other community service could further benefit participants and help them generalize goals and objectives to settings and circumstances outside of therapy sessions.

**Rigor of Music Therapy Interventions and Studies**

The use of research evaluation tools developed by Phillips and Merrill (2015) and Robb (2011) further outlined the advancements and gaps in treatment of persons of concern with music therapy. In Table 1, one study received the lowest possible rigor value, nine studies received a rigor value of 2 while the remaining seven studies all received the highest rigor value of 5. These results were highly indicative of a gap in research design within the field of music therapy. However, this means that approximately 41% of the included studies were quite rigorous in design.

Although qualitative studies were high in rigor, because of the nature of qualitative research, it is not possible to generalize the results of the included studies. However, this indicates that there are studies in music therapy of high rigor that are both quantitative and qualitative, further contributing to a high standard of evidence-based practice. A greater variety of highly rigorous research designs could also more accurately and authentically reflect the unique experiences of their participants.

Results from Figures 6 and 7 indicate that approximately 72% of Robb’s music-based intervention criteria were reported. For criteria with multiple components, such as “intervention delivery schedule” (number of sessions, session duration, session frequency) and “setting” (location, privacy level, ambient sound), the researcher accepted information if the majority of the sub-components were reported. For example, if an
author explicitly reported the number of sessions and session frequency, but not session duration, the majority of the criteria were reported. However, only a small number of studies provided all pieces of information for these two criteria. Similarly, a lack of detail regarding facilitation, materials, and musical structure was apparent in the criterion of “Intervention Strategies,” especially for the intervention of “musical improvisation.” Referring to Comte (2016), it could be an assumption of the authors and researchers that “improvisation” is understood by the readers and the study participants from a Western viewpoint.

With numbers of persons of concern expected to increase, it is imperative that music therapists stay active in their clinical and scholastic education. It is expected of music therapists to clearly and objectively report information about music-based interventions so others can fully grasp the methods being used. Not only will a lack of details do a disservice to music therapists hoping to replicate these interventions, it would do a disservice to other professionals wishing to learn more about music therapy in general.

The criterion with the lowest frequency of reporting was “Interventionist” (see Table 4). Only 10 studies specified the interventionist’s credentials or qualifications for facilitating music therapy treatments and research, as well as the exact number of interventionists delivering the treatments. The majority of the seven studies who did not explicitly report this used the terminology “the therapist” within the narrative, and while the authors of these studies may have also been the primary researcher, it was unclear and vague. Music therapy advocacy efforts have been ongoing for several years in order to educate the public about music therapists’ credentials and the repercussions of the
attempted therapeutic use of music by an untrained individual with no formal training and education. The low frequency of interventionist reporting by authors of music therapy studies could perpetuate the misconception that music therapy research may be conducted by anyone with access to persons of concern.

This integrative review yielded a relatively equal number of studies with participants who were immigrants and participants who were refugees. There is potential that there could be more populations of asylum-seekers or displaced persons who would benefit greatly from music therapy. It is estimated that for every refugee, there are two people awaiting to be granted refugee status (UNHCR, 2016). With this possibility in mind, creating relevant, evidence-based, and accessible opportunities for music therapy treatment could open up new pathways to preventative care and cultural support.

**Research Question 3**

*How effective are music therapy techniques with immigrant and refugee populations?*

Compared to evaluating the rigor of music therapy studies and the quality of music therapy intervention reporting, assessing the effectiveness of music therapy interventions with immigrant and refugee populations was difficult. Among the 17 included studies, only two studies (Baker, 2005 and Schwantes, 2010) were randomized controlled trials, but only Baker’s study used differing control and experimental treatment conditions to directly measure the effects of music therapy over time. While a number of the included studies may have been of moderate to high rigor, the lack of direct measures and treatment conditions contributes little to the argument that music therapy interventions are more effective than other therapeutic interventions. After the initial
data collection, the researcher also came across a second randomized controlled study with both a control group and experimental group (Schwantes, 2014). This study with Mexican farmworkers living in North Carolina, USA indicated that a treatment condition of weekly interactive music therapy interventions of instrumental improvisation, songwriting, and lyric analysis directly contributed to effect sizes of depression and feelings of social isolation when compared to a non-music therapy treatment condition of delivering CDs with participant-preferred music. With direct measures such as these being used by a small number of music therapists and researchers, it is possible that music therapy interventions with immigrant and refugee populations are effective when compared to other interventions, but additional direct measures are needed to confirm this hypothesis.

Limitations

The researcher completed a hand search of nine music therapy journals and a keyword search of six online databases. It is possible that studies concerning immigrants, refugees, and other persons of concern could exist outside the inclusion criteria set by the researcher (studies published in a language other than English, non-music therapy studies that use music-based interventions or activities, studies that have not yet been published). In fact, in a period of time well after the initial literature search, the researcher came across two studies online (Schwantes, 2009; Schwantes, 2014) that met inclusion criteria but were not identified in the initial search. Even though the studies met the inclusion criteria, they were not included in this integrative review due to the timeline of research procedures. The study by Schwantes (2009) describes administering music therapy services to children learning English as a Second Language, and in the text there is one
mention of the children coming to the research site from Mexico. However, the words “immigrant” or “refugee” are not present in the study’s title or abstract, which may have resulted in the study not being found by the researcher in their literature search. This is also true of the study by Schwantes (2014), which was published in *The Arts in Psychotherapy* journal. The researcher did not include *The Arts in Psychotherapy* in the list of peer-reviewed journals to hand-search, and there may be additional studies that could meet the inclusion criteria that have been published through this source. It is recommended that, for future research purposes, music therapists should include *The Arts in Psychotherapy* in their literature search.

It is also possible that there are ongoing initiatives within the music therapy community that have not been formally researched or published. Due to the high number of results from the original literature search, it is possible that there are studies the researcher missed or discarded, or more relevant keywords and databases that were not used in the literature search. It is also evident that, despite the efforts of culturally-centered music therapy, there are still limitations in communication, musical knowledge, and accessibility of music therapy services. The researcher also recognizes and understands the inability to generalize results or calculate effect sizes due to the fact that most of the included studies were qualitative and that studies were heterogeneous when it came to outcome measures.

**Implications for Music Therapists**

For current and future music therapists, there has been progress in uncovering similarities and differences across cultures (Comte, 2016). Music can serve a unifying, validating purpose when used effectively and appropriately. Culture and identity can
vary from country to country and even region to region, so investigating and confirming these differences is crucial to ensuring the facilitation of the most effective, client-centered treatment. The American Music Therapy Association’s list of Professional Competencies are explicit in music therapists’ duties to clients with regard to culture, ethnicity, and identity (see competencies 1.2, 11.1, 13.12, and 17.10). Like other populations with whom music therapists work, immigrants and refugees may experience immediate dangers, challenges, and changes both inside and outside a therapeutic setting that directly affect their needs and goals.

The methods used by researchers of the studies included in this review often relied on multi-dimensional session plans in order to feasibly address myriad target areas. Results of this review indicate that the combination of movement, singing, listening, instrument-play, discussion, and sharing are current techniques being used by music therapists among persons of concern. Music therapists may be able to identify interventions from other populations they currently work with and adapt them for persons of concern based on age ranges and therapy settings. See Figures 12 and 13 for a list of specified interventions for each age category from the studies included in this review.
Most of the music therapists who conducted research with young persons of concern implemented singing or chanting, movement to music, and instrument play or improvisation. This demonstrates a cognizant used of verbal and non-verbal participation, as well as active or passive participation. Improvisation was also the most-used technique used with adult persons of concern (see Figure 13). However, it should also be noted that musical improvisation was the intervention which was least-explained in detail by the authors whose studies were analyzed by the researcher.

**Figure 12.** Interventions used with participants 18 years and younger.
Gender roles and age-related roles should also be considered to foster a culturally appropriate therapeutic relationship. Upon reflection of Comte’s 2016 article, it seems that the two most prevalent assumptions music therapists make when working with populations of diverse individuals are over-valuing of a person’s immigrant or refugee status (rather than individual characteristics) and that Western characteristics of music are shared globally. Music therapists should gather as much personal, demographic information as possible and look deeper past a status of refugee or immigrant, as it might isolate an individual and lead to an assumption of life experiences that may be inaccurate or not as relevant to that person’s immediate needs. A second recommendation is to further study musical differences of each global culture or region, including instrumentation, time signatures, melodic contour, arrangements, and roles or purposes of well-known songs.

Figure 13. Interventions used with participants 18 years and older.
Suggestions for Future Research

The results of the present study suggest that, while a moderate percentage of analyzed studies met high standards of rigor and intervention quality reporting, there is still need for further research. Most specifically, there is a need for more quantitative research with immigrant and refugee groups most frequently encountered in the U.S., randomized controlled trials that are high in rigor, and music therapy research with clear reporting of intervention qualities. Particular attention and preparation of music therapy research should be paid to interventionist qualifications, intervention materials, music used in interventions, and intervention structure.

The majority of the studies included in this integrative review took place in group settings with participants from multiple countries and with relatively small sample sizes. Dependent on the setting and resources, participation may have been low due to accessibility, recruitment, or convenience sampling. Researchers might also have been limited in participant recruitment due to temporary placements of persons of concern that were inaccessible.

Although authors of most studies gave explicit information about participants’ demographic background, some did not include one or more pieces of information (e.g., age, country of origin, ethnic background, refugee/immigrant status, or length of stay in the country in which the study took place). This information could provide better context for the design, intervention, and outcome choices made by researchers in the studies and influence implications for future research with those populations. Other limitations noted by the researcher of this integrative review were the manner in which music therapists
made music therapy accessible to participants through communication (verbal and non-verbal) or language.

The implementation of more rigorous and detailed music therapy practices and research has the great potential to contribute to a reduction of harmful assumptions, act as a catalyst for more resources to become available to persons of concern, and to create pathways to provide services in more diverse settings. Along with improvements to clinical practice, the dissemination of additional research results could contribute to the teaching of future generations of music therapists. It is the desire of the researcher for this integrative review to motivate and inform music therapists to continue providing culturally-centered care using meaningful, relevant, accessible music-based interventions and methods and continue to research the ways in which we can serve these populations.
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