Appendix B

Responses to Open-ended Questions

Q7 In your experience preparing students to take the CBMT exam, what do you think the exam evaluates?

Their cumulative skills, their ability as music therapists, their overall knowledge of music therapy clinical practice.

The exam evaluates the skills identified by the CBMT Practice Analysis Study, which relates to what entry level music therapists in their first five years of practice are doing in the music therapy profession.

The knowledge obtained by a successful beginner music therapist.

Competence to work as a clinical music therapist.

Competencies that can be tested on such an exam. Such as knowledge of certain techniques and skills.

Application of principles in the clinical setting. Facts and terms about music therapy practice.

The exam evaluates a student's understanding of the content of the CBMT Board Certification Domains, which reflect current practice.

Musical knowledge, clinical reasoning, basic knowledge or research methods, basic knowledge of theoretical orientations; to some extent – ability to take multiple choice exams

Minimal academic competency to enter the field

Competency in areas of current music therapy clinical practice

Foundational knowledge of the process and principles of music therapy

Knowledge (versus skill and values/attitudes)

I am not sure, since I, myself, have not taken the test. However, I think the test evaluates students' knowledge and skills - basically, their ability to think as independent clinicians.

I am not sure. Sometimes I think it evaluates the ability to take multiple choice questions; other times I think it is a talent attempt to measure competence in a profession in which there is not just one way to use music experiences to address treatment goals.

Somewhat, their ability to understand the structure of the test and ability to take a test and somewhat testing clinical knowledge

Test taking. I do not believe the exam evaluates the ability of a student to practice safely.
It reflects one type of thinking, cognitive behavioral.

I think it evaluates a theoretical thinking model rather than actual skills in a therapeutic environment.

In some ways it evaluates the ability of the students to work out what the questioner might think is right

How well they can discern multiple choices questions. Some exams focus on one particular area, i.e. autism. And really neglect other areas

Specific academic knowledge which at times may be skewed toward a specific philosophical orientation, which may represent more advanced training than the exam should test

An ability to take a basic test that is not reflective of evaluating ability to understand and translate clinical concepts of advanced levels of MT practice that is related to AMTA training competencies.

It evaluates deductive reasoning as applicable to standardized tests. I've had to spend more time teaching test taking strategy than content. Finding the "correct" response among other "good answers" is now the critical piece.

Advanced clinical knowledge and experience, beyond the entry level.

Test-taking ability

On a terribly concrete level, the exam evaluates the taker's ability to determine the exact content of the question in order to determine an answer. In my opinion and despite the very high effort on the part of the exam committee, there is no way to escape the fact that passing an objective exam does not reveal what an individual understands or can do in the clinical setting. It can test for facts, like what is the definition of this word or that word, and it can set up a simple scenario for instances in which there is only one correct answer. What it CANNOT EVER do is evaluate the clinical thought process and the quality of decisions in music therapy clinical practice, where there isn't a correct answer and there are only better or not as good answers. There is no escaping this shortcoming if board certification is going to be based on an objective test.

It evaluates a watered down version of music therapy practice that has been bastardized by early professional trainings in things like child life specialist and then morphed into advanced practice as new professionals take advanced training in the profession.

Students' abilities to answer logic questions/solve word puzzles and to not read anything into a question, i.e., to take at face value the "prompt" without making any assumptions about it's context

The ability to read critically and determine the intended answer.

The exam evaluates how well the student takes exams and does touch on all of the requirements of being a music therapist.

Ability to think and synthesize complex information from musical, clinical, and academic knowledge.

It is not about the therapeutic process, but about how to take an exam.

I find that the exam is more effective at evaluating test-taking strategies than clinical knowledge. I have had several students with less-than-stellar clinical knowledge pass the exam the first time they took it, whereas other students with incredible clinical skill and sensitivity have had difficulty passing.

Ability to take standardized exam, vocabulary, ability to think critically about a exam question, ability to read nothing into an exam question and look for an answer based solely on the question

Knowing how to take the test

Test-taking skills

As I understand it from a Facebook post by a past member of the executive board, the CBMT exam is designed to evaluate the domains stated but questions are designed based off of a survey of clinicians and internship directors based on "things they should know before entering the field". It would seem this information would be best utilized to improve our Professional & Advanced Competencies rather than the test given the academic program curriculum being designed from and measured upon the Competencies

I help them prepare by focusing on the CBMT Board Domains, as I believe it is these "competencies" that are evaluated by the exam.

Q9: Statement Regarding Academia not keeping up with Clinical Practice

People who have problems with the CBMT exam might be having more of an issue with specific degree programs in the US, in which the professors are not staying up-to-date in their knowledge of current, evidence-based practice.
Educational curricula are much slower to change and adapt to clinical practice. Therefore, if we keep the BC, we should have NASM, AMTA and CBMT all on the same page for assessing minimum competency instead of not being aligned for accrediting educational programs.
So far, most of our students are passing the exam.
The Practice Analysis of MT-BCs completed every 5 years surveys what MTs are doing as clinicians at work. Responses are only used if they are the same across years of practice AND across all regions. With some programs using the same syllabi and resources year after year without checking in on the reality of clinical work, it makes sense that education is not driving clinical practice.
I agree that the exam is driven by clinical practice. Educators are often removed from the clinical world. Many have very limited clinical experience with a narrow focus.
There’s no evidence this is accurate. It relieves CBMT of all responsibility for ensuring the validity of the exam. It only has data from the practice analysis for which there is no evidence this reflects undergraduate professional practice. It may reflect inflated responses of survey participants and/or may conflate u’grad and grad equivalency students. CBMT has no evidence that Music therapists without the CBMT credential practice unsafely.
The cut score increased 2x without my knowledge. Apparently, that was my fault as an educator. Had I know the cut score increased, I would have considered changing my approach to test preparation (not necessarily the curriculum itself). The pass rates declined due to the changes in cut score/pass score. It is unfair to in turn blame this on education. If clinical practice is advancing, it is fair to conclude that education had nothing to do with this?
The declining pass rates may be an indication of the level at which the practitioners who make the exam questions are practicing at. It may be that the students are being taught more up to date or advanced clinical and thinking skills than those of the examiners. Also, many times there are more than one possibly correct answer to the question and the context would really determine that. For those students who think more deeply about the questions, that can pose a real difficulty.

If I understand the statement correctly, it is almost blaming colleges/universities for the reason for lower passing rates. Makes absolutely no sense-- the test questions are derived often from professionals with advanced training, such as NMT, who may not be able to separate their current work practice from their prior educational experience. Why are educators not involved in writing the test? Why are we in the dark? it may be a faulty assumption that a decline in the pass rate is correlated with some aspect of music therapy education and training. Even when I took the test for my own re-certification (and thus had a good sense of what the test was all about), I did not "teach to the test," and I never will because the test can not sufficiently evaluate the competencies that (should) drive curriculum development and delivery.

I am not sure I understand the question fully, but I do see the variance in academic programs and I believe this further complicates the situation. It was always my understanding that the undergraduate programs were to be "comprehensive" in nature and that graduate programs were to be "specialized". However, we have undergraduate programs with isolated focus on various philosophical orientations and even techniques (i.e., NMT, Analytical Music Therapy, etc.). It is evident, however, that even if we design "decision making" skill building in our courses, implement vignettes and scenarios across our coursework to exercise prepare for the "best-choice" method of the exam, or otherwise, there is no way for us, as educators and program directors to predict where the attention will shift within the exam (e.g., diagnostic terms, etc.). I have maintained that my responsibility was to design and deliver a comprehensive program that prepared students with music skills, clinical skills, and music therapy skills as well as critical and creative thinking skills to include the ability to manage "self-study" beyond the classroom and clinical-training to be "ready" for all referrals across settings and populations. If they feel they have the tools and resources, they will see being a professional music therapist as something more fluid and accept that this is a profession that requires "continuous learning".

The declining pass rates may possibly be due to improvements in education. I say this because, if a student takes this objective test and responds to questions by thinking about the best thing to do in a clinical setting, they are likely to fail. The questions are about figuring out what the question is about. Takers who are considering what are best clinical decisions invariably make incorrect answer choices because they aren't recognizing that the question is really about a different aspect or a different topic. The distractors in the questions don't identify

It makes no sense to me that there is little to no collaboration with educators for our practice exam. Or that the exam is so super-secret that educators don't know how to help students gain the knowledge-base that is being evaluated. I don't believe that is the case with other practice exams like the Praxis exam for education. This is all very frustrating for this educator. We facilitate the education and training of exceptional music therapy clinicians and our pass rates are dropping and I don't know how to help the students b/c I'm not allowed to know how to help them. What kind of way is that to develop a profession?

Frustrating! The exam is not reflecting advanced practice, it is reflecting a dogma towards the medical model

The problem is the exam. It has gone too far for entry level. It is more of a Masters exam and has become almost impossible to pass the first time. In my opinion, it has gone way over the top.

MT undergraduate education curricula are already too dense in breadth and depth to expect the programs to be able to add additional content to reflect practice. This is why a continuing education process is in place.

There is no communication or transparency (and possibly conflicting views of what practice is) between AMTA approved programs and the CBMT. This is a huge problem for our profession. They operate completely separately and unrelated which is an intrinsic problem and creates confusion and chaos for graduates and educators. Having an exam that evaluates undergraduate and graduate level training and expectations of knowledge is a missed opportunity to further the profession and causes confusion and is a redundant process and procedure. It needs to change asap. The public is so confused about what music therapy is based on this exam. It is impacting our economy and job market for graduates. Nothing can move forward if this confusion remains as is.

I feel strongly that I do not have enough time within my 4 year bachelors degree to prepare students with the knowledge and skills of a beginning practitioner. Therefore, I understand the declining pass rates.

The CBMT Board Domains reflect current practice, not the AMTA Professional Competencies. Thus, if educators are not referencing the BDs, critical content may be omitted from their academic and clinical curricula.
The probable is not a lack of preparation for the exam, but the test was originally supposed to be ENTRY level, not the only test to measure music therapy knowledge.
I'm not sure that this is totally reflective of the ability to teach the scope of practice at the undergraduate level. I'd like to see addressed the obstacles to teaching within the existing structure (i.e. NASM percentages, etc.)
The test does not reflect the AMTA entry level competencies
Because students who are equivalency or traditional students are also surveyed along with person receiving their master's equivalency the way they collect their data on entry level skills is flawed. Yes, they are surveying entry level MTs in that they are newly certified. However, an increasing number of certificants have life and even work experience and are taking graduate courses prior to the certification exam. Their first jobs are indeed likely to have advanced expectations that they are more likely to be able to meet than a traditional undergraduate certificant. It also is a fact where I live that positions post for master's level therapists, but pay low enough that they wind up accepting someone straight out of internship with unrealistic expectations. As an educator I have received calls from several new hires (not even all my grads) seeking advice and assistance for their programs.
What was revealed to me in that meeting (where this was discussed with the assembly and faculty) is that the practice analysis is being influenced by students in graduate equivalency programs and that the exam is not a true measure of undergraduate level education or practice. This may put UG students at a disadvantage on the exam as they will have had fewer credits in their program. Therefore, the exam may be driven by education, but at the graduate level.
CBMT measures current practice competency; AMTA defines the training program. It does not appear that AMTA is keeping up to date with training expectations that meet current practice.
This statement is not taking into account multiple factors which could be affecting not only the outcome of the practice analyses and statistical indication to increase cut scores, but also the decline in first-time pass rates. It's not clear to me that the practice analyses have accounted for previous education and training which may be affecting music therapy practice for those seeking post-bachelor's accreditation, nor does the analysis consider the nature of the work people are being hired to do with their music therapy degrees. MTs take on a very wide range of jobs, include case management, directing recreational therapy programs, etc. Are these essential_ components of being a music therapist? I think not. Nor do I necessarily think the practice analysis is indicating "advancing" music therapy practice. Broadening, certainly. But this is not the same thing.
The change is being driving by an increasing breadth and depth of practice. I am uncertain that the BC exam domains are filled with material based solely on practice at the undergraduate level.
I think that some universities probably have more students that don't pass the test and there should be a way as to help the university understand what kind of questions are not being answered correctly or a more exact method of looking at this rather than general category labels such as "assessment...etc." I do not understand why the cut scores have increased so much over the past ten years and why that has become such an indicator of whether a student actually has the clinical and/or functional skills to be an effective music therapist. Also, it may be that the various students from different universities are unfamiliar with taking a test like the BC offers.
I'm not sure if this is the right box to mention this in, but I believe we must reevaluate the education and preparation of a music therapist for the 21st century. Are the current AMTA-required and NASM-required competencies all still relevant in today's practice? Would eliminating Music Theory III & IV make more room in the undergraduate degree for additional music therapy classes? Would eliminating Music History I & II and replacing it with History of Popular Music and a World Music class be more relevant? Would requiring less applied lessons on a primary classical instrument and replacing those hours with additional study on guitar, piano, voice, and percussion be more relevant? Could we then fit in more clinical improvisation training and more counseling skills training? Maybe the answer is not MLE, but rethinking

the undergraduate degree to focus on music therapy clinical skills that are relevant, timely, and functional. "We all took it, so they should have to" is no longer an option and not in the best interest of growing the field. Gen Z wants to get to work. They don't want to be in school for 6 years accumulating debt.

Q20 What type(s) of preparation do you provide for students?

Twenty-six faculty responded to this question, describing a range of techniques they utilized to support exam preparation. Both formal and information approaches were undertaken. Formal approaches are those in which the faculty member organizes instruction during the academic program. This can include instructional methods undertaken during a specific course (6 responses), specific exam preparation sessions (6 responses) and distribution of prepared materials (2 responses). Informal instruction (3 responses) tended to involve faculty working 1:1 with students in order to meet their learning needs, and included informal meetings and assigning mentors who have already taken the exam. Additionally, nine faculty described specific workshops and test preparation sessions that have the above characteristics, but did not indicate whether these were included in coursework, or occurred outside or regularly scheduled class time.

> We integrate domains into introductory courses so we can have more consciousness about it when we teach skills and theory. [This is part of the same response, but not integral to the question: In my faculty retreats and annual reviews, we have needed to focus on increasing our pass rate for our students in the MA program, even though it is not adequately designed to evaluate their knowledge. We owe it to our graduates to prepare them, even though get numerous complaints and grads who cannot pass it and who tell me it did not evaluate their level of knowledge or relevance to advanced clinical practice].

> All of our senior students are required to take the CBMT Self-Assessment Examination as a part of their coursework. I think this is one of the best ways for students to experience the types of questions on the test. This is done the semester prior to internship, which also helps them realize their areas of strengths and needs on the exam and provides a focus for internship. Students are also required to take an comprehensive exam prior to internship (pass/fail course), in which they are tested on concepts from all levels of their training.

> There is a greater emphasis on what information might be on the exam during an intern seminar for students attending affiliated internship sites.

> The only official prep would be in the inclusion of types of questions into regular course exams that reflect the same types of questions in style and level of difficulty that are on the board exam.

> We integrate "best answer" questions in all classes. This helps them with the thinking needed on the exam - primarily in identifying what the question is really asking and thinking through the possible answers. We also give them a study list when they leave for internship.

> I make sure that my students know how to answer a standardized multiple choice question. I teach them how to narrow down the answers and how to choose the best one. I give multiple choice tests in my classes so they can practice this, because I know the CBMT exam is all multiple choice.

> Periodic discussions while students are in the program and an exam prep session toward the end of internship

> One 3 hour session with recommendations for reading, taking the sample test, psychological strategy for preparation

> We have them take one version of the SAE during the final semester on campus and strongly encourage them to take the second version toward the end of their internship prior to taking the exam.

A 2-hour test preparation session (near graduation time) that goes over some structure of the test and how to prepare for it.

In each course, the Board Certification Domains are referenced and students take exams that use some multiple choice questions to promote application of knowledge.

Study sessions

I do not have a designed course or procedure. However, as more student fail the first time, I've developed a study guide and spend time with the student (3 to 10 hours individually) working with them until they pass. Eventually, everyone has passed.

Review sheets

We actually try to find the graduates mentors who have taken the exam.

I do not have a designed course or procedure. However, as more student fail the first time, I've developed a study guide and spend time with the student (3 to 10 hours individually) working with them until they pass. Eventually, everyone has passed.

Informal info and prep sessions.

Educate students regarding the materials CBMT prepares for exam candidates, i.e, SAE, SAE Bibliography. Students are encouraged to purchase the SAE not just for the purpose of becoming familiar with the type of questions presented on the exam, but to utilize the SAE as a study guide.

Workshops and preparation in several different classes. But it doesn't seem to be enough to increase our pass rate. Looking into other options.

We spend 4 questions [sp? Sessions] going over practice questions and tips/strategies.

We spend time reviewing a sample exam and discussing how to provide best answers.

We discuss sample questions from the practice test to work through the problems and perceptions as a group.

Students complete a mock exam

I don't not teach to the CBMT exam. I DO teach about how to read exam questions (nothing about specific content), and we have had only one student fail in the past 10 years. That student failed prior to our raising the cut score.

We teach to the AMTA competencies but because the AMTA and CBMT competencies do not align then I really don't properly educate my students. I've heard of professors who took the exam so they could know the questions and I think that is a great idea. If this problem doesn't get fixed there will be more people willing to cheat the system.

Review of exam taking strategies, review of self-assessment examination questions

Q 22 What, if anything, prevents you from being more effective in preparing students to take the CBMT exam?

I feel that my philosophy differs to such an extent that my help would not be effective.

I have no idea what's on the exam, which is ridiculous. The way I think about music therapy is not consistent with exam wording and types of questions.

I took the exam every 5 years for recertification until this last cycle since I'm no longer allowed to use this option. It wasn't necessary until the last 3 to 4 years to "teach to the test" as the majority of my students passed on the first time (2006-2011 - 100% first time pass rate). I am learning over time what "effective preparation" is (decision making on tests, strategy for the right answer and not what you'd actually do, trends and patterns in populations (as reported to me), etc.).

I have never taken the exam nor seen it's questions.

Lack of understanding what is on the test and having a bank of former test questions to help structure some of my teaching throughout the program

Lack of experience in taking the exam - to feel what the experience is actually like, and to feel the types of questions asked

Lack of detailed information about the exam.

I never used to worry about it, honestly. Our domains were 'inline' so I assumed questions were designed to evaluate the students understanding and application within our scope of practice... at entry level. It seems the targets have shifted and we as program directors are not a part of the conversation. This is not simply a educator problem, this is systemic and involves committees for professional competencies, APAC, CBMT, Standards, and faculty... and more! I believe these committees want to be involved with one another.

Previously stated comment about impossibility of adding content plus I have never seen the exam.

It doesn't reflect advanced MT clinical and theoretical knowledge, creativity, improvisation, diversity or inclusion, clinical case studies that require a thoughtful written out treatment plan, summary, assessment, or theoretical philosophical stance as integrated into clinical practice, and so on.

The 4 years of undergraduate education is not enough to prepare clinicians for the current skills needed in clinical settings.

Finding sufficient time within the curriculum for all our academic and clinical educational needs will always be a challenge.

The breadth of knowledge in the field is expanding more rapidly than its inclusion into curriculum. We need more flexibility to adjust program curriculum outside of the exhaustive and expensive NASM review process.

The number of credits in our programs already stretches most universities' limits, so more time for reflection and discussion in classes is challenging.

The practice test (I have not seen form B yet) is reportedly far from the current exams in content and style. Students ace the practice and are very frustrated by the actual exam.

Lack of ability to be all things to all areas of practice, i.e., there is no way I can teach all of the vocabulary required for students to pass the exam by more than 1 to 10 points

Students who don't take tests well, but are fantastic therapists. Students who don't take multiple choice tests well; distractors and answers that could possibly be correct but are counted wrong.

It is impossible for the students to be able to anticipate who is writing the question, and from what philosophical perspective. So, how could we prepare for that? Except helping them be better test-takers. Reading the question through the lens of the questioner. How does that show a music therapist's competence? I don't know.

I believe students need to take responsibility for studying for the exam and learning how to apply their knowledge.

we have difficulty preparing international students for the exam. The language used is really difficult for an ESL student.

They take the exam after internship, many times they return back to their home cities and do not ask for assistance.

I encourage my students to take the exam as quickly after the internship as possible, but for many different reasons they don't always do that. It seems that the longer they wait, the higher chance that they will not pass the first time. Also, some students, not matter how hard you work to teach them, are just not good critical thinkers. I have had a couple of students who had great instincts with clients - knew what to do in the session because it felt right, but didn't necessarily understand WHY they did it. It seems that students who have the natural music therapy instinct (kind of like students who taught themselves to play an instrument by ear, and then had to go back and learn to read music) seem to struggle with the exam, even though they could be very good clinically.

I think having outdated classical music requirements that are NASM-mandated are an obstacle to having a fuller music therapy degree program.

The burgeoning amount of literature and knowledge available as the field has developed. Difficult to teach within an undergraduate curriculum.

Nothing. I feel as though our students are prepared to take the exam.

Our students are doing fine on the exam; thus, I feel that our constant evaluation of our program and the changes being made to curriculum and clinical training is allowing us to effectively prepare our students.

Our students have generally been very well-prepared for the exam, with the occasional exception of international students.

Overall, I do think that I'm doing all that I can.

Time.

I'm feeling like the issue belongs to CBMT.

Actually having resources like boot camps, study groups, etc. have been more effective than having a special day for students to work with faculty to study for the exam

Q23. What changes, if any, would you make to the CBMT exam?

Get rid of it. It’s utterly ridiculous. It tests a student’s ability to take a test and only evaluates one way of thinking about Music therapy - cognitive behavioral thinking. It’s therefore bias as well as not being able to demonstrate that it protects the public because it has no evidence that it improves safety or prevents harm.

Make the test for entry level not a Masters test.

Create 2 exams. 1 of undergad entry level and 1 for advanced clinical work that includes specifics around what is taught in the MM, MA, and MSc criterion, as per AMTA educational standards. I have been saying this for 20 years. MT is not an evolving undergraduate profession, we have huge burn out because jobs are being created for graduates with undergaduate level training who cannot and should not be exposed to the deeper, advanced clinical work required from graduate level training. We are in desperate need to re-think this as it impacts so much more than internal decisions. This one exam is impacting our profession and field as it is known to the public, job market, and any kind of potential career trajectory right up into leadership positions in admin where we need grads to be heading to support and sustain the future of the field.

Bring the test back to being an entry level exam.

More emphasis on clinical practice.

Add a live clinical component.

Educators should be involved in writing the questions. The exam should have some kind of clinical component requirement-- I don't know what that would look like, but it seems skewed towards behavioral model and medical model.

Reduce the scope of practice and the extent of the vocabulary covered

The AMTA competencies and the CBMT competencies should align.

I would like the CBMT to ensure that the practice analysis is at an undergraduate level (unless we move to masters level entry). Otherwise the exam is not fair to the educational requirements.

I disagree with the premise of the application of the practice analysis - there needs to be a whole new approach to determining exam content. It doesn't make sense to create an exam based upon entry-level practice when that does not necessarily reflect evidence-based or competent practice. Educational programs teach to the AMTA competencies; this is what is required of us. The exam should reflect this in whole or in part.

Tighten the scope of practice that is tested. Remove theoretical orientations that are inappropriate for professional level practice (psychodynamic) or require institute training (NMT, GIM, AMT, NR).

lower cut scores, questions that have a definitive answer rather than some questions where a philosophical may generate a wrong answer.

I would re-examine the cut score. I heard the report on why this increased, but was it truly necessary. What say does CBMT have with NCOA (whatever that group is)? It seems that states license exams are lower cut scores than CBMT is.

One area is Termination - this section seems to be long (at least it is on practice exams) and is mostly related to private practice. Client termination practices are specific to each setting and difficult to questions as a set of "norms".

I think it is complex to create an exam like this. I have not thought a lot about what changes to make. I do think that there should be educators or researchers who could go over the exam and see which questions are confusing in terms of multiple possible correct answers. I also think there should be options for students with disabilities to take the exam in another format.

I am unsure concerning the difficulty for some international students. If the exam questions are still created so that 2 of the answer options are very close, that could make it much more difficult for a person for whom English is not their first language.

Revise it to better reflect the competencies

I can only speak to the practice exam, but students struggle with the language and ambiguity of the situations.

Lessen the amount of information, particularly the information that does not relate to "music" therapy

None. I would move to masters entry level, not change the exam in order to better the pass rate

Difficult to respond to this without actually referencing the content of the current exam!

Not in a position to comment since I am unfamiliar with the current content.

I would need to take the exam to provide an answer

I don't know enough about the current written portion to comment on this, but I believe strongly that skill and values/attitudes should also be evaluated somehow.

I have not taken the exam in 20 years and therefore I do not know. However, I do see the practice exam these students purchase and they report a disconnect between this study tool and the exam. I encourage them to use the bibliography provided. Although the majority of these students pass the first time they do report the practice test did not help them prepare and that there were medical terms they were unfamiliar with. The balance for me has been aiming for a program that prepares the students to acquire theories and skills they can apply, provide them with skills to be observers of behavior and analyze impacts of other variables (i.e., medication, environment, etc.), and navigate resources to extend and supplement their learning when specifics are required (e.g., the extremely rare genetic disorder they will likely encounter). I have not approached the curriculum with the desire to "teach to a test" EVER or encourage "memorization" above utility. I don't believe it is as easy as making a change to the exam but rather revisiting the process and its impact on the academic programs AND the internship programs. It is possible.

I am not sure, but I do feel that there are folks that seem to have more time to devote to this important task.

This is not within my purview; the content is in direct relation to the Practice Analysis Survey which MT-BCs are incited to complete every 5 years.

I cannot answer this question because I have never seen the CBMT exam. Plus, I feel AMP and CBMT need to be given the freedom to do their work.

I don't have a good answer to this question. Something should change, but I don't know how you test for the most important things that account for effectiveness and safety, such as building healthy relationships with good boundaries, understanding how to validate, understanding what the structures of music provide for clients' processes, understanding emergent process, etc.

I think the CBMT Exam Committee members have the responsibility of ensuring that exam content reflects current practice and that questions are indeed sensitive to multicultural and inclusionary best practices. I trust them to do this.

None. I believe the exam to be accurate and valid. (Though it is clear from this survey, and how it is worded, that there are people who do not believe that to be the case.)

None. I served on the exam committee years ago, and I feel that the rigorous process that the committee and Applied Measurements Professionals (AMP) provides is appropriate.

None. I really believe that the changes are needed at the educational/university level, not with the exam. The exam is written from the Board Certification Domains which come from a practice analysis survey of the actual music therapists working in the field, so the exam represents current practice. I fear that our degree programs DO NOT represent current practice. I would LOVE to overhaul my degree program to better reflect current practice, but don't know where to start. It has to start with AMTA and a complete review of our educational competencies for current relevance to practice. Then they can give us educators new guidelines to make sure we reflect that.

None
More availability of retired test questions; More resources for preparation for foreign students

More study guides.

Q24 If there's anything you'd like to add, please do so here

Faculty need to talk about the exam. There are lots of problems.

The cut score of the exam has to be looked at. I saw a presentation re this and I think I remember that the approximate % of students passing the exam from 10 years ago is the same ratio now as the numbers are larger. That may be a mistaken evaluation on my part, but that also might be a way of looking at why so many are not passing - because there are more taking the exam.

Be realistic about expectations. Some questions that have been added after by people who teach a particular way and if others are not taught that way, the question is confusing and often misleading. It's become too specific toward certain programs.

I would love to see direct comparative data between bachelors (first time in college) scores and equivalency students and the equivalency/master's students. If the EQM is truly superior as evidenced by higher pass rate, I want to know that. That could strongly influence my decision regarding masters entry and adopting the EQM as our entry degree. These data were not shared, though I believe they exist.

Successful test-takers have developed skills to do such. I believe educators have a responsibility to assist students in developing these skills and can do so by the way in which they evaluate student learning outcomes. If students never work with objective - based tests (i.e., multiple-choice questions) they could be at a disadvantage for the CBMT board exam. While some programs and/or internships require students to purchase the CBMT SAE, not all do. It's potentially possible that a candidate may not be exposed to this testing format until the day of their board exam. I also believe it is the educator's responsibility to be familiar with the Board Domains and emphasize them throughout their curricula. (Perhaps this is what is meant by "teaching to the test." I do not know. Also, as practice analysis is regularly evaluated to remain consistent with current practice, so should be our curricula.

I believe that we should begin to exam programs with high pass rates to see what those programs are doing to produce successful students, who are passing the exam. It is possible that there are faculty who are not teaching evidence based practice and who are not keeping up with current practice (as the exam is based on what clinicians are doing). This could be because there are faculty who are not members of AMTA, and are not regularly reading our professional journals. It may also be because they disagree with how others are practicing and do not acknowledge in their teaching various philosophies of music therapy and their credibility.

It is incumbent on the faculty to be aware of the Board Certification Domains and to educate their students regarding not only the Competencies, but the Board Certification Domains as well. Faculty must maintain awareness of current practices in a variety of settings and with a variety of populations. Assembling a faculty from varied backgrounds wound help in this way, as opposed to a faculty being dominated by one-way thinkers.

We need to do this differently, and create a tiered system that reflects the different levels of training and expertise. Nursing in particular followed a very good plan, and has been successful in that over the last 30 years. We can do it too. Thanks for putting this out there. I appreciate the effort and support to see what we can do differently to move the field forward!

Maybe it is time for AMTA to examine what is happening with universities and the passing rates of students. I know there is a lot of unhappiness, especially when students fail the exam and when it is failed multiple times.

I believe STRONGLY in the CBMT and MT-BC credential. I am not in favor at all in eliminating this. It is important and moving us forward in state licensure. I would not support removing this. But, we can improve this somehow. Thank you for this survey. First step to creating as solution.

I left a few items blank because of the way the item was phrased and/or the limited response options.

This survey is obvious an outlet for faculty members to complain about the board exam, especially those who have students failing the exam. I am not sure what the answer is to this problem, other than examining what is working at specific universities in relationship to high passing rates and course content/curricular development/teaching effectiveness. Maybe it is time

for AMTA to examine what is happening with universities and the passing rates of students. I know there is a lot of unhappiness, especially when students fail the exam and when it is failed multiple times.

To my knowledge, the exam is not biased or insensitive to various populations -- I'm quite curious what prompted those questions to be asked on this survey.

It might have been helpful to add a preliminary question about the exposure the respondent has had to exam content (e.g., I have taken the exam within the last two years; I have never taken the exam for re-certification; I have served on the exam committee; I know what I know about the exam from comments my students have made; I know what I know about the exam from my experience with the self-study, etc.).
This survey assumes that we know the content of the exam and how individual students score. Unless you expect your students to share their reports with you, and we cannot, that information is not available.

It is impossible for me to answer the questions on culturally sensitivity as I have not seen the test questions.

I feel very frustrated at the negative attitudes towards masters level entry. To me as a music therapy director, it is really obvious that this is what is needed to create successfully prepared clinicians.

I would like to be part of the solutions.

As faculty we don't see the exam, so when answering these questions I am reliant on my student's reports and perceptions of the exam. We receive our pass rate results; however, the information we receive is not very helpful in understanding how to better prepare students. We are required to teach the AMTA competencies, but we must also look at the CBMT Domains in order to make sure we are covering the necessary material. This results in a lot of topics to cover in an undergraduate program. I realize that it is difficult to construct an exam for a dynamic field such as music therapy; however, it is important that the exam accurately reflect practice at the level that it is supposed to be testing.