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Who are the Music Therapists in Mexico and How Do They Practice?

An Online Survey of Professionals and Students

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Abstract

Music therapy in Mexico has a limited history, with isolated efforts to establish the discipline, lack of university programs, and limited public awareness of the profession. Given the lack of research about music therapy in Mexico, we implemented a quantitative online survey to understand the status of music therapy practice, inviting any self-identifying music therapists that had practiced between 1997 and 2022. A small sample of self-identified music therapists (*N* = 33, including practicing music therapists and students) responded to the survey. This sample seems representative of practitioners in the country. Educational level varied widely, from no university degree (in any discipline) to master's degrees in music therapy, obtained in other countries. Most practitioners (*n* = 20) reported having no university degree in music therapy. According to our results, music therapists working in Mexico address similar needs and are in similar settings to other music therapists around the world. The most common music therapy approaches are a humanistic approach developed in Mexico and the Bonny Method of Guided Imagery and Music, with receptive methods most often employed. Young adults with mental health needs, with self or family funding, are the most common clientele. Costs, treatment duration, and session duration are comparable to other therapies in the country, but the income from this practice is very limited. About two thirds of practitioners engage in supervision, and most use several documentation methods. We consider that Mexico displays an emerging discipline, with practitioners showing optimism, commitment, and enthusiasm to the professionalization of music therapy in Mexico. Suggestions for organizational efforts and support from other countries are included.

Keywords: Mexico; emerging discipline; music therapy development

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Authors' Positionality

I (Eugenia Hernandez-Ruiz) am a Mexican music therapist, with a Bachelor's degree in music composition and theory from the Trinity College London and Centro de Investigación y Estudios Musicales, A.C. (Mexico), and master's with equivalency program and PhD degrees in music therapy from the University of Kansas. After graduating in 2004 from my master's program, I went back to Mexico, created a music therapy agency, and practiced as a full-time music therapy clinician in Mexico City until 2014, when I went back to the University of Kansas to complete my PhD. I am now a faculty member at Arizona State University where I have taught since 2018. I continue to provide music therapy services online and occasionally in person, and conduct research, in Mexico. I am very invested in the development of music therapy in my country, and, after completion of the current survey, I was invited to serve on the Board of Directors of the Asociacion de Musicoterapeutas en Mexico (AMME). I work collaboratively with the current professionals in the country in several ways, including coordinating the Training commission of the AMME (2023-2026) to create the training and certification guidelines that will support university programs in Mexico. I am aware that my unique experiences as a U.S.-trained music therapist with a PhD, and faculty member, bias my opinions regarding the professionalization of music therapy towards international standards, higher education programs as foundational for the discipline, and high levels of musicianship as indispensable requirements to become a professional music therapist. I firmly believe that only the highest level of ethical and clinical standards will allow the profession to flourish and the public to be protected. On the other hand, my lived experience of having to uproot myself and my family twice to achieve the highest degree in the profession, as well as the effort to establish a music therapy practice where there is no professional recognition, has sensitized me to the challenges of becoming a music therapist in Mexico. As a person of lighter skin color and who had access to higher education in my country and abroad, I am aware that my perspective is privileged and limited. As a woman, I am sensitive to the discrimination, violence, and limited access to economic and political opportunities that many women in my country experience. My scientific upbringing influenced my thinking towards an objectivist research approach. However, my long-standing participation in a non-profit organization that worked against domestic violence from a humanistic, systemic, and feminist perspective greatly influenced my work. All these professional and personal experiences have made my approach to scholarship and research a complex endeavor. I attempt to integrate different perspectives, methodologies, and purposes, with the understanding that knowledge creation is a continuous effort of many actors. My main goal with this project was to put my strengths, knowledge, and complex experience at the service of the profession in my country. In this way, I hope to contribute to the facilitation of access to the profession for future students.

I (Jill Sullivan) am a white, cisgender female. I am a Music Learning and Teaching professor at Arizona State University. I am a feminist scholar, an historian, and a quantitative researcher. I have published one historical music therapy article in the *Journal of Music Therapy*. My interest in the current research is solely as a status study of music therapy in Mexico. I provided my expertise in survey research and supported the analysis of the results. I have researched and published on the beginnings of music therapy in the United States and am familiar with the professionalism of the field that has developed since its start with the medical and military community of the 1940s. I have an enormous respect for the music therapy university programs throughout the United States. I consider them exemplars for any degree program in academia, community-based health services, as well as socially embedded medical and K-12 school partnerships throughout the United States. My knowledge and admiration of the music therapy profession, education, and

credentialing in the United States may be a bias and may have influenced some of my thinking when supporting the design of this survey study and the interpretation of its results.

Introduction

Music therapy as a profession has an important history, particularly in countries where it has been established at the university level (i.e., bachelor's to PhD programs in music therapy), with longstanding professional organizations, standards of practice and codes of professional conduct, and board certification and licensure (Kern & Tague, 2017). However, the development of the profession has not been homogenous across countries and world regions (Kern & Tague, 2017; World Federation of Music Therapy [WFMT], n.d.). In several countries, music therapy practice has reached at least state regulation and is considered a healthcare profession, such as Austria (Böhm-Oppinger, 2015), Argentina (Ley No. 27.153, 2016), Latvia (Paipare, 2015), Panama (WFMT, n.d.), and the USA (American Music Therapy Association [AMTA], 2022). Although some countries have only recently established university degree programs, they have quickly gained legal regulation and national recognition as a healthcare profession, such as Latvia (Paipare, 2015) and Panama (Comité Latino Americano de Musicoterapia [CLAM], 2021). Some countries have achieved or made important progress toward official recognition and legislation in recent times, such as Argentina (Ley No. 27.153, 2016) and Brazil (Associação Portuguesa de Musicoterapia, 2022). Other countries, despite having university-degree programs with considerable longevity, do not yet have legislation of professional practice, for example, Spain (Sabbatella & Mercadal-Brotons, 2014). In other countries and continents, clinical practice presents in different forms (e.g., workshops, one-time sessions, music listening programs), has limited or no legal regulation, and is performed by professionals with varied amounts of training, such as in some countries in Africa (Smith, 2023; WFMT, n.d.). Other countries, despite having a small group of professional music therapists, do not have university programs that provide a music therapy degree, music therapy is scarcely recognized as a profession, and public awareness of the qualifications to become a music therapist is limited, such as in Ecuador (CLAM, 2021). These examples illustrate that music therapy across the globe is at very different stages of development and professionalization.

Understanding the state of a profession in a country is important to facilitate conversations that allow the development of standards of practice to protect the public, the planning and establishment of educational programs to educate well-trained professionals, and advocacy for the profession (Certification Board for Music Therapists, CBMT, n.d.; CLAM, 2021). For music therapists already in practice, having ethical standards and guidelines for training and practice increases quality of clinical practice, professional development, job recognition, higher income potential, and permanence in the field (AMTA, 2022; CBMT, n.d.; Vega, 2010). In countries where regulation is limited or non-existent, understanding the state of clinical practice is essential to promote legislation, to create university programs and professional training options, and to advocate for the profession. Further, professional standards and regulation support ethical practice that protects the public from inappropriate use and abuse of music interventions (CBMT, n.d.; WFMT, n.d.).

Music Therapy in Mexico

Mexico is a country with limited professional music therapy history, and one that is scarcely documented. Like other countries without music therapy university programs (WFMT, n.d.), clinical practice in Mexico has evolved through the work of dedicated professionals with limited training, international degrees, or self-created approaches

(Asociación de Musicoterapeutas en México [AMME], n.d.). Without attempting to be an historical account, some initial evidence shows that the first efforts to establish music therapy programs in Mexico included work by Consuelo Deschamps, Jose Guillermo Villegas, Mariela Petraglia, Esther Murow, and Victor Munoz Polit in the 1980s (AMME, n.d.). The training of each of these professionals varied, with some of them having university degrees in music therapy (from non-Mexican institutions) and others developing their own approach in the use of music for psychotherapy (Asociación de Musicoterapeutas en México, n.d.). Internationally trained music therapists contributed to the development of the profession in Mexico by providing short-term training (e.g., the Bonny Method of Guided Imagery and Music training by Ginger Clarkson, ca. 2004–2006). Other professionals, mostly trained outside of Mexico, have developed clinical practices from the early 2000s to 2022 (time of this writing). In 2018, the first national music therapy association, the Asociación de Musicoterapeutas en México, was legally established (AMME, n.d.).[1]

More recently, with the advent of social media, music therapy has increased substantially in the public discourse in Mexico. We have informally observed that people are using the term “musicoterapia” more frequently on social media, more people are interested in courses and presentations, and more professionals are offering music therapy services than in the previous decade. A recent study on music therapy training in Latin America (CLAM, 2021) found several unofficial training programs in the country with an increasing number of recent students and graduates. However, to our knowledge, no study has investigated the state of music therapy clinical practice in this country.

Research Aims and Questions

In an effort to contribute to the professional conversation of music therapy in Mexico with systematic, research-based information, the current survey study aimed to (1) identify the educational and demographic profile of the professionals that self-identify as music therapists in Mexico, and (2) create an initial portrait of music therapy clinical practice in this country. Specific research questions were divided into five main sections. The first section contained demographic questions (i.e., age, gender, nationality, place of residence, main musical instrument). The second section collected respondents’ educational training in music therapy (i.e., university degree in any major; institution that granted the degree; degree in music therapy; other trainings; clinical hours during training; music therapy approach learned during training). The third section highlighted job conditions (i.e., groups/needs served, settings, job referrals, number of clinical hours, income from music therapy practice). A fourth section gathered specific information about music therapy clinical practice (i.e., music therapy approaches used in practice, referrals, supervision, and documentation). Finally, a fifth section explored attitudes and beliefs towards music therapy in Mexico (e.g., confidence in training, public awareness of music therapy, confidence in music skills of music therapists, perceptions of training in music therapy). We consider that all sections except the fourth pertain to the first aim, which is to identify who the music therapists are in Mexico. The fourth section pertains to the second aim, which is to understand how music therapy clinical practice is implemented in Mexico.

Method

Research Design

We conducted a descriptive study using a quantitative online survey design. The survey included open-ended questions (e.g., “other: _____”) to allow participants to provide free responses on most items. We also included a final open-ended question to address any

additional comments or concerns that participants may have had (i.e., "Is there anything else that you would like us to know?"). Despite limited data, the latter was analyzed through thematic analysis.

Participants

Our sample consisted of any professional or student who self-identified as music therapist and had practiced in Mexico at any time within the past 25 years, or who was currently enrolled in any music therapy "diploma"[2] or course in Mexico. The recruitment post on social media (Facebook®, Instagram® and Twitter®) presented variations of the following statement: "If you identify as a music therapist and are working/have worked in Mexico between 1997 and 2022, we want to know more about you." The post was also shared with the CLAM and the Latin American Music Therapy Network (LAMTN) social media platforms as these are commonly used by music therapists who have practiced in Mexico. We also sent email invitations to members of Mexico's national music therapy association, the AMME.

Instrument Design

This descriptive quantitative survey used a 42-item online questionnaire delivered to participants through Qualtrics™ software. To develop the survey, we reviewed previous instruments with similar topics (Kern et al., 2013; Kern & Tague, 2017; Sabbatella, 2003; Sabbatella & Mercadal-Brotons, 2014). Questions for demographic information, educational level, work conditions, and attitudinal scales were replicated from Kern and Tague (2017). Questions regarding clinical practice were adapted from Sabbatella (2003). These resources were used as models as they are some of the most comprehensive international surveys about music therapy practice (Kern & Tague, 2017) or were implemented in a Spanish speaking country with some similarities in music therapy development (Sabbatella, 2003).

This survey was created in English as the second author and the consultant are English speakers. The first author (who has Spanish as her first language) translated and adapted the items from Sabbatella (2003) to English for this first step. The second author then read and advised on all items. An external music therapy consultant, with expertise in organizational research and national surveys, pretested the survey and provided feedback as a respondent and as a designer. The consultant's feedback on content, format, and validity was incorporated into a new draft. Once the survey was completed, the first author translated each question into Spanish and adapted for language and context. The Spanish version was piloted with two practicing music therapists in Mexico who provided feedback on readability, limitations, and time investment. Their suggestions were incorporated to the final version.

The main areas of interest, as described by our research questions, included (1) participants' demographic information, (2) educational degrees and trainings, (3) work conditions of practicing music therapists, (4) characteristics of clinical practice in Mexico, and (5) attitudes and beliefs towards music therapy in Mexico and towards belonging to professional associations. Question formats included multiple-choice items with single- and multiple-answer selection, single-line text for short answers, ranking order questions, Likert-type attitudinal scales, and short answer responses as open-ended questions. All questions with the option to respond "other" presented a single-line text box for free responses. Some questions (e.g., age, years of practice, number of hours of clinical practice) were collected as interval variables to allow for both descriptive and inferential statistical analyses. The questionnaire is available upon request to the first author.

Procedure

The authors' university Internal Review Board (Study #00015813) approved this survey for human subjects, ensuring that it met international research guidelines. The first author posted the social media flyer every five days for six weeks. A staff member at the AMME distributed an approved recruitment email to all its members, with two reminders. A video post of the first author inviting members to respond was also distributed to AMME members. The survey was open from April 8 to May 31, 2022.

The social media posts and emails contained a link, which provided complete anonymity to the participants and directed them to the Qualtrics™ survey. Participation was voluntary. After reading the online informed consent, participants were given the option to "accept" and were directed to the survey. The survey required between 30 to 45 minutes to complete. All data was aggregated and downloaded for analysis.

Data Analysis

The authors discussed and agreed on best practices for data analysis. The first author scrubbed the data to exclude invalid responses (i.e., blank responses or nonsensical text "xiksjoijf") and conducted descriptive statistics (mean, median, mode, and standard deviation, when appropriate; and percentages for all items). Percentages were calculated per item. Open-ended questions were analyzed through a brief thematic analysis (Vaismoradi, Turunen, & Bondas, 2013) by (1) reading the data several times, (2) finding essential themes across participants, and (3) reporting results and number of participants who responded in that way. Due to the limited number of responses ($N = 33$), inferential statistics and more in-depth qualitative analysis were not possible.

Results

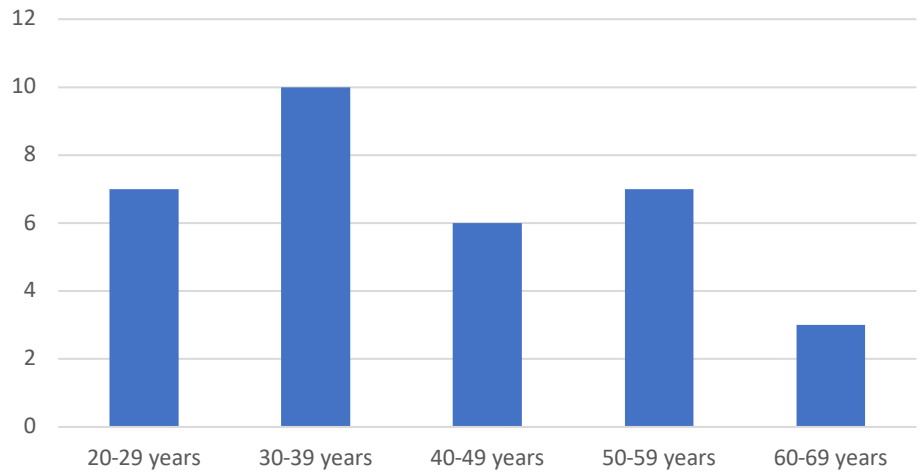
We received a total of 37 responses to the survey. However, we excluded four responses because: (1) Qualtrics software and our analysis [3] indicated that two participants responded twice (we excluded one for each); (2) we had a blank response (no responses after the informed consent); and (3) a participant responded that they currently practiced in a different country than Mexico, and there was no indication that they had practiced in Mexico at any point.[4] From the 33 retained responses, 25 respondents indicated being practicing music therapists, and eight participants identified as music therapy students (i.e., currently enrolled in a diploma or course) and not currently practicing. The survey items regarding job conditions and clinical practice were only available to practicing music therapists. A first question after the demographic and education questions asked whether the participants had professional clinical practice as a music therapist in Mexico between 1997 and 2022. If the person answered positively, the online survey presented all questions. If not, the software skipped the job conditions and clinical practice questions and redirected the participant to the Attitude and Beliefs section. From the 25 professional music therapists, seven participants did not respond to all items in the survey. For these reasons, we share the number of valid responses for each question. We calculated percentages in relation to the number of respondents for each question, and not the total sample.

Demographic Information

Age and Gender ($N = 33$). The mean age of participants was 41.8 years ($SD = 12.45$, range 23 to 67). Approximately half of the participants ($n = 17$) are 39 years of age or younger (see Figure 1 for frequency distribution by age groups). Participants were asked to select their gender from the following options: female, male, transgender female,

transgender male, varying gender/gender non-conforming/non-binary, other, prefer not to answer. If participants selected "other" a single-text box allowed them to give a free response. Participants self-identified as female (51.5%) and male (48.5%). No other gender identifiers were selected or mentioned.

Figure 1. Music Therapists' Age Group Distribution.



Nationality and Place of Residence (Nationality, *N* = 32 responses. Place of residence, *N* = 32 responses, but only 21 clearly identifiable.) Participants' nationality was mainly Mexican (n = 27, 84.4%) and Argentinian (n = 4, 12.5%), with one other nationality from South America mentioned. Participants were asked their state and country of current residence. Most participants lived in central Mexico: Mexico City (n = 7, 21.9%), Estado de México (n = 3, 9.4%), and Morelos (n = 3, 9.4%). Other participants (n = 7) indicated their place of residence within five other states and in a different country.[5] Twelve participants (36.4%) responded "Mexico" as their place of residence. As it was unclear whether they meant Mexico City, Estado de Mexico (one of the 32 Mexican states), or Mexico (country), they are not included in the previous percentages.

Education and Training

Instrument Playing (*N* = 32). Respondents had an average of 19.6 years of experience playing their instrument (SD = 15.3, range 0 to 59). Notably, four participants who identify as practicing music therapists indicated that they do not play any instrument. Another two practicing music therapists indicated having less than 5 years of experience playing their instrument.

Highest Educational Degree in Any Field (*N* = 32). Respondents indicated that their highest educational degree in any field was: No university degree (n = 3, 9.4%); bachelor's degree (n = 18, 56.3%), and master's degree (n = 9; 28.1%).[6] Two participants (6.3%) indicated a master's degree, but after further investigation of other responses (e.g., institution where degree was obtained) showed that those programs did not constitute a master's degree. It is important to note that two of the participants with no university degree are self-identifying practicing music therapists, and another one is a student pursuing a music therapy diploma.

University Degree in Music Therapy ($N = 29$). Three respondents (10.3%) had a bachelor's degree in music therapy and one (3.4%) had a master's degree in music therapy, all from non-Mexican institutions. Five participants (17.2%) indicated a master's in music therapy from institutions that do not offer one.[7] In this case, it is unclear to the authors whether participants misunderstood the question or considered their training a university degree in music therapy. Most participants ($n = 20$, 69%) indicated having no university degree in music therapy. Of these, nine participants indicated an unofficial "master" in music therapy; three participants had a "diploma" in music therapy; one had a "specialty"; and seven did not specify their training.

Supervised Clinical Practice with a Music Therapist during their Training ($N = 20$). This item asked participants the "number of hours during clinical training supervised by a professional music therapist (i.e., a music therapist with a university degree in music therapy)." Participants indicated an average of 212 hours of clinical practice during their training, with a median of 135, and a range of 0 to 1600. The highest numbers (i.e., 500, 500, and 1600) corresponded to the three participants with a bachelor's degree in music therapy. It is important to note that *all* respondents indicated receiving supervision from a music therapist with a university degree in music therapy during their training. However, most of these respondents were trained in Mexico, in unofficial diplomas, some with professionals who do not have university degrees in the discipline. It is unclear to the authors whether participants misunderstood the question or were unaware of this fact.

Music Therapy Approach during Training ($N = 24$). Participants were given a list of the most common music therapy approaches. They identified the approach they were trained under as Humanistic ($n = 16$; 66.7%), Eclectic (i.e., more than 4 approaches; $n = 5$; 20.8%), Benenzon ($n = 1$; 4.2%), Bonny Method GIM ($n = 1$; 4.2%), and all approaches ($n = 1$; 4.2%). Some of the respondents who chose four or more approaches indicated different combinations of the following approaches: Analytical, Benenzon, Cognitive-Behavioral, Community Music Therapy, Dalcroze-Eurhythmics, Family-Centered, Bonny Method GIM, Humanistic, Multidisciplinary, Music Learning, Neurologic, and Nordoff-Robbins.

Job Conditions

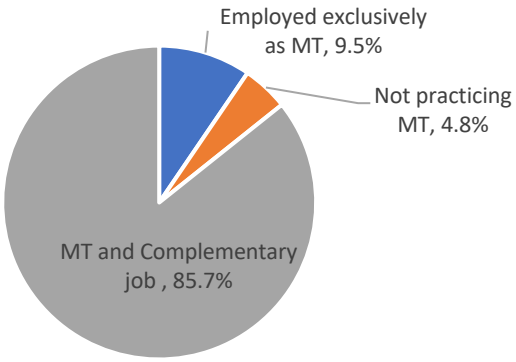
Of the 25 practicing music therapists, seven did not answer all of the questions in this section. We show the number of responses for each question.

Years of Professional Practice ($N = 21$). Participants have practiced music therapy for an average of 6.69 years (median = 5 years; $SD = 5.74$; range 0.5 – 20 years).

Job Referral and Job Description ($N = 21$, with some participants choosing multiple options). Most respondents indicated that they created their own private practice or music therapy agency ($n = 10$; 43.5%). Six participants (26.1%) were referred to their job, and four created a music therapy job within an institution (17.4%). Three participants (13%) indicated that they were not formally hired (i.e., they were volunteers or unemployed), they were complementing a different job with music therapy strategies or did not specify their job referral. Eight respondents (38.1%) indicated that their job description was "music therapist"; four (19%) indicated "therapist" (i.e., psychotherapist, clinical or rehabilitation therapist); three (14.3%) specified an administrative position (i.e., director, administrator, or supervisor); one (4.8%) identified as creative arts therapist; and four (19%) chose a different descriptor (teacher, consultant, volunteer, or self-employed).

Number of Hours of Clinical Practice and Complementary Job (N = 21). Respondents worked an average of 14.3 hours (median = 12 hours, SD = 12.01, range = 1 – 45) in direct clinical practice (i.e., sessions with clients). Figure 2 shows the percentages of practicing music therapist who work in complementary jobs or who are solely employed as music therapists. From the 21 respondents, 18 also had a complementary job aside from music therapy, two participants were exclusively employed as music therapists, and one did not have a paid job.

Figure 2. Complementary Jobs of Practicing Music Therapists.



Income from Music Therapy Practice (N = 21). We asked participants about their average monthly income from their work as music therapy clinicians. Monthly income was reported as ranges of Minimum Monthly Wages (MMW). The MMW is the amount of monthly income that the federal government defines every year as the lowest monthly wage that an employer should legally pay. It is supposed to be the minimum income that a person needs to pay for essential necessities (Consejo Nacional de Salarios Minimos [CONASAMI], 2023). Although we received 21 responses, the data do not clearly show whether all respondents selected their income bracket based on their clinical practice or on all sources of income. For example, a participant reported a salary in the highest income bracket (above 5 MMW, more than $36, 787 MXP). However, they also reported working as a psychotherapist. This participant (and others) may have reported their total income from all sources, and not only their music therapy clinical practice, as the survey item required. Table 1 shows frequency and percentages of participants' income, as ranges of MMW.

Table 1. Income from Clinical Practice of Music Therapists in Mexico (in Minimum Monthly Wages).

	Frequency of responses	Percentage
Less than 1 MMW	11	52.4%
Between 1 and less than 2 MMW	3	14.3%
Between 2 and less than 3 MMW	4	19.0%
Between 3 and less than 4 MMW	0	0%
Between 4 and less than 5 MMW	1	4.8%
More than 5 MMW	2	9.5%
	21	100.0%

Note: 1 MWW = $5,255 MXP, approx. $262.75 USD

Settings and Groups/Needs Served (N = 21). For settings and groups/needs served, participants selected more than one response; therefore, the total number of responses exceeds the number of respondents. Most participants work in private practice (n = 15;

66.7%), five work in community centers (23.8%), three work in a hospital or clinic (14.3%), two in a school setting (9.5%), and two in a residence for older adults (9.5%). The most common diagnoses or needs of people served by music therapists are mental health needs (i.e., depression, anxiety, schizophrenia, substance abuse, eating disorders and "mental health") with 57 responses, and neurodevelopmental disorders (ADHD, autism, learning disabilities and language disorders) with 23 responses. Other diagnoses or needs addressed are represented in Table 2. Interestingly, 11 respondents (52.4%) indicated that they work with 1 to 5 different groups/needs, seven respondents (33.3%) indicated work with 6 to 10 different groups/needs, two participants selected 11 to 15 different groups/needs (9.5%), and one (4.8%) selected more than 15 different groups as their clientele.

Table 2. Group and/or Needs of People Served by Music Therapists in Mexico.

Group or need addressed	Responses
Mental health (depression, anxiety, mental health, schizophrenia, substance abuse, eating disorders)	57
Neurodevelopmental Disorders (ADHD, ASD), Learning Disabilities and Language Disorders	23
End of Life Care (palliative care and mourning process)	10
Medical conditions (cancer, chronic pain, coma, stroke)	8
Neurodegenerative Disorders (dementias, Alzheimer)	5
Physical and Sensory Disabilities (visual disability, deafness, multiple disability)	5
At-risk Youth (e.g., youth living in the streets, in violent homes, using drugs)	4
Pregnancy, birth, postpartum	1
Other (personal development, "Parkinson," "sing therapy," unspecified)	8
Total	121

Clinical Approaches & Strategies

Clinical Approaches Used in Practice (N = 21). Most participants (n = 12; 57.1%) practice from a Humanistic Music Therapy approach developed in Mexico by Dr. Victor Muñoz Polit, medical doctor with a master's degree in Humanistic and Gestalt psychotherapy (AMME, n.d.). Other music therapists used an eclectic combination of BMGIM, Benenzon, Orff-Schulwerk and/or Community Music Therapy (n = 4; 19%), or BMGIM and Humanistic Music Therapy (n = 2; 9.1%). Three (14.3%) respondents indicated using more than six different approaches (e.g., Analytic, Community, Cognitive-Behavioral Culture-centered, Family-centered, Nordoff Robbins, Music Learning Theory, other) and one participant selected all possible options.

Music Therapy Strategies Used (N = 21). Respondents could select more than one response for this item; therefore, the percentages add to more than 100%. Respondents selected music and movement as the most used strategy (90.5% respondents selected this option). Active listening of recorded music and active listening of live music were equally used, with 71.4% of the respondents using these strategies. Active music making (i.e., those strategies that require client musicking, such as singing, instrument playing, songwriting, and music composition) were reported by less than 50% of the respondents. Please see Table 3 for all results.

Table 3. Music Therapy Strategies Used in Clinical Practice (Number and Percentage of Respondents).

MT Strategy	Number	Percentage
Music and movement	19	90.5%
Active listening of recorded music	15	71.4%
Active listening of live music	15	71.4%
Music activities with technology	13	61.9%
Musical improvisation	12	57.1%
Music with other arts	11	52.4%
Singing and vocalizing	10	47.6%
Structured instrument playing	7	33.3%
Music or lyric analysis	5	23.8%
Songwriting	4	19.0%
Musical composition	4	19.0%
Other (participant did not specify, "humanistic MT techniques")	3	14.3%

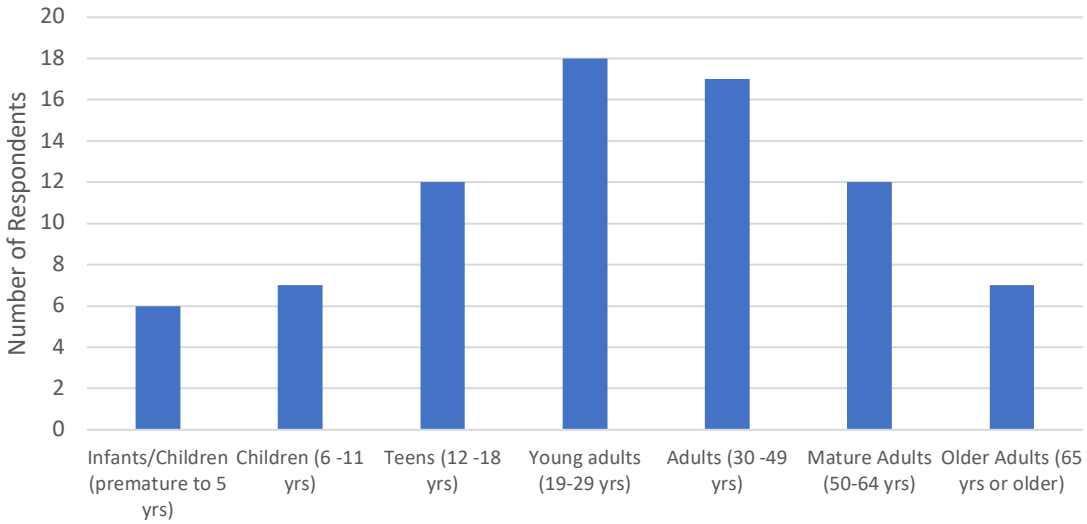
Note: The sum of all percentages is more than 100% because respondents could select more than one strategy used in their practice.

Clientele Description

Clientele Age Range (N = 21). All respondents indicated working with several age groups; therefore, the frequency and percentages exceed the number of responses. Young adults (aged 19 – 29) are the group most often served by music therapists in Mexico (n = 18; 85.7% of respondents). Infants and young children (less than 5 years old) are the group least served (n = 6; 28.6%). Full results are shown on Figure 3.

Number of Clients served per week (N = 21). Most practicing music therapists serve less than 10 clients per week (n = 11; 52.4%). Eight music therapists (38.1%) serve between 11 and 20 clients per week, and a small percentage (n = 2; 9.5%) serve between 21 and 50 clients per week.

Figure 3. Number of Participants Working with Each Age Group.



Treatment Description

Treatment Duration (N = 21). A large proportion of practicing music therapists (n = 10; 47.6%) provides music therapy sessions for 1 to 3 years on average. 28.6% of music therapists (n = 6) provide sessions for 3 to 6 months. Three practitioners (14.3%) reported providing sessions for 4 to 6 years on average. Other treatment durations included 4 to 6 months (n = 1, 4.8%) and less than one month (n = 1, 4.8%).

Session Type (N = 21). Most participants (n = 15; 71.5%) provide both individual and group sessions. A considerable proportion only works in individual sessions (n = 5; 23.8%), and one person (4.8%) provides group sessions exclusively.

Session Duration (N = 20 for individual sessions; N = 16 for group sessions). Most participants provide one-hour individual sessions (n = 16; 80%). Respondents who provided information about group sessions (N = 16) indicated providing sessions longer than one hour (n = 11; 68.8%). See Table 4 for full results.

Table 4. Average Duration of Individual and Group Sessions.

Duration	Individual N = 20 (%)	Group N = 16 (%)
30 minutes	1 (5.0%)	1 (6.3%)
45 minutes	3 (15.0%)	1 (6.3%)
1 hour	16 (80.0%)	3 (18.8%)
More than 1 hour	0	11 (68.8%)
	100%	100%

Session Rates, Funding Sources, and Professional Collaboration

Session Rates (N = 21). Respondents reported on rates for individual and group sessions. The average rate for individual sessions was $564 Mexican pesos (MXP; $28.39 USD approx.), with a median of $500 MXP ($25.16 USD), *SD* of $210 MXP ($10.57 USD), and range between $250 MXP ($12.58 USD) and $1,200 MXP ($60.40 USD). The average rate for group sessions was $919.23 MXP ($46.26 USD), with a median of $500 MXP ($25.16 USD), *SD* of $1,292.69 MXP ($65.06 USD), and range between $250 MXP ($12.58 USD) and $5,000 MXP ($251.65 USD).[8]

Funding Sources (N = 21). Participants ranked the funding sources for their music therapy sessions according to the amount each source contributed to their income. Heading numbers on Table 5 indicate ranking (i.e., 1 – 6). Numbers in each column indicate the number of participants that selected that ranking number for the given funding source. Interestingly, three respondents mentioned insurance as a source of funding. It is unclear whether these sessions were coded as “music therapy” or “psychotherapy” for reimbursement. Please see the complete results on Table 4.

Table 5. Ranking of Funding Sources for Music Therapy Sessions According to Practicing Music Therapists.

		Ranking					
Funding sourse	**Not a funding source**	**1**	**2**	**3**	**4**	**5**	**6**
Client or Family Payment	1	16	1	1	0	1	1
Institutional Budget	12	2	4	1	1	1	0
Government Funds	14	1	2	1	1	1	1
Donations	17	0	1	2	0	0	1
Insurance	17	0	0	1	2	1	0
Other (unspecified)	18	0	0	0	2	1	2

Note: Heading numbers indicate ranking (i.e., 1 – 6). Numbers in each column indicate the number of participants that selected that ranking number for the given funding source. For example, 16 respondents indicated that client/family payment was their #1 funding source, whereas client/family payment was a #2 funding source for one participant.

Referrals and Interdisciplinary Work ($N = 21$). All participants, except two, reported multiple sources of client referral. Complete results are available on Table 6.

Table 6. Referral Sources as Reported by Practicing Music Therapists.

Referral source	**Number of respondents**	**Percentage**
Client/User themselves	15	71.4%
Psychologist/Psychiatrist	11	52.4%
Another Music Therapist	10	47.6%
Family member	8	38.1%
Teacher	7	33.3%
Medical Doctor	4	19.0%
University Professor	4	19.0%
Other (internet, friends, community center, other patients)	4	19.0%
Nurse or other healthcare professional	2	9.5%

Note: All participants, except two, selected more than one referral source; therefore, the number and percentages exceed the number of respondents.

Most respondents ($n = 15$; 71.4%) indicated providing music therapy sessions as "part of an interdisciplinary treatment approach." Three participants (14.3%) reported that music therapy sessions were the "only treatment," two participants (9.5%) indicated that music therapy was "auxiliary to other treatments," and one participant (4.8%) selected "other (sometimes interdisciplinary)."

Professional Responsibility

Documentation ($N = 19$). We asked participants what documentation method they used at three different stages of the therapeutic process: initial assessment, ongoing assessment, and final evaluation. For each stage, we gave them the same five documentation methods to select from: descriptive report, standardized tests, oral report, note in clinical history, or other. Participants selected *yes* or *no* in each stage, to indicate whether they used each of these documentation methods. Complete results are available in Table 7. Notably, for all three stages, most participants used more than one documentation method. However, one person reported using only oral reports for all stages. Other documentation forms included experience scales, phenomenological logs, case analysis, and "body reading."

Table 7. Documentation Methods Used per Therapeutic Stage.

	Initial assessment		Ongoing assessment		Final evaluation	
Descriptive Report	11	57.9%	14	73.7%	14	73.7%
Standardized Tests	9	47.4%	4	21.1%	11	57.9%
Oral Report	10	52.6%	12	63.2%	11	57.9%
Note in Clinical History	13	68.4%	3	15.8%	7	36.8%
Other	5	26.3%	8	42.1%	10	52.6%

Supervision (N = 19). We asked practicing music therapists whether they received supervision regarding their music therapy practice. Most participants (n = 12; 63.2%) indicated receiving supervision. We also investigated the frequency of supervision from different professionals by requesting participants to indicate how often they received supervision from: another music therapist, psychologist, nurse, interdisciplinary team, teacher/instructor, medical doctor, or other. Music therapists received supervision from *another music therapist* most frequently, with 45.5% respondents selecting "always" or "almost always." Next most frequent professionals providing supervision were *psychologists* (36.4% of respondents selected *always* or *almost always*), *teacher/instructor* (18.2%), and *medical doctor* (18.2%). Complete results are available on Table 8.

Table 8. Frequency of Supervision Per Professional Supervising.

	Never		Almost never		Sometimes		Almost always		Always	
Nurse	10	90.9%	0	0%	1	9.1%	0	0%	0	0%
MT	0	0%	1	9.1%	5	45.5%	2	18.2%	3	27.3%
Psychologist	1	9.1%	0	0%	6	54.5%	1	9.1%	3	27.3%
Teacher/Instructor	3	27.3%	3	27.3%	3	27.3%	1	9.1%	1	9.1%
Medical doctor	4	36.4%	4	36.4%	1	9.1%	1	9.1%	1	9.1%
Interdisciplinary team	5	45.5%	0	0%	5	45.5%	1	9.1%	0	0%
Other (psychiatrist, psychoanalyst)	8	72.7%	0	0%	2	18.2%	0	0%	1	9.1%

Attitudes and Beliefs Regarding Music Therapy in Mexico

This section of the survey was available to all respondents, but only 19 of 25 practicing music therapists and one out of eight students completed this section. For brevity, we highlight the most salient results. Please refer to Table 9 for the full data set.

Confidence in Training and Confidence in Music Therapy's Future in Mexico (N = 19). Participants indicated high confidence in their training in music therapy, with 15 (78.9%) responding "agree" or "strongly agree" to the statement "*I am confident that I am well prepared to work as a music therapist with different types of clients*." Only one person (5.3%) indicated disagreement. Similarly, 84.2% of participants seemed to have confidence in the future of music therapy in Mexico (i.e., responded "agree" or "strongly agree").

Table 9. Attitudes and Beliefs towards Music Therapy in Mexico by Music Therapists and Music Therapy Students (N = 19).

Item	Totally disagree *n, %*	Disagree *n, %*	Neither agree nor disagree *n, %*	Agree *n, %*	Totally agree *n, %*
I am confident that I am well-prepared to work as a music therapist with different types of clients	0 0	1 5.3%	3 15.8%	7 36.8%	8 42.1%
I have confidence in the future of music therapy in Mexico	0 0	1 5.3%	2 10.5%	3 15.8%	13 68.4%
Music therapy is well-known in Mexico	2 10.5%	10 52.6%	7 36.8%	0 0%	0 0%
Music therapists in Mexico adhere to high standards of clinical practice	2 10.5%	4 21.1%	12 63.2%	1 5.3%	0 0%
Music therapists in Mexico are well-trained	0 0%	2 10.5%	14 73.7%	2 10.5%	1 5.3%
Music therapists in Mexico are good musicians	0 0%	1 5.3%	15 78.9%	1 5.3%	2 10.5%
Music therapists in Mexico are well-respected professionals	0 0%	5 26.3%	11 57.9%	2 10.5%	1 5.3%
Music therapy in Mexico should be taught at the university level	0 0%	1 5.3%	5 26.3%	5 26.3%	8 42.1%

Training, Standards of Practice, and Musicianship (N = 19). Contrastingly to participants' confidence in their training, only 15.8% (n = 3) indicated agreement or strong agreement to the statement "*music therapists are well trained in Mexico*." Most participants 73.7% (n = 14) indicated "neither agree nor disagree," and 10.5% (n = 2) indicated disagreement. To the statement "music therapists in Mexico adhere to high standards of clinical practice," 63.2% (n = 12) chose "neither agree nor disagree," while 31.6% (n = 6) disagreed or strongly disagreed. Regarding musicianship, 15.8% (n = 3) participants agreed or strongly agreed with the statement "music therapists in Mexico are good musicians," while the majority (n = 15, 78.9%) chose a neutral response ("neither agree nor disagree").

Public Perception of Music Therapy in Mexico (N = 19). Regarding public perception of the profession, 63.1% (n = 12) of respondents disagreed or strongly disagreed with the statement "*music therapy is well known in Mexico*," and none showed agreement. Regarding "*music therapists are well-respected professionals*," the opinions were more diverse, with 15.8% (n = 3) indicating agreement or strong agreement with this statement, 57.9% (n = 11) having a neutral position ("neither agree nor disagree"), and 26.3% (n = 5) disagreeing.

Music therapy Requiring a University Degree ($N = 19$). Regarding the statement "*Music therapy should be taught at the university level*," most respondents ($n = 13$, 68.4%) indicated agreement or strong agreement. Five participants (26.3%) indicated no preference (i.e., "neither agree nor disagree"), and only one participant indicated disagreement.

Participation in a Professional Association

This section of the survey was available to all practicing and student participants. Only two out of eight students, and 22 out of 25 practicing music therapists answered these questions. We specify the number of respondents for each item.

Belonging to a Professional Association ($N = 24$). Twelve participants (50%) indicated that they are current members of an association; eleven (45.8%) participants indicated that they do not belong to any music therapy association; and one (4.2%) indicated that they used to belong but do no longer. Of those who belong to an association, 10 belong to the recently formed Asociación de Musicoterapeutas en México (AMME). Other associations mentioned were the American Music Therapy Association, the World Federation of Music Therapy, and a service agency (not a professional association). Only one respondent belonged to more than one association.

Benefits of Belonging to a Music Therapy Association ($N = 23$). In response to an open-ended question, "*What are the benefits of belonging to a national association?"* respondents identified as the main benefits: (1) networking, (2) staying current and having access to courses, training, and research, (3) institutional support and recognition, (4) regulation of the profession, (5) disseminating information to the public, and (6) discounts in trainings. Two respondents indicated that they "did not know," and one said "none."

Challenges of Belonging to a Music Therapy Association ($N = 23$). In response to the open-ended question, "*What are the challenges of belonging to a national association?"* respondents identified as the main challenges: (1) cost, (2) political and personal interests interfering with support to the discipline, (3) elitism, (4) time investment, (5) "stigma" towards a certain approach, and (6) lack of official recognition of the profession (in Mexico and internationally). Three participants could not identify challenges ("I don't know") and one said "none."

Open-Ended Comments

To the question, "*Is there anything else you would like to comment about music therapy in Mexico?*" twelve participants provided a response. We report the themes from those responses and the number of respondents for each theme. Given the scarcity of data, no in-depth thematic analysis was possible. Responses included (1) suggestions to create alternative paths to music therapy degrees (e.g., validation of programs through RVOE[9]) ($n = 1$), (2) requests that previous and longstanding work in music therapy in Mexico is honored and recognized by the newer generations of music therapists, lamenting the "prejudice against our approach" and/or "the ego, fanatism, and institutional protocol" ($n = 2$), (3) desire for the professionalization of music therapy in Mexico, and desire to engage in research, like the present study, to support said professionalization ($n = 4$), (4) recognition of the large amount of work and time needed to establish a music therapy degree in the country ($n = 2$), (5) need for orientation and public awareness of the qualifications needed to be a music therapist ($n = 3$), and (6) a call for unity and collaboration among music therapists ($n = 4$).

Discussion

The present survey study investigated the state of the music therapy profession in Mexico. One of the overarching aims was to identify *who the music therapists in Mexico are.* A second aim intended to identify the *characteristics of clinical practice in music therapy in this country.*

We found a complex portrait of a profession that has garnered increased interest in the last five to ten years. Regarding demographic information, we found that self-identified professionals are older on average than music therapists in other countries such as the USA (AMTA, 2022) and even worldwide (Kern & Tague, 2017). Mexican professionals often study music therapy as a graduate degree (in other countries) or as post-baccalaureate diplomas or training. Also, there was an almost equal distribution among females and males, different from the distribution in other countries (Kern & Tague, 2017). Although the specific reasons are unknown, a possible explanation is that music as a profession is often discouraged among females in this country and is a mostly male-dominated field (Castillo Silva, 2017). Further, the Global Gap Report (World Economic Forum, 2023) indicates that the economic participation and opportunity index in Mexico shows a significant gender gap (.602), unfavorable to females as it represents a much lower economic opportunity (60%) for women compared to men despite similar educational attainment (99.5%). Becoming a music therapist, a little-known profession with no university degrees and limited income potential in the country, is probably not within the realm of possibility for many females in Mexico. In countries where music as a profession is not discouraged among females and has higher earning potential, more females than males choose to become music therapists (AMTA, 2022; Kern & Tague, 2017).

Professional Training and Education

Regarding educational background, we found a large variation among self-identified music therapists. There was a large percentage of self-identified music therapists without a university degree in the discipline. This is unsurprising given that Mexico does not yet have a music therapy university program. However, some practicing music therapists reported having no university degree in *any* field. This situation is concerning, considering that practicing music therapists reported working with most of the vulnerable populations commonly encountered in clinical practice. Qualifications of these professionals to work in these settings are unclear.

Further, we observed confusion or misunderstanding about the recognition of certain trainings. Some respondents indicated having a “master’s degree” in music therapy. When asked which institution granted their degree, we realized that some of those trainings did not constitute a master’s degree. It is important to note that in Mexico there is a semantic distinction between master’s degree (i.e., “maestría”) and “master,” which typically refers to unofficial trainings, mostly provided by private institutions without official recognition, and that can vary widely in their formal requirements and duration. This use is different from some other Spanish-speaking countries (e.g., Spain) where a “master” can indeed be a master’s degree granted by a university.

Clinical supervision by trained professionals *during their training* also varied widely among practicing music therapists, with some respondents indicating having none. Although some of these professionals may have corrected this limitation with supervision during professional practice, clinical supervision is clearly an urgent need for ethical and safe practice in the country. Similarly, it was surprising to find self-identifying music therapists without training or experience playing a musical instrument. Some of these respondents mentioned using “recorded music.” Again, qualifications and trainings, and even the definition of music therapy, seem to be less formalized than in other countries where the degree exists such as the USA (AMTA, 2022) and Argentina (CLAM, 2021). In such countries (e.g., USA, Argentina), the profession has a specific definition, professional

competencies, standards of practice and university programs approved by either the national associations (e.g., AMTA and National Association of Music, NASM, in the USA) or the education department (e.g., Ministerio de Educacion, in Argentina). As indicated by the WFMT Foundational Guidelines for Music Therapy Education and Training (WFMT, 2022), competencies developed in these programs pertain to music skills, clinical skills, and music therapy skills. Of note, some of these programs include between 500 and 1000 hours of clinical practice during training. Contrastingly, our results indicate that several educational offerings in Mexico include 20 hours of clinical practice. These results are similar to surveys implemented when the profession was in emerging stages in countries where no clear professional training guidelines are available and clinical training is more limited (Sabbatella, 2003).

Clinical Practice

Regarding clinical practice, we sought to understand what music therapy approaches and strategies are used in Mexico, who is the clientele that most often seeks these services, who refers clients to music therapists, what are the funding sources, and how is music therapy a part of a treatment team. We also investigated accountability measures used by practitioners, specifically documentation of initial, ongoing, and final evaluations, and supervision practices.

Most practicing music therapists (15 out of 21) indicated working in private practice. Many practicing music therapists also indicated working in several settings concurrently or at different times in their career. The average number of hours of clinical practice was 14 hours (range = 1 to 45), which corresponds to less than a full-time clinical practice (commonly considered 20 hours/week of direct contact, AMTA, 2022). In fact, 43% of respondents reported a clinical practice of less than 10 hours a week. With 47.6% (10 out of 21) of respondents indicating that they work with more than five populations, it brings into question the level of training, practice, and specialization these professionals have in order to address the needs of so many vulnerable groups.

We found that most practitioners used a humanistic approach developed by Dr. Victor Muñoz Polit, a Mexican medical doctor with a master's degree in psychotherapy. This is unsurprising, given that most self-identified music therapists in Mexico are trained under this model (see Education and Training section). Also important to note, at the time of this writing, the program does not have official recognition as a university degree and has been provided in different program durations (1 or 2-year diploma, master, or master's degree).[10] Clinical supervision hours in this training have varied across the years but are fewer than in established university programs (20 to 120 hours, according to our respondents).[11] Further, music performance skills are not required to participate in this training, as mostly receptive methods are employed. Another common approach reported was the Bonny Method of Guided Imagery and Music (BMGIM). This training has been offered in Mexico to professionals as a specialization program, and not as a music therapy degree (AMME, n.d.); however, some respondents self-identified as music therapists with only this training.

Importantly, session rates as reported by participants are comparable to psychotherapy rates (Galindo, 2022). However, given Mexico's income averages (CONASAMI, 2023), it is reasonable to assume that music therapy services are mostly accessible to people with higher socioeconomic status (Galindo, 2022). Although three respondents indicated insurance reimbursement for music therapy services, to the first author's knowledge, there is no insurance company that covers music therapy services in Mexico. Given that several respondents were trained and employed as psychologists, it is probable that those services were reported as psychotherapy and reimbursed as such.

Despite the limited development of the discipline at the university level and in clinical

practice, there are encouraging signs of support and development. The average number of years of practice is low (6.69 years, $SD = 5.74$), indicating an emerging discipline, with many new professionals entering the job market in the last few years. On the other hand, most practicing professionals reported complementing their income with different jobs and disciplines. Fifty percent of music therapists earn less than a minimum monthly wage from clinical practice. Only two of all practicing music therapists could be considered to make a living from their music therapy work, although the responses do not clarify whether all their income indeed comes from music therapy practice. This result may be due to several factors, for example, part-time jobs, limited number of clinical hours, or lack of recognition of the profession. More research is needed to fully identify these factors, but it is not unreasonable to assume that the lack of legislation of professional practice, as well as limited qualifications of current practitioners, impact income potential.

Similarly, most respondents indicated working in interdisciplinary teams. Given the limited number of clinical hours, limited income from music therapy practice, and varied job descriptions, it is possible that this interdisciplinarity is the result of respondents being employed as psychologists, teachers, or other professionals already inserted in treatment teams. This finding may be an area of opportunity for music therapy development in the country: if professionals already inserted in institutional teams are further trained to professional standards of music therapy, they may facilitate the integration of the profession in those communities. However, it is imperative that music therapy is conceptualized, trained, practiced, and advocated for as a separate profession, and not as an adjunct technique or strategy to other disciplines.

Professional Responsibility

Regarding professional responsibility measures, we found that about two thirds of practitioners engage in supervision of their professional clinical practice. This result is encouraging for the future of the profession in Mexico. However, the fact that a third of practitioners do not have any supervision is concerning, particularly given that many had very limited clinical supervision during their training. Supervision during training and professional practice seems an urgent need for safe and ethical practice.

Documentation is considered a professional standard in some countries as it is the foundation of treatment evaluation, future planning, and interprofessional collaborations, among other benefits (AMTA, n.d.; Hanser, 2018; Jacobsen et al., 2019). Documentation practices in Mexico seem to be well-established among practitioners, with the vast majority employing multiple forms of documentation, ranging from standardized tests to oral reports, in all therapeutic stages (i.e., initial assessment, ongoing assessment, and final evaluation). However, the use of oral reports as the sole documentation form in at least one case is cause of concern as this type of report does not provide any tangible documents, thus limiting professional accountability. Like other aspects of clinical practice, limited training in professional standards may be responsible for this result. On the other hand, this situation is similar to other countries when the profession was emerging, such as Spain (Sabbatella, 2003).

Groups and Needs Served

According to our respondents, most of their clientele is self-referred and pay for the services themselves or with family support. Like trends worldwide (Kern & Tague, 2017), music therapists serve infants and young children the least. This finding may indicate that music therapy is still perceived as a psychotherapeutic option that people seek for themselves, and not a health profession incorporated in institutional settings. Also possible is that young adults, who more often access social media, have learned about music

therapy through these sources and are interested in trying this "new" therapeutic modality. Results pertaining to the groups/needs served by music therapists in Mexico, namely that young adults with mental health needs are the largest group served, support these assumptions (See Groups/Needs Served).

Attitudes and Beliefs

Regarding attitudes and beliefs towards music therapy in Mexico, the authors found the conflicting responses worth discussing. Most practicing music therapists are highly confident in their training; however, they do not seem confident that music therapists are well prepared in Mexico. The reason for this discrepancy may be that people feel confident about their own training, yet they consider other professionals' training more critically. At the same time, some respondents considered that "music therapists are respected professionals," and yet most reported on the limited public awareness of the profession. This result may have several explanations: for example, participants may have reported on their own clients' positive feedback and the respect earned in their own individual jobs while at the same time reporting the lack of general awareness of the profession. Encouragingly, most music therapists have a positive outlook regarding the future of music therapy in the country, almost all of them consider that music therapy should be taught at the university level, and most of them are aware of the challenges and time required to establish the profession. Open-ended questions reflected enthusiasm toward supporting the profession, calls for unity and collaboration among music therapists, and awareness that divisiveness and power struggles would limit the development of the profession as a whole.

Half of our respondents do not belong to any music therapy association, and only 10 of 24 mentioned being a member of Mexico's national association (AMME). However, most professionals, including those not affiliated, could identify at least one benefit of belonging to a professional association. Those identified benefits are congruent with other responses, highlighting the ability to network, professional development opportunities, and public recognition. Participants also mentioned challenges to belonging to an association, including costs, politics (i.e., power struggles), "stigma" of a certain approach, and time investments. These responses are consistent with the first author's observations and conversations with key actors that indicate that an emerging discipline and a newly formed association may be at the root of the limited participation in the association. A professional association is one of the best vehicles to transform policy and increase public recognition and institutional acceptance of a profession (Oselame, 2022). Future developments, emerging literature, and continued communication to and from the professional body may increase current interest and participation.

Limitations

Our sample size was small ($N = 33$). We cannot calculate our response rate as there is no formal census of music therapists in Mexico. However, the number of members of the recently formed national association, Asociación de Musicoterapeutas en Mexico, at the time of this survey was approximately 40 members, including professionals and students (Camarena, personal communication, March 8, 2022). Only 10 (30.3%) of our sample were members of the AMME, indicating that a larger group of music therapists is probably practicing in Mexico.[12] Of note is that at least 25% (10 of 40) of the AMME members *did* answer the survey, which represents an acceptable response rate for an online survey (Sue & Ritters, 2012; Poynton et al., 2019; Wu et al., 2022). We consider our total sample size to be representative of the music therapists in Mexico, and thus, our results can be considered meaningful and valuable. A longitudinal investigation of the profession every

two years may allow us to appreciate the ongoing growth in this country.

Another limitation was the length of the survey and the fact that not all participants completed the survey. Response rate per item varied (e.g., only 72% of practicing music therapists answered the attitudinal scales). It is possible that participants considered the survey to be too long, found the questions irrelevant, or were unwilling to commit to a response. Further research should strive to make the survey shorter and use other methods (e.g., qualitative interviewing) to improve our understanding. Another limitation is the apparent confusion in participants' responses maybe due to limited understanding of music therapy approaches. For example, we noticed that some participants without a music therapy degree indicated that they practice all music therapy approaches. We consider that it is highly unlikely that a fully trained music therapist would respond in that way even if they espouse an integrative perspective given the amount of time, training, and effort required to master each approach. Further information and education may help clarify these misunderstandings. Also, as germane to any survey, in-depth exploration of respondents' perspectives was not attempted. Future qualitative research should consider in-depth interviews of key actors to understand the unique processes they engaged in to establish and develop a music therapy practice in Mexico. However, as the first research study on the state of music therapy practice in Mexico, the results seem valuable.

Conclusion and Future Recommendations

Through this first survey of music therapists and clinical practice in Mexico, we found a complex picture of an emerging discipline with a limited number of professionals, no established standards of practice, educational programs, or regulation of the profession. Institutional, governmental, economical, and societal forces, and not only professionals' disposition, may limit the establishment of music therapy within educational and professional institutions. We consider that the AMME could take the lead in developing a music therapy definition, guidelines, and standards for Mexico, congruent with international standards. At the time of this writing, the AMME's Professional Training Commission has initiated the process of creating these guidelines. The commission is constituted by Mexican music therapists and music therapists living in Mexico, who utilize different clinical approaches, and who have varied educational trainings and degrees, international perspectives, and diverse clinical experience. The process will entail reviewing previous guidelines (e.g., WFMT Foundational guidelines for Music Therapy Education and Training, and other countries' published documents), designing guidelines relevant to Mexico's professional, cultural, and educational reality, and receiving feedback from the Board of directors of the AMME, members of the AMME, and other potential stakeholders.

Most music therapists with a music therapy degree currently practicing in the country have been trained in non-Mexican institutions. The level of commitment and financial investment that traveling and studying in another country entails is accessible to only a few. The discipline would benefit from university programs in Mexico that allow interested professionals to develop their practice to international standards (WFMT, 2022). Private unofficial programs help students gain an initial understanding of music therapy and indeed provide social benefit. However, short unofficial programs may interfere with the creation of university programs by divesting efforts and forming practitioners with very limited training, who then compete for positions and create a distorted public perception of what music therapists can do. Efforts to regulate the profession, and to encourage standards of professional competency across educational programs, protect work opportunities and incentivize higher income for graduates, ensure ethical practice, and support the prestige of the profession among the public. Encouragingly, most respondents

in our survey support the establishment of university programs.

There are also valuable examples in Latin America of success in establishing university programs and passing legislation to protect the profession. For example, music therapists in Panama developed an unofficial diploma in music therapy as a first step to advocate for a university program. With clear vision and intent of visibility for music therapy, the proponents, among them, Patricia Zarate, only offered this diploma once (personal communication, Dec. 14, 2021). The evident need and interest generated by this diploma convinced the university of the viability of a degree and negotiated with those professionals the development of the first master's program in music therapy at the Universidad Especializada de las Americas (CLAM, 2021; Zarate, personal communication, Dec. 14, 2021). This program opened its doors to its first cohort of students in 2023. Regarding regulation, Panamá is also an example of effective collaboration. Although music therapy in Panama has a history of more than 30 years, with professionals trained in other countries practicing since 1990, the national association was only formed in 2021. However, with collaborative work, they led the passing of the first law to protect the music therapy profession in Panama in 2022, which is a considerable feat in a Latin American country (WFMT, n.d). The AMME could model their work after countries like Panama.

Educators and institutions from high-income countries who wish to support the development of the profession in middle- and low-income countries could consider providing training opportunities (e.g., conferences, courses, online programs) on sliding scales or alternative fees, and other sources of financial support for education (e.g., scholarships, assistantships, and fellowships). These educators and institutions should also carefully consider the contextual, political, social, and educational circumstances of the country they intend to serve, to avoid colonizing practices. Similarly, educators and supporters from other countries should take time to carefully understand the professional dynamics among key actors already established in the country.

Future surveys may include improved questions. For example, questions regarding training and practice may include brief explanations of music therapy approaches for respondents who are not familiar with them. Questions regarding income may ensure that participants share information regarding income from music therapy practice (and not their whole income). The Attitude and Beliefs scale may come earlier in the survey to allow more respondents to complete it; and qualitative interviews with volunteers after the survey may complement the responses and give depth to our understanding.

Finally, participation of all music therapists is essential for the development of the discipline and profession. Professionals practicing in Mexico may consider active participation in the national association, the Asociación de Musicoterapeutas en México. As an emerging profession without legislation, much work needs to be done to establish music therapy in the country. This work will take time and effort and requires the concerted strength of all voices. Collaborative discussions are required to establish national standards, codes of professional conduct, and training guidelines for the discipline in this country. These conversations should acknowledge the experience and trajectory of professionals already established in the country and incorporate the enthusiasm of new voices.

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[1] The WFMT 2011 fact sheet about music therapy in Mexico indicated the establishment of a professional organization called *Instituto de Musicoterapia Humanista* in 1996. The *Instituto de Musicoterapia Humanista (IMH)* is a private organization, with a specific and limited training approach, and not a national association.

[2] A *diploma* in Mexico is a non-official, short-term course (commonly provided as once-a-month weekend classes for a few months), typically offered in a very specific topic as a continuing education opportunity. Most students take these diplomas as professional trainings/specializations after a bachelor's degree.

[3] Qualtrics software has a series of functions (such as a bot detector) that identify duplicates by assessing a respondent's browser, device, and location. This information is not recorded, but the responses are flagged as *duplicate*. Our analysis of the content indicated that responses were, in fact, identical for these two cases.

[4] Although we specifically recruited participants in Mexico, recruitment flyers posted in social media reached international audiences. A Spanish-speaking music therapist from a country other than Mexico may have misread the post.

[5] Because the survey asked for practice in Mexico between 1997 and 2022, participants could respond to it even if currently living elsewhere.

[6] Because the first author is a researcher in this study, her own practice and educational background is not reflected in this survey despite her practice in Mexico.

[7] Different from other countries (e.g., Spain) "master" in Mexico refers to an unofficial postbaccalaureate program, with limited prerequisites, credits, and recognition, generally provided by private organizations. In contrast, "maestría" refers to an official graduate degree approved and offered by a university. A *master* is typically longer than a *diploma*.

[8] Based on interviews conducted with key actors outside of this project, the first author considers that it is possible that some of these group sessions were, in fact, large-group, one-time workshops, and not therapeutic groups as more often reported in the music therapy literature.

[9] RVOE stands for Revalidacion de Validez Oficial de Estudios, which is a mechanism where the educational authority recognizes professional training programs from private institutions after legal requirements are met.

[10] As mentioned, in Mexico there is a semantic distinction between master's degree (i.e., "maestría") and "master." The English word "master" is preserved in Spanish.

[11] In a conversation unrelated to this study, one of the creators of this humanistic model noted that they require 500 hours of clinical practice. However, none of our participants mentioned having that number of hours during training.

[12] Not all participants responded to the question regarding affiliation to an association, so this result should be considered with caution.