

Global Music Therapy Survey 2025: Developments and Trends a Decade Later

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Abstract

The 2025 Global Music Therapy Survey offers a long-term examination on the profession's evolution, a decade after the inaugural 2016/2017 study. Designed to track developments in demographic characteristics, professional practice and processes as well as emerging trends, the survey gathered responses from 1,183 current practitioners (67.6% response rate) across 8 World Federation of Music Therapy regions. Quantitative and qualitative analyses provide insight into both consolidation and transformation within the field. The profession remains predominantly female, though gender plurality is rising, and educational attainment remains high. Since 2016, entrepreneurial role creation has more than doubled, reflecting professional adaptation to persistent gaps in regulation and systemic support. Practice patterns reveal a shift toward healthcare and private practice alongside sustained work in education and community programs. Music therapists serve clients across the lifespan, with developmental disabilities, mental health, and neurological conditions most frequently

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addressed. In-person delivery continues to dominate, yet telepractice and digital tools—largely absent a decade ago—have emerged as supplemental models, offering expanded access but also professional ambivalence regarding their integration. Respondents emphasized music therapy’s contributions to resilience, social connection, prevention, and global health, yet identified enduring barriers of insufficient policy recognition, inequitable compensation, and fragile infrastructures that constrain sustainability. Overall, the survey portrays a profession that is increasingly confident, globally relevant, yet structurally vulnerable. Advancing its potential as a vital contributor to international health agendas, the field must now progress through coordinated policy advocacy, accessible education, equitable labor protections, ethical use of technology, and sustained research to strengthen legitimacy, and global impact.

Keywords: global workforce, music therapy, professional trends

Key Points

- **Global workforce transformation:** The profession demonstrates increased diversity, higher educational attainment, and a notable rise in self-created, entrepreneurial roles, reflecting both resilience and systemic gaps in recognition and employment.
- **Evolving practice models:** Music therapists worldwide now work across broader healthcare, educational, and community settings, with gradual integration of telepractice and digital tools alongside enduring reliance on in-person, relational care.
- **Future imperatives:** Despite advances in confidence and global reach, challenges in policy legitimacy, compensation equity, and sustainable infrastructure persist—requiring coordinated advocacy, education, and cross-sector partnerships to ensure music therapy’s long-term impact on global health.

In recent decades, healthcare delivery has undergone substantial transformation, driven by advancing public health priorities, rapid technological innovation, changing demographic patterns, and a growing emphasis on integrated care within the global health ecosystem. International bodies such as the World Health Organization (WHO), the United Nations (UN), and the UN International Children's Emergency Fund (UNICEF) have advanced policies that promote community-based, collaborative models of care adaptable to diverse population needs. Guided by initiatives like the WHO's *Global Strategy on People-Centered and Integrated Health Services 2016–2026* (2015), the *Comprehensive Mental Health Action Plan 2013–2030* (2021), the UN's *2030 Agenda for Sustainable Development* (2025), and the UNICEF's *Community-based Mental Health and Psychosocial Support in Humanitarian Settings: Three-Tiered Support for Children and Families* (2018), these efforts converge on a shared emphasis: strengthening nonpharmacological approaches, expanding psychosocial supports, and fostering cross-sectoral collaboration as pillars of sustainable health systems.

Within this evolving global shift, creative arts therapies—particularly music therapy—have gained increased visibility as adaptable, people-centered approaches, capable of addressing a broad spectrum of health, psychosocial, and mental health needs (Bartleet & Hesser, 2020). As an evidence-informed profession, music therapy draws on the therapeutic potential of music to support health and well-being across physical, cognitive, emotional, and social domains (Certification Board for Music Therapists [CBMT], 2025). Rooted in a rich history and applied across diverse cultural and clinical contexts, it is now practiced worldwide with populations whose needs range from emotional regulation and trauma recovery to cognitive rehabilitation and social integration (Knight et al., 2018; Lindahl Jacobsen et al., 2019).

Over the past decade, the field of music therapy has undergone marked transformation. Advances in telepractice and digital health (Clements-Cortés et al., 2023, 2025; Kern, 2025), heightened public awareness of mental health (Silverman, 2022), and growing emphasis on interdisciplinary collaboration (Twyford, 2016) have reshaped both service delivery and conceptual frameworks (Knott & Block, 2020; McFerran, et al., 2023). At the same time, systemic challenges—including organizational restructuring, fluctuating membership engagement, resource constraints, and uneven opportunities for professional development—have, in some

regions, hindered coordination efforts in innovation, professional recognition, reimbursement advocacy, and the cultivation of strategic partnerships essential to long-term sector growth (Basford Canales, 2024; Kern, 2024). These converging dynamics underscore the importance of understanding how music therapy is currently practiced worldwide—by whom, in what context, and under what professional and structural conditions.

In 2016, Kern and Tague conducted the first large-scale international workforce survey of music therapists in collaboration with the World Federation of Music Therapy (WFMT), culminating in a foundational publication in the *Journal of Music Therapy* in 2017. This landmark study collected demographic, clinical, and professional data from nearly 2,495 practitioners affiliated with 19 WFMT member organizations across multiple regions. It provided the first systematic profile of the global music therapy workforce, revealing a profession distinguished by high educational attainment, diverse clinical practices, yet challenged by persistent disparities around recognition, funding, and employment stability (Kern & Tague, 2017, 2019).

Building on that foundational effort, the present study offers a repeated cross-sectional survey of global music therapy workforce trends. Conducted in 2025, this follow-up survey replicates and extends the original design to examine directional shifts and evolving patterns in the profession over the past decade. As music therapy continues to align with global health initiative, a clear, evidence-informed understanding of current practice is essential.

Therefore, this study addresses the following four research questions:

1. Which demographic characteristics define the current global music therapy workforce?
2. How do music therapists currently practice across regions?
3. How have therapeutic processes developed over the past decade?
4. What key developments and trends are present compared to 2016?

Methods

Participants

This cross-sectional survey assessed contemporary global developments in music therapy, replicating and extending the methodology of a 2016 investigation. Data were collected between April 7 and 25, 2025, via the Qualtrics platform and disseminated internationally through formal and informal professional channels. A total of 1,750 individuals accessed the survey. Of these, 1,183 met the inclusion criteria. Participants self-identified as active, currently practicing music therapists at survey entry, without prescriptive criteria, consistent with the 2016 global survey. Professional certification (e.g., MT-BC or equivalent) was not required due to regional variability in credentialing, ensuring accurate representation of the global workforce. The remaining 567 entries were excluded either due to ineligibility or because the survey was started but not submitted.

The final sample included music therapists affiliated with 25 of the 32 WFMT organizational members plus individual members from the 2023–2026 membership cycle and respondents from non-participating or unaffiliated entities. Participants represented all eight WFMT world regions, with seven organizational members not participating in the 2025 study. The respondent pool reflected a broad, globally distributed cross-section of active, practicing professionals (see [Table 1](#)). Participants' self-reported information was considered a reliable source of insight into current global practice, while acknowledging variation across regional contexts. Based on eligible completions ($n=1,183$) and total survey access ($n=1,750$), the overall response rate was 67.6%.

Instrument Design

The survey instrument was updated to capture current global developments in music therapy while maintaining continuity with the 2016 version to enable repeated, cross-sectional analysis. Revisions reflected substantial changes in professional roles, service delivery models, and international trends, and were developed through a collaborative, globally inclusive process.

Central to this effort was a Regional Focus Group ([Nassar-McMillan & Border, 2002](#); [Sousa et al., 2021](#)) composed of 15 expert contributors representing 7 WFMT regions: Africa, Australia/New Zealand, Europe, Latin America, Southeast Asia, United States/Canada, and the Western Pacific. Although the

TABLE 1.
Participation and Response Rates

Participants (1,127 respondents)	Potential sample (N)	Respondents (n)	Respondents (%)	Organizational response rate (%)
WFMT organizational members				
American Music Therapy Association (AMTA)	1,044	220	19.5	21.1
Deutsche Musiktherapeutische Gesellschaft (DMtG) e.V.	1,589	91	8.1	5.7
The Italian Association of Music Therapy (AIM)	250	74	6.6	29.6
União Brasileira das Associações de Musicoterapia (UBAM) ^a	2,534	60	5.3	2.4
Canadian Association of Music Therapists (CAMT)	1,200	60	5.3	5.0
Associação Brasileira de Musicoterapeutas (ABMT)	319	49	4.3	15.4
Australian Music Therapy Association (AusAMTA)	899	40	3.5	4.4
Association of Music Psychologists and Music Psychotherapists (Russia)	120	34	3.0	28.3
Polskie Stowarzyszenie Muzykoterapeutów (Poland)	56	25	2.2	44.6
Finnish Society for Music Therapy (BAMT)	1,212	23	2.0	1.9
Punto di Svolta, Musicoterapia Umanistico Trasformativa (Italy)	164	20	1.8	12.2
Music Therapy Association of Taiwan	32	20	1.8	62.5
Muzikoterapeutická Asociace České Republiky, z.s. (CCMTA)	56	19	1.7	33.9
Hong Kong Music Therapy Association	34	16	1.4	47.1
South African National Arts Therapies Association (SANATA)	85	14	1.2	16.5
Asociación de Musicoterapeutas en México (AMME)	62	14	1.2	22.6
The Association for Music Therapy (Singapore)	44	14	1.2	31.8
Asociación Argentina de Musicoterapia (ASAM)	48	13	1.2	27.1
Greek Association for Certified Professional Music Therapists (ESPEM)	132	12	1.1	9.1
Music Therapy New Zealand	80	12	1.1	15.0
International Association of Art Therapies (MAUT)	88	11	1.0	12.5
Malaysian Music Therapy Association (MMTA)	18	11	1.0	61.1
	19	9	0.8	47.4

(continued)

TABLE 1. Continued

Participants (1,127 respondents)	Potential sample (<i>N</i>)	Respondents (<i>n</i>)	Respondents (%)	Organizational response rate (%)
National Association of Korean Music Therapists (NAKMT)	300	2	0.2	0.7
Müzikterapi Derneği (MÜZTED)	8	1	0.1	12.5
Nonorganizational members	N/A	153	13.6	N/A
Unlisted organizational members	N/A	72	6.4	N/A
Europe (<i>N</i> = 31)				
Latin American (<i>N</i> = 6)				
Southeast Asia (<i>N</i> = 8)				
Western Pacific (<i>N</i> = 4)				
Africa (<i>N</i> = 1)				
Undefined (<i>N</i> = 22)				
Members of nonparticipating WFMT organizations				
Cyprus Music Therapy Association (<i>N</i> = 1)	N/A	20	1.8	N/A
Asociación Chilena de Musicoterapia (<i>N</i> = 9)				
Japanese Music Therapy Association (<i>N</i> = 2)				
Gesellschaft für Musiktherapie zu Lëtzebuerg (GML) (<i>N</i> = 1)				
Dutch Music Therapy Association (NVvMT) (<i>N</i> = 7)				
WFMT individual members	N/A	18	1.6	N/A

Note. ^aOutlier (unconfirmed sample). N/A = not available; WFMT = World Federation of Music Therapy.

Eastern Mediterranean was not represented, the group ensured wide input across cultures, clinical contexts, and professional roles. Selection criteria emphasized WFMT engagement, regional diversity, clinical and academic experience, and commitment to cultural and professional inclusivity.

The instrument underwent a structured, four-phase revision process: (a) expert review by WFMT-affiliated scholars, (b) cognitive testing with practitioners from multiple regions, (c) alignment with the 2016 instrument to ensure comparability, and (d) iterative author consensus meetings to resolve discrepancies and finalize item structure. Focus Group members reviewed the 2016 instrument with a structured revision guide and provided feedback via live working sessions or written submissions. Revisions addressed structure, terminology, item clarity, and cultural relevance, culminating in a synthesis meeting in which remaining differences were discussed and resolved.

To enhance clarity, accessibility, and technical performance, the revised instrument was pilot tested by one representative from each participating WFMT region. Pilot testers assessed item flow, linguistic clarity, cultural appropriateness, survey length, and platform usability. Feedback was reviewed and incorporated before launch; no changes were made thereafter.

For accessibility, artificial intelligence (AI)–assisted translation was enabled in eight languages—Chinese, German, Italian, Japanese, Korean, Portuguese, Russian, and Spanish—based on WFMT country delegate requests. Respondents received instructions for using the integrated tool and were encouraged to use personal AI translation tools for additional support. The final questionnaire comprised three sections:

1. Demographic information: Expanded gender identity options; refined items on regional and organizational affiliation; and more detailed income reporting, including the percentage derived from music therapy practice.
2. Professional practice: Broadened categories for work settings and client populations (e.g., telehealth, veterans, LGBTQIA+ communities); introduced ranked items on professional roles and funding sources; and included new questions on digital service delivery and private practice models.
3. Therapeutic process: Updated lists of techniques (e.g., artificial intelligence, virtual reality/augmented reality, technology-assisted methods); expanded domains for

referral sources and assessment practices; and added Likert-scale items measuring professional integration, interdisciplinary collaboration, digital readiness, and global engagement. Three open-ended questions invited qualitative reflections on digital innovation in practice, music therapy and global health, and the future of music therapy.

The 2025 questionnaire is a content-validated instrument developed through a multiphase refinement process and available as a [Supplementary Material](#) to this article.

Procedure

All study procedures were approved by a U.S.-based university Institutional Review Board (IRB #25-002). Before beginning the survey, participants reviewed an IRB-approved consent form outlining the study's purpose, estimated completion time (20–30 min), voluntary nature, potential risks and benefits, confidentiality safeguards, and researcher contact details. Consent was confirmed electronically and required for participation. Respondents could skip nonmandatory questions or withdraw at any time without penalty.

The survey was hosted on Qualtrics, which provided encrypted data storage and compliance with international privacy regulations and institutional data protection standards. No identifying information or IP addresses were collected. Platform safeguards prevented duplicate submissions and allowed respondents to pause and resume their progress.

Recruitment employed a multimodal dissemination strategy. World Federation of Music Therapy country delegates served as primary recruitment partners, receiving a study briefing and IRB-approved materials to distribute through organizational mailing lists, newsletters, websites, and internal networks. To extend reach, the researchers posted IRB-approved messages on social media platforms (e.g., Facebook, Instagram), enabling engagement through informal and regional networks.

Dissemination success varied by organization, reflecting differences in infrastructure, capacity, and international coordination. While some organizations experienced delays or limited social media reach, others leveraged personal and regional networks effectively. Response rates were calculated only for organizations with reliable membership estimates and confirmed recruitment activity. The União Brasileira das Associações de Musicoterapia (UBAM), which reported a

disproportionately large target population ($N=2,534$) without evidence of active dissemination, was excluded from these calculations.

Data Analysis

Quantitative Analysis

Quantitative data were collected via the Qualtrics platform from multiple-choice items, including single-response, multiple-response, slider, and ranked formats. Descriptive statistics (i.e., frequencies, percentages, and means) were generated within the platform for applicable variables. All datasets were manually reviewed by the researchers for eligibility, completeness, internal consistency, and potential outliers (Gutterman & Creswell, 2024). A completeness threshold was applied, excluding cases in which respondents submitted less than 50% of core items. Internal consistency checks were conducted on select conceptually related items; however, given the survey's descriptive purpose and mixed item types, formal reliability statistics were not applicable across all sections.

Qualitative Analysis

Three open-ended survey questions were analyzed using a hybrid qualitative approach that integrated AI-assisted tools with human-led thematic analysis (Creswell & Poth, 2025; Zhang et al., 2024). Responses were translated into English using Google Translate followed by verification with ChatGPT-4, ensuring that discrepancies were systematically checked and then resolved by the researchers. All identifying information was removed prior to analysis. The coding proceeded through an integrated analytic process that combined initial inductive coding (informed by grounded-theory techniques) with reflexive thematic analysis, allowing both structured categorization and interpretive depth. Coder 1 used ChatGPT-5 (OpenAI, 2025), applying structured prompts informed by Zhang et al.'s AI-assisted coding guidelines to generate preliminary codes and thematic groupings. Coder 2 used MAXQDA (VERBI Software, 2024) to code the same dataset independently and to generate an initial theme structure. The outputs were then subjected to a three-way reconciliation process comparing AI-generated, human-coded, and collaboratively reviewed and refined outputs. From this process, the final themes were generated inductively, following Gutterman and Creswell's (2024) thematic analysis procedures, and refined through iterative review to ensure coherence, consistency, and fidelity to the data. Validation procedures included analyst triangulation

(AI + human + joint reconciliation), iterative review of thematic structures, intercoder agreement via code-level and themes cross-checking, audit trail documentation, including reconciliation notes, and cross-cultural interpretation checks to ensure global relevance. Saturation was assessed by monitoring the point at which no new codes or thematic elements emerged during the final coding cycle. Full human oversight was maintained throughout to ensure methodological integrity and to prevent overreliance on automation.

Results

Demographic Information

Demographic data were obtained from 1,127 to 1,183 respondents per item, with minimal missing responses across variables (see Table 2). Respondents reflected a professionally and geographically diverse global sample of active music therapists, with strong representation across gender identity, age groups, education levels, professional affiliations, world regions, and practice characteristics.

Gender Identity

Of the 1,182 respondents, the majority identified as female (77.7%, $n = 918$), followed by male (19.9%, $n = 235$). An additional 1.5% ($n = 18$) identified as nonbinary or third gender, and less than 1% opted not to disclose their gender identity.

Age Distribution

Among 1,183 participants, the largest age group was 35–44 years (28.1%, $n = 332$), followed by 25–34 years (24.5%, $n = 290$) and 45–54 years (23.8%, $n = 281$). Respondents over the age of 55 represented 21.5% of the sample, including 5.2% ($n = 61$) who were age 65 or older. The youngest group, under 25 years of age, comprised 2.2% ($n = 26$).

Educational Background

Among 1,182 respondents, 54.4% ($n = 643$) held a master's degree, 25.0% ($n = 295$) a bachelor's degree, and 8.7% ($n = 103$) a doctoral degree. An additional 11.3% ($n = 134$) reported completing a diploma or certificate program, while a small proportion (0.6%, $n = 7$) reported high school as their highest level of education.

TABLE 2.

Respondent Demographics

Gender identity	Female	Male	Nonbinary/third gender	Prefer not to say		
(1,182 respondents)	77.7% (918)	19.9% (235)	1.5% (18)	0.9% (11)		
Age distribution	<25	25–34	35–44	45–54	55–64	65+
(1,183 respondents)	2.2% (26)	24.5% (290)	28.1% (332)	23.8% (281)	16.3% (193)	5.2% (61)
Education background	High school	Diploma/certificate	Bachelor's	Master's	Doctoral	
(1,182 respondents)	0.6% (7)	11.3% (134)	25.0% (295)	54.4% (643)	8.7% (103)	
Professional organization	Participants	Nonorganizational members	Unlisted organizational members	Members of nonparticipating WFMT organizations	WFMT individual members	
(1,127 respondents)	76.7% (864)	13.6% (153)	6.4% (72)	1.8% (20)	1.6% (18)	
Geographic region	Europe	North America	Latin America	Southeast Asia	Australia/NZ	
(1,179 respondents)	37.2% (438)	31.8% (375)	17.0% (200)	7.6% (90)	3.5% (43)	
	Western Pacific	Africa	Eastern Mediterranean			
	1.4% (16)	1.3% (15)	0.2% (2)			
Years of practice	<1	1–5	6–10	11–19	20–29	30+
(1,180 respondents)	7.7% (91)	26.2% (309)	20.5% (242)	22.5% (265)	13.7% (162)	9.4% (111)

(continued)

TABLE 2. *Continued*

Job acquisition	Self-created (e.g., private practice)	Job posting/ advertisement	Referral	Postinternship/ training hire	Title ≠ “music therapist” but practicing
(1,178 respondents)	31.1% (367)	26.3% (310)	24.5% (289)	10.1% (119)	7.9% (93)
Primary role	Clinician	Educator (college/ university)	Business owner	Consultant/coach	Administrator
(1,178 respondents)	77.1% (908)		6.3% (74)	3.5% (41)	2.6% (31)
Weekly hours	0–9	10–19	20–29	30–39	40+
(1,180 respondents)	19.2% (227)	19.7% (233)	18.3% (216)	18.4% (217)	24.3% (287)
Income	Overall mean	North America	Australia/NZ	Southeast Asia	Latin America
(1,159 respondents)	<i>M</i> = 62.7%	<i>M</i> = 71.1% (369)	<i>M</i> = 68.6% (43)	<i>M</i> = 62.2% (88)	<i>M</i> = 61.3% (199)
		Western Pacific	Europe	Africa	Eastern Mediterranean
		<i>M</i> = 59.2% (16)	<i>M</i> = 56.5% (427)	<i>M</i> = 49.1% (15)	<i>M</i> = 2.5% (2)

Note. NZ = New Zealand; WFMT = World Federation of Music Therapy.

Professional Organization Membership

Of the 1,127 respondents to this item, 86.4% ($n = 974$) reported active membership in a professional music therapy organization. Additionally, 1.6% ($n = 18$) identified as WFMT individual members, 6.4% ($n = 72$) held membership in unlisted organizations, and 1.8% ($n = 20$) were categorized as undefined (see [Table 1](#)).

Geographic Region

Among 1,179 respondents, the largest representation came from Europe (37.2%, $n = 438$) and North America (31.8%, $n = 375$), followed by Latin America (17.0%, $n = 200$) and Southeast Asia (7.6%, $n = 90$). Additional respondents were based in Australia/New Zealand (3.6%, $n = 43$), the Western Pacific (1.4%, $n = 16$), Africa (1.3%, $n = 15$), and the Eastern Mediterranean (0.2%, $n = 2$).

Years of Practice

Of the 1,180 respondents to this item, 26.2% ($n = 309$) reported 1–5 years of experience. Respondents with 11–19 years of experience accounted for 22.5% ($n = 265$), followed by those with 6–10 years (20.5%, $n = 242$), 20–29 years (13.7%, $n = 162$), and over 30 years (9.4%, $n = 111$). Early-career professionals with less than 1 year of experience comprised 7.7% ($n = 91$).

Job Acquisition

Among 1,178 respondents, 31.1% ($n = 367$) reported creating their own music therapy position, such as establishing a private practice or launching a business. Employment through job postings accounted for 26.3% ($n = 310$), while 24.5% ($n = 289$) were hired via referral. Another 10.1% ($n = 119$) secured employment following an internship or clinical training placement. A smaller subset (7.9%, $n = 93$) held positions in which their official job title did not include “music therapist,” though they actively practiced music therapy.

Primary Role

Of the 1,178 respondents, 77.1% ($n = 908$) identified their primary role as clinician. Other reported roles included educator (7.9%, $n = 93$), business owner (6.3%, $n = 74$), consultant or coach (3.5%, $n = 41$), administrator (2.6%, $n = 31$), and researcher (2.6%, $n = 31$).

Weekly Hours

Among 1,180 respondents, reported weekly work hours ranged from 0 to 50, with a mean of 24 hr ($SD = 13.9$). The most frequently reported ranges were 40+ hr (24.3%, $n = 287$) and 10–19 hr (19.7%, $n = 233$). A total of 39.0% ($n = 460$) reported working less than 20 hr per week.

Income

Among 1,159 respondents, the average percentage of personal financial needs met through music therapy income was 62.7% ($SD = 33.4$). Responses ranged widely, indicating variation in financial reliance on music therapy as a primary source of income. Regional comparisons showed highest average proportions reported in the North America (71.1%, $n = 369$), Australia/New Zealand (68.6%, $n = 43$), Southeast Asia (62.2%, $n = 88$), Latin America (61.3%, $n = 199$), Western Pacific (59.2%, $n = 16$), followed by Europe (56.5%, $n = 427$), Africa (49.1%, $n = 15$), and Eastern Mediterranean (2.5%, $n = 2$).

Professional Practice

To understand the scope of global music therapy practice, respondents answered a series of questions related to work settings, client populations and age ranges, caseload, primary function, service delivery models, session length, salaries and compensation, duration of service, and funding sources. Response rates remained high across all items in this section, ranging from 1,118 to 1,181.

Work Settings

Among the 1,181 multiple-choice responses, healthcare settings were reported most frequently (45.6%, $n = 539$), followed by private practice (43.0%, $n = 508$) and education-based environments (31.0%, $n = 366$). Community-based programs were reported by 26.9% ($n = 318$), with smaller proportions working in public service (9.3%, $n = 110$), arts and recreation (5.8%, $n = 68$), and military or veterans' contexts (1.4%, $n = 16$). A regional comparison of these work settings is shown in Figure 1, illustrating distributions across eight world regions.

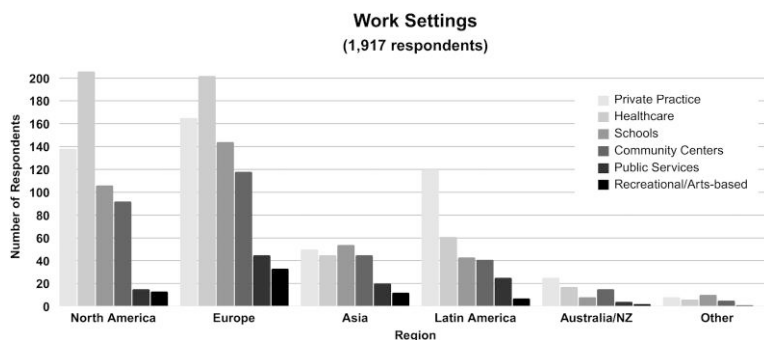


FIGURE 1.
Work Settings Across Eight Regions

Populations Served

Of the 1,170 multiple-choice responses, the largest group reported working with individuals with developmental delays and disabilities (61.4%, $n = 718$), followed by clients with mental health conditions (45.5%, $n = 532$), neurological conditions (37.9%, $n = 443$), and medical conditions (27.2%, $n = 318$). Additional populations included those with sensory or communication impairments (23.8%, $n = 279$) and individuals identified as at-risk (10.0%, $n = 117$).

Client Age Groups

Respondents ($n = 1,178$) indicated in a multiple-choice response that they serve a broad range of age groups. Adults aged 18–64 years (58.8%, $n = 691$) and school-aged children (6–12 years; 57.1%, $n = 673$) were the most frequently reported, followed by adolescents (48.8%, $n = 575$), older adults (47.3%, $n = 557$), preschool-aged children (46.8%, $n = 551$), and young adults (46.5%, $n = 548$). Infants and toddlers (0–2 years) were served by 22.9% ($n = 270$) of respondents.

Caseload and Contact Volume

Of the 1,178 respondents, 31.9% ($n = 376$) reported seeing 11–20 clients per week, and 31.0% ($n = 365$) served 21–50 clients. Approximately one-quarter (25.6%, $n = 301$) served fewer than 10 clients, while 11.5% ($n = 136$) reported caseloads exceeding 50 clients per week.

Primary Service Activity

Among 1,121 respondents, clinical service was most frequently ranked as the primary activity (81.2%, $n=910$; mean = 1.5). Secondary roles included education and training (9.7%, $n=109$; mean = 2.7), business operations (2.6%, $n=29$; mean = 4.8), administration (2.3%, $n=26$; mean = 4.8), research and evaluation (2.0%, $n=22$; mean = 5.1), consulting and coaching (1.2%, $n=13$; mean = 3.8), and advocacy/outreach (1.1%, $n=12$; mean = 5.3).

Service Delivery Models

Of the 1,179 multiple-choice responses, 96.9% ($n=1,143$) delivered services in onsite, in-person formats. Telepractice was reported by 18.1% ($n=213$), curated therapeutic resources by 16.5% ($n=194$), custom content creation by 13.9% ($n=164$), and hybrid models by 12.0% ($n=142$).

Session Length

Among 1,177 respondents, most reported session durations of 46–60 min (44.0%, $n=518$) or 30–45 min (32.2%, $n=379$). Shorter sessions of 15–30 min were noted by 5.1% ($n=60$), while 0.8% ($n=9$) reported sessions longer than 90 min. Another 12.1% ($n=143$) indicated that session length varied depending on client needs.

Compensation and Salaries

Hourly rates ($n=1,151$) also varied: \$57/hr for onsite ($n=561$), \$80/hr for telepractice ($n=154$), \$99/hr for custom content creation ($n=58$), \$103/hr for curated resources ($n=28$), and \$151/hr for workshops ($n=177$). Group rates were typically higher, averaging \$118/hr for onsite sessions ($n=6$). Fee variability was reported in open-text responses and appeared influenced by region, format, and service type. [Figure 2](#) presents hourly rate patterns by service delivery mode, highlighting differences across eight world regions.

Among salaried respondents ($n=453$), nearly a quarter (23.2%, $n=105$) earned less than \$20,000 annually, while 21.0% ($n=95$) reported incomes between \$20,001 and \$40,000. Another 24.7% ($n=112$) fell into the \$40,001–\$60,000 range. Approximately 19.9% ($n=90$) earned between \$60,001 and \$80,000, and just

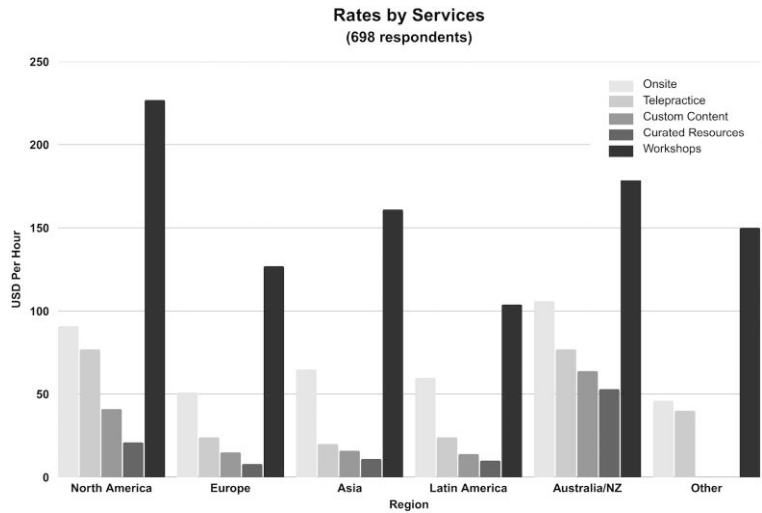


FIGURE 2.
Hourly Rates by Service Delivery Mode Across Eight Regions

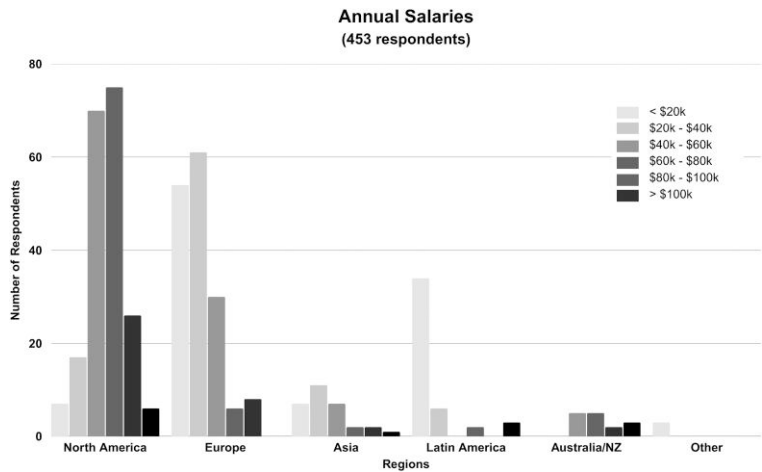


FIGURE 3.
Annual Salary Distribution Across Eight Regions

8.4% ($n=38$) reported salaries between \$80,001 and \$100,000. Only a small fraction (2.9%, $n=13$) earned more than \$100,000

per year. Variations in annual salary levels across eight regions are displayed in [Figure 3](#).

Duration of Service

Among 1,165 respondents, 44.1% ($n = 514$) reported seeing clients for more than one year. Other durations included 1–3 months (17.0%, $n = 198$), 7–12 months (16.6%, $n = 193$), and 4–6 months (14.3%, $n = 167$). Short-term engagements of a single session were reported by 1.4% ($n = 16$).

Primary Funding Source

Of the 1,118 respondents, 33.8% ($n = 378$; mean = 2.3) identified public funding (e.g., government programs) as their primary source. Private sources, including insurance and out-of-pocket payments, were identified by 31.8% ($n = 356$; mean = 2.2). Institutional funding (e.g., schools, hospitals) was reported by 23.8% ($n = 266$; mean = 2.6). Community-based funding (5.5%, $n = 61$; mean = 3.9), pro bono work (2.5%, $n = 28$; mean = 4.9), and other sources (2.6%, $n = 29$; mean = 5.7) were reported less

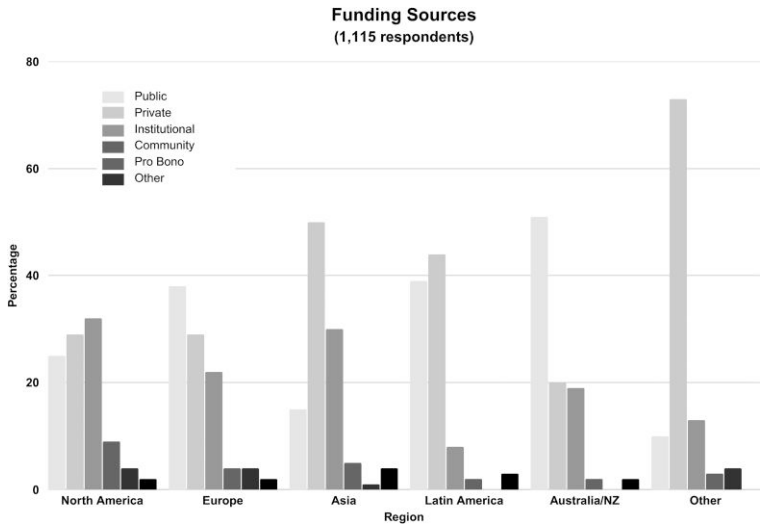


FIGURE 4.
Funding Sources of Music Therapy Services Across Eight Regions

frequently. [Figure 4](#) outlines the funding sources for music therapy services, with comparisons drawn across eight regions.

Therapeutic Process

To examine how music therapy is conceptualized and delivered across global contexts, the survey explored elements of the therapeutic process, including referral sources, assessment and documentation practices, goal domains, therapeutic approaches, clinical techniques, professional perceptions, and professional development interests. Item-level response rates in this section ranged from 1,155 to 1,179.

Referral Sources

Among the 1,173 respondents, multiple-choice responses showed that the most common referral pathways were medical professionals (67.0%, $n = 786$) and allied health providers (62.7%, $n = 736$). Family members or caregivers (49.3%, $n = 578$), self-referrals (47.5%, $n = 557$), educational professionals (37.5%, $n = 440$), and social workers (37.1%, $n = 435$) also played substantial roles. Community organizations accounted for 22.5% ($n = 264$) of referrals. A small number of respondents noted social media platforms as informal pathways to client engagement.

Assessment and Documentation

Of 1,176 respondents, 64.1% ($n = 745$) reported documenting progress after every session. Assessment practices varied: 34.8% ($n = 409$) assessed clients after each session, while 30.1% ($n = 354$) assessed as needed. Monthly (11.7%, $n = 138$), end-of-program (12.2%, $n = 143$), and weekly (8.9%, $n = 105$) assessments were less commonly used.

Primary Goal Areas

Respondents ranked nine clinical goal domains. Emotional expression or regulation was most frequently ranked first (31.5%, $n = 365$; mean = 2.5), followed by quality of life/well-being (20.5%, $n = 238$; mean = 4.5) and social-communication skills (18.3%, $n = 212$; mean = 3.2). Other goals ranked lower included academic/cognitive skills (13.0%, $n = 151$; mean = 5.4), identity/intrapersonal growth (3.6%, $n = 42$; mean = 6.1), physical/motor skills (3.2%, $n = 37$; mean = 5.3), behavioral regulation (3.0%, $n = 35$; mean = 5.4), sensory processing (3.2%, $n = 37$; mean = 5.5), and pain management (3.6%, $n = 42$; mean = 7.1).

Orientations, Approaches, Methods, and Models

Of the 1,167 respondents, 84.0% ($n = 980$) reported using eclectic practice, whereas 16.0% ($n = 187$) relied on a single primary form of practice. Among those using a singular model or approach, Neurologic Music Therapy (NMT) was most common (40.6%, $n = 76$), followed by the Humanistic Music Therapy Model (14.4%, $n = 27$), the Analytic Music Therapy Model (8.0%, $n = 15$), and the Music-centered Approach (4.8%, $n = 9$).

Music Therapy Techniques

Of 1,155 respondents, singing and vocalization was most frequently ranked as the primary technique (42.4%, $n = 490$; mean = 2.4), followed by instrument play (17.8%, $n = 206$; mean = 2.7) and improvisation (20.8%, $n = 240$; mean = 3.3). Other techniques were more frequently ranked in mid to lower tiers: receptive listening (10.5%, $n = 121$; mean = 4.6), songwriting (1.3%, $n = 15$; mean = 5.1), movement-based activities (2.9%, $n = 34$; mean = 5.3), lyric analysis (1.2%, $n = 14$; mean = 6.1), guided imagery (1.0%, $n = 12$; mean = 7.8), and technology-assisted tools (0.3%, $n = 3$; mean = 8.2). Over half of respondents (58.5%, $n = 676$; mean = 5.15) ranked technology tools last.

Perceptions of Clinical Practice

A total of 1,179 respondents rated their agreement with a series of professional statements. Confidence in clinical competence was high, with 70.4% ($n = 830$) strongly agreeing. Perceived respect from interdisciplinary colleagues was also notable—21.8% ($n = 257$) strongly agreed, and 50.8% ($n = 599$) somewhat agreed. Fewer respondents agreed that music therapy education was accessible in their country (38.7%, $n = 456$), that public awareness was high (15.5%, $n = 183$), or that music therapy was well-integrated into healthcare and education systems (14.5%, $n = 171$). Only 6.7% ($n = 79$) agreed that service funding was sufficient. Regarding newer indicators, 62.4% ($n = 735$) reported that traditional/cultural practices were supported in their work, 62.6% ($n = 739$) reported using current technology, 41.9% ($n = 494$) reported high involvement in the global music therapy community, and 62.6% ($n = 738$) reported adequate access to professional development. A detailed breakdown of these perceptions is provided in [Table 3](#).

TABLE 3.
Perception of Music Therapists

Statements (1,179 respondents)	Strongly agree %	Somewhat agree %	Somewhat disagree %	Strongly disagree %
Access to study music therapy is easy in my country.	8.5% (100)	30.2% (358)	36.5% (430)	24.7% (291)
Strong public awareness of music therapy exists.	1.0% (12)	14.5% (171)	43.2% (509)	41.3% (486)
Music therapy is integrated into healthcare/education systems.	2.0% (23)	12.5% (147)	39.6% (466)	46.0% (542)
I feel respected when working with other professionals.	21.8% (257)	50.8% (599)	22.1% (260)	5.3% (62)
I am confident in delivering effective music therapy services.	70.4% (828)	27.0% (318)	2.1% (25)	0.4% (5)
Traditional and cultural practices are encouraged.	18.0% (211)	44.4% (520)	28.6% (335)	9.0% (105)
I am highly involved in the global music therapy community.	12.2% (143)	29.7% (349)	31.5% (370)	26.6% (313)
I use current technology (e.g., AI, VR, digital tools) in practice.	12.5% (147)	37.9% (446)	28.7% (338)	20.9% (246)
Funding for music therapy services is sufficient.	1.5% (18)	5.2% (61)	29.0% (341)	64.2% (754)

Note. AI = artificial intelligence; VR = virtual reality.

Professional Development Interests

Among the 1,166 multiple-choice responses, the most frequently selected professional development preferences included continuing education or certification workshops (76.7%, $n = 894$), cross-cultural learning (66.7%, $n = 778$), and training in emerging areas such as AI and telepractice (66.0%, $n = 770$). Additional areas of interest included advocacy and funding resources (61.7%, $n = 719$) and networking/support groups (57.6%, $n = 672$). Open-ended responses emphasized interest in accessible, affordable, and regionally relevant training, including ethics, supervision, and advanced clinical specialization.

Digital Innovation in Practice

Respondents ($n = 891$) described in open-ended responses mixed experiences with digital technologies, ranging from limited adoption to selective integration. Many reported minimal or cautious use, citing philosophical concerns, lack of training, or a preference for embodied presence: “Digital resources do not replace the power of in-person contact, nonverbal nuance, or the embodied, sensory experience of sound in shared space” (R#451). Others described pragmatic use of digital tools to improve efficiency, particularly for administrative tasks, though some expressed unease about overreliance. Digital tools were also valued for expanding access, particularly through telehealth, which allowed practitioners to reach rural or homebound clients: “Options for telehealth have greatly increased the reach we can have, particularly when working with clients in more remote areas” (R#577). Alongside opportunities for enhanced personalization and creative engagement, respondents raised concerns about ethics, privacy, and the importance of ensuring that technology supports rather than replaces core therapeutic values.

Music Therapy and Global Health

Respondents envisioned in their narrative responses, music therapy as a flexible, accessible, and socially relevant contributor to global health and well-being. A frequently emphasized theme was its role in enhancing quality of life across the lifespan, supporting individuals in everyday contexts as well as moments of vulnerability: “It supports mental health, reduces stress, enhances emotional expression, and fosters connection across diverse populations”

(R#303). Participants highlighted music's power to foster social connection and community cohesion, transcending cultural and linguistic barriers and offering resilience in times of crisis. Music therapy was also described as a cost-effective, nonpharmacological approach, with growing scientific legitimacy strengthening its case for inclusion in healthcare. Several noted its preventive potential in schools, workplaces, and communities, where it could support coping and social-emotional well-being before crises arise. While many expressed optimism for a global healing role, respondents also acknowledged barriers such as limited funding, policy challenges, and uneven infrastructure that constrain the profession's broader impact.

Future of Music Therapy

Respondents' reflections on the future underscored aspirations for stronger integration, recognition, and sustainability of the profession. The most consistent vision was system-wide integration, embedding music therapy in healthcare, education, and community systems: "I advocate for official institutional recognition of the profession and its integration into clinical care protocols" (R#44). Many tied this vision to legitimacy and funding, stressing that policy recognition and insurance reimbursement are necessary for growth. Workforce development was highlighted as an urgent priority, with calls for more training programs, greater geographic reach, and stronger professional networks. Respondents also emphasized awareness and advocacy, noting that public and professional understanding remains limited: "In the future, I hope to see music therapy more widely accepted as a complementary part of mental health and medical care, with clear standards for education, certification, and practice" (R#373). Finally, participants underscored the importance of research and evidence to strengthen credibility, inform policy, and refine clinical practice. These perspectives are synthesized in Table 4, which presents the emergent themes alongside concise descriptions and representative quotes illustrating the core insights.

Discussion

Demographic Developments and Workforce Trends

The 2025 dataset demonstrates expanded participation across all WFMT regions, including representation from the Eastern

TABLE 4.

Perspectives on Music Therapy in the Digital Age, Global Health, and Future Directions

Themes	Core insights	Representative quotes
Topic 1: How is the digital age, including AI and virtual tools, shaping your music therapy practice and the profession? (<i>n</i> = 891)		
Limited adoption and resistance	Practitioners avoid or minimize use of AI/digital tools due to philosophical concerns, lack of training, cost, or infrastructure limits.	For me, human relationships—built through analog connection—are what define our humanity. [R#587]
Selective integration and efficiency	AI and digital tools selectively used for administrative support, documentation, or planning, though caution persists regarding overreliance.	Trying to use AI for administrative tasks to work smarter not harder. [R#811]
Remote access and equity in care	Telehealth and virtual platforms extend reach to rural, isolated, or mobility-limited clients.	Options for telehealth have greatly increased the reach... particularly in remote areas. [R#577]
Personalization and engagement	Technology supports creative, client-centered approaches through apps, songwriting, and digital production.	Music production applications make it possible to create sound experiences tailored to each client's needs. [R#603]
Ethics, privacy, and security	Concerns over confidentiality, misuse of AI-generated content, and threats to professional authenticity.	Technology should enhance—not replace—the core values of our profession. [R#84]
Topic 2: In your opinion, what role can music therapy play in improving global health and well-being? (<i>n</i> = 829)		
Quality of life across the lifespan	Music therapy promotes holistic well-being, daily functioning, meaning, and joy across developmental stages and life contexts.	Music therapy can have a significant positive impact on mental health and well-being, supporting individuals across the whole lifespan! [R#383]
Social connection and community	Music therapy fosters peace, belonging, and resilience by overcoming cultural and linguistic barriers.	Music therapy strengthens resources and promotes resilience in the face of global crises. [R#774]
Accessible, nonpharmacological care	Cost-effective, evidence-informed complement to conventional medicine, increasingly legitimized by neuroscience research.	Music therapy is a highly effective and low-cost non pharmacological method that can address many need areas. [R#193]

(continued)

TABLE 4. Continued

Themes	Core insights	Representative quotes
Public health and prevention	Applications in early intervention, schools, workplaces, and communities to promote mental health, coping skills, and resilience.	Music therapy plays a significant role in global health by serving as a preventive tool and helping individuals build health-promoting resources. [R#460]
Global vision and professional barriers	Aspirations for global healing role tempered by funding, policy, and infrastructure limitations.	Music therapy can facilitate health and well-being of people of all ages and abilities, improving global health outcomes. [R#649]
Topic 3: What is the future of music therapy in your country, and what changes do you hope to see? (n = 897)	Envisioned as a standardized service embedded in healthcare, education, and community systems.	I hope to see even greater integration of music therapy into public health services, hospitals, care centers, and mainstream schools. [R#61]
Legitimacy and funding	Calls for legal recognition, licensure, insurance reimbursement, and policy-level support.	I still hope to see our professional role and training fully recognized, placing us on equal footing with other healthcare and educational professionals. [R#253]
Workforce development	Desire to expand accredited training, increase practitioner numbers, and strengthen networks.	I hope to see more officially recognized training programs that elevate music therapy, as well as growth in the association to create stronger support networks and increase outreach. [R#296]
Awareness and advocacy	Greater visibility and understanding seen as essential for public understanding and professional recognition.	I hope for greater awareness of the profession among colleagues from other fields, families, caregivers, and the community, and that professional recognition is achieved. [R#349]
Research and evidence	Stronger scientific foundations needed to build credibility, influence policy, and refine practice.	I hope there would be more research... in order to validate its effectiveness and gain professional credibility. [R#238]

Note. AI = artificial intelligence.

Mediterranean for the first time. Europe (37.2%) and North America (31.8%) remain the most represented regions, while Latin America (17.0%) and Southeast Asia (7.6%) show emerging international engagement (Kern & Tague, 2017).

The profession remains predominantly female (77.7%), though gender diversity has slightly increased with 1.5% identifying as non-binary or third gender, reflecting broader recognition of gender plurality. Age distribution is stable, with most respondents aged 25–54, and a growing proportion (5.2%) aged 65+ still in clinical practice, suggesting increased career longevity (Meadows et al., 2023; Silverman & Segall, 2024).

Educational attainment continues to rise, with 54.4% holding a master's degree and 8.7% a doctoral degree, up from 50.2% and 7.8% in 2017, respectively. The workforce remains intergenerational, with 26.2% in their first 5 years and 9.4% having over 30 years of experience—creating opportunities for cross-generational mentoring, knowledge transfer, and collaboration (Chaudhary, et al., 2025).

Notably, 31.1% reported creating their own positions (vs. 16.0% in 2017), reflecting a shift toward entrepreneurial practice models, particularly in underregulated or underfunded regions (Kern & Tague, 2019). Clinical work remains central (77.1%), though slightly decreased from 85.8% in 2017, suggesting modest diversification into education, research, and administrative roles. Work hours remain varied, with part-time more common in Europe and full-time trends more typical in North America—possibly reflecting regional differences in healthcare infrastructure and reimbursement.

Income from music therapy services covered only 62.7% of respondents' financial needs, consistent with continued concerns around undercompensating (Kern & Tague, 2019) and correlating with reported job satisfaction (Kantor et al., 2024; Meadows et al., 2022) and burnout among music therapists (Gooding, 2019). Where comparable data allowed, income patterns showed partial but uneven improvement relative to 2016.

Practice Characteristics and Clinical Trends

Practice settings in 2025 show a shift toward healthcare (45.6%) and private practice (43.0%), moving away from 2017's emphasis on mental health and school-based settings. Community-based work (16.5%) has expanded, highlighting a growing preference

for decentralized, prevention-focused models of care (WHO, 2015). Music therapists continue to serve a wide range of populations, with developmental disabilities (61.4%) and mental health (45.5%) most common. Compared with 2017, services have grown in early childhood and neurodevelopmental care, consistent with international early intervention priorities (UNICEF, 2023a, 2023b; WHO, 2020). Demographically, the most served groups in 2025 were adults (58.8%) and school-aged children (57.1%), with a visible shift from 2017's focus on older adults. Caseloads and session durations remain stable: most therapists serve 11–50 clients weekly, with 30–60-min sessions prevailing. Long-term services (1+ year) are still common (44.1%), indicating the sustained therapeutic engagement typical of music therapy practice.

However, short-term funding models may challenge this continuity. Though hourly compensation has increased, especially for workshops and telepractice, financial instability persists: 44.2% earn under U.S.\$40,000. Funding remains split between public (33.8%) and private (31.8%) sources, with persistent regional disparities.

Therapeutic Process and Clinical Approaches

Referral patterns remain multidisciplinary, with medical (67.0%) and allied health (62.7%) professionals leading. Notably, self-referral (47.5%) and caregiver access (49.3%) increased since 2017, signaling greater public awareness and shifts toward consumer-driven care (WHO, 2015). Assessment and documentation practices remain robust: 34.8% assess clients after each encounter, and 64.1% document after every session. These practices reinforce the profession's alignment with evidence-informed care but also highlight administrative challenges in underresourced settings lacking digital infrastructure (Clements-Cortés et al., 2025). Psychosocial goals remain central, with emotional regulation and communication consistently prioritized. While onsite services remain dominant (96.9%), there is increasing integration of telepractice (18.1%) and digital tools—changes likely accelerated by the COVID-19 pandemic (Clements-Cortés et al., 2023).

Theoretical orientation continues to diversify. While psychodynamic and behavioral approaches were most common in 2016, 2025 data show increased alignment with eclectic frameworks. NMT (21.4%) stands out among respondents who reported a single preferred model, reflecting increased specialization alongside integrative practice as

outlined by [McFerran et al. \(2023\)](#). Core techniques such as singing and instrument play remain foundational, while the use of curated digital content is growing, aligned with shifts toward remote and asynchronous therapy formats ([Knott & Block, 2020](#)).

Clinical confidence has increased markedly (70.4% in 2025 vs. 48.9% in 2017), though public awareness (15.5%) and funding (6.7%) remain low. Encouragingly, access to professional development, cultural resources, and technology is on the rise. Interest in continuing education is high, especially in certification (76.7%), cross-cultural training (66.7%), and emerging areas like AI and telepractice (66.0%).

Themes from the three open-ended questions mirror and extend the broader trends captured across the 2025 Global Music Therapy Survey. They portray a profession in transition—negotiating both the promise and the perils of the digital age. At the same time, they reveal an urgent call for enduring growth, dependent on structural legitimacy, sustainable financing, workforce investment, and research visibility—issues already strongly voiced in the 2016 survey. The persistence of these issues across nearly a decade underscores slow progress and structural fragility, despite growth in awareness. On the other hand, there is a strong consensus about music therapy's unique contribution to human well-being across individual, community, and global levels, with an increasingly future-oriented vision of the profession as a driver of prevention, community cohesion, and global health. The juxtaposition of long-standing structural challenges with emerging aspirations signals both the resilience and the unfinished agenda of the field. A visual comparison of key 2016 and 2025 indicators is provided in [Figure 5](#).

Limitations

Several methodological constraints must be considered when interpreting results. Inconsistent dissemination across regions—due to variable distribution efforts, delayed organizational announcements, and email errors—likely introduced participation bias. These inconsistencies may have particularly affected representation from countries with limited professional infrastructure or digital outreach capacity.

Survey attrition also posed challenges. Although 1,750 individuals accessed the survey, only 1,183 met eligibility and completed core items, yielding a response rate of 67.6%. This denominator

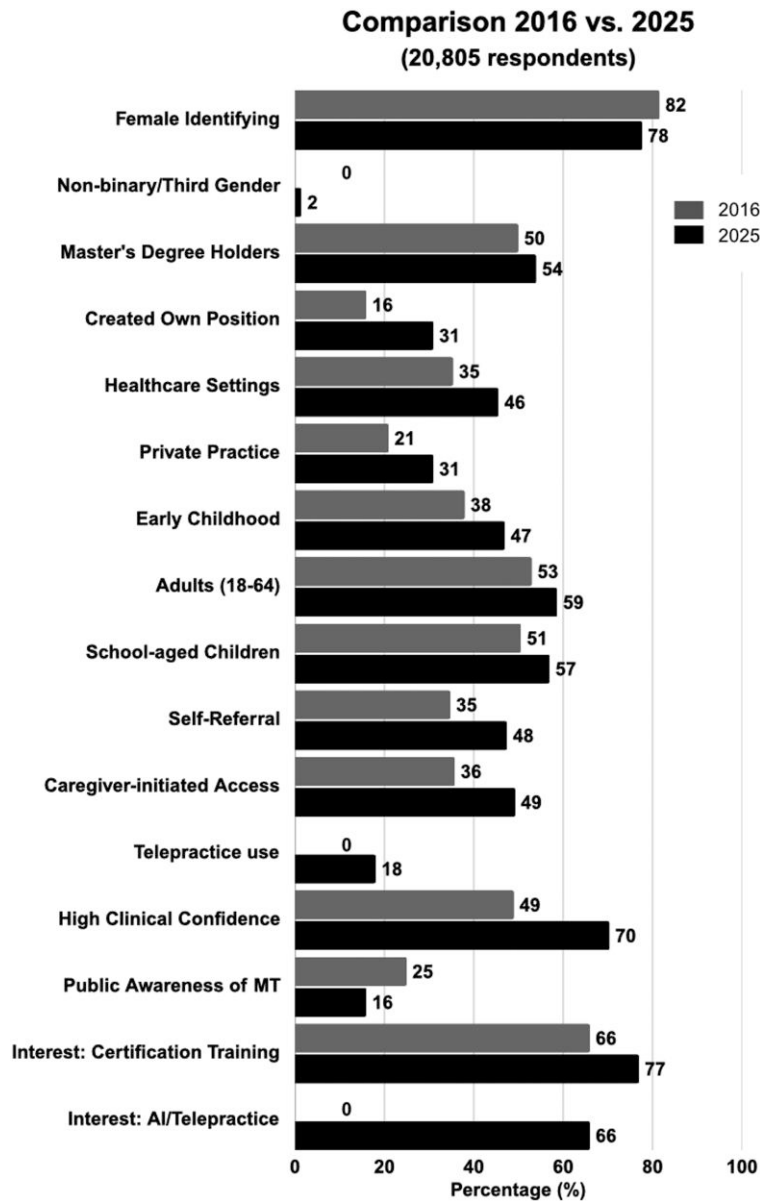


FIGURE 5.
Comparison of Key Global Music Therapy Indicators of Growth

reflects valid, analyzable data rather than speculative organizational totals, ensuring a methodologically sound and defensible base for interpretation. Dropout was most pronounced in items related to income and professional affiliation, suggesting potential burden or discomfort with sensitive questions.

Broader shifts in professional infrastructure, such as declining membership in formal organizations and growing engagement through informal networks, may have shaped participation trends. Additionally, ambiguities in terminology (e.g., distinctions between setting and population) revealed variation in how music therapy is conceptualized globally, despite careful survey design.

Updates to item structure, particularly regarding technology use and therapeutic process, enhanced relevance for 2025 but introduced comparison limitations with the 2016 dataset. While these refinements allowed for the inclusion of emerging practices like telepractice, they limit direct follow-up analysis.

Lastly, as primary analyses were conducted by authors based in specific world regions, researcher positionality may have influenced interpretive emphasis despite cross-regional collaboration.

Implications and Future Directions

The 2025 Global Music Therapy Survey illustrates a profession that is globally increasingly diverse, and clinically responsive—yet still constrained by structural limitations. As music therapy continues to integrate into global health, education, and community systems, several key areas require strategic focus:

- Policy advocacy is essential to address inconsistent recognition and funding across regions. The continued reliance on therapist-created roles and informal employment models—seen in both 2017 and 2025—underscores the need for national regulation and public reimbursement frameworks to ensure occupational legitimacy and access to services.
- Educational capacity-building must also be prioritized. Access to formal training remains limited in many regions. Curricula should expand to include competencies in digital service delivery, trauma-informed care, and culturally responsive practice, preparing professionals for increasingly complex and global demands.
- Technological fluency is becoming integral to service accessibility. The rise in curated content and telepractice indicates a

TABLE 5.

Strategic Action Items for Advancing Global Music Therapy

Domain	Strategic priority	Key actions
Policy and regulation	Increase public recognition and formal regulation	Advocate for licensure, public funding, and job protections
	Improve compensation and labor conditions	Develop global pay benchmarks and promote access to benefits
Education and training	Expand access to culturally relevant training	Support multilingual programs and regional hubs
	Prepare therapists for evolving practice models	Include telepractice, hybrid delivery, and integrative approaches in curricula
Clinical practice	Strengthen adaptive and equitable service delivery	Create resources for community-based care and low-resource settings
	Support person-centered care across cultures	Invest in culturally responsive and relational training
Public engagement	Raise visibility and clarify professional contributions	Launch public education campaigns; promote media storytelling, develop briefings for stakeholders

shift toward flexible, digitally mediated care. Sustained investment in infrastructure, ethical guidance, and clinician training is needed to support quality and continuity across remote and hybrid models.

- Theoretical integration also requires attention. The profession’s growing orientation toward eclectic and integrative models—alongside ongoing use of structured frameworks like NMT—calls for education systems and credentialing bodies to formally support cross-theoretical fluency. Clarifying mechanisms of change will also support interdisciplinary collaboration and accountability.
- The findings also highlight the absence of perspectives from external stakeholders such as policymakers, healthcare colleagues, and service users—an important area for future research to strengthen global advocacy and professional recognition.
- Finally, equity in compensation and labor protections must be addressed. Despite expanding roles and increasing specialization, many therapists remain underpaid and without

benefits. Regional disparities in income and job security persist. Global standards for fair pay and employment protections are essential for workforce sustainability.

To advance these aims, a coordinated set of priorities must guide global efforts. [Table 5](#) outlines strategic action items across five domains critical to the profession's future: policy, education, technology, theory, and labor. These action points provide a roadmap for collaborative progress.

Conclusion

The 2025 Global Music Therapy Survey affirms that music therapy has grown into a more diverse, resilient, and globally connected profession. Across regions, greater clinical confidence, expanded roles, and wider public awareness signal meaningful steps forward. Yet, the findings also reveal that the pace of progress remains uneven and that structural, financial, and systemic challenges continue to constrain full integration into health, education, and community systems. The next decade will therefore require intentional alignment with broader global priorities—public health, social cohesion, humanitarian response, and life-long well-being—domains where music therapy's unique contributions are both relevant and urgently needed. The future of music therapy is not guaranteed; it must be built. It will require courage, creativity, and shared responsibility. By working together across regions and sectors, the global community can ensure that music therapy not only endures but continues to grow as a vital force for human connection and care.

Supplementary material

Supplementary material is available online at [Journal of Music Therapy](#).

Author Contributions

Petra Kern (writing—original draft [lead]) and Daniel Tague (writing—review & editing [supporting])

Artificial Intelligence Transparency Statement

AI tools were used for language translation, AI-assisted qualitative analysis, and text editing. All outputs were critically reviewed, verified, and revised by the authors.

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