# Music Therapists' Awareness for the Potential of Harm in Music Therapy: A Qualitative Analysis

by Olivia M. Wendel, MT-BC

A Thesis Submitted in Partial
Fulfillment of the Requirement
for the Master of Arts Degree

Master of Arts in Music Therapy Program in the Departments of Graduate Studies
Saint Mary-of-the-Woods College
Saint Mary-of-the-Woods, Indiana

December 2023

## Abstract

Music therapists are not immune from causing harm to their clients within music therapy services. Understanding how harm might occur in sessions from direct experience has been under researched, despite emerging literature conceptualizing where harm might arise. The purpose of this qualitative survey study was to examine instances of harm from music therapists who have caused or observed harm within a music therapy setting. Ten music therapists' responses were recorded. Responses of instances of harm were analyzed by comparing to the Music Therapy and Harm Model (Murakami, 2021) sections (harm arising from the 1) music, 2) the music therapists, 3) therapeutic application of music, 4) client-music associations, 5) therapeutic application of music, and 6) ecological factors). Other responses recorded including music therapists' observed client responses, the music therapists' awareness to the harm, how the music therapist addressed the harm, and what the music therapy field could do to prevent harm. These responses were analyzed using in-vivo and descriptive codes to generate themes. Upon completion of this study, it was confirmed that the Music Therapy and Harm Model has provided a foundational framework to conceptualize where and how an instance of harm might arise within music therapy sessions, which includes harm arising from all six of the MTHM sources named above. emerged, including the primary music therapists' awareness of the harm occurred, how the music therapist addressed the harm, how music therapists might prevent harm, and how the music therapy field should respond to harm. Additional research into including a larger sample size, identifying music therapist theoretical approaches, specific setting/population studies recommended to continue to understand the potential for harm and how music therapists might prevent these instances.

**Acknowledgements**

I would love to thank all the people who have helped me throughout the thesis writing process and fueled my passion for this topic and the field of music therapy. First, I would like to thank my thesis committee for their unwavering support, including Gray Baldwin, Lindsay Camplin, and a special thanks to Brea Murakami for her creation of the Music Therapy and Harm Model. Without this model, this thesis might not exist! Each person provided invaluable feedback and patience with me through this learning process—thank you!

I would like to also thank the people at the Woods, who have made my undergraduate and graduate experience phenomenal. A special thanks to Dr. Sharon R. Boyle and Dr. Tracy Richardson for taking a chance on me!

I owe my amazing cohort a special thanks—it has been amazing to learn and grow with you all and I am so thankful for each one of you!

Last, I would like to thank my family. My mother, Barb Wendel, has supported me throughout my educational career and provided me with unconditional love and support through each step. To my husband, Timothy, for being my biggest cheerleader, encouraging me through the hard trials and late nights of writing, and believing in me. A special thanks to my cats, Millie, Autumn, and Kit, who provide a sense of comedic relief through the long hours of typing. Thank you all!

Olivia Wendel, MT-BC

## Table of Contents

**ABSTRACT** ..... ii

**ACKNOWLEDGEMENTS** ..... iii

**TABLE OF CONTENTS** ..... iv

**LIST OF TABLES** ..... vi

**CHAPTER I: INTRODUCTION** ..... 1

Operational Definitions/Terminology ..... 3

**CHAPTER II: LITERATURE REVIEW** ..... 5

Potential for Harm in Therapy ..... 5

Harm Definitions ..... 5

Symptoms and Side-effects of Psychotherapy ..... 7

Rational Model of Adverse Processes in Psychotherapy ..... 8

Music Therapy ..... 10

Music Therapy and Harm Model ..... 14

Problem Statement ..... 18

**CHAPTER III: METHODOLOGY** ..... 19

Design ..... 19

Participants ..... 19

Procedures and Instruments ..... 20

Ethical Considerations ..... 21

Data Analysis ..... 22

**CHAPTER IV: RESULTS** ..... 25

Demographics ..... 24

Responses ..... 26

**CHAPTER V: DISCUSSION** ..... 50

Comparison to Previous Literature ..... 50

Implications for the Music Therapy Field ..... 52

Limitations ..... 54

Recommendations for Future Research ..... 54
Conclusion ..... 55
**REFERENCES** ..... 56
**APPENDICES**
Appendix A: Institutional Review Board Approval ..... 61
Appendix B: Invitation to Participants ..... 62
Appendix C: Informed Consent Page ..... 63
Appendix D: Survey Questions ..... 65

## List of Tables

**Table 1:** Instances of Harm ..... 25

**Table 2:** Definitions of Client Response to Harm ..... 32

**Table 3:** Music Therapist Awareness to Harm ..... 35

**Table 4:** How the Music Therapist Addressed the Harm ..... 38

**Table 5:** What Music Therapists Could Do to Prevent Harm ..... 42

**Table 6:** How the Field of Music Therapy Could Prevent Harm ..... 45

# Chapter 1: Introduction

Harm is a short word for something that can create a huge impact in a person's life, especially when the harm occurs in therapy. Harm, in a broad sense, can be defined as any physical or psychological injury (Cambridge Dictionary, n.d.). Psychotherapy researchers have identified various types of harm including iatrogenic harm (unintentional harm in therapy; AMA Journal of Ethics, 2021) and torture (intentional harm in therapy; American Psychological Association Ethics Committee, 2016). Scholars have found that the harm clients experience may be caused by various things, such as unexpected negative emotions, inappropriate therapeutic techniques, and more (Batic & Hayes, 2020). Symptoms of harm caused in therapy can range from anxiety, depression, and post-traumatic stress disorder (Hook and Devereux, 2018; Resnik, 2016).

While the literature surrounding harm in traditional talk therapy is quite vast, very little research exists in the music therapy realm. Outlined in the American Music Therapy Association Code of Ethics (2019), the intent of music therapists should be to provide safe and adequate treatment for clients; however, mentions of the potential for harm in music therapy is not listed. Murakami (2021) formulated the *Music Therapy and Harm Model (MTHM)*, which identifies several components of the music therapy treatment that have the potential to cause harm. This model outlines harm arising from six sources: 1) the music, 2) the music therapist, 3) the therapeutic application of music, 4) the client-music associations, 5) the therapeutic relationship, and 6) the ecological factors present in the dynamic (Murakami, 2021).

The field of music therapy deserves to have forthcoming literature to highlight the potential for harm within the field. Gauging awareness for the potential of harm from current

music therapists could add valuable literature to build educational opportunities. Furthermore, researching instances of harm could help validate components of the MTHM (Murakami, 2021) and aid music therapists in categorizing occurrences of harm.

Although the model's publication marked an initial effort in conceptualizing harm within music therapy practice, minimal research has substantiated the actual implementation of the MTHM's framework in real-life clinical settings. Because there is a lack of literature surrounding the potential for harm in music therapy, a qualitative survey study and analysis could be beneficial to identify various factors, such as what stimulus harm arises from, how clients reacted, how music therapists responded, and how the field of music therapy might prevent further harm. The purpose of this study was to identify components of the MTHM (Murakami, 2021) that music therapists have observed in real-life practice, identify how clients responded to harm (physical or psychological response), when the music therapist became aware, how the music therapist responded to the client-experienced harm, and how music therapists might prevent further harm.

**Research Questions**

Since music therapists do not understand the psychological harm that a client may be experiencing in a session, the music therapist will not know harm is being done. The purpose of this study is to answer the questions:

1. *What are music therapists' awareness for the potential of harm in music therapy?*
2. *What are client responses music therapists have observed to instances of harm from the music therapy?*
3. *How and when did the music therapist become aware of the instance of harm?*
4. *What actions did the music therapist take to address the harm?*

5. *What can music therapists do to help prevent harm in music therapy sessions?*
6. *How should the music therapy profession respond to harm in sessions?*

## Operational Definitions/Terminology

### *American Music Therapy Association (AMTA)*

AMTA is the national organization for music therapists within the United States of America. The mission is to increase awareness of the music therapy profession and increase access for music therapy services.

### *Certification Board for Music Therapists (CBMT)*

Established in 1983 in the United States of America, the CBMT is the national credentialing organization for music therapists.

### *Harm*

Any adverse event that a client experiences throughout the course of any therapeutic treatment.

### *Music Therapy*

Music therapy is the clinical use of music to address cognitive, emotional, physical, and social goals of individuals conducted by a board-certified music therapist. Music experiences can be recreational, compositional, improvisational, and receptive in nature.

### *Music Therapy and Harm Model (MTHM)*

Created in 2021, Murakami formulated this theoretical model as an initial effort to conceptualize how harm may arise in music therapy from six different components: 1) the music,

2) the music therapist, 3) the therapeutic application of music, 4) the therapeutic relationship, 5) the client-music associations, and 6) ecological factors.

# Chapter II: Review of Literature

## Potential for Harm in Therapy

Often, individuals come to a therapist in a time of crisis. Whether they are grappling with a new diagnosis, a recent significant life change, or a debilitating mental illness, individuals are in a vulnerable space (Davis Behavioral Health, 2021). Vulnerability is defined as "easily hurt or harmed physically, mentally, or emotionally" and "open to attack, harm, or damage" (Britannica Dictionary, n.d.). Over the course of therapy, an individual will work with their therapist to identify areas of needs, goals to reach for, work on homework, and translate the information discussed in therapy to the "outside world" (Mental Health America, 2022).

Despite the intention to provide a supportive space for vulnerable individuals, therapy does not always have positive results. Instead, therapy has the potential to cause harm to the individual receiving the service. Much of the information regarding harm in the therapeutic space is centered around traditional talk-therapy/psychotherapy settings. In fact, reports indicate that around 40-60% of patients do not achieve a "recovery criterion" due to harm caused (Fisher & Durham, 1999; Gyani et al., 2013; HSCIS, 2018).

## Harm

For this study, harm is defined as any adverse encounters that a client experiences throughout the course of their treatment (Hook & Devereux, 2018). Parry et al. (2016) outlined three different definitions in relation to negative effects of therapy. First, *adverse effects of therapy* are major occurrences occurring during or shortly after treatment, a noticeable decline in clinical condition post-treatment, and experiencing adverse effects as reported by the patient (para 14). Second, *clinical deterioration* refers to specifically to the worsening of one's mental state after the conclusion of therapy, which might include the appearance of new symptoms (para

15). Lastly, *patient-experienced harm* is characterized by a situation where the individual has a negative therapeutic experience, resulting in lasting adverse effects, even if these issues aren't detected through adverse event monitoring or observed clinical decline (para 16).

Psychotherapy and medical researchers have theorized several other types of harm that clients may experience during the course of psychotherapy treatment. *Iatrogenic harm* is harm suffered by patients due to the therapeutic intervention, with negligence specifically defined as a deviation from the standard level of care (American Psychological Association, 2021). Examples of iatrogenic harm may include a worsening of symptoms, misdiagnosis, ethical violations, a lack of cultural sensitivity, and retraumatization. *Retraumatization* is the recurrence of emotional and psychological distress brought on by a harmful situation, which triggers past negative experiences—potentially leading to new symptoms in relation to the previous difficult event (Substance Abuse and Mental Health Services Administration, 2017; Batic & Hayes, 2020).

A more serious form of harm is *torture*. Torture is the term used to describe intentional pain caused by the therapist. Torture can be defined as any deliberate action causing intense physical or mental pain or suffering inflicted by an individual (The American Psychological Association Ethics Committee, 2016; para. 3). Examples include any practices that go against the well-being of the client, violates human rights, and causes intentional harm to the client.

While all forms of harm cause negative impacts to a client and should be taken very seriously, it is noteworthy to mention that harm in therapy is relatively infrequent, occurring less than 5-10% of the time (Hannan et al., 2005; Hatfield, McCullough, Frantz, and Krieger; Heins et al., 2010; Lambert et al., 2002). Additionally, a majority of harm is caused inadvertently or unknowingly by the therapist (William & Mary School of Education, n.d.).

**Symptoms and Side-effects of Psychotherapy**

Defining the cause of symptoms of harm can present challenges, as client's reactions may vary depending how they perceive the experience. However, defining *unwanted events* may be a general starting place. Unwanted events are occurrences that take place concurrently with or in the backdrop of treatment and impose challenges on the patient and/or their surroundings, irrespective of whether they are inevitable or deemed necessary to achieve a treatment objective (Linden & Schermuly-Haupt, 2014). Unwanted events may arise from various areas, including new symptoms arising, lack of progress, any life change in for the client, various familial strains, and client's non-compliance (table 1).

The way a client responds to harm in the therapeutic process varies due to their own, unique experience. Various symptoms and side-effect definitions have been identified by researchers. Linden and Schermuly-Haupt (2014) defined *adverse treatment reactions* as "all unwanted events which are caused by the treatment." Severe adverse effects might require high-intensity treatment as a result of harmful treatment (Klatte et al., 2018). Emergence of data identifies that unwanted events can include failure of treatment and worsening/emergence of symptoms, shifts and changes in life routine, conflict in social structures, dependence on therapy, and a loss of self-worth (Klatte et al., 2018). *Side-effects* have been identified as bouts of depression, regression, anxiety, various dependencies (Hook & Devereux, 2018; para 6).

Other serious side-effects might emerge when there is a violation with boundaries (such as a therapist engaging in sexual relationships with clients), for example, clients may experience symptoms of "post-traumatic stress disorder, suicidal ideation and suicide attempts; contemplated suicide also occurs" (Resnik, 2016). Clients who have experienced harm may also have additional struggles with time, money use, and experience a deterioration in relationships as

a result (Hook & Devereux, 2018, p. Clients who have experienced harm may also have additional struggles with time, money use, and experience a deterioration in relationships as a result (Hook & Devereux, 2018, p. 367).

*Rational Model of Adverse Process in Psychology*

Psychotherapy researchers have put forward a model to conceptualize harm in psychotherapy. The Rational Model of Adverse Processes in Psychotherapy (Curran et al., 2019), is built of eight domains which have been identified for potential areas to cause adverse effects. The model was built using responses from services users (individuals receiving psychotherapy services), clinical psychologists, counselors, researchers, and psychotherapists. The first of the domains are *contextual factors,* which refers to access to services for individuals, organizational factors (poor support and barriers to enrolling in services), socio-economic factors, ideology/political factors, lack of access to accurate information, and medication impacting functioning (para 12). Individuals from a lower socioeconomic level have reported having less access to various types of therapy and supportive services, especially if individuals do not have insurance (Benedict, 2006; para 21).

The second domain includes *pre-therapy factors* (Curran et al., 2019), including lack or poor pre-therapy contracting (no informed consent, group ground rules, etc.), previous therapy experiences (from either the client or therapist), client expectations for a specific type of therapy (CBT, DBT, etc.), therapist focus on symptoms v. the whole individual, client being too or not compliant, and client in therapy in the wrong time of their life (para 12).

Curran et al.'s (2019) third domain that can lead to adverse events are *therapist factors*, which include the confidence of the therapist, the financial interest of the therapist and potential conflicts of financial interest, the therapist attitudes over various topics (rigidity, over- or lack of

control, over- and under confidence, etc.), responsiveness, and the character of the therapist (Curran et al., 2019; figure 2). The fourth domain includes *client factors*, which include the demographics (ethnicity, health, age), awareness and understanding of therapy, strong sense of unknowing causing fear, desperation for help and fear of "messing up," and the specific needs of the individual (Curran et al., 2019; figure 2).

The *relationship processes* comprise Curran et al.'s fifth domain and refers to the negative relationship patterns, countertransference, fit between client and therapist, and power dynamics (use and abuse). Furthermore, this could also relate to any "pseudo alliances," as well as the therapist not taking the clients preferences into account (Curran et al., 2019; figure 2). The sixth domain is *therapist behaviors*, which include any therapist errors, including practicing beyond scope/competence, threats and blaming the client, malpractice, inappropriately applied therapeutic techniques, over-/under-adherence, poor or lack of communication, poor therapist self-monitoring, and inappropriate therapist behaviors (Curran et al., 2019; figure 2).

Curran et al.'s seventh domain are *therapy processes*, including various types of therapies that have potential to cause harm, as outlined by Curran et al. (2019), which include "Critical Incident Stress Debriefing, 'Boot camps,' Expressive-experiential therapies, recovered memory techniques, breathing retraining." Along with this category, the authors highlight elevating rates of transference interpretation, contradiction, "therapy by number," when helpful processes become detrimental, "no contracting, negotiation, reviews," various relational factors, and an early client-therapist alliance and "lack of negotiation over goals" (Curran et al., 2019; figure 2).

The final domain that Curran et al. (2019) put forth to explain adverse therapeutic events are centered on *therapeutic endings* or *termination*. This domain includes "unprepared/abandonment/sudden; terminal alliance rupture; client left 'high and dry' ('that's it'

without review). ‘What happens afterwards?’; Short-term therapies ‘opening a can of worms;’ no ‘maintenance’ dose” (Curran et al., 2019; figure 2).

Each of the previously mentioned factors are examples of specific times of vulnerability within the therapeutic process when the therapist is most likely to cause harm to the individual receiving services and cause adverse effects (Curran et al., 2019). This model has provided the groundwork for conceptualizing harm within psychotherapy treatment.

At this time, long-term effects of harm from therapy have not been documented. While the preceding ways of understanding harm via the psychotherapy literature, many of the definitions, such as unwanted events (Linden & Schermuly-Haupt, 2014), are presented as theoretical categorizations. Additional psychotherapy studies that directly exam instances of harm, such as Curran et al. (2019)'s Rational Model of Adverse Process in Psychology, does not provide a timeframe in their study. I was unable to find empirical evidence that observes the long-term effect of harm in psychotherapy. Hopefully emerging literature will be able to follow-up with participants who experienced harm in therapy to produce data identifying last impacts of harm in psychotherapy.

**Music Therapy**

Although the articles discussed above illustrate the evolving understanding within the psychotherapy field regarding the potential for harm, smaller therapeutic professions, like music therapy, are still in the process of developing field-specific discussions on the potential for harm. Since music therapists work in many settings with different populations, including individuals and groups with a variety of diagnoses, the potential for harm exists when music therapists do not employ a nuanced approach in understanding the impact of music therapy in practice—considering the intricacies of each individual and their therapeutic needs and goals. These

populations include individuals with intellectual and developmental disabilities, those with substance use disorders, hospice/palliative care patients, geriatric patients, maternal/infant, incarcerated, and other mental health/psychiatric disorders. Music therapists can be found working with individuals or groups in private practice, neonatal intensive care units, nursing facilities, intensive out-patient care facilities, forensic facilities, schools, and in-home (Association for Indiana Music Therapist, n.d.). The current educational standards for music therapists, and subsequent certification requirements, may not encourage a focus on understanding the potential for harm.

Undergraduate music therapy students are required to have a foundational education which spans across several topics, including music theory, functional instrument skills, psychology, music therapy assessment and research, clinical practicum and internship, and general education classes. Music therapy degree programs must be approved by the American Music Therapy Association (AMTA) and follow the competency-based standards put forth by AMTA and the National Association of Schools in Music (AMTA, 2021). AMTA provides an outline, which divides areas of study into the following percentages: musical foundations (45%), clinical foundations (15%), music therapy (15%), general education (20-25%), electives (5%).

Music therapy-specific courses only account for 15% of educational course work per degree requirements from the National Associations of Schools of Music (NASM). This curriculum structure gives educators and students a limited amount of time to cover every topic pertaining to music therapy, which may include theoretical approaches, clinical practicum experiences, therapeutic music experiences, etc. Once a student is finished with their course work, they move on to their clinical internship training to accrue a minimum of 900 post-practicum hours. In an internship, the internship supervisor is then left to identify and fill in

additional gaps not covered in the intern's coursework. Following the completion of a clinical music therapy internship, one may sit for their board-certification exam.

The inconsistencies related to harm education often continue into the intern's professional career. The intern will complete the board-certification exam put forth by the Certification Board for Music Therapists (CBMT). CBMT is the credentialing body for music therapists practicing in the United States, who are tested on CBMT's Board Certification Domains in order to use the "MT-BC" (music therapist-board certified) credential. These three board certification domains include: 1) referral, assessment, and treatment planning, 2) treatment implementation and termination, and 3) ongoing documentation and evaluation of treatment (CBMT, 2013). Harm is alluded to several times throughout these domains. For example, CBMT provides guidance that music therapists should acknowledge any biases and limitations they may have when working with clients—especially during the interpretation of assessment information. In section 2) treatment implementation and termination, music therapists are reminded to "recognize the potential harm of music experience and use them with care" and "recognize the potential for harm of verbal and physical interventions during music experiences and use them with care" (2015; p. 3) but fails to provide any examples of what this harm may look like or the what the catalyst for harm may be. In 2020, CBMT put forth updated Board Certification Domains, which included an addition that music therapists should be aware of the client's location, access to materials, and the potential for harm at all times; however, this still does not provide explicit examples of what this might look like in practice (p. 1).

Furthermore, the professional association (the American Music Therapy Association) for music therapists practicing in the United States does not provide detailed guidance on the potential for harm or how to respond. The AMTA and CBMT joint Scope of Music Therapy

Practice (2015) does not explicitly identify areas where harm might arise; however, the Scope of Practice recommends that music therapists continue to engage in continuing education courses, understand their limitations in the professional practice, as well as recognize when they need to seek further assistance, or refer the client to another professional (AMTA, 2015; para. 11).

To ensure quality care of clients, the AMTA Standards of Clinical Practice (2013) provide an overview of procedures that music therapists follow, including 1) referral and acceptance, 2) assessment, 3) treatment planning 4) implementation, 5) documentation, and 6) termination. This document provides guidance and information about procedures for several populations and settings, including intellectual and developmental disabilities, educational settings, older adults, medical settings, mental health, physical disabilities, wellness, and private practice. Harm is mentioned once in this document; footnote section xii. "Safety—Avoidance of harm through structuring care processes, supplies, equipment, and the environment to reduce/eliminate client and staff injuries, infection, and care errors" (AMTA, 2023). Furthermore, awareness of auditory safety is mentioned; however, no other concrete definitions of where harm might arise is listed.

Continuing education is a standard for each population/setting listed within the AMTA Standards of Clinical Practice (2013), with each population/setting having brief topics music therapists should continue to receive continuing education (i.e., for working with individuals with intellectual and developmental disabilities, a music therapist should maintain knowledge of psychopharmacology, neurology, special education, early intervention, etc.; Standard 7.1.1).

Additionally, CBMT provides more guidance within the Recertification Manual (2020), highlighting the specific continuing music therapy education requirements. Music therapists are required to acquire at least 100 continuing music therapy education credits (CMTEs) within the

five-year certification cycle. Ethics are a required topic and music therapists must accrue at least three CMTEs within the cycle. CBMT provides a list of possible ethics topics, including "cultural competency, end-of-life care issues, ethical supervision, sexual harassment, confidentiality (HIPAA), informed consent, business practices, academic integrity, citizenship, and client/civil rights" (CBMT, p. 9). While some guidance is provided, the lack of concrete explanation and resources for conceptualizing harm is still present and should be explored to prevent or mitigate negative results.

*Music Therapy and Harm Model*

In light of the vague guidance around harm in music therapy from educational and professional sources in the United States, music therapists began proposing their own frameworks for understanding this phenomenon. In 2018, Goldschmidt and Murakami produced the podcast, "Music and Harm: What We Know and What We Need to Know" introducing the potential for therapeutic music experiences to cause harm, both physical and/or psychological. From there, Murakami (2021) further refined the Music Therapy and Harm Model (MTHM) which identifies six various causes of harm to a client that may arise during music therapy treatment. These six sources include harm from the music, the music therapist, the therapeutic application of music, the therapeutic relationship, the client-music associations, and ecological factors.

The first component of the MTHM that has the potential to cause harm is the "music stimulus." The music stimulus refers to any intentional acoustic sound arranged or guided for clinical purposes, such as live or recorded music, musical improvisations by the therapist and/or client, or any other clinical musicking. Harm arising from the musical stimulus is originating from the "psychoacoustic energy," rather than a client's psychological associations with or

knowledge about the music (Murakami, 2021, para 18). Music holds the capacity to overstimulate clients through varying elements such as tempo, dynamics, and range in voice or instrumentation (para 19). For example, a person with chronic migraine might experience a worsening of symptoms if exposed to loud, intricate music in a room with no sound-dampening tiles.

The second component of the MTHM potential for harm arises from the role of the board-certified music therapist. Harm arising from the music therapist may occur if the music therapist lacks the clinical expertise that results in poor decision-making or observation/responsiveness throughout the course of treatment (Murakami, 2021, para 20). This second source of harm aligns with the AMTA and CBMT joint Scope of Music Therapy Practice (2015) which offers information relating to music therapist's attunement to client responses, including client's "non-verbal, verbal, psychological, and physiological responses to music and non-musical stimuli in order to be clinically effective and refrain from contra-indicated practices" (para 10). An example might include the music therapist practicing with limited knowledge or training in a specific therapeutic approach, such as Bonny Method of Guided Imagery and Music, vocal psychotherapy, neurologic music therapy, etc.

The third component of the MTHM (Murakami, 2021) includes the "therapeutic application of music" and is a form of harm unique to music therapy practice. Music therapists create therapeutic, music-based experiences tailored to the clients' individual needs. Harm arises when the music therapist makes inadequate musical decision and/or fails to respond appropriately to a negative reaction from a client during a music experience. For example, a music therapist might cause harm by choosing to apply rapid and unsteady music during a rhythmic auditory stimulation for a client who experienced a hemiparetic stroke. Utilizing rapid

and unsteady music is not indicated during rhythmic auditory stimulation as it does not provide a steady beat for a client to entrain to—leading to disruption in cognitive and motor control (Gonzalez-Hoelling et al., 2021).

The "therapeutic relationship" is the fourth component the MTHM (Murakami, 2021, para 22). The potential for harm comes from "unhealthy or inappropriate client-therapist interactions." This source of harm might include exploiting the inherent power-difference, and engaging in sexual, financial, emotional, and verbal abuse. Furthermore, engaging in dual relationships with a client has the potential cause a shift in the therapeutic relationship, leading to potential harm.

The fifth component of the MTHM is the "client-music associations." Client-music associations refer to the client's interpretations, feelings, memories, or thoughts in response to the music presented in music therapy sessions (Murakami, 2021; para 23). While this phenomenon is not easily controlled by the music therapist, the music therapist should continuously monitor the client for any indications of harm that arise and address them immediately. For instance, if a music therapist working with an individual who lost their home due a tornado, they might unintentionally present a song featuring a loud bass and lyrics centered around "braving the storm." In this scenario, the client may have an emotional response, associating the loud bass with thunder and interpreting the lyrics as a reflection of their perceived lack of bravery.

The final component, based on Bronfenbrenner's ecological theory of development (Bronfenbrenner & Morris, 2007), is harm arising from "ecological factors." Murakami (2021) acknowledged the potential for harm in music therapy arising from three different levels of context inherent to every session. She names these as the micro-, meso-, and macro- ecological

dimensions (Murakami, 2021; para 24). Micro-ecological factors are the physical environment the session is held in, such as the location, other people present, and time of day of the session (para 25). An example of harm arising from the micro-ecological level could occur when bright overhead lighting, echoing room acoustics, and loud instrument playing lead to the overstimulation of a client. Meso-ecological factors encompass elements such as "race, gender, socioeconomic status, disability, the client's life circumstances, and the therapist's cultural background and identity" (para 25). For instance, if the therapist and client come from a different culture and the music therapist lacks cultural competence in a therapeutic approach, it might lead to harm, misunderstandings, misinterpretations, and a fracture in the therapeutic relationship. Macro-ecological factors refer to the broader societal and contextual elements that directly impact a client's life, including any source of oppression (race, gender identity, socioeconomic status, etc.; para 27). An example of harm arising from the macro-ecological factor includes a client's access to services due to inequities in a society's healthcare system or unfair discrimination due to racism, ableism, or sexism.

While the MTHM provides an initial starting point for conceptualizing potential sources of harm in music therapy, the model remains theoretical. Utilizing the MTHM (Murakami, 2021) as a foundation for research exploring participants' or music therapists' first-hand experiences of harm (whether harm caused by the music therapist or observed harm) could garner important information such as identifying common harm components and provide validation for the MTHM.

**Problem Statement**

Murakami's (2021) MTHM details areas for harm to occur, but data to confirm this model has not yet been produced. Murakami (2021) explicitly names this consideration for future research in her article:

> Another potential study may gather and analyze observations of music's negative effects as reported by board-certified music therapists, other practitioners implementing music-based interventions, or clients. Such a survey would also provide a starting point to understand the rate or types of adverse responses that may occur during TMEs (p. 14).

A plethora of literature outlines the potential for harm in traditional talk psychotherapy. However, the music therapy field's understanding of harm needs to be extended beyond theoretical frameworks and into music therapists' real-life experiences and observations. The purpose of this qualitative analysis is to discover how music therapists have observed harm being caused, how the client reacted, how the music therapist addressed the harm caused, and what music therapists could to do prevent harm in the future.

# Chapter III: Methodology

## Design

This qualitative study investigated how music therapists responded to instances of harm experienced by clients during music therapy sessions conducted or observed by the reporting music therapist. Through this qualitative survey, this researcher explored the sources of harm that a client experiences in relation to the Music Therapy and Harm Model (harm from the music, board-certified music therapist, the therapeutic application of music, client-music associations, therapeutic relationship, and outside ecological factors present; Murakami, 2021). This study focused on information from the music therapist due to feasibility matters regarding client confidentiality. Focusing on self-reports from music therapists provided detailed reports of the harm within music therapy; however, further research on harm experienced directly from clients is recommended.

## Participants

Participants were recruited through a call for responses on social media platforms, including information about the survey and a direct link to the survey. The survey provided various questions to help find a common theme in the responses to help validate the MTHM. A total of eighteen questions were asked to collect information. These questions included verifying participants' comprehension of the informed consent, asking about their educational and practice background questions, and the direct responses regarding the experiences harm they have observed.

Participants in this study were board-certified music therapists who have worked with clients who experienced harm in music therapy treatment. Furthermore, participants must have been able to read English or have a software that can translate to preferred language. Thirty-five

participants responded to the survey, but only ten fully completed the entirety of the survey. When asked if participants had observed harm, ten participants reported "yes" (and continued the survey), eight reported "no" (and exited the survey) and seventeen did not respond (and exited the survey). Thus, only ten responses were utilized due to these participants responding to each question fully.

**Procedures and Instruments**

SurveyMonkey® was used to create a survey (Appendix D) and collect data. Participants were required to utilize a device with internet connection to complete this survey, as well as have the ability to read English or utilize a language translating program. The survey consisted of eighteen questions; six are yes/no format, two are multiple choice, and ten are open-ended questions with a text box. Yes/No survey questions included #1 acknowledgement of informed consent, #2 the confirmation of board-certification for at least one year, #3 access to a virtual method to complete survey (phone, computer, tablet, etc.), #4 ability to read English or utilize translating software, #9 reading definition of harm and potential sources, and #12 confirmation of observing harm in music therapy.

Multiple choice questions included #5 identifying how long the participant has been practicing given a range of years and #6 what the participant's highest level of education in music therapy is. Open-ended questions included #7 highest level of education in another disciple (discipline name and degree level), #8 populations and settings participants works with, #10 participants awareness for the potential of harm, #11 where the participant learned about the potential of harm, #13 describing the instance of observed harm, #14 client responses observed to instance of harm, #15, how and when the music therapist became aware of the harm, #16, actions the music therapist took to address the harm, #17 actions music therapist could take to

prevent future harm, and #18 how the field of music therapy should respond. It took the ten participants an average of fifteen minutes to complete the survey.

In consultation with my thesis advisor and incorporating feedback from peer music therapists, this researcher structured the remaining open-ended survey questions in a manner to encourage participants to report on observations of harm—whether personally experienced or observed in another music therapist. By opening the survey to include observations of other music therapists, this researcher believed it might have garnered more responses while also mitigating potential risks for the participants. Identified risks might have included recalling painful memories, admitting to potential harm, and having a lack of support following the survey. The term "observation" was intentionally utilized to convey that participants could draw from their own experiences or report on instances of harm observed from other music therapists. To maintain consistency, the questions were phrased to center around the "music therapist" (rather than "you"), allowing flexibility to focus on either the participant or the music therapist they observed.

**Ethical Considerations**

The Saint Mary-of-the-Woods College Institutional Review Board (IRB) reviewed this study to ensure the safety of the participants and potential risks were minimal (Appendix A). This survey was posted on Facebook groups pertaining to the music therapy profession. The responses were collected utilizing SurveyMonkey®, a program that protects the identity of the participant. No personally identifying data were collected in the process of the survey. Participants could exit the survey if they did not wish to proceed at any time and there would be no penalties to the participants if they chose to do so.

**Data Analysis**

This researcher reviewed the responses directly from the participants in a confidential and verbatim manner via Survey Monkey. Each category was noted, including the informed consent, confirming participants read the definition and potential sources of harm, background information (length of board-certification, level of education in music therapy and related fields, populations, and settings), and then the participants awareness of the potential of harm in music therapy and any observations they have witnessed.

The MTHM (Murakami, 2021) was utilized to analyze responses for Table 1, (survey question #12: "Have you observed harm in a music therapy session? Survey question #13: If yes, please explain"), and categorize the instances of harm into the distinct components outlined in the MTHM framework. These components include harm originating from the 1) music, 2) the music therapist, 3) the therapeutic application of music, 4) client-music associations, 5) the therapeutic relationship, and 6) ecological factors. Utilizing this framework, common words and synonyms were identified and were then compared to Murakami's model to participant responses. Once completed, participant responses were then able to categorized into the different components used for Table 1.

To analyze the responses for Table 2, (survey question #14: "What are client(s) responses you've observed to the instances of harm from the music therapist?"), this researcher utilized Murakami's (2021) definitions for physical and psychological harm. This researcher searched for words and synonyms that Murakami utilized to define each word and compared to the participant responses. Participant data was then extrapolated the into the two different categories.

Braun and Clarke's (2006) Six-Phase Guide to Thematic Analysis was then utilized as a framework to analyze the remainder of the questions, which include music therapist's awareness

to the occurrences (Table 3), how the music therapist addressed the harm (Table 4), and considerations regarding what music therapists (Table 5) and the field of music therapy could do to prevent harm (Table 6). The Six-Phase Guide of Thematic Analysis includes: 1. Familiarizing yourself with your data, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, 6. Producing the scholarly report (pp. 16-23).

To generate initial codes for tables 3-6, this researcher identified in vivo codes (codes that are an exact phrase from a participant; Saldaña, 2009) and descriptive codes (short phrases that highlight the meaning of a passage; Saldaña, 2009, p. 70; Wheeler & Murphy, 2016, p. 567) to further extrapolate data and categorized the reported harm. When identifying in vivo codes, repeated words and synonyms that highlighted the meaning of the participants reports were dissected and put into a data chart (tables 3-6). For example, when asked "What actions can music therapists take to help prevent harm in the music therapy sessions?" (survey question #17), four participants used the word "education" in their reports, which warranted the in vivo code of "education" to be included. By included in vivo codes, the participants direct quotes were used to describe their experiences and perspectives.

Next, this researcher created descriptive codes to provide further information and clarity for each table. By doing so, this researcher was able to provide the reader with a brief overview of the data collected. Furthermore, this was helped to solidify the placement of the data within the MTHM components (Table 1), physical and psychological definitions (Table 2), and subsequent themes (Tables 3-6).

# Chapter IV: Results

This study examined responses from board-certified music therapists and their experiences and observations of harm in the music therapy process. All personally identifying factors were not included in this study to protect the identity of the participants. Of the thirty-five participants that initiated the survey, only thirty-three answered a majority of the questions, and ten answered every question fully. When asked survey question #12 “Have you observed harm in a music therapy session?” twelve participants indicated they have, while eight reported they have not. For the accuracy of results, results of the only the ten participants those who fully completed the survey were analyzed. This researcher believes that utilizing the results of the ten participants provided accurate and consistent data. Responses varied, including instances where music therapists unintentionally caused harm, observations of harm by music therapists from their peers or other healthcare professionals, and a situation where a music therapist assisted a volunteer during a group session.

## Demographics

Ten participants responses were utilized in this survey—each having been a board-certified music therapist (MT-BC) for at least one year. Each participant consented to being a participant in this study. Five participants identified being an MT-BC for between one to five years, three identified being an MT-BC for six to ten years, and two participants reported being an MT-BC for over sixteen years.

When asked, “What is your highest level of education in music therapy?” three participants reported having a bachelor’s, one reported a bachelor’s equivalency, and six reported a master’s. When asked, “What is your highest level of education in another discipline (discipline name and degree level)?" one participants reported a bachelor’s degree in music

education, one reported a Master of Music Performance, and one reported being a current Master of Social Work student.

Participants were then asked about the populations and settings they primarily work with. The responses varied with each participant highlighting multiple populations they work with. Generally, participants described working with diverse populations, with the frequency of reports ranging from most to least as follows: children/adolescent, adults, and older adults. Additionally, they engage in various settings, with frequency of reports ranging from the most to least, including community, medical, psychiatric, schools, virtual, and veteran center. Diagnoses mentioned encompassed intellectual and developmental disabilities, substance use disorders, mental health conditions, and disorders of consciousness. One participant shared their dual role in higher education and active practice as a music therapist.

When asked about their awareness for harm, each of the 10 participants who answered all survey questions identified having an awareness. Participants were then asked about how they were introduced to the concept of harm in music therapy. Responses varied; four participants reported learning from Murakami's MTHM (2021), four participants reported this topic being covered in their college education, and two reported learning through conversations with peers and in their own work.

**Table 1:** ***Instances of Harm***

| | |
|---|---|
| **Component 1: Music Presented** | *In Vivo Codes:* "music"<br>*Descriptive Codes:* music caused harm |
| **Component 2: Board-Certified Music Therapist** | *In Vivo Codes:* "ignoring," "forced," "unresponsive," "not ready"<br>*Descriptive Codes:* forcing a conversation when client was not ready; ignoring client emotional response; music therapist response was unintentional |
| **Component 3: Therapeutic Application of Music** | *In Vivo Codes:* "not mindful," "unclear purpose," "inadequate" processing, "inappropriate," "violent"<br>*Descriptive Codes:* not mindful of music experiences; no clear therapeutic purpose or rationale |
| **Component 4: Therapeutic Relationship** | *In Vivo Codes:* "ambiguous answer," "fearful," "agitated"<br>*Descriptive Codes:* client left upon music therapists bringing out guitar; increased agitation, confusion in the presence of the music therapist |
| **Component 5: Client-Music Associations** | *In Vivo Codes: "*focused imagery," "anxious," "discussions," "instruments," "fear"<br>*Descriptive Codes:* instrument turning on and scaring client, avoiding and fears instrument; highly triggered by negative musical meanings resulting in harmful memories |
| **Component 6: Ecological Factors** | *In Vivo Codes:* "institutional," "isolation," "restraint," "compliance," "punish," "racist"<br>*Descriptive Codes:* unable to regulate leading to isolation and/or restraint, aiding medical staff with restraints, behavioral punishment from non-music therapy staff |

## MTHM Components

*Have you observed harm in a music therapy session? If yes (observed harm), please describe the instance of the situation.*

To answer question #12 and #13 of the survey, "Have you observed harm in a music therapy session? If yes, please describe the instance of the situation," participant responses from the survey were analyzed. Ten participants affirmed that they had observed harm in a music therapy session and my analysis verifies that the MTHM (Murakami, 2021) provides a useful framework by which music therapists' real-world reported of observed harm can be categorized.

### *MTHM Component #1: Music Presented*

The music presented refers to any music utilized in the session, including any live, recorded, improvised, and pre-written music (Murakami, 2021; p. 6). The music presented was identified as a source of harm by one participant. In vivo and descriptive codes included "music," music caused harm (Table 1). Participant D reported "a couple situations where music caused harm;" however they did not provide a specific instance of harm.

### *MTHM Component #2: The Board-Certified Music Therapist*

The board-certified music therapist refers to the trained and accredited professional who is facilitating the music therapy session (Murakami, 2021; p. 7). The theme of harm arising from the board-certified music therapist was evident from two participant responses. In vivo and descriptive codes (Table 1) included ignoring client's emotional response, "forced a conversation the client was not ready for," "unresponsive," "not ready," indicating harm originating from the lead music therapist's poor judgment of the client's desire to participate. Each situation that induced harm involved the music therapist responding to a client. Participant D reported a couple situations where "my response to a client unintentionally caused harm," however, they did not report a specific instance of the harm caused. Participant G provided a clear example of a

harmful interaction initiated by a music therapist: “An MT-BC forced a conversation the client was not ready to have resulting in emotional distress, and a [music therapist] causing harm after ignoring a client on their caseload.”

Both instances recognize the board-certified music therapist as the source of harm directly and by sharing the specific instances of the harm from the music therapist.

***MTHM Component #3: Therapeutic Application of Music***

The therapeutic application of music refers the purposeful use of music to address and support various goals; this can involve compositional, recreative, receptive, or improvisational music play (Murakami, 2021; p. 7). Two participants identified the therapeutic application of music to be a catalyst for harm. In vivo and descriptive codes included “not mindful,” “unclear purpose,” “inadequate;” each codes providing context for harm arising from the therapeutic application of music (Table 1).

Both participants identified the use of music inappropriately in a session, which ultimately led to harm to the client. In some situations, the music itself was harmful, in others the response from the music therapist was harmful. Participant C identified the potential for harm arising from interns who did not have a clear purpose or intent for the music they brought into the sessions. Participant G reported observing a music therapist singing an inappropriate song in another language, causing a client to have an emotional reaction.

***MTHM Component #4: Therapeutic Relationship***

The therapeutic relationship is “comprised of the interactions between the client and music therapist” (Murakami, 2021, p. 8). This researcher identified one response aligning with the therapeutic relationship being a source of harm. In vivo and descriptive codes included “fearful; agitated,” client left the room upon the music therapist bringing out their guitar; client

being confused about the music therapist's presence (Table 1). Participant J reported a specific instance where their presence had escalated a client:

> In a recent hospice session, I approached a patient in her room at a skilled nursing home. She was in bed awake, resting quietly. I offered music verbally. She gave what I thought was an ambiguous answer, so I got out my guitar to gauge her reaction. She stood up and walked out of the room. I believe this was evidence of increased agitation—she was confused about my presence, if not fearful.

Without further context for the therapeutic relationship prior to this incident, this researcher believes this incident aligns with harm within the therapeutic relationship due to the music therapist's lack of alignment with the client's wishes, thus breaking the client's trust in the moment. It is possible that the therapeutic relationship might have experienced a fracture due to the music therapist not understanding the client's communication.

***MTHM Component #5: Client-Music Associations***

The client-music associations encompass non-musical connections to the music presented in a session, such as any emotional responses and associations to the music, evoked memories, knowledge of the music, and history (Murakami, 2021, p. 8). Five participant responses fell into the client-music associations theme with the most observed examples of all six MTHM components, making it the most reported category. In vivo and descriptive codes including "focused imagery," "anxious," "fear," instruments turning on and scaring a client, avoiding the instrument; highly triggered by negative musical meanings resulting in harmful memories (Table 1). Each of the five participants have identified the music eliciting memories, or harm arising from an instrument, causing a client to be afraid. Participant A, having completed level 1 guided imagery in music (GIM) training, reported attempting an adapted focused music imagery

experience with their autistic young adult student (within a school setting). Participant A reported the focus was intended to promote relaxation and calmness for the student, however, after the experience, the student reported feeling the opposite. The participant had hoped to provide a sense of autonomy for the student by leaving the experience open to "their own choice of imagery."

Participant C reported discussing with clients about the music associations they had with the music presented. Participant C believed that a client may have had harmful music associations during a discussion about the music used in the session, that Participant C felt they may have been unaware of. Participant E identified an instance where a music volunteer played a "violent song," and the patient had a major emotional reaction—sharing that it brought back negative memories from their childhood. While Participant E reported harm being induced by a volunteer, this researcher felt it was necessary to include as Participant E, the board-certified music therapist, was present and addressed the issue and aided the patient in this scenario.

Participant H reported an instance where a young client was scared by an instrument, which randomly turned on. The client associated the instrument with being startled in subsequent sessions and responded with fear and avoidance. Participant H also reported the use of a song with triggering lyrics and not providing the clients with the proper space and time to process the lyrics led to a harmful event for the clients. Participant I's response provided a clear example of an instance where the client-music associations caused harm, as well as how they were able to mitigate the harm:

> "During a group session I played and sang a song that is less common, and a client (inpatient psychiatric unit) was highly triggered by the song as it had happened to be his

parents' wedding song. Since I observed the response from the client, I was able to mitigate the harm and the client was responsive and highly gracious of the situation."

***MTHM Component #6: Ecological Factors***

Ecological factors refer to the "physical, social, cultural, and historical aspects within which the music therapy session occurs" (Murakami, 2021). The factors can further be split into three dimensions. The micro-ecological factors involve immediate session elements, such as the physical setting and people present in the space. Meso-ecological factors incorporate considerations such as race, gender, socioeconomic status, disability, and life circumstances, and the cultural background and identity of the music therapist. At the outermost level, macro-ecological factors encompass overarching cultural ideologies, attitudes, and systems impacting the client's access to services (Murakami, 2021).

Two participants identified harm arising from ecological factors, arising from institutional guidelines and non-music therapy personnel within the sessions. In vivo and descriptive codes were generalized into the respective categories, which included: "institutional," "isolation," "restraint," unable to regulate leading to isolation and/or restraint, behavioral punishment from non-music therapy staff (Table 1).

Participant F identified harm occurring in the micro-ecological factor, which includes the people present and the physical space in where the session is located (Murakami, 2021, p. 9). Participant F provides an example of how the paraprofessionals present in the physical space were the antecedents of harm: "Aides being a bit too physical with students during sessions so that they would comply; talking about students right in front of them; taking students out of sessions as a punishment."

Participant A and B identified harm arising from the macro-ecological factor. Participant B reported a "Supervisor in [their] internship played a racist song." It is unknown what song was played; however, racism is identified as harmful. Participant A provides explicit examples illustrating how harm, originating from institutional structures within both school and medical settings, has the potential to directly impact a client.

> "I have observed harm from instructional needs, both in a school and medical setting and several separate instances, unrelated to the music therapy session itself, but to structure the needs of the setting itself. This happens sometimes due to a lack of ability for a student to regulate and remain in a group of classroom setting without agitating other students, leading to isolation or restraint based on the students response, or a patient in the hospital unwilling to comply with a medical need, such as changing dressings or receiving a shot and having to be held, while in the midst of a music therapist session. I have had to perpetuate the actions of the school or hospital, taking part in restraints, or standing by, leading to my own inclusion in the occurring harm."

**Table 2:** ***Client Response to Harm***

| | |
|---|---|
| **Definition 1: Physical Response** | *In Vivo Codes:* "fight or flight," "body language," "overstimulation," "arousal" *Descriptive Codes:* flattened affect; physical aggression; increase heart and breathing rate |
| **Definition 2: Psychological Response** | *In Vivo Codes:* "anxious," "crying," "screaming," "agitation," "depression" *Descriptive Codes:* emotional reactions to harmful stimuli; crying, yelling, dissociation |

## Definitions

*What are client(s) responses you've observed to the instances of harm from the music therapist?*

Each of the ten participants identified client responses to the harm that occurred in the music therapy session. Murakami (2021) highlighted responses from clients in the MTHM, including physical and psychological responses. By utilizing the definitions "physical response" and "psychological response" put forth in the MTHM, I identified key words from responses that relate to each definition. I then separated the words into the different definitions.

### *Definition 1: Physical Response*

Themes of physical responses to a harmful situation were identified from three participants—one describing the situation and all describing the physical responses. Murakami (2021) identified that physical harm could present as an adverse reaction in client's physical, brain, or other physiological composition (p. 4). Examples Murakami (2021) provided include: "bodily injury, an increase in plain, the creation of maladaptive neural connections, or sensory regulation issues" (p. 4). In vivo and descriptive codes relating to physical responses included "fight or flight," "overstimulation," "arousal," flattened affect, physical aggression, increase heart and breath rate (Table 2). Participant B noted a visible change in the client's bodily

presence; a flattened affect, closed off from the music therapist, and appeared overall uncomfortable. Participant I reported an increase in arousal, including an increase in heart rate and respirations, as well as increase agitation. Participant A provides an especially clear example of a physical response from a client, writing:

> "I have seen both students in schools and patients in hospitals react in trauma responses to occurrences of their setting. They have entered at times a fight or flight response in which they cannot be engaged in discussion or rationalization due to the nature of their feelings and state. It often leads to tears, screaming, threat, and aggression, with a need for the music therapist or other staff to continue with response actions, which in itself can appear or be harmful, due to a need to keep the individuals and other staff safe."

Participants explicitly mention sensory regulation issues and an increased heart and respiration rates—directly relating to Murakami's (2021) definition of physical response. Additionally, participants identified other physical responses, including physical aggression, threatening others, and a visible change in body language.

***Definition 2: Psychological Response***

Themes of psychological response were evident through five participants responses. Murakami (2021) highlights that psychological harm may involve a in an emotional dysregulated state, a heightened sense of awareness, distorted perceptions of reality, or the initiation of new symptoms (p. 4). In vivo and descriptive codes relating to psychological response include "anxious," "crying," "agitation," "depression," emotional reactions to harmful stimuli, crying, and dissociation (Table 2). Participants E, G, and H reported clients crying and emotional distress. Participants C and E report clients screamed because of the harm. Participants C, E, and

H reported that some clients were able to directly communicate the instance of harm after the music experience. Participant I reported clients occasionally dissociate as a result of the harm.

When comparing results to Murakami's (2021) definition of psychological response, there are striking similarities, including the client self-reporting harm, the music therapist observing the client behavior shift, displaying distress, and a shift in a client's perception of reality. In terms of a behavioral shift and presence of distress, participants identified clients crying and screaming.

**Table 3:** ***Music Therapist Awareness to Occurrence of Harm***

| | |
|---|---|
| **Theme 1: In the Moment** | *In Vivo Codes:* "immediately," "during"<br>*Descriptive Codes:* notify during music experience; direct client communication; when client left |
| **Theme 2: After the Session** | *In Vivo Codes:* "after," "waiting"<br>*Descriptive Codes:* client waited until after session to notify |
| **Theme 3: Combination** | *In Vivo: "*varied," "some"<br>*Descriptive:* waiting until after, completion of session |
| **Theme 4: Outside Observation** | *In Vivo Codes:* "unaware," "observation"<br>*Descriptive Codes:* observer notified the music therapist; observing client increased agitation; in supervision |

## MT-BC Awareness Themes

*In the instances of harm occurring in a session, how and when did the music therapist become aware of the instance of harm?*

Each of the ten participants responded to this question; seven participants reported that the music therapists had a sense of awareness during the session and three identified the lead music therapist was not aware until after the session. Themes of awareness were divided into four sections: in the moment, after the session, combination, and outside observation.

### *MT-BC Awareness Theme 1: In the Moment*

Three participants identified that the music therapist was aware of the harm done immediately. In vivo and descriptive codes include "immediately," "during," notified during the music experience, direct client communication; each code identifying the music therapists became aware in the moment (Table 3). Participant H reported that a client directly

communicates with them that harm had occurred, while Participant J became aware when a client stood up and exited the room. Participant D further shares that "In three of the four situations, I was aware immediately that harm had been caused."

### *MT-BC Awareness Theme 2: After the Session*

Two participants identified situations where they became aware of the harm after the session with clients. In vivo and descriptive codes included "after," "waiting," client waited until after session to notify (Table 3). Participant D reported that in the fourth vignette shared, their clients informed them after the group.

### *MT-BC Awareness Theme 3: Combination*

Participant C identified a varied response from clients, including some clients notifying them during the musical experience, while others waited until after the experience, and some waiting until the entre session was completed before reporting harm. This theme was created specifically for this participant, considering their work in a group setting where client responses may vary. In vivo and descriptive codes included "varied, some," waiting until after, completion of session (Table 3).

### *MT-BC Awareness Theme 4: Outside Observation*

A fourth theme of the music therapist being aware from an outside observer and during a supervision (after the session). Four participants reported learning about the harm from outside observation from others. In vivo and descriptive codes include "unaware," "observation," observer notified the lead music therapist, observing client increased agitation (Table 3). Participants B and G directly reported that the leading music therapist was unaware of the harm they had caused until it was brought up to them in an outside conversation. Participant H

reported learning about the harm in a supervision. Participant I reported observing a music therapist and becoming aware of a client growing more agitated as the music continued.

**Table 4:** ***How the Music Therapist Addressed the Harm***

| | |
|---|---|
| **Theme 1: Ending Session/Services** | *In Vivo Codes:* "terminating services," "stop interacting," "client leaving"<br>*Descriptive Codes:* ending services; ensuring continuity of care between group providers |
| **Theme 2: Apologizing** | *In Vivo Codes:* "apologizing," "thanking"<br>*Descriptive Codes:* thank clients for telling, apologizing for harm; commitment to do better; following up with clients after session |
| **Theme 3: Removal from Session** | *In Vivo Codes:* "removing self," "help regulate"<br>*Descriptive Codes:* removing client from group to help regulate; provide support |
| **Theme 4: Preemptive** | *In Vivo Codes:* "prevention," "opportunities," "establish boundaries"<br>*Descriptive Codes:* provide content warnings; clear boundaries on how clients can engage; provide opportunities to leave session; discuss how to reduce potential harm in future |
| **Theme 5: Discussion Throughout** | *In Vivo Codes:* "reflect," "adapt experience," "continuously assess"<br>*Descriptive Codes:* open discussion with client about support in medical procedures; ask client if they are "okay" during experience; adapt experience if client requests |
| **Theme 6: Nothing** | *In Vivo Codes:* "none," "unaware"<br>*Descriptive Codes:* none, as they were unaware; nothing |

**Addressing Harm Themes**

*What actions did the music therapist take to address the harm?*

When participants were asked how they responded/how they observed the lead music therapist responding, several themes emerged: ending the session/services, apologizing, removal from session, preemptive, discussion throughout, and nothing. Each participant provided context

for their responses, which gave context for their responses and insight for why the music therapists responded the way they did.

### *Addressing Harm Theme 1: Ending Session/Services*

Two participants reported that ending music therapy sessions or terminating services altogether was warranted in their situations. In vivo and descriptive codes included "terminating services," "stop interacting," "client leaving," ensuring continuity of care between group providers (Table 4). Participant J identified that ending the session was the most beneficial for the client, as the client was aroused and walking around the nursing home. Participant J reported to the nursing home staff the incident so that they would understand why she (the client) was confused and agitated. Participant H identified that terminating services entirely was the most beneficial course of action for the client. This participant noted that they ensured the continuity of care between the client's group providers.

### *Addressing Harm Theme 2: Apologizing*

One participant reported apologizing after a harmful interaction. In vivo and descriptive codes relating to apologizing included "thanking; apologizing," commitment to do better, following up with clients after session (Table 4). Participant D provides information about a situation where they directly caused the harm and how they remedied the situation: "In the situations where I caused harm, I thanked them for telling me apologized, and committed to doing better in the future, making specific plans for how to do this as was appropriate."

Furthermore, participant D shared that they followed up with their client to ensure they had a care plan for themselves, as well as following up with their primary counselor.

### *Addressing Harm Theme 3: Removal of the Client from Session*

Removal of a client from a session or group has been reported by two participants. In vivo and descriptive codes included “removing self,” “help regulate,” providing support (Table 4). In both situations, the participant reported removing the client from the harmful stimuli to help the client regulate, as well as address the harmful stimuli. Participant E reported the harmful stimuli as a triggering song for a veteran and participant F reported the harmful stimuli being the group aides. Participant F reported that after the client had regulated, they were able to safely return to the group.

### *Addressing Harm Theme 4: Preemptive*

Two participants reported that they were able to preemptively address harm before the occurrence. Preemptive in vivo and descriptive codes included “opportunities,” “establish boundaries,” providing content warnings, clear boundaries on how clients can engage, opportunities to leave session (Table 4). Participant D identified that working with clients to problem-solve situations and identify options for reducing the future potential for harm for clients. Participant C provided a clear example of preemptive prevention of harm:

“I err on the side of preventing harm whenever possible: providing content warnings for song lyrics, establishing clear boundaries for how to engage in the music when needed, and providing opportunities for clients to remove themselves from the situation/music when they start to feel activated.”

### *Addressing Harm Theme 5: Discussion Throughout*

A discussion throughout a harmful situation was identified by two participants—both reported instances of supporting a client during a harmful situation and providing a space for

them to process what had happened. In vivo and descriptive codes that were identified included "reflection," "adapt experience," open discussion with client about support, ask clients if they are "okay" (Table 4). Participant I reported they checked in with a client during a song that elicited memories and receiving affirmation that the client was able to finish the song. Participant A reported that having a foundational therapeutic rapport was helpful in the instance of harm during a focused music imagery experience and they were able to adapt the experience to something the client was able to actively engage with. In another clinical experience, Participant A shared:

> "Often touching base with the student or patient after these situations, repairing the rapport and relationship to the best of your ability, letting them know that you are on their side, not upset by their actions, and want to help, is important. It is not ideal to have to address harm after, rather than preemptively, but in situations where it cannot be avoided, like a medical need, what we can do best is continue to return and continue to show support, and that we are not 'done with them' or upset in anyway, often because their actions may have been harmful toward the music therapist or staff. Additionally, creating a plan with the rest of the staff, to try and create better support or prevention of these situations beforehand is vital."

***Addressing Harm Theme 6: Nothing***

Two participants identified that the lead music therapist did nothing to address the harm. In vivo and descriptive codes included "none" and "unaware" (Table 4). Participant B and G reported that the music therapist did not address the harm due to being unaware of the instance.

**Table 5:** ***What Music Therapists Could do to Prevent Harm***

| | |
|---|---|
| **Theme 1: Continuous Assessment** | *In Vivo Codes:* "interview," "communication," "avoid triggers," "observations"<br>*Descriptive Codes*: interview with patients; constant communication with clients |
| **Theme 2: Education** | *In Vivo Codes:* "continuing education," "cultural education," "musical meanings"<br>*Descriptive Codes*: increased education on appropriate interactions; education on cultural awareness |
| **Theme 3: Self-Reflection** | *In Vivo Codes:* "cultural humility/responsiveness," "acknowledgement"<br>*Descriptive Codes:* need to acknowledge harm can happen; plan for how to address |
| **Theme 4: Immediate Response to Harm** | *In Vivo Codes:* "respond sensitively," "prevent escalation," "trigger warnings," "options"<br>*Descriptive Codes*: provide space for client to practice coping skills; providing options |

## Preventing Harm Themes

*What actions can music therapists take to help prevent harm in music therapy sessions?*

When asked what steps music therapist could take to help prevent further harm, several themes emerged, including continuous assessment in the session, continuing education, self-reflection, and a plan to immediately respond to harm.

### *Preventing Harm Theme 1: Continuous Assessment*

Four participants reported continuous assessment as a way to prevent harm in music therapy sessions. In vivo and descriptive codes that were identified included "interview," "avoid triggers," constant communication with clients (Table 5). Participant E reported to observe for

triggers, and "avoid sounds, songs, topics, etc. that one knows will very likely be triggering for a patient." Along with this, participant C shares that music therapists should continuously communicate with clients and caregivers to ensure that the "preventative measures in place are enough and if they need to be adjusted." Participant I expressed providing trigger warnings prior to the session, as well as providing safe ways for clients to not participate and leave the session, if need be.

### *Preventing Harm Theme 2: Education*

Two participants reported a continuation of education would help prevent harm in sessions. In vivo and descriptive codes included "cultural education," "musical meanings," increased education on appropriate interactions (Table 5). Participant B shared that music therapists should have knowledge of songs and the meanings associated with them, as well as education on cultural awareness. Participant F reported that "more education on what is appropriate prompting and an appropriate situation for removal [of client]."

### *Preventing Harm Theme 3: Self-Reflection*

Four participants reported themes of self-reflection as a preventative measure for harm in music therapy. In vivo and descriptive codes included "cultural humility/responsiveness," "acknowledgement," plan for how to address (Table 5). Participant G also reported than engaging in supervision and having an unbiased assessment could help music therapists prevent harm. Participants C and D identified the need for music therapists to continue to do preventative work, as well as engaging in self-reflection as to why they are utilizing specific music experiences—such as how they relate to their clients' goals, objectives, and therapeutic outcomes and well as how to address harm when it arises. Participant J reported the importance of cultural

humility and responsiveness and provides a clear example: "A huge area for potential harm has to do with cultural responsiveness. Music therapists need to be working on recognizing their own cultural lenses and potential biases and gaining understanding of how to practice in a culturally responsive way."

### *Preventing Harm Theme 4: Immediate Response to Harm*

Two participants reported that having an understanding and way to respond to harm immediately is crucial. In vivo and descriptive codes included "respond sensitively," "prevent escalation," options," provide space for client to practice coping skills, provide options (Table 5). Participant D expressed that checking in with clients and reminding they have the choice to practice coping skills or leave the space until the music experience has ended then returning could prevent harm. Participant J reported the importance of understanding the potential for harm and how to respond: "[Music therapy] is not entirely without risk. Be we can mitigate risk by knowing how to respond sensitively in this kind of situation, to prevent escalation and to help patients return to a baseline as soon as possible."

**Table 6:** ***How the Field of Music Therapy Could Prevent Harm***

| | |
|---|---|
| **Theme 1: Education** | *In Vivo Codes:* "research," "work to avoid"<br>*Descriptive Codes:* increase literature around cultural humility and responsiveness; more accessible education |
| **Theme 2: Collaborative Therapeutic Relationships** | *In Vivo Codes:* "collaborative," "meaningful" "communication;" "help"<br>*Descriptive Codes:* work with clients as partners; reducing potential for harm; able to address in meaningful manners; work to de-escalate; help patients process |
| **Theme 3: Acknowledgement and Accountability** | *In Vivo Codes:* "acknowledgement," "openly talk"<br>*Descriptive Codes:* accept harm cannot be avoided due to humanness; not shameful; perceive music therapists as people; listen to client experience |
| **Theme 4: Method for Reporting** | *In Vivo Codes:* "report," "investigate," "intentional"<br>*Descriptive Codes:* profession should have reporting process; investigation; necessary process to prevent further harm |
| **Theme 5: Work Environments** | *In Vivo Codes:* "supervision," "caseloads," "additional trainings"<br>*Descriptive Codes:* increase supervision availability; decrease caseloads |

## Professional Prevention Themes

*How should the music therapy profession respond to harm in sessions?*

To wrap up the survey, participants were asked how the field of music therapy should respond to harm experienced by clients in session. A majority of responses included themes of continuing education and acknowledgement and accountability for the harm caused. Other themes included building a collaborative therapeutic relationship between music therapist and

client, a method for reporting harm, and additional support in the work environment.

### *Professional Prevention Theme 1: Education*

Two participants identified continuing education as a method for the field of music therapy preventing harm. In vivo and descriptive codes included “research,” work to avoid,” more accessible education (Table 6). Participants reported that most times, the music therapists believe they are doing the right thing. Participant J reported that continuing the discussion about harm prevention would be beneficial, as well as “improving the area of cultural humility and responsiveness.”

### *Professional Prevention Theme 2: Collaborative Therapeutic Relationship*

A collaborative therapeutic relationship theme was mentioned by three participants. In vivo and descriptive codes included “collaborative, meaningful,” work with clients as partners, able to address in meaningful manners, work to de-escalate (Table 6). Participant D shared that the music therapists should work as partners with the clients to reduce potential of harm and apologize and address the instances of harm in meaningful ways. Furthermore, participant E expressed that the music therapist should attempt to de-escalate the situations and then help the clients process the harmful event.

### *Professional Prevention Theme 3: Acknowledgement and Accountability*

Four participants identified that acknowledging and taking accountability could help prevent harm as a field. In vivo and descriptive codes included “acknowledgement,” “openly talk,” accept harm cannot be avoided due to humanness, not shameful (Table 6). Participants B and J expressed that music therapists need to acknowledge that music therapists have the potential to cause harm and some music therapists have caused harm. Acknowledging this potential and having conversations about this topic is vital. Both participant A and I provided

examples highlighting the significance of acknowledging that music therapists, like all humans, are prone to making mistakes. Embracing this understanding allows music therapists to acknowledge their fallibility and strive for improvement in their practice:

> Participant A: "We need to know [harm] is a thing not to be ashamed of, but aware of, and talk about it as something that cannot be avoided but will happen. It is a part of human nature, and if we try to perceive ourselves as a people that cannot prevent harm, we can only create ignorance of its occurrence or shame around admitting to it, talking about it, and doing better in the future."
>
> Participant I: "Be aware that it happens! Even with something that seems so innocuous as music, we can still cause harm, we are not exempt from needing to understand that it does occur and how to debrief with clients and help them process OR have the capacity to understand when we are out of our depth and another professional needs to take over to return the client to safety."

***Professional Prevention Theme 4: Method for Reporting***

One participant proposed a method for reporting. In vivo and descriptive codes identified included "report," "investigate," profession should have reporting process (Table 6). Participant C proposed providing resources (such as supervision, continuing education experiences, more trainings, etc.) to music therapists who unintentionally cause harm due to their own ignorance and/or incompetence. Participant C also reported that music therapists who intentionally cause harm should be reported, thoroughly investigated, and take actions to mitigate the harm or prevent future harm. They reported that they are not aware of any such processes.

### *Professional Prevention Theme 5: Work Environment*

One participant identified a change to music therapists' work environments may help prevent harm. In vivo and descriptive codes included "supervision, caseloads, additional trainings," increase supervision, decrease caseloads (Table 6). Participant G identifies a work environment shift as a potential to prevent the instance of harm within the field. They identify that increasing supervision availability might help, as well as decreasing caseloads of music therapists.

# Chapter V: Discussion

The purpose of this study was to gather information from music therapists who have caused or observed harm being done to clients to better identify where harm might arise from, how music therapists have responded, and how might the music therapy profession might respond. Based on the data, the responses were varied with little differences in response statistics. Descriptive experiences (client identifiers, specific music experiences, song names, instrument usage, etc.) were not reported by the participants; however, each identified that harm was caused to the client.

## Comparison to Previous Literature

The basis of this qualitative study was built on Murakami's *Music Therapy and Harm Model* (MTHM; 2021) and supports every area outlined in this model. Furthermore, numerous other themes emerged within this study from Murakami's writing. When comparing the results of this study to the MTHM, each of the sections of the model were identified by participants, including harm arising from the music stimulus, the music therapist, the therapeutic application of music, the therapeutic relationship, the client-music associations, and ecological factors (pp. 6-9).

When comparing the prevention of harm from the music therapists and from the music therapy field, themes were consistent from themes highlighted by Murakami (2021). These themes include increased education, increased supervision, method of reporting harm, cultural sensitivity, self-examination, and self-acceptance.

### *Increased Education*

There is no standard training for harm prevention within music therapy curriculum. However, a couple of participants identified this would be an area to address. Increasing the

potential for harm through utilizing the MTHM (Murakami, 2021) to identify how and where negative effects may arise from within music therapy sessions. Murakami (2021) identified that conversations about the potential for harm should be a continuous conversation, which builds and evolves as the student progresses through their education, practicum experiences, and internship (p. 12).

### *Increase Professional Supervision*

Several participants highlighted the need for an increase in professional supervision. Murakami (2021) highlighted that, "opportunities for mentored supervision are often sparse and not required after obtaining board-certification in the United States, despite AMTA Professional Competency C.19.1 recommending music therapists to participate in multiple forms of supervision" (p. 11). Engaging in individual and/or group peer or professional supervision over a long course of time could help provide the music therapist with a supportive environment to feel comfortable with acknowledging harm, how to address harm, and how to prevent future harm.

### *Method of Reporting*

One participant identified a method of reporting intentional harm. This mirrors Murakami's (2021) notion of reporting instances of harm in research, which is limited in music therapy literature. Murakami hypothesized, "If researchers consistently and transparently monitor negative clinical effects, then patterns relevant to understanding harm may begin to emerge" (p. 13). Having this knowledge could help identify harm caused, as well as ways to prevent harm. Furthermore, having a reporting method could identify ways to address the harm caused. This might emerge though identifying common harm themes, ways other music therapists have addressed related harm, and perhaps a standard harm-addressing procedure.

### *Cultural Sensitivity*

Participants noted the need for increased culturally responsive practices and humility. Murakami (2021) suggests "music therapists need to develop a holistic responsiveness to cultural issues and power differences that inevitably arise within the clinical space" (p. 9).

### *Self-Examination & Acceptance*

An area that most of the participants identified is the need for self-examination and acceptance. Murakami (2021) identifies that

> "Coming to terms and being accountable to the fact that oneself has probably caused or allowed harm at some point is a process that involves introspection and acceptance in order to move from a defensive stance to an increasingly aware outlook on one's own actions as a music therapy professional." (p. 10)

Furthermore, participants identified that self-acceptance and opening the conversation for the potential for harm could lessen the stigma and show clients that music therapists are "humans" who also make mistakes. Acknowledge the harm that occurred, apologizing to the client, and working together with the client to move forward (either together or with a new provider) could be beneficial for the music therapy field.

## Implications for the Music Therapy Field

This study provides clinical examples of instances of harm directly from music therapists who have either caused the harm or observed it. Out of the thirty-five participants that initiated the survey, eight participants reported no observations of harm in music therapy sessions. When considering why a music therapist might not have reported harm within this survey, this researcher believes it stems from a lack of awareness regarding the possibility of harm in music therapy, unfamiliarity with potential harm triggers (relating to the MTHM; Murakami, 2021),

and a general lack of self-awareness. The participants whose data was collected provided concrete examples on potentials to mitigate and prevent harm. Educational resources based on cultural responsiveness/humility, identifying various types of harm and how to respond, and ways music therapists could prevent harm would be beneficial for the music therapy field at large. The MTHM (Murakami, 2021) provides a foundation for identifying areas of harm, including harm arising from the six components: 1) music presented; 2) board-certified music therapist; 3) therapeutic application of music; 4) therapeutic relationship; 5) client-music associations; and 6) ecological factors).

This researcher believes that the normalization of the potential for harm is crucial for the safety and well-being of the clients served. Music therapists have an ethical duty to prevent harm at all costs and it is imperative to recognize that music therapists, as humans, have the potential to cause harm. By engaging in proactive peer discussions about the potential for harm in music therapy practice may allow music therapists to feel less guilt and support should the instance of harm arise in their work. Acceptance of this reality and fostering open communication within the therapeutic relationship can contribute to harm prevention to clients.

This information should prompt self-reflection and introspection for practicing music therapists. By reflecting on past experiences where harm may have occurred and understanding the responses from both the client and the music therapist, an MT-BC can initiate conversations about preventing harm with both peers and clients. Furthermore, this thesis also acknowledges that music therapists have the potential to cause harm—not as a source of shame, but as a call for acceptance and a commitment to continually improve for the clients they serve.

## Limitations

This qualitative study did have limitations. First, the sample size was quite small and only explored the experiences of a small number of board-certified music therapists. My survey received thirty-five responses from individuals and only ten responses were utilized due to these participants responding to each question fully. This small number represents a very small fraction of board-certified music therapists practicing in the United States. Another limitation that has been identified is that utilizing a virtual survey platform might have closed off further information and details about a scenario that is given. By doing face-to-face interviews, more details about situations might have been gathered. Furthermore, the populations and settings where these music therapists worked within was limited; however, due to confidentiality, the ages, diagnosis, and locations were not able to be identified.

## Recommendations for Future Research

Additional research on this topic would be beneficial to the music therapy field. Expanding the range of eligibility for participants, identifying therapeutic approaches, and expanding to music therapist around the world might garner more responses and ultimately help identify more areas where harm might arise from. Along with this, additional data might be collected to identify themes arising from specific areas more frequently, certain therapeutic approaches inducing harm, and further prevention methods might be able to be identified.

Furthermore, having directly focused qualitative studies based on client settings, diagnoses, and therapeutic techniques might provide more in-depth literature. For example, examining harm experienced during a guided-relaxation music experience for individuals in a psychiatric inpatient setting. It might also be beneficial to study experiences of clients who have experienced harm in music therapy treatment. This could further the conversation surrounding

experiences of harm directly from those who have been harmed, as well as potentially build a foundation for remedying the harm a client experienced.

## Conclusion

In conclusion, the potential for harm in music therapy is evident and the continuation of research has profound implications for both the field of music therapy and the safety of clients. In reviewing the findings, harm potentially arises from numerous areas in the therapeutic process, as identified by the responses from participants: 1) the music, 2) the music therapist, 3) the therapeutic application of music, 4) the therapeutic relationship, 5) the client-music associations, 6) and various ecological factors (Murakami, 2021). Harm occurs with varying levels of therapist awareness and corresponds with various types of responses. The field of music therapy would greatly benefit from further research on the potential for harm including how to mitigate and prevent adverse experience. This study provided the groundwork of personal reports and observations of harm in music therapy, but future research is still needed.

Overall, the potential for harm should continue to be studied, conversations amongst music therapists with different viewpoints should unfold, and research should continue to be conducted. The potential for harm is not stagnant and differing themes of harm will continue to emerge as global events occur. Accepting the possibility of harm in a shame-free way might allow music therapists to take responsibility without a feeling of failure, as well as work to prevent future harm.

## References

American Music Therapy Association. (n.d.) Education and Clinical Training Standards. https://www.musictherapy.org/members/edctstan/

American Music Therapy Association, Certification Board for Music Therapists. (2015). Scope of music therapy practice. https://www.musictherapy.org/about/scope_of_music_therapy_practice/

American Music Therapy Association. (2013). American Music Therapy Association Standards of Clinical Practice. https://www.musictherapy.org/about/standards/#PREAMBLE

McKay, D., & Jensen-Doss, A. (2021). Harmful treatments in psychotherapy. *Clinical Psychology: Science and Practice*, *28*(1), 2-4. http://dx.doi.org/10.1037/cps0000023

American Psychological Association. (2016). Revision of ethics code standard 3.04. Retrieved October 17, 2022, from https://www.apa.org/ethics/code/standard-304

Batic, B., & Hayes, D. (n.d.). *Exploring harm in psychotherapy: Perspectives of clinicians working ... Wiley Online Library*. Retrieved September 12, 2022, from https://onlinelibrary.wiley.com/doi/full/10.1002/capr.12347

Benedict R. E. (2006). Disparities in use of and unmet need for therapeutic and supportive services among school-age children with functional limitations: a comparison across settings. *Health services research*, *41*(1), 103–124. https://doi.org/10.1111/j.1475-6773.2005.00468.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, (3)2, 77-101. https://doi.org/10.1191/1478088706qp063oa

CBMT. (n.d.). Board Certification Domains. from https://www.cbmt.org/wp-content/uploads/2019/09/CBMT_Board_Certification_Domains_2015.pdf

Certification Board for Music Therapists. (2020). Board Certification Domains. From https://www.cbmt.org/wp-content/uploads/2020/03/CBMT_Board_Certification_Domains_2020.pdf

Certification Board for Music Therapists. (2020). Recertification Manual. From http://www.cbmt.org/wp-content/uploads/2020/08/CBMT-Recertification-Manual-2020.pdf

Curran et al. (2019). How does therapy harm? A model of adverse process using task analysis in the meta-synthesis of service users' experience. *Frontiers in Psychology*. DOI: https://doi.org/10.3389/fpsyg.2019.00347

Encyclopædia Britannica, inc. (n.d.). *harm*. Encyclopædia Britannica. Retrieved September 25, 2022, from https://www.britannica.com/dictionary/harm

Encyclopædia Britannica, inc. (n.d.). *vulnerable*. Encyclopædia Britannica. Retrieved November 21, 2022, from https://www.britannica.com/dictionary/vulnerable

Fisher, P. L., and Durham, R. C. (1999). Recovery rates in generalized anxiety disorder following psychological therapy: An analysis of clinically significant change in the STAI-T across outcome studies since 1990. *Psychological Medicine*. 29, 1425-1434. doi: 10.1017/S0033291799001336

Gonzalez-Hoelling, S., Bertran-Noguer, C., Reig-Garcia, G., & Suñer-Soler, R. (2021). Effects of a Music-Based Rhythmic Auditory Stimulation on Gait and Balance in Subacute Stroke. International Journal of Environmental Research and Public Health, 18(4), 2032. doi: 10.3390/ijerph18042032

Gyani, A., Shafran, R., Layard, R., and Clark, D. M. (2013). Enhancing recovery rates: lessons from year one of IAPT. *Behavior Research and Therapy*. 51, 597-606. doi: 10.1016/j.brat.2013.06.004

Hannan, C., Lambert, M.J., Harmon, C., Nielsen, S.L., Smart, D.W., Shimokawa, K., & Sutton, S.W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*, 155–163. 10.1002/jclp.20108.

Hatfield, D., McCullough, L., Frantz, S.H.B., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. Clinical Psychology & Psychotherapy, 17, 25–32. 10.1002/cpp.656.

Heins, M.J., Knoop, H., Prins, J.B., Stulemeijer, M., van der Meer, J.W.M., & Bleijenberg, G. (2010). Possible detrimental effects of cognitive behaviour therapy for chronic fatigue syndrome. Psychotherapy and Psychosomatics, 79, 249–256. 10.1159/000315130.

HSCIS (2018). Quarterly improving access to psychological therapies data set reports, England summary statistics and related information. Health and Social Care Information, from https://digital.nhs.uk/data-and-information/publications/statstical/psychological-therapies-report-on-the-use-of-iapt-services/

Hook, J., & Devereux, D. (2018). Boundary violations in therapy: The patient's experience of harm. *BJPsych Advances*, *24*(6), 366-373. doi:10.1192/bja.2018.26

Klatte, R., Strauss, B., Flückiger, C., & Rosendahl, J. (2018). Adverse effects of psychotherapy: protocol for a systematic review and meta-analysis. *Systematic reviews*, *7*(1), 135. https://doi.org/10.1186/s13643-018-0802-x

Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. Psychotherapy, 50, 42–51. 10.1037/a0030682.

Lazar, E. (2017). Client deterioration in individual psychotherapy: A systemic review. (Doctoral dissertation). Indiana University of Pennsylvania, Indiana, Pennsylvania.

Linden, M., & Schermuly-Haupt, M.-L. (2014, October). *Definition, assessment and rate of psychotherapy side effects*. World psychiatry: official journal of the World Psychiatric Association (WPA). Retrieved September 25, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4219072/

Mental Health America. (2022, May 6). *How does therapy work? what to expect*. MHA Screening. Retrieved November 21, 2022, from https://screening.mhanational.org/content/how-does-therapy-work-what-expect/?layout=actions_b

Murakami, B. (2021, April 1). The Music Therapy and Harm Model (MTHM): Conceptualizing harm within music therapy practice. *ECOS*, *6*(1), 003-003. https://doi.org/10.24215/27186199e003

Murakami, B., & Goldschmidt, D. (Hosts). (2018, October). Potential harm in music therapy? [Audio podcast]. *American Music Therapy Association*. https://amtapro.musictherapy.org/?p=2100

Oasi, O & Werbart, A (2020). Editorial: Unsuccessful psychotherapies: When and how do treatments fail? *Frontiers in Psychology.* 11:578997. doi: 10.3389/fpsyg.2020.578997

Parry, G., Crawford, M., & Duggan, C. (2016). Iatrogenic harm from psychological therapies – time to move on. British Journal of Psychiatry, 208(3), 210-212. doi:10.1192/bjp.bp.115.163618

*Publications and Digital Products*. Search SAMHSA Publications and Digital Products | SAMHSA Publications and Digital Products. (2017). Retrieved November 21, 2022, from https://store.samhsa.gov/

Sampath, R (2021). *AMA J Ethics.* 2022;24(8):E735-739. doi: 10.1001/amajethics.2022.735.

Sells, N. (2021, January 26). *Reasons to see a therapist*. Davis Behavioral Health. Retrieved November 21, 2022, from https://www.dbhutah.org/reasons-to-see-a-therapist/

The Association for Indiana Music Therapy. (2022). *About AIMT*. Retrieved September 25, 2022, from https://indianamusictherapists.com/aboutaimt/

William & Mary School of Education. (n.d.). *The skill of self-disclosure.* Retrieved October 17, 2022, from https://counseling.education.wm.edu/blog/the-skill-of-self-disclosure

# Appendix A

*IRB Approval*


**MEMO**

To: Gray Baldwin, MA, MT-BC

Olivia Wendel

From: Lamprini Pantazi, Ph.D., & Chair of the Human Subjects –Institutional Review Board

Date: March 30th, 2023

Re: Human Subjects Institutional Review Board Application

Thank you for submitting a Human Subjects proposal entitled "**Music Therapists' Awareness for the Potential of Harm in Music Therapy: A Qualitative Analysis"**. The Institutional Review Board (IRB) of Saint Mary-of-the-Woods College has **approved your research.** Unless renewed, this approval will expire on March 29th, 2024. If any changes need to be made during implementationof this research project, please submit those changes to the IRB for its approval. Also, if any incidents occur, please notify the IRB as soon as possible.
We wish you success with your research project.
Institutional Review Board members:

Lamprini Pantazi, Ph.D.
Kimberly LaComba, Ph.D.
Scott Ripple, MD
Douglas Sperry, Ph.D.
Christine Wilkey, MSW, LCSW
Tricia Pierce, DHSc, ACSM-CEP.

## Appendix B

*Invitation Letter*

Dear Board-Certified Music Therapist,

I am Olivia Wendel, MT-BC, (she/her) a graduate student at Saint Mary-of-the-Woods College in the Master of Arts in Music Therapy program. You are being invited to participate in a research study titled **"Music Therapists' Awareness for the Potential of Harm in Music Therapy: A Qualitative Analysis."** You are being asked to participate in the study to explore music therapists' awareness of the potential for harm in the music therapy treatment. Your participation will entail completing an online survey that will take approximately 20-25 minutes.

Participation criteria includes:

1. Being a board-certified music therapist for at least one year.
2. Access to a computer, phone, or tablet to complete the survey.
3. Be able to read English or utilize a language translating software.

If you fit the criteria, you will be asked to:

1. Provide how long you have been a practicing board-certified music therapist, highest level of education in music therapy or related field
2. What populations/settings you primarily work with
3. Your awareness of the potential for harm in music therapy, instances where you have observed harm, how the harm was addressed from the music therapist, and how music therapists could prevent harm from occurring.

In the event a participant provides identifying information about a client or music therapist, the response will be discarded.
This survey is completely voluntary, and you will not receive any compensation for your participation. You are welcome to discontinue the survey at any time without any penalty.

The Saint Mary-of-the-Woods College IRB has approved this research study. If you have any questions or concerns about this survey study, please contact me, the co-investigator, at olivia.wendel@smwc.edu.

If you are interested in participating, please click the link below:

https://www.surveymonkey.com/r/NBM897B

If you have any questions, comments, or concerns, please email me (the co-investigator) at olivia.wendel@smwc.edu

***If you have any questions regarding this survey, please email me directly and do NOT post a comment—so as to protect confidentiality. ***

Thank you for your time and effort! Olivia Wendel, MT-BC (she/her)

# Appendix C

*Informed Consent*

**Music Therapists' Awareness for the Potential of Harm in Music Therapy: A Qualitative Analysis**
**Informed Consent**

**Purpose of the Research**

The purpose of this study is to explore board-certified music therapists' awareness of the potential for harm in music therapy, as well as how music therapists and the music therapy profession have responded.

You are being asked to participate in this study because you are a board-certified music therapist of at least one year and your experience is valuable to expanding the literature surrounding harm to the music therapy field.

**Procedures**

Participants will be recruited through email messaging, as well as a call for responses on social media platforms. Email addresses will be obtained through the CBMT database.

Utilizing CBMT information for email addresses, the researcher will send out the survey. The survey will provide various questions to explore music therapists' awareness for harm in music therapy, as well as explore common themes in relation to the Music Therapy and Harm Model (Murakami, 2021).

**Risks or Discomforts**

Risks or discomforts from this research study include unpleasant and uncomfortable memories of harm caused by the music therapist and client descriptions. Mental health crisis resources will be provided at the completion of the survey. If the participant experiences discomfort, the researchers encouraged them to seek out supervision.

**Potential Benefits**

No direct benefits have been identified for the individual taking the survey. Professional benefits that may be expected from this research study include expanding the literature of the potential for harm in music therapy and identifying methods of remedying harm for future clients.

**Confidentiality**

No personally and directly identifying information will be collected through this survey.
Any of your information that can directly identify you will be stored separately from the data that will be maintained for a period of three years in a password-protected electronic storage.

**Voluntary Participation**

It is entirely voluntary to participate in this research study. You can decline participation in the study by not signing the consent form. You can withdraw from the study at any time without penalty by contacting the co-investigator, Olivia Wendel, MT-BC at olivia.wendel@smwc.edu even if you decide to be part of the study now.

**Use of Data for Future Study**

Data that does not contain information directly identifying you could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

If you have questions about this research study, please contact the principal investigator or co-investigator.

**Principal Investigator**
Gray Baldwin, MA, MT-BC
1 St. Mary of Woods Coll, Saint Mary-of-the-Woods, IN, 47885
gray.baldwin@smwc.edu

**Co-investigator**
Olivia Wendel, MT-BC
1 St. Mary of Woods Coll, Saint Mary-of-the-Woods, IN, 47885
olivia.wendel@smwc.edu

This study was approved by the Saint Mary-of-the-Woods College Human Subjects Institutional Review Board on March 30th, 2023. If you have questions or concerns about your rights as a research participant, you may contact the chair of the Human Subjects Institutional Review Board.

**Chair, IRB**
Dr. Lamprini Pantazi, Chair, Human Subjects Institutional Review Board
Saint Mary-of-the-Woods College

1. I have read the informed consent and agree to participate in this research study
    a. Yes
    b. No

# Appendix D

*Survey Questions*

**Eligibility**

**1. Do you meet the following eligibility criteria?**

1. **Be board-certified for at least one year**
2. **Access to a computer, phone, or table to complete the survey**
3. **Be able to read English or utilize a language translating software.**
    - **Yes**
    - **No**

**Informed Consent**

**1. I have read the informed consent and agree to participate in this research study**

- **Yes**
- **No**
- How long have you been a board-certified music therapist?
    - >1 year
    - 1-5 years
    - 5-10 years
    - 10-15 years
    - 15+ years
- Highest level of education in music therapy?
    - Bachelor's
    - Bachelor's Equivalency
    - Master's

  - Master's Equivalency
  - Doctorate

- Highest level of education in another discipline (name and degree level):

  _____

- What populations/settings do you primarily work with?

  _____

Definitions

Harm, as defined by Hook & Devereux (2018), is "any sustained negative consequence that the patient experiences as a result of engaging in a treatment." Furthermore, Murakami's (2021) Music Therapy and Harm Model conceptualizes the potential for harm arising from the following sources: the music, the board-certified music therapist, the therapeutic relationship, the therapeutic application of music, and/or the client-specific associations with the music. Please indicate that you have read the definition and potential sources of harm:

  - I have read the definition
  - I have read the potential sources of harm in music therapy

Research Questions

1. What is your awareness of the potential for harm in music therapy?

   _____

2. If you were aware prior to this survey, when and where did you learn about this?

   _____

3. Have you observed harm in a music therapy session?
   - Yes

- No

4. If yes, please describe the instance of the situation:

   _____

5. What are client(s) responses you've observed to instances of harm from the music therapist?

   _____

6. In the instances of harm occurring in a session, how and when did the music therapist become aware of the instance of harm?

   _____

7. What actions did the music therapist take to address the harm?

   _____

8. What can music therapists do to help prevent harm in music therapy sessions?

   _____

9. How should the music therapy profession respond to harm in sessions?

**If you are in a mental health crisis, get help at: 988 Suicide & Crisis Lifeline**

Call or text 988; utilize the Lifeline Chat. This Lifeline provides 24/7 confidential support from a trained crisis counselor to those in a mental health crisis.