Understanding Safety in Music Therapy

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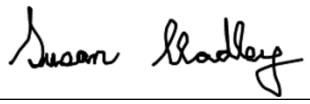

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Abstract

Although there is a growing emphasis on trauma-informed care in music therapy clinical practice, research specifically addressing the concept of safety—particularly psychological and physical safety—remains limited. Therefore, this thesis aimed to understand the concept of safety in the field of music therapy and how it informs practice, education, and professional interactions. Given the limited existing research on this topic, a grounded theory methodology was employed to generate a deeper understanding of how safety is conceptualized in the field based on the lived experiences and insights of practitioners. The primary researcher conducted semi-structured interviews with a total of 11 participants. The interviews were recorded and transcribed, and the transcripts were analyzed and coded using ATLAS.ti. The findings proposed the following theory: Within music therapy contexts, safety is a dynamic experience that is constantly negotiated and co-constructed by participants through prioritizing care and well-being in the relationship and conditions for safety, including trust, are present. Interpretations of findings, implications for music therapy practice, and recommendations for future research were included.

Keywords: safety, physical safety, psychological safety, trauma-informed care, harm, music therapy, grounded theory

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Acknowledgments

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Introduction

As a queer Black man, I have often found music to be an avenue to both explore and affirm my own identity and sense of self. My relationship with music developed further through formal education and involvement in vocal ensembles and singing became a core component of myself. It was and is an enjoyable form of emotional expression, and through membership in high school choirs, I felt a sense of community. Singing, more than other forms of music making, comes from my core and helps me feel connected to myself. As I neared the end of my undergraduate music therapy coursework, I developed a strong interest in identity development and musical identity. Thus, I wondered how music therapy could influence musical identity, especially for clients whose primary avenue of engaging in music might be through clinical services.

My clinical experiences in special education, adult day programs, and community settings reflected this interest. During my internship, I worked with students in special education classes that genuinely loved performing but could not participate in ensembles like band or choir at their schools due to lack of accessibility. Yet, their teachers and family members often shared sentiments of how they were born to perform. Knowing this about certain students, I observed my internship supervisors collaborate with band and choir directors to include interested students in rehearsals and performances. I even helped one student make a CD of songs they learned to play on the piano to share with their peers and staff. These experiences prepared me well for the community-oriented work with disabled adults I did immediately following my internship. In individual and group sessions, some participants identified a joy in performing, and we developed several compositional and performance opportunities together with other community members, including audio recordings and live performances. In both contexts, my clients shifted

from being solely recipients of music therapy to performers and composers. I continued to witness how music can be a space for people to realize themselves.

Through my reading and these experiences, something became more apparent: exploration is necessary for identity development. While receiving supervision for my work, the discussions often highlighted the vulnerability and trust needed for my clients to explore these avenues with me. I knew from my own experiences with singing how scary it can be to perform, yet I still felt a strong desire to share that passion with others. The same sentiment is true when exploring identities and sharing them. When I disclose my identities to others, I know they may react in a variety of ways from affirmation and acceptance to tolerance, rejection, or violence. Typically, I try to complete some vetting process or gauging to ensure that I can share without fear of rejection or violence, but, in general, people need to feel like they can explore freely and openly to understand their sense of self more fully. However, doing so requires individuals to feel a sense of safety to take such a risk.

As defined by Merriam-Webster (2023), safe is an adjective that means “free of harm or risk.” The same dictionary defines safety as “the condition of being safe from undergoing or causing hurt, injury, or loss” (Merriam-Webster, 2023), and according to Blokland and Reniers (2019), most people in Western society operate under the assumption that everyone agrees upon the same definition of safety. However, what constitutes safety for groups and individuals is not universal. This becomes more apparent when understanding the impact of sociocultural location, identity, and lived experience. Even if we use the same definition, the conditions to reach it are unique to an individual’s experience.

I have experienced the struggle to define and share definitions of safe and safety firsthand in multiple roles and contexts. As a clinician, I worked with someone who never felt safe. This

client had a deep fondness for singing, and they shared with me how they wished they could perform in front of an audience someday. With this interest highlighted, I conducted their sessions as therapeutic voice lessons learning and rehearsing their favorite songs. However, the structure and format of the sessions often shifted due to this client's constant state of fear and concern for their safety. They frequently expressed fears of intruders and attackers entering our building, often citing news stories. To alleviate their concerns, the other staff and I would show them that the doors were locked and review our protocols and emergency drills. I even had them determine how to set up the room for our individual sessions and had them choose where they would like to sit in groups. No matter what I did to secure our physical space, they continued expressing fear of people invading our building.

After some conversations with each other, I understood that the problem in this situation was that I was trying to create a "safe" space for this person, and, as we continued working together, I realized that safety was not something I could guarantee them or anyone else, myself included. Instead, I adjusted my language and explicitly asked how I could make them feel more "comfortable" in our space. This shift in language was successful in a sense because we could still validate their concerns while also fostering a space that allowed them to engage in therapy and with other people more readily without perseverating on the fear of invasion.

I struggled to find words to explicitly describe this experience to others, so I used the words "comfortable" and "uncomfortable" when explaining my process with this client. Still, I found that language insufficient in communicating the nuance of the situation. Later, I attended a closed conference session for BIPOC students and professionals, and one of the facilitators, a friend and colleague, Marisol Norris, shared a sentiment that safety does not exist when the group was establishing guidelines for interacting and sharing, and due to in part my experiences

with my client as described above, this idea resonated with me. I realized how often I suspend my need to feel safe when interacting with the world around me, and I questioned if there were ever spaces or people that truly provided me a feeling of safety in my life.

As I continued wrestling with the question of safety's existence, I wondered how this applied to music therapy clinical practice, education, and training, especially considering the recent discourse about safe spaces at conferences and how often I have heard sentiments that music therapy is safe and non-invasive. Thus, this thesis emerged.

Review of the Literature

As shared previously, Merriam-Webster (2023) defines safe as an adjective meaning "free of harm or risk" and safety as a noun meaning "the condition of being safe from undergoing or causing hurt, injury, or loss." In both definitions, there is a sense of absoluteness, and many discussions about safety specifically have revolved around absolute versus relative understandings. When safety is understood as absolute, there is a problematic perception that implies harm and risk do not exist if safety is present (Boholm et al., 2015). On the other hand, relative understandings imply that less risk and harm are present the more safety is present (Boholm et al., 2015), and thus, other definitions reflecting this perspective have emerged, including that "[s]afety is the condition/set of circumstances where the likelihood of negative effects on objectives is [l]ow" (Blokland & Reniers, 2019 p. 19; Blokland & Reniers, 2020, p. 11).

Furthermore, the terms safe and safety are typically defined in contrast to their opposites, focusing on what they lack rather than what they embody. In doing so, challenges arise by not defining "safe" and "safety" by what they are due to the assumption that society shares a broad

and general understanding of it intuitively (Blokland & Reniers, 2019). As such, the fields of safety and security sciences and risk management have made efforts to generate a standard definition of safety to address this concern (Blokland & Reniers, 2019).

Although the field of safety and security science is relatively novel as a domain of study, several theories, models, and metaphors have proposed what safety is and how to achieve it. Many of them often draw from investigations and lessons learned from catastrophes and disasters, and this approach highlights how efforts to improve safety frequently rely on hindsight and further perpetuate defining safety by what it is not – the antonym of risk (Blokland & Reniers, 2019). With these considerations, the concepts of risk, safety, and security and their applications in language have garnered academic interest and attention (Boholm et al., 2015).

Blokland and Reniers (2019) share the following definitions for risk, security, and safety provided by the International Organization for Standardization (ISO) in the *ISO 31000: 2009 Risk Management – Principles and Guidelines* (2009):

- *Risk* is the effect of uncertainty on objectives.
    - *Objectives* are those matters, tangible and intangible, what individuals, organizations, and societies (as groups of individuals) want, need, pursue, try to obtain, or aim for.
- *Security* is the condition/set of circumstances where the combination of likelihood and intentional negative effects on objectives is Low; or the condition/set of circumstances where the alignment of objectives is high and where the combination of likelihood and intentional positive effects on the objectives is High.
- *Safety* is

- *(Broad perspective, including security)* the condition/set of circumstances where the combination of likelihood and negative effects on objectives is Low; or the condition/set of circumstances where the combination of likelihood and positive effects on objectives is High
- *(Narrow perspective)* the condition/set of circumstances where the combination of likelihood and unintentional negative effects on objectives is Low.

Given the broadness of the previously shared definitions, specific types of safety have been identified and explored, including physical and psychological safety.

Physical safety typically focuses on injury prevention and reduction of bodily harm and is often the subject of studies in safety and security science (Blokland & Reniers, 2019; Blokland & Reniers, 2020; Boholm et al., 2015). In many instances, physical safety measures are objectively measurable. For example, wearing a helmet and protective pads when riding a bike is objectively safer than riding a bike without them. The absence and presence of these items directly affect the likelihood of harm resulting from any physical risk.

Psychological safety is the feeling that taking interpersonal risks will not result in embarrassment, ridicule, or shame thus enabling people to engage, connect, change, and learn (Wanless, 2016). This concept was initially studied within organizational psychology and applied primarily to the business sector and workplace interactions (Edmondson & Lei, 2014). Research furthered the understanding of psychological safety by identifying its presence on individual, team, and organizational levels (Edmondson & Lei, 2014; Newman et al., 2017) and differentiating it from similar constructs, such as trust, the willingness to be vulnerable to the actions of others (Frazier et al., 2016). With this knowledge of psychological safety in business and workplace interactions, scholars and researchers have considered its applications in other

areas, such as education, healthcare, and human development (Wanless, 2016; Nembhard & Edmondson, 2012).

In particular, the education and training of education and healthcare professionals, such as teachers and nurses, provide a unique intersection of the previously listed areas of interest for psychological safety's application (Edmondson et al., 2016; Higgins et al., 2011; Johnson et al., 2020; Nembhard & Edmondson, 2006; O'Donovan & McAuliffe, 2020b; Torralba et al., 2020; Tsuei et al., 2019). Research has shown that "healthcare and education sectors are hampered by norms of autonomy and hierarchical structures that limit the flow of help-seeking actions and ideas that support learning and change" (Edmondson et al., 2006, p. 79). Many employees and students can be self-conscious about showing their limitations or offending their leaders and educators, and research shows that employees and students struggle to take risks associated with the behaviors of organizational learning out of fear or concern of being judged harshly and negatively by leaders and educators (Johnson et al., 2020; Nembhard & Edmondson, 2006; Tsuei et al., 2019).

Various strategies and approaches have been presented to mitigate the above issues and to foster what can be considered a psychologically safe learning environment. Nembhard and Edmondson (2012) provided a theoretical and evidence-based argument that psychological safety facilitates three key factors of organizational learning:

- *Speaking up*: open and authentic communication, including speaking up with questions, concerns, and suggestions. It raises awareness of problems and opportunities for improvement and increases knowledge transfer. Speaking up takes some degree of interpersonal risk to offer content that one believes is relevant.

- *Collaboration*: cooperation between individuals working toward a common goal and includes conversation and coordination. It enables the process to draw on greater expertise and facilitates action through coordination.
- *Experimentation*: trials to develop innovations, skills with new practices, or solutions to problems. Failures from experimentation can motivate learning and provide lessons in psychologically safe contexts.

Additional strategies and approaches to support psychologically safe learning environments include leader inclusiveness, defined as behaviors and attitudes of people in charge that encourage team members to take initiative, share input from others, and value others (Nembhard & Edmondson, 2006), as well as the concept educator as ally, which emphasizes working alongside the learner (Johnson et al., 2020). These approaches also reflect themes identified by healthcare teams from the research of O'Donovan and McAuliffe (2020b), including

- *Prioritizing patient safety* – a professional responsibility and shared goal of the organization and its members
- *Improvement or learning orientation* – the capacity for the organization to have continuous improvement through openness to new ideas
- *Support* from the organization, leadership, and peers
- *Familiarity with colleagues*, including team members, other professionals on different teams in the organization, and leadership
- *Status, hierarchy, and inclusiveness* – promoting a more egalitarian environment so that challenging dialogue is not always from those in higher positions of power to those in the lower positions; acts of inclusive leadership encourage and invite feedback from all team members

- *Individual differences* of the people that comprise the team, including factors such as gender and personality

Particularly, trust and vulnerability in relationships have been shown to serve as antecedents to psychological safety in these contexts, and educators that embrace psychological safety tend to facilitate high-performing learning spaces (Torralba et al., 2020).

For instance, multiple studies have explored the role of psychological safety in nursing education (Park & Kim, 2021; Roh et al., 2021; Stephen et al., 2020; Turner & Harder, 2018), and students have reported the importance of having relationships with their educators that were collaborative and supportive (Stephen et al., 2020). Specifically, clinical simulation in nursing education highlights the importance of psychologically safe learning environments. In medicine, there can be a lot of ambiguity and uncertainty, so experimentation is necessary to find solutions (Torralba et al., 2020). However, in practice, experimentation can have dire consequences for patient health, so clinical simulations allow nursing students to make mistakes without such consequences (Turner & Harder, 2018). To promote psychological safety in these simulations, educators often provided foundational information and expectations to their students to set them up for optimal success in learning (Stephen et al., 2020; Turner & Harder, 2018). Research has shown that experiencing psychological safety in simulation education significantly impacts learning outcomes positively (Roh et al., 2021).

For professional nursing practice, Groves et al. (2021) shared a continuous, iterative process of creating space for open safety communication which includes the following steps:

- *Anticipating safety concerns* typically by providing safety education and information about potential areas of concern to patients and families before they are voiced

- *Inviting open safety discussion* by making a point of inviting patients and their families to share their concerns by letting them know the nursing staff cares. It also involves nursing staff investigating or asking clarifying questions when they notice any seeming insecurities from patients or their families.
- *Being accessible* by making sure that nurses are available to listen to concerns. This may include providing detailed information on how to contact or communicate with them.
- *Recognizing insecurity* through both verbal and nonverbal communication with patients and their families.
- *Trustworthy reaction:* reacting in a way that respects the concerns expressed by the patients or their families.
- *Sharing the plan* that has been developed to address the safety concern.
- *Follow up* with patients and their families about their concerns and how they were addressed.

This process also discusses the importance of 1) fostering and maintaining trust between nurses, patients, and their families and 2) patients feeling cared for by their nursing staff to feel enough security to engage in open safety communication (Groves et al., 2021). Johnson and Delaney (2006) identified a process called "Keeping the Unit Safe" which involves (1) individual and milieu strategies and (2) day-to-day and episodic strategies directed toward the outcome of safety on the unit. Individual and milieu strategies can include developing patient safety plans or having staff participate in trainings and professional development to ensure they have skills needed to appropriately engage with patients (Svensson, 2022). Day-to-day and episodic strategies can include drills for events like a fire or armed intruder or organizational protocols for things like fall prevention (Svensson, 2022). Additionally, the four dimensions of Johnson and Delaney's

(2006) process – ideology, people, space, and time – showcased how complex and dynamic interactions, although understudied, strongly influence the experience of safety in a unit for both patients and staff.

As the research above implies, physical and psychological safety influence a person's ability and choice to take risks, and the willingness to take interpersonal risks impacts the ability to build relationships. Within therapy, there is an emphasis on the role of therapeutic alliance and rapport in supporting client/patient goal outcomes, and a therapist's ability to provide a feeling of safety is considered important in the development of a positive therapeutic alliance (Allison & Rossouw, 2013; Erkkilä & Samaritter, 2023). Polyvagal theory proposes that a state of safety is mediated by neuroception, a neural process that may occur without awareness, which constantly evaluates risk and triggers adaptive physiological responses that respond to features of safety or danger (Geller & Porges, 2014). When safety is communicated effectively through avenues such as facial expressions and body language, defensiveness and apprehension can be down-regulated (Erkkilä & Samaritter, 2023; Geller & Porges, 2014). The belief is that if someone feels safer within the context of the therapeutic space and relationship, they are more likely to take meaningful risks in their therapy journey and make progress towards their goals and outcomes.

However, given this previous information, it becomes apparent that safety cannot be guaranteed. By taking risks, there is potential to experience negative outcomes, including harm. As such, structuring safety, the practices of negotiating or co-constructing conditions, structures, and agreements that will make space for safe enough work, has been implemented when working with people who have experienced trauma (Richardson/Kianewesquao & Reynolds, 2014). In their work alongside Indigenous people preparing to speak publicly about their experiences of violence in Canadian residential schools, Richardson/Kianewesquao and Reynolds (2014) share

how they structure safety in therapeutic work with survivors by contesting neutrality, negotiating permission instead of assuming it, making potential risks apparent, anticipating backlash, holding space for hope, engaging in reflexive questioning, and not retraumatizing the person.

For music therapists, the limitations of safety and the potential for harm are vital considerations in clinical work due to music's influence on the experience and perception of safety. Studies have shown that sound and music seemingly carry safety-related information through elements, such as rhythm and timbre, that influence listeners' perceptions of security and/or danger (Sayin et al., 2015; Schäfer et al., 2015). Additionally, Murakami (2021) has presented the Music Therapy and Harm Model (MTHM) as a way for music therapists to better conceptualize the potential sources of harm, including music, within clinical music therapy practice.

Music therapy research has explored trauma-informed approaches in clinical practice, and within this framework, safety is considered a core component (Bensimon, 2020; Heiderscheit & Murphy, 2021; Lai et al., 2020; Lai et al., 2024; Scrine & Koike, 2022). Fairly recently, Lai et al. (2020) and Lai et al. (2024) have researched how music therapists describe providing safety and their perceptions of creating it for children and adolescents who experienced trauma. However, Scrine and Koike (2024) provide critiques that question the promise of safety in trauma-informed care and challenge the assumption of its presence. Instead, they suggest the practice of structuring safety in therapeutic work (Scrine, 2020) like the work described by Richardson/Kianewsquao and Reynolds (2014) by creating safe enough conditions for meaningful work to occur. Still, very little research is dedicated to how music therapists conceptualize safety.

Given the emphasis on trauma-informed care in clinical practice and the limited amount of research specifically about safety, the purpose of this thesis is to understand the concept of safety in the field of music therapy and how it informs practice, education, and professional interactions.

Methods

Grounded Theory

Because the primary aim of this study was to develop a theory of safety due to the limited conceptual understanding of safety in a music therapy context, a grounded theory methodology was utilized to answer the following research questions: 1) How do music therapists understand the concept of safety in the field of music therapy? and 2) How does their understanding of safety inform practice, education, and professional interactions? Narratives from a diverse group of music therapists were analyzed to uncover a shared understanding of safety (broadly) and safety in music therapy, a focus that is particularly significant given the emphasis in trauma-informed care in the field (Heiderscheit & Murphy, 2021).

Grounded theory is a qualitative methodology that aims to discover or construct theory from data systematically obtained and analyzed using comparative analysis (Chun Tie et al., 2019). In music therapy, grounded theory has been described both as a constructivist methodology (O'Callaghan, 2012) and as a socially constructed methodology (Matney, 2019). In this study, I take a social constructionist approach holding the belief that "the creation of meaning [is] through social contexts" (Matney, 2019, p.11).

This methodology provides the guidelines and approaches needed to achieve the aim of answering a rather broad question about a complex phenomenon through an iterative process

(O'Callaghan, 2016). The main procedures in grounded theory as outlined by Chun Tie, Birks, and Francis (2019, p.3) are displayed in the following graphic (Image 01):

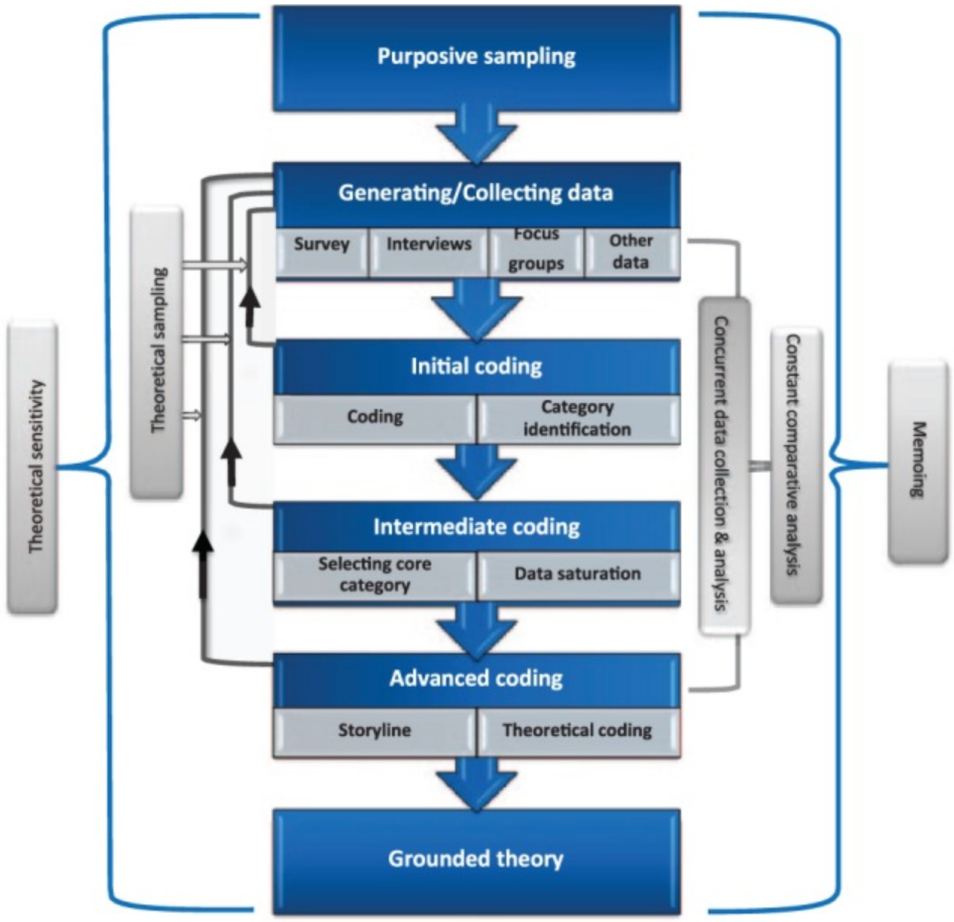

Image 01. "Research design framework: summary of the interplay between the essential grounded theory methods and processes" (Chun Tie et al., 2019, p. 3).

Participants

To be considered eligible for participation in this research study, participants had to be board-certified music therapists (or eligible to take the board certification exam) with at least six months of clinical experience post-internship to ensure that they had practical experience with situations requiring the creation and maintenance of therapeutic safety. International participants qualified if they met similar criteria in their respective countries of residence and practice. Participants needed to be proficient in English to ensure clear communication during interviews

and the accurate interpretation of their narratives during analysis. They also needed to have access to the Internet and an audio device to record interviews for transcription.

To recruit participants, the researcher posted an open call for participants on various social media platforms utilized by professional music therapists. Given the nature of this study, purposeful and snowball sampling were employed in order to obtain information-rich narratives. Purposeful sampling is a type of sampling in qualitative research where potential research participants are selected by the researcher because "there are things that can be learned from them" (Wheeler, 2016, p. 137). The type of purposeful sampling used can be referred to as theory-based sampling (Mertens, 2015) in that participants were invited based on their experiences within clinical, pedagogical, and professional spaces from a variety of sociocultural locations. Snowball sampling is a process where the researcher asks participants to recommend other people who might be knowledgeable about the topic (Mertens, 2015). As such, in this study, the researcher identified potential interviewees and individually reached out to them to request their participation in addition to the open call via social media.

Once potential participants expressed interest, they were required to complete a demographic information intake form to provide the researcher with more context about their background (Appendix B) to be considered for an interview. 27 potential participants completed a demographic information form. The researcher and their advisor reviewed the collected responses and invited 12 individuals to interview based on their responses on the demographic information form to ensure diversity of sociocultural locations (race, ethnicity, age, disability status, gender, sexuality, geographical location, and religious beliefs) and professional experiences (clinician, supervisor, and educator). 11 out of 12 invited participants accepted and completed the informed consent form and were interviewed. The selected participants were all

board-certified music therapists from diverse backgrounds residing and practicing in the United States with more than a year of clinical experience post-internship. See Table 01 for demographic information of participants.

Table 01: Participant Demographics

Age	29-45
Country of Residence	USA
Country of Practice	USA
Race	Mixed Race, Black, White, Asian, Brown
Ethnicity	European, Indigenous, Black, Jewish, Puerto Rican, Italian, Portuguese, Chinese Malaysian, South Asian
Gender Identity	Men, Women, Genderqueer, Non-binary
Sexuality	Straight/Heterosexual, Queer, Open, Pansexual, Lesbian, and Gay
Religious Beliefs	Christian, Buddhist, Hindu, Agnostic, Non-Religious, Other spiritual practice
Disability Status	Disabled and Non-disabled

Data Collection and Analysis

Selected participants took part in individual semi-structured interviews (Appendix C). The interviews took place over the video telecommunication platform Zoom and were recorded. They were subsequently transcribed by the telecommunication platform. One interview did not generate a transcript due to technical issues and user error and was transcribed using a transcription service, GoTranscript. The files for the audio recordings and transcriptions of each interview were downloaded and stored on a password protected device, and they were deleted from the cloud storage via Zoom. Each transcript, along with the appropriate accompanying audio, was independently reviewed multiple times. Initially, an open reading of each transcript was conducted. Subsequently, the researcher divided the transcripts into sections and performed open coding on the first section of each transcript using ATLAS.ti, a software qualitative data analysis tool. The researcher analyzed the responses and identified prominent themes found in the interview responses. After the initial analysis, participants had the chance to review their interview analysis and offer feedback via email (participants reviewed how their coded responses were used in supporting the findings). The researcher continued the process of analysis and review with the participants until saturation was reached.

Ethics and Trustworthiness

This research study was approved by the Slippery Rock University of Pennsylvania Institutional Review Board. The primary researcher and their advisor completed the required CITI training on the following topics: conflict of interest, social and behavioral research, revised common rule, and students conducting no more than minimal risk research. No conflicts of interest were identified by the institutional review board.

Before conducting interviews with participants, the researcher held four mock interviews with peers in their cohort. Each of these interviews was observed by either their advisor or a member of their thesis committee. After each mock interview, interviewees, the advisor, and members of the thesis committee provided feedback on the researcher's questions and how they conducted the interview. The researcher incorporated the feedback and made appropriate updates before starting the recruitment process for participants, including the wording of questions and additional sections in the demographic information intake form, like adding a section for "ethnicity." Also, it should be noted that these interviews, both the mock interviews and the research interviews, were conducted in the summer and fall of 2022, and all participants discussed the impact of current events, including, but not limited to, the COVID-19 pandemic, anti-racism movements (Black Lives Matter and Stop Asian Hate), and mass shootings.

Selected participants were emailed the informed consent form with an accompanying email explaining the purpose of this research study and were required to complete it before participating in an interview. Participants were given a list of mental health resources compiled by the National Alliance for Mental Illness (NAMI) before interviewing in the case of psychological distress or harm. Additionally, all participants were verbally informed by the researcher when meeting via Zoom that they were allowed to withdraw at any point during the

completion of the thesis. Both the recordings and transcripts of the interviews were anonymized by removing the names of participants and any employers or institutions with which they were affiliated and kept confidential on a password-protected device only accessible by the researcher. The anonymized transcripts were uploaded to ATLAS.ti and only accessible through password-protected accounts used by the researcher and their advisor. When conducting the analysis, the researcher used both the audio recordings and transcriptions of the interviews to ensure greater accuracy of the collected data.

The researcher also spent prolonged time with the data and utilized reflexive journaling throughout the interview and data analysis process for a clearer understanding of their reactions to the content. The researcher had multiple check-in meetings with their advisor and thesis committee and openly discussed their reactions to the collected material to prevent skewed analysis. As shared above, the researcher incorporated member-checking to ensure the most accurate interpretations of the interview content and used the participants' words to support the findings and confirm their inclusion in this thesis.

Due to the nature of the iterative process of grounded theory methodology, the review of the literature was continually conducted throughout the analysis of data, and the researcher included literature from the fields of safety and security science, healthcare, therapy, music therapy, education, and healthcare education for the literature review. In addition to this, the presentation of the findings for this thesis will not follow the conventional structure of research literature. Instead, the process will be presented in the order of refining the concept, findings, interpretations, and conclusion. The subsequent sections will be supported by the literature and direct quotes from participants’ interview responses.

Refining the Concept

Definition and Theory

As mentioned in the review of the literature, safety is often defined by what it is not rather than by what it is (Blokland & Reniers, 2019), so it was not surprising that the interviewed participants shared experiences of being unsafe or experiencing harm. Still, their narratives and responses to the interview questions allowed me to identify what was present during their described experiences of safety instead of what was absent. This was prevalent when identifying conditions for safety, like well-being. For instance, Cara Liss stated, "I do not believe in this idea that we should ignore our own safety in order to make a space safe for clients. I just don't believe it. I don't think it's good for the clients. I don't think it's good for us." As such, this statement describes the importance of well-being in experiencing safety.

Additionally, the proposed theory that will be presented in the findings was determined because a point of saturation was reached during the data analysis and could not be broken down any further. All the interviewed participants endorsed the different components included in the theory. Considering the total number of interviewed participants, 11, and their diverse backgrounds, it was pleasantly surprising to find an unanimously shared conceptualization of safety in music therapy contexts.

Interconnectedness Between the Determined Settings

After conducting the review of the literature, issues of safety, both physical and psychological, frequently arose in clinical and professional interactions (Edmondson & Lei, 2014; Frazier et al., 2016; Nembhard & Edmondson, 2012; Newman et al., 2017), especially in healthcare settings (Edmondson et al., 2016; Groves et al., 2021; Johnson & Delaney, 2006; Nembhard & Edmondson, 2006, 2012; O'Donovan & McAuliffe, 2020a; O'Donovan &

McAuliffe, 2020b; Svensson, 2022) and therapeutic work (Allison & Rossouw, 2013; Bensimon, 2020; Erkkilä & Samaritter, 2023; Geller & Porges, 2014; Heiderscheit & Murphy, 2021; Lai et al., 2020, 2024; Richardson/Kianewesquao & Reynolds, 2014; Scrine & Koike, 2022). Furthermore, the implications of psychological safety have garnered attention in human development (Wanless, 2016), and research has highlighted its importance in the fields of healthcare (Edmondson et al., 2016), education (Edmondson et al., 2016; Higgins et al., 2011), and healthcare education (Johnson et al., 2020; Park & Kim, 2021; Roh et al., 2021; Stephen et al., 2020; Torralba et al., 2020; Tsuei et al., 2019; Turner & Harder, 2018). Thus, the three areas identified for this thesis were music therapy clinical, pedagogical, and professional contexts, and the interview data highlighted the interconnectedness of the three identified contextual spaces for this thesis.

When asked to clarify if their response to a question about fostering safety in the clinical context was about professional spaces and contexts, Peony explicitly stated, “Yeah, it does. But it's also for me, it's [all connected].” It should also be noted that almost all clinical work occurs in professional spaces as identified for this thesis. Additionally, many interviewed participants shared the similarities between working with clients and students and interns in terms of fostering safety. Overall, the interviewed participants highlighted how people need to feel enough safety to take the risks necessary to achieve growth in personal (Allison & Roussouw, 2013; Bensimon, 2020; Geller & Porges, 2014; Heiderscheit & Murphy, 2021; Lai et al., 2024; Richardson/Kianewesquao & Reynolds, 2014; Wanless, 2016), educational (Edmondson et al., 2016; Higgins et al., 2011; Roh et al., 2021; Stephen et al., 2020; Tsuei et al., 2019; Turner & Harder, 2018), and professional (Edmondson & Lei, 2014; Frazier et al., 2016; Nembhard & Edmondson, 2012; Newman et al., 2017) contexts discussed in the literature.

Role of Music

From the responses gathered, it appears that music influences the perception of safety. As evidenced by the work of Sayin et al. (2015) and Schäfer et al. (2015), music, its elements, and sound can carry safety-related information that directly impacts the listeners' perception of safety, and this was discussed in detail by all interviewed participants. For instance, Brawly shared how rhythm and the structure it provides can support feelings of safety by saying:

> I think that, you know, rhythm as a dimension or an element of music can contribute to safety building and structuring … maybe there's been some, um, a musical experience in improvisation that's been a little bit more arhythmic, you know. It's like [hesitance]. … It was like a noticeable shift when the, you know, these other harmonic instruments, piano, the guitar came in, and, like everybody, was like, and everybody was in. It was just kind of like everybody felt like, "Oh, now we can go," right? Or, like, "now we can, we, we feel comfortable enough and safe enough," or whatever, whatever the terminology is here to like, actually like, be in the music, right? And I just, and we talked about that afterwards. It's just like, "What was that?" you know? Because everybody was like real tentative, like, "Where's the thing? Where [where's the beat]? What's the, what's the vibe? Do I go? Is it my turn? Is it your turn?" But then there was something when that drop really really dropped and was really anchored. Um, everybody was, it just, it was instant. Everyone was was flexin', you know? … I think some of the power of of rhythm and rhythmic elements and and steadiness, or like that groove, you know, being able to support um potentially, yeah, safety [and] people.

Music also can provide a direct metaphorical representation of experiencing safety. For example, Peony discussed the temporal structure of music and how it is representative of experiencing occurrences of safety by saying:

> With risk of oversimplifying things, I think one of the things that I find most important about finding safety [in] music is the temporal structure of music in, in the context that we think of it like a song, or like a piece or something that has an ending. Um, and it represents a moment in time. And I think for me that's important, that there are moments in time where you can experience a feeling of safeness and, and music. … I think that's a reassurance more than a point of anxiety that that those things do exist, those experiences [do] exist, even though they sometimes can be rare. I mean for some people, maybe it's not more common and longer in duration.

Additionally, engaging in music is a direct representation of one of the previously shared definitions of experiencing psychological safety – the feeling that taking interpersonal risks will not result in embarrassment, ridicule, or shame, enabling people to engage, connect, change, and learn (Wanless, 2016). Engaging in music with others inherently includes interpersonal risk. Inviting someone to play an instrument or sing in front a person who is a professional musician is a huge ask. This can also make things more complicated in group contexts due to the reactions and responses of peers. Thus, as clinicians, our responses, both musical and non-musical, to a client's "performance" can directly impact their experience and perception of safety.

Engaging in music with others can also foster connection and relationships. All interviewed participants discussed how shared music experiences, ranging from group improvisations as described previously in this section to listening to preferred recorded music

with other people, can provide opportunities for connection between people, and the relationships that can form as a result are where we can experience the conditions for safety.

Conversely, the ways in which music can be harmful as noted by Murakami's (2021) MTHM were identified as well. Grant shared:

> I get very passionate about [how music can be harmful] because I've just, I've seen it go so wrong. And I've seen clients be harmed because it's "just music," and I've seen clients be harmed because [music therapy students didn't] understand the power that they have when they hold a guitar. Because I've seen students not understand the power that they have when they're facilitating a drum circle and they're begging someone by leading them into sharing, even a drum solo, when that client is not ready. When we are not prepared for, or have not done the trauma work, or we are trying to work outside of our scope of practice – that scope of practice is there because music is powerful because music can cause harm.

As they shared, it is important for us to be aware of the music and its elements, context, and content, and how it could potentially impact the clients we work with.

Sociocultural factors

According to the responses of the interviewed participants, sociocultural factors directly impact a person's perception of safety, and the intersections of their identities and the power and privilege they experience from them influence how they navigate the precarious nature of fostering safety. Regarding the perception of their own safety, interviewed participants with privileged identities noted the ways in which their privilege afforded them the experience of safety whereas interviewed participants with marginalized identities discussed how they were

often aware of threats to their safety, both psychologically and physically. For instance, Blaine shared:

> I'm also just a white male that also I think, in general, I'm a pretty gregarious guy. I feel often non-threatened socially, culturally, and I also think I generally give off non-threatening vibes. From that aspect, personally, I feel pretty comfortable in my setting due to a lot of my privileges as well. I also live in an area that I am not dealing with that. I have white privilege and things in a not the most diverse area, but I also parent children of color. There's [an] extra layer of that as well.

Grant shared, “Let me preface this by saying I fully understand the body that I'm living in, right? I am a white man. … If I need to be, I can be straight-passing, right? So, … I will lean into privilege, if I need to, right?” They followed this with:

> The culture that I grew up in was if I am who I am, then I’m going to hell. If I am who I am, then I deserve to be beaten. If I am who I am, I deserve to not have autonomy over my own body. [It] really created a foundation that I know that myself and a lot of queer people … and a lot of people with disabilities, and people of minority status, … have to be cognizant of and again find those, find that safety, create and cultivate that safety because the environment doesn't necessarily teach us that we can [find safety].

Interestingly, interviewed participants with privileged identities tended to discuss threats to their safety as threats to reputation whereas interviewed participants with marginalized identities were more explicit about how negative perception due to systemic oppression could escalate to them and others with shared identities experiencing violence due to their own personal experiences. For example, Natalia shared:

> I think that because of my own sociocultural like navigations, I take offense to it because I remember being in a bunch of different work dynamics where the Black and the Brown kids were the ones that were deemed difficult, aggressive, um, or the ones that … needed to do like the least in order to get the police called on them, or they need to do like the least in order to get codes, you know, called on them, um, and it was a very, like, it's such a fucking difference, you know?

Given their experiences, interviewed participants shared that being in spaces where their identities are affirmed allowed them to feel more safety and comfort. This consideration was extended to their work with clients, students, and other professionals as well. Some of the examples that contributed to this experience were:

- Inclusive paperwork that allows clients to self-identify instead of providing boxes with pre-determined responses to check off
- Disclosing their identities, including disability, gender identity, and sexuality, in their workplaces and being affirmed appropriately (referring to them with correct pronouns and names; using inclusive language like spouse or partner; providing necessary accommodations and checking in if they are sufficient or if more are needed)
- Providing information in multiple languages
- Offering telehealth sessions or virtual classes
- Flexible scheduling
- Having different kinds of seating available

Overall, the collected responses highlighted the importance of culturally reflexive and sustaining practice and anti-oppressive approaches in the field of music therapy especially when fostering safety.

Trust

Trust, defined as the willingness to be vulnerable to the actions of others (Frazier et al., 2016), could be considered a necessary condition for safety for the proposed theory. A necessary condition is a condition that must be present for an event to occur, but it alone is not enough to cause the event (Brennan, 2022). All interviewed participants discussed this condition in their responses, and it was identified in different contexts. Lorelei discussed the importance of trust in relationships and the challenges of building it in a digital space by saying:

> There's an acknowledgement and a trust that we have shared values and then can, you know, even if we disagree about something, I can go back to, "Oh, but, like, I thought we're prioritizing empathy?" or, "we're prioritizing efficiency," or whatever it is, and so there's this ability to have an exchange or explore or discover, or even just like talk through options, even if it's not very elegant

Lorelei also said, "It was just hard to verify my relationships with my students. [L]ike, how do I demonstrate being trustworthy when, like, it's just [disembodied] to some degree, even if [it's online] classes?"

The felt sense of trust can be challenging to reach because trust is typically established and demonstrated over time. However, efforts to establish trust can be made during initial interactions. For example, Kukui shared a situation in which they explicitly name the racial medical bias to the people they work with by saying, "'I do not have the experiences of what you experience as a Black woman going through chronic pain going through the American healthcare system, but I just want to let you know that I believe you. I will believe you with anything you want to share about your pain and your experiences with the American healthcare system.'"

Autonomy and Agency

Many of the interviewed participants spoke to the importance of agency, described in this thesis research as the capacity to act on one's own accord, and autonomy, described in this thesis research as the right to make one's own decisions, in connection to each other. However, autonomy and agency were not determined to be necessary conditions for safety for the proposed theory.

In particular, the participants primarily spoke about autonomy and agency with respect to exerting or having control, especially when someone is unsure of or afraid to work with someone in a position of greater power, like a therapist. For instance, Bugsy shared:

> I really believe in resistance and lines of flight and stuff like that. Like, basically if a child or a client is saying "no" in some way, … my belief is to really validate that, to not like push or force it, and to actually name and encourage, like, "oh wow," you know, like, "that was really good communication." And then, you know, of course, 'cause I'm working with little ones, … we're working on how to see things, right? So, some of what I want to make a point to teach refusal and to teach claiming space, right? [S]o we've done the song where we say, "I need," someone says, "I need space," and then everyone backs away, and we practiced that so that it's, applicable in other settings kind of thing. So, yeah, encouraging refusal and responding to refusal and no one being in trouble for it is a big one.

However, when exerting autonomy, agency, and control directly leads to harming oneself or others, it is directly in opposition with safety. For example, when discussing their work with children, Grusha shared:

> There are times when I do, like, gently block the door with, like, little children who will run out all over the place. So that is, like, a decision I make to keep them safe, while also still trying to give them choices, and, like, I will let them leave the room [if] they need to leave the room, and like verbalizing what's going on, so that they don't feel like I'm trapping them in the room.

Iris noted the further complication of these areas when working with hospitalized children by sharing:

> I do think about their physical safety, too, especially with children with boundary setting and stuff like because I, I have trouble with boundaries, like, with myself and with setting up with children [most definitely] because children, like, they're playing and exploring but then, if I have set a boundary, like, "oh you can't like jump on the bed with your IV in. That's not safe," … to really communicate that this is not me with as a grown up with these arbitrary rules [about] what you can or can't do it. It's me as the grown up who's responsible for your safety or concerned about your safety, so like communicating that I'm cognizant of like their physical safety.

Although these responses spoke to working with children, there are implications for working with older people, including adolescents and adults, particularly if they pose a risk of harm or danger to themselves or others. As such, autonomy and agency could be considered necessary conditions for safety in some cases but not all.

Power and Responsibility

All interviewed participants discussed how power influences interactions and perception of safety. Kukui shared:

> That position of power as a therapist also innately gives me that feeling of safety, too. Even though we are trying to equalize the power dynamics between me and the client, [it's] still my responsibility to support them [and] to initiate that process and take [the] lead in that process for a more equitable experience between me and my clients. [S]o yeah, no matter how we try to make those power dynamics more equitable, more equal, we, the therapist is going to be in power, right, within the session.

Power is not inherently a bad thing. Being in a position of power is not inherently a bad thing. It is the misuse of power that often harms others. As shared by Grant, "If you have the power, then you have the responsibility. If you don't have the power, then the responsibility may belong to someone else." The person in power cannot deem a space safe for everyone present. However, the person with the most power in the relationship has the responsibility to initiate the difficult conversations/interactions needed to structure and foster safety. This can be complicated by systems of oppression, including, but not limited to, systemic racism, patriarchy, and cisgenderism. People with marginalized identities are more likely than those with privileged identities to have their positions of power challenged. For example, a queer Black nonbinary supervisor may be met with frequent microaggressions from their white coworkers and students. As such, the ability to exert one's power responsibly could be a necessary condition for safety but being in a position of greater power is not a necessary condition.

Safety and Comfort

All interviewed participants discussed comfort in their responses. From the interviews, there appears to be a relationship between comfort and safety, but they are not the same. Comfort cannot be conflated with safety. Discomfort cannot be conflated with harm and danger. As

shared by Grusha, “Because discomfort does not necessarily mean that you're not safe. … I feel like discomfort can feel like you're not safe if you don't understand where it's coming from …”

Multiple interviewed participants shared that they believed they could handle more discomfort when they were experiencing safety. A great metaphor for this is the healing of a wound. When someone has an open wound, they need to have it cleaned with disinfectant to prevent further infection. That experience is often uncomfortable and sometimes painful, but it leads to a better outcome for healing. Another example is having uncomfortable conversations with loved ones. Such conversations occur typically because those are valued relationships that people want to continue, not end. Experiencing safety allows for a greater capacity for discomfort with the hope for a better overall outcome. As such, comfort and discomfort cannot be reliable indicators of safety.

Findings

Proposed theory:

Within ***music therapy contexts***, safety is a ***dynamic experience*** that is ***constantly negotiated*** and ***co-constructed*** by ***participants*** where ***care*** and ***well-being*** are prioritized in the relationship and ***conditions for safety*** are present.

Music therapy contexts are 1) spaces in which music therapy is practiced and conducted; 2) spaces in which music therapy is learned, taught, and trained; and 3) spaces in which people with the role of music therapist, music therapy educator, music therapy student, or music therapy intern are expected to demonstrate their knowledge and expertise of music therapy.

As stated previously, the three areas identified for this thesis were music therapy clinical, pedagogical, and professional contexts due to their prominence in the review of the literature,

and their respective descriptions were determined from the responses of the interviewed participants.

Dynamic experience – Safety is not static; it is a precarious and continuous, non-ending process. Absolute safety from specific/certain occurrences is conditional and timebound; relative safety is continuously reevaluated based on the context and circumstances present.

Kukui described safety as "a dynamic and moving process, and it's one of those like take one step forward and two steps back kind of deal. That's what makes us human, right?" Additionally, all interviewed participants discussed the challenges of both achieving and maintaining safety. For instance, Grant shared, "Once it's achieved, safety doesn't stay achieved, right? We have to shift and continually engage with safety. So, do I think that safety is possible? Absolutely, and it should be. I also understand that it can't happen in every context, and I also recognize [and] just assert that it, it, once it's reached, it doesn't self-maintain. Well, especially within the systems that we're working in".

Constantly negotiated – Refers to the ways that we seek, manifest, foster, and experience safety. Safety occurs within an interactional context in which there is some form of exchange. The degree to which someone experiences safety is dependent on the actions, efforts, and contributions of interacting participants.

All interviewed participants expressed constant negotiation in their responses. For example, when asked to what degree safety could be achieved, Brawly discussed safety being both a dynamic process and constantly negotiated by saying, "Can it be achieved? That's why I say it's a trick question. I don't know that it can be achieved. Maybe it's like the cultural humility thing where it's a, it's a, an ongoing, active dynamic process, you know. Um, that is, I think maybe it's constantly negotiated." Peony expressed a similar perspective through saying, "I think 'achieved'

is such a like, a final, like, provide some kind of finality to the quest. And so, I'm, I'm somebody who's of the understanding that, you know, safe spaces as they as they are don't exist. Safety, safeness, I think present themselves. I don't think it's something that is accomplished or achieved. I think it occurs. And I think it's based on so many things that we've already talked about."

Co-constructed – Within music therapy contexts, all involved participants are actively and continuously engaged in shaping, structuring, and influencing the experience of safety. Safety cannot be generated nor provided by a sole participant.

All interviewed participants discussed how safety is a relational and collaborative effort and how the participating collaborators can influence the perception of safety. For example, Cara Liss shared, "Because safety is a two-way street, there are places where I feel comfortable that others are not comfortable with me being." Natalia shared, "what do you do to make clients do anything, you know? Do I make clients do anything, you know? Like, am I taking away their ability, or the willingness, or their like inherent right for a consent? Like, am I really making, or am I – Because I think I define therapy as more of like a space where we co-create." Iris shared a sentiment that reflected the previously stated responses by saying, "so I think right now I am striving to like work with the definition of safety that is co-constructed and collaborative that the group or the community decides what safety is and what it looks like" and "that definition of safety should be one that's reached by a group or by a community, and that what safety looks like should be a like collaborative co-constructed effort. That one person cannot decide like what safety means for a group or for a community".

Participants are the active contributors present and in relationship with each other who interact with one another. Participants can include people (clients, therapists, students, other

professionals, peers, etc.), community, environment, and music. Participants' interactions and responses determine how safety is experienced by them.

All interviewed participants discussed not only how the people interacting impacted their perception of safety but also how their environment influenced it. For instance, Lorelei and Blaine discussed how an online environment impacted their feeling of safety by sharing the following responses:

Lorelei: "I would say I feel the least safe in maybe something like Internet forums. [T]here's something about like the disembodied nature of a lot of social media, I think that I'm, I feel like I'm not getting a lot of feedback about how I'm coming across. Yeah, so, I think situations in which I'm not getting meaningful feedback about how I'm coming across and that could be for a lot of reasons".

Blaine: "we can have different opinions and not blast each other on the Internet because I feel the Internet is the main space that, which sounds so old to say the Internet, but I do feel the online world is where most music therapists are interacting in a big professional sense because not everybody has a nearby network. The nature of the Internet is people are usually shitty to each other on the Internet."

Care is an intentional process to prevent harm or danger by which actions are taken to better the conditions for participants. Participants who experience care feel valued and affirmed. Care, as an action, is a necessary condition for safety.

The concept of care was identified in the literature (Groves et al., 2021) and discussed in a variety of ways by all the interviewed participants. It was noted to be of importance especially for those that experience less power in relationships, like students in pedagogical spaces. For example, Lorelei stated, "It feels like to me that my students are looking for both knowledge and

care. A different level of care than I expected from my professors". Iris shared, "I think that helps people [feel] safety with me, and I think it's probably mostly because they just feel like I like care about them, which something that, unfortunately, a lot of students don't always feel from their teachers".

Well-being is the state in which you receive the necessary contributions to promote physical, social, and emotional health and being. Participants experience well-being when receiving care. When well-being is prioritized, conditions are present for growth, freedom, and expansion. Well-being, as a state of being, is a necessary condition for safety.

The aspect of well-being was discussed by all interviewed participants. In addition to the sentiment shared previously by Cara Liss, Grusha highlighted well-being in their personal definition of safety by saying, "I think there's a physical component, so that your body, it's not going to be harmed, or it's going to be healthy. If there is stress on your body, you know you're going to bounce back from it. Um, but there's also like emotional safety. This, knowing that, like you, can emotionally handle something similarly to physical, and I think there's also like a spiritual, social, spiritual safety of something that's just more like with your identity, and like who you are, you can be who you are, and be accepted."

Conditions for safety are factors that need to be present for people to experience safety. These include "necessary conditions" for safety, including trust.

Although a shared understanding of safety was ultimately derived from interviewed participants' responses, various unique factors and conditions were identified as well. As Blaine shared, "I think also recognizing that how I might feel safe is not how other people might feel safe [is important]." With that consideration, interviewed participants discussed authenticity and the ways in which it helps support feelings of safety, but it was not identified as a requirement

for everyone. For example, Bugsy shared, “I honestly think that the authenticity piece works both ways where I'm pretty openly how I am. And I don't think that that makes everyone feel comfortable by any means, but I do think that it makes some people feel safer to witness someone like me be in this field or do well.” As such, authenticity is not considered a necessary condition for safety within the context of the findings of this thesis.

Interpretations of Findings

Implications for clinical work

As shared by Scrine and Koike (2022), safety cannot be assumed in music therapy practice. It cannot be guaranteed. Operating under the assumption that music therapists and, by extension, music therapy are safe is inherently dangerous. Due to the dynamic and precarious nature of safety, if we operate under the assumption that once safety occurs it is permanently achieved, we can cause harm to the people with whom we work.

An implication from the findings in this thesis is that the approach described by Richardson/Kianewesquao and Reynolds (2014) of structuring safe enough spaces to do meaningful work is most likely the best approach in fostering the experience of safety in music therapy practice. The proposed theory highlights what we need to convey to those working with us, especially in situations where there is an inherent power dynamic that is not egalitarian.

One approach to structure safety could be establishing guidelines for interactions. Blaine described their process of doing this by sharing the following responses:

- It's also when appropriate, setting ground rules of just simple things like, “Hey, we can share whatever, do whatever, you're not going to scare me with a song or something like that, or your thoughts or whatever, but we are going to be kind to other people.”

- I think other things are intentionally saying those things like, “Hey, we're not going to talk at each other like that,” and setting up those ground rules like I just mentioned and really setting it up to be a place that you can share whatever. You can even have hurt feelings about other people. It's okay to be mad at someone. It's not okay to be a jerk to people.
- I think you have to make some compromises for the group for everyone feeling as safe as possible because there's more convoluting factors of group dynamics of if someone doesn't feel safe, they're probably not going to tell you that they don't feel safe, or that you're going to realize that they left the group and didn't come back because of that. I think that's where you have to be more upfront about those respect guidelines.

As previously mentioned by Bugsy, it is important to not label resistance as merely insubordination. Cara Liss expanded upon the possible role of resistance by sharing, “One of my biggest frustrations is that I see so many kids taken out of therapeutic services because they won't participate. And I think what they're doing when they are not participating is [surveying] for safety.” In my experience as a clinician, this often means not doing “textbook music therapy” in some instances. For example, letting a client refuse a session when they do not want to have one (even if caregivers or other staff are saying they need one) or having seemingly mundane conversations about various topics, like video games or snacks. Clients need to know that you can be present for them in their entirety and wholeness without judgment.

Additionally, we need to be aware of limitations and, essentially, stay in our lanes. We should not push for anything unnecessarily. For instance, if a patient is admitted to a hospital for a surgical procedure, how important is it that the music therapist on staff dive into their traumatic experiences in their home life? Can the staff available when the music therapist is not present

hold the complexity of the patient's trauma? If so, what happens when the patient is medically cleared for discharge, but they are still working through trauma with the music therapist? There are many considerations to determine what level of practice we should engage in with clients, and just because we have the skillset necessary to work in these areas, it is not always appropriate or safe to do so.

Lastly, it is vital to understand that experiencing safety happens in relational contexts. Despite policies and protocols, institutions cannot keep people safe. The relationships people have with each other and the communities they are part of determine the experience of safety (Edmondson & Lei, 2014). As such, developing meaningful relationships and connections are necessary conditions for safety and more efforts should be made in teaching people how to be in relationship safely with others.

Implications for further research

Although a screening process and purposive sampling were utilized when selecting participants, convenience sampling limits the perspectives included in this study. In particular, having an open call via social media does not reach all music therapists. Purposeful and snowball sampling were utilized to mitigate that limitation, but both approaches are limited to the researcher's and participants' networks and awareness at time of recruitment. Furthermore, all participants volunteered, so vital perspectives are likely missing from the data analysis and thus cannot be representative of the entire music therapy community.

If possible, this research would be much stronger if the perspectives of music therapy clients were included and analyzed. Given the nature of recruitment, most interviewed participants were in the multiple roles included and impacted by the power differentials identified in this thesis research (student, educator, client, coworker/colleague, supervisee,

supervisor, etc.). However, despite many interviewed participants expressing and sharing their experiences in therapy, not everyone interviewed was a client of a music therapist. Given the unique aspects of our profession, there is an element that is missing from this research design, and I hope that future research can and will incorporate client perspectives.

Due to the initial stages of this understanding, it was difficult for me to focus on just one of the three determined areas (clinical, pedagogical, and professional). I hope future studies can focus more intently on just one of the areas identified, especially in pedagogical and professional spaces and for perspectives of music therapists on their safety. Often, there is a focus on music therapy practice when the topics of safety and trauma-informed paradigms are studied, so providing a broader scope of these concepts in the other areas of our profession is needed because they do not solely occur within the context of conducting clinical work.

Just as structuring safety is a non-ending process, I hope this definition and proposed theory do not stay stagnant. I hope that as we gain and develop more language and become more intentional with our efforts, we can continue to review and update our understanding of safety accordingly and appropriately.

Conclusion

As showcased by the interview responses, people can have a shared understanding of safety, but how they experience it is unique to the individual and their context. All of the interviewed participants endorsed each of the components of the proposed theory, and the components could not be broken down any further. Additionally, the attempt to structure safety within the research process and data collection – including, but not limited to, allowing participants to drop out whenever they wanted, providing mental health resources prior to

conducting interviews, practicing via mock interviews, and researcher preparedness – provided opportunities for vulnerable and open responses that allowed me to identify the various themes that ultimately developed the proposed theory.

Music therapy is uniquely positioned in its capacity to foster safety. In addition to the ways music therapists can inform their approaches with the research conducted in related fields about physical and psychological safety, music can directly influence perceptions of safety. When navigated carefully, music can further develop trust and connection within relationships with others. However, music can be dangerous and cause harm if not approached with the appropriate care and understanding.

Overall, safety is a precarious and dynamic experience that occurs in relational contexts. As such, music therapists need to be aware of how they engage with other contributors when structuring safe enough spaces for meaningful work. The degree to which safety can be achieved is not fully agreed upon, and some do not believe that it is possible. However, if there is enough safety fostered and structured in the relationship, meaningful and transformative experiences can occur.

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Appendix A

IRB Approval

Slippery Rock University of Pennsylvania

TO: Dr. Susan Hadley
Music Therapy

FROM: _____
Michael Holmstrup, Ph.D., Chairperson
Institutional Review Board (IRB)

DATE: May 17, 2022

RE: Approval is Pending Receipt of Requested Information

Protocol #: 2022-086-56-A
Protocol Title: Understanding the Concept of Safety in Music Therapy

The Institutional Review Board (IRB) of Slippery Rock University has received and reviewed the above-referenced protocol, under the "exempt" category and requires the following information and modifications ***before*** approval can be granted:

1. This is not an intervention, and therefore does not qualify as Exempt Category 3. If satisfied, it would be appropriate for Exempt Category 2. One minor request, please provide a specific list of resources to cope with psychological risk in the consent form. Participants may be hesitant to reach back out to the investigators.

Please include a memo detailing how you have addressed the required changes including the name of the principal investigator, the protocol number and the protocol title. Also, include a copy of the protocol with any changes to the original protocol highlighted. Please include two copies of the consent form (if applicable), one with any changes highlighted and the other should be a final version to be stamped and returned to you.

Please contact the IRB Office by phone at (724)738-4846 or via email at irb@sru.edu if you have questions.

As shared in the methods section, participants were given a list of mental health resources compiled by the National Alliance for Mental Illness (NAMI) before interviewing in the case of psychological distress or harm.

Appendix B

Demographic Information Form

Understanding the Concept of Safety in Music Therapy Demographic Information Form

Please complete this form if interested in being a participant in this qualitative study. All responses are kept confidential. You will be contacted if selected to participate.

* Indicates required question

1. Name *

2. Pronouns *

3. Age (You must be at least 18 years old to participate in this study) *

4. Country of Residence *

5. Country of Practice *

6. Are you proficient in English? *

Mark only one oval.

- ◯ Yes
- ◯ No

7. Do you have access to the Internet and an audio recording device (such as an internal/external microphone found in a laptop, tablet, or mobile device)? *

Mark only one oval.

- ◯ Yes
- ◯ No

8. Are you a qualified music therapist in your country of residence and practice with at least six months of clinical experience post-internship? *

Mark only one oval.

- ◯ Yes
- ◯ No

9. Do you have experience in the following roles (check all that apply): *

Check all that apply.

- ☐ Music Therapy Clinician
- ☐ Music Therapy Student/Intern
- ☐ Music Therapy Educator
- ☐ Supervisor for Pre-professional Music Therapists (Supervising music therapy students and interns in clinical placements, practicum/internship sites, etc.)
- ☐ Supervisor for Professional Music Therapists (Provides clinical supervision to music therapists)
- ☐ Recipient of Professional Music Therapy Supervision
- ☐ Therapy Client

10. Race/Racial Identity *

11. Ethnicity

12. Gender Identity *

13. Sexuality *

14. Religious Beliefs

15. Disability Status *

16. What accommodations, if any, can be provided if selected to participate?

17. Email address for contact *

18. If there are any additional methods of contact you would like to share with us, please provide them here

Appendix C

Interview Questions

Briefly review consent form with person. (I know we know each other, so I'm separating this data from our personal relationship... this is why I may ask even if I already know the answers) Give time parameters and say *"I've gotten enough, thank you, so I want to ask*.../check in about time/ thank you, you gave me what I needed)

Participants will be asked to share their demographic information, the context of their current professional environment, and their career path as it relates to the study topic. (Can you tell me about your music therapy journey? What led you to music therapy? Where are you now?)

How are you feeling about being interviewed (by me if we know each other)?

1. In your own words, define *safety*.
2. In your own words, how do you know that you are experiencing safety?
3. In what ways does your sociocultural location influence your perception of safety?
    1. Given your sociocultural location, in what contexts do you feel most safe?
    2. Given your sociocultural location, in what contexts do you feel least safe?
4. Next, I am going to ask about the ways you attempt to foster and/or structure safety in different spaces and settings.
    1. In clinical spaces (conducting music therapy)
        i. What do you do to feel safe in the role of therapist?
        ii. What do you do to make clients feel safe?
        iii. Are there any differences between working with an individual and with a group? If so, what are they?
    2. In educational and pedagogical spaces (with students, interns, and practicum students)
        i. What do you do to feel safe when you are in the role of educator and/or supervisor?
        ii. What do you do to make students and/or interns feel safe?
        iii. Are there any differences between working with an individual and with a group? If so, what are they?
    3. In professional spaces (such as your workplace, supervision, conferences with other professionals and colleagues)
        i. What do you do to feel safe?
        ii. What do you do to make others feel safe?
        iii. Are there any differences between individual (one-on-one) and group interactions and experiences? If so, what are they?
5. In what ways can music foster safety? What is its role (in fostering safety)?
6. To what degree do you believe that safety can be achieved? What thoughts, beliefs, considerations, experiences, etc. inform your response?

Potential Supplemental Questions (these may be asked if more information is needed to better illustrate their initial responses):

- 1a. How do you define other kinds of safety?
- 1b. Is there a relationship between safety and comfort for you? Can you handle more discomfort when you are experiencing safety?
- 2a. If you are comfortable sharing, can you describe a personal experience when you felt safe?
- 2b. Describe feeling unsafe. If you are comfortable sharing, can you describe a personal experience when you felt unsafe.
- 2c. In what ways do/does [sociocultural location] make you feel safer/less safe?
- 4d. How do power/control/sociocultural location impact your sense/feeling of safety?
- 4e. Can you describe/imagine what conditions would need to be in place to not feel safe?
- 6a. How does this belief change in different environments or contexts? For example, is this different in different areas (clinical, educational, and professional)?