

**THE EXPERIENCE OF MAD MUSIC THERAPISTS:
AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS**

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PHENOMENOLOGICAL ANALYSIS

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Abstract

THE EXPERIENCE OF MAD MUSIC THERAPISTS: AN INTERPRETIVE
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This study aims to develop an in-depth understanding of the lived experience of mad music therapists. The term “Mad” is employed throughout this study in the fashion of activists and academics alike as it pertains to the areas of Mad Studies and Mad Pride. The usage of this term to describe the participants in this study seeks to pitch a wide tent to encompass the shared interests of individuals with lived experiences consistent with what in may be referred to as “mental illness,” “neurological disorder,” or “mental difference.” Semi-structured interviews were conducted with professional music therapists (N=6). Transcribed interviews were coded with Atlas.ti software to generate themes. An interpretive phenomenological analysis was conducted to explore the potential impact of mad identity on the perception of stigma, self-disclosure, therapeutic relationship, and clinical efficacy. Seven themes and 51 subthemes appeared in the data: 1) navigating authenticity, 2) construction of self, 3) professional implications, 4) dimensions of the therapeutic relationship, 5) access to support, 6) sanism, and 7) ecological perspectives. Findings further understanding of the strengths and challenges particular to the experiences of music therapists who identify in this way.

Dedication

For Nagypapa

Acknowledgments

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CHAPTER 1: INTRODUCTION

Motivation for research

Long before I began training to become a music therapist, I was a patient--a consumer of mental health care. In fact, my own personal experiences of music as a means of self-expression, emotion regulation, and social connection were the first inklings that drew me to the field of music therapy in the first place. Much like the Mad music therapists interviewed in this study, my personal journey with mental health is interwoven with my development as a musician and later as a music therapist. I turned to singing and songwriting as a source of comfort and security in my darkest moments, and I found refuge in the sense of artistic community found in choirs and theatre productions. The journey of building my technique as a vocalist runs in parallel with my personal development to find my voice.

I have always been in awe of the ability of music to so perfectly encapsulate emotions, especially the feelings that felt far too big, far too unsafe to hold in my own body. That is still what mesmerizes me about opera. As a soprano, it is not lost on me that I was always drawn to the so-called “Mad Arias.” The Elektras and Lucias of the world had their space—a stage even—to feel their feelings, and the depth of their emotion was allowed to erupt in an outpouring of artistry, met with admiration and applause. Wanting to connect others with the transformative potential of the creative process, I set out to be a music therapist.

In my senior practicum as an undergraduate, I had the opportunity to create a group music therapy program with a fellow student on the psychiatric unit of a local detention center. Getting to know these incarcerated women, making music with them, and hearing their stories, I was most struck by a sense of sameness. Despite what I had been taught in my coursework about the roles of “therapist” and “patient,” these feelings recognizing a deeply shared humanity led

me to question this clinical binary of us and them. Week after week, I would bring into supervision these questions, struggling to find language to articulate the feelings that were evoked for me in this work. If I had some of the same diagnoses and took the same medications as these women, why exactly was it that I got to sit in the “therapist’s chair” and they had to sit in the “patient’s chair”? What about my life—my family of origin, my race, my class—allowed me to get to this scenario in which I was supposedly the “healer” and they “needed to be healed?”

These curiosities carried me through to graduate school, in which I really began to crack open my understanding of music therapy as a helping profession. My coursework prompted a great deal of learning and unlearning, and I grew to understand myself as a therapist and a sociocultural being. My personal and professional commitment to politicizing the therapeutic relationship grew, and I worked to unpack my self-of-the-therapist. I gained a wealth of language to describe the intersection of my race, gender, sexuality, class, religiosity, and ability. The area of critical disability studies and online communities of neurodivergent music therapists planted seeds that eventually allowed me to consider dis/ability in terms of my own mental illnesses. As I explored new ways of conceptualizing my identity as it pertained to my own lived experiences in mental health care, I tried on new language. I sought out the work of scholars and activists that explored mental illness/wellness in new ways. On this pursuit, I was introduced to the burgeoning field of Mad Studies. Not only did I find language that felt fluid enough to encapsulate the laundry list of sometimes contradictory diagnoses that I had collected over the years, I found voices which challenged me to reconsider the ways in which I was taught as a therapist to assess “disorder.” An interesting paradox emerged. Critique of psychiatry seemed

personally liberating, yet on the other hand, seemed to call into question my own chosen career path in mental health. The present study seeks to dive into that intersection.

Mad Studies

LeFrancois, Menzies, and Reaume (2013) define Mad Studies “as a project of inquiry, knowledge production, and political action devoted to the critique and transcendence of psy-centered ways of thinking, behaving, relating, and being” (pp. 13). Music therapy literature has explored therapist self-reflexivity through the lenses of other identities and critical perspectives, and the present study seeks to build upon this tradition through the lens of Mad Studies and Mad identity.

The term “Mad” is employed throughout this study as an umbrella term which seeks to encompass a plurality of experience that maintains utility in coalition politics among consumer/survivor/ex-patient advocacy, Mad Pride, anti-psychiatry, and disability justice movements. The usage of this term to describe the participants in this study seeks to pitch a wide tent to encompass the shared interests of individuals with lived experiences consistent with what in may be referred to as “mental illness,” “neurological disorder,” or “mental difference.” This language, though used in many healthcare contexts, demonstrates an assumption of pathology that may not accurately reflect the lived experience of individuals labeled in this manner. The significance of this phenomenon should be of interest not only to those individuals labeled as “other” but also to the *labelers*, a category largely composed of mental health professionals. However, a simply dichotomous/binary understanding of *labeler/labeled* fails to consider the possibility that one of *the labeled* might become a *labeler* or vice versa. The observed phenomenon of *music therapists who are also mad* or *mad persons who are also music therapists* stands to problematize the neat categories often utilized by the dominant Western

medical perspective. Mad Studies, like many perspectives in a tradition of critical theory, stands to critique dominant narratives of what is *normal* in terms of human expression and *being*.

Definition of terms

No term in the history of madness is neutral, not mental illness, madness, or any other term—Geoffrey Reaume, Mad People’s History

As explored throughout this study, the language one uses to articulate one’s identity and sense of self is both personal and political. As reflected in the voices of study participants, academic literature and professional mental health discourse, a variety of terms can be used to construct what is referred to throughout this paper as a “Mad Identity.”

Mad/Madness. A “complex and contested term,” madness used in the context of this paper as a reclamation in the spirit of Mad studies and Mad-positive activism (Rashed, 2019a). This descriptor includes lived experiences that from a traditional medical perspective would be referred to as “mental illness” or “mental disorder.” Price (2013) wrote, “As with *queer*, the broad scope of *mad* carries the drawback of generality but also the power of mass” (p. 299). The intentional use of this word by so-identified individuals follows in a standing tradition of reclamation as disability rights advocates have done with “crip” and the feminist movement has done with “bitch.”

c/s/x. This is an acronym found in Mad and disability studies literature to denote “consumer/survivor/ex-patient” of mental health care. Similar to “Mad,” this use of language is an attempt at depicting the spectrum of lived realities resulting from interaction with mental health care ranging from benign to abusive (Price, 2013). Similar uses of language include “service user within mental health care” and “consumer of care.”

Sanism. Ehlert (2020) describes sanism as “the systematic oppression of people who have experiences often labeled as mental illness” (p. 99). Other terms like “mentalism” and “ableism” are often used interchangeably in the literature.

Mad Pride. This is an activist movement which works to critique psychiatric systems and medical narratives that over-pathologize mental differences, problematizing what constitutes “normal” behavior and experience. Members of this movement explore peer-run alternatives to traditional mental health care and support. The start of this movement can be traced back to 1886 to the seminal establishment of Elizabeth Ware Packard’s *Anti-Insane Asylum Society* (Lewis, 2013).

Neurodivergent. A term coined by Kassiane Asasumasu, neurodivergent is a label indicating any neurotype that diverges from what is socially constructed as “typical.” While it is most often associated with self-advocacy movements of Autistic and ADHD people, this concept includes individuals with learning disabilities, epilepsy, Madness, and other ways of being characterized by atypical neurology.

MMIND. This acronym is found in online organizing spaces to denote the identity markers of “Mad, mentally ill, neurodivergent, and disabled,” recognizing the co-conspiratorship of these allied movements while honoring the distinctions of these descriptors.

Paradigm and Assumptions

This research inquiry operates within the assumptions of social constructionism. Identity is understood as a discursive process situated within a sociocultural context. Madness, like disability, is understood from a social model rather than the dominant medical model (Beresford & Russo, 2016; Rashed, 2019b; Wallin, 2013). The present study seeks to further progress

towards epistemic justice by centering lived experiences of mad music therapists, adopting an ethic like the axiom of disability justice: *nothing about us without us*.

Context of the researcher

I, as the researcher, bring the conditions of my own lived experience with me to this research. My own lived experience as a service user in mental health care has fueled a personal interest in Mad Studies as an area of academic study as well as in Mad Pride as a movement of social justice. Engaging in regular self-reflection and interpersonal reflection throughout this research process has aided in my pursuit of understanding of this topic for personal, professional, and political reasons. Some of my other sociocultural identities such as whiteness and financial means have enabled me to experience unearned advantages in accessing mental health care. Concurrently, other aspects of my identity like gender and sexuality have influenced my experiences of marginalization as they pertain to my own Madness. Little about these intersecting identities is discrete and tidy, so it has remained essential to rely on careful self-reflection as I have engaged with participants' stories, parts of which rang true to my own, while others diverged considerably.

CHAPTER 2: REVIEW OF THE LITERATURE

This review of the literature seeks to explore foundational concepts in Mad Studies as they pertain to the practice of music therapy. By reflecting on dominant ways of thinking within mental health professions, the realities of sanism even within mental health disciplines and the contributions of Mad practitioners available in present literature, one can begin to appreciate the positionality of Mad Music Therapists. This overview is an invitation to a more robust discourse of anti-oppressive practice and an opportunity to reevaluate an often falsely rigid understanding of the therapeutic relationship as an interaction between a “healed therapist” and a “client in need of healing” (i.e. labeler and the labeled).

Music and Madness

Clinicians and philosophers alike have wrestled with possible links between madness and creativity (Cooper, 2022; MacKinnon, 2003, 2006). What is the relationship of music and madness: Is music an expression of madness, a cure for it, or a co-conspirator with madness? Claridge and Barrantes-Vidal (2013) held that a fully dimensional understanding of madness or, to use their term, psychoticism would differentiate between state and trait characteristics, like state versus trait anxiety. In their view, clinically significant psychoticism is not creatively generative; however, personality traits associated with madness may indeed support the creative process. For instance, just as some anxiety is functional and indeed supports adaptive progress towards the anxious person’s goals, other human experiences often pathologized in medical psychiatric contexts like fantasy may also serve adaptive and creative purposes. By divesting from a strictly medicalized understanding of psychiatry, one might come to understand the “healthy side of madness”: creativity (p. 115).

From traditional indigenous healing practices to contemporary creative arts therapies, music has played a role in the *treatment of or healing from* Madness (Jackson, 2015; Unkefer & Thaut, 2005). In an important distinction, however, the practice of music therapy cannot be understood as inherently beneficial to or allied with a Mad Studies perspective. In fact, music therapy practice that fails to unearth and attempt to reconcile the normative and therefore oppressive foundations of some music therapy practices only stands to further harm Mad individuals (Castrodale, 2019). Growing efforts in community music therapy and community music appear to be moving towards an anti-oppressive stance by incorporating Mad service-user perspectives in music therapy (Baines, 2014; Castrodale, 2019; McCaffrey, 2018).

If not a symptom of nor a salve for madness, music may play a crucial role in *singing truth to power*. Castrodale (2019) illustrated ways in which the ability of mad-positive music can powerfully present counter-knowledge, complex radical narratives, and lived-experience of Mad activists to mental health practitioners. Rather than prioritizing musical aesthetics (e.g., tempo, dynamics, lyrics) that seek “to calm, render complacent, encourage coping with the present world injustices,” mad-positive music holds space for the dissonances of a Mad experience (p. 42).

Epistemic Justice and Mad Narratives

Crichton et al. (2017) defined epistemic injustice as “a harm done to a person in her capacity as an epistemic subject (a knower, a reasoner, a questioner) by undermining her capacity to engage in epistemic practices such as giving knowledge to others (testifying) or making sense of one’s experiences (interpreting)” (p. 65). In music therapy, the notion of epistemic injustice has been considered when working with children (Klyve, 2017) but not specifically with Mad individuals. Mad individuals are often more vulnerable to epistemic

injustice at the hands of physicians, educators, and colleagues due to prejudiced stereotypes about what it means to experience Madness. One of the central critiques of the field of psychiatry offered by Mad activism is of the epistemic *violence* by which “certain persons or groups within society are disqualified as legitimate knowers at a structural level through various institutional processes and practices” (LeFrancois et al., 2013, p. 123). Exclusion of Mad voices in the fields of psychiatry and similar mental health professions not only disempowers Mad individuals’ ownership of their story but also may lead to poorer diagnostic and treatment outcomes (Crichton et al., 2017). Experiential knowledge comprised of social, emotional, and embodied knowledge informs the expertise of Mad individuals in the realities of living and coping with mental illness, stigma and navigating complex systems to receive adequate support (Grim et al., 2022). Despite growing support in music therapy and allied mental health fields, implementation of service-user knowledge may face significant barriers, such as stigmatizing beliefs held by policymakers, and the pervasiveness of deficit-based models (Grim et al., 2022).

The task of epistemic resistance, that is, using epistemic resources to change oppressive normative structures (Medina, 2012), is the responsibility of researchers, educators, and practitioners in fields like music therapy. Mad-positive, anti-oppressive, and recovery-oriented mental health care philosophies champion service user knowledge and Mad narratives in evidence-based practice through means like participatory action research and consumer-focused program evaluation (Baines, 2014; Grim et al., 2022). In clinical contexts, a growing number of community mental health agencies and addiction recovery programs are employing the help of peer support services (Shalaby & Agyapong, 2020). The Substance Abuse and Mental Health Services Administration of the United States delineates the core competencies of peer support workers as: recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-

informed (Substance Abuse and Mental Health Services Administration, 2023). Peer support workers are trained professionals employed by mental health institutions to participate in treatment by providing psychosocial support, often in group settings (Grim et al., 2022).

When mental health professionals seek out Mad narratives, it is critical to maintain a stance of receptivity to Mad narratives that fail to conform to dominant narratives (Daya et al., 2020; Gosselin, 2022). Mad narratives may differ from medical disease trajectory as presented in some graduate courses focused on diagnosis and assessment and instead these firsthand accounts may be characterized by spiritual transformation, a double-edged sword, or an internal site of growth (Rashed, 2019b). For some, the collective struggle towards social justice is central to their story. Gosselin (2022) explained that “proponents of Mad identity reject the psychocentric view of mental illness that views it as necessarily disabling and focus on the way mental illness experience is integrated, sometimes in a positive way, into one’s identity” (p.#).

Mad stories disrupt clear-cut dimensions of voice like temporality, sociality and place (Hess, 2022). Consequently, Hess (2022) proposed that authentic understandings of Madness and musicking necessitate *polyrhizovocality*: “a way to consider both the multiplicity of voices (which may occur in a single person) alongside the rich textures of the dimensions of voice.” The present study seeks to position itself as an act of epistemic resistance, centering the authentic voices of Mad music therapists.

Moving Past “Recovery”

Growing support for service user involvement in mental health care has grown in tandem with a recovery-oriented perspective or the “recovery model” (Solli et al., 2013); however, simply adding service users to the workforce does not create the necessary paradigm shift (Slade et al., 2014). The intent of mental health recovery is to support service users’ “right to a safe,

dignified, and personal and gratifying life in the community despite [their] psychiatric condition” (Davidson et al., 2009, p. 11). Through the lens of recovery, the espoused liberation occurs *despite* Madness as opposed to liberation from a carceral psychiatric system and cultural values that privilege non-Mad ways of being in the world.

The recovery model does make a considerable effort to move past a strictly medicalized, deficit-based understanding of Madness and disability, instead focusing on social and contextual factors associated with rehabilitation (Solli et al., 2013). Shifting from coercive treatments and medication dominant in conventional institutional responses, community mental health responses support self-determination and leverage a holistic range of therapeutic support services (Slade et al., 2014). Considering this development, proponents and practitioners of community music therapy and resource-oriented music therapy have often embraced the ideals of the recovery framework and service user contributions (Solli & Rolvsjord, 2008; Solli, 2008; Solli et al., 2013).

The recovery model of disability and mental illness could benefit from further exploration and incorporation of a social justice approach to disability and Madness (Mahaffey, 2019). Mahaffey (2019) conducted a collaborative inquiry, a participatory research methodology, in a community health center with occupational therapists and disabled clients. Results suggested the education about critical disability studies and discussion of disability rights advocacy founded on the social model of disability strengthened the helping relationship, and findings recommend the recovery model of disability and madness could benefit from further exploration and incorporation of a social justice approach to disability and Madness. Mahaffey (2019) recommended development and implementation of a curriculum for service users and providers to explore topics of disability and mad studies through a collaborative inquiry approach that

could effectively promote self-determination. Mahaffey (2019) problematized simplistic narratives that depict linear recovery arcs, instead maintaining that “proponents of stigma reduction must reconsider their reliance on the use of overcoming illness stories. This study suggests that these stories serve only to increase the public's perception of the seriousness or dangerousness of psychiatric disability” (p. 1).

Cvetovac and Adame’s (2017) narrative content analysis of 10 published memoirs of therapists with personal experience cautioned against universal criterion for recovery and instead calls for future research to explore means of support therapists to cultivate self-awareness around their lived experience and its relationship to clinical work. Integrating lived experiences with professional identity appears to be a critical step in identity development for these therapists. Of note, very few characterized this as *healing* or recovery.

Decontextualized recovery narratives of individualistic overcoming of “illness” deflect from social inequalities (Woods et al., 2022). Woods et al. (2022) critiqued the “Recovery Narrative” as circumscribed and too frequently co-opted by neoliberal institutional agendas to produce “normal,” economically productive members of society. While they concede that sharing personal experience through narrative can be a tool for liberation, Woods et al. (2022) maintained that situating narratives within sociopolitical contexts is essential to a critical disability and Mad Studies lens.

Contextualizing a Third Space

In creating a Mad Studies movement, one must honor heterogeneity of experience and resist the temptation of a neat, unified survivor/recovery narrative (Russo, 2016). Beresford and Russo (2016) maintained that the success of Mad Studies will be realized with an integration of theory and practice. This effort should not primarily be in the service system or the academy, but

the effort should also seek to connect with and honor the contribution of service-user led organizations. Intersectional analyses of these contributions remain essential.

Co-production of knowledge in mental health—collaboration between experts by experience and experts by education—promises what Homi Bhabha (1994) referred to in postcolonial theory as a “Third Space.” This possible heterogeneous landscape is one where dominant and subjugated perspectives can intermingle and hybridize. Rose and Kalathil (2019) translated this idea to Mad Studies context, holding that co-production of knowledge—whether in participatory action research or user-involvement in community health settings—often retains the “residue” of hegemonic hierarchies and dualisms in academic and governmental settings. Thus, narratives that present knowledge without social context, relying heavily on individualism or universalism, preserve dominance of a white, Eurocentric understanding of Madness:

If this knowledge draws on elements of Enlightenment thinking, if it uses the methods of mainstream “psy” science and its hidden epistemology, if it does not reflect on white privilege, is it then a White Mad Knowledge which excludes racialized groups in a way that aligns with both the academy and society generally in the Industrialized West?

(Rose & Kalathil, 2019, p. 6)

The Third Space can only be realized when sociocultural realities are used to contextualize the narratives, knowledge, and research we seek to center.

Collective artmaking between providers and consumers in a mental health setting has been explored as a potential Third Space. Lewis and Spandler (2019) used a critical feminist lens to analyze mutuality and power relations in a community-based participatory arts project that involved both art therapists and community participants. In this setting, art therapists served as “studio managers” and community participants were “studio members.” Mutual art-making acted

as a “social leveler,” facilitating human connection that blurred binary notions of *us* and *them*, instead bolstering a shared identity of *artist*. A critical reflexive lens remains crucial, for dimensions of creative expression might also reinforce or reconstruct social hierarchies (i.e. using certain mediums like sculpture or advanced techniques indicating extensive formal training). Likewise, Lewis and Spandler (2019) urged sensitivity to sociocultural positionalities. Role navigation was considered a nuanced constructive process through which participants could navigate social asymmetries. This open studio setting allowed for “role reversals” in which studio members offered interpretations of “studio managers’” creative work. This re-evaluation of boundaries was not always smooth, and art therapists shared a perceived need to control how vulnerable and transparent they were in their art-making process, still holding to professional ethos of preserving a therapeutic relationship. Overall, this community-oriented, mutual approach of shared participation offered opportunities for humanistic connection and re-negotiation of professional boundaries in a mental health setting.

Similarly, according to Castrodale (2019), music can be a “pedagogical site” for critiquing psy sciences, resisting sanism, and furthering Mad Pride. Mad-Positive Music has the potential to enlighten music therapists and other psy-professionals about Mad experience, psychiatric violence, and Mad activism (Castrodale, 2019). As anti-oppressive movements strive to de-pathologize ways of being, mad-positive music seeks to de-pathologize ways of musicking. Music can be a site of resistance and Mad pride by offering authentic aesthetic representations of Mad experience and lyrical critique of the psy-professions.

Stigma and Sanism

Public Stigma

Sanism functions within a web of interlocking oppressions such as racism, sexism, and colonialism (Wolframe, 2012). Stigma can consist of pejorative labeling, negative attitudes, status loss, social distancing, and discrimination (Njaka et al., 2023). Prevalence of mental health stigma is understood to be diminishing over time (Cain, 2000; Kolbeinsen, 2022); however, public perception of Mad people as threatening, incompetent, irresponsible, and less human persists, often insidiously (Njaka et al., 2023). Bias can lead to disproportionate scrutiny of physical and verbal presentations, parenting abilities and professional capacity (Wolframe, 2012). Acting on stigmatizing notions, or *sanism*, not only impacts those diagnosed with mental health conditions, but a growing body of research suggests that *associative stigma* may impact the social standing of mental health professionals, and stigma by association may further contribute to professional trends such as burnout (Njaka et al., 2023).

Sanist microaggressions occur when pejorative language associated with mental illness is used to represent that which is dangerous, discreditable, unpredictable, or flamboyant and thus conveys implicit bias (Gosselin, 2022). Casual parlance of words like “insane,” “psychotic,” “maniac,” and even use of clinical diagnoses like obsessive compulsive disorder (OCD) as hyperbolic descriptors (e.g., “she’s so OCD about her closet”) uphold reductive stereotypes about Madness, subtly demeaning the experience of people with mental illness. These linguistic and symbolic indicators of implicit bias are often reinforced in media representations of Madness. Of particular relevance to creative arts therapists, romantic depictions of creatives as tortured, mad geniuses in the media may contribute to discrediting the voices of Mad self-advocates (Alacovska & Karreman, 2022).

Music therapists and other professionals within the field of mental health may be well positioned to address stigma both inside and out of the therapy room. Firmin et al. (2017) characterized stigma *resistance* as “an ongoing, active process of using one’s experience, skills, and knowledge to develop a positive identity” (p. 2) and proposed this form of self-advocacy as an important therapeutic intervention.

Professional Stigma

Aside from stigmatizing beliefs held by the public, stigma can often be inconspicuously held by individuals working in the field of mental health (Cain, 2000), and witnessing routinely stigmatizing behavior can lead to internalized stigma for Mad mental health professionals (Zerubavel & Wright, 2012). Professional stigma may be a primary concern for Mad mental health professionals and especially inhibit disclosure to colleagues in their field (Vally, 2019). Stigma, particularly among helping professionals, often leads to concealing support needs and avoiding help-seeking behavior (Tay et al., 2019; Zerubavel & Wright, 2012). The impact of stigma may increase when mental health professionals move from a therapeutic role with clients to a gatekeeping role (e.g., a supervisor or program director) and publicly advocate for their profession (Zerubavel & Wright, 2012).

Sanism can also hinder professional advancement in one’s field, resulting in Mad therapists being passed over for promotions (Cain, 2000). Colleagues and supervisors may perceive Mad therapists as personally responsible for their impairments or attribute a moral shortcoming to their Madness (Zerubavel & Wright, 2012). In a similar fashion, Mad individuals may be advised to pursue “less stressful” occupations (Wolframe, 2012).

Elliot and Ragsdale (2020) interviewed practicing psychotherapists ($n=12$) who identified as having a mental illness about stigma, disclosure, and impacts on their practice. Thematic

analysis of these semi-structured interviews highlighted a prevalent perception of stigma among fellow mental health professionals. Prejudicial attitudes and witnessing discriminatory behavior discouraged participants from disclosing their experiences to colleagues in the workplace.

Similarly, results from a 2018 survey conducted by Tay et al. indicated that psychologists who identified as having a mental illness were more likely to disclose in social settings over professional settings due to concerns about the negative consequences of disclosure. Tay et al. (2018) surveyed 678 UK-based clinical psychologists to evaluate prevalence of mental health problems, stigma, self-disclosure, and help-seeking. These phenomena were assessed via standardized measures, including the Social Distance Scale, Stig-9, Military Stigma Scale, Secrecy Scale, Attitudes towards Seeking Professional Psychological Help Scale-Short Form, personal experience, and demographic questions. 62.7% of respondents reported personal experience of mental health problems. Measures of stigma suggest that there is greater likelihood of Mad clinical psychologists anticipating stigmatization from others for their lived experience than the likelihood of stigmatizing others or self.

To assess incidence of and probable disclosure of mental health challenges among 348 trainee clinical psychologists in the UK, Grice et al. (2018) utilized standardized measures on a web-based survey. 67% of respondents endorsed personal lived experience of a mental health concern (this includes but is not limited to DSM and ICD criteria for diagnosis). Maladaptive perfectionism, as assessed by the Multidimensional Perfectionism Scale, was negatively correlated with anticipated disclosure. Findings were consistent with a conclusion that trainees with greater incidences of maladaptive perfectionism were more likely to conceal information that might be appraised by superiors as negative. These findings suggest stigma is a mediating factor in disclosure of mental health concerns among these trainees.

Sanism within helping professions is often reinforced by institutional policies. Practices around professional regulation often reinforce stigma against practitioners with disabilities and conditions such as mental illness (Stanley et al., 2011). Regulatory bodies in place to enforce gatekeeping measures for health professions can and do restrict individuals from working based on “fitness to practice.” Interviews with health professionals and students ($N=60$) highlighted the role of current licensure practices in excluding individuals with both seen and unseen disabilities (Stanley et al., 2011). Thus, material ramifications like the possibility of losing licensure may deter Mad professionals from disclosing their identity in professional spaces.

It has been noted that stigma may vary based on specific symptoms of diagnoses (Mula, 2022). Perceptions of “dangerousness” of psychosis versus rather benign perception of panic may contribute to greater stigmatization of schizophrenia as compared to panic disorder (Zerubavel & Wright, 2012). Indeed, Cvetovac and Adame (2017) speculated that there may be more perceived stigma against Mad therapists with identifiable diagnoses rather than consumer-practitioners whose “psychological wounds” are greatly tied to a particular traumatic event. Stigma may vary based on the nature of the therapists’ personal experience, the way the therapist conceptualizes and conveys their experience, and the nature of the supervisory relationship (Cvetovac & Adame, 2017).

All in all, professional disclosure may invite hostility or judgment upon the Mad therapist, and supervisors and peers may perceive Madness as an impairment (Zerubavel & Wright, 2012). In light of this stigma, disclosing one’s identity as a Mad therapist may be an act of advocacy and activism, positioning Mad mental health professionals as advocates for mental health, both experts by education and experience.

Sanism in Educational Settings

Education and the culture of practitioner training programs influences the development of professional stigma (Cain, 2000). Huet and Holtum (2016) conducted an open-ended questionnaire survey of the British Association for Art Therapists to assess disclosure practices of art therapists during training ($N=20$). Survey questions sought to understand motivations for disclosure and decisions to not disclose experiences of mental distress. Respondents described both encouraging and discouraging reactions to disclosure in training contexts, citing perceptions related to professional stigma (e.g., judgment, perceived incompetence, fear of not being admitted to the training program) as barriers to disclosure. Furthermore, Ehlert (2020) described a sense of erasure evident in art therapy training, resulting from an assumed *us and them* binary between therapist and client. Though concealing a mental health history avoided judgment or rejection by peers, “passing [as sane] was a gift that also hurt” (p.#). Thus, Ehlert (2020) called for wider adoption of anti-oppressive praxis in education that is inclusive of disability justice discourse.

Stigma and ableism have also been explored in the context of music therapy education and clinical training (Warren, 2020; 2023). Warren (2020) examined the experiences of music therapy practica students with invisible illnesses and invisible disabilities, inclusive of chronic illnesses, mental illnesses, and developmental disabilities. In an online survey of 136 undergraduate music therapy students, 71 (59.7%) self-identified as having an invisible diagnosis. Mental illness was the most frequently reported invisible illness in the sample, with 45% of respondents identifying this way. Several participating students reported avoiding disclosure out of fears of mistreatment or possible removal from their practicum placement or

program of study. Students' experiences of stigma from peers and professors undoubtedly shaped their introduction to stigma in the field of music therapy.

Continuing her research in this area, Warren's (2023) dissertation delved into student and educator perceptions of ableism in music therapy education and clinical training. In this phenomenological inquiry, disability was used as an umbrella term for physical and sensory disabilities as well as chronic and mental illnesses. In a series of focus groups and through creative writing responses, both self-identified disabled music therapy students and educators explored the construct of prejudice against disabled people as it manifests in the field of music therapy. Students in this study reported a pervasiveness of the stigmatizing assumption that students with mental illness should not become music therapists or that personal therapy is a tool to be used solely in service of professional development. Stigma and marginalization were also furthered by experiencing or witnessing microaggressions from peers and professors. Participants highlighted foundational features of some music therapy curricula that perpetuate ableism such as behavioral approaches to practice that frame music therapists as "fixing" disabled people.

Given the implication that educational and clinical training practices perpetuate stigma in mental health professions, these spaces can therefore also be pivotal in eradicating stigma. Introducing theoretical frameworks of Mad Studies alongside other areas of critical discourse can address sanism in higher education (Wolframe, 2012). Important strides to this end have been made by incorporating critical disability studies perspectives in music therapy pedagogy (LaCom & Reed, 2014; Pickard, 2022; Warren, 2023) and queering music therapy pedagogy (Fansler et al., 2019), thus challenging hegemonic dichotomies and hierarchical thinking styles.

Mad Practitioners

Despite sanist assumptions that the categories of “patient” and “practitioner” are distinct, academic literature has begun to explore the prevalence of Mad practitioners and the impact of lived experience as a consumer of mental health care. After analysis of five studies examining mental health professionals seeking personal therapy, Norcross and Connor (2005) suggested that practitioners seeking therapy appear to be driven predominantly by personal motivations rather than for purely professional development. They noted that “presenting problems” demonstrated by Mad practitioners do not differ from the general populace. Similarly, Kalkbrenner et al. (2019) conducted a factor analysis using the Fit, Stigma and Value scale to assess mental health counselors’ ($n = 312$) pursuit of personal counseling. 90.3% of participants endorsed attending at least one counseling session in their lifetimes, with 27% of respondents reporting that they are currently in counseling. In addition, a 2015 survey of 6,112 licensed social workers suggested that four out of every 10 social workers have a history of mental health diagnoses (Straussner et al., 2018), suggesting that mental health concerns were just as if not more prevalent in this population.

Specifically within the field of music therapy, a survey of 932 music therapists reported that 74.01% of respondents have been in personal therapy at some point in their careers (Kendrick, 2021). Of the 418 respondents who had engaged in some form of therapy, most (79.9%) had received talk therapy and counseling. The second most popular modality of therapy was creative arts therapy (13.88%). The most frequently reported reason for seeking personal therapy was to “manage mental illness” (p. 208) (endorsed by 314 respondents).

Similarly, in collaboration with a variety of allied mental health disciplines in the United Kingdom, Richards et al. (2016) sought to understand how mental health professionals who are also service users in mental health care construct their identities as both “professional” and

“patient” through a discourse analysis. Participants included ($N = 10$) professionals from several allied disciplines (art therapy, nursing, management, social work, peer work, psychology, occupational therapy, and psychiatry). Identity constructions included separate “professional,” “patient,” “unintegrated,” and “integrated” identities. Some participants described a separation between the professional/patient dynamic that resulted in the “unintegrated” identity—a necessary capacity to switch back and forth. This dichotomous experience seemed to reinforce the dominant medical psychiatry model. Conversely, the “integrated” construction appeared to consider the professional/patient dynamic as complementary. Development of an integrated identity suggests a particular capacity for empathy and a potential for activism within the mental health field.

In sum, available research suggests that being Mad and being a mental health professional are not mutually exclusive, yet there remains a paucity of research characterizing the experience of Mad therapists and their professional identities.

The Wounded Healer Archetype

From Greek mythology and early Christian texts to Jungian analysis, the archetype of the wounded healer symbolizes those who encompass the duality of personal vulnerability and strength to serve others (Austin, 2002; Lunt, 2002). The healer’s own wounds are believed to hold curative power for others when shared (Zerubavel & Wright, 2012). This symbol often resonates with helping professionals with lived experience of adversity (Kolbeinsen, 2022). The use of this schema has been applied to the training and professional development of psychiatrists (Hankir & Zaman, 2013), psychologists (Cain, 2000; Zerubavel & Wright, 2012), social workers (Regehr et al., 2001; Straussner et al., 2018; Cuseglio, 2021), mental health nursing (Gilbert & Stickley, 2012), and music therapists (Austin, 2002; Lunt, 2002; Dunn, 2009; Kolbeinsen, 2022).

Zerubavel and Wright (2012) delineated the wounded healer as a framework for professional identity development. They underscored the importance of differentiating between the *wounded healer* and the *impaired professional*. Strengths of wounded therapists include greater empathy, patience, and tolerance for slow therapeutic processes, and adept positive use of countertransference. However, they also cautioned that mental health professions maintain an ethical responsibility of gatekeeping in situations where therapists may be impaired. They state that it is crucial that wounded healers and their supervisors are vigilant around boundary confusion or violation in clinical work. Professional ethics demand particular attention is paid to vulnerabilities of compassion fatigue or possibilities of vicarious trauma. Having considered these ethical concerns, Zerubavel and Wright (2012) were critical of the development of a professional “atmosphere in which it is stigmatizing to acknowledge vulnerability or woundedness” (p. 487). They underscored the importance of addressing matters of the wounded healer early in training. Indeed, they found it imperative that supervisors feel competent inquiring about trainee’s mental health and are responsive and supportive, remaining mindful of the tenuous line between distress and impairment. Ultimately, they recommended professional support like supervision and personal therapy alongside a call for professional organizations that cultivate cultures which invite support-seeking.

Woundedness and Madness in Music Therapy

While using the symbology of the wounded healer may be more commonplace in music therapists who more frequently draw from archetypal imagery in their clinical work (Austin, 2002; Lunt, 2002), the phenomenon of bringing one’s *woundedness* or Madness to the work of music therapy is not new. Music therapists have explored the particular capacity of music therapy processes like the Bonny Method of Guided Imagery and Music and Vocal

Psychotherapy to support posttraumatic growth of mental health practitioners with histories of abuse and trauma (Austin, 2002; Rinker, 2012).

Examination of the life and work of Mary Priestley reveals an early account of lived experience of mental illness informing music therapy practice (Hadley, 2001). Priestley, the co-developer of Analytical Music Therapy, cited her own lived experience as a psychiatric patient treated for what was then known as manic-depression as the exigence for her professional pursuit of music therapy. After being discharged from a psychiatric ward, Priestley pronounced to her mother, “One day I’ll do something for these people” (p. 32).

In 2002, Helen Lunt published a personal account in the *British Journal of Music Therapy* identifying with the “wounded healer.” Lunt explained that her lived experiences of schizophrenic psychosis and psychiatric hospitalization became a viable and precious resource in her clinical work in acute psychiatry. Similar to many first-hand accounts of Madness, she expressed concerns about stigma, worries about holding a job, wrestles conflicting feelings about taking psychotropic medications, and references the importance of self-care. Lunt credited her music therapy training as instrumental in learning to cope with her experiences of Madness and characterizes the support of her professors as critical to her success.

Similarly, Austin self-identified as a wounded healer and referenced her personal journey of healing traumatic childhood wounds as an instrumental catalyst in developing what is known today as Vocal Psychotherapy. Austin (2002) wrote about the capacity for wounded healers to experience enhanced empathy, compassion, insight, and conviction. Austin also noted the vital importance of viewing “the therapist as an instrument in constant need of tuning, an instrument that needs to be looked after and played with sensitivity” (p. 246) via personal creative expression, peer support groups, personal therapy, and supervision.

Music therapist, Henry Dunn (2009) followed a similar trajectory and described the “parallel journeys” of his and one of his earliest clients. Dunn recounted his childhood experiences with clinical depression, paranoia, and psychotropic medication, and he described his professional journey through music therapy that culminated in an integration of the wounded healer archetype. Most recently, Kolbeinsen’s (2022) master’s thesis, titled “Wounded Healers in Music Therapy” explored Norwegian music therapists’ experiences of mental health challenges, self-care, and stigma. A thematic analysis of interviews with five music therapists practicing in mental health care and/or substance use recovery contexts who self-identified as wounded healers yielded recurrent themes of shared human experience, stigma, and educational/professional life. Participants discussed how they viewed themselves (e.g., unique capacities and limitations resulting from mental health diagnoses), crucial resources (e.g., professional development, self-care practices), and their therapeutic role (e.g., situating themselves as part of a broader system of mental health care). Thus, in this study, music therapist participants underscored a sense of divided-attention, a meta perspective allowing insight into the experiences of their clients, regard for their autonomy, as well as attunement with professional and academic expectations and attitudes. Participants relayed their perception that language shapes how Madness or woundedness is perceived, and several participants critiqued popular use of diagnostic language (e.g., *depressed*, *anxious*) as casual adjectives, suggesting that this use effectively dilutes the clinical significance and overall utility of these terms. Boundaries emerged as an important sub-theme not only for ethically navigating the therapeutic alliance but also for establishing spaces to attend to one’s own mental health needs. Like in Warren’s research (2020; 2023), participants acknowledged the enormous responsibility of music therapy educators to adequately prepare wounded healers for their careers. Kolbeinsen (2022) called for more robust

education about and implementation of self-care practices in the education and training of music therapists. In congruence with a recovery model perspective, Kolbeinsen (2022) stressed that deeper understanding of mental health concerns as a typical part of the human experience can address stigma and promote help-seeking behaviors.

Mad Supervision

Clinical supervision is often cited as one of the most salient factors in the success of Mad therapists (Regehr et al., 2001; St. Arnaud, 2017; Wheeler, 2007). In a practical sense, establishing professional and academic cultures in which disclosure and help-seeking are supported is fundamental to ensuring ethical service delivery for consumers of mental health (Vally, 2019). Likelihood of disclosure in the context of a supervisory relationship may vary based on theoretical orientation of the parties involved. For example, Spence et al. (2014) found that behaviorally oriented practitioners more highly value a clear distinction between a “well” clinician and an “ill” patient than those who practice from other theoretical orientations.

Turner et al. (2022) put forth a theoretical framework for trainee psychologists’ disclosure of mental illness as it emerged from a grounded theory analysis. Motivations for self-disclosure to educators and supervisors appear to be driven by desires to be understood, the need to seek support, and a sense of professional values. Factors like safety and trust often facilitate disclosures, while perceived consequences for training and internalized stigma act as barriers. Reactions and responses from educators to self-disclosure were deemed most effective and positive when approached with earnest curiosity and a desire to actively listen rather than “jumping to fix.”

St. Arnaud (2017) highlighted the ambiguity produced by supervisory dynamics with wounded healers, blurring lines between personal therapy and supervision. They noted that

vigilance for parallel processes in the supervisory relationship necessitates awareness of possible transference toward the supervisor and countertransference toward the supervisee. Despite this ambiguity, Wheeler (2007) stressed that a trainee's wounds should not be avoided in supervision. She underscored that ethical standards do not allow supervisors to assume the dual role of supervisor-therapist; therefore, supervisors must delicately highlight the ways in which a trainee's firsthand experiences may impact their relationship with clients. It has been noted that non-judgmental reflection and disclosure of personal experience by the supervisor may aid in the development of a strong supervisory alliance (St. Arnaud, 2017; Wheeler, 2007), which is essential for effective supervision to take place. When working with Mad supervisees, Wheeler (2007) noted increased frequency of supervision may be necessary to ensure that the trainee is not practicing psychotherapy impaired by their symptoms. Self-care is particularly important for identified wounded healers and should be underscored by mentors (Dunning, 2006). Cuseglio (2021) stressed the importance of connecting to the wounded healer archetype in supervision to not perpetuate negative impacts of countertransference.

Also, stressing the need for competent supervision, Cain (2000) interviewed 10 psychotherapists (psychologists, social workers, and a psychiatrist) who had personal histories of psychiatric hospitalization, to determine the impact of countertransference on therapeutic relationships. Through thematic analysis four main themes emerged: 1) common countertransference experiences, 2) impacts on the therapeutic process, 3) processing these complex dynamics, and 4) experiences of stigma due to mental illness. Participants noted the fine line between identification with clients and over-identification with clients, a delicate reality best navigated with supervision and diligent self-care. Many participants described their personal experience as contributing to a sense of professional drive either to live up to the top-quality care

they received as patients or to seemingly rectify the poor-quality care they received by offering more empathetic care to others. Participants described negative impacts of countertransference as well, including distress, frustration, and internalized stigma. All participants perceived that positive countertransference seemed to promote empathy and rapport building efforts, thus increasing a sense of trust and hope. Awareness of interpersonal dynamics in therapy and professional ethics are essential for any helping professional. Wheeler (2007) stressed the importance of person-of-the-therapist work in supervision, especially for trainees with mental health concerns. In sum, supervision and personal therapy can have a role in ensuring safety for both therapist and clients (Zerubavel & Wright, 2012).

Disclosure

There is little research dedicated to self-disclosure in the context of the therapeutic relationship (Cvetovac & Adame, 2017). Mad therapists cite societal stigma as a significant barrier to disclosure (Cain, 2000). General acceptance and expectations of self-disclosure in the therapist-client relationship may vary based on clinical context; wherein, substance use or eating disorder counseling may more highly regard this therapeutic use of self (Zerubavel & Wright, 2012). There appears to be broad consensus among clinicians that self-disclosure as a therapeutic tool should be used delicately and judiciously (Elliot & Ragsdale, 2020; Turner et al., 2022).

By first examining motivations, Mad therapists can confirm that the disclosure acts in best interest of the client (Zerubavel & Wright, 2012). Zerubavel and Wright noted that benefits of disclosure include redistributing power in the therapeutic alliance, instilling hope, and increasing motivation to engage in one's own healing journey. They stated that some therapists may caution therapists away from disclosing active or ongoing concerns (Zerubavel & Wright, 2012), but clinical judgement and philosophical orientation often shape this deliberation. Jones

and Hutson (2020) explored the obligation of humanistic therapists to present “authentically” in the therapeutic relationship and therefore employ intentional self-disclosure in clinical work. However, Jones and Hutson (2020) maintained a sense of guarded ambivalence about the realities of public disclosure in the age of social media and internet discourse.

Disclosure for creative arts therapists may not always take place in a verbal sense but rather in the shared artistic space (Dunn, 2007; Huet & Holttum, 2016). Huet and Holttum’s (2016) survey of art therapists suggested that Madness may be self-evident through art; some participants shared that they felt their artwork articulated their lived experience and therefore disclosed this part of self. Equivalently, in a case study drawing parallels between therapist and client, Dunn (2007) articulated the perspective that verbal self-disclosure to his client would disrupt the therapeutic relationship and decenter the concerns of the client. On the other hand, Dunn explained that musical self-disclosure is not only possible but essential in the “joint play” of improvisatory music psychotherapy. A beneficial byproduct likely in the parallel journey of co-improvisation is the secondary personal growth of the therapist as they support the growth of the client. By authentically meeting the client in the music, the therapist can guide the client towards their own inner healer: “the result is an increase in our sense of wholeness, with the therapist acknowledging inner weakness, the client finding inner strength” (p.18).

Person of The Therapist

Music therapy literature has recognized that sociocultural identities and lived experience of the therapist shape both personal and professional development as well as clinical practice. Sociocultural identities of music therapists have been examined through the lenses of race (Hadley, 2013; Imeri & Jones, 2021; Norris, 2019; Thomas, 2021; Webb, 2019), gender (Hadley, 2006; Gumble, 2020; McSorley, 2020; Besse, 2021; Hardy, 2021), sexual orientation (Lee, 2019;

Hardy, 2021), disability (LaCom & Reed, 2014; Leza, 2021; Kalenderidis, 2020; Warren, 2020; 2023), religion (dos Santos & Brown, 2021), and fatness (Taylor, 2021). As society and academia come to understand Madness as a dimension of identity, so too should it be examined by music therapists and thus represented in music therapy literature.

CHAPTER 3: METHOD

Purpose Statement

The present inquiry seeks to address a current gap in music therapy literature by honoring the lived experiences of music therapists uniquely positioned to speak to the roles of both therapist and service user via their identities under the umbrella of Madness, thus contributing to a phenomenological understanding of the experiences of Mad music therapists.

Research Design

Interpretive Phenomenological Analysis (IPA) was selected to conceptualize participants' perceptions and the underlying meaning of the participants' lived experiences as they pertain to this phenomenon in the field of music therapy. This reflexive qualitative approach was utilized to explore the experience of what it is to be a Mad music therapist. Because identity is not solely a product of introspection but also one of interaction, social categories, especially this burgeoning category of *mad identity*, play a crucial role in construction of self (Rashad, 2019a). An interpretive rather than descriptive approach to understanding the data can more accurately reconcile and synthesize the multilayered perspectives of participants into a discussion of clinical utility of findings. The ontological understanding embodied in this research also respects the multiplicity of realities reflected in the voices of participants—a polyrhizovocality that is crucial to honoring Mad narratives (Hess, 2022).

Scholars in critical disability studies have critiqued the role researchers may play in reinforcing oppressive understandings of disability (Stone & Priestley, 1996) and Madness, by extension. Stone and Priestley (1996) put forth a framework of emancipatory research that the present study seeks to emulate. Principles of their paradigm have been adapted to align with a Mad Studies perspective.

Striving towards Epistemic Justice

The present research is epistemologically situated within a social understanding of disability and Madness as a human experience largely constructed by sociocultural forces.

Problematizing Objectivity

This inquiry and design did not strive for proposed “objectivity” of the researcher as espoused in positivist and post-positivist research. Rather, through diligent self-reflection via multiple reflexive practices (e.g., journaling, consultation with research advisor, artistic reflection), the researcher strove towards self-awareness and authenticity.

Politically Engaged

The researcher must not lose sight of the goal of improving the lives of Mad people by identifying and challenging barriers that are disabling or Maddening through this study. The researcher is tied to political action through the stewardship of these Mad voices, not only in production of the research but also through publication, presentation, professional advocacy, and political activism.

Destabilizing hierarchies

The researcher must seek to challenge hierarchies emblematic of the researcher-participant relationship. As similarly observed in Kolbeinsen (2022), this value is embodied in the decision to disclose the researcher’s Mad identity at the outset of interviews.

Personalizing the political and politicizing the personal

This study strives to honor the knowledge inherent in personal account while recognizing the variance of Mad narratives. Furthermore, it recognizes the value of these contributions to analysis of human rights and social justice.

Pragmatism

Though this thesis research has been carried out through a subjectivist design, the researcher does not hold a belief that this methodology must be the singular academic pursuit of Mad Studies. The researcher's stance remains pragmatic, with primary consideration attuned to making a material difference in the lives of Mad music therapists. Recommendations for future research need not be restricted to any particular manner of inquiry whether objectivist, constructivist or subjectivist (Matney, 2019).

Participants

Participants were at least 18 years of age and were qualified music therapists in their country of residence and practice (e.g., eligible to take the board certification exam in the United States) who also self-identified as a consumer/survivor/ex-patient in mental health care or as having a mental illness/psychiatric disability. This included having received a diagnosis (e.g., bipolar disorder, obsessive compulsive disorder, complex post-traumatic stress disorder) and/or receiving psychiatric treatment (e.g., psychotherapy, psychotropic medication, hospitalization for acute psychiatric care). Researchers prioritized recruiting participants with lived experiences consistent with diagnosed conditions such as bipolar disorder, schizophrenia, and/or personality disorders to center experiences of Madness that may be more marginalized or stigmatized (Mula, 2022). Due to the researchers' limitations, participants needed to be proficient in English and have access to the internet.

Of the six participants in this study, five trained and currently practice in the United States, and one was trained and practices in Australia. Two participants were second-career music therapists, meaning they pursued undergraduate and/or graduate degrees in music education, performance, and composition prior to training as music therapists. Also of note, two participants had completed academic degrees at the doctoral level (one in music therapy, the

other in another music field), and two participants reported current academic pursuit of a doctoral degree (one as a second doctorate, the other as a first).

Data Collection

This study was approved by the Institutional Review Board of Slippery Rock University (#2023-075-56-A). To recruit participants, a call for participants was posted to professional social media spaces and sent via email invitation to reach music therapists of varied sociocultural identities. Interested parties completed an interest form via Google Forms to submit demographic information. Of the 17 who completed the google form, six were chosen purposively to ensure a diverse group of music therapists with varied lived experiences. The consent form (see Appendix A) was signed and returned by all participants invited to complete a semi-structured interview via Zoom.

Semi-structured interviews

Recorded interviews were conducted in a live, virtual Zoom call and later transcribed. Interview questions (see Appendix C) were developed to guide the interview and were designed in such a way as to allow participants to share their perspectives on their personal and professional identity as well as their lived experiences and its impact on their development as music therapists. Participants were given the option of selecting pseudonyms to protect confidentiality. Some opted to maintain their given names as an act of pride and/or advocacy. At the outset of each interview, the researcher welcomed the participant and disclosed the fact that her own experiences of Madness were the impetus for this research inquiry. The interviews ranged from 35 to 75 minutes. After the conclusion of each interview, initial impressions were journaled on by the researcher, particularly noting any emotions arising because of shared

experience. Further creative reflection such as visual art, musical improvisation, and song writing were utilized by the researcher to promote reflexivity and continued self-awareness.

Data Analysis

Transcriptions approved by participants were uploaded to Atlas.ti software and read in several iterations by the researcher. Initial observations were reflected upon via journaling. Initial codes were noted as they emerged in the transcripts. After all interviews had been initially coded, codes were grouped and further analyzed to reveal emergent themes. Codes were then organized and consolidated into themes and subthemes.

Member checking

After semi-structured interviews were transcribed, each participant was emailed a copy of their interview and invited to offer corrections or feedback to ensure that their voices were accurately represented throughout the data collection process. Corrections offered were changed in kind. Additionally, after themes and subthemes were established by the researcher, a copy of the results section was emailed to each participant for further feedback to continue to center them as the authority on their lived experiences.

Ethical Considerations

Participants were not deceived in the course of this study and were aware of the purpose and rationale throughout the process. While there were no anticipated risks or discomforts as a result of participating in this research, interviews pose a minimal risk of breach of confidentiality and discussing one's identity can elicit emotional discomfort. To mitigate against the risk of breach of confidentiality, recordings were deleted as soon as the interview was transcribed, and participants were offered the chance to select a pseudonym. Resources were identified in the

Institutional Review Board materials and remained available if anyone experienced emotional discomfort and needed the care of a professional therapist.

Cultural and Critical Considerations for Research

Mad Studies and service user-led movements aptly critique the ways in which mental health care can be compulsory and coercive. Emerging discourse in Mad Studies literature notes the potential for “dilution of radical critique” by attempting to incorporate the efforts of service-led movements into institutions such as universities and health systems (Mckeown et al., 2018, p. 154).

Many marginalized groups have been historically pathologized by the “psy professions” (psychiatry, psychology, psychotherapy, and related professions inclusive of music therapy/music psychotherapy) (Spandler & Carr, 2021). The advent of medicine in the United States is inseparable from the realities of scientific racism and eugenics. Diagnoses of “mental illness” and “disease” were leveraged against enslaved Africans to justify the cruelty of physical abuse and confinement (Bailey et al., 2021). Calls to remove homosexuality as a diagnosed disorder, as enshrined in earlier versions of the Diagnostic Statistical Manual (DSM), coincided with the aims of the anti-psychiatry movement in the 1960s and 70s (Spandler & Carr, 2021). Similarly, psycho-pathologization of female bodies and sexuality has been critiqued and rebutted by feminist psychologists. Gender that does not conform to cisnormative designations are still pathologized and included as disorders in the DSM 5.

Early attempts at mainstreaming the activist sentiments in such professions often adopted “a distinctly white middle-class feminist perspective”—aligning with the dominant demographic of many of those professional spaces (Spandler & Carr, 2021, p. 133). To honor an anti-oppressive ethic, the researcher must recognize the power dynamic established by the research

process. Spandler and Carr (2021) stressed that it is incumbent upon the researcher to problematize “psy authority” and investigate personal and professional implications of wielding that power.

In short, it was not lost on me that I was simultaneously occupying the roles of several key stakeholders in the Mad Studies discourse: researcher (academic authority), therapist (psy authority) and patient/service user. As such, in my analysis of respondents’ stories, I was intentional in my consideration of the multiplicity of roles articulated by participants.

CHAPTER 4: FINDINGS

The purpose of this study was to explore the experience of music therapists with lived experience as consumers/survivors/ex-patients of mental health care. Six participants (see Table 1) engaged in semi-structured interviews which were transcribed and then sent to participants to ensure accuracy. Interviews were coded and managed using Atlas.ti software. After reviewing and analyzing the codes, seven themes and 51 subthemes appeared in the data. The emergent themes were: 1) navigating authenticity, 2) construction of self, 3) professional implications, 4) dimensions of the therapeutic relationship, 5) access to support, 6) sanism, and 7) ecological perspectives (see Table 2).

Demographics

Table 1.

Participant Demographics

| <i>Demographics</i> | <i>N</i> |
|---------------------|----------|
| Gender | |
| Cis-female | |
| Transmasculine | 4 |
| Genderqueer | 1 |
| | 1 |
| Years in the field | |
| 0-5 | 2 |
| 6-10 | 1 |
| 11-15 | 1 |
| 21-25 | 2 |
| Racial identity | |
| White | 5 |
| Latinx | 1 |

Emergent Themes

Table 2.

| <i>Themes</i> | <i>Subthemes</i> | <i>Endorsed (N=6)</i> |
|---------------|------------------------------------|-----------------------|
| Navigating | Masking | 3 |
| Authenticity | Concealing identity | 5 |
| | Internal conflict about disclosure | 5 |

| <i>Themes</i> | <i>Subthemes</i> | <i>Endorsed (N=6)</i> |
|--|--|-----------------------|
| | Appropriateness of disclosure | 6 |
| | Context-dependent disclosure | 6 |
| | Consequences of disclosure | 6 |
| | Detriment of not disclosing | 1 |
| | Partial disclosure | 2 |
| | Creating authentic spaces | 6 |
| | Signaling | 4 |
| | Visibility | 3 |
| Construction of self | Identifying with patient/clients | 3 |
| | Distancing from patient/clients | 2 |
| | Exceptionalism | 5 |
| | Dual awareness | 4 |
| | Differentiating from other professionals | 6 |
| | Language/labels as personal | 6 |
| | Self-diagnosis deepening personal insight | 2 |
| Professional Implications | Critique of the medical model | 4 |
| | Gatekeeping the profession | 1 |
| | Influencing professional aspirations | 6 |
| | Impeding ability | 5 |
| | MT Support Spaces | 2 |
| | Role of educators | 5 |
| | Role of Supervisors | 2 |
| | Work as a means of coping | 2 |
| Dimensions of the Therapeutic relationship | Authentic witnessing | 3 |
| | Bracketing | 2 |
| | Compassion | 2 |
| | Empathy | 4 |
| | Insight | 5 |
| | Egalitarian relationship | 4 |
| | Non-pathologizing stance | 2 |
| | Not giving up | 3 |
| | Observational skills | 2 |
| | Rapport | 2 |
| | Respect for autonomy | 3 |
| | Rendering lived experience useful | 5 |
| | Thoughtful versus prescriptive | 3 |
| Access to Support | Concerns about asking for accommodation | 5 |
| | Engaging in holistic care | 6 |
| | Engaging in standard medical care | 6 |
| | Requiring structural support | 4 |
| | Intersecting identities as mediating factors | 5 |
| Sanism | Professional stigma | 6 |
| | Stigma outside of the field | 4 |
| | self-stigma/internalized sanism | 2 |

| <i>Themes</i> | <i>Subthemes</i> | <i>Endorsed (N=6)</i> |
|-------------------------|---|-----------------------|
| | Hierarchichalization of diagnoses | 6 |
| | Safety and vigilance | 6 |
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Navigating Authenticity

Participants described multiple ways in which they show up in clinical, professional and academic settings. The extent to which participants felt they could present their fullest selves in these spaces varied widely.

Masking. Three participants described camouflaging their behavior to appear “normal.” Ellie shared, “I think that like for years I just kept thinking, ‘oh, yeah, I’m not normal. And they’re normal, and I have to be like them.’ And now in the last 5 years, I’ve thought, well, ‘no, actually I don’t.’ [laughs]”

Participants expressed grappling with the reality that their personal values around authenticity and their best interests as professionals may exist in conflict. Dee highlighted the discrepancy in her outward professional efforts to combat the stigma of mental illness and her personal decisions to conceal her own bipolar disorder at work. She explained, “But I never would have self-disclosed that in the interview to the school, which is unfortunate in the sense of number one—I’m all about destigmatizing, but I’m the first one that is living by the stigmas in terms of not destigmatizing by not disclosing.”

Appropriateness of disclosing. Among the many considerations weighed when deciding to disclose, five participants described exercising prudence especially when considering disclosing to a client within the context of a therapeutic relationship. Ellie noted that disclosure is not always appropriate, noting, “And with other people, I think sometimes it’s appropriate, and sometimes it isn’t. I just think every situation is different.”

Lynn shared that they carefully considered the impact of revealing their lived experience to the clients with whom they work, prioritizing therapeutic outcomes over personal satisfaction:

I did self-disclose when I felt that it was appropriate. You know, there are, as with any other kind of self-disclosure, you always need to be thinking about, you know: Is it appropriate? Is it healthy? Will it be helpful to the client? Or, is it just me wanting to like share this, you know, whatever, and you know. So, it's something that . . . I'm always thinking about.

Beau explained that he is more guarded disclosing to clients than in personal and professional relationships: “I’m a bit more free about self-disclosure in a professional and personal context than in a client context where I’m the therapist and there's a client or clients. I wouldn't self-disclose unless it was relevant to the therapeutic process.” Overall, it appears that there is a consensus among participants that disclosure to clients requires tact and keen attunement with the needs of the clients.

Context-dependent disclosure. All participants endorsed considering contextual factors before deciding to disclose their lived experience. Clinical setting, cultural factors and clinical wisdom appear to inform these decisions. Angie explained:

I think that societal conception and perspective is different demographic[ally] or geographically again, going back to . . . where you are in the world, not just the setting, whether it’s inpatient, outpatient or community because . . . cultural aspects come into play then, too. Because working in Southern California in a community setting is very different from working in a community setting in the Midwest in Michigan or in rural Montana, because society is different in those different places. You know, I would probably—I would definitely consider the community and cultural aspects before

disclosing and deciding what and how much to disclose in each one of those different places.

Ellie also shared that the format in which she could disclose to other professionals would shape her purposeful decision to share her lived experience:

But it feels like it's okay now. I wouldn't go around you know, with the microphone going, "Hi everybody, listen to this." But I might talk about it in a presentation these days. But I don't know. I still feel like it's got to have some kind of purpose to it. If I'm divulging this information at a conference, it's not just: [dramatic affectation] *Oh, and then this happened, and then back and look at me.* It's gotta have it's kind of purpose to help maybe some other young music therapist think "Oh, I'm not the only one."

Consequences of disclosing. Adverse events resulting from disclosure such as judgment from other professionals and fallout from a potentially tarnished professional reputation was a concern voiced by all participants. Dee stated, "I don't feel comfortable disclosing either about mental illness or about LGBTQ stuff in my school to my boss, or whatever, out of, you know, fear of repercussions for my job."

Lynn explained that, for them, disclosure of mental illness or appearing to exhibit symptoms of mental health challenges would translate to adverse ramifications in academic and professional settings:

You know, if you revealed any kind of crack in your facade, you know, then you were going to be denied advance from opportunities, or you were going to be written off as being emotionally unstable, and you know it was clearly never a safe thing to talk about.

They go on to describe further concerns about music therapy educators intervening and potentially diverting their professional aspirations as a result of disclosure:

I felt very insecure about self-disclosing much because, you know you're being judged and graded and you don't know, you know, if people are going to think less of you, or they're going to not write you a good recommendation for your internship, or they're going to think that, you know, oh, you shouldn't go to a psych hospital for your internship, because you know, you've had this experience, and where you need to be *protected* from it.

Detriment of not disclosing. Dee was the only participant to reflect on a perceived negative impact of deciding to not disclose. She explained:

I have often not disclosed to superiors to the detriment I believe of, they could have possibly, you know, been helpful if I would have trusted that they were gonna be understanding and supportive and that there wouldn't be negative repercussions.

While only one participant mentioned this possibility, this subtheme was included in the analysis due to salience of this potential for further harm.

Partial disclosure. Andrea and Dee shared a greater willingness to claim or disclose some of their lived experience while also withholding certain details. In applying for an accommodation for flexible remote work, Dee stated, “basically I asked my psychiatrist to write a note, that it was giving me anxiety . . . to go [in to work during COVID-19], and I think I purposefully asked her not to put the bipolar in there.” Andrea noted a variance in her level of comfort sharing all of her diagnoses:

I am super comfortable claiming diagnostic labels for the mental health conditions.

Regarding autism, I have a lot of internalized ableism, as well as the stigma about self-diagnosis, so I generally will say “neurodivergence.” I kind of separate those, I guess.

In this example, Andrea highlighted the impact of stigma in driving decisions to be open about parts of herself.

Creating authentic spaces. All participants referenced a desire to participate in the creation of clinical, academic, and professional spaces in which people felt safe to be more authentic and open about mental health. Many described this drive as a moral charge, with a sense of “obligation” given their own experiences. For some, this would entail presenting in-services to colleagues and taking on roles as advocates for change. For instance, Dee noted that her motivation for collaboration with her local NAMI chapter is rooted in a desire to combat stigma surrounding mental health.

Beau described taking an active role as an educator for his colleagues:

In my previous role as a hospice music therapist, specifically, one of the big parts of my role was education. Not just on the LGBTQ issues, though that was the main part, but other educational things. And one of those was stigma as far as mental illness and people receiving psychiatric care because a lot of us do. . . a lot of mental health professionals have or are currently receiving mental health services for a variety of reasons, and that doesn't make them incompetent. And that doesn't make them bad at their job, and that doesn't make them dangerous. And you know some co-workers were receptive to that. And some weren't.

Lynn similarly described their perception of their lived experience as a call to action:

I've moved much more towards, I don't know, activism, advocacy. Like I'm like “No, this is, you know, this is part of my identity, and it's an important part of my identity,” and if I don't, if I don't get out there and say, this is part of my identity, then I'm just adding to this idea that there's something shameful about having this kind of identity.

Signaling. Aside from direct disclosure, five participants mentioned being aware of or actively engaging in subtly indicating that they are a “safe person” with whom one can openly discuss mad identity. Details like a passing comment, a tattoo, or a pin that might appear innocuous to a layperson can be a beacon for those with similar lived experience.

Lynn described their decision to cover scars from non-suicidal self-harm with a meaningful tattoo to this effect:

It's a semicolon butterfly. You know. If someone is casually looking at it, it's like it's a butterfly. People like butterfly tattoos, you know. But if you're part of the Mental Health Recovery community, then there's the meaning of the butterfly, and there's the meaning of the semicolon. And so it was a way of both hiding and also revealing that aspect of my identity. You know, like for that was the idea that, you know, I would be able to get a job because I wouldn't go into the interview with obvious scars. And yet I would be able to, you know, communicate with patients: “I get you,” you know. We have this shared experience, you know. I'm a safe person to talk to about this experience.

Signaling appears to be a pragmatic approach to engaging authentically in spaces where total transparency may be risky.

Visibility. Related to the concept of signaling, three participants described visibility of mad identity as an important factor. Beau noted the power of this: “And I believe, very strongly in visibility on a different front as a way to combat stigma.” This, however, does not come without risk. Even in scenarios in which an individual does not disclose their experience with mental illness, visibility of symptoms can influence how they are perceived by colleagues. Ellie shared a significant recollection that ultimately deterred her from disclosing in professional spaces:

I know that there was another music therapist that was more visibly having mental health issues. And this person was spoken about and judged by the so-called elite of music therapy, who are the people who are in charge and presenting at conferences. And then, when this person died young, there was mention of that, they, “Oh, was it suicide?” Blah blah, blah blah! And it did end up not to be. But there was this judgment around this person, and so I just felt like it was never safe to talk about it with any other music therapist.

Construction of Self

All participants defined their unique experiences as music therapists with lived experience as consumers of mental healthcare in relationship to other stakeholders like fellow professionals and identified patients/clients. Because of their experiences in multiple roles within the larger system of mental healthcare—patient, provider, supervisor, or educator—participants often reflected a hybridization of these sometimes conflicting lenses.

Identifying with patient/clients. Ellie, Lynn, and Andrea described instances of seeing themselves in their patients when working as a music therapist in an inpatient setting. Ellie observed, “I felt like it was a very thin veil between me and them.” She went on to describe resonating with clients in this setting, despite not having the experience of hospitalization herself:

The first year I worked as a music therapist, I also worked on the acute psych unit of a hospital, and that was kind of interesting. Because quite often I think, “Well. Where's my bed? Can I stay here tonight too?” [Laughs] I'd see that there wasn't much difference between me. And then I mean there *was*. But there wasn't *really*, between me and the people that were locked in the acute unit. That was kind of interesting.

Lynn similarly felt a solidarity with patients in a psychiatric setting:

In the program that I was at, the third practicum was in a psych setting, and you know, at the weekly meeting where all the students get together and talk about, you know, at the you know, at the first meeting of that semester there was several people who were like “I’m so scared of going into that place with those people,” and just going on and on and on about it, and you know to the point where I was like: “I am those people, all right?!”

These descriptions suggest that mad music therapists do not experience the often assumed, clear-cut clinical distance between therapist and client.

Distancing from patient/clients. In contrast to identifying with those with whom this therapist works, Ellie and Andrea also made distinctions between themselves and patients with whom they have come into contact. Both participants shared that they have not experienced inpatient psychiatric care, and Ellie noted a conscious effort to avoid this possibility: “I was determined, and I- it’s still- it’s the case. It’s like a- it’s like a battle within myself where I’ve been determined to never be an inpatient of a psychiatric facility, and I haven’t been... yet. [laughs]” Furthermore, Ellie alluded to the importance of clear boundaries in professional contexts, “I think, like we need to protect ourselves, too, from the people that we work with.” Andrea noted that viewing oneself as different may be exacerbated while working in acute inpatient psychiatry, stating, “And then there’s the othering, like ‘I’m not acute, I’m not like these people.’ It almost turns into rationalizing to keep myself from facing internalized ableism and what that means for my self-concept.”

Exceptionalism. Most participants described a pressure or drive to succeed despite their setbacks, overcoming the challenges presented by their experiences of mental illness. Whether

explicitly or implicitly, many participants indicated that they felt they had something to prove by defying stereotypes about what it means to be Mad.

Ellie reported feeling “like I wanted to do what I thought was the absolute top of the tree music therapy job which was working there [in pediatric oncology] so that I could prove that even someone like me could do it.” Lynn similarly noted the role of achievement in challenging reductive narratives, explaining, “[I]f I go out there and own it, and I'm like, okay. I have a doctorate and 2 master[s] degrees, and I have history as a mental health consumer and I'm Autistic. So there! You know, like. . . So take that, you know.”

This perceived need to be exceptional might be also felt as a pressure to deny oneself additional support. Dee admitted, “So I guess there's part of me that wants to feel or believe that I am functioning well enough, or whatever, that I don't need to seek an accommodation.” Beau noted that this idea of perseverance despite the odds dovetails with a more general narrative for helping professionals:

We have this ethic depending on where you are. It's more or less, but overall there's this ethic of, you know, suck it up and push through, work the extra hours. Show up for the clients, and take care of yourself later in your off time. And so, especially as a new therapist, newly graduated, I hadn't yet learned the importance of setting those boundaries and realizing those needs, and taking mental health days and putting my foot down and saying, “No, this isn't worth me making myself frazzled and unoperational,” or “I've got to take care of myself.”

Double consciousness. First used by W.E.B. Du Bois to describe the dual self-perception of Black Americans through the hegemonic lens white supremacy, the concept of double consciousness has been expanded to analyze the experience of marginalized groups navigating

both dominant and subjugated perspectives. Lynn, Beau, Andrea, and Angie described this unique level of insight in which they perceived clinical situations from both the perspective of client and therapist. Angie explained:

I have the perspective and the experience of those different aspects of the process myself as a patient or client, or you know, as a- as a person who has experienced these things, and so I can slow down and take a look at those different parts of the process through this lens and consider them differently and consider how this person that I'm working with, or this group, or whatever it is, how they may be experiencing the therapy of it, and whether or not, we need to, you know, slow down and take more time at one process or at a point in the process, or if we can move through it onto the next thing you know. Like if, if I need more time in the assessment process to figure out a different aspect of whatever is going on.

Beau described how the intersection of the different roles of patient and therapist developed throughout his education and training to become a music therapist. Reflecting on his undergraduate training, “there was a great intersection” between their own experience receiving mental health care and the content of his music therapy curriculum. He continued:

And then going through internship was again very stressful for anybody and difficult to navigate while trying to figure out mental health things. But again, there was a good intersection of learning how to be present with people and learning to respond to my different patients, and learning things about myself as an up and coming professional and learning about myself as far as what my mental health needs were.

Differentiating from other professionals. An important distinction by all participants involved how in which they viewed themselves as different from other professionals in

healthcare, such as perceiving themselves to have different philosophies, approaches, and techniques. Andrea put it frankly: she sees herself as “not a normal therapist, but a cool therapist. I speak really casually with my patients, I don't censor lyrics a whole lot. Anything I can do to make them feel more like people, not merely a psych patient.” Likewise, Dee shared feeling that her lived experience with bipolar disorder made her “more empathetic and a better music therapist in a way than if I didn't have it.”

Another key difference delineated by Ellie, Lynn, and Andrea was the quality of “not giving up on clients” in circumstances where other professionals would or did. Beau distanced himself from the traditional hierarchical power structure of a therapist-client relationship:

And a lot of the bad stems from professionals that weren't listening, that came to the therapeutic relationship from a place of: “I've read all the books, so I know everything, and I know everything about you, and you don't know anything about yourself.”

When it's not that way, right? Everyone's an expert in who they are.

Angie explained that “specifically as a music therapist, you know, I have a different perspective on like what types of music, and the way we use it, how it affects mental health, I think, than maybe other folks who haven't had this living experience. Maybe they approach it or think of it.” She went on to underscore an important yet often overlooked consideration for the use of music in a therapeutic setting:

I think at times it can be challenging, because... I can see how a lot of people a lot of times people think, you know, music is always good. Music is always helpful. I know from experience that that is not true. There are times that music can be, can actually be harmful, and . . . the way you use it can cause harm. And I don't. . . I don't think I would

have that perspective and not experienced it myself. And so that is challenging in that sort of explaining that to people and getting that point across.

Language/labels as personal. All participants articulated their personal relationship with Madness and lived experience as service users quite differently. This suggests that choice of language is deeply personal and nuanced.

Dee, Angie, and Ellie expressed discomfort with adopting Madness as an identity marker. Dee likened this to her perspective on sexual orientation:

I would prefer to like not even label, like I would be more about . . . Like with LGBTQ, it's like so- like rather than have to have a label, or whatever, it's like . . . I love my partner, and . . . her name is [Name], so it's like I'm [Name]-loving, you know. So labels is not something that I really even want for us.

While she explained that some of her values align with the Mad Pride movement, the language does not aptly fit her experience:

I don't know, like mad, it's just not the language that we use. You know we're more about like de-stigmatizing mental health, you know. Stuff like that. So, it was interesting to briefly, very, very briefly—I haven't really researched it much, you know—see that there is even like Mad Pride. It's kind of like, . . . because I know about LGBTQ, whatever. It's kind of like if somebody had said, I don't know, a word that's like not queer. Another like total random word that could be considered disrespect, you know demeaning or something. Anyway, I thought it was interesting, because I guess I related to a word that could possibly sound demeaning, but some people, you know, taking it up as kind of reclaiming it as something positive, so I mean, I can now see that that's a possibility. It's

just very new to me. It's not the language that I typically would have, or possibly still would choose to use.

In contrast, Lynn described having a long personal attachment to the term “survivor” and the language of “survivorship.”

In addition to preferences for certain terminology, some participants more readily identified phrases that they do not prefer. Angie detailed her opinion on the use of “suffering” to describe her experience:

I'm not a fan of . . . the language of saying, I *suffer* from depression, or I *suffer* from anxiety. . . Guess . . . I can suffer at times, but that's something I avoid when I talk about it, and also when I work with people who have mental health diagnoses, I avoid talking about it for them as well in that context. But I myself. . . I don't think of it as part of like my identity as a person, that I have depression and anxiety. That's not part of who I am. It is something that I, well, it's like I think of it like in the context of, you know, if I had a cancer diagnosis, it was a similar thing. You know . . . I don't say I'm a person with cancer; that's part of my life journey. So that's how I think of these mental health issues.

Beau, Andrea, and Lynn expressed greater comfort in using diagnostic labels when talking about their lived experience; however, as Andrea elucidated, relying on diagnostic labels may not come without some internal consternation:

Regarding labels for my neurodivergence, it's still ambiguous. I'm cool using the neurodivergent label with whoever, but I wouldn't say I'm Autistic to a room full of doctors because I haven't been formally diagnosed. The OCD label can also be complex, because I have a (surprisingly common) obsession that I've accidentally been faking everything regarding the diagnosis. Like that I've been faking everything for attention, I

don't actually have OCD, that this isn't real. So within my self-concept surrounding diagnostic labels, there's an element of, am I making all this up? Am I just lying to collect another little label? Rationally, I can tell you for a fact that I'm not. It helps that, unlike autism, I have been formally diagnosed with OCD, but these thoughts still complicate things. I can't always trust my brain.

Self-diagnosis deepening personal insight. Three participants shared that at least one of their diagnoses were self-identified, and some noted that they doubted the need to receive a formalized evaluation. Beau described the impact of insight gained through self-diagnosis:

I had mentioned that I'm on the autism spectrum. That's not-That is an undiagnosed determination, and I had been asked, would you want to go actually get diagnosed with that? And I didn't see how that would be meaningful, just knowing that about myself really helped me navigate life a little better. But sometimes you don't know that about yourself until you're officially diagnosed with something. So, . . . It depends.

For these three participants, formal diagnosis appeared necessary for accessing adequate support, and self-diagnosis allowed for a satisfying level of self-understanding.

Professional Implications

Critique of the medical model. Four participants highlighted the limitations of viewing the therapeutic relationship in a distinctly Western medical model in which mental illness is a disease to be cured through rigorous treatment. Beau stated:

I think overall that there's a lot of work and building and improvement that needs to be done in our mental health system. I feel that there are some antiquated ideologies that are utilized still by both young and old practitioners and in between that need to be re-

examined really, and it needs to be revisited what the actual effect is on the people we're here to serve and help and heal.

Lynn reflected on the ways in which contemporary practice of music therapy diverges from the ways in which they instinctively used music to transform their own experiences with mental illness. They make a distinction between music therapy as a *treatment for mental illness* and music therapy as a relational context for patient/client empowerment:

I mean for me it's been interesting, because another thing that I talk about a lot with my students is, you know . . . I mean, the way that music therapy developed from such a medical model, like everything is sort of pathologized and like, I think if someone had tried to do music therapy to me I would have absolutely hated it. And yet music saved my life. So, I feel like as a music therapist, what I want to do is make music available to people so that it can save their life, not do it to them, you know, and part of that is just being so focused on the folks that you're working with, and what they want and need to do on that. You know, if they want to learn how to play a song on the piano, that's what I do. You know, like . . . that's therapeutic, even though it's not [air quotes] "therapy according to the notes" that you have to write in those places.

Experiencing the role of patient within mental health care appears to have offered insight into the pitfalls of viewing mental health needs through a lens of pathology.

Gatekeeping the profession. Ellie considered the ethical imperatives of ensuring music therapists meet professional competencies and do not put potential patients at risk. Though she was the single participant to do so, the relationship that this has to the core values of a helping profession to first do no harm makes it worthwhile to consider:

How mentally ill or neurodiverse can you be before you start not being a useful therapist? And do we have the insight like, how does each individual measure that really? Because like, if I were completely manic like I've seen, like I remember some people in the psych ward, I wouldn't know that I was. So, How... How does the profession be able to include people with mental health issues, but also look after the people that they were working with? How? How is that . . . I don't even know about the word monitored. But how do you figure that out? And I think probably, in the first place, actually, it has to be okay to talk about it as a student. It has to feel safe in that initial space when you are studying music therapy. So, it has to come from the University, from your lecturers. etc., and I feel like at [University], as far as I can tell, that is an okay space to do that these days. So yeah, it has to start from there. How would you know if someone... Yeah like, what do you have a body like saying, "oh, this type of neurodivergence is okay, but that one is not? Like...[cringes] Oh, it's a bit of a mine field. Isn't it? Do you only work with autistic people if you're autistic yourself? Do you only work with people who are mentally ill if you're mentally ill yourself? I don't think so. I think that will be boring. I certainly haven't done that.

Ellie alluded to the reality of significant power dynamics at play. She noted that those responsible for training future music therapists are arbiters of acceptable professional "capacity," and such a responsibility carries with it the possibility of enforcing ableist and sanist ideas about whom might be "well enough" to become a therapist.

Influencing professional aspirations. Most participants cited their own experiences of being consumers in mental health care as having an impact, whether overt or indirect, on their decisions to pursue practice in certain clinical contexts. For some, working in psychiatric

contexts was described as “that’s *my* population” and “that’s my *passion*.” Andrea shared that her personal experience informed her professional aspirations early on in her training:

I knew I wanted to go into mental health. I think it was the lived experience, like this is something that super resonates for me. I find the field fascinating so I have a really strong clinical interest in it, but I also have the emotional connection. So I knew I wanted to work in mental health because of that combination

By contrast, Angie reported that she initially felt drawn to work in contexts similar to where she sought care previously, but learned that full-time employment in an inpatient psychiatric setting was not appropriate for her:

At first, I thought that since . . . because of how I came to music therapy that that would give me a pretty specific viewpoint on the mental health setting, and I did work in the mental health setting. And yes, it did give me a certain perspective there. But I know now that that is not the context that's right for me to work there . . . specifically the inpatient in the more acute mental setting. I've worked, you know, in working with a private practice, I've worked with individuals with these diagnoses of depression and anxiety, and that has been fine. But for me . . . I stay away from the more acute settings now, mostly because . . . it brings things up for me, and I think that there's a little too much association and too much a chance for transference and countertransference there that it's not helpful.

Participants that did not have much professional experience in psychiatric work shared a number of rationales for this decision. Dee expressed that she has never worked in psychiatric contexts as “a choice.” Similar to experiences shared by Beau and Angie, working in the hospice setting appears to require an empathetic skill set bolstered by personal experiences of depression and grief. Additionally, Ellie shared that her motivation to work in pediatric oncology was

connected to a sense of having something to “prove.” Lastly, Beau found his draw to work in hospice to be a compatibility of “personality” unrelated to Madness.

Impeding ability. Five participants described ways in which symptoms or features of their Madness presented challenges for their professional duties. Dee shared the impact of mania on her work, “I ended up losing several contracts. Partly because I didn't go to work that was with mania. Or because I was doing inappropriate stuff like . . . all of a sudden starting to bring my dog to a private music therapy session, and never did that before.” Blurring of professional boundaries were described by Lynn also:

I think I can tend to have boundary issues. And you know, when there's a defined “we're having group from this time to this time,” there is a set boundary there that helps to maintain, you know, the sort of personal boundary in a way. But being on the unit, you know, 8 hours a day, 5 days a week, it very quickly eroded, and it became increasingly, emotionally challenging for me to be there because it was . . . just having no space to even go to sort of like reset it you know.

Professional support spaces. Both Dee and Ellie describe the liberatory capacity of having support spaces like online communities, employee resource groups, or regional affinity groups. Participating in such a space at a professional music therapy conference was transformative for Ellie:

It felt like I was having to pretend a lot of the time, and only in the last year in [country] they had a pre-conference day where people with different neurodivergences and mental health issues could have a day to talk about things. And then there was also- there's a group now that meet online, and also there was a group at the conference. And so it

finally felt like some kind of support from within the music therapy profession is happening.

Dee described a sense of yearning for a space to connect with professionals and share openly about lived experiences:

But, like I could almost cry right now, but not to that extent. But it brings up a lot of emotion in me to be like. I would love to show up at the next AMTA meeting like- might be [regional] let's keep it like [regional] like more local. Let's call it like the [state-wide conference] and have a session on-I don't know-"It's okay to be. . . or you know, have bipolar disorder and identify as LGBTQ and let's all bring our shit." And let's destigmatize by like speaking about these things and not feeling like we have to hide them.

Role of educators. Five participants mentioned the crucial role of music therapy educators in establishing academic cultures that uphold a set of values around ability, illness, and accommodation. Lynn reported their concerted efforts as a professor themselves to counteract reductive and oppressive narratives about Madness and disability, but other participants elucidated a reality that students are not always met with understanding. Discussing stigma, Angie explained that stigmatizing ideas were not necessarily overt, but they were “implicit in the educational setting.” Certainly, educators can play a vital role in establishing support for students. Dee noted that one of her music therapy professors was a catalyst for first seeking mental health care, recalling, “I am very grateful to my music therapy professor in undergrad who was the first person who caught it [mania]. I wasn't ready to accept it, but she was the first one who caught it and you know, who realized it and you know, mentioned it and all that.”

Role of supervisors. Similar to the impact of music therapy educators, clinical supervisors involved in training practicum students and interns often leave a lasting imprint on

their students, a responsibility that participants suggested should not be taken lightly. Ellie delineated some of her philosophy of being a clinical supervisor:

I feel like if you are in a position of authority that has to be some kind of- that a student would feel safe around you. So, if you were kind of going, “[pretends to cry] Oh, this is all my stuff” to the student, and I think that wouldn’t be very helpful. I think that's where you need to look for your own therapist. We're not there to. Well, I don't think, maybe I'm old fashioned, but I feel like as an older person, I would be more there to support somebody else, and that I would need someone that isn't related to that young person to assist me if I had some issue.

Lynn shared the pivotal role her internship supervisor played for her own identity development, they explained, “After getting to know my supervisor, I did disclose some of my experience. He was very supportive, and continues to be a very supportive, you know, very supportive and a mentor kind of person.”

Work as a means of coping. Dee and Ellie reported taking on the professional role of therapist as personally beneficial to their own wellness. During her most challenging experiences with mental health, Dee shared feeling “grateful that I have the routine of work because otherwise it would have been worse.” Similarly, Ellie described her professional activities as helpful for maintaining mental wellness, she explained, “Being with other people and having to not focus on myself, but focus on others. And plainly you can sing. Then I would feel temporarily better. But then, after I stop then quite often, I’d go back into feeling low, so it kind of helped me in that way.”

Dimensions of the Therapeutic Relationship

All participants described ways in which they felt their lived experience influenced the ways in which they engaged with patients/clients as a music therapist within a therapeutic relationship.

Authentic witnessing. Beyond the ability to validate a client's experience, three participants illustrated a deep sense of shared knowing felt between client and therapist which allows a Mad music therapist to acknowledge the emotional realities of the client with an intimate level of reverence. Lynn explained their intentional cultivation of this capacity:

That's something that I work very hard at, you know, trying to see what people's emotional truths are, and validating that, responding to that. You know, rather than I mean, I've heard people get in arguments about the factual truth, and it's like: It doesn't matter, you know. You're not ever going to talk someone out of a delusion or a—you know, and that's not important. . . . What's important is that you're here with this person experiencing this emotion with them.

Ellie described her ability to “give people the space to be able to voice their concerns. It's not like just smoothing over everything. So . . . being that space where people can be as vulnerable as they want to be.” By not “just smoothing over everything,” the Mad therapist is able to access a more intimate truth. In sum, Ellie, Lynn, and Beau endorsed the benefit a deep ability to validate client experiences can have for the therapeutic alliance.

Bracketing. The therapeutic skill of temporarily compartmentalizing one's own emotional reaction in a therapeutic scenario was underscored by Lynn and Ellie. Lynn described their awareness of this need:

Being challenged, you know, occasionally . . . can retrigger my PTSD. . . If I get someone, you know, with a similar kind of experience, or a similar kind of self- injury history . . . can sometimes be triggering. . .I mean, it's a thing that you . . . learn how to do. You know, as a therapist. . . you're like in the session, and you're like, "oh, this is happening. I'm going to put this in a little box right now, so that I can continue the session. And I'm going to take this little box and talk about it when I have my next therapy session.

Compassion. Dee, Ellie, and Angie described experiencing compassion for others in similar situations more deeply as a result of their lived experiences. Angie stated, "I think it does give me a little more compassion."

Empathy. Four participants described the sense that they were more apt to share in the emotional experiences of their clients. Dee explained, "I mean, like I said I, I feel that I am more empathetic and a better music therapist, in a way, than I would have been if I didn't have it."

Insight. Five participants discussed ways in which their lived experience nurtured an ability to access an accurate understanding of their clients/patients and clinical contexts. Ellie described her insight as:

Just being able to pick up on like kind of connecting the dots of like: "Yep. This patient escalated because of this and this and this," and like I'm just able to pick up on that quickly. And then, like the intuition of like: "okay, like I've been through the similar thing. And this thing really helped me, or like I've been like- I've had like a meltdown with like over stimuli of over stimulation before." So I know, like you need this this and this so just like some of that, like the intuition and the like- I think I'm like a creative de-escalator. I guess so like trying, like some of those other things that other people might

not think about, because you get like the textbook like, try these things to ... de-escalate, and I'm like: "what would help me in this situation is this thing instead?" Yeah.

Andrea went on to explain her perceived connection with patients in psychiatric settings as "a lot of those are the patients that I really vibe with, and who I have insight into that other people might not. They are the ones that I'll gravitate towards doing one-to-ones and extra work with."

Egalitarian relationship. Ellie, Beau, Lynn, and Andrea emphasized their efforts to establish a therapeutic alliance that decentralized the power of the therapist. Beau described his egalitarian approach:

And to approach each therapeutic relationship, because even if it's someone who's actively dying and I'm at their bedside, and I am providing music therapy to ease their passing, that's still a relationship, however brief, and understanding that we're equals in that I'm not above them. I'm coming to it with a certain base of knowledge, but I'm not an expert in them.

Likewise acknowledging the traditional power differential, Andrea explained, "I always try to keep that in mind when I'm interacting with the patient, and try to figure out whatever way I can help them take some power back. So like giving them a choice between options for de-escalation, rather than forcing one approach."

Non-pathologizing stance. Counter to the language of the medical model, Lynn and Andrea characterized their efforts to eschew the language of pathology in their work. Andrea explained her humanistic approach as "I try to see the person in their entirety, not one aspect like a behavior or symptom. Treat them as people, not as patients. I think sometimes I'm hypersensitive to pathologizing."

Perseverance. Not giving up is another lesson Ellie, Andrea, and Lynn reported taking from their experiences as service-users. Lynn explained their sense of perseverance in contrast to general attitudes in psychiatric settings:

I mean, I've met so many coworkers in some of these different settings who are like, give up on, on patients or they, you know, if someone doesn't respond within a certain period of time. They're like, give up on them, or, if they, you know, go out and then come back in...Well, I think it's been hugely beneficial, I mean. You know, I don't. I mean, I don't ever give up on people, you know.

Observational skills. Ellie and Lynn correlated their lived experience with an enhanced ability to “just pick up on the smallest of sign” (Ellie). Lynn elucidated the professional impact of taking an observer role in non-professional settings:

I mean ... both my lived experience, you know, with the mental health challenges, but also the autism. You know it's made me a very good observer, and I'm able to. . .

You know I spent my whole life observing people very closely to figure out, you know, for myself how to act. . . I mean any person who has any kind of marginalized identity or any kind of identity that's less powerful has to become a good observer, because that's the only way to maintain personal safety. So, you know, I definitely feel like my experiences have made me a much better observer.

Rapport. Andrea and Lynn described an ability to establish a trusting professional relationship with clients/patients quickly. Andrea explained “I just click with those patients [described as aggressive by colleagues]. I’m able to de-escalate a lot of times.” Similarly, Lynn said, “I was always able to establish really good rapport with my clients.”

Respect for autonomy. Beau, Lynn, and Andrea underscored a particular focus on supporting client/patient agency. Beau highlighted, “Everyone’s an expert in who they are.”

Lynn explained this rationale:

So, one thing that is a really strongly part of my practice is choices. . . How can I optimize the available choices? Because this is the only place where this person has any choice. You know, even in the other therapy sessions they don't have a [choice] so, you know. So, I go in, just I go in ready for whatever.

Andrea acknowledged the paternalistic nature of psychiatric institutions: “I try to keep in mind that patients have often lost every semblance of power that they have, being on a locked unit.”

Rendering lived experience useful. Most participants alluded to making meaning of their experiences by transmuting their experience of Madness into something productive professionally. Lived experience was generally deemed useful to have as a therapist. Dee described what she calls the “blessing” of her diagnosis as “helping others by being able to share what I went through, what I overcame. And, for example, like I see that I can like help parents by saying, ‘I’m so grateful to my parents because, like they put me in a hospital, and it’s the best thing that could have ever happened.’ And stuff like that.”

Lynn’s desire to fashion their survivorship into a vehicle for change through music even predated their clinical training: “I also worked as a community artist, and I worked mostly with migrant populations, and it was... a lot about identity and self-esteem, and so I’ve always felt like a very strong moral obligation to use my survivorship as a way of helping other people.”

Thoughtful versus prescriptive. Lynn, Andrea, and Angie found that their lived experience informed their treatment planning process as clinicians. Their personal insight

seemed to deem the process as more “fluid.” Angie described case conceptualization as an evolving process:

I think [my lived experience] makes me slow down a bit and look at the different steps or I don't know if the steps but it, you know, like the the continuum of the process. Makes me consider those more rather than just barreling ahead and saying, “we're gonna use music to help you feel better.” It's not so much like a series of boxes that I check, *done*, *moving on*. I think it helps me to see it a little differently, and see it more as a fluid thing.

Access to Support

Concerns about requesting accommodation. Dee and Andrea expressed fears about asking for accommodations in professional and academic spaces related to professional stigma.

Angie explained her concerns with maintaining professional reputation:

My perspective, and my experience of it is that...students with and, or even teachers having been both with these experiences and diagnoses, I think, are oftentimes in my experience, treated differently. It's almost like you're not...You can't be as good of a student or as good of a teacher, professor, because you have this diagnosis, or you have this experience, and you experience these things?... I don't know that that's actually the way that people think. But it that's what it seems like, and that's what it feels like oftentimes, especially in things like, you know. If you need accommodations for your classes or things like that.

Engaging in standard medical care. All participants described experiences with conventional ways of treating mental illness such as psychotropic medication, inpatient therapy and outpatient therapy. As Beau explained, the quality and success of these therapies often varied for participants: “I’ve been to many different counselors over the years. Some good, some bad,

some neutral is there. There have been some hospitalizations and an actual psychiatrist prescribing meds at different points. So I think those are the key services.” Most participants shared pursuing a combination of standard treatments for their mental health.

Engaging in holistic care. All participants also described requiring non-standard forms of care such as mindfulness, spiritual practices, and artistic expression. Angie centered the consistent presence of music as it “always played role in helping, when I first started experiencing depression and anxiety, I would turn to music to help with that.” Both Dee and Ellie made a point of challenging a Cartesian split in addressing health. Dee explained that she remained “very much involved in like mindfulness-based stress reduction, kind of like mind-body medicine stuff.”

Requiring structural support. Beyond concrete support services, Ellie, Lynn, Angie, and Beau referenced the necessity of accommodations inherent in workplace settings, like “mental health days.” Lynn cited their experience with an unsustainable work environment as spotlighting particular workplace needs:

So, the State Psych Hospital that I worked at here, because of Covid, ended up being assigned to a particular unit, and we had to be on the unit all day, every day. And that was horrible. That was a horrible experience, because I mean, for one thing, there was no downtime, and I need downtime. I need some time, but there was no downtime, no place that I could go.

Intersecting identities as mediating factors. Participants to varying degrees characterized their intersecting sociocultural identities as mediating their access to adequate support. Some participants felt that factors like race and class had negligible impact on mental health outcomes. Ellie explained:

I've always had enough money, so...I haven't had to worry, but that doesn't have anything to do with how I cope with life, like it really feels irrelevant in a way, and I'm sure, you know, if I had problems with money, that would have been another thing. But sometimes, like the mental health, I'm just going to call it mental health because I can't think of something or anything else, problems with size to be that it doesn't matter if you're the richest person on earth, that doesn't help.

Other participants noted that greater access to quality mental health care was an unearned advantage of membership in dominant groups. Lynn described explaining to their students that:

[I]f I were not white and educated, and someone who had health insurance, then as a young adult, I would have been sent to a state psychiatric hospital which probably would have been the end of my life, as we know it. And I'm very aware that you know, because of my race, because of my socioeconomic background... that didn't happen. I had resources.

Additionally, intersecting subjugated identities were found to exacerbate experiences of marginalization, further preventing adequate mental health support. For instance, religious perspectives on suffering and concepts of “guilt” contributed to negative feelings for Lynn, Dee and Beau. Similarly, Beau described the intersection of gender, minority stress and mental health outcomes: “I mean growing up transgender. It always brings with it lots of challenges and lots of mental health concerns, not by virtue of being transgender in and of itself, but the abuses and the societal discrimination that one faces, especially as a young kid.” Other sociocultural factors like geographical location and religion mediated support to varying degrees. Angie described with nuance the manner in which religion and geographical location “can either help or hinder” positive mental health outcomes:

My family's way of seeing it was more like...you have to have more faith, and then it will go away. And so that's how I thought of it. For a long time. I don't think of it that way anymore. I know that it's not going to go away, and it doesn't have anything to do with my faith...So, though that has definitely shaped how I think of things, and also how I cope with things, I don't I know that that faith and your experience of like a higher power, or a religion, or anything like that can I think it can either help or hinder sometimes... I think another part of these, how like different aspects of life connect and how they affect things is actual, physical. It's like where I live. You know I lived in rural, rural [state] for most of my life, and experience of health care. There is very different than other places now. I live in [Midwestern state] ... so my experience of health care is different. Here I lived in [coastal, populous state] for a while: very different there. So I think that actual physical demographic can play role, and I've had different experiences of support and of like just in the general medical sense of how you know how things are approached, depending on where I've lived throughout my life.

In general, participants acknowledged that intersectional identities modulated the impact of marginalization and access to support.

Sanism

Sanism is “the systematic oppression of people who have experiences often labeled as mental illness” (Elhert, 2020, p. 1). This prejudice is evident in explicit and implicit ways in the experiences described by participants.

Professional stigma. All of the participants described ways in which practitioners in mental health care can uphold systems of oppression. Often communicated through the manner in which they talk about Madness, and their actions towards patients and other professionals with

visible needs for support, professionals perpetuate harmful ideas that conflict with the inherent worth and dignity of Mad individuals. Professional stigma weighed heavily in participants' decisions to disclose to colleagues and request accommodations in the workplace. Beau noted that despite working to support patients with mental illness, medical professionals can maintain prejudiced assumptions about those with whom they work:

Well, ... it's gotten a little better. But there is still stigma. Of course, even among medical professionals and you know, having it come out that one has received psychiatric care or counseling services or things like that can impact therapeutic relationships, can impact working relationships with other therapists who might have a certain bias or other medical professionals, because we do work in interdisciplinary teams a lot of the time.

And so, I have encountered some of that bias that was difficult to overcome at times.

Beau underscored the disastrous amount of pressure this can create for mental health professionals, "Because there is like I said, there are antiquated ideologies like *physician, heal thyself...therapist, therapize thyself*. And that's not how human beings work. But we all need care and attention." Expectations for therapists to seldom require mental health support themselves is are misguided and unrealistic, yet they appear to remain prevalent.

Stigma outside of the field. Most participants alluded to the ways in which sanist ideas pervade mainstream culture, both in what is said about Madness and what remains taboo. Angie explained the undeniable prevalence of regressive ideas about mental illness in media messaging:

I think a lot of it is implicit in like in media, whether that's through like news media or in things like television and movies and things like that. And now social media influencers, and just in general, the fact that everyone puts everything out there. And so, even though

they may not explicitly say things like this, I feel like it is sort of interwoven into the conversations and things that we consume through social media and through other things.

Self-stigma/internalized sanism. Dee and Andrea admitted awareness of internalized feelings that held them back from acting freely and authentically. In reflecting on how she describes herself, Dee noted, “I don't even love this, but I can live with like saying. You know I *have* bipolar disorder. I just don't love those words. It's like I have experienced mania, and I can, you know, share that. But it's, there's I guess there's shame around some of it.” Andrea shared similar feelings about claiming parts of herself, “With the neurodivergence, I still very much have that internalized ableism. I don't even like admitting things to myself sometimes, let alone telling others.”

Hierarchicalization of diagnoses. All participants alluded to Madness as a spectrum, parts of which fall beyond what is often considered “normal” and “acceptable.” Certain ways of being increased a likelihood of experiencing stigma and sanism. Lynn notes that non-suicidal self-injurious behavior for instance maintains a greater level of stigma than other expressions of mental illness such as low mood or worrying. Furthermore, Andrea reported that this variance in stigma translated to differing feelings about disclosing certain diagnoses over others:

I was pretty vocal about my depression and anxiety. I was a college student, it seemed like everyone dealt with depression and anxiety. I didn't personally feel like there was a big stigma about those ones. I got my OCD diagnosis my senior year so it didn't come into play much in college, but I think I would have felt differently about self-disclosing that one.

Additionally, restricting one's understanding of what it is to be Mad to a particular region of this continuum can further stigmatizing assumptions. Andrea observed, “Working in inpatient,

the stigma almost gets worse sometimes instead of better. You see people with mental health conditions at their absolute lowest all the time, which paints a very narrow view of those diagnoses, people, and the recovery journey.” Understanding certain presentations of Madness as a hierarchy, with some more palatable than others, reinforces sanist respectability politics about how a Mad person must present to be deemed worthy of empathy or help.

Safety and vigilance. All participants referenced remaining highly attuned to possible threats to their professional reputation, their job prospects, and their mental wellness. Most participants described seeking a feeling of safety prior to disclosing and presenting their full, authentic selves in academic, professional, and clinical spaces. Beau described an ever-present awareness of risk “with each situation, with each interpersonal contact. You've gotta weigh, you know. Is this going to bring harm to me? Maybe? Is this going to put me in a potentially dangerous situation for it?” In a similar fashion, Angie shared a similar tension when describing disclosure, noting “It's never completely comfortable, at least for me.”

Ecological Perspectives

All participants regarded mental health care as a complex system with multiple stakeholders like patients, therapists, doctors, educators, and administrators. “The system” is shaped by forces such as sociopolitical processes, cultural perspectives, and regulatory practices. Each participant communicated an awareness of the complicated nature of mental health institutions, and their perceptions of these realities were further complicated by experiencing the impact of the system from multiple vantage points: sometimes patient, sometimes therapist, sometimes educator.

Negative experiences as consumers. Five participants cited adverse experiences receiving mental health care as seminal in their outlook on mental health care as a “broken system.” Lynn highlighted the lasting impact of a professional’s harsh words:

I experienced that, too, like when I had my several hospitalizations as a young adult, I had a nurse say to me on my second hospitalization, “I knew you wouldn't make it.” You can't even imagine how, you know, how someone can say those things to a mental health patient, and yet they do. They do, you know, and if they don't say them directly to the patients, they say them to each other in the patients’ auditory space.

In addition, Beau shared how his perspective on the benefits of diagnosis are colored by his experience of misdiagnosis:

So I think diagnosis is a double-edged sword in some ways, because it can it can open up that roadmap to you that you didn't know existed, but it can also--I had mentioned misdiagnoses--it can also lock you into a mindset that isn't serving you like being misdiagnosed as bipolar for several years really got me off the track I needed to be on, and got me on some dangerous meds that I didn't need to be on.

Internal conflict about working within the system. Most participants also described intense personal conflict about taking part in a system that has enacted harm on people whom it professes to help. Lynn straddled the tension of their lived experience and professional practice, reporting, “I worked most of my professional career, until this year I worked in in largely in hospital and psychiatric settings. So that's my- it’s challenging, because that's my population. But I hate institutions.” Likewise, Andrea characterized her inner debate as a moral injury:

I’m trying to piece all that together, my values with my workplace. I'm working in a system that I understand harms people. I can see how it can be life changing and

necessary for a lot of people, but sometimes it causes harm. It's an ethical dilemma- can we cause harm when it's necessary for that person's greater good? And who are we to decide what that greater good is?

She continued:

Working in inpatient, there's a weird moral injury of learning how traumatic hospitalizations are, actively fighting for change, while also being a part of the system.

How can I be someone with this condition, working in this system that I know has hurt so many people like me? How can I justify working in this setting that I know is harmful?

Participants' decisions to participate in mental health care as providers appear to be rooted in a belief that they can reduce harm and take part in reforming oppressive practices.

CHAPTER 5: DISCUSSION

The present inquiry sought to understand the experience of mad music therapists.

The following research questions were explored via interpretive phenomenological analysis of semi-structured interviews with professional music therapists who self-identified somewhere under the umbrella of Madness:

1. How do mad music therapists conceptualize their identities/lived experiences as consumers/survivors/ex-patients in mental health care?
2. How does this identity and its accompanying experiences influence participants' role as a music therapist?
3. How does this identity and its accompanying experiences influence participants' perception of their clients, who are also service users in mental health care?
4. What challenges or benefits has this identity/lived experience contributed to for these music therapists?

Mad Music Therapist Identity

Participants articulated a diversity of perspectives on Madness as an identity. For some participants, their lived experiences in mental health care were central to their personal and professional identity. For others, their lived experiences were influential in their ways of being but labelling themselves as Mad or mentally ill was not a salient dimension of how they articulate themselves. This variance in perspective underscores that there is no singular Mad Narrative (Rashed, 2019a).

As described in Richards et al. (2016), participants in the current study suggested that Mad music therapists must navigate the dialectical roles of “patient/service user” and “professional.” As Elhert (2020) also illustrated, professional environments and academic

cultures can reinforce an *either/or* dichotomy between these facets of self. Richards et al. (2016) noted that the course of developing an “integrated” identity, drawing simultaneously on the expertise of patient *and* professional, is a gradual, individual process. In the present study, several participants described their collective experiences over time, including diagnosis, help-seeking, and personal development, as evolving processes. These findings suggest that Mad music therapist identity formation is a developmental process.

While engaged in the process of self-construction, participants sought to differentiate themselves from other professionals. Richards et al. (2016) highlighted how mental health professionals with experience as service users often referenced a discourse of “expected versus disallowed ways of being a professional” (p. 7). Mad music therapists appear to refute reductive professional scripts by leveraging shared experience with clients, critiquing dominant philosophies in music therapy, prioritizing thoughtful versus prescriptive approaches to clinical work, and intentionally engaging in self-disclosure. Furthermore, Richards et al. (2016) noted that some Mad mental health professionals draw on an “activist” discourse as they move along a developmental trajectory towards identity integration. Present study participants’ mirror this by reporting an enthusiasm for and at times moral obligation to engage in creating public and professional spaces rooted in authenticity and social justice.

Along the lines of an “integrated” identity, there appears to be an overlap between the “double consciousness” described by the present study participants and what Kolbeinsen (2022) called the meta-perspective of *divided attention*. Participants in both studies described simultaneously attuning to the perspectives of patients/clients and professional expectations. As explored by Jones and Hutson (2020), *authenticity* was a central value for participants, but there was a multiplicity of ways that was navigated. Many participants shared needing to conceal

aspects of their Madness to avoid negative professional consequences, and others described practicing openness as a principle and a tool for advocacy.

Role of the Therapist

While no participants referenced the wounded healer archetype, all participants described ways in which their identity and its accompanying experiences influenced their role as a music therapist. Some participants cited their lived experience as patients within mental health care as a catalyst for their own professional aspirations, much like Mary Priestley described, where a desire to be part of fixing a broken system propelled them. All participants acknowledged the brokenness and injustices of mental health care, suggesting an ecological awareness ushered in by existing at the crossroads of systemic forces like stigma and sanism. A sense of conflict, and even moral injury, described by participants resulting from participation in these oppressive structures appeared to fuel convictions about advocacy and reform. Some participants voiced perspectives like Gosselin (2022) about the function of self-disclosure and visibility as an act of epistemic resistance. Many participants described efforts to normalize general conversations of mental health and assume advocacy roles in their communities or workplaces, suggesting that becoming an advocate may be a significant dimension of being a Mad music therapist.

Therapeutic Relationship

An experience of Madness as a music therapist may promote a more humanistic view of clients/patients. All participants suggested that their lived experience benefited them as music therapists. The *double consciousness* of a Mad music therapist may engender empathy, compassion, insight, and offer an authentic witness to the experiences of a client/patient within the context of the therapeutic relationship. These findings were consistent with previous accounts of Mad practitioners which suggested such individuals view those with whom they work with

empathy and keen understanding (Austin, 2002; Cain, 2000; Kolbiensen, 2022; Zerubavel & Wright, 2012). Similarly, Kolbiensen (2022) described wounded healer music therapists experiencing a sense of deep intuition borne of lived experience that allowed them as therapists to quickly attune to the needs of patients with similar experiences.

Disclosure

A dimension of the therapeutic relationship of particular concern for Mad music therapists is the role of self-disclosure. Participants concurred with perspectives in the literature suggesting that self-disclosure as a therapeutic tool should be used delicately and judiciously (Elliot & Ragsdale, 2020; Turner et al., 2022). As in Zerubavel and Wright (2012), participants who shared experiences of disclosing some aspect of their lived experience in clinical scenarios suggested that this therapeutic use of self could be validating and an effective means of decentralizing therapist power when used appropriately.

One participant did mention making indirect disclosures to validate client experience (e.g., sharing the fact that they use an ocean drum at home for their own emotion regulation). This subtle way of acknowledging the emotional regulation needs of the therapist appears to decenter the power of the therapist and challenge a hierarchized therapeutic relationship. Simultaneously, such a disclosure opens a door to a possible conversation in which the client may choose to explore the self of the therapist of their own volition in future sessions. This approach to disclosure also seems to address the concern voiced by participants that some forms of disclosure may overstep the ethical confines of the role of therapist. When navigating authentic ways of being a Mad music therapist, the therapist must still prioritize the needs of the client. If partial disclosure by the therapist merely opens a door, autonomy of the client to choose to walk through that door can remain supported and respected. The disclosure in this sense is not

a declaration of therapist stating plainly their personal history of diagnosis, but rather an organic “me, too” acknowledgement. This objective may be reached by validation or observation statements from the therapist that imply shared experience. For example, the therapist could validate a client’s experience by saying, “As someone who has experienced similar feelings myself, I can see how you would react that way.” Partial disclosures to patients in which therapists may identify themselves as having similar lived experiences to their clients may not need to be explicit to be effective. Future research may continue to explore appropriate modes of disclosure that destigmatize Madness and deconstruct “mental illness” while prioritizing safety and stability for the benefit of clients.

Though Dunn (2007) underscored the role of self-evident disclosure through the musical relationship in music therapy, none of the participants of the current study mentioned disclosure through music in the same fashion. Future research should continue exploring the role of the creative process as a means of authentic being and therapist self-disclosure. Aesthetic values of mad-positive music appear to resist essentialist flattening of Mad narratives (Castrodale, 2019), so future inquiries might explore a liberatory therapeutic potential of Mad music therapist and Mad client co-creating a mad-positive relationship through music.

Sanism

Like Kolbeinsen (2022) described in their thematic analysis of music therapists’ experiences of their own mental health challenges, participants expressed bias against Mad people as a principal concern governing personal and professional disclosures, despite shared perceptions that stigma is diminishing over time particularly for certain conditions like anxiety and depression. As in Elliot and Ragsdale (2020), participants described a strong sense of professional stigma prevailed in their workplaces. Also like the practicing psychotherapists in

this study, participants often recalled witnessing prejudicial or discriminatory behavior thus making examples out of other Mad clinicians. As described by Zerubavel and Wright (2012) and Tay et al. (2019), professional stigma incentivized hiding one's identity, needs for support as well as prevented help-seeking behavior like requesting accommodations. One participant also described experiencing sanism in the form of being steered away from practicing in mental health contexts due to a perception of weakness and fragility, a prejudice outlined in Wolframe (2012).

Transability

Stigma and sanism are not experienced uniformly by Mad music therapists, and participants' characterization of their lived experiences suggest that visibility and the extent to which a presentation of Madness is able to be hidden (e.g., self-injury scars, active symptoms) are mediating factors. Similar to findings by Kolbeinsen (2022), participants illuminated trends in discourse around the mental health of music therapists suggest that some diagnoses (e.g., anxiety and depression) are deemed more acceptable to discuss than others. Acknowledging this variance, Kolbeinsen (2022) described a spectrum of vulnerability (“spektrum av sårbarhet”) experienced by wounded healer music therapists. There is a natural continuum of ability, innate to human experience. Kolbeinsen (2022) highlighted that all humans experience some level of vulnerability at some point in their lives. However, often in medical understandings of “treatment” there is a clear distinction between the healer and the healed/identified patient.

Given the propensity of sanism within the mental health fields to silence Mad therapists, those invested in transforming discourse must remain vigilant and responsive to attempts to hierarchize vulnerabilities, ability, or experiences of oppression. Without resisting the potential pressure of a Recovery Model perspective to demand a Mad music therapist achieve a certain

level of “recovery” by way of performed normality, one may reinforce systemic sanism. Without reflection on the potential draw of individualistic, inspirational narrative of over-coming one’s human condition as if that were a fixed obstacle (i.e., what critical disability studies terms the “supercrip” narrative), even those intending to destigmatize mental “illness” may reinforce dominant oppressive ways of thinking.

Joel Michael Reynolds (2014) held that the boundaries of ability and disability are much more fluid than most public discourse suggests by virtue of the fact that most people will have the experience of being medically or socially disabled at some point in their lives. Instead of clinging to a rigid binary of abled/disabled, Reynolds calls for a paradigm shift to instead recognize one’s *transability*, the non-fixed possibility of existing somewhere between these two poles. Transability seeks to establish a normative ethics centered on the variability of the body, holding that all humans find themselves somewhere along a continuum between abled-disabled and thus are all implicated in systems that pathologize a particular subset of that continuum. An extension of this idea could include natural variation of the mind, akin to the concept of neurodiversity. In kind, a hierarchy of diagnoses or presentations of Madness, as described by Mula (2020) and reiterated by participants, exemplifies sanist norms by demonstrating the impact of stigma according to the degree to which a presentation of Madness conforms to narrow, prescribed way of being as informed by White Imperialist heteropatriarchy. Understanding Madness through the lens of transability, one may account for the fluid nature of human health experience and begin to chart a course forward that is responsive to the needs of Mad music therapists without bolstering reductive hierarchical thinking in music therapy education, supervision, and professional policy.

As highlighted by Ellie, instituting professional policy that is sensitive to the needs of Mad music therapists but also honors the ethical imperative of prioritizing client safety may present challenges and require radical reimagination by music therapy leaders. Legislative and/or professional policy decisions necessitate consideration of competency and “fitness” to practice, definitions of which are socially constructed and steeped in White Imperialist heteropatriarchy which deploys sanism as a force of conformity. It stands to reason that further research is necessary to determine ethically responsible and anti-oppressive routes incorporating Mad Studies perspectives in music therapy theory and practice.

Accessing Support

Participants reported coping with the challenges that Madness may present in a variety of ways. Like 74% of the music therapists surveyed in Kendrick (2021), participants all reported taking part in personal therapy at some point in their careers. Conventional means of support such as psychotropic medication and talk therapy were commonly utilized in tandem with other methods such as meditation, spiritual practices, and creative expression. Participants concurred with Kolbeinsen’s (2022) finding that robust self-care practices should remain a priority for music therapists with experience as service users.

Professional Implications

Participants offered several insights into the experiences of Mad music therapists that pertain to education, clinical training, and professional development. Participants’ narratives illustrate that the influence of educators on the experience of their students can be subtle, but it can leave a lasting impact. The manner in which educators talk about mental illness and accommodations shapes general attitudes in academic programs. Like the art therapists surveyed in Huet and Holtum (2016) and the music therapists in Warren (2020), participants voiced

concern about the ramifications of disclosing to professors (e.g., judgment, perceived incompetence, being overlooked for opportunities). Concurring with Warren (2020; 2023) and Kolbeinsen (2022), participants highlighted the immense responsibility of training future generations of music therapists thus setting the tone for discussions of mental health. Similar to Lunt's (2002) characterization of the pivotal role her music therapy professors played in her personal and professional development as a wounded healer, participants highlighted the positive influence affirmation, understanding, and support can had on their success as music therapists. Like the disabled music therapists and educators in Warren (2023), participants critiqued the influence of the medical model on foundational academic and professional discourses. Drawing from their experiences as both therapist and patient/client, Mad music therapists appeared to further problematize notions of music therapists as professionals who "treat" or "fix" Madness.

Participants offered several solutions to address these challenges. Echoing calls from Elhert (2020) and LaCom and Reed (2014), one participant emphasized a need for greater incorporation of critical disability, Mad Pride and anti-psychiatry discourse in music therapy education. Similarly, one participant who held a role as a music therapy professor highlighted their commitment to historicizing and culturally situating the use of the DSM-5 in their teaching. Many participants reported actively addressing stigma and sanism through their own means and expressed a desire to see these efforts within music therapy grow. Zern et al. (2022) delineated practical means for challenging sanism in the field of biological psychiatry such as building mentorship networks for students and new professionals, conducting accessible conferences, and inclusion in journal editorial boards and in organizational leadership. Applying these ideas to music therapy spaces, like developing a Mad music therapists peer support group, would appear to address needs for connection and professional mentorship expressed by participants.

Limitations and Future Research

Due to the time constraints of this thesis research, recruitment was limited to a narrow window. Likewise, the labor and time commitment of study participants may have been a barrier to participation for some Mad music therapists. Lack of racial and ethnic diversity in study participants runs the risk of further contributing to assumptions of whiteness in Mad studies (Rose & Kalathil, 2019), and care must be taken to not presume the perspectives shared in this study can account for the perspectives of all Mad music therapists. Participants were sent transcripts and findings, but few edits were made. Though the researcher engaged in several reflexive practices during data collection and analysis, findings may be susceptible to confirmation bias.

Additional research is necessary to cultivate a deep understanding of the experiences of Mad music therapists. Due to a lack of research in this area, future research should further explore topics raised by participants such as the impact of sanism, the role of Mad advocacy, and the importance of Mad-positive supervision. Additionally, future research should examine more closely the role of music in self-disclosure, as Dunn (2007) pointed out this is a unique dimension of the therapeutic process in music therapy. Future research should continue to seek to center the most marginalized Mad voices and take care to uphold epistemic justice in their methodological approaches. Building a greater awareness of the needs of Mad music therapy students, interns, and young professionals will better equip educators and supervisors with knowledge essential to implementing anti-oppressive pedagogy, designing Mad-positive curricula, and offering responsive accommodations. As support for diversity, equity, and inclusion initiatives and social justice perspectives in the field of music therapy grows, Mad

Studies should be included in efforts of anti-oppressive transformation following in the tradition of efforts to incorporate other critical theories into academic discourse.

Conclusion

The aim of this interpretive phenomenological analysis was to develop an understanding of the experiences of Mad music therapists. Findings offered insight into the ways in which Mad music therapists view themselves, how they view their patients/clients, how their identity impacts their role as a therapist as well as challenges and benefits presented by this identity. Participants highlighted the major role stigma and sanism plays in creating academic and professional cultures of silence around mental health and accommodation. In contexts where participants felt safe from negative professional consequences, they described presenting their fullest selves and taking on roles as advocates for mental health. While participants each embraced Madness as an identity to varying degrees, all participants cited their lived experience as service users in mental health care as an asset to their practice of music therapy. As the field of music therapy continues to evaluate dimensions of sociocultural identity and their intersection with music therapy practice, the perspective of Mad music therapists can offer a unique and valuable lens through which to view anti-oppressive practice.

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APPENDICES

Appendix A: Consent Form



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 Theatre

Programs

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 OSH Public Humanities
 Wilfong Center

CONSENT TO PARTICIPATE IN RESEARCH

The Experiences of Mad Music Therapists: An Interpretive Phenomenological Analysis

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Carly Poloskey, MT-BC; cxp1053@sru.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be at least 18 years old, a board-certified (or equivalent) music therapist (or eligible for professional certification) who also has self-identified as a consumer/survivor/ex-patient in mental health care or as having a mental illness/psychiatric disability. This may include having received a diagnosis (e.g., bipolar disorder, schizophrenia and/or personality disorders) and/or receiving psychiatric treatment (e.g., psychotherapy, psychotropic medication, hospitalization for acute psychiatric care). Though not required, researchers will prioritize recruiting participants that have lived experiences consistent with diagnoses conditions such as bipolar disorder, schizophrenia, and/or personality disorders. You may note that the term "mad" is employed throughout this study as an umbrella term which seeks to encompass a plurality of experience that maintains utility in coalition politics among consumer/survivor/ex-patient advocacy, Mad Pride, anti-psychiatry, and disability justice movements. Due to the researchers' limitations, participants must be proficient in English and have access to the internet. Taking part in this research project is voluntary, and you can change your mind about participation at any point in the research.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore how mad music therapists conceptualize their identity, its impact on their self-perception and how they perceive those with whom they work as music therapists.
- If you choose to participate, you will be asked to participate in an approximately one-hour long interview with the researcher about your identity/lived experience with mental healthcare and current practice of music therapy.
- While we do not anticipate risks or discomforts associated with this study, you may experience some discomfort related to questions regarding your identity/lived experience. Given that it is an individual interview and is being recorded, there is minimal risk of breach of confidentiality. There is also minimal risk of emotional discomfort. Precautions will be taken to eliminate or reduce these risks.
- You may experience emotional benefits from participating in this study, such as increased self-awareness and/or awareness of the impact your identity/lived experience has on your practice of music therapy.
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

Initials _____ * Every page must be initialed by research participant

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What is the Study About and Why Are We Doing It?

The purpose of the study is to explore how mad music therapists conceptualize their identity. This inquiry seeks to understand this aspect of identity as it pertains to music therapists' perception of self and the clients with whom they work. We explore the potential impact of these dynamics on the perception of stigma, self-disclosure, therapeutic relationship, and clinical efficacy. Music therapy literature has recognized that sociocultural identities and lived experience of the therapist shapes both personal and professional development as well as clinical practice (Hadley, 2021, 2013, 2006), and the present inquiry seeks to deepen this understanding by exploring how mad identities impact these dynamics. We anticipate findings to further understanding of the strengths and challenges particular to the experiences of music therapists who identify in this way.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be invited to participate in an approximately one-hour long individual interview with the researcher, which will include open-ended questions regarding your experiences of mental health care as a consumer/survivor/ex-patient. After the interviews are conducted, they will be transcribed, coded, and organized into themes for analysis. After initial analysis, participants will have the opportunity to review the analysis of their interviews and offer feedback. If appropriate or requested, another virtual meeting will be scheduled to discuss participant feedback to ensure the analysis accurately represents their responses.

How Could You Benefit From This Study?

Participating in the experience of reflection and group discussion may provide you further insight and perspective into your own professional practice.

What Risks Might Result From Being in This Study?

Participants will not be deceived in the course of this study and will be aware of the purpose and rationale throughout the process. While there are no anticipated risks or discomforts as a result of participating in this research, when interviews are recorded there is a minimal risk of breach of confidentiality. To mitigate against the risk of breach of confidentiality, recordings will be deleted as soon as the interview is transcribed, and participants will be assigned a pseudonym. There is also minimal chance that the experience may cause emotional discomfort. As professional music therapists, we understand that you have access to resources for professional supervision or therapy services should you experience emotional discomfort as a result of the interview. We can provide additional resources if needed.

How Will We Protect Your Information?

We plan to publish the results of this study. To protect your privacy, we will not include information that could directly identify you. You may choose a pseudonym, or one will be given to you by the researcher(s). Transcriptions of the interviews will be kept in a password-protected folder on the password-protected computer(s) of the researcher(s).

What Will Happen to the Information We Collect About You After the Study is Over?

We will not keep your research data to use for future research or other purposes. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project. Research materials will be kept for two years and then destroyed.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

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What are the Costs to You to be Part of the Study?

There are no costs associated with participating in this research study.

What Other Choices do I Have if I Don't Take Part in this Study?

If you choose not to participate, there are no alternatives at this time.

Your Participation in this Research is Voluntary

The decision to participate in this research study is entirely up to you. Participation in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and may withdraw from participation at any time. If you decide to withdraw before this study is completed, any data collected during your participation will be destroyed. You do not have to answer any questions that you do not want to answer.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, please contact Susan Hadley at susan.hadley@sruc.edu or Carly Poloskey at exp1053@sruc.edu. We welcome any questions you may have about this study.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sruc.edu

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Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. We will give you a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about, and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

Printed Participant Name

Signature of Participant

Date

By signing below, I indicate that the participant has read and to the best of my knowledge understands the details contained in this document and have been given a copy.

Printed Name of Investigator

Signature of Investigator

Date

Audiotape Release Form:

We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper. Regarding the use of your likeness in audiotape/videotape, please check one of the following boxes below:

I do...

I do not...

give unconditional permission for the investigators to utilize audiotapes of me as described above.

Printed Participant Name

Signature of Participant

Date

Initials _____ * Every page must be initialed by research participant

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Appendix B: Semi-structured interview guide

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.

1. How do you describe your identity with regard to mental health?
 - a. Are there any labels or terms you find personally meaningful or helpful for you?
2. What, if any, supports have you utilized with regard to this experience (e.g., psychotherapy, medication)?
 - a. How has music played a role in this, if at all?
3. Given that all parts of our identity/experience influence other parts of our identity/experience, are there other aspects of your identity that you find shape your perspective on this matter?
4. How does this identity and its accompanying experiences influence how you view your role as a music therapist?
5. In what ways does this identity impact the therapeutic process?
6. How does it shape the way you view your clients?
7. Has it influenced your decision to practice in certain contexts?
8. In what ways, if any, might it benefit practice (e.g., therapeutic alliance, empathy)?
9. What, if any, challenges have you encountered as a result of this identity in your role as a music therapist and as a music therapy student (e.g., clinical challenges, stigma, lack of appropriate accommodations in the workplace)?
10. How does society's conception of this identity/experience impact self-disclosure or other authentic ways of being in:
 - a. Educational spaces?

- b. Clinical spaces?
 - c. Professional spaces?
11. Under what conditions would self-disclosure occur?
 12. What, if any, other thoughts or feelings would you like to share on this topic?
 13. In closing, how has this experience of sharing your story been for you?

Appendix C: Institutional Review Board Approval



TO: Dr. Susan Hadley
Music Therapy

A handwritten signature in black ink, appearing to read "Michael Holmstrup".

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

DATE: March 7, 2023

RE: Protocol Approved

Protocol #: 2023-075-56-A

Protocol Title: The Experience of Mad Music Therapists: An Interpretive Phenomenological Analysis

The Institutional Review Board (IRB) of Slippery Rock University has conducted an administrative review of the above-referenced protocol under the "exempt" category.

You may begin your project as of March 7, 2023. Your protocol will automatically close on March 6, 2024 unless you request, in writing, to keep it open.

Please contact the IRB Office by phone at (724)738-4846 or via e-mail at irb@sru.edu should your protocol change in any way.