5-28-2024

The Experiences of Stigma Amongst Practicing Music Therapists Living with Depression and/or Anxiety: An Exploratory Qualitative Study

Hally Batterman

THE EXPERIENCES OF STIGMA AMONGST PRACTICING MUSIC THERAPISTS LIVING WITH DEPRESSION AND/OR ANXIETY: AN EXPLORATORY QUALITATIVE STUDY

A Thesis Submitted to Molloy University
Music Department, Rockville Centre, NY

In Partial Fulfillment
of the Requirements for the Degree

Master of Science
In
Music Therapy

---

by
HALLY BATTERMAN, MT-BC
MAY 2024

Molloy University

A thesis committee has examined the thesis titled

THE EXPERIENCES OF STIGMA AMONGST PRACTICING MUSIC THERAPISTS LIVING WITH DEPRESSION AND/OR ANXIETY: AN EXPLORATORY QUALITATIVE STUDY

Presented by HALLY BATTERMAN, MT-BC

A candidate for the degree of Master of Science in Music Therapy

And hereby certify that the thesis was read and approved by the committee.

Stephanie Jones, MM, MTBC — 5/28/24

Thesis Advisor — Date

Alejandra Ferrer — 5/28/24

Committee Member — Date

Suzanne Sorel — 5/28/24

Dr. Suzanne Sorel — Date
Director of Graduate Music Therapy

Abstract

This study explored the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. Three study participants were selected from social media groups through purposive sampling. Participants were board-certified music therapists (MT-BC's) living in the United States. They all had been practicing as full-time music therapists for at least 5 years and had depression and/or anxiety for a minimum of 2 years during practice as an MT-BC. Qualitative data sources included in-depth interviews with participants conducted over Zoom. The results of the study suggest that music therapists' experiences of stigma for their mental illness (MI) had a negative impact on their mental health journey, life, and career. The thematic analysis of interviews yielded four themes: Music Therapists with MI Experience Self-, Institutional, and Public Stigma; Music Therapists with MI Need Changes in Society's Perception of MI, Education, and Workplace Environments; Disclosure, Education, and Self-Reflection are Tools to Tackle Stigma, and Learning to Live with MI is a Process. The results of this study suggest that further research is needed to raise awareness of an underexplored but serious issue, combat stigma, and further develop anti-stigma initiatives to support music therapists with MI.

Keywords: stigma, mental illness, music therapists, depression, anxiety

Dedication

To the music therapists living with mental illness. May you all experience the day when you do not feel the need to hide parts of yourselves. May you live loudly and be proud of who you are.

Acknowledgements

First, I would like to extend an enormous thanks to my thesis advisor, Stephenie Sofield. Thank you for dedicating hours upon hours of your time as you guided and mentored me through an extremely difficult process. Thank you for listening during my spiraling moments and for helping me out of them. You have been incredibly gentle and supportive in my endeavors as a new researcher while still pushing me to do my very best. I truly could not have done this without you. I am a better music therapist and human because of your teachings. I am eternally grateful to have had the opportunity to learn from you as both a professor and a thesis advisor. Thank you to my committee member, Dr. Alejandra Ferrer, for your support and dedication to my work. It was an honor to have you on my team. I would also like to thank Dr. Suzanne Sorel for believing in me and supporting me throughout my graduate studies at Molloy University. To all my Molloy University professors and peers, thank you for the wisdom you have bestowed upon me over the years. You have all helped shape the music therapist that I am today. To Elizabeth Schwartz, thank you for being my guiding light from when I was a baby intern until now. I will always cherish the knowledge, opportunities, and love you have graciously given me. I would not be who I am today without you. To my dear friend and colleague Sarah Mayr, thank you for your constant support and friendship during such a significant moment in our careers. You have been there for me every step of the way and for that, I am forever grateful. I would not have made it to the finish line without you. To my colleagues, clients, and their families at the Music Academy for Special Learners, thank you for your patience, understanding, and support as I navigated writing a thesis, attending graduate classes, and balancing clinical work. To my fiancé, John Allen, thank you for keeping me smiling and laughing even on the darkest of days

and for always being my biggest cheerleader. You are my best friend and I love you more than words could ever express. Finally, I would like to thank my mother and father for their endless love, support, and compassion. You two have always been my biggest supporters in everything I do. Thank you for understanding, accepting, and supporting my mental health journey. The world needs more people like you. I am forever grateful to be your daughter.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Anxiety and depression are the two most common mental illnesses in the United States (Anxiety & Depression Association of America [ADAA], 2023). Approximately 40 million Americans experience an anxiety disorder annually, and according to research conducted in 2023, about 17.3 million Americans have experienced at least one major depressive episode (ADAA, 2023). Research has demonstrated how these two mental illnesses together represent one of the more common comorbidities (National Alliance on Mental Illness [NAMI], 2018). Individuals who develop depression tend to have experienced an anxiety disorder earlier in their lives (ADAA, 2023). According to the National Institute of Mental Health (NIMH, 2023), anxiety can originate from traumatic life experiences, physical conditions, and genetics. Depression can originate from the same conditions, life events, and genetic factors (NIMH, 2023). This means anxiety and depression can be both hereditary and caused by environmental factors.

Stigma affects approximately nine out of ten people living with mental illness (Mental Health Foundation, 2021). Experiences of stigma can serve as a barrier to self-care and improvement of mental health services (World Health Organization [WHO], 2022). Stigma frequently leads to discrimination and isolation, which, in turn, can affect an individual's financial status, voice within society, access to care, sense of community, and chances of recovery (WHO, 2022). Almost 60% of adults living with mental illness do not receive treatment, which means that approximately 27 million people in the United States are untreated (Mental Health America [MHA], 2022). A study of 90,000 people across the globe found that stigma is one of the leading causes of lack of treatment (Krans, 2018).

Stigma toward mental illness has also been found to be a significant problem among mental health professionals, both in how they perceive their patients and their colleagues living with mental illness (Knaak et al., 2017). Identified consequences of stigma include delays in seeking help, termination of treatment, patient safety concerns, poor therapeutic relationships, lack of health insurance coverage, and lower quality of physical and mental care. Knaak et al. (2017) also detailed the inward element of stigma in how it impacts health professionals and their willingness to disclose personal mental illness. This can lead to decreased support and judgment from peers and an increased risk of suicide.

Music therapists work with a wide range of clientele, including individuals with mental illness. Music therapy as a mental illness treatment is provided as a psychotherapeutic tool and is used to help clients develop relationships, manage symptoms, and receive psychosocial support (American Music Therapy Association [AMTA], 2021). Stigma and ableist attitudes towards clients and fellow music therapists living with mental illness have briefly been touched upon in studies surrounding ableism (Bruce, 2022; Dunn, 2021; Shaw et al., 2022). The literature has shown that more awareness of ableist attitudes and stigma is needed to understand the systemic problems embedded within the profession and how they affect us and those we serve (Bruce, 2022).

Ableism can be defined as "a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as perfect, species-typical and therefore essential and fully human" (Campbell, 2009, p. 5). It is a form of oppression that leads to disablism. Disablism can be understood as "the discriminatory, oppressive, or abusive behaviour arising from the belief that people who do not have certain abilities are inferior to others" (Wolbring, 2009, p.151). Ableism places people living with

mental illness in a category that requires fixing or a cure. In the context of mental health and music therapy, Shaw et al. (2022) discussed how the idea of the 'helper' therapist trope and the desire to fix/perfect mental illness and disability may reinforce ableist perspectives of the therapeutic relationship and thus, increase stigma towards the client or therapist living with mental illness. Ableism views mental illness in a negative light rather than as a part of humanity that one can live alongside.

Gross (2018) wrote about the need for a shift in music therapy practice. Much of music therapy aligns with the medical model of disability in which disability is viewed as a flaw that requires change or treatment. Gross proposed that music therapists move to a social model to break down ableist views and see disability in a new light. Davies (2022) addressed ableism and the minority stress model from the point of view of a neurodivergent music therapist living with autism. The minority stress model explains the differences in health between the majority as compared to stigmatized minority groups. This model looks at the adverse effects of living as a minority neurotype in a society designed for the neurotypical majority. The impact of minority stress can lead to increased levels of anxiety, depression, and a higher risk for suicide (Botha & Frost, 2020). Davies proposed a shift in language and a re-framing/re-defining of pathology as culture or a different way of being within society to combat negative attitudes and stigmatization (Davies, 2022).

Researchers have investigated the prevalence of stigma within the mental health profession, as well as experiences of stigma amongst people with mental illness (Knaak et al., 2017). Additionally, there is a body of research regarding music therapy treatment for mental illness symptom management (Erkkilä et al., 2011). However, there is a gap in the literature regarding stigma towards mental illness within the music therapy profession. Therefore, this

study sought to examine the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. Through illuminating experiences of music therapists living with mental illness, this study contributes to increased anti-oppressive considerations within music therapy education and training. The research questions guiding this study were:

1. What are the personal experiences of stigma in music therapists living with mental illness?
    a. What forms of stigma do music therapists living with mental illness experience and how do these manifest?
2. What are the needs of music therapists living with mental illness who have experienced stigma?

An exploratory qualitative study (Hunter et al., 2019) was conducted, using three in-depth interviews to explore the under-researched phenomena. The interview data was analyzed through a thematic analysis (Braun & Clarke, 2013).

Worldview and Epistemology

Throughout this written report, I used the word "I" in reference to the primary researcher, Hally Batterman. I am a board-certified music therapist and identify as living with depression and anxiety. I was diagnosed with Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) in 2018. However, MDD and GAD have been a part of my life for much longer than the official diagnosis.

Over the years, I have matured and grown into a professional within the music therapy practice, as well as a human being in that I have learned to recognize, accept, and seek my own personal therapy for my mental illnesses. Counseling has played a huge role in helping me find meaning in my life and pushing me to become the best music therapist I can be. Medication

coupled with counseling helped to balance my brain chemistry and allowed me to be more present and authentic with my clients. Counseling helped me gain more insight into the importance of the therapeutic relationship, human connection, and empathy – all critical elements of music therapy treatment.

Despite my progress and growth in learning to live alongside mental illness, I constantly find myself biting my tongue and hiding behind the walls that I have built for myself in terms of being my true self in the workplace. I have found that personal mental illness and neurodivergence are typically not discussed among coworkers. We discuss our clients and new interventions we might consider trying with them. We bounce ideas off one another, empathize when needed on those tough workdays, and engage in professional small talk. We are encouraged to seek out supervision with our assigned supervisors whenever necessary, but typically regarding our clientele. I believe this is a common way of life in the workplace in many settings within music therapy. I often wonder why I fear the disclosure of my mental illnesses. Could it be the fear of being ostracized and stigmatized by coworkers? Could there be a fear of consequences surrounding employment? I worry I'll be treated differently or looked at in a different light that separates me from the rest of the staff. My coworkers have personally never made me feel uncomfortable or unsafe, however, I think in today's society, I will always feel uncomfortable disclosing my true self in the workplace. It marks me as extra vulnerable and susceptible to opposing views from those around me, however, not disclosing is not an easy task. Mental illness is very much a part of who I am. I live with it every second of every day of my life and many times, it can feel overwhelming to try to silence it when I spend much of my week at work.

As a music therapist living with MDD and GAD for much of my life, I have learned that these disorders affect a large part of the population around me. I have witnessed family members, friends, as well as fellow peers learn to live with the same diagnoses and experience the same lack of support. These shared experiences, especially with those within helping fields, pushed me to dive deeper into self-care techniques for music therapists during my clinical work and education and general self-care methods for coping with these disorders. Growing up around so many people with the same mental illness influenced my desire to want to enter a helping field as a future career path. However, stigma, in its many forms, consistently seems to be present in my professional life, and I cannot help but wonder if I am not the only one with these experiences.

I ascribe to an interpretivist epistemology, which is defined as a division of research in which the purpose is to explore a particular unknown phenomenon as it unfolds throughout the study (Wheeler & Murphy, 2016). I believe that each participant's lived experience has a place and a particular meaning within the context of the research. A human's experience within the world is highly individualized and may share common threads with others, but it can also vary greatly. In alignment with an interpretivist worldview, I utilized interviews to gather rich narratives about the participants' personal experiences. I believe first-hand accounts best capture the experience of what it is like to encounter stigma while working as a professional music therapist living with mental illness.

I was eager to shine a light on experiences of stigma to advocate for increased anti-oppressive considerations within music therapy education and training. I was particularly interested in raising awareness of those music therapists who provide support for other individuals living with similar mental health challenges as themselves. I am a firm believer in

mental health being just as essential to address as physical health, and I believe there is a need for people to come together to support tolerance and acceptance of mental health treatment and leave the stigmatizing attitudes behind.

CHAPTER 2: LITERATURE REVIEW

This study sought to understand the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. Before exploring the related body of literature, I identified and defined depression, anxiety, and stigma. I then examined the literature regarding stigma towards mental illness among mental health professionals. Following this, I reviewed the literature regarding music therapy for stakeholders living with mental illness, as well as research studies and theoretical publications that explored music therapy, ableism, and stigma within the profession.

Depression, Anxiety, and Stigma

According to the World Health Organization (2022), approximately 970 million people across the globe were living with a mental illness in 2019, with depression and anxiety being the most common. Researchers have found that stigma plays a vital part in negatively impacting the lives of those with mental illness (Borenstein, 2020). According to NAMI (2023), 53% of people are caring and sympathetic towards those with mental illness. 15% view people with mental illness as a burden to society.

Depression

More than 20 million Americans experience depression, a serious mood disorder with symptoms that can interfere with daily life (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Depression can occur as a result of trauma, significant life changes, side effects from medications, physical illnesses, stress, and/or genetics, such as a family history of depression. Perhaps most importantly, this disorder can result in self-harm and/or suicide. Recent research indicates that more than 95% of people who take their own lives have depression or some other mental illness (Cincinnati Children's, 2023). Depression has also

caused a significant economic burden. In 2018, the estimated cost of depression in adults living in the United States was approximately $236 billion (American Psychiatric Association [APA], 2021). There are approximately 280 million people globally who are currently living with depression, and it is estimated that approximately 49% of adults with a diagnosis of Major Depressive Disorder are not receiving treatment (ADAA, 2023). This lack of treatment may be due in part to an under-investment in mental health care, as well as the stigma surrounding mental health (WHO, 2023).

When diagnosing depression, there tends to be an emphasis on the symptoms. Symptoms of depression must be present for at least two weeks and include persistent sadness, feelings of hopelessness, guilt, irritability, frustration, or restlessness, loss of interest in pleasurable activities, decreased energy, fatigue, difficulty concentrating, lack of sleep or oversleeping, changes in appetite, physical pain, and thoughts of death/suicide (NIMH, 2023). It can occur at any age and happen to people of all races and ethnicities, however, it most often occurs during adulthood.

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition [DSM-5] (APA, 2013) identifies a variety of depressive disorders, including but not limited to Major Depressive Disorder, Persistent Depressive Disorder, Disruptive Mood Dysregulation Disorder, Premenstrual Dysmorphic Disorder, and Substance/Medication-Induced Depressive Disorder.

Studies have shown that parental depression can have an intergenerational effect (Yale Medicine, 2023). Depression interferes with parental bonding and can lead to an inability to keep children safe and healthy. Children of parents living with depression are at an increased risk for academic challenges and have been found to have more behavioral issues. Intergenerational transmission of disorders such as depression and anxiety can continue the cycle of mental illness

and, hence, stigma. Parents with depression may be unable to bond and provide for their children and, in some instances, lose their parental rights due to the symptoms of these illnesses.

Research indicates that stigma and stigmatizing attitudes towards those with depression play a part in whether people seek and receive proper treatment and support for this serious illness. Depression impacts the individual and their family, can be hereditary, leading to an increased risk for depression in children, and is an economic burden on the healthcare system.

Anxiety

Anxiety is another serious mood disorder that can affect a person's daily life. Anxiety is considered to be the world's most common mental disorder and affected approximately 301 million people in 2019 (WHO, 2023). Symptoms of anxiety disorders include feelings of restlessness, fatigue, difficulty concentrating, increased irritability, physical pain, sleep problems, and excessive and persistent worry (NIMH, 2023). Anxiety typically begins in childhood and the average age of onset is seven years old. Anxiety can originate from experiences of trauma, significant life changes, physical conditions, and a family history of anxiety disorders (NIMH, 2023). Only about one in four people living with anxiety receive some form of treatment. Barriers to treatment include a lack of awareness that anxiety can be treated, a lack of investment in services, a lack of trained health professionals, and stigma.

The DSM-5 (APA, 2013) identifies a variety of anxiety disorders, including but not limited to Generalized Anxiety Disorder, Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder, Panic Disorder, Agoraphobia, and Substance/Medication-Induced Anxiety Disorder. Approximately 7.3% of the global population lives with one of these disorders (Psych Central, 2022).

Mohandes and colleagues (2022) conducted a survey that examined the economic impact of varying anxiety levels among adults living in the United States. They found that higher anxiety levels, along with co-morbid depression, contribute to an overall increase in cost. They discovered that an improvement in symptoms of both anxiety and depression could reduce the economic burden.

Mental Illness and Stigma

For the purposes of this study, stigma is defined as: "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency" (American Psychological Association [APA], 2018, para. 1). Researchers have posited that stigma surrounding anxiety and depression may act as a barrier to treatment and self-care, and that stigma may be rooted in ignorance, fear, or lack of understanding (APA, 2020). Stigma can be understood as a serious issue for those with mental illness, as it can lead to discrimination. Additionally, for those with mental illness, experiences of stigma can result in feelings of defeat, reluctance to seek help/treatment, lack of understanding from others, decreased opportunities, social isolation, bullying and harassment, and inadequate health insurance coverage for treatment.

According to the American Psychiatric Association (APA, 2020), stigma can be categorized into three types: public stigma, self-stigma, and institutional stigma. Public stigma refers to negative attitudes from others towards mental illness. Self-stigma refers to negative attitudes that are internalized and cause feelings of shame regarding one's mental illness. This form of stigma can negatively impact recovery amongst people with severe mental health diagnoses. Institutional stigma refers to systemic discrimination perpetuated by organizations, governments, and agencies that limit opportunities for individuals with mental illnesses.

Perceptions associated with public stigma include ideas that people with mental illness are dangerous, incompetent, or unpredictable, and people with mental illness are to blame for their disorder (APA, 2020). Self-stigma is associated with perceptions about oneself as dangerous, incompetent, or to blame for their illness. Institutional stigma includes stereotypes that are embedded in laws and other institutions that perpetuate the loss of opportunities for those with mental illnesses, whether intentional or not.

Studies have found that self-stigma towards mental illness has a negative impact on recovery (Batterham et al., 2013; Heinz et al., 2021; Oexle et al., 2018). A longitudinal study conducted by Oexle and colleagues (2018) examined the effects of self-stigma on 222 participants with mental illness, all of whom were receiving disability pensions. The researchers found that higher self-stigma at baseline predicted a decrease in mental illness recovery after one year. They expressed that interventions proven to reduce stigma could improve recovery.

Heinz et al. (2021) explored the phenomenon in which patients with depression only report physical symptoms to their general practitioners. The researchers sought to investigate potential associations between the reports of those patients with a depression diagnosis and the desire to conceal their diagnosis for fear of being stigmatized. The patients with depression displayed a significantly higher level of perceived stigma than those without depression. The researchers concluded that the perceived stigma could inhibit patients from seeking and receiving proper care. They suggested that the internalized fear of being stigmatized can negatively impact the patient's mental health, thus increasing symptoms.

Batterham et al. (2013) explored the predictors of stigma towards anxiety by surveying 617 Australian adults using the Generalized Anxiety Stigma Scale (GASS). The GASS assessed the predictors of both personal and perceived stigma associated with GAD. The results showed

that women, individuals living around others with anxiety, and individuals who reported a previous anxiety diagnosis demonstrated lower personal stigma towards anxiety. The researchers also found that individuals who were exposed to anxiety through the media presented as no more stigmatizing than those who were in direct contact with individuals with anxiety disorders. The researchers believed that the media could be used as an effective platform for decreasing stigma within the community.

The literature suggests that stigma, in its many different forms, is present among those living with mental illness, particularly among those with depression and/or anxiety. Stigmatizing attitudes can lead to barriers in treatment and negatively impact an individual's road to recovery (APA, 2020).

Mental Health Professionals and Stigma Towards Mental Illness

Researchers have explored the phenomenon of stigma toward mental illness among healthcare professionals. The medical profession can sometimes enact stigma against those with mental illness (Brower, 2021). A stigmatizing culture within the medical field can contribute to higher rates of suicide among medical professionals with mental illness. It can also lead to a delay in seeking treatment. Researchers have investigated the need for training and the responsibility of the medical faculty to improve the learning environment surrounding these issues.

A theoretical article by Knaak et al. (2017) summarized the main barriers to access and quality of care that have arisen due to stigma within the healthcare system. The authors took note of the negative impact that stigma has had on not only the patients but also on the help-seeking behaviors of healthcare professionals living with mental illness. The authors characterized stigma in the workplace as a problem of culture in which staff are discouraged from speaking about their

mental health challenges as well as seeking help for their psychological issues. They found a lack of research on the impacts of anti-stigma initiatives on patient experiences. The authors concluded that a shift in the organizational culture – one that promotes staff health/well-being and tackling stigma in patient care – could positively impact both staff and patient safety. They recommended approaching stigma through an organizational culture lens, as this could potentially address the aspects of stigma that have become part of the healthcare system.

Brower (2021) explored the idea that medical professionals can be both the cause and the solution to the stigma of mental health issues. The author noted that medical students are impacted by stigma throughout their training, leading to burnout, depression, shame, silencing, and a high prevalence of suicide attempts/completions. Brower proposed the normalization of moderate to severe depression in an effort to decrease stigma and encourage an increase in seeking treatment.

Researchers have found that stigma has a negative impact on both mental health professionals living with mental illness as well as individuals diagnosed with a mental illness. Because it has been established that stigma can prevent the recovery and progress of those with mental illness, researchers have begun to study anti-stigma initiatives. It is believed that anti-stigma initiatives and training can positively impact mental health professionals and their service users (Sreeram et al., 2022).

Music Therapy and Mental Illness

Music therapists work with individuals living with anxiety and depression in a variety of facilities, including psychiatric partial, outpatient, and inpatient/residential facilities, as well as forensic, correctional, medical, educational, and community settings (AMTA, 2021). When compared to standard treatment, music therapy has been found to be significantly more likely to

decrease anxiety and depression symptoms (Aalbers et al., 2017). Music therapists have utilized such experiences as songwriting (Baker, 2015), singing (Cho, 2018), improvisation (Meadows & Wimpenny, 2017), and music psychotherapy (Arthur, 2018) to address goals of reducing muscle tension, decreasing anxiety and/or agitation, enhancing relationships, increasing self-image/esteem, and catalyzing emotional release (AMTA, 2021). Common interventions include improvising, composing, recreating, and listening or receptive experiences (AMTA, 2021).

Erkkilä et al. (2011) explored the efficacy of music therapy combined with standard care amongst clients with depression. Participants diagnosed with depression were randomized into groups receiving music therapy and standard care or solely standard care. The data indicated that those receiving both music therapy and standard care demonstrated greater improvement in depression, anxiety, and general functioning as compared to the group only receiving standard care. The study concluded that music therapy could be an effective enhancement compared to standard care amongst people with depression.

Gutiérrez and Camarena (2015) examined music therapy as a modality to treat Generalized Anxiety Disorder (GAD). A pilot group of 7 patients was recruited based on specific inclusion criteria such as having persistent symptoms despite pharmacological treatment for at least one year. The music therapy treatment plan consisted of 12 two-hour weekly sessions over the course of three months. The results indicated that there was a significant decrease in anxiety levels after music therapy treatment. The researchers concluded that music therapy proved to be an effective treatment modality in reducing anxiety and depression levels in patients with GAD.

The body of music therapy literature demonstrates a concern for individuals with depression and anxiety, and research has been conducted to test the impact of music therapy on

these symptoms and diagnoses. However, there is little written on the stigma surrounding those disorders within the profession of music therapy.

Music Therapy, Ableism, and Stigma

While the concepts and attitudes that create the foundation of ableism are not new, literature has begun to focus on ableism within the music therapy profession. Ableism can be defined as: "prejudice and discrimination aimed at disabled people, often with a patronizing desire to 'cure' their disability and make them 'normal'" (Dunn, 2021, para. 1). Ableism is an attitude that portrays disabled individuals as inferior to nondisabled people. There are a variety of factors that can contribute to ableism, including, but not limited to, social/cultural norms, anxiety in social situations (where neurotypical people behave awkwardly around those with mental illness), gender, personality, hierarchical attitudes (some disabilities are viewed as more acceptable than others), ignorance about disability, and severity of disability (Dunn, 2021). This is relevant to the present study because many people with mental illness consider themselves to fall under the disability umbrella.

Shaw and colleagues (2022) presented a study composed of 10 different authors. These authors consisted of practicing music therapists, college professors, and students, all with lived experience of disability, chronic mental and/or physical pain, or neurodivergence. The essay aimed to discuss the impact of ableism on the music therapy work for both the participants and the music therapists. They expressed the need for more awareness of music therapists living with a disability. They believed this increased visibility could lead to community, knowledge, and alternative ways of practicing that could positively impact the profession. The authors also noted that the experiences in training could either help or harm a disabled music therapist. They felt that post-ableist music therapy ideals need to be implemented into the profession's standards of

practice to create change, and educators need to move away from a deficit perspective of music therapists with these conditions. Post-ableist music therapy allows for the celebration of what music therapists with these lived experiences have to offer. It creates a safer space for the clients and therapists while moving away from the need to "cure" or fix."

Bruce (2022) explored the concept of systemic ableism in relation to music therapy. She discussed her lived experience as a blind musician and music therapist, beginning with her encounters with ableism in her high school music education. Bruce analyzed the idea of the "performance of normal" and identified it as a systemic problem that is not only external but also internalized within those who identify as disabled. Society has perpetuated the need to be "normal" and has encouraged people to overcome their disability. Bruce pointed out that this is evident in the music therapy profession through how music therapists work with their clients and within the professional competencies and education/training. She began to speak out about reframing disability. Bruce worked to change the idea of disability into that of a valued identity to move away from the deficit narrative way of thinking. She believed that disability provides society with a different way of knowing that can contribute to the music therapy profession. She called for the focus to be put on the voices of disabled therapists in moving forward within the post-ableist music therapy movement. She felt that too often, nondisabled people are viewed as the authoritative voices on the subject, and yet they do not have the lived experiences to support their thoughts. Disabled music therapists can provide new perspectives to help others understand the complex relationship disabled people share with music.

The theoretical literature exploring ableism in music therapy suggests that increasing awareness is critical to addressing and decreasing stigma and ableist attitudes toward disabled and/or mentally ill individuals. The little research that exists focuses on the proposal of a cultural

shift in how society views disability as a whole. The proposed shift discussed in the literature involves moving from a deficit view of curing/fixing mental illness toward living alongside and celebrating disability.

CHAPTER 3: METHODS

Research Objectives and Purpose

This study sought to explore the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. The research questions for this study were: What are the personal experiences of stigma in music therapists living with mental illness? What forms of stigma do music therapists living with mental illness experience and how do these manifest? What are the needs of music therapists living with mental illness who have experienced stigma?

In gaining a better understanding of stigma amongst music therapists with mental illness, I had hoped to identify any potential implications for self-care, advocacy, and community. The thinking behind this centered around the idea that these lived experiences could paint a clearer picture of what the needs are of these individuals in terms of anti-stigma initiatives, education, and treatment.

Research Design

This study employed an exploratory qualitative research design, which is typically used when the particular phenomenon has yet to be studied at length, if at all (George, 2023). It can be considered a form of interpretive research and is frequently used when the researcher wants to better understand a specific topic without adding any preconceived notions. The exploratory qualitative design helps the researcher develop a general understanding of the topic while contributing towards creating a narrower approach for future research. This design is typically used when researchers are interested in gaining greater insight on the topic of interest before developing a solution to the problem (Shukla, 2010).

Participants

Three music therapists were recruited through social media groups on Facebook using purposive sampling based on the following inclusion criteria:

1. Board-Certified Music Therapist (MT-BC) living in the United States
2. Minimum five years practicing as a full-time MT
3. Must have depression or anxiety for a minimum of two years during practice as an MT-BC

Recruitment

After receiving approval from the Molloy University Institutional Review Board (IRB), I used purposive sampling to recruit participants through social media groups on Facebook, including social justice music therapy groups, groups for music therapists working in mental health, and the Disabled Music Therapists Collective. The social media post detailed the purpose of the study and the inclusion criteria and provided my contact information. The first three participants who responded were sent an email that included further information about the study and the consent form. All other inquiries were added to a waitlist in the event that one of the first three participants was unable to complete participation. Participants provided informed consent before the interview began.

Data Collection Procedures

Interviews were conducted over Zoom and lasted about 45-60 minutes. Participants were asked to participate in these interviews in a private and quiet location, such as the participants' homes. The interviewer was located in a private room. The Zoom interviews were recorded through the Zoom software, which produced audio, video, and transcript files for later

analysis. Before conducting the interviews, the principal investigator conducted a verbal screening process, utilizing the inclusion/exclusion criteria to determine eligibility.

In-Depth Interviews

Three in-depth interviews were conducted as primary data with music therapists who met the inclusion criteria. In exploratory qualitative research, in-depth interviews are used to gain insight from individual participants on the research topic. The interviewer's goal is to discover participants' motivations, attitudes, feelings, and beliefs toward the particular phenomenon. The interviewer can then turn the responses from each participant into related questions to gather more detailed information (Shukla, 2010).

Interview questions were open-ended and allowed for the discussion of each participant's lived experience of stigma as a practicing music therapist living with depression and/or anxiety. For this study, interview topics were centered around the definition of stigma, the participant's experiences of stigma, experiences of stigma as they directly relate to being a music therapist, thoughts on disclosure of mental illness, and the needs of music therapists who experience stigma for their mental illness (See Appendix A). The interview protocol was created after a careful review of relevant literature (Brinkmann and Kvale, 2014). The interview protocol was broken into introductory, follow-up/probing questions, and general topics to be covered (See Appendix A).

The Zoom software on a MacBook Pro was utilized to conduct audio/video recordings of the interviews. All audio and video recordings were immediately transferred to the principal investigator's Molloy OneDrive following each interview and deleted from the original device after analysis.

Data Analysis Procedures

After the transcriptions produced through the Zoom application were cleaned up, interview data was analyzed for themes using a thematic analysis. According to Braun and Clarke (2006), thematic analysis can be defined as "a method for identifying, analyzing, and reporting patterns (themes) within data" (p. 79). The six steps of thematic analysis are: 1) familiarization of data, 2) generation of codes, 3) combining codes into themes, 4) reviewing themes, 5) determining significance of themes, and 6) reporting of findings (Braun & Clarke, 2013). During the first step, familiarization of data, the researcher must transcribe, read/re-read the data, and make notes on any ideas that come up. In the second step of the generation of codes, Braun and Clarke (2006) suggested that the researcher code any interesting features of the data. During the third stage, combining codes into themes, it is suggested that the researcher break the data down into relevant themes. In the reviewing themes stage, the researcher must check if the codes relate/work with each theme and create a thematic map of the analysis. During the determining significance of themes phase, an ongoing analysis is conducted to refine each theme. This is where clear definitions are extracted. Lastly, during the reporting of findings stage, a scholarly report of the analysis is produced.

Scientific Integrity

To address dependability, I maintained consistency and trustworthiness through a research log in which I recorded the research steps in detail. To address credibility, I utilized multiple sources through data triangulation and engaged in member-checking. During the member-checking process, I sent the narratives to the participants to ensure they agreed with the information provided before proceeding with the study. To address confirmability, I wrote an epoché before beginning data collection and engaged in memo-writing throughout the data

collection and analysis. I also employed bracketing during data analysis. According to Charmaz (2015), memo-writing involves having private conversations with oneself as the researcher while taking the codes apart and analyzing what they could mean. I consistently took note of what happened after each interview and addressed anything that came up internally for me as the interviewer/researcher to identify any important pieces of the research data. Creswell (1998) defined bracketing as a tool in which the researcher can separate personal experiences and biases from the topic that is being studied. I used this tool to ensure the information was accurate by setting aside any personal biases before collecting/analyzing the data and writing this in the form of an epoché. To address transferability, I utilized thick descriptions when addressing each theme and multiple explanations of the results.

Epoché. Before the qualitative data from the in-depth interviews was collected, transcribed, and analyzed, I constructed an epoché. I took note of personal assumptions and biases I held prior to data collection to consciously set them aside and ensure accurate data. The epoché is as follows:

> I believe that the participants will have experienced some form of self-stigma in their careers as music therapists living with depression and/or anxiety. I believe that the participants will have encountered an experience in which they felt stigmatized by others or witnessed someone being stigmatized by others. I believe that the participants will feel a stronger sense of stigma from older generations in comparison to younger generations. I believe that the participants will have feelings about disclosing mental illness to others due to stigma, especially in the workplace. I believe that the participants' views on stigma will connect back to their upbringing. I believe that the participants will speak about the need for resources and a sense of community.

I revisited the epoché to accurately draw conclusions from the thematic analysis. The themes present within the assumptions and biases that were held prior to analysis were compared to the themes present in the interviews.

Data Management and Protection

All interview recordings were stored on a password-protected laptop that was not accessible to anyone other than me as the primary researcher. All identifying information was removed from the transcripts prior to data analysis. Data produced through Zoom, including the audio, video, and transcript files, were stored in password-protected files on the laptop. Only the principal investigator had access to these raw data files. A password-protected file connecting the participants' names to their participant identification numbers (PIN) was stored on the laptop. No committee members outside of the principal investigator had access to these files. After each interview, all video and audio recordings were immediately transferred to the principal investigator's Molloy OneDrive and deleted from the original device. The thesis committee members only had access to the de-identified transcripts through the principal investigator's Molloy OneDrive. Additionally, the laptop on which these were stored was kept in a locked cabinet when not in use. All data will be destroyed three years following the completion of the study.

CHAPTER 4: RESULTS

Content advisory: The following material contains mention of self-harm and suicidal ideation and may not be suitable for all readers. Readers sensitive to these elements should take note before proceeding with this section.

A thematic analysis of the three participants' interview data was conducted. The analysis produced four major themes and fourteen subthemes (See Table 1). The raw quotes from the interviews were coded, and examples of the coding process can be seen in Table 2.

Table 1

Themes and Subthemes

Theme	Subtheme
Theme 1: Music therapists with Mental Illness Experience Self-, Institutional, and Public Stigma.	Subtheme 1: Self-Stigma Subtheme 2: Institutionalized Stigma and Power Structures Subtheme 3: Public Stigma
Theme 2: Music Therapists with Mental Illness Need Changes in Society's Perception of Mental Illness, Education, and Workplace Environments.	Subtheme 1: Systemic Changes Needed in Society Subtheme 2: Changes Needed in Music Therapy Training/Education Subtheme 3: Changes Needed in the Workplace Subtheme 4: Positive Changes and Trends in Stigma of Mental Illness
Theme 3: Disclosure, Education, and Self-Reflection Are Tools to Tackle Stigma.	Subtheme 1: Disclosure as a Tool for Tackling Stigma Subtheme 2: Education as a Tool for Tackling Stigma Subtheme 3: Self-Reflection as a Tool for Tackling Stigma
Theme 4: Learning to Live with Mental Illness is a Process.	Subtheme 1: Learning to Recognize and Understand Mental Illness Subtheme 2: Learning When to Disclose and Be Open About Mental Illness Subtheme 3: The Impact of Having Mental Illness in the Clinical Setting Subtheme 4: Finding Community and Identity in Mental Illness

Table 2

Example Process of Thematic Analysis

Raw Quote	Code	Subtheme	Theme
"I think those childhood experiences definitely shaped who I am today of like, I have to be the best. I have to be perfect." (Participant 101)	Childhood experiences and generational trauma shape our present self	Self-Stigma	Music therapists with Mental Illness Experience Self-, Institutional, and Public Stigma.
"Build a culture that it's okay to say we care about your mental health." (Participant 101)	A change in work culture is needed to prioritize mental health and tackle stigma.	Changes Needed in the Workplace	Music Therapists with Mental Illness Need Changes in Society's Perception of Mental Illness, Education, and Workplace Environments.
"It's a calculated decision you know, and it's not always something that I do, but again, I think it helps to decrease some of the stigma and just to normalize the way that we talk about mental health and how common it is." (Participant 103)	Disclosure is a tool for tackling stigma and providing support to others.	Disclosure as a Tool for Tackling Stigma	Disclosure, Education, and Self-Reflection Are Tools to Tackle Stigma.
"I don't claim the identity of neurodivergent just because it doesn't fully resonate." (Participant 102)	MI is related to neurodivergence but is not the same.	Finding Community and Identity in Mental Illness	Learning to Live with Mental Illness is a Process.

Research Questions

The research questions for this study were as follows:

1. What are the personal experiences of stigma in music therapists living with mental illness?
    a. What forms of stigma do music therapists living with mental illness experience and how do these manifest?
2. What are the needs of music therapists living with mental illness who have experienced stigma?

Theme 1: Music Therapists with Mental Illness Experience Self-, Institutional, and Public Stigma.

The participants described their thoughts and experiences regarding the three forms of stigma – self- (or internalized), institutional, and public stigma. The data for this theme consisted of their thoughts on the meanings behind each form of stigma and how these forms manifested in their lives.

Subtheme 1: Self-Stigma

All participants highlighted feelings of inadequacy, internal fears (i.e., fear of failure), and their own internalized labels. They all acknowledged how self-stigma impacted their lives, as well as their mental health journeys. They also touched on the idea of being in a helping field while experiencing those self-stigmatizing thoughts and feelings. For example, Participant 101 expressed that they had internalized labels including ‘broken’ and ‘damaged’ due to their depression and anxiety. They described childhood stigma and generational trauma in terms of the expectation to be perfect all the time, which resulted in perfectionism and negative thoughts. They continued to describe their experience with self-stigma as follows:

> I definitely have a lot of internalized self-stigma because, just from my 'perfect' upbringing. I'm not perfect, therefore I'm broken. I am incompetent, and this might get a little too heavy, and you can leave it out of your writings if you...if it's too dark, but it has kind of instilled in me the sense that I don't deserve to live because I'm not perfect. So yeah, 100%. I can identify with that self-stigma of, like, the...it just burrows into my brain, and it's like, I'm not perfect, therefore I'm incompetent, and I don't deserve to be living.

Additionally, being a music therapist in a field involving advocacy and a need for representation also added to the participant's experiences of self-stigma in that they felt pressure to uphold a positive image of the field.

Feelings of inadequacy also manifested in fear. For example, Participant 102 mentioned feelings of inadequacy as an intern and their fear of how it could impact their career path as a music therapist. They stated: "I had concerns that, like, because of this new set of symptoms that popped out of nowhere, I would not be a good therapist or I was not being a good intern and like, objectively, maybe I wasn't, right?"

Another manifestation of self-stigma arose in comparison to other therapists and clients. Participant 103 spoke about their experience working in mental health. They noted the self-stigma they encountered due to a comparison to other therapists, as well as clients living with mental illness (MI). For example, they stated: "'I should be able to deal with this'" and, you know, 'I should have it all together' and kind of comparing myself to other therapists. 'Well, they seem to be able to handle this sort of stuff. Why am I having such a difficult time?'" They also touched on the self-stigma from their perfectionistic tendencies and the expectation that music therapists should have all the knowledge in the clinical setting.

Subtheme 2: Institutionalized Stigma and Power Structures

Institutionalized stigma manifested in a variety of ways. A major topic of discussion centered around the negative experience institutionalized stigma brought to the workplace. Participant 101 described the loss of employment due to a lack of awareness of MI diagnosis. They stated:

> I was going through kind of a rough patch in my depression, but I didn't know that's what it was. I had not received my diagnosis yet, so the accommodations were not there. To my boss, it looked like I was just a terrible employee, and like on paper, I was, but for the lived experience of me, I think if the awareness had been there, maybe my boss would have been like, 'Oh, hey, this, I noticed that A, B, and C are happening. This could be a mental health issue. How can I help,' instead of what actually happened, which is, I was fired.

They also added that their mental health issues impacted every single job they ever had. They said that larger corporations would not admit it was due to their MI but would make up another reason why they should be terminated. They noted that smaller workplaces felt safer and more accepting of MI than larger corporations. Participant 101 went on to reflect on an experience and said that they checked themself into a hospital because they were drowning and having thoughts of self-harm. Six months later, they terminated their employment and acknowledged that they could not keep up with their documentation. The participant described the push for 100% productivity in American culture and how institutionalized stigma has manifested in the workplace mindset that you are "deficient" or "bad" for wanting to rest.

Other forms of institutionalized stigma were found in outdated resources/a deficit view on MI in education, helper versus client power structures, and their promotion of ableism. For example, Participant 102 mentioned that they felt "othered" by outdated textbooks, how MI was

taught using a recovery model, and the pushed power structures of a client-therapist dichotomy in which the therapists are expected to have all the knowledge and use it to "help them recover." They described the pushed power structures, stating the following: "We are helpers. These people need help. We are better than them, and so, we will help them."

Participant 103 also described the stigmatizing nature of the helper/intervention mentality and how it made it difficult for them to seek help for their own MI. They stated:

> This was prior to my own mental health diagnoses, and so, then, when I was diagnosed, I had a really hard time because it was this kind of idea that you're a helper. You're supposed to be over here and, you know, people who need the help are supposed to be, you know, over here not that they are the same exact group...and so that, you know, just that...that approach is very stigmatizing, you know, and then when you do end up needing help, you know, I had a really hard time with that.

This view on MI and the client-therapist dichotomy added to instances of internalized stigma in that, as a helper, they felt they were not allowed to have mental health diagnoses. This added to self-stigmatizing thoughts of therapists needing to have it all together.

Subtheme 3: Public Stigma

Public stigma was discussed as a mark of othering and a consensus that stigma paints MI in a negative light. Participant 101 stated that stigma is a prejudice with a view that people need to be treated differently. Participants 102 and 103 described stigma as an act of othering. Participant 102 noted that stigma tends to be based on characteristics that are outside one's control, while Participant 103 noted that stigma views people with MI as "less than."

All the participants mentioned the difference in the public stigma that still exists surrounding taking medication for MI. For example, Participant 102 offered views that the public

holds towards medication using the phrase: “People who take medication for mental illness are dangerous.” They also expressed the idea that the public fears people who take medication for MI because they are seen as unstable, out of control, and potentially violent or harmful to themselves or others.

Participant 103 spoke about how the public discourse on MI contains false narratives and simplifications that promote feelings of inadequacy and make it difficult for people to want to seek help. They stated:

> A lot of the discourse that's going on right now is not actually helping. ‘Oh, just exercise and eat right,’ and you're like, ‘No.’ Yes, that can help, but I am someone who eats right and exercises and I still live with mental health challenges. It doesn't fix it.

Theme 2: Music Therapists with Mental Illness Need Changes in Society’s Perception of Mental Illness, Education, and Workplace Environments.

The participants described their needs as music therapists who experienced stigma for their MI. They also provided their thoughts on the possible needs of other music therapists who may have experienced the same issues throughout their careers. These involved systemic changes and changes in education and the workplace.

Subtheme 1: Systemic Changes Needed in Society

All the participants noted that music therapists with MI want people to know that MI exists, is not shameful, and should be talked about rather than hidden. They also mentioned that mental health needs to be viewed as the same as physical health because they both encompass health. Participant 103 stated: “Brain health, body health, it's all health.” Participant 101 described MI as “a physical thing happening in my brain.” All three participants also mentioned

a need for more research to document the experiences of music therapists who experience stigma for their MI to raise awareness and create change.

Participant 102 discussed the value, importance, and need for positive attitudes and receptiveness toward how they view and talk about MI. They expressed that having a family member understand and demonstrate their receptiveness to their MI felt "affirming."

Subtheme 2: Changes Needed in Music Therapy Training/Education

The participants discussed the need for support from professors, a push for personal therapy, and changes made to how MI is addressed in education. For example, Participant 102 discussed their experience with a supportive professor who shared his thoughts on how their MI could make them a better therapist. The professor also encouraged them to find a way to make a change in the outdated/stigmatizing resources (i.e., textbooks). In contrast, Participant 103 discussed a different professor who told their friend not to enter the field of music therapy based on the student's personal experiences with MI. It was stated that this exchange was damaging and stigmatizing for the student.

Participant 103 discussed the importance of having your own personal therapist while being a music therapist. They mentioned how their art therapist colleagues were required to go to therapy and said they felt this was a great suggestion.

Participant 103 described the us versus them approach in the clinical setting. Participants 102 and 103 expressed the need to change the client-therapist dichotomy and how clients should be viewed differently. They believed therapy should be seen as a place where two flawed human beings come together to grow.

Subtheme 3: Changes Needed in the Workplace

The participants discussed a need for more support from bosses and a culture shift in which mental health is prioritized in the workplace. Participant 101 spoke about the times in which they felt the need to lie to their boss to take a mental health day. They used physical illnesses as excuses and wished they didn't feel compelled to lie. They expressed a need for a culture shift in the workplace. They stated:

> The one thing that comes to mind is that maybe they need to have a culture of, 'It's okay to take a mental health day,' that I wouldn't feel compelled to lie that, oh yes, I'm having a physical problem instead of a mental problem, like build a culture that it's okay to say we care about your mental health. And also companies need to be OK with their employees taking PTO.

Participant 103 spoke about the lack of support they received from their boss when experiencing both mental and physical health conditions. They expressed that the stress and issues they encountered with their boss were some of the primary reasons they sought out therapy in the first place.

Subtheme 4: Positive Changes and Trends in Stigma of Mental Illness

All the participants noted the positive trends in stigma towards MI. They all felt that society's perception of MI is changing. Participants 101 and 102 discussed the idea that younger generations seem more open and accepting of MI than older generations. Participant 103 spoke about their frustrations with the public discourse regarding MI but noted that the discourse does seem to be changing to include more of the symptomology of MI.

Theme 3: Disclosure, Education, and Self-Reflection are Tools to Tackle Stigma.

The participants discussed tools and actions that can be enacted to work towards tackling stigma. Some tools included disclosure of MI, more education/advocacy of MI, and self-reflection to recognize and correct human biases.

Subtheme 1: Disclosure as a Tool for Tackling Stigma

The participants spoke about the benefit of disclosing MI as a tool for normalization and solidarity. Participant 102 stated:

> So I've commonly done it in session, right? Like when a client is struggling with things that I have personal experience with...And so I find that I am drawn to disclose in those moments as like almost like a tool for normalization and solidarity. Right? So, like, 'Hey, you're not alone in this. This is not just a thing that's happening to you, and you're in this little bubble of 'It sucks right now.' 'It happens to other people, and I've been dealing with it' because I work with children, 'I've been dealing with it for a little bit longer, and I've maybe learned some things that you haven't learned yet.'

Participant 103, in discussing the benefit of disclosure, stated: "I think it helps to decrease some of the stigma and just to normalize the way that we talk about mental health and how common it is."

Subtheme 2: Education as a Tool for Tackling Stigma

Some of the participants touched on the importance of education/advocacy as a tool for tackling stigma. They expressed that advocating for one's needs through transparency, openness, and honesty can help decrease stigma and educate those who might not fully understand the needs of people with MI. Participant 101 made note of the benefit of the internet/social media as

a tool for educating others on MI. They felt that the spreading of information and positive ideas surrounding MI could be useful in decreasing stigma.

Subtheme 3: Self-Reflection as a Tool for Tackling Stigma

Self-reflection in the form of recognizing human biases was presented as a tool for tackling stigma. For example, Participant 101 stated that all humans carry biases, and the goal is to recognize and understand these biases as erroneous thoughts. This can help tackle many different forms of stigma. Participant 102 spoke about self-reflection in terms of labeling intrusive thoughts. This was viewed as a tool to conquer self-stigma while living with MI.

Theme 4: Learning to Live with Mental Illness is a Process.

All the participants discussed the nuanced process of the mental health journey and what it is like to learn to live with MI. The data in this theme consisted of thoughts surrounding the process of learning to live with MI, deciding when to disclose/be open about MI, the impact of having MI in the clinical setting, and the process of finding community/identity in MI.

Subtheme 1: Learning to Recognize and Understand Mental Illness

The participants acknowledged the time and energy that is required to live with MI. Participant 101 discussed how their sometimes depleted "battery" interferes with their daily functioning. They said that the toll MI takes on their body has impacted their home life and career. Participant 102 described living with MI as a nuanced process in which they were forced to navigate their career while learning to live with "a whole new set of circumstances." This took some of their time and focus away from their duties as an intern and music therapist. They expressed that they weren't as aware of the stigma and the power structures pushed in music therapy education prior to their discussion. A lot of those realizations came later. They stated:

"My mental health stigma radar was not as finely tuned not having had the lived experiences going through the diagnostic process and identifying as somebody with a mental illness."

Subtheme 2: Learning When to Disclose and Be Open About Mental Illness

The participants discussed the process of deciding when to disclose and be open about their MI. Participant 103 labeled disclosure as a "calculated decision." They expressed that they typically did not disclose exact diagnoses but would choose to disclose with people they felt close to or clients that could potentially benefit from their disclosure. Participant 101 only disclosed to their boss when they were drowning and feared a loss of employment, while Participant 102 stated that it is sometimes necessary to disclose to form a working relationship and gain access to supports. The participants acknowledged that disclosing is not always something they are comfortable doing, and they all held somewhat differing views on how, when, and with whom to disclose.

Subtheme 3: The Impact of Having Mental Illness in the Clinical Setting

The idea that mental illness is a strength, particularly in the clinical setting, was a key point in some of the participants' responses. Participant 103 stated:

> Everyone needs help, and the fact that I live with mental health challenges myself, you know, means that I'm better able to help people who share these experiences, not that I have the exact same experience or I'm going to make it about me because I'm not as a therapist, but I can recommend things that I know work for me and hopefully then they will work for other people.

They explained that they felt better equipped to empathize, support, relate, and connect to their clients due to their experiences with their own MI. Participant 102 spoke about how they had to learn to live with MI while learning to be a music therapist in their internship. They stated:

> When you look at it from one lens, like, I wasn't writing good session plans, or I wasn't enacting the good session plan well because I was freaking out and not being as effective. On the other hand, from a different lens, I was learning to live with a mental illness as somebody who is being trained to work with people who are working with a mental illness. I was learning to go through the steps that my clients need to go through. I think it makes me a better therapist and like...Yeah, it sucked, and I was doing poorly in my internship, but also, like, I was learning the things that I needed to learn to be a good therapist and to be a good intern, and like, and that's part of the process.

The participants also noted how the process of learning to live with MI impacted their view on the therapeutic relationship and the enforced power structures in training. For example, Participant 102 spoke about becoming more aware of the power structures/the client-therapist dichotomy as they became more aware of their own MI. This awareness led them to want to break down those power structures and become a more egalitarian therapist. Participant 103 also touched on the breaking down of power structures in music therapy. They stated:

> 'You're there for the client and to focus on the client,' and you know, and that has been a little bit detrimental to our...the humanity of helping professionals because then it's, again, that expectation that you have to have everything together, that you can't be struggling with stuff, and so I, you know, I've gotten away from that. It's really like, you know, more of a partnership.

The topic of countertransference also came up in some of the interviews. For example, Participant 103 spoke about instances working in mental health in which the clients with whom they worked reminded them of other people in their life or brought up feelings/memories that have impacted their mental health. They stated:

> Patients who remind me of my sister who also lives with major mental health challenges, and you know, hers are very severe, you know, and so yeah. There are times where like, you know, I'm very cognizant, 'Oh yeah, that person reminds me of my sister,' you know, that one particular person that I was working with that really, you know, kind of held that mirror up to me just by her own disclosure.

They went on to discuss how these instances helped them to realize that there were some areas they needed to address in their life, and they would take the time to thank the client who disclosed the information. They said: "'Your sharing what you did was just really helpful for the group,' and then I said, 'and actually was helpful for me personally.'"

Subtheme 4: Finding Community and Identity in Mental Illness

The participants discussed the importance of community when living with MI and the idea of discovering one's identity. Participant 101 mentioned the higher prevalence of MI since the COVID-19 Pandemic, leading to a greater community of people living with the same mental health issues. They also noted the benefit of the internet/social media as a place for community. Participant 102 discussed how the music therapy community is typically well-educated on mental health and thus tends to present with less ignorance towards MI. They expressed the importance of having appropriate community spaces in which people with MI can be vulnerable and transparent with one another. They stated: "Community and places where we can be transparent and vulnerable with one another and places where it can be safe to not say, 'Having anxiety is a superpower.'"

Participant 102 acknowledged their conflicting thoughts on identity in MI. They expressed that: "Identity is a weird thing" and that they did not always identify as a person with MI. They also spoke about finding a sense of belonging as someone with MI. When discussing

neurodivergent community spaces/affinity groups, they expressed that they were not sure if they belonged in those groups and that appropriate community spaces for people with MI are needed. They stated:

> I don't claim the identity of neurodivergent just because it doesn't fully resonate. Like I'm aware that like, yeah, my literal, my neurology is divergent. It is different. But I don't know that that feels like an authentic label to me because it is so broad and so all-encompassing, and I don't know that my lived experiences would resonate with somebody who is an autistic adult or a late-diagnosed ADHD. Like I don't know that I can claim affinity with those because I haven't struggled the same way that they have.

Participant 102 also discussed the concept of people with MI identifying as having invisible disabilities. They described having this identity as a way that makes people with MI "slip under the radar." They expressed that this could be detrimental to people with MI because "they can kind of pass for abled, which can lead to, like, them not having supports and understanding from the community."

CHAPTER 5: DISCUSSION

The purpose of this study was to explore the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. I aimed to identify potential implications for education, self-care, and anti-stigma initiatives, focusing on participant experiences of stigma to illuminate the needs of music therapists living with mental illness. These experiences were ascertained through semi-structured interviews, which indicated how self-, public, and institutionalized stigma may manifest in the lives of music therapists living with MI. Finally, a thematic analysis of the transcriptions from each in-depth interview yielded four main themes and 14 subthemes. The four main themes were: 1) Music Therapists with Mental Illness Experience Self-, Institutional, and Public Stigma; 2) Music Therapists with Mental Illness Need Changes in Society's Perception of Mental Illness, Education, and Workplace Environments; 3) Disclosure, Education, and Self-Reflection are Tools to Tackle Stigma; and 4) Learning to Live with Mental Illness is a Process. When contextualized alongside existing literature, the data emphasize the impact of ableism within music therapy and other medical/helping professions. The results of this study also highlighted the needs of music therapists who experience stigma for their MI, including the desire for a sense of community and changes needed in society, music therapy training and education, and the workplace. This discussion will examine the depth and meaning behind the data and illuminate the seriousness of stigma as a systemic issue. Limitations include those inherent in small exploratory qualitative studies, such as the inability to achieve transferability through results or draw causal relationships between variables. Therefore, recommendations for further research include larger studies from individuals with MI in varying intersectional sociocultural identities, studies designed to examine causal relationships, and qualitative studies that allot more time for larger sample sizes and in-depth analyses.

Mental Illness Can Be a Strength

The participants expressed that having MI can be a strength, where the experience of MI leads to a greater sense of empathy and the ability to relate to others. It is possible that people living with MI develop their own coping mechanisms and tools for a more balanced life. A study conducted by Elliot et al. (2020) examined the experiences of mental health professionals who identify as having MI. The therapists emphasized their enhanced ability to empathize with their clients due to having personal experience with MI.

Self-Stigma

One participant spoke about their experiences with self-stigma, which led to thoughts of suicidal ideation. However, before speaking on this topic, they prefaced these thoughts with a warning and suggested that it could be left out of the study if it was "too heavy." The participant may have wanted to protect readers from such a strong statement or may have internalized stigma or shame related to the comment. This possible connection between self-stigma and suicidal ideation aligns with a study conducted by Oexle et al. (2017), which found a significant relationship between self-stigma and suicidality amongst people living with MI and demonstrated a potential causal relationship between the two.

The participants spoke about feelings of inadequacy and fears of not being good therapists. These feelings of inadequacy can be understood as examples of internalized stigma (APA, 2020). Participant 103 attributed some of these feelings to comparing themself to coworkers and clients while working in a mental health setting. They could not understand why they did not feel as though they had it "all together" while those around them, such as clients also living with MI, seemed to be coping. Participant 102 spoke about feelings of failure as an intern and future music therapist due to the internalized stigma that arose from the onset of panic

attack symptoms. They expressed that they were eventually able to label these feelings as intrusive thoughts. It is possible that depression and anxiety inherently involve intrusive thoughts and, thus, could create a higher potential for self-stigma. Corrigan and colleagues (2016) explored the "why try" phenomenon as a consequence of self-stigma, which occurs when people apply the stereotypes of MI to themselves, resulting in feelings of inadequacy. This further causes people to feel unable to achieve their goals. Participant responses and the extant literature explain how self-stigma and decreased levels of self-respect and motivation can negatively impact emotion and behavior.

Criticisms of the Medical Model

The participants felt that oppressive power structures were present within music therapy education. Specifically, they spoke about how the helper versus client binary is emphasized within the training, strengthened by the use of outdated textbooks that espouse the medical model and deficit/recovery perspectives. This emphasis on the 'helper' therapist trope may act to reinforce ableist perspectives of the therapeutic relationship (Shaw, 2022) and, according to the participants, could be ableist and stigmatizing towards the music therapist or student living with MI as well. This perspective was explored by Shaw and colleagues (2022), who expressed a need for greater visibility and awareness of music therapists living with disabilities, advocated for a shift towards post-ableist music therapy in which music therapists are celebrated for their differences, and an understanding of the deficit/recovery perspective as harmful. There is a need in the music therapy profession to reconcile the ideas of the expert, helper, and infallible therapist with the reality that therapists also have mental health needs.

The participants spoke about a need for systemic change to combat stigma, with one participant (Participant 103) speaking more specifically about the medical field. Participant 103

discussed the recovery perspective that is so often taught in the medical model, along with how professionals discuss patients with MI. They expressed how patients were frequently referred to by their diagnosis, such as: “He’s a bipolar.” They believed that this could be damaging for professionals and patients alike. Given that this perspective challenges the medical/deficit/recovery model, it is directly contradicted by many published research studies. For example, a study conducted by Iasiello et al. (2019) explored the concept of mental health and mental illness existing on opposite ends of the same continuum. It defined high levels of positive mental health as a state in which an individual can flourish with or without MI symptoms. They found that individuals who maintained or achieved the highest levels of positive mental health were significantly more likely to recover from MI compared to individuals who held the lowest level of positive mental health in which they were defined as languishing instead of flourishing on the continuum. They frequently used terms such as “recover” when discussing the treatment of MI throughout their research. Studies like those of Iasiello et al. (2019) contradict the findings of this study because they do not center the perspectives of individuals with MI and do not take into consideration the experiences of stigma that accompany such "recovery” perspectives.

Music Therapist as Helper

The results challenged the power structures supported in some of the seminal works in music therapy, including those by Dr. Kenneth Bruscia. In the book *Defining Music Therapy*, Bruscia wrote:

> [A]lthough the agreement between client and therapist involves an exchange of therapist services for client remuneration, it is not reciprocal in kind… By definition, then, a therapist is a person who helps, and the client is the person who receives that help, and

> this commitment to a relationship of 'helper and helped' is unidirectional and one-sided—it does not go both ways. (2014, p. 68)

While it was acknowledged by a participant of this study (Participant 103) who discloses to their clients that there are boundaries that must be set to remain ethical in the clinical setting, they stated their belief that therapy can be reciprocal and serve as a partnership.

Bruscia's writings prioritize important aspects of therapy such as professionalism, appropriateness, and ethics, however, it can also be understood through the lens of saviorism. A therapist operating from a savior perspective prioritizes helping or saving the client. There is an inherent power dynamic in this perspective, wherein the therapist knows all and is in a higher position of power, and the client is lesser or in need of intervention. The saviorism perspective can be traced directly to white saviorism, "a network of relationships and resources that is guided by an ideology that centers white bodies as essential helpers to social problems" (Finnegan, 2022, p. 617). While the participants of this study did not directly name whiteness or white saviorism, it is relevant to name this relationship between ableism and racism, such that critical scholars assert that these are not only related, but upholding one strengthens the other (Siuty et al., 2024). The assumption of the all-knowing therapist can place unattainable standards upon the therapist by making them feel as if they must be free from mental illness or disability in order to practice. This assumption may even lead to a decreased desire on the part of the therapist to seek help for their mental illness or may cause the client to feel incapable, less than, and lack a sense of control. Gilman (2022) described the hierarchies that are so often found within music therapy settings, situating saviorism through an emphasis on the privileges that music therapists hold in many areas, including race, disability, class, and language. As demonstrated in the interviews for the present study, this way of thinking can be oppressive and ableist and promote greater levels

of stigma towards mental illness. Participant 103 spoke about their belief that this perspective can be detrimental to the humanity of people working in helping professions by perpetuating the hierarchy and authoritarian power structures within a clinical setting.

A study conducted by Rolvsjord (2015) utilized a thematic analysis of semi-structured interviews with clients and music therapists to explore clients' contributions within therapeutic collaborations. This study resulted in a conceptualization of therapy as a partnership. The findings illuminated the participating clients' agency within therapy through the four main themes of taking initiative, exerting control in sessions, commitment to the relationship, and engagement across contexts. The research emphasized the client's involvement and agency within the clinical setting. This conceptualization of the client as equal in importance to the therapist challenges writings by authors such as Bruscia but supports the experiences shared by participants for this study.

Physical Versus Mental Health

Prioritizing mental health as equally as physical health came up frequently in the interviews. Participant 103 noted that physical and mental health should be considered equally important to monitor, maintain, and treat. Holistic approaches to discussing and treating health espouse similar beliefs (Peate, 2014). The results of the present study promote the idea that mental health should be just as important as physical health. Participant 103 described their frustration with this discourse, labeling it a "false narrative." Another idea to explain the prioritization of physical health over mental health could be due to the thought brought up by Participant 102 that MI can be categorized as an invisible disability. People with MI might appear able and healthy in comparison to people with physical or visible disabilities. Therefore, it may be easier to prioritize visible physical ailments over invisible mental ailments.

Workplace Support for Music Therapists with Mental Illness

All three participants discussed a need for more support, acceptance, and awareness of MI in the workplace. This lack of support in the workplace has been documented by researchers such as Janssens et al. (2021), who found that a significant percentage of managers report reluctance to hire people with current and past mental health issues. Interestingly, Participant 101 expressed that they felt unsafe disclosing their MI to large corporations because, in their experience, those companies would have found ways to fire them. The participants noted a lack of support in the workplace and had experienced loss of opportunities/employment due to their MI. A survey conducted by Hogg et al. (2023) found that only 26.2% of academic experts, representatives of small/medium enterprises, specific sector organizations, labor/advocacy groups, and occupational health organizations felt that employees should speak openly about their MI, while 81.5% of experts expressed a significant unmet need for support of people with MI in the workplace. Based on the present study and the current body of literature, it seems that there is a lack of awareness and understanding of the nuances surrounding MI, particularly as MI impacts those in the workplace. MI is painted in a negative light in the research regarding workplace environments and does not seem to focus on the potential strengths that can come from having MI.

Disclosing Mental Illness

Differing perspectives surrounding disclosure arose throughout the interviews, in which the participants discussed the potential benefits and harm that could arise from disclosure. Loss of opportunities/employment could be due to a lack of understanding of MI diagnosis from the boss and/or the employee. Disclosing to a trusted individual could create a sense of safety in which they can feel confident knowing they will not feel judged or treated differently. In

alignment with these findings about disclosure, Prizeman et al. (2024) explored the positive and negative aspects of disclosure and secrecy, personal preferences surrounding disclosure, and selectiveness in disclosing. The young people involved in the study described non-disclosure as a way to maintain control but acknowledged that non-disclosure could prevent engagement with others. They described disclosure as necessary to gain help but felt that, ultimately, disclosure leads to a greater level of stigma. Finally, they described the difficulty in knowing how much of their MI they could disclose and with whom. Disclosure seems to differ for everyone and involves weighing the positives and negatives before choosing to disclose. It also appears to vary based on the particular workplace environment. The participants also discussed the process of disclosing to their clients. A study conducted by Elliot et al. (2020) examined this process and found that the therapists chose to disclose their MI in sessions only when it would benefit the clients.

Suggested Anti-Stigma Initiatives

The participants in the present study all spoke about the importance of education as an anti-stigma initiative, whether through spreading information or being more open about MI. Research conducted by Lien et al. (2021), which aimed to challenge mental illness stigma among healthcare professionals and students, found that education coupled with social contact was the most effective anti-stigma initiative. Oexle et al. (2017) presented anti-stigma initiatives such as systemic change and community spaces, which aligned with other suggested initiatives in the present study. Social media was also noted as a tool for educating, advocating, and sharing information about mental health among the participants in the present study. Additionally, a literature review conducted by Mari (2018) demonstrated that social media is an integral advocacy tool for raising awareness of MI. The public mainly accesses health information

through the Internet and social media. Thus, social media campaigns tend to reach a wider audience. Young people proved most receptive to social media campaigns surrounding mental health.

Implications for Music Therapy

The results of this study suggest that changes in music therapy training and education could be beneficial for decreasing stigma towards MI. Participants 102 and 103 discussed their views on the client-therapist dichotomy, labeling the therapeutic relationship as a partnership or two human beings helping each other. They acknowledged that both the client and the therapist have something to offer that can begin to flatten the relationship's inherent power hierarchy. There is a need for a shift in how music therapists position themselves amongst their clients. Enforcing previously taught power structures in the clinical setting can be damaging and stigmatizing for the clients, especially those with MI.

Music therapy educators and supervisors might consider acknowledging these power structures and begin to implement the values of liberatory or anti-oppressive therapeutic approaches into their practices. Educators and professionals alike can work together to become less ableist towards those with whom they serve by striving to explore the research on the harmful impact of stigma. This study demonstrated how stigma led to feelings of inadequacy, worsening of MI symptoms, and even the loss of employment due to not being sure how to advocate for oneself. Educators and professionals must continue to learn and seek out updated information on best practices in music therapy to better support clients and fellow colleagues. Some avenues of exploration might be the growing body of anti-oppressive/anti-ableist research and public-facing scholarship authored by music therapists with disabilities.

The participants also expressed a desire for generative community spaces for music therapists living with MI. Community spaces could be beneficial in raising awareness while also allowing space for discussing the nuances of living with MI, where practical skills, coping mechanisms, and support can be shared amongst individuals with shared lived experiences.

The participants spoke about the concept of MI being a strength, particularly in the clinical setting. Their experience of MI and knowledge of their own personal resources could be utilized in sessions and offered to clients living with the same illnesses. The participants' responses and the extant literature suggest that experiences with MI could strengthen a therapist's ability to relate, connect, and empathize with others, especially those with similar diagnoses.

Limitations

There are several limitations to the present study. Due to the design of this study, which prioritized deep exploration of a little-researched topic with a small sample size, data saturation could not be achieved. Furthermore, in exploratory qualitative studies, no causal relationships can be drawn. The thematic analysis was also completed in a shorter time frame than recommended, given the time constraints of completing the study within an academic semester. Typically, the researcher should have more time to fully immerse oneself in the data before moving through each step of the thematic analysis (Braun & Clarke, 2006). Additionally, while the advisor for this thesis served as a second coder to achieve intercoder reliability, an external coder could have achieved further reliability. Finally, the study did not represent diverse perspectives, as the respondents shared similar intersectional identities. As race and other factors directly impact experiences of stigma, this is a limitation of the study.

Recommendations for Future Research

First, I recommend that this study be replicated with a larger sample of participants to increase transferability. Additionally, it is recommended that participants are drawn from a larger population to better understand intersectional experiences of stigma. Interestingly, the participants in this study all discussed a need for more research on the experiences of stigma amongst practicing music therapists living with MI. They felt that these studies could help to provide support and further resources regarding the navigation of being a music therapist while living with MI. Based on the requests made by the participants, it is evident that future research should examine resources and tools that other music therapists have used to help combat stigma and learn to live with MI while working in the field. Another avenue for future research could involve exploring the deficit/recovery model while centering the perspectives of individuals with MI.

I hope to discover a greater number of studies surrounding the present topic in the future. More research could illuminate the severity of stigma amongst practicing music therapists living with MI and the impact this stigma has on their ability to experience success within the profession.

CHAPTER 6: CONCLUSION

Practicing music therapists living with depression and/or anxiety experience stigma for their MI. Research has shown that experiences of self-, public, and institutionalized stigma can have a negative impact on mental health and worsen the symptoms of existing MI (Borenstein, 2020). The results of this study illuminated how power structures in the clinical setting, as well as within music therapy education, contribute to stigma and promote ableism. Disclosure of MI can sometimes be detrimental to a music therapist's employment but can also be a tool for raising awareness and tackling stigma. Music therapists who experience stigma for their MI need more support and acceptance in the workplace and systemic change towards tackling public stigma, which in turn affects other forms of stigma and community spaces where they can feel comfortable to be vulnerable about their experiences living with MI.

The purpose of this exploratory qualitative study was to examine the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. The results indicated that respondents experienced all three well-researched forms of stigma: self–, public, and institutionalized (APA, 2020). Respondents reported that most stigmatizing experiences occurred in the workplace, usually stemming from a lack of support from superiors or a lack of acceptance from the facilities/institutions themselves. Self-stigma resulted from experiencing consistent public stigma, from the way in which family members and/or strangers perceive or speak about MI to the way MI is discussed in university training programs. The results demonstrate a need for anti-ableist approaches to music therapy education, a culture shift in how MI is discussed in society, and a greater acceptance, understanding, and tolerance of MI in the workplace. Further research on the experiences of stigma amongst practicing music therapists

living with MI is recommended to provide insight and resources to those struggling with their mental health and to raise awareness that stigma is indeed a serious problem.

Appendix A: IRB Approval Letter

MOLLOY UNIVERSITY

1000 Hempstead Ave., PO Box 5002, Rockville Center, NY 11571-5002
www.molloy.edu

Patricia A. Eckardt, PhD, RN, FAAN
Chair, Molloy University Institutional Review Board
Professor, Barbara H. Hagan School of Nursing and Health Sciences
E: peckardt@molloy.edu
T: 516.323.3711

DATE:	February 22, 2024
TO:	Hally Batterman
FROM:	Molloy University IRB
PROJECT TITLE:	[2141041-1] The Experiences of Stigma Amongst Practicing Music Therapists Living with Depression and/or Anxiety
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	February 22, 2024
EXPIRATION DATE:	February 21, 2025
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # 7

Thank you for your submission of New Project materials for this project. The Molloy University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval 45 days before the expiration date of February 20, 2025.

Appendix B: Recruitment Language

My name is Hally Batterman and I am a graduate music therapy student at Molloy University. You are being invited to participate in this research study titled: The Experiences of Stigma Amongst Practicing Music Therapists Living with Depression and/or Anxiety. I am conducting this study as part of my master's thesis to explore the lived experiences of stigma amongst practicing music therapists living with depression and/or anxiety. In gaining a better understanding of stigma amongst music therapists with mental illness, I hope to identify any potential implications for self-care, advocacy, and community. These lived experiences could paint a clearer picture of what the needs are of these individuals in terms of anti-stigma initiatives, education, and treatment.

You are eligible to participate in this study if you are a board-certified music therapist (MT-BC) living in the United States, have been a practicing full-time music therapist for a minimum of 5 years, and identify as having depression and/or anxiety for a minimum of 2 years during practice as an MT-BC.

Your participation in this study will include a screening and consenting process, as well as a private virtual interview over Zoom. During this interview, you will be asked about your experiences with stigma as a practicing music therapist living with depression and/or anxiety, and it will take you approximately 45-60 minutes to complete. The interview will be recorded through the Zoom platform. After the interview, you will be emailed a written script of the interview and asked to read it over to confirm all language is correct. You will also be asked to review a summary of the analysis of your transcript as a form of member-checking.

This study involves minimal risk and you do not have to be in this study if you do not want to be. You may withdraw from the study at any time. All information will be de-identified and remain confidential.

We will be happy to answer any questions you have about this study. If you have further questions about this survey or if you have a research-related problem, you may contact me, Hally Batterman, at hbatterman@lions.molloy.edu or my thesis advisor, Stephenie Sofield, at ssofield@molloy.edu.

If you have any questions about your rights as a research participant, you may contact the Molloy University IRB Chair, Dr Patricia A. Eckardt, at peckardt@molloy.edu.

APPENDIX C: Consent Form

Music Department/Music Therapy
1000 Hempstead Ave.
Rockville Centre, NY 11570
(631) 903-9458

Study Title: The Experiences of Stigma Amongst Music Therapists Living with Depression and/or Anxiety

This study as part of a Master's Thesis for Molloy University by: Hally Batterman; hbatterman@lions.molloy.edu.

The faculty advisor for this study is: Stephenie Sofield; ssofield@molloy.edu

Key Information:

This consent form is designed to inform you about the study you are being asked to participate in. Here you will find a brief summary about the study, however, you can find more detailed information later on in the form.

This study seeks to explore the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. The aim of this study is to raise awareness on this under-explored issue. The research questions for this study are:

1. How do music therapists living with mental illness experience stigma?
2. What forms of stigma do music therapists living with mental illness experience and how do these manifest?
3. What are the needs of music therapists experiencing stigma while living with mental illness?

To participate in this study, you must: 1) be a board-certified music therapist (MT-BC) living in the United States, 2) have been working full-time in the field in any setting for a minimum of 5 years, and 3) identify as having depression and/or anxiety for a minimum of 2 years during practice as an MT-BC. You will not need to disclose any medical or diagnostic information to participate in this study.

Why am I being asked to take part in this study?

This study will explore the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. Through an analysis of these experiences, we hope to identify potential implications for self-care, advocacy, and community. We also hope to uncover the needs of these individuals in terms of anti-stigma initiatives, education, and treatment for music therapists.

What will I be asked to do?

If you agree to take part in this study, you will be asked to participate in a screening and consenting process, as well as a private virtual interview over Zoom. During this interview, you will be asked about your experiences with stigma as a practicing music therapist living with depression and/or anxiety and it will take you approximately 45-60 minutes to complete. The interview will be recorded through the Zoom platform. After the interview, you will be e-mailed a written script of the interview and asked to read it over to confirm all language is correct. You will also be asked to review a lay language narrative summary of the analysis of your transcript as a form of member-checking.

Where is the study going to take place, and how long will it take?

The study will take place in the comfort of your own home or other location of choice. It will be conducted over Zoom and will take no longer than 1.5 hours including the consent session prior to the interview. The consent session can take place during a separate meeting, if preferred.

What are the risks and discomforts?

It is not possible to identify all potential risks in research; however, reasonable safeguards have been taken to minimize known risks. You may experience some mild discomfort or emotional response while sharing personal experiences of stigma towards mental illness. If you feel you need to seek additional support following the interview, counseling services are offered through the Mental Health and Wellness Center at Molloy University. They can be reached at (516) 323-3854. You may also utilize the 24/7 Substance Abuse and Mental Health Services Administration (SAMHSA) hotline. They can be reached at 1 (800) 662-4357.

What are the expected benefits of this research?

You may not directly benefit from this research; however, we hope that your participation in the study may help to raise awareness about the experiences of stigma amongst practicing music therapists living with depression and/or anxiety. In gaining a better understanding of stigma amongst music therapists with mental illness, there is a possibility of identifying potential implications for self-care, advocacy, and community. Your lived experiences could inform recommendations for anti-stigma initiatives, education, and other supports for music therapists living with mental illness.

Do I have to take part in this study?

Your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.

What are the alternatives to being in this study?

Instead of being in this research, you may choose not to participate.

Who will have access to my information?

All information gathered during the study will be stored on a password-protected laptop that only the principal investigator and thesis supervisory committee can access. All transcripts will be immediately de-identified; any potentially identifying information will be redacted (names, locations, schools, places of employment).

Additionally, to ensure that this research activity is being conducted properly, Molloy University's Institutional Review Board (IRB), whose members are responsible for the protection of human subjects 'rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.

What if I have questions?

If you have questions about the study, you can contact Hally Batterman, MT-BC at hbatterman@lions.molloy.edu, or Stephenie Sofield, MM, MT-BC, at ssofield@molloy.edu.

What are my rights as a research participant?

You have rights as a research participant. All research with human participants is reviewed by a committee called the *Institutional Review Board (IRB)* which works to protect your rights and welfare.

If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB contact the Molloy IRB office at irb@molloy.edu or the IRB CHAIR :Dr. Patricia A. Eckardt peckardt@molloy.edu call (516) 323-3000.

Documentation of Informed Consent:

You are freely making a decision whether to be in this research study. Signing this form means that:

1. You have read and understood this consent form.

2. You have had your questions answered, and

3. After sufficient time to make your choice, you have decided to be in the study.

You will be given a copy of this consent form to keep.

_____ _____

Your signature Date

_____ _____

Your printed name Date

Electronic Signature Agreement:
I agree to provide an electronic signature to document my consent.

Zoom Audio/Zoom Video Agreement:

_____ _____

Your signature Date

_____ _____

Your printed name Date

_____ _____

Signature of researcher explaining study Date

_____

Printed name of researcher explaining study

Appendix D: Interview Protocol

Introductory: I am interested in experiences of stigma amongst practicing music therapists living with depression and/or anxiety. I am coming at this from the perspective of someone who does have a mental illness. This research is driven by my own lived experiences. I am going to give you an example definition of stigma, but I understand that the definition that you hold might be different from mine. Stigma, according to the American Psychological Association (2018, para. 1), is defined as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency."

Key Questions:

- What is stigma to you?
- Tell me about a time in which you felt stigmatized/experienced stigma.
- Do you experience different forms of stigma depending on the context? For example, are your experiences different in your personal life versus your professional life?
- Do you have any experiences of stigma that are directly related to being a music therapist or studying music therapy?
- Is there anything else you want to tell me about stigma, music therapy, and mental illness?
- According to the American Psychological Association, internalized stigma or self-stigma refers to the negative attitudes that are internalized and cause feelings of shame regarding one's own mental illness. Self-stigma is associated with perceptions about oneself as dangerous, incompetent, or to blame for their illness. What comes up for you after I read that definition? What is the impact of these stigmatizing experiences on you/How have these experiences impacted you?
- How serious of a problem do you think stigma is?
- Keeping stigma in mind, what are your thoughts on the disclosure of mental illness?
- So, you have told me a lot about your experiences of stigma. What do you feel are the needs of music therapists who experience stigma for their mental illness?
- I have completed my list of key questions and was wondering if you had anything else you would like to add pertaining to stigma.

Follow-Up Questions/Phrases and Probing Questions:

- Can you give me an example of that?
- How was that experience for you?
- Thank you for sharing that with me.
- Mm.
- Pause.
- Say more.
- What did you mean when you said this?
- Can you give further detail on this?

REFERENCES

Aalbers, S., Fusar-Poli, L., Freeman, R. E., Spreen, M., Ket, J. C., Vink, A. C., Gold, C. (2017). Music therapy for depression. *Cochrane Database of Systematic Reviews, 2017*(11), https://doi.org/10.1002/14651858.CD004517.pub3

American Music Therapy Association (2021). *Music therapy for adults with mental health and substance use conditions.* https://www.musictherapy.org/assets/1/7/FactSheet_Music_Therapy_for_Adults_with_Mental_Health_and_Substance_Use_Conditions_2021.pdf

American Psychiatric Association. (2020). *Stigma, prejudice and discrimination against people with mental illness.* https://www.psychiatry.org/patients-families/stigma-and-discrimination

American Psychiatric Association. (2021, May 27). *The economic cost of depression is increasing; Direct costs are only a small part.* https://www.psychiatry.org/news-room/apa-blogs/the-economic-cost-of-depression-is-increasing

American Psychological Association. (2018). *APA dictionary of psychology – Stigma*. https://dictionary.apa.org/stigma

Anxiety & Depression Association of America. (2023). *Depression facts & statistics.* https://adaa.org/understanding-anxiety/depression/facts-statistics

Anxiety & Depression Association of America. (2023). *What are anxiety and depression?.* https://adaa.org/understanding-anxiety

Arthur, M.H. (2018). A humanistic perspective on intersubjectivity in music psychotherapy. *Music Therapy Perspectives, 36*(2), 161-167. https://doi.org/10.1093/mtp/miy017

Baker, F.A. (2015). What about the music? Music therapists' perspectives on the role of music in the therapeutic songwriting process. *Psychology of Music, 43*(1), 122-139. https://doi.org/10.1177/0305735613498919

Batterham, P.J., Griffiths, K.M., Barney, L.J., & Parsons, A. (2013). Predictors of generalized anxiety disorder stigma. *Psychiatry Research, 206*(2), 282-286. https://doi.org/10.1016/j.psychres.2012.11.018

Botha, M. & Frost, D.M. (2020). Extending the minority stress model to understand mental health problems experienced by the autistic population. *Society and Mental Health, 10*(1), 20-34.

Braun, V. & Clarke, V. (2013) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2), 120-123

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

Brinkmann, S. & Kvale, S. (2014). *InterViews.* Thousand Oaks, CA: SAGE Publications, Inc.

Brower, K.J. (2021). Professional stigma of mental health issues: Physicians are both the cause and solution. *Academic Medicine, 96*(5), 635-640. https://oi.org/10.1097%2FACM.0000000000003998

Bruce, C. (2022). Performing normal: Restless reflections on music's dis/abling potential. *Music Therapy Perspectives, 40*(2), 125-131. https://doi-org.molloy.idm.oclc.org/10.1093/mtp/miab015

Bruscia, K.E. (2014). *Defining music therapy* (3rd ed.). Barcelona Publishers.

Campbell, F.K. (2009). *Contours of ableism: The production of disability and abledness*. Palgrave MacMillan. https://doi.org/10.1080/10304311003797498

Charmaz, K. (2015). Teaching theory construction with initial grounded theory tools: A reflection on lessons and learning. *Qualitative Health Research, 25*(12), 1610–1622. https://doi.org/10.1177/1049732315613982

Cho, H.K. (2018). The effects of music therapy-singing group on quality of life and affect of persons with dementia: A randomized controlled trial. *Frontiers in Medicine, 5*. https://doi.org/10.3389/fmed.2018.00279

Cincinnati Children's. (2023). *Depression and suicide.* https://www.cincinnatichildrens.org/health/d/depression-suicide#:~:text=What%20Are%20Signs%20of%20Depression,combination%20with%20other%20mental%20disorders.

Corrigan, P.W., Bink, A.B., Schmidt, A., Jones, N., & Rüsch, N. (2016) What is the impact of self-stigma? Loss of self-respect and the "why try" effect. *Journal of Mental Health, 25*(1), 10-15. https://doi.org/10.3109/09638237.2015.1021902

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: SAGE Publications, Inc.

Davies, H. (2022). 'Autism is a way of being': An 'insider perspective' on neurodiversity, music therapy and social justice. *British Journal of Music Therapy, 36*(1), 16-26. https://doi.org/10.1177/13594575221090182

Dunn, D.S. (2021). *Understanding ableism and negative reactions to disabilities.* https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/ableism-negative-reactions-disability

Elliot, M., Ragsdale, J.M., McLeigh, J.D., & Spaulding, W. (2020). Mental health professionals with mental illnesses: A qualitative interview study. *American Journal of Orthopsychiatry, 90*(6), 677-686. https://doi.org/10.1037/ort0000499

Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., Vanhala, M., & Gold, C. (2011). Individual music therapy for depression: Randomised controlled trial. *British Journal of Psychiatry*, *199*(2), 132–139. https://doi.org/10.1192/bjp.bp.110.085431

Finnegan, A.C. (2022). Growing up white saviors. *Journal of Applied Social Science, 16*(3), 617-636. https://doi.org/10.1177/19367244221082023

George, T. (2023). *Exploratory research | Definition, guide, & examples.* https://www.scribbr.com/methodology/exploratory-research/

Gilman, V. (2022). Ableism and colonialism in international music therapy service-learning settings: A critical discourse analysis. *Qualitative Inquiries in Music Therapy, 16*, 23-70. https://molloy.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/ableism-colonialism-international-music-therapy/docview/2851292624/se-2.

Gross, R. (2018). The social model of disability and music therapy: Practical suggestions for the emerging clinical practitioner. *Voices: A World Forum for Music Therapy, 18*(1). https://doi.org/10.15845/voices.v18i1.958

Gutiérrez, E.O.F. & Camarena, V.A.T. (2015). Music therapy in generalized anxiety disorder. *The Arts in Psychotherapy, 44*, 19-24. https://doi-org.molloy.idm.oclc.org/10.1016/j.aip.2015.02.003

Heinz, I., Baldofski, S., Beesdo-Baum, K., Knappe, S., Kohls, E., Rummel-Kluge, C., & Hashimoto, K. (2021). "Doctor, my back hurts and I cannot sleep." Depression in primary care patients: Reasons for consultation and perceived depression stigma. *PloS One, 16*(3), Article e0248069. https://doi.org/10.1371/journal.pone.0248069

Hogg, B., Moreno-Alcázar, A., Tóth, M.D., Serbanescu, I., Aust, B., Leduc, C., Paterson, C., Tsantilla, F., Abdulla, K., Cerga-Pashoja, A., Cresswell-Smith, J., Fanaj, N., Meksi, A., Ni Dhalaigh, D., Reich, H., Ross, V., Sanches, S., Thomson, K., Van Audenhove, C., Pérez, V., Arensman, E., Purebl, G., & Amann, B. (2023). Supporting employees with mental illness and reducing mental illness-related stigma in the workplace: an expert survey. *European Archives of Psychiatry and Clinical Neuroscience, 273*(3), 739-753. https://doi.org/10.1007/s00406-022-01443-3

Hunter, D., McCallum, J., & Howes, D. (2019). Defining exploratory-descriptive qualitative (EDQ) research and considering its application to healthcare. *Journal of Nursing and Health Care, 4*(1).

Iasiello, M., van Agteren, J., Keyes, C.L.M., & Cochrane, E.M. (2019). Positive mental health as a predictor of recovery from mental illness. *Journal of Affective Disorders, 251,* 227-230. https://doi.org/10.1016/j.jad.2019.03.065

Janssens, K., Weeghel, J., Dewa, C., Henderson, C., Mathijssen, J., Joosen, M., & Brouwers, E. (2021). Line managers' hiring intentions regarding people with mental health problems: a cross-sectional study on workplace stigma. *Occupational and Environmental Medicine, 78*(8), 593-599. https://doi.org/10.1136/oemed-2020-106955

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*(2), 111-116. https://doi-org.molloy.idm.oclc.org/10.1177/0840470416679413

Krans, B. (2018, October 20). *Stigma still a major hurdle in getting people the mental health care they need.* https://www.healthline.com/health-news/mental-health-treatment-hindered-by-stigma-030214#Some-Advice-From-a-Stigma-Breaker

Lien, Y., Lin, H., Lien, Y., Tsai, C., Wu, T., Li, H., & Tu, Y. (2021). Challenging mental illness stigma in healthcare professionals and students: a systematic review and network meta-analysis. *Psychology and Health, 36*(6), 669-684. https://doi.org/10.1080/08870446.2020.1828413

Mari, S. (2018). The online fight against stigma: Resources for clinicians and families to realize social justice for youth with mental illnesses. *Journal of the American Academy of Child and Adolescent Psychiatry, 57*(10), S8-S8. https://doi.org/10.1016/j.jaac.2018.07.036

Meadows, A. & Wimpenny, L. (2017). Core themes in music therapy clinical improvisation: An arts-formed qualitative research synthesis. *The Journal of Music Therapy, 54*(2), 161-195. https://doi.org/10.1093/jmt/thx006

Mental Health America. (2022). *Access to care data 2022.* https://mhanational.org/issues/2022/mental-health-america-access-care-data#:~:text=Over%20half%20(56%25)%20of,mental%20illness%20are%20going%20untreated

Mental Health Foundation. (2021, October 4). *Stigma and discrimination.* https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/stigma-and-discrimination#:~:text=Nearly%20nine%20out%20of%20ten,negative%20effect%20on%20their%20lives.

Mohandes, A., Tak, C., Mackie, D., Rowland, J., & Modi, K. (2022). POSA51 Economic burden of anxiety severity in a general population of US adults based on national health and wellness survey (NHWS). *Value in Health, 25*(1), S42-S42. https://doi.org/10.1016/j.jval.2021.11.196

National Alliance on Mental Illness. (2018, January 19). *The comorbidity of anxiety and depression.* https://www.nami.org/Blogs/NAMI-Blog/January-2018/The-Comorbidity-of-Anxiety-and-Depression#:~:text=In%20mental%20health%2C%20one%20of,with%20depression%20also%22experiencing%20anxiety.

National Institute of Mental Health. (2023, April). *Anxiety disorders.* https://www.nimh.nih.gov/health/topics/anxiety-disorders

National Institute of Mental Health. (2023, September). *Depression.* https://www.nimh.nih.gov/health/topics/depression#:~:text=Depression%20is%20one%20of%20the,it%20often%20begins%20in%20adulthood.

Oexle, N., Rüsch, N., Viering, S., Wyss, C., Seifritz, E., Xu, Z., & Kawohl, W. (2017). Self-stigma and suicidality: a longitudinal study. *European Archives of Psychiatry and Clinical Neuroscience*, *267*(4), 359-361. https://doi.org/10.1007/s00406-016-0698-1

Oexle, N., Müller, M., Kawohl, W., Xu, Z., Viering, S., Wyss, C., Vetter, S., & Rüsch, N. (2018). Self-stigma as a barrier to recovery: a longitudinal study. *European Archives of Psychiatry and Clinical Neuroscience*, *268*(2), 209-212. https://doi.org/10.1007/s00406-017-0773-2

Peate, I. (2014). Making mental health as important as physical health. *British Journal of Healthcare Assistants*, *8*(2), 92-93. https://doi.org/10.12968/bjha.2014.8.2.92

Prizeman, K., McCabe, C., Weinstein, N. (2024). Stigma and its impact on disclosure and mental health secrecy in young people with clinical depression symptoms: A qualitative analysis. *PloS One, 19*(1). https://doi.org/10.1371/journal.pone.0296221

Rolvsjord, R. (2015). What clients do to make music therapy work: A qualitative multiple case study in adult mental health care. *Nordic Journal of Music Therapy, 24*(4), 296-321. https://doi.org/10.1080/08098131.2014.964753

Shaw, C.M. (2022). An autoethnographic journey in developing post-ableist music therapy. *Voices: A World Forum for Music Therapy, 22*(1). https://doi.org/10.15845/voices.v22i1.3314

Shaw, C., Churchill, V., Curtain, S., Davies, A., Davis, B., Kalenderidis, Z., Langlois Hunt, E., McKenzie, B., Murray, M., & Thompson, G.A. (2022). Lived experience perspectives on ableism within and beyond music therapists' professional identities. *Music Therapy Perspectives, 40*(2), 143–151. https://doi-org.molloy.idm.oclc.org/10.1093/mtp/miac001

Shukla, P. (2010). *Essentials of marketing research: Part I approach, research design, and sampling.* Paurav Shukla & Ventus Publishing ApS.

Siuty, M. B., Beneke, M. R., & Handy, T. (2024). Conceptualizing white-ability saviorism: A necessary reckoning with ableism in urban teacher education. *Review of Educational Research,* 0(0). https://doi.org/10.3102/00346543241241336

Sreeram, A., Cross, W. M., & Townsin, L. (2022). Anti-stigma initiatives for mental health professionals – A systematic literature review. *Journal of Psychiatric and Mental Health Nursing, 29*(4), 512-528. https://doi.org/10.1111/jpm.12840

Substance Abuse and Mental Health Services Administration. (2023, April 4). *Depression.* https://www.samhsa.gov/mental-health/depression

Wheeler, B.L. & Murphy, K.M. (2016). *Music therapy research: Third edition.* Barcelona Publishers.

Wolbring, G. (2009). What next for the human species? Human performance enhancement, ableism and pluralism. *Development Dialogue, 2*(August), 141-163.

World Health Organization. (2023, March 31). *Depressive disorder (depression).* https://www.who.int/news-room/fact-sheets/detail/depression

World Health Organization. (2022, June 16). *Knowledge is power: Tackling stigma through social contact.* https://www.who.int/news-room/feature-stories/detail/knowledge-is-power--tackling-stigma-through-social-contact

World Health Organization. (2022, June 8). *Mental disorders.* https://www.who.int/news-room/fact-sheets/detail/mental-disorders

Yale Medicine. (2023). *Parental depression: How it affects a child.* https://www.yalemedicine.org/conditions/how-parental-depression-affects-child#:~:text=Depression%20not%20only%20interferes%20with,car%20seat%20or%20getting%20immunizations).