The Current State and Future Direction of Counseling Skills Training in Music Therapy: A Descriptive Survey

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Abstract

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The Current State and Future Direction of Counseling Skills Training in Music Therapy: A Descriptive Survey

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This descriptive study investigated counseling skills training in the field of music therapy. A cross-sectional survey was administered to 371 board-certified music therapists to investigate their educational experiences, level of satisfaction with the education they received, and level of confidence in using counseling skills in their work. Survey questions were in multiple choice and Likert scale format. Results indicated that most participants learned counseling skills through a combination of music therapy coursework, supervision, and clinical experience. On average, participants reported feeling confident using counseling skills, although they reported feeling less confident using a subset of influencing skills. Results were mixed on participants' level of satisfaction in their counseling skills education and training, with the largest number of participants indicating that they were somewhat satisfied and the second largest indicating that they were somewhat dissatisfied. Implications for the field are discussed and recommendations for future research are provided.

Keywords: Counseling skills, music therapy, education, cultural responsiveness, trauma-informed care.

Dedication

To my friends and colleagues in music therapy.

Acknowledgments

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Chapter 1: Introduction

The Role of Counseling Skills in Music Therapy

Counseling skills in music therapy refer to the therapeutic communication and interpersonal skills that music therapists use to build rapport and facilitate therapeutic processes within music therapy (Grocke & Wigram, 2007; Ivey, et al., 2022). Although the term *counseling skills* may only bring verbal skills to mind, they also refer to the observation, attending, and listening skills that music therapists use to improve communication, connection, and understanding within a music therapy session. Counseling skills involve much more than what one says during a session; they require self-awareness, cultural awareness, a desire to understand the needs and experiences of others, basic knowledge of therapeutic processes and dynamics, and the intent to empower the people with whom one works (Beck & Kulzer, 2018; Ivey, et al., 2022; Ratts, et al,. 2016). Music therapists may use counseling skills in a general or in-depth manner, based on their education, training, work setting, and therapeutic approach (Bruscia, 1998; Schwartz, 2019; Ventre & McKinney, 2015; Wheeler, 1983).

Music therapists do not necessarily need to develop advanced counseling skills to work effectively with clients (Gooding, 2017; Grocke & Wigram, 2007). Indeed, the music therapy is a diverse field and serves people with a range of physical, mental, intellectual, and developmental conditions (American Music Therapy Association [AMTA], 2020). Some music therapists may not work within a psychotherapeutic orientation or use extensive verbal processing skills, depending on the needs of the people with whom they work. Even so, basic counseling skills such as empathy, listening

skills, reflection, and validation are essential in all therapeutic settings (Adado & Games, 2021; AMTA, 2019; Beck & Kulzer, 2018; Dileo, 2021; Gooding, 2017; Grocke & Wigram, 2007; Ivey, et al., 2022).

The Therapeutic Relationship

The therapeutic relationship is a key element of music therapy practice (AMTA, 2013, 2019; Dileo, 2021). Basic counseling skills such as empathy, positive regard, genuineness, culturally appropriate eye contact, providing the client with enough time to speak, and active listening are necessary for building a strong therapeutic bond (Grocke & Wigram, 2007; Ivey, et al., 2022; King, 2021). Other counseling skills, such as reflecting key words, paraphrasing, and open questioning allow music therapists to explore client thoughts and feelings, check for understanding, and affirm client experiences (Grocke & Wigram, 2007). Interacting with clients in a supportive, nonjudgmental way creates a sense of emotional safety and provides the client with space to work through pertinent issues (Ivey, et al., 2022). All counseling skills must be used sensitively and should be adapted to meet the needs of the client (Dileo, 2021; Ivey, et al., 2022).

Power dynamics are integral to the therapeutic process and must be considered when working with clients. Music therapists are in a relatively powerful position given their education, license/certification to practice, and role as a treatment provider (Dileo, 2021; Wilson, 2021). Music therapists have the power to conduct assessments, put their findings into writing, determine the focus of the session, determine treatment methods, use influencing and motivational techniques, and provide music therapy expertise within

the therapeutic relationship (Bruscia, 2014; Dileo, 2021; Wilson, 2021). Clients are experts in their own lives, needs, experiences, and preferences, and have unique strengths and resources that can be utilized for therapeutic change (Rolvsjord, 2010). Clients may also exercise power by choosing to start or stop therapy, deciding to what degree they would like to engage, and accepting or rejecting interventions that are introduced by the therapist (Wilson, 2021). Music therapists use collaborative processes to access both sources of power for the benefit of the client (Bruscia, 2014; Stige, 2015; Rolvsjord, 2006; Wilson, 2021). This collaboration can include therapist actions such as building a mutually empowering relationship that is characterized by empathy, authentic presence, mutual respect, and openness to change; exploring and incorporating the client's culture, values, and preferences into music therapy; and ensuring that clients are included in treatment decisions (AMTA, 2019; Dileo, 2021; Rolvsjord, 2006). Each of these processes is directly supported by basic counseling skills (Grocke & Wigram, 2007; Wilson, 2021).

Multiculturalism

The *AMTA Standards of Professional Practice* (2013) and the *AMTA Code of Ethics* (2019) state that music therapists (a) learn about cultural groups specific to the clients with whom they work, (b) acknowledge their own personal biases and ensure that they do not discriminate against others, and (c) use culturally informed methods to assess client strengths, needs, preferences, musical functioning, and development. Culture refers to "a set of norms, beliefs, values, and customs that are shared by a group of individuals" (Tribe & Tunariu, 2018). Culture is often linked to race, ethnicity, gender,

age, sexual orientation, ability status, socioeconomic status, education, religion, location of residence, and other factors (Dileo, 2021; Kim, 2021; Tribe & Tunariu, 2018). Both client and music therapist bring their unique identities and experiences to music therapy; therefore, all music therapy is cross-cultural (Dileo, 2021; Kim, 2021). Given their unique experiences and backgrounds, music therapists and clients may have different ideas about health, disability, illness, and appropriate treatment methods in music therapy (Dileo, 2021; King, 2021; Swamy, 2014). Music therapists should therefore become aware of their own culture, values, and beliefs, and how they may differ from those of the client (AMTA, 2013; Dileo, 2021; Kim, 2021).

According to King (2021), multicultural skills in music therapy involve exploring the client's cultural background, exploring the client's perception and expression of their personal identity, and exploring their musical preferences in a cultural context. These actions build rapport and provide necessary information for culturally informed services (King, 2021). Music therapists can obtain cultural information through their own research, by consulting with the client, and by consulting with family members and caregivers, if appropriate (Kim & Whitehead-Pleaux, 2015). King suggests that music therapists use basic counseling skills along with openness, respect, and cultural humility to inquire about the client's history, including where they grew up, their cultural and musical influences, and their preferred musical styles. When listening to client-preferred music that is unfamiliar to the music therapist, the music therapist can ask about the style, history, and other specific information that the client may enjoy sharing (King, 2021). The therapist can also use open questions about the music to express genuine interest and

to learn more about the client's perspectives and relationship to the music (King, 2021). The music therapist can assess client reactions to the music by observing any changes in the client's temperament, facial expression, and body language, and by engaging the client in verbal dialogue about their experiences if indicated (King, 2021). Finally, music therapists can share music from their own repertoire with similar elements or themes to further support therapeutic goals (King, 2021). Clearly, the basic counseling skills of listening, attending, observing, reflecting, and validation are vital in these interactions (Grocke & Wigram, 2007; Ivey, et al., 2022).

Music Therapy Interventions

As the previous section demonstrates, basic counseling skills are often used before, during, and after music therapy interventions. Many standard music therapy interventions such as songwriting, song sharing, and music-based reminiscence directly involve verbal skills, such as brainstorming, self-disclosure, and exploration of thoughts and feelings (Baker, 2017; Bruscia, 1998; Gardstrom & Sorel, 2017; Kelly & Ahessy, 2021). Other interventions, such as music improvisation, can be augmented by verbally exploring client reactions afterwards (Amir, 1999; Bruscia, 1998). Music therapists often lead groups and may need to set boundaries and navigate challenging topics and relational dynamics (Pavlicevic, 2003). Music therapists also use basic verbal skills to open and close sessions, find a therapeutic focus, assess client progress in therapy, and better understand the issues that clients bring to music therapy (Amir, 1999; Grocke & Wigram, 2007; Lindblad, 2016; Nolan, 2005).

Problem Statement

Despite the integral nature of counseling skills in music therapy, research suggests that counseling skills training is inconsistent and at times absent within entry-level music therapy programs (Amir, 1999; Clements-Cortés, 2015; Nelligan & McCaffrey, 2020). Music therapy educators are under intense pressure to teach a wide array of musical, therapeutic, and music therapy skills and competencies by the time students graduate (Lloyd, et al., 2018). Furthermore, there are no established guidelines for providing counseling skills training in music therapy education (AMTA, 2021). Therefore, the type and quality of counseling skills training varies considerably between music therapy programs. In fact, reports from the research indicate that some music therapists did not receive any training in this area and that they engaged in efforts to develop these skills after graduating (Amir, 1999; Nelligan & McCaffrey, 2020). Other music therapists have indicated that they did not feel confident using basic counseling skills, particularly at the start of their careers (Clements-Cortés, 2015; Nelligan & McCaffrey, 2020). However, no studies to the researcher's knowledge have exclusively examined counseling skills training in music therapy, and little is known about the extent of this issue in the field. Research is needed to identify current methods of counseling skills training and to identify strengths and areas for improvement.

Statement of Purpose

The purpose of this study was to investigate the state of counseling skills training in music therapy. A self-report survey was created by the researcher and administered to board-certified music therapists to investigate the counseling skills training that they

received, their satisfaction with such training, and their confidence in using counseling skills in their work.

Research Questions

The research questions for this study are as follows:

1. How do music therapists learn and develop counseling skills for clinical practice?
2. How confident do music therapists feel using counseling skills in music therapy?
3. How satisfied are music therapists with counseling skills training in the field of music therapy?

Chapter 2: Literature Review

Counseling Skills Overview

Counseling Skills Definition

For the purposes of this paper, counseling skills may be defined as the therapeutic communication and interpersonal skills and behaviors that therapists use to (a) build and maintain the therapeutic relationship, (b) gather pertinent information, (c) establish shared goals and objectives, (d) guide the session, (e) develop client insight and motivation, and (f) assist the client in generalizing skills learned to daily life (Flückiger, et al., 2020; Ivey, et al., 2022; Miller & Rollnick, 2013; Zhang, et al., 2022). Counseling skills include observational, attending, listening, and influencing skills and may be verbal or nonverbal in nature (Ivey, et al., 2022). Counseling skills are distinguishable from general communication and interpersonal skills in that they are informed by the therapist's knowledge of therapeutic processes and dynamics and are used purposefully to accomplish therapeutic goals and objectives (Ivey, et al., 2022; Ridley, et al., 2011b). Counseling skills provide an effective means of working with clients to facilitate the helping process and may be used within any theoretical approach or orientation in psychotherapy (Ivey, et al., 2022). Although they originated in psychotherapy, they are not limited to the field and are frequently used in medicine, pharmacy, nursing, rehabilitation therapies, spiritual care, and other helping professions (Beck & Kulzer, 2018; Kooij, et al., 2016; Nelson-Jones, 2012).

Ivey's Microskills Model

Ivey, et al.'s (2022) microskills model is the standard approach for teaching basic counseling skills to students of counseling and psychotherapy. First outlined by Allen Ivey in 1971, this approach teaches students specific skills that promote effective communication, foster a mutual understanding of pertinent issues, and facilitate the therapeutic process (Ivey, et al., 2022; Ridley, et al., 2011a). Counseling microskills may be conceptualized as a hierarchy of skills that build upon one another. Skills at the bottom of the hierarchy, such as effective listening skills and empathy, must be employed to effectively utilize skills at the top, such as interpretation or reframing (Ivey, et al., 2022). Students take at least one microskills class and learn these skills through study, observation, supervised practice, video recording and analysis, and ongoing reflective work (Ivey, et al., 2022).

At the base of the hierarchy a foundation of ethics and multiculturalism, as knowledge and competency in these areas are necessary to truly understand client needs and act in their best interests (Ivey, et al., 2022). Communication itself is a cultural phenomenon, with social norms often dictating what is acceptable in terms of body language, personal space, eye contact, vocal tone, and speech content (Paré, 2013; Zalaquett, et al., 2019). For example, silence in one culture may indicate uncertainty or an unwillingness to engage, whereas silence in another culture may indicate a polite invitation to continue speaking (Zalaquett, et al., 2019). Furthermore, understanding social issues, such as societal oppression and marginalization, and their impact on mental and physical health, is essential in providing an emotionally safe environment for clients

to share their perspectives and concerns (Ratts, et al., 2016; Zalaquett, et al., 2019). Counselors must identify their own biases and beliefs and actively avoid imposing them on clients, as doing so could cause harm (Sue, et al., 1992; Ratts, et al., 2016). Therefore, counselors must have multicultural knowledge, skills, and the ability to engage in critical self-reflection to effectively use counseling microskills.

The rest of the microskills hierarchy may be divided into three parts: attending and observation skills, listening skills, and influencing skills (Ivey, et al., 2022). Attending skills are the verbal and nonverbal behaviors, such as eye contact and verbal encouragers, that convey that one is listening (Ivey, et al., 2022). Listening skills such as questioning, encouraging, and paraphrasing, allow counselors to identify and explore the client's concerns, needs, values, and feelings (Ivey, et al., 2022). Influencing skills are found toward the top of the hierarchy and include skills such as focusing, reframing, instruction, and empathic confrontation. These skills are used to help clients view their story from multiple perspectives and generate new ways of thinking about the issues that they bring to therapy (Ivey, et al., 2022). Influencing skills can be powerful and inspire change in clients' lives; however, they are more direct than listening skills and should be used judiciously (Ivey, et al, 2022).

There are many benefits to using counseling microskills in therapeutic settings, even if one is not a licensed counselor. First, the microskills model outlines specific skills and behaviors that support effective communication, thus providing the clinician with clear, concise options for initiating and facilitating discussion. Clinicians who study this model also become more aware of the impact of their own actions on the therapeutic

process. For example, they become aware of what they are conveying to the client through their own responses, body language and use of personal space. Finally, counseling microskills tend to yield predictable responses (Ivey, et al., 2022). For instance, when clinicians use encouragers, such as nodding or repeating key words, they can expect clients to continue talking or elaborate on what they are saying. If clinicians ask a closed question, they can expect a short response. Having this knowledge allows clinicians to practice with intentionality, or "acting with a sense of capability and deciding from among a range of alternative actions" (Ivey, et al., 2022, p. 8). There is no single correct skill that should be used in a situation; rather, clinicians have a range of options from which to choose (Ivey, et al., 2022). This provides clinicians with the flexibility that is needed to meet the client's needs in the moment and accomplish other therapeutic goals.

Common Factors in Therapy

Counseling microskills directly support common factors in therapy. Common factors refer to the powerful social and intrapersonal processes that produce therapeutic change (Norcross & Wampold, 2011; Wampold, 2015). Common factors are found in most if not all therapeutic approaches and have been estimated to account for 30 percent of the change that takes place in psychotherapy (Lambert, 2013; Wampold, 2015). One important common factor is the therapeutic alliance, which involves the bond between therapist and client, the establishment of shared treatment goals, and shared agreement on interventions (Wampold, 2015). Other common factors include empathy, trust, setting expectations for treatment, client insight, cultural adaptation of treatment, and therapist

qualities, such as humility and interpersonal skills (Wampold, 2015; Zalaquett, et al., 2019). Practices that support common factors, such as active listening, collaboration, acknowledging mistakes, and remediating problems early in the treatment process, have been shown to reduce dropout rates and significantly improve therapeutic treatment outcomes (Flückiger, et al., 2020; Wampold, 2015; Zalaquett, et al., 2019; Zhang, et al., 2022). Such results highlight the importance of incorporating effective counseling skills into therapeutic settings.

Counseling Skills in the Healthcare Setting

Counseling microskills and common factors are not limited to psychotherapy. In fact, these practices have been increasingly recognized as essential in healthcare, mental health, and other human service settings. Research shows that patient-centered care, in which the provider takes the time to learn about the patient's concerns, values, goals, and needs, improves client experiences during treatment, improves treatment outcomes, and lowers healthcare costs (Adado & Games, 2021; Alshahrani, et al., 2022; Kooij, et al., 2016; Spencer, et al., 2019; Valentijn, et al., 2013). Such outcomes are in line with the Quintuple Aim for Healthcare Improvement, which seeks to improve patient experiences, improve treatment outcomes, lower healthcare costs, reduce provider burnout, and improve public health equity (Coleman, et al., 2016; Itchhaporia, 2021).

Trauma-Informed Care. Basic counseling skills also help prepare clinicians to work with people who have experienced trauma. It is estimated that nearly 70 percent of the population has been exposed to at least one potentially traumatic event in their lifetime (Benjet, et al., 2016). Although anyone can experience trauma, studies suggest

that people who belong to marginalized communities, including people who identify with racial and/or ethnic minority groups, people who live in poverty, people with disabilities, people with addictions, people who do not have access to stable housing, and people who have serious and/or chronic health conditions, are more likely to have a history of trauma (Levin, et al., 2021; Presnell, et al., 2022; Williams, et al., 2023). Trauma, in turn, is linked to adverse health outcomes, such as heart disease, cancer, lung disease, and early death (Centers for Disease Control and Prevention, 2022). Healthcare experiences themselves can be traumatizing, particularly when they involve invasive procedures and treatment methods that are not delivered with patient consent (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Given this, healthcare organizations are increasingly adopting trauma-informed practices to provide appropriate and effective care to people who seek healthcare services (Garami, et al., 2016; Menschner & Maul, 2016; Presnell, et al., 2022).

Trauma-informed care aims to foster physical and psychological safety, trust, transparency, equalized power dynamics, peer support, collaboration, empowerment, and culturally responsive care (SAMHSA, 2014). Clear parallels may be drawn between trauma-informed principles and common factors in therapy, e.g., empathy, trust, working alliance, and so on. However, people who have experienced trauma may have difficulty trusting others or may be hypervigilant to danger cues even in safe environments (Van der Kolk, 2014). It is therefore imperative for trauma-informed practitioners to understand the prevalence of trauma in the community, recognize the signs of trauma within the treatment setting, and structure treatment in such a way to minimize the

potential for psychological harm and support healing processes (SAMHSA, 2014). Basic counseling skills are essential in trauma-informed care in that they give clinicians the skills to recognize subtle cues, listen to patient stories with openness and empathy, validate feelings, explore patient expertise, acknowledge challenges or mistakes during treatment, collaborate, and find new meaning in past or current experiences.

Counseling Skills in Music Therapy

Music Therapy Definition

Music therapy is defined as "the clinical and evidence-based used of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (AMTA, 2015). Music therapists often work in healthcare, mental health, residential, gerontological, school-based, private practice, and wellness settings (AMTA, 2015). Music therapists use music listening, music improvisation, songwriting, familiar music, interactive musical experiences, and other music experiences to support physical, cognitive, social, emotional, spiritual, and wellness-based goals for clients of diverse identities and cultural backgrounds (AMTA, 2021, 2023; Bruscia, 1998).

Rationale for Counseling Skills in Music Therapy

Change in music therapy may be attributed to musical, social, relational, developmental, behavioral, neurological, and psychological processes (Abrams, 2018; Aigen, 2005; Briggs, 2015; Hanser, 2015; Hurt-Thaut & Johnson, 2015; Isenberg, 2015). Although they are not the focus of every approach in music therapy, social and relational processes, and particularly the therapeutic relationship, impact every

interaction that occurs between client and music therapist. The common therapeutic factors of empathy, trust, collaboration, cultural responsiveness, and so on, are likely to strongly influence treatment outcomes in music therapy as they do in other fields (Rolvsjord, 2010; de Witte, et al., 2021). Additionally, music therapists often work with people who have experienced or are currently experiencing stress, trauma, crisis, illness, loss, marginalization, and other challenging life situations. Respectful, empathic, trauma-informed, culturally responsive therapeutic communication skills are invaluable in navigating client thoughts, feelings, and in a sensitive way, regardless of a music therapist's theoretical orientation, approach or work setting.

Scope of Practice & Professional Competencies

Basic counseling competencies in music therapy may be found within the *AMTA Professional Competencies*, the *AMTA Code of Ethics*, and other pertinent music therapy documents. According to the *AMTA Professional Competencies* (2013), music therapists should demonstrate basic knowledge in therapeutic approaches, processes, and dynamics (items 8.1 and 8.3). Music therapists establish therapeutic relationships with clients and "recognize the impact of their own feelings, attitudes, and actions on the therapeutic process" (AMTA, 2013, item 9.1). Music therapists use empathy, authenticity, appropriate self-disclosure, and other therapeutic skills to achieve therapeutic outcomes (AMTA, 2013, item 9.3). They use "therapeutic verbal skills" (item 13.5) including reflecting, rephrasing, interpreting, and providing feedback to clients for the same purposes (AMTA, 2013). The *AMTA Professional Competencies* also outline several areas of music therapy practice that are facilitated by basic counseling skills, such as

establishing and maintaining therapeutic relationships with clients, promoting a sense of group membership, modeling and communicating expectations, resolving conflicts in therapy, and providing opportunities for closure as treatment comes to an end (AMTA, 2013).

Similarly, the *AMTA Code of Ethics* (2019) and the *Music Therapy Board Certification Domains* (Certification Board for Music Therapists, 2020a) further specify that music therapists act with authenticity and respect, establish trust, set boundaries, and use active listening, affirmation, and validation in their work with clients. Music therapists respect and protect each client's right to safety, dignity, self-determination, and the right to participate in treatment decisions (AMTA, 2019, item 1.3). Music therapists also "recognize and respond appropriately to significant events in music therapy as they occur" (AMTA, 2013, item 13.1). While these responses may be musical or verbal in nature, there are certainly times where verbal skills are needed, as may occur if a client has a strong emotional reaction to music, or as a music therapist sets boundaries and expectations for group therapy. In all cases, music therapists must "recognize the potential harm of verbal interventions and use them with care" (AMTA, 2015, p. 1).

Counseling Skills in Music Therapy Practice. Reports from the music therapy literature suggest that music therapists often use basic counseling skills throughout their sessions to support therapeutic processes. Grocke and Wigram (2007) observe that music therapists use counseling skills to greet clients, build rapport, explore how clients are feeling, and focus the session on relevant issues. During the session, music therapists attune to clients by adapting their tone of voice and body language to mirror that of the

client (Lindblad, 2016; Nolan, 2005). Music therapists use open and closed questions, reflections, verbal processing, musical instruction, educational comments, reinforcement, reframing, self-disclosure, and silence for therapeutic purposes (Grocke & Wigram, 2007; Lindblad, 2016; Nolan, 2005; Wolfe, et al., 1998). Finally, music therapists use counseling skills at the end of music therapy sessions to initiate closure and help the client transition from a creative, musical mindset to a more ordinary way of thinking (Nolan, 2005). Notably, the skills described in these sources closely align with the attending, listening, and influencing skills in Ivey, et al.'s (2022) counseling microskills model.

Music experiences and counseling skills cannot always be easily separated. In fact, they often overlap or build upon one another, as they do in many standard music therapy experiences. Such experiences include music-based discussion and reminiscence, song analysis, song sharing, songwriting, and guided imagery experiences (AMTA & CBMT, 2015; Baker, 2017; Gardstrom & Sorel, 2017; Kelly & Ahessy, 2021). Baker (2017) provides an example of this process in her description of a group songwriting process with caregivers of people living with dementia. According to Baker (2017), the music therapist facilitates group discussion and collaboration throughout the songwriting process; engages members in reflection to identify key issues and emotions to include in song lyrics; summarizes member contributions to the discussion; acknowledges and affirms member experiences; encourages reflection, processing, and reprocessing of member experiences through the lyric creation and editing process; and encourages the development of new narratives and meaning throughout the process. By

the end of the process, group members have created a song that captures their experiences, promotes a sense of accomplishment, and connects them to other caregivers. This song could be played together, discussed, and recorded to provide caregivers with a resource that can be used moving forward. Similar processes of alternating verbal and musical intervention may be found within music-based discussion, reminiscence, and song sharing experiences (AMTA & CBMT, 2015; Gardstrom & Sorel, 2017; Kelly & Ahessy, 2021).

It is important to note that the type and depth of verbal intervention used depends upon the music therapist's education and training in verbal skills, which may range from basic to advanced. For example, an entry-level music therapist may use verbal skills to lead a guided imagery experience and engage clients in basic verbal processing afterwards to explore their reactions. Alternately, a music therapist who is certified in the Bonny Method of Guided Imagery and Music (BMGIM) uses an imagery and music protocol to facilitate in-depth self-exploration and spiritual growth (Isenberg, 2015; Ventre & McKinney, 2015). In fact, music therapists who use this method use verbal skills throughout the nearly two-hour session to explore, guide, and process client experiences (Ventre & McKinney, 2015). Music therapists must operate within their level of competency and only use skills that they are trained and licensed to use (AMTA & CBMT, 2015; Schwartz, 2019). Otherwise, music therapists may use their clinical judgment when integrating verbal interventions into music therapy.

Music and Therapy in Music Therapy

As the above examples illustrate, music therapy is a diverse field with many potential applications of counseling skills. On a basic level, all music therapists use therapeutic communication skills to act with empathy and respect toward clients, to learn about client needs, values, and preferences, the build the therapeutic alliance, and to guide the treatment process (AMTA, 2013; 2019). This corresponds to the use of counseling skills in other health and human service disciplines, such as medicine, nursing, rehabilitation sciences, and so on, where the purpose is not to provide psychotherapy, but to use effective listening, influencing, and observational skills to provide effective treatment to clients. Other music therapists, particularly those who adopt psychotherapeutic orientations, may use counseling skills to a greater degree or in greater depth than others, as may be seen with music therapists who practice the Bonny Method. In these cases, it is helpful to clarify how music and therapy function within music therapy. This distinction is explored below.

Wheeler's Psychotherapeutic Classification of Music Therapy Practices. Wheeler (1983) proposes a psychotherapeutic framework that divides music therapy into three levels: (a) music therapy as an activity therapy, (b) insight music therapy with re-educative goals, and (c) insight music therapy with reconstructive goals. According to Wheeler (1983), music therapists practicing at the first level use music experiences to provide clients with opportunities to learn and practice new skills, such as cognitive, behavioral, and social skills. Verbal skills are typically used to direct the session and discuss what occurred during the activity (Wheeler, 1983). At the second level, music

experiences are used to elicit feelings and interactions that can be explored verbally to gain insight. This increase in insight leads to improved functionality (Wheeler, 1983). In the third level of music therapy practice, music therapists use musical and verbal techniques to help clients gain insight into their unconscious thoughts, feelings, and motivations (Wheeler, 1983). In doing so, clients can resolve previously unresolved issues and begin to achieve personality reconstruction (Wheeler, 1983). The third level merges music therapy practice with psychoanalytic techniques and should only be used by music therapists with advanced training in these areas (Wheeler, 1983).

Music in Therapy vs. Music as Therapy. Bruscia (1987) divides music therapy approaches into two categories: those that use music as therapy and those that use music in therapy. According to Bruscia (1987), when music is used as therapy, the music itself is the agent for change. Any verbalizations are supportive, if present at all (Bruscia, 1987). When music is used in therapy, the therapeutic relationship is the agent of change (Bruscia, 1987). Music experiences provide the context for therapeutic work, and both music and verbal interventions may be used by the music therapist (Bruscia, 1987). Amir (1999) points to a third category in which music is the primary agent of change, but verbal interventions are needed to fully benefit from the musical experiences. Amir lists the Bonny Method of Guided Imagery in Music (BMGIM) and Priestly's Analytical Music Therapy as examples of this approach. Bruscia (1987) notes that most practitioners use elements of each approach, though they may lean more strongly toward one or the other.

Bruscia's Levels of Music Therapy Practice. In a later writing, Bruscia (1998) identifies four levels of music therapy practice and describes the nature of the therapist-client relationship and the use of verbal skills in each level. Auxiliary music experiences describe those that are musical but cannot be considered music therapy, as there is no client-therapist relationship, and there is no therapeutic process taking place (Bruscia, 1998). An example of this would be adapted music lessons for people with intellectual and developmental disabilities (Bruscia, 1998). At the augmentative level, music therapy enhances or reinforces the educational, developmental, or psychotherapeutic services provided by other disciplines and therefore fulfills a primarily supportive role in treatment (Bruscia, 1998). The therapeutic relationship is necessary but not the primary means of change in music therapy (Bruscia, 1998). This level corresponds to Wheeler's (1983) activity therapy, and therefore verbalizations are likely to involve rapport building, directions, instruction, and discussion that is focused on the present moment (Bruscia, 1998). At the intensive level, music therapists work at an equal level with other disciplines and therefore function as a primary therapist (Bruscia, 1998). At this level, the role of the therapist is determined by client needs, and the agents of change may be both music and the therapeutic relationship (Bruscia, 1998). Since this level corresponds to Wheeler's (1983) reeducative level, verbal skills are geared towards generating increased insight and awareness into present feelings and interpersonal issues (Bruscia, 1998). Finally, at the primary level, music therapy is necessary to meet the therapeutic needs of the client (Bruscia, 1998). Music therapy at this level often entails a merger of didactic, healing, medical, and/or psychotherapeutic practices in music therapy, and

verbal skills generate increased insight into core causes of client issues (Bruscia, 1998). Music therapy at this level stimulates significant and pervasive change in a client's life (Bruscia, 1998).

Concerns With Using Counseling Skills in Music Therapy

Scope of Practice. Despite their inclusion in the *AMTA Standards of Practice* and their prevalence in music therapy practice, many music therapists express hesitancy about using counseling skills in music therapy. One concern that arises in the literature is the potential for practicing psychotherapy without a license (Schwartz, 2019). Certainly, a music therapist should never claim to provide "counseling" or "psychotherapy" if they are not licensed to do so. Counseling is provided by mental health professionals who have completed at least a graduate degree in counseling or a related field (Granello & Young, 2019). Counselors serve as primary therapists and are licensed to provide diagnosis, treatment planning, therapy, crisis management, case management, and other mental health services to consumers (Granello & Young, 2019). Music therapists, on the other hand, may or may not specialize in the mental health field and do not have the education, training, and licensure to fill the role of a counselor unless they pursue such training. However, like other helping professionals, music therapists can use basic counseling skills to facilitate therapeutic processes in their work, given that they act in accordance with their professional role, education, and scope of practice (Beck & Kulzer, 2018; Grocke & Wigram, 2007; Schwartz, 2019).

Counseling Skills With Nonspeaking Individuals. Another suggestion that arises in the literature is that counseling skills, and specifically, verbal skills are not

needed when working with people who are nonspeaking, minimally verbal, or who have lost the ability to speak (Bruscia, 2006, as cited in Nelligan & McCaffrey, 2022). This may include people with severe or profound intellectual disabilities, developmental conditions or differences, severe mental health conditions, and people with acquired disability, such as late-stage dementia and other neurodegenerative diseases. The reasoning may be that since the client does not use speech as their primary means of communication, the therapist will not need to use verbal skills when working with them. While music therapists may not engage in verbal processing with nonspeaking clients, this does not mean that basic counseling skills are not needed. As noted above, counseling skills entail both verbal and nonverbal communication and should be adapted to meet the needs of the individual client (Ivey, et al., 2022; Lindblad, 2016; Martin, et al., 2022). When working with clients with profound disabilities, observation skills can be instrumental in identifying client attempts to communicate, while listening skills can provide time and space for clients to express themselves. Core counseling skills such as empathy, positive regard, and respect are essential when working with all clients (Ivey, et al., 2022). Finally, most music therapists often use verbal skills with people with disabilities to provide instruction, ask questions, set boundaries, give directives, and verbally reflect client actions to increase engagement and facilitate other therapeutic goals and processes (Grocke & Wigram, 2007; Martin, et al., 2022). Ultimately, it is the music therapist's responsibility to adapt their communication style to facilitate effective communication with clients. It is therefore imperative that all music therapists to receive basic counseling skills training and to learn effective communication strategies for the

populations with whom they work (Feil, 2012; Gooding, 2017; Martin, et al., 2022; Sánchez-Martínez, et al., 2023).

Balance Between Talking and Music-Making. Another question that has arisen in several studies is the appropriate balance between music and talking in a music therapy session. Student music therapists may feel unsure about how much time they should spend talking with their clients. Even music therapists report feeling pressured to return to the music, particularly when a client seems to want to do more talking than music making (Amir, 1999; Nelligan & McCaffrey, 2020). According to Silverman (2022), it is normal for the balance between musical and verbal interventions to shift within and between sessions. The ratio of music to verbal interaction in each session likely varies based on a music therapist's approach, the treatment setting, the therapeutic goals, client needs, client preferences, and the music therapist's comfort level with their own verbal and musical skills (Amir, 1999; Darrow, et al., 2001; Silverman, 2022).

There are a small number of studies that investigate the balance of verbal to musical interactions in music therapy sessions (Darrow, et al., 2001; Lindblad, 2016; Wolfe, et al., 1998). All suggest that it is not unusual for a session to contain more talking than active music making. During an analysis of 12 music therapy sessions led by undergraduate and graduate level practicum students, Darrow, et al. (2001) found that on average, the students spent over 50 percent of their session time using verbal skills and interventions. Darrow, et al. (2001) found no significant difference in the time spent using verbal skills between undergraduate and graduate students, suggesting that the results were not due to level of education or skill in implementing music therapy. Wolfe,

et al. (1998) examined the ratio of music to verbalizations within 12 group music therapy sessions led by a board-certified music therapist. Results showed that on average, group sessions consisted of 27% music and 63% verbalization. In this case, the percentage of verbalizations was likely high since the groups consisted of music therapy students and were designed to elicit verbal feedback. However, these results may mirror what occurs with similar groups of highly verbal, highly motivated adult clients. Finally, in an analysis of three sessions led by experienced music therapists, Lindblad (2016) observed that a significant part of each session was spent in verbal dialogue. Although sessions in this study were 45 to 75 minutes in length, the session with the most music contained a total of 15 minutes of music (Lindblad, 2016). Notably, these sessions were standalone sessions conducted for the purposes of research, so the music therapists may have spent more time verbalizing to build rapport, explain what to expect, and engage in closure at the session's end. However, many music therapy sessions are standalone sessions, particularly in hospital settings. Therefore, while these findings do not describe all music therapy sessions, they shed insight into the balance of verbal and musical interaction within music therapy under certain circumstances.

The findings of these studies may contradict the expectation that most of the time spent in music therapy involves actively listening to or creating music. In fact, some music therapy sessions contain mostly music, as may occur when a music therapist engages a client in music-assisted relaxation with the goal of helping them fall asleep, while others may contain a small amount of music that generates discussion and increased insight. These findings suggest that the ratio of music to talking does not

matter as much as the therapist's intention, their ability to apply musical and therapeutic skill sets, and the impact that such experiences have on the client. If a music therapist and client have established a therapeutic relationship and use music experiences to address a health concern, they are engaged in music therapy (Bruscia, 1998). Of course, if sessions typically contain little to no music, or if the music therapist finds that the client has needs that cannot be addressed in music therapy, it may be necessary to re-evaluate the need for music therapy and make a referral to the appropriate party.

When Verbal Skills Are Contraindicated. A final concern found in the literature is that verbalization can be unnecessary, unhelpful, or even contraindicated in some music therapy settings (Amir, 1999; Lindblad, 2016; Nolan, 2005). For example, some approaches in music therapy strongly rely on the unique qualities of music to facilitate change. In music-centered music therapy, music is both the process and product of therapy (Aigen, 2005). In other words, the experience of making music is considered to be inherently healing and a therapeutic goal in its own right (Aigen, 2005). Similarly, in Nordoff-Robbins Music Therapy, music is used as a form of communication with children who have profound disabilities (Guererro, et al., 2015). In this approach, music therapists use musical improvisation to create an inviting space for the child to explore and interact with their environment and with others (Guererro, et al., 2015). Depending on the music therapist's approach, verbal interactions may not be as prevalent in these interactions. However, they are not prohibited and may be used to support musical processes if the music therapist finds them necessary (Aigen, 2005).

There are certainly times when talking with a client is contraindicated in music therapy. Some clients may feel overwhelmed by excess verbalization or questioning, as may be the case with some clients with advanced dementia. Musical experiences are abstract and sometimes cannot be put into words (Lindblad, 2016). Other times, verbalization can be used to avoid deeper therapeutic work or making music altogether (Amir, 1999). Indeed, it is important for all music therapists to consider client needs and preferences, therapeutic goals, and their own when using counseling skills in music therapy. In other words, counseling skills should be used intentionally within music therapy with an understanding of the impact that they will have on the client and the therapeutic process (Grocke & Wigram, 2007; Ivey, et al., 2022). Focused training in basic counseling skills provides music therapists with an array of verbal techniques from which to choose and a greater understanding of how and when to use such skills.

Counseling Skills Training in Music Therapy

The American Music Therapy Association establishes the guidelines for music therapy education and training within the United States (AMTA, 2021). These guidelines are based on the *AMTA Professional Competencies* (2013), which outline the musical, clinical, and music therapy knowledge, abilities, and skills that are necessary for professional practice (AMTA, 2021). Prospective music therapists must complete an undergraduate degree in music therapy, complete 1200 hours of supervised clinical training, and pass a music therapy Board Certification Exam that is administered by the Certification Board for Music Therapists (CBMT) to practice music therapy (CBMT,

2020b). Music therapists must also complete 100 hours of continuing education every five years to maintain their board-certification status (CBMT, 2020b).

Counseling skills training in music therapy can vary widely between programs. Although the *AMTA Professional Competencies* (2013) indicate that entry-level music therapists should be able to proficiently use basic counseling skills by the time they graduate, there are no specifications for how these skills should be taught within the music therapy curriculum (AMTA, 2021). In fact, counseling skills are not listed as a required topic in the *AMTA Standards for Education and Clinical Training* and may in some cases be covered at a surface level or not at all in music therapy programs. Programs that do offer counseling skills training primarily do so through coursework and clinical training.

Counseling Coursework

Some music therapy programs require students to take a counseling microskills course during their studies (Gooding, 2017). In fact, Gooding (2017) suggests teaching Ivey, et al.'s (2021) microskills model at the beginning of a student's education so that students may practice these skills throughout their undergraduate training. This mirrors the model of instruction that is used in counseling and psychotherapy, where students study counseling microskills and then learn to apply them through supervised clinical work (Miville, et al., 2011). Microskills training represents a promising option for music therapy students, as they can learn basic counseling concepts and behaviors in one class and apply them in various music therapy settings (Gooding, 2017). Unfortunately, many undergraduate music therapy programs are already filled with required courses, and

program directors may be hard pressed to fit another course into the curriculum (Lloyd, et al., 2018). Furthermore, since counseling coursework is not currently required in the field, some educators may not feel it is necessary to add an entire course on counseling skills to the music therapy curriculum. Regardless, counseling microskills training is utilized within some music therapy programs (Gooding, 2017).

Another option found in the literature is the integration of counseling skills into music therapy classes. In general, this method involves teaching counseling skills within the context of various music therapy experiences (Gardstrom, 2001, 2007). Curriculum decisions are largely left up to the instructor and therefore vary from program to program. Class time is also divided between musical and counseling skills to some degree. Therefore, students who learn this way may not receive a well-rounded education in basic counseling skills. However, this approach is valuable since it provides students with opportunities to integrate select counseling skills into music therapy work. Gardstrom (2001) offers several suggestions for teaching students to attend to sound and music, develop and use a musical vocabulary, and facilitate verbal processing after musical experiences (Gardstrom, 2001). Gardstrom (2001, 2007) further provides concrete examples for incorporating such skills into improvisational music therapy coursework, including various tasks, exercises, and sample questions that may be practiced by students in class. This type of training is presented on its own in the literature, but it could be easily combined with counseling microskills training to support learning outcomes.

Clinical Training

Music therapy students must attend at least three practicum sites for a minimum of 180 hours during their undergraduate education (AMTA, 2021). They also complete at least 900 hours at an approved internship site of their choosing for a total of 1200 clinical training hours (AMTA, 2021). These clinical placements are intended to provide students with experience in diverse settings to help them develop the minimum competencies for professional practice (AMTA, 2021). Music therapy supervisors are directly involved in this process, as they observe and provide feedback for 40% of students' practicum sessions and provide music therapy interns with four hours of direct supervision and feedback per week (AMTA, 2017, 2021). Supervisors also review and provide feedback on students' session planning, treatment planning, clinical documentation, and other activities that directly relate to clinical work (AMTA, 2021). As such, music therapy supervisors play a large role in ensuring that students acquire the necessary skills before they graduate (Rushing, et al., 2018). While many music therapy program directors report using the *AMTA Professional Competencies* to guide their training, there is no standardized measure for assessing student competency within the field (Hsaio, 2014; Lloyd, et al., 2018).

Problems With Current Training Methods

Counseling coursework and clinical training are essential for developing basic counseling skills (Ivey, et al, 2022; Miville, et al., 2011). However, problems arise when students do not receive enough training to internalize and utilize basic counseling skills in diverse clinical situations. This may occur when students learn the theory behind basic

counseling skills but do not have the opportunity to practice until these skills are mastered (Ridley, et al., 2011a). This may also occur when students learn primarily through clinical experience, with no opportunity to learn specific counseling behaviors and the impact that they have on the therapeutic process (Ridley, et al., 2011a). Since counseling skills training is not required in music therapy, a third challenge that may arise is working with supervisors who themselves have not received basic counseling skills training. While any experienced clinician likely knows a great deal about working with people, they cannot teach the purposeful use of counseling skills if they do not have this knowledge themselves. New music therapists may then be left to learn these skills on their own through additional coursework or continuing education.

Reported Training Outcomes

Although no previous studies to the researcher's knowledge directly investigate counseling skills training in music therapy, several studies provide insight into current training outcomes. In one study, Amir (1999) interviewed six music therapists, with one commenting that they had never received training in therapeutic verbal skills. Another reported that they found it taxing to use verbal interventions and felt like they had to think about what they were doing more than they did with musical interventions (Amir, 1999). Mixed results are reported by Nelligan and McCaffrey (2020), who interviewed three music therapists with 10 to 20 years of professional experience to learn more about their use of verbal dialogue in clinical practice. One participant shared that she did not feel prepared to use verbal skills in music therapy at the start of her career, and all three participants indicated that they engaged in supervision and continuing education to

develop their verbal skills for clinical practice, particularly at the beginning of their careers (Nelligan & McCaffrey, 2020). Participants reported feeling confident using counseling skills at the time of the study, though they reported using counseling skills in different ways. For example, one participant reported limiting her skills to discussion rather than interpretation, and another reported that he felt comfortable handling any verbal material in music therapy (Nelligan & McCaffrey, 2020).

In another study, Clements-Cortés (2015) asked 55 Canadian music therapy students to rate their confidence in using various skills pre- and post-internship and found mixed results. On average, participants rated themselves as satisfactory in their ability to build relationships with clients, family members, and other professionals, but poor in their level of comfort in using counseling skills in session. While their comfort levels improved significantly during their internship, their mean score for counseling skills was still slightly below satisfactory by the end of internship. During a post-survey interview, participants reported that additional observation opportunities and a greater focus on counseling skills training during their undergraduate training would have helped them feel more prepared for clinical work (Clements-Cortés, 2015). As a result, Clements-Cortés (2015) recommends that music therapy educators find ways to incorporate group counseling skills training into the music therapy curriculum.

Sevcik, et al. (2017) also found mixed results in their study of 123 music therapists who were dual trained as counselors. Results indicated that two-thirds of the participants agreed or strongly agreed that their undergraduate training prepared them for clinical practice, while nearly a third of respondents reported feeling neutral or

underprepared by their undergraduate program. Thirty-seven percent of participants agreed or strongly agreed that level of preparation was a factor in pursuing graduate training, and nearly 85% of participants indicated that they sought advanced training to expand their knowledge of verbal processing techniques. While these results pertain to a subset of music therapists, namely, those who are dual trained in counseling, they do suggest that a substantial number of music therapists are seeking further training in counseling skills.

Finally, Hsaio (2014) investigated gatekeeping practices in music therapy academic programs and internships, including remediation methods and student dropout rates related to severe professional competency problems. According to Lamb, et al. (1987), severe professional competency problems refer to an individual's unwillingness or inability to acquire professional standards and/or skills that allow them to reach a minimal level of acceptable professional competency in a field. Hsiao (2014) found that over 93% of program directors who participated in this study reported having at least one student with severe professional competency problems in the last five years, while about 66% of internship directors reported the same. Interestingly, aside from inadequate musical development, two of the most commonly reported issues involved limited communication and interpersonal skills (Hsaio, 2014). In addition, some students were reported to have poor boundaries, deficient leadership skills, and a lack of social appropriateness (Hsaio, 2014). Participants indicated that they typically remediate these issues with increased supervision, increased advising, special assignments, personal referrals to therapy, repeated coursework, and extended time in clinical placements.

Notably, counseling skills training was not mentioned as a remediation method, even though it is specifically designed to develop therapeutic interpersonal and communication skills. It is possible that some of these issues could be remediated by such training. All in all, the above studies indicate that music therapists value counseling skills but do not always receive the training that they need to prepare them for clinical practice.

Chapter 3: Methodology

Research Method

This study used a descriptive, quantitative, cross-sectional survey design (Creswell & Creswell, 2018). The purpose of the study was to gain a broad understanding of the current state and impact of counseling skills training in music therapy. Specifically, the research questions were to (a) determine how music therapists develop basic counseling skills, (b) investigate whether music therapists feel satisfied with the counseling skills training they received, and (c) investigate music therapists' confidence in using such skills. Data was collected through an online survey due to its potential to reach a large number of participants in a short amount of time and its cost effectiveness (Fowler, 2014).

Participant Recruitment

The target population for this study was board-certified music therapists (MT-BC's) who have successfully completed at least a bachelor's or equivalency degree in music therapy. Participants were also required to be 18 years of age or older. Undergraduate music therapy students and interns were not included in this study because they have not yet finished their entry-level education and training. A list of currently certified MT-BC's who have not opted out of invitations to participate in research was obtained from the Certification Board for Music Therapists. A total of 5,000 MT-BC's were randomly selected from this list to receive an email invitation to participate. However, this still represents a convenience sample, since board-certified music therapists who opted out of receiving email invitations were not included in this list. The

invitation to participate may be found in Appendix A. Those who opted to take the survey were provided with an online consent form before taking the survey. Participants completed one screening question at the beginning of the survey to ensure that they met inclusion criteria for the study. The survey was open for two weeks, after which the survey was closed, and incomplete responses were discarded.

Ethical Considerations

This study was approved by the researcher's thesis committee and the Ohio University Institutional Review Board. Before starting the survey, participants were provided with an anonymous online survey consent form which outlined the information necessary for participants to make an informed decision to participate in this study. Participants were informed that their responses were anonymous and their participation voluntary (Fowler, 2014). Participants could skip questions, including potentially sensitive demographic questions related to race/ethnicity and gender, and could also leave the survey at any time by closing their browser. Survey data was stored within Qualtrics, within the researcher's university-provided OneDrive account, and on the researcher's password-protected personal laptop.

Survey Instrument

The survey instrument was developed by the researcher and was divided into three sections: (a) entry-level education and training, (b), skill development after certification, and (c) confidence in using counseling skills. Survey questions were designed to investigate the research questions and may be found in Appendix C. Question types included five multiple choice questions and six Likert scale questions.

All survey questions provided pre-determined response options to participants. However, due to the exploratory nature of this study, four of the five multiple choice questions provided respondents with the option to select "other" and to provide their own text response in addition to the options provided. The survey was created and distributed using Qualtrics.

Reliability and Validity

Several actions were taken to improve the reliability of the survey instrument. Definitions were provided to clarify terms that have more than one meaning and improve survey reliability (Fowler, 2014). For example, the term *counseling skills* was defined for the purposes of the survey. Likewise, questions about individual counseling skills also contained definitions within the question to ensure a consistent meaning to all respondents (Fowler, 2014). Since this survey collected a relatively large amount of data, efforts were taken to make questions as concise as possible without jeopardizing clarity. The survey was designed to be compatible with mobile devices and take no more than 20 minutes to complete to reduce participant dropout rates (Fowler, 2014).

Additionally, efforts were taken to improve question validity. Survey questions were provided to the thesis committee for external review and feedback. One question was added and several were revised based on committee recommendations. The survey was also pre-tested by three board-certified music therapists who studied at different institutions, received varying levels of education within the field, and worked in different settings. These music therapists provided feedback based on question content, wording,

survey flow, and question clarity. Revisions were completed based on this feedback, and the final version of the survey was confirmed with the researcher's faculty advisor.

Variables & Data Analysis

The variables in this study included participant demographics, reported educational experiences and level of satisfaction in these experiences, and level of confidence in using basic counseling skills in music therapy. Qualtrics and Microsoft Excel were used to generate descriptive statistics related to these variables including the mean, median, mode, standard deviation, frequency counts, and/or percentages.

Text responses were included in the analysis to supplement quantitative data. Qualtrics Text iQ was used to sort text responses into descriptive categories based on key words within the response. Responses that used the same terms or described the same experiences were grouped together and a frequency count was given for each category. For example, when investigating resources that participants have used since graduating to develop their counseling skills, two respondents wrote, "continuing ed related to counseling but not MT" and "I attended many conferences and workshops outside of music therapy (like DBT for instance)." Both responses were sorted into the category, "Pursued continuing education in mental health/counseling fields." Some responses were sorted into more than one category. For example, "I pursued counseling for myself and noticed my self-awareness increase, which has improved my basic counseling skills" was sorted into "Personal therapy" and "Self-awareness/Critical reflexivity." Since interpretation is needed to sort responses, researcher bias is introduced into this process (Creswell & Creswell, 2018). The researcher made a continued effort to focus on the key

words in participant statements and refrained from adding meaning to vague responses. For example, one participant indicated that they had taken an “expressive skills class” to learn counseling skills during their undergraduate training. Since it was unclear if this class was within the music therapy program, the researcher refrained from placing it in the “coursework outside of the music therapy program” category and created a new category (i.e., “expressive skills class”) for that response. After sorting the data, the researcher reviewed and revised the categories to ensure they meet these guidelines and submitted the data and analysis to the thesis advisor for review, feedback, and revision. Off-topic text responses (i.e., those that did not answer the survey question) were not included in the analysis.

Chapter 4: Results

Survey links were emailed twice over the course of two weeks to 5,000 randomly selected MT-BC's. During the process, 49 emails bounced or otherwise failed to reach potential participants. As a result, 4,951 music therapists were invited to participate in this study. Four hundred and fourteen music therapists started the survey and 371 participants finished. Therefore, the response rate for this survey was 7.50% and the completion rate was 90%. All participants indicated that they are board-certified music therapists over the age of 18 and thus met criteria for participating in the study.

Some respondents skipped questions in the survey. The question that was skipped the most frequently was Question 6, which inquired about potential challenges that participants have encountered when developing their counseling skills. While this question was skipped by eight participants, most skipped questions in the survey were only skipped by one to three participants. Due to the relatively low number of skipped questions compared to the total number of responses, surveys with skipped questions were included in the analysis. Statistics for each question were calculated out of 371 total responses unless otherwise noted.

Demographics

The demographic makeup of participants closely resembles that of other large music therapy surveys (AMTA, 2021b). The majority of respondents were Caucasian women who were less than 40 years old. Specifically, 328 participants (88.41%) identified as White or Caucasian and 324 (87.33%) identified as women. The mode for age was 20 – 29 years, which represented 33.78% of participants (n = 125), and 64.86%

of participants (n = 240) were between the ages of 20 and 39. Likewise, the most frequently reported number of years in the field was 1 – 5 (26.45%, n = 100), with 6 – 10 years representing the next highest category (22.91%, n = 85). Participants had relatively high levels of education, as over 40% reported having a master's or master's equivalency in music therapy (41.78%, n = 155), over 15% (15.36%, n = 57) reported having a master's in another field, and 6.47% (n = 24) reported having a doctorate in music therapy or another field. Table 1 provides a summary of participants' demographic information. The number of respondents for each category is 371 unless otherwise noted. Percentages regarding racial identity, gender identity and educational background do not add up to 100% because participants were able to select more than one option.

Table 1

Participant Demographics

Variable	n	%	Variable	n	%
Gender			Country		
Woman	324	87.33	USA	358	96.50
Man	32	8.62	Canada	8	2.16
Non-binary	9	2.43	Japan	1	0.27
Self-described[a]	6	1.62	Taiwan	1	0.27
Prefer not to say	1	0.27	Other[b]	3	0.81
Race			Age (n = 370)		
Caucasian	328	88.41	Under 20	1	0.27
Asian or Asian American	18	4.71	20 – 29	125	33.78
			30 – 39	115	31.08
Latin(o/a) or Latinx	13	3.40	40 – 49	46	12.43
			50 – 59	41	11.08
African American	11	2.88	60 – 69	30	8.11
			70 or older	12	3.24
Self-identified[c]	4	1.08			
Prefer not to say	8	2.16			
Education			Years in practice		
Bachelors/Equiv in MT	278	74.93	Less than 1	37	9.97
			1 – 5	100	26.45
Bachelors in another field	56	15.09	6 – 10	85	22.91
			11 – 15	54	14.56
Masters/Equiv in MT	155	41.78	16 – 20	30	8.09
			20 – 25	24	6.47
Masters in another field	57	15.36	Over 25	41	11.05
Doctorate in MT	9	2.43			
Doctorate in another field	15	4.04			

[a]Gender non-conforming, genderqueer, gender fluid, trans, and/or transmasculine. [b]Malaysia, Scotland, and both the US and Taiwan. [c]Mestizo, biracial/mixed race, Eastern European, and/or Middle Eastern.

Out of 368 participants, 302 (82.07%) indicated that they are currently employed as a music therapist. Sixty-four participants (17.39%) reported that they are not currently

employed as a music therapist, and two (0.54%) indicated that they are in graduate school. The most common work roles included clinician (95.41%, n = 353) and supervisor (48.11%, n = 178). About a quarter (24.59%, n = 91) of participants were educators in the field. Over half of participants (50.81, n = 188) reported work experience in the private practice setting. Other frequently reported work settings included inpatient psychiatric care (48.79, n = 181), assisted living (46.36%, n = 172) and hospice/palliative care (46.09%, n = 171). The top three theoretical orientations were humanistic (73.58%, n = 273), cognitive-behavioral (46.90%, n = 174) and psychodynamic (23.72%, n = 88), and the top three approaches were community music therapy (31.04%, n = 113), neurologic music therapy (30.49%, n = 111), and resource-oriented music therapy (29.40%, n = 107). About 4% of participants reported that they do not have a theoretical orientation, and 20.60% (n = 75) reported that they do not use an approach in their work. A summary of participants' work experience may be found in Table 2.

Table 2

Participant Work Experience

Variable	n	%	Variable	n	%
Role (n = 370)			Theoretical Orientation		
Clinician	353	95.41	Humanistic	273	73.58
Supervisor	178	48.11	Cognitive-Behavioral	174	46.90
Educator	91	24.59	Psychodynamic	88	23.72
Internship director	85	22.97	Multicultural	71	19.14
University program director	16	4.32	Social Justice/Advocacy	71	19.14
			Existential	60	16.17
No experience	5	1.35	None	16	4.31
Other[a]	29	7.84	Other[b]	51	13.75
Work setting			MT Approach (n = 364)		
Private practice	188	50.81	Community	113	31.04
Inpatient psych	181	48.79	Neurologic	111	30.49
Assisted living	172	46.36	Resource-Oriented	107	29.40
Hospice/Palliative	171	46.09	Nordoff-Robbins/CMT	77	21.15
Hospital/Medical	143	38.54	None	75	20.60
School-based	142	38.27	Biomedical	64	17.58
Outpatient mental health	111	29.92	Feminist	50	13.74
			Analytical	48	13.19
Rehabilitation	93	25.07	Bonny Method of GIM	43	11.81
Day treatment	87	23.45	Other[c]	50	13.74
Addictions	82	22.10			
Wellness	40	10.78			
No experience	4	1.08			
Other	45	12.13			

[a]Business owner, researcher, facility/program director, activities coordinator, consultant, board member, leadership. [b]Trauma-informed, neuroscience-informed, neurodiversity-affirming, transpersonal, systemic, relational, queer, wellness, narrative, behavioral, Gestalt, music-centered, Jungian, ACT, DBT, feminist, ecological, developmental, and anti-oppressive practices. [c]Multimodal stimulation, NICU music therapy, Dalcroze method, vocal psychotherapy, gender-affirming voicework, Safe and Sound Protocol

Survey Results

Undergraduate Education & Training

The first section of the survey investigated participants' experiences developing counseling skills during their undergraduate or equivalency program. Question 1 asked participants how they learned basic counseling skills during their entry-level training in music therapy. Participants were provided with five multiple choice options as well as an option to provide their own brief description of how they learned counseling skills during this time. Participants were able to select more than one option, so percentages do not add up to 100%. Out of 367 responses, 262 (71.39%) participants indicated that they learned through direct experience working with clients in practicum/internship, 257 (70.03%) learned through class lectures, 245 (66.76%) learned through supervisory feedback, and 234 (63.76%) learned through role play with other students. While 143 participants (39%) reported that they experienced all four learning methods, 41 (11.17%) reported that they did not learn counseling skills during their undergraduate or equivalency program.

Thirty-two participants (8.63%) provided their own description of how they learned these skills. Qualtrics Text iQ was used to sort responses into the following categories: taking courses outside of music therapy (n = 7), obtaining a minor or major in another field (n = 3), personal therapy (n = 3), and self-study (n = 2). Participants also reported learning through lived experience (n = 2), peer mentorship outside the field (n = 2), an expressive skills class (n = 1), and a communication skills presentation (n = 1).

Off-topic responses that did not answer the survey question were not included in the analysis.

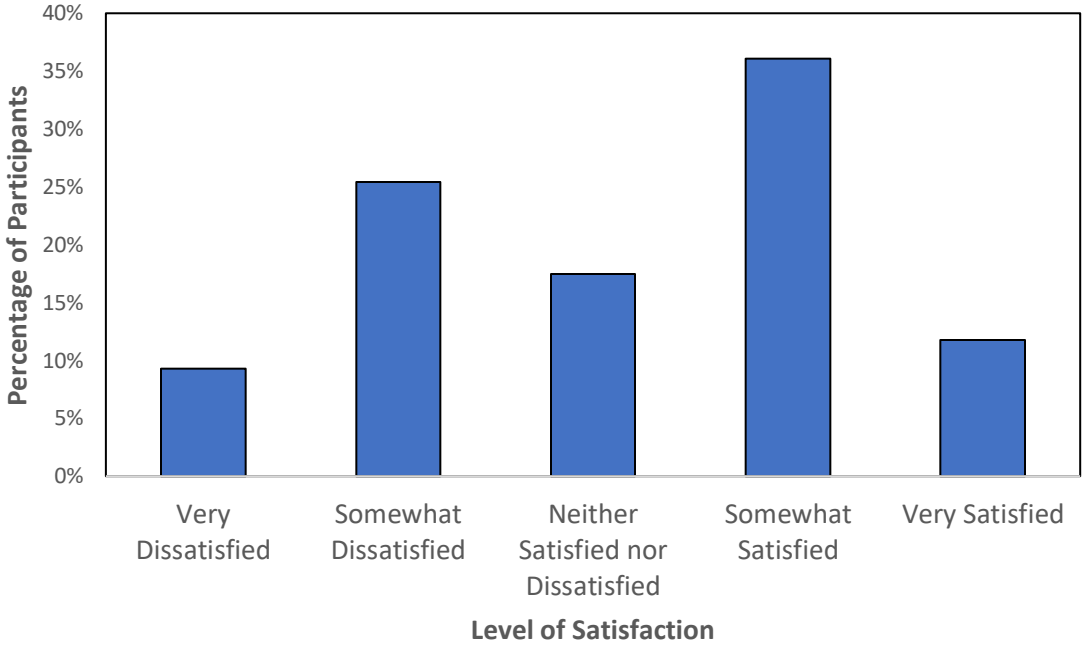
Question 2 asked participants to describe the nature of the coursework that they took to develop basic counseling skills in music therapy. Out of 368 responses, 85 participants (23.10%) indicated that they took a counseling microskills course as part of their music therapy education. One hundred and fifty-four participants (41.85%) indicated that they took a class that taught counseling skills in the music therapy setting which provided regular opportunities for students to practice and receive feedback. One hundred and forty-three (38.86%) reported that counseling skills were occasionally discussed in class, with few opportunities to practice. Twenty-eight participants (7.61%) indicated that while counseling skills were occasionally discussed in their coursework, no opportunities were provided to practice in class. Fifty-one participants (13.86%) reported that they did not take a class that taught counseling skills. Since participants were able to select more than one option, data were analyzed to determine the number of participants who received both microskills training and training on using counseling skills in the music therapy setting. Thirty-eight respondents (10.33%) selected both categories. Therefore, 201 participants (54.62%) received focused training on using counseling skills, whether through microskills training or within a music therapy context.

Question 3 asked participants to rate their level of satisfaction with their entry-level education and training in counseling skills for music therapy. The total number of respondents for this question was 366. Participants were divided in their feelings of satisfaction, with 43 (11.75%) feeling very satisfied, 132 (36.07%) feeling somewhat

satisfied, 64 (17.49%) feeling neutral, 93 (25.41%) feeling somewhat dissatisfied, and 34 (9.29%) feeling very dissatisfied. Overall, 175 participants (47.81%) reported feeling somewhat or very satisfied with their training, while 127 (34.70%) reported feeling somewhat or very dissatisfied. Results are displayed in Figure 1.

Figure 1

Reported Satisfaction With Counseling Skills Training



Question 4 asked participants what suggestions they might have for improving the counseling skills training that they received at the undergraduate level. Three hundred and sixty-six participants responded to this question. Twenty-four participants (6.56%) had no suggestions, meaning that over 94% of participants had suggestions for improving the counseling skills training that they received. The most frequently selected suggestion was offering more training on using basic counseling skills with clients of various ages,

abilities, cultures, and communication styles (71.31%, n = 261). Two hundred and forty-seven participants (67.49%) felt it would be helpful to receive more training on using counseling skills within music therapy interventions (songwriting, lyric analysis, etc.). Over 53% of participants (n = 197) felt their education could have been improved with more class content on basic counseling skills, and nearly 60% (n = 217) felt it would be helpful to spend more time practicing basic counseling skills in class. Twenty-seven participants (7.38%) provided their own suggestions. Qualtrics Text iQ was used to sort text responses into the following suggestions:

- Provide counseling microskills training to students (n = 8),
- Require students to take a counseling skills course outside of the music therapy department (n = 4),
- Integrate multiculturalism and/or trauma-informed care into counseling skills training (n = 4),
- Provide education on counseling theories and techniques (n = 3),
- Clarify music therapists' scope of practice related to counseling skills (n = 2),
- Integrate counseling skills throughout the music therapy curriculum (n = 2),
- Invite independently licensed counseling supervisors to provide guest lectures/training to students (n = 2),
- Provide opportunities for students to observe counseling skills used in various music therapy settings (n = 1), and
- Establish set criteria to evaluate counseling skill development in music therapy (n = 1).

Continuing Education in Counseling Skills

The second section of the survey inquired about efforts that music therapists have undertaken to learn basic counseling skills after obtaining board-certification. Question 5 asked participants what resources they have used to develop their skills after graduation. The top three responses selected by participants were developing skills through direct work experience with clients (85.98%, n = 319); self-study using books, articles and other resources (59.84%, n = 222); and music therapy supervision (41.78%, n = 155). Additional resources include continuing music therapy education (41.24%, n = 153), earning a graduate degree in music therapy (32.08%, n = 119), earning a graduate degree in counseling or a related field (21.82%, n = 78), and completing advanced training in a music therapy method that emphasizes counseling skills (16.71%, n = 62). Twelve participants (3.23%) reported that they have not used any resources to develop their counseling skills since graduating.

Forty-three respondents (11.59%) reported that they developed their counseling skills using different resources from those listed above and used text entries to describe the methods they used. Qualtrics Text iQ was used to sort text entries into categories. Respondents indicated that they:

- Pursued continuing education in mental health/counseling fields (n = 12),
- Received supervision from other disciplines, including psychologists, social workers, counselors, and/or chaplains (n = 7),
- Obtained licensure/certification in another field, including health coach training, Dalcroze Eurythmics, and various counseling domains (n = 7),

- Received personal therapy (n = 6),
- Completed counseling coursework (n = 6),
- Engaged in self-reflection and/or clinical reflexivity (n = 5),
- Received employer-provided training (n = 3),
- Sought education and training on trauma-informed care (n = 3),
- Consulted with colleagues (n = 2),
- Provided supervision and counseling skills training to students (n = 2),
- Obtained a combined music therapy/counseling master's degree (n = 1), and
- Engaged in personal music therapy (n = 1).

Question 6 asked respondents to select any challenges or barriers that they have encountered in developing counseling skills since graduation. Out of 363 respondents, 151 (41.60%) indicated that they did not encounter any major barriers in doing so. One hundred and sixteen respondents (31.96%) reported that the cost of additional education and training was a major barrier, 94 (25.90%) reported that they did not have enough time to work on these skills, and five participants (0.77%) indicated that they did not feel the need to work on these skills. Forty-one participants (11.29%) reported that they encountered another challenge or barrier not listed in the survey. In addition to elaborating on financial (n = 8) and time restrictions (n = 2), participants reported:

- Feeling uncertain about one's scope of practice (n = 5),
- Having few to no opportunities to practice counseling skills in one's current work setting (n = 4),
- Feeling as though counseling skills are not needed in one's work setting (n = 3),

- Feeling as though one would need a graduate degree to advance counseling skills (n = 3),
- Not having access to music therapy supervisors who are knowledgeable in using counseling skills (n = 3),
- Struggling to find multiculturally competent resources (n = 3)
- Struggling to adapt counseling skills to music therapy settings (n = 2),
- Having concerns with content and quality of CMTE's on this topic (n = 2),
- Needing to intentionally look for resources (n = 2), and
- Feeling underprepared to develop/use counseling skills (n = 1).

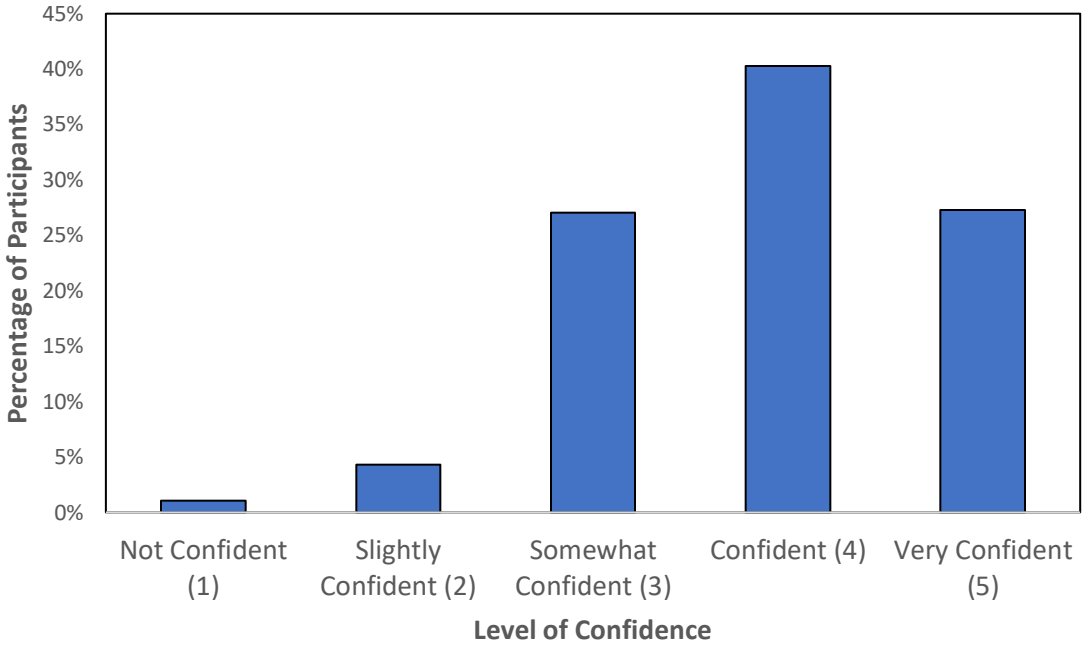
Confidence in Using Basic Counseling Skills

The third and final section of the survey investigated participants' current level of confidence in using counseling skills and their opinions on the importance of counseling skills in music therapy. Question 7 asked participants to rate their level of confidence in using basic counseling skills in their current work setting. Three hundred and seventy respondents answered this question. Response categories included "not confident," "slightly confident," "somewhat confident," confident," and "very confident." Numbers were assigned to each response category ranging from 1 ("not confident") to 5 ("very confident") and the mean score (mean = 3.89) and standard deviation (SD = 0.90) was calculated using Microsoft Excel. A mean score of 4 or higher indicates that on average, participants felt confident using counseling skills in music therapy. While the mean was slightly below 4, the median score was 4, suggesting that overall, respondents felt somewhat confident to confident using counseling skills. Over 27% of respondents

(n = 101) felt very confident, 40.27% (n = 149) felt confident, 27.03% (n = 100) felt somewhat confident, and 4.32% (n = 16) felt slightly confident. Four participants (1.08%) rated themselves as not confident. Results are shown in Figure 2.

Figure 2

Reported Confidence in Using Basic Counseling Skills



Question 8 asked participants to rate their level of confidence in using specific counseling skills in music therapy. The list of counseling skills was adapted from Ivey, et al.'s (2022) counseling microskills model and definitions for each skill were provided within the survey. The number of responses for each skill varied from 369 to 371. As in Question 7, responses included "not confident," "slightly confident," "somewhat confident," "confident," and "very confident," response categories were assigned a number, ranging from 1 (not confident) to 5 (very confident). Mean scores and standard

deviations were calculated for each skill to compare participants' mean comfort level between skills, and a score of 4 or higher indicates that participants felt confident using a particular skill. Mean, standard deviation, and total number of responses are reported in Table 3.

Table 3

Reported Confidence in Using Specific Counseling Skills

Skill	Mean	SD	n
Empathy	4.59	0.61	371
Positive regard	4.54	0.67	371
Genuineness	4.53	0.67	371
Active listening	4.42	0.78	371
Body language	4.28	0.67	371
Observation skills	4.25	0.84	371
Identifying/ Using key words	4.13	0.86	371
Paraphrasing	4.11	0.97	370
Summarizing	4.02	1.00	370
Therapeutic self-disclosure	3.96	0.97	370
Focusing the session	3.90	1.01	369
Therapeutic silence	3.89	1.12	369
Interpreting/Reframing	3.74	1.14	369
Immediacy	3.61	1.13	370

Key: 1 = Not confident; 2 = Slightly confident; 3 = Somewhat confident; 4 = Confident; 5 = Very confident

As can be seen in Table 3, participants' average level of confidence differed for each skill, ranging from somewhat confident to confident. While participants rated their level of confidence at a 4 or higher for many skills, five skills obtained an average score below 4. These skills include therapeutic self-disclosure (mean = 3.96), focusing the

session (mean = 3.90), therapeutic silence (mean = 3.89), interpreting or reframing (mean = 3.74), and immediacy (mean = 3.61). The counseling skills that participants felt most confident using were empathy, positive regard (mean = 4.54), and genuineness (mean = 4.53).

Question 9 asked participants to rate their skill level in various AMTA professional competencies that describe or relate to basic counseling skills. The number of respondents for each competency ranged from 368 to 370. Respondents selected "not skilled," "slightly skilled," "somewhat skilled," "skilled," or "highly skilled" for each competency. Each response category was assigned a number, ranging from 1 (not skilled) to 5 (highly skilled). As with Question 8, the mean and standard deviation was calculated for each skill, and a mean score of 4 or higher indicates that on average, participants considered themselves to be skilled in the competency. Results suggest that participants considered themselves skilled in each competency except for one, "informing and preparing clients for termination of music therapy services" (mean = 3.83). The average scores for demonstrating an awareness of the influence of race, ethnicity, and other aspects of identity on the therapeutic process (mean = 4.04) and modeling and communicating expectations (mean = 4.09) were just above the cutoff for skilled. Participants rated themselves highest in their ability to form a therapeutic relationship with clients (mean = 4.54). Additionally, participants rated themselves as skilled in using verbal skills in music therapy (mean = 4.16). Overall, music therapists reported feeling somewhat skilled to skilled in the AMTA competencies that were investigated in this study. Mean, standard deviation, and total number of responses are reported in Table 4.

Table 4

Reported Skill in Related AMTA Competencies

Skill	Mean	SD	n
Establishing the therapeutic relationship	4.54	0.63	370
Exploring client needs, values, and preferences	4.28	0.78	370
Recognizing the impact of one's thoughts, feelings, and actions on the therapeutic process	4.19	0.76	370
Using verbal skills	4.16	0.84	370
Recognizing and responding appropriately to significant events	4.10	0.85	368
Modeling and communicating expectations	4.09	0.87	369
Demonstrating an awareness of the influence of race, ethnicity, gender, age, religion, ability, and other aspects of identity on the therapeutic process	4.04	0.82	370
Informing and preparing clients for termination of services	3.83	0.98	369

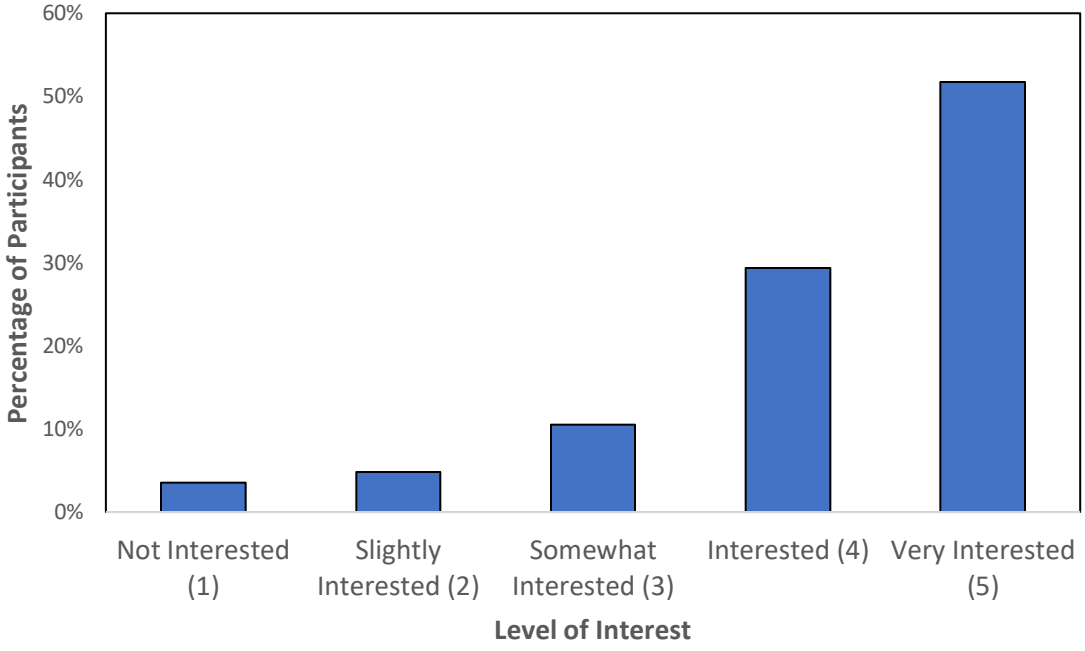
Key: 1 = Not skilled; 2 = Slightly skilled; 3 = Somewhat skilled; 4 = Skilled 5 = Highly skilled

Question 10 investigated participants' level of interest in further developing their counseling skills. Responses included "not interested," "slightly interested," "somewhat interested," "interested," and "very interested." Values were assigned to each response category ranging from 1 (not interested) to 5 (very interested), and the mean (4.12) and standard deviation (1.04) were calculated. Results suggest that on average, participants

felt interested in developing their skills. In fact, over 80% of participants indicated that they felt interested or very interested in further developing their counseling skills. The remaining participants felt somewhat interested (10.51%, n = 39), slightly interested (4.85%, n = 18) and not interested (3.50%, n = 13). Results may be found in Figure 3.

Figure 3

Participant Interest in Further Developing Counseling Skills

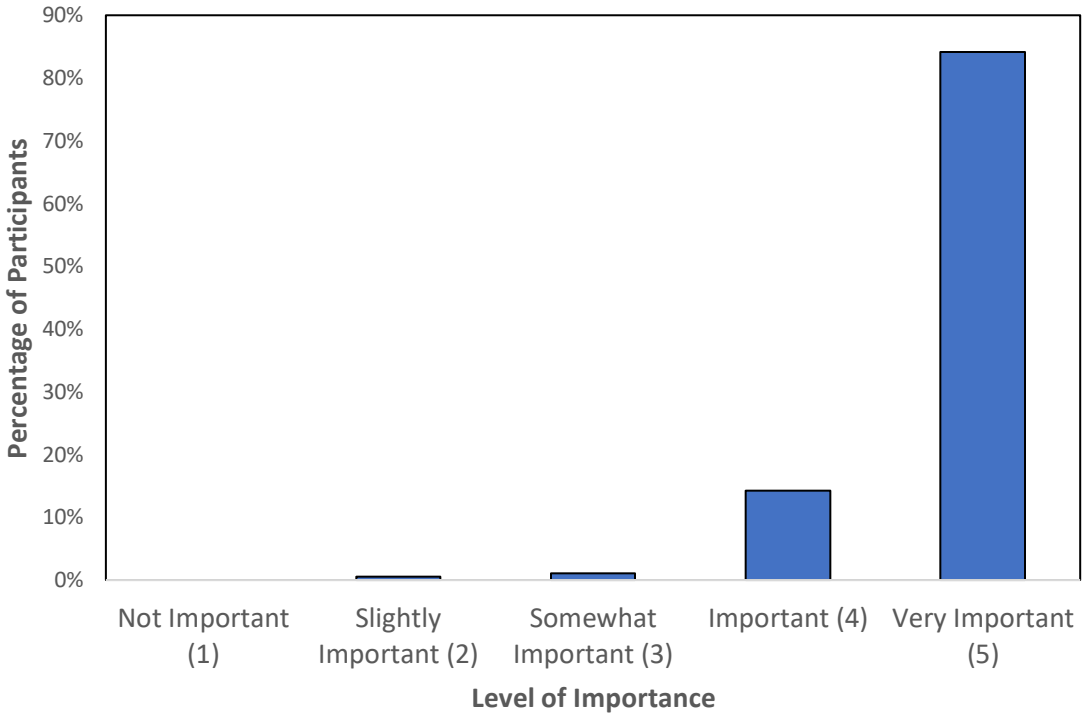


Finally, Question 11 asked participants to rate how important they felt basic counseling skills were for music therapy practice on a scale of 1 (not important) to 5 (very important). The mean score was 4.82 and the standard deviation was 0.44. Out of 371 participants, 312 (84.10%) reported feeling counseling skills were very important; 53 (14.29%) felt they were important; four (1.08%) felt they were somewhat important; and two (0.54%) felt they were slightly important. In sum, 98.39% of participants felt

counseling skills were important or very important for music therapy practice. No participants reported feeling counseling skills were not important in music therapy. Overall, participants felt counseling skills are very important in music therapy. Results are depicted in Figure 4.

Figure 4

Perceived Importance of Counseling Skills in Music Therapy



Chapter 5: Discussion

Research Findings

The purpose of this study was to gain insight into current state of counseling skills training in music therapy. This study investigated the following research questions:

1. How do music therapists learn and develop counseling skills for clinical practice?
2. How confident do music therapists feel using counseling skills in music therapy?
3. How satisfied are music therapists with counseling skills training in the field of music therapy?

Research Question 1

The first research question was, "How do music therapists learn and develop counseling skills for clinical practice?" As expected, most participants received some level of training during their initial music therapy degree program, and most reported learning counseling skills through class lectures and supervised clinical experience. However, many participants reported that counseling skills were only occasionally discussed in class and that they had few to no opportunities to practice using these skills outside of practicum. More respondents reported learning about counseling skills in a music therapy context (42%) than in a counseling microskills context (23%). Nearly 14% (n =51) of participants in this study reported that counseling skills were not addressed in their entry-level coursework, and an additional 7.61% (n = 28) reported that their courses did not provide opportunities to practice counseling skills in class. Therefore, reported training methods and depth of training varied considerably among participants in this study. These findings are congruent with reports from previous

studies which suggest that student music therapists have mixed training experiences (Amir, 1999; Nelligan & McCaffrey, 2020; Sevcik, et al., 2017).

Over 98% of respondents indicated that they felt counseling skills were important or very important in music therapy, and 97% of respondents reported engaging in efforts to develop their counseling skills after graduation. Although the largest number of music therapists reported developing these skills through direct work with clients, they also reported learning through self-study, supervision, continuing music therapy education, and other methods that they undertook on their own. This indicates that participants in this study were highly motivated to continue developing their counseling skills. Furthermore, participants appeared to view counseling skills as something to be refined over time, as over 81% reported feeling interested or very interested in developing their counseling skills further. These results parallel those from Nelligan and McCaffrey's (2020) study, in which participants reported that they regularly utilized verbal skills in music therapy and intentionally engaged in various efforts to develop these skills after obtaining board certification.

Research Question 2

The second research question was, "How confident do music therapists feel using counseling skills in music therapy?" To answer this question, participants were asked to rate their confidence in using counseling skills, their confidence using specific skills, and their perceived skill in implementing related AMTA competencies. Just over two-thirds of participants reported feeling confident or very confident in their counseling skills. Comparing average scores, participants reported feeling the most confident using

empathy, positive regard, and genuineness; confident using active listening, reflecting key words, and paraphrasing; and somewhat confident using immediacy, reframing, and therapeutic silence. These results suggest that participants in this study felt more confident establishing core therapeutic conditions and using basic listening skills in music therapy, and less confident using influencing skills.

Participants also rated themselves as skilled in nearly every AMTA competency listed in the survey. The highest rated competency was "establishing the therapeutic relationship." Upon further review of the data, the researcher found that 96% of participants rated themselves as skilled or very skilled at this competency. Although this result is quite high, it is not entirely unexpected given participants' theoretical orientations. Seventy-four percent of participants described their theoretical orientation as humanistic, which emphasizes change through the therapeutic relationship (Corey, 2013). Additionally, about 84% of respondents rated themselves as skilled or very skilled in their ability to "recognize the impact of one's thoughts, feelings, and actions on the therapeutic process," while about 77% felt they were skilled or very skilled in their "awareness of the influence of race, gender, ability status, and other aspects of identity on the therapeutic process." According to Ivey, et al. (2022), therapists must develop their self-awareness and multicultural competence to appropriately use counseling skills. Therefore, while it is promising that most participants reported feeling confident in their counseling skills and skilled in most AMTA competencies, these results demonstrate that more training is needed in self-awareness and multiculturalism.

The single competency in which participants rated themselves as "somewhat skilled" was informing and preparing clients for termination of services. Upon further review of the data, it was found that a surprising 29% of respondents reported feeling somewhat, slightly, or not skilled in this area. Termination in therapy typically involves reviewing treatment goals and client progress, exploring and processing any feelings related to the ending of services, and identifying strategies for clients to use moving forward (Corey, et al., 2017). In music therapy, closure can be facilitated through musical and verbal means, including verbal discussion, songwriting, and asking clients to share songs that represent what they have gained from the treatment process (Hudgins, 2013). It is not clear why participants felt less skilled in this competency, as music therapists presumably terminate treatment as frequently as do related disciplines. This finding deserves further exploration since the termination phase is an important part of the therapeutic process (Corey, et al., 2017; Hudgins, 2013).

Research Question 3

The final research question was, "How satisfied are music therapists with counseling skills training in the field of music therapy?" When asked about their level of satisfaction with their entry-level education and training, participant responses ranged from very satisfied to very dissatisfied. Given that over a third of participants reported that they were somewhat or very dissatisfied, this study suggests that there is significant room for improvement in counseling skills training in the field. When asked what could be done to improve counseling skills training in their academic program, an overwhelming 71.31% of respondents selected that they would have liked more training

on using basic counseling skills with people of diverse ages, cultures, and abilities. Over 67% indicated that they would have liked to have spent more class time on using counseling skills within music therapy interventions, such as songwriting and lyric analysis, and over half felt that more course content and opportunities to practice counseling skills was warranted. Although a sizeable number of participants reported feeling dissatisfied with the counseling skills training that they received, they offered many suggestions for improvement.

One last finding that emerged from this study is that several participants reported developing their counseling skills through their own efforts or by looking for resources in other fields. Nearly 86% of participants reported developing counseling skills through direct work with clients, nearly 60% reported learning through self-study, and about one in five participants reported pursuing a degree in counseling or a related field. Through text response, participants also reported seeking continuing education from mental health fields and seeking supervision from counselors, psychologists, and other mental health professionals. Only 42% of respondents reported developing their counseling skills through music therapy supervision, and 41% through continuing music therapy education. These results highlight a need for music therapy supervisors who are knowledgeable in using these skills and for relevant continuing education offerings within the field.

Limitations

This study has limitations that should be considered when interpreting the research findings. Due to convenience sampling, results cannot be generalized to the

total population of board-certified music therapists. Therefore, statistics found in this study should not be interpreted to reflect the experiences of all music therapists, since a subset of music therapists (i.e., those who opted out of research invitations) were not included in the study. Since the survey was self-report, there is the potential that the results do not accurately capture the thoughts and experiences of music therapists due to social desirability bias or due to partial or inaccurate recall of educational experiences. Finally, only 7.5% of those who were invited to participate completed the survey. The low response rate introduces the potential that those who participated were different from the total population in a way that could impact research findings (Fowler, 2014). For example, this survey may have captured the opinions and experiences of music therapists who have a strong interest in counseling skills or those who have had very positive or negative experiences with their education and clinical training. Still, the results should not be disregarded, as the sample size is relatively large and the demographic makeup of participants similar to that of larger studies in music therapy (AMTA 2020, 2021b). These limitations are taken into consideration in the following implications for this study.

Implications

For Educators

This study has several implications for the field of music therapy. Although statistics cannot be generalized to the total population of music therapists, results do demonstrate that some music therapists do not receive formal counseling skills training during their entry-level studies. Additionally, many respondents reported receiving limited counseling skills training with few to no opportunities to practice their skills in

class. At the very least, this should be addressed at the program level to ensure that students can effectively utilize basic counseling skills as outlined in the *AMTA Professional Competencies*. In the counseling field, students take at least one counseling microskills class and receive clinical experience and ongoing supervision to develop these skills throughout their program of study (Beck & Kulzer, 2018). Music therapy educators should evaluate whether their current teaching methods effectively prepare students to use these skills and should consider supplementing their program with focused training, such as a counseling microskills course. As previously mentioned, the undergraduate music therapy curriculum is already quite full, and educators may need to adjust their existing curriculum to achieve these goals. However, these challenges should not prevent educators from undertaking these efforts. Since there are presently no guidelines for incorporating these skills into the music therapy curriculum and no research to indicate the best methods of doing so, each music therapy department must determine the best course of action given student needs, university requirements, and faculty resources.

Another implication of this study is that educators should ensure that they cover influencing skills as well as basic listening and observation skills in their classes. Many participants in this study only felt somewhat confident using influencing skills such as self-disclosure, focusing the session, and reframing. While listening and observation skills are powerful by themselves, influencing skills can further develop client change and facilitate the successful navigation of therapy sessions (Ivey, et al., 2022). Influencing skills are listed in the *AMTA Professional Competencies* and can therefore be

used within a music therapists' scope of practice, given appropriate training. As several participants mentioned, therapist role should be clarified when teaching these skills so students understand how to use basic counseling skills within the context of music therapy. The application of these skills can be nuanced and take time to develop. For example, reframing should only be used after listening closely to a client, and never to minimize immediate reactions to a situation (Ivey, et al., 2022). Therefore, students should practice these skills outside of practicum so they can focus on skill development before attempting to use them with clients. Furthermore, since many participants reported feeling less confident using these skills, continuing education is needed to help practicing music therapists feel more confident in this area.

Finally, although not the focus of this research, results also suggest that some music therapists do not receive adequate training in multiculturalism, trauma-informed practices, and identity-affirming practices, which are increasingly recognized as standards of care in health and educational settings (Bhugra & Bhui, 2018; Dallman, et al., 2022; Downey & Greco, 2023; Garami, et al., 2016; Itchhaporia, 2021; Lown, et al., 2016; Menschner & Maul, 2016; Presnell, et al., 2022). Nearly one in four participants in this study felt not confident to somewhat confident in their awareness of multicultural issues in therapy, and over 71% of respondents reported that they would have liked more training in using basic counseling skills with diverse populations. Counseling skills that are utilized without an awareness of multicultural issues, communication differences, power dynamics, and the effects of trauma may not be as effective and may at times cause harm to clients (Ivey, et al., 2022; Paré, 2013; SAMHSA, 2014; Zalaquett, et al.,

2019). In fact, there is a growing call to integrate multicultural foundations throughout music therapy practice (Belgrave & Kim, 2021; Hadley & Norris, 2016; Mahoney, 2015). If music therapists are to learn basic counseling skills, they must learn to apply them in a compassionate, ethical, and culturally informed manner.

For Continuing Education Providers

Likewise, these results highlight a need for increased continuing education opportunities for music therapists who aim to develop their counseling skills. Participants in this study overwhelmingly indicated that they felt counseling skills were important in their work and that they continue to develop these skills throughout their career. Based on participant suggestions, courses that are relatively short (e.g., three hours or less) may be more accessible and affordable to music therapists who are busy with a limited income. Topics suggested by participants include counseling microskills training, integrating counseling skills into music therapy practice, scope of practice, using counseling skills with people of diverse ages, abilities and cultures, and trauma- and culture-informed practices.

For Supervisors

Participants in this study and previous studies (Clements-Cortés, 2015; Nelligan & McCaffrey, 2020) overwhelmingly reported that they engaged in efforts to continue developing counseling skills after graduation and that it is difficult to develop these skills on their own. Additionally, some participants in this study reported not having access to supervisors who are knowledgeable in using counseling skills in music therapy. Supervisors should ensure that they are trained to use basic counseling skills and that they

are competent in applying these skills in the settings in which they supervise. By teaching and reinforcing basic counseling skills, supervisors can directly address supervisee needs, promote supervisee development of effective therapeutic skills, demonstrate appropriate therapeutic role and scope of practice when using these skills, improve the quality of services provided by the supervisee, and reduce the potential stress and burden associated with having to learn such skills on one's own without guidance.

For Clinicians

These results highlight many opportunities for clinicians to continue to develop their counseling skills after graduation. Some music therapists develop these skills through advanced training, either within the field of music therapy or in a mental health field. However, music therapists should be aware that there are less expensive and time-consuming options for developing basic counseling skills in music therapy. A single counseling microskills course should provide most music therapists with the foundation that they need to intentionally use counseling skills in their work (Gooding, 2017). Additionally, quality supervision can help develop counseling skills, particularly regarding self-awareness, multicultural issues, and skill application. If music therapy supervisors are not available to help music therapists develop these skills, music therapists may consider seeking supervision from mental health professionals. Personal therapy was also identified as a means of developing greater self-awareness and understanding of counseling skills. Finally, there are many books and other educational resources that can be used to increase one's knowledge of counseling skills. Music

therapists should consider developing their counseling skills in a way that aligns with their approach, work setting, client needs, and financial resources.

Recommendations

This study adds to the growing body of research that explores the use of counseling skills in music therapy. It is the first study to the author's knowledge that explores the counseling skills training that music therapists have received, their level of satisfaction in said training, and their level of confidence in using such skills. Further quantitative research is needed to investigate the best methods of counseling skills instruction within the field, whether it be microskills training, integration into music therapy interventions, or a combination of the two. It would also be beneficial to identify and describe music therapy programs who have successfully integrated counseling skills training into their curriculum. These examples could help guide music therapy program directors, internship directors, educators, and supervisors who want to integrate these practices into their own educational work. Future qualitative research could explore music therapists' needs and suggestions for improving counseling skills training in greater depth than was achieved in this study to inform future educational practices. Finally, the surprising finding that 29% of participants did not feel skilled at terminating treatment with clients suggests that more research is needed to establish guidance and best practices in this area.

Conclusion

Music therapists use a combination of musical, therapeutic, and music therapy skills to provide treatment to people with diverse mental, physical, and developmental

conditions (AMTA, 2013, 2021a). Basic counseling skills are indispensable for music therapists as they build rapport, set boundaries, collaborate on treatment goals, facilitate music therapy experiences, and provide an emotionally safe environment for clients to engage in music therapy. Effective therapeutic communication and interpersonal skills are even more vital when working with marginalized groups and people who have experienced trauma. Participants in this study strongly affirmed the importance basic counseling skills in their work but reported mixed experiences regarding the training that they received to develop these skills. Most participants reported developing these skills further after graduation and feeling confident using a variety of basic counseling skills. This study highlights a need for improved counseling skills training in the field of music therapy and offers suggestions for improving current training practices.

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Appendix A: Invitation to Participate in Survey

IRB# 23-E-95

Hello music therapists,

My name is Kelsey Hoisington and I am a music therapy graduate student at Ohio University. My advisor is Assistant Professor Jessica Fletcher, MM, MT-BC. I am conducting a survey as part of my master's thesis to learn more about counseling skills training in music therapy. Survey questions will ask about your educational experiences, your level of confidence using counseling skills, and your thoughts on the importance of counseling skills in music therapy. This survey is anonymous, consists of 11 questions on the survey topic, and should only take 15 to 20 minutes to complete.

To participate, you must be a board-certified music therapist (MT-BC). Since I am interested in the experiences of all who have completed entry-level requirements for the field, you do not need to be currently practicing music therapy to complete this survey. Participation is voluntary, and you may skip questions or end the survey at any time without penalty. Although there are no direct benefits to you, your responses will shed light on the current strengths, needs and experiences of board-certified music therapists and could help inform future research, education, and supervision practices.

Questions about this research may be directed to myself at kh259607@ohio.edu or my thesis advisor, Jessica Fletcher, MM, MT-BC at fletchej@ohio.edu. If you would like to participate, you may access the survey by clicking the link below.

Follow this link to the Survey:

Or copy and paste the URL below into your internet browser:

Thank you for your time!

Kelsey Hoisington, M.Ed., MT-BC, LPC (she/her)

Music Therapist, Licensed Professional Counselor

Graduate Student, Ohio University Music Therapy

Follow the link to opt out of future invitation emails:

Your email address was acquired from the Certification Board for Music Therapists. You may opt-out of future research, educational and professional emails by confirming your preference in your online CBMT account.

Appendix B: Ohio University Anonymous Online Consent Form

Title of Research: Counseling Skills in Music Therapy

Researcher: Kelsey Hoisington, LPC, MT-BC

IRB number: 23-E-95

You are being asked by an Ohio University researcher to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks of the research project. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to participate in this study. You may print a copy of this document to take with you.

Summary of Study

This study will use an online survey to investigate music therapists' experiences developing and using counseling skills in their work.

Explanation of Study

This study is being done in partial fulfillment of the researcher's master's degree in music therapy. Although counseling skills are commonly used in music therapy, little is known about the counseling skills training that music therapists receive and whether music therapists feel prepared to use these skills in clinical practice. The purpose of this study is to investigate (a) how music therapists develop basic counseling skills for clinical practice and (b) how confident music therapists feel using counseling skills in their work.

Inclusion Criteria

To participate, you must:

- Be 18 years or older
- Have a bachelor's degree (or equivalency) or higher in music therapy
- Be board-certified to practice music therapy (MT-BC)

Participation in this survey is completely voluntary. If you agree to participate, you will be asked to respond to demographic questions as well as 11 questions on the survey topic. Survey questions will inquire about your entry-level education and training, your efforts to develop counseling skills after graduation, and your level of confidence in using basic counseling skills in your work. You will be asked to select the best response(s) and rate your feelings on a Likert scale. It should take approximately 15 to 20 minutes to complete this survey. By completing the survey, you indicate that you have given informed consent to participate.

Risks and Discomforts

No risks or discomforts are anticipated. You may skip questions or withdraw from the study at any time by discontinuing the survey.

Benefits

Although there are no direct benefits to you, your responses will shed light on the current strengths, needs and experiences of board-certified music therapists and could help inform future research, education, and supervision practices.

Confidentiality and Records

All responses are anonymous, and no identifying information will be collected during this study. Survey data will be stored within Qualtrics and within the researcher's secure,

university-provided cloud drive. For maximum confidentiality, please clear your browser history and close the browser before leaving the computer.

Future Use Statement

Survey data may be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you or your legally authorized representative.

Contact Information

If you have any questions regarding this study, please contact the investigator, Kelsey Hoisington, LPC, MT-BC at kh259607@ohio.edu, or the advisor, Jessica Fletcher, MM, MT-BC at fletchej@ohio.edu.

If you have any questions regarding your rights as a research participant, please contact the Director of Research Compliance, Ohio University, (740)593-0664 or compliance@ohio.edu.

By agreeing to participate in this study, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks and they have been explained to your satisfaction;
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study;
- you are 18 years of age or older;
- your participation in this research is completely voluntary;
- you may leave the study at any time; if you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

If you agree to participate, please click the "next" button below.

Version Date: ***[05/17/2023]***

Appendix C: Survey Instrument

Screening Question

Q1 Have you obtained your music therapy credential (MT-BC) through the Certification Board for Music Therapists?

a. Yes, I obtained my MT-BC credential, even if I am not currently practicing
b. No, I have never obtained my MT-BC credential

Demographics

Q2 How old are you?

a. Less than 20 years old
b. 20 - 29 years old
c. 30 - 39 years old
d. 40 - 49 years old
e. 50 - 59 years old
f. 60 - 69 years old
g. 70 years or older

Q3 What is your gender?

a. Woman
b. Man
c. Non-binary
d. Not listed/Prefer to self-describe in the field below

   _____

e. Prefer not to say

Q4 With which racial and/or ethnic identities do you most identify?

a. White or Caucasian

b. Black or African American

c. Hispanic, Latin(o/a)/Latinx

d. Asian, Asian American, Pacific Islander or Desi

e. Native American or Alaskan Native

f. Not listed/Prefer to self-identify, below

_____

g. Prefer not to say

Q5 In what country do you live?

a. USA

b. Japan

c. Taiwan

d. Canada

e. Other (please specify below)

_____

Q6 Please select all degrees that you have completed to date.

a. Bachelor's in music therapy

b. Bachelor's equivalency in music therapy

c. Bachelor's in another field (please describe below)

_____

d. Master's in music therapy

e. Master's equivalency in music therapy

f. Master's in another field (please describe below)

_____

g. Doctorate in music therapy

h. Doctorate in another field (please describe below)

_____

Q7 How many years have you been a board-certified music therapist?

a. Less than 1 year

b. 1 - 5 years

c. 6 - 10 years

d. 11 - 15 years

e. 16 - 20 years

f. 21 - 25 years

g. Over 25 years

Q8 Are you currently employed as a music therapist?

a. Yes, I am working part-time or full-time as a music therapist

b. No, but I plan on practicing music therapy in the future

c. No, and I do not plan on practicing music therapy in the future

d. I am in school and may or may not be completing advanced practicum, supervision duties, and/or other music therapy related graduate work

Q9 What professional roles have you held in your music therapy career? Please select all that apply.

a. Clinician
b. Educator
c. Supervisor
d. University program director
e. Music therapy internship director
f. I have not yet worked professionally
g. Other (please describe below)

_____

Q10 In what setting(s) have you worked as a music therapist? Please select all that apply.

a. Inpatient psychiatric care
b. Outpatient mental health
c. Addictions
d. Hospice and palliative care
e. Hospital/Medical settings
f. Rehabilitation settings
g. Assisted living/Skilled nursing facilities
h. School-based settings
i. Day treatment centers
j. Prevention and wellness settings
k. Private practice

l. I have not yet worked professionally

m. I've worked in a setting that is not listed here (please describe below)

_____

Q11 What is your theoretical orientation? If your orientation is integrative or eclectic, please select all that apply.

a. Psychodynamic

b. Humanistic

c. Existential

d. Cognitive/Behavioral

e. Multicultural

f. Social Justice/Advocacy

g. I do not have a theoretical orientation

h. My theoretical orientation is not listed here (please describe below)

_____

Q12 What music therapy approach(es) do you use? Please select all that apply.

a. Nordoff-Robbins / Creative Music Therapy

b. Bonny Method of Guided Imagery in Music (BMGIM)

c. Analytical Music Therapy

d. Neurologic Music Therapy

e. Biomedical Music Therapy

f. Resource-Oriented Music Therapy

g. Community Music Therapy

h. Feminist Music Therapy

i. I do not use an approach in my work

j. My approach is not listed here (please describe below)

_____

Survey Questions

For the purposes of this survey, ***basic counseling skills*** are the verbal skills and behaviors that music therapists may use to (a) build and maintain the therapeutic relationship, (b) guide the session, (c) gather information relevant to therapeutic work, (d) navigate emergent thoughts, feelings, experiences, and interpersonal dynamics in music therapy for therapeutic purposes, and (e) close the session (Ivey, et al., 2022; Nolan, 2005). Some examples of these skills include conveying empathy; clarifying, reflecting and reframing client statements; empathic confrontation; and self-disclosure for therapeutic purposes, to name a few. These skills may be used to varying degrees within any music therapy approach or setting.

Please take a moment to consider your education and training in basic counseling skills in music therapy.

Q1 How did you learn basic counseling skills during your ***undergraduate*** (or equivalency) education and training? Please select all that apply.

a. Class lectures

b. Role play with other students

c. Supervisory feedback during practicum/internship
d. Direct experience working with clients during practicum/internship
e. I did not learn basic counseling skills during my undergrad/equivalency studies
f. I learned in a way that is not listed here (please describe below)

_____

Q2 Which of the following best describes the coursework that you took during your ***undergraduate*** (or equivalency) studies to develop your counseling skills?

a. I took a counseling microskills class that taught basic skills (listening, reflecting, reframing, etc.) and had regular opportunities to practice and receive feedback
b. I took a music therapy class that emphasized counseling skills in the music therapy setting (verbal processing after music experiences, etc.) and had regular opportunities to practice and receive feedback
c. Basic counseling skills were occasionally discussed in one or more music therapy classes, with a few opportunities to practice and receive feedback
d. Basic counseling skills were briefly discussed with no opportunities to practice in class
e. I did not take a class that taught basic counseling skills during my undergraduate/equivalency studies

Q3 How satisfied are you with your ***undergraduate*** (or equivalency) education and training regarding counseling skills in music therapy?

a. Very satisfied
b. Somewhat satisfied
c. Neither satisfied nor dissatisfied
d. Somewhat dissatisfied
e. Very dissatisfied

Q4 What suggestions, if any, would you make to improve the counseling skills training you received as an ***undergraduate*** (or equivalency) student?

f. More class content on basic counseling skills
g. More time spent practicing counseling skills in class
h. More education/training on using counseling skills within music therapy interventions (lyric analysis, songwriting, verbal processing after improvisation, etc.)
i. More education/training on using basic counseling skills with clients of various ages, abilities, and communication styles (highly verbal adults, people who use augmentative/alternate methods of communication, etc.)
j. I don't have any suggestions for improving the counseling skills training that I received
k. I have a suggestion not listed here (please describe below; please limit your response to 1-2 sentences)

_____

Q5 What resources have you used ***since graduating*** to develop your counseling skills? Please select all that apply.

l. I pursued a graduate degree in music therapy

m. I pursued a graduate degree in counseling or a related field

n. I completed continuing music therapy education (CMTE) about counseling skills

o. I pursued advanced training in a music therapy approach that emphasizes counseling skills (for example, the Bonny Method of Guided Imagery & Music)

p. I learned through professional experience working with clients

q. I sought music therapy supervision and/or consultation

r. I engaged in self-study using books, articles, and other resources

s. I haven't worked on these skills since graduating

t. I used a resource that isn't listed here (please describe below)

_____

Q6 What, if any, barriers or challenges have you encountered in developing counseling skills ***since graduating***? Please select all that apply.

u. I have not encountered any major barriers or challenges in developing these skills since graduating

v. The available resources for developing counseling skills after graduation are too costly

w. I have struggled to find resources that teach me what I need to know

x. I do not have enough time to work on these skills

y. I do not feel I need to work on these skills

z. I have encountered a barrier or challenge not listed here (please describe below)

_____

Q7 How confident do you ***currently*** feel using counseling skills in your work?

f. Very confident

g. Confident

h. Somewhat Confident

i. Slightly Confident

j. Not confident

Q8 How confident do you feel using each of the following counseling skills in music therapy sessions?

	Very confident	Confident	Somewhat confident	Slightly confident	Not confident
Feeling and conveying empathy in a way that the client understands and accepts					
Unconditional positive regard, or demonstrating a caring, nonjudgmental attitude toward the client regardless of their thoughts, feelings, actions, opinions, identity, or needs					
Genuineness, or acting in a way that is congruent with your thoughts and feelings as appropriate					

Monitoring and adapting one's body language (e.g., position, eye contact, proximity, etc.) and vocal tone for therapeutic purposes
Observation skills, or noticing and interpreting the client's verbal, nonverbal, and musical forms of communication
Identifying and reflecting key words, thoughts, feelings, and/or behaviors expressed by the client for therapeutic purposes
Active listening, or listening to understand and effectively conveying that understanding to the client
Paraphrasing client statements to support further verbal exploration and/or insight development
Summarizing what the client has said or done in the session to integrate learning, facilitate transitions, and/or close the session

Immediacy, or talking openly about what is occurring between client and therapist in the present moment for therapeutic purposes
Focusing the session on issues relevant to therapeutic work, such as current objectives or client feelings that emerge in session
Interpreting/reframing, or assisting the client in thinking differently about an issue or experience
Appropriate self-disclosure for therapeutic purposes
Using silence for therapeutic purposes

Q9 How would you rate your abilities on the following *AMTA Professional Competencies*?

	Highly skilled	Skilled	Somewhat skilled	Slightly skilled	Not skilled
Recognizing the impact of one's own feelings, attitudes and actions on the therapeutic process					
Establishing and maintaining therapeutic relationships with clients					
Demonstrating an awareness of the influence of race, ethnicity, gender, age, religion, ability, and other aspects of identity on the therapeutic process					
Exploring client needs, values, and/or preferences throughout the therapeutic process					
Verbally responding to					

client statements and behaviors throughout the session as needed
Recognizing and responding appropriately to significant events in music therapy
Modeling and communicating expectations to clients
Using verbal skills in music therapy
Informing and preparing clients for termination of music therapy services (e.g., providing opportunities for closure)

Q10 How interested are you in further developing your counseling skills?

a. Very interested
b. Interested
c. Somewhat interested
d. Slightly interested
e. Not interested

Q11 How important do you feel counseling skills are for music therapy practice?

a. Very important
b. Important
c. Somewhat important
d. Slightly important
e. Not important

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