Multicultural Orientations in Music Therapy Education

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MULTICULTURAL ORIENTATIONS IN MUSIC THERAPY EDUCATION

A DISSERTATION

submitted by

DEBRA JELINEK GOMBERT

In partial fulfillment of the requirements for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
February 2020
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSERTATION APPROVAL FORM

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Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

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Final approval and acceptance of this dissertation is contingent upon the candidate’s submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

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ACKNOWLEDGEMENTS

Thank you to my dissertation committee: Dr. Michele Forinash, Dr. Melita Belgrave and Dr. Jason Butler. Michele, as my chair, you were an invaluable source of advice and encouragement as you listened, provided feedback or asked questions. Melita and Jason, I appreciate your time, wisdom, and insight, as you each brought a different lens to my work.

I could not have done this work without the many music therapists who responded to my survey, and those who agreed to be interviewed. I extend my deepest gratitude to each and every one of you.

Many thanks to Cassandra Barragan for your help with statistical analysis. I also want to thank those who provided administrative, organizational, structural, and/or editorial support: Angela Crawford Ervin, Rena Seltzer, Melanie Sobocinski, Bryan Alfaro, and Rachel Neve.

My students and colleagues at Eastern Michigan University have been cheering me on throughout my dissertation. Students, I extend my heart-felt gratitude for your undying enthusiastic support. Colleagues, a few of you were guides on this journey long before I started my PhD. Thank you to Roberta Justice, Theresa Merrill, Diane Winder, Jody Stark, and Laura Pawuk. I am indeed fortunate to count you among my teachers, mentors, former employers, and now as colleagues and friends.

Thank you to my friends Kim Chung, Genene Holt, and Lynae Darbes, for our writing sessions and weekly meetings; and to Leslie Lundquist for support that I can best describe as intuitive, persistent, and energy-balancing. Raymond Grew’s friendship was also invaluable. Raymond, thank you for your keen questions. I always left our conversations feeling inspired and re-energized. And thank you to Lesley Cohort 9 for the support, intellectual stimulation, and artistic inspiration.

Other friends played an important role as parents of Carl’s friends: Candace and Eric Bramson; Melissa and Adam Dorfman; Pauline Jones Luong; Caroline Richardson and Paul Resnick. Thank you for the many times you took Carl for a day, offered me support, or understood why your son was only fed pizza when he spent time here.

My parents nurtured a family culture of support for each other’s pursuits, especially those related to learning or the arts. Thank you to Bill and Jane Jelinek and to my siblings, Margaret Jelinek Lewis, David Jelinek and Betsy Jelinek for the love, laughter, advice (or just listening), and support that has carried me through so much more than my PhD. A special thank you for the times you invited Carl to travel with you to Europe, Texas, New York, the mall, or the diner for a burger and shake.
My husband, Jan, has always lovingly supported me along an ever-twisting path of musical and academic pursuits. Thank you for your unwavering support on this one! My son, Carl, kept me grounded in what is important: family dinners, family movie night, art and music. Carl, you were a tremendous source of inspiration. Jan and Carl, thank you both for your support, understanding, and love.

And in blessed memory of Omi, Ilse Riesenfeld, my grandmother and first music teacher. Omi was always demonstrating the power of music to forge strong connections even when differences in language, abilities, communication style, or politics might have seemed insurmountable.
# TABLE OF CONTENTS

LIST OF TABLES AND FIGURES ............................................................................. 8

ABSTRACT ........................................................................................................... 9

1. INTRODUCTION ........................................................................................................ 11
   Purpose of Study .................................................................................................. 15
   Research Questions ............................................................................................. 15
   Researcher’s Identity and Assumptions .............................................................. 16
   Anticipated Contribution ..................................................................................... 17

2. LITERATURE REVIEW .......................................................................................... 18
   Multicultural Guidelines ...................................................................................... 18
   Expressive Therapies .......................................................................................... 19
   Music, Culture, and Identity ............................................................................... 21
   Music and Culture ............................................................................................... 21
   Identity and Creative Arts Therapies .................................................................. 22
   Music Therapy With Specific Populations ......................................................... 24
   Descriptive Studies of Multicultural Music Therapy ......................................... 26
   Guidelines for Specific Populations ................................................................... 28
   Studies Focused on Specific Populations ......................................................... 29
   Student Experiences of Culture ....................................................................... 31
   Education in Multicultural Awareness ............................................................. 33
   Studies of Music Therapists’ Multicultural Knowledge .................................... 37
   Summary ............................................................................................................. 42

3. METHODS ............................................................................................................. 44
   Design ................................................................................................................. 44
   Participants ......................................................................................................... 44
   Survey ................................................................................................................. 46
   Interview .............................................................................................................. 47
   Procedure ............................................................................................................ 48
   Protection of Participants .................................................................................. 48
   Data Analysis ..................................................................................................... 49

4. RESULTS ............................................................................................................. 51
   Quantitative Results .......................................................................................... 52
   Description of Respondents to Survey ............................................................... 52
   Personal Demographics ....................................................................................... 52
   Professional Demographics ............................................................................... 55
   Education and Advanced Training .................................................................. 56
   Data Analysis .................................................................................................... 57
   Question 1: Differences in Attitudes and Skills ............................................. 57
   Question 2: Demographic Comparisons of Scores ........................................ 59
   Question 3: Education ...
Summary of Quantitative Results.................................................................76
Qualitative Results......................................................................................78
Description of Participants ........................................................................78
  Group Description ..................................................................................78
  Individual Participants ...........................................................................79
Interview Questions .....................................................................................81
Themes .........................................................................................................82
  Theme 1: Personal Connection to Conversation ....................................84
  Theme 2: Silenced Minority Experiences .................................................86
  Theme 3: Teaching - Where to start? ......................................................89
  Theme 4: A Master’s Level of Knowledge .................................................94
  Theme 5: A Very White Lens ..................................................................96
  Theme 6: When Does Culture Matter? ....................................................99
  Theme 7: I’m Not Racist! I’m a Good Person .........................................102
  Theme 8: What Do We Know? ...............................................................104
  Theme 9: Toward a More Diverse Profession .......................................108
Summary of Qualitative Results .................................................................109

5. DISCUSSION ..........................................................................................111
  Interpretation of Survey Results .........................................................111
    Demographics ......................................................................................111
    Concept Groups for Attitudes and Skills ..........................................112
    Differences in Cultural Attitudes and Skills .......................................114
    Educator Portion of Survey ...............................................................119
    What Was Present in Individuals’ Education .....................................120
  Relationships Between Survey and Interview Results .......................122
  Interview Results ...................................................................................123
    White Fragility ..................................................................................124
    Structural Competence .....................................................................126
  Limitations ...............................................................................................127
  Future Studies .......................................................................................129
  Recommendations ................................................................................132
  Contribution to Expressive Therapies ..................................................134

APPENDIX A: Survey Instrument ..............................................................135

APPENDIX B: Interview Questions ..........................................................148

APPENDIX C: Internal Review Board Approval .......................................150

APPENDIX D: Initial Email and Informed Consent Forms .......................152

APPENDIX E: Tables and Figures .............................................................156

REFERENCES ............................................................................................163
LIST OF TABLES AND FIGURES

TABLE 1, Personal Demographic Information .................................................. 54
TABLE 2, Professional Demographic Information: Region and Type of Work ........ 55
TABLE 3, Professional Demographic Information: Degrees and Advanced Degrees .. 56
TABLE 4, Means for Cultural Attitudes and Skills Subscale for all Participants ...... 58
TABLE 5, Means and Standard Deviations for Attitudes and Skills by Gender, Ethnicity/Race, Sexual Orientation, and Religion ......................................................... 61
TABLE 6, T-Test Comparison of Attitudes and Skills by Position........................... 63
TABLE 7, Means and Standard Deviations for Cultural Attitudes and Skills Concepts by Highest Level of Education .................................................................................. 65
TABLE 8, Means and Standard Deviations for Cultural Attitudes and Skills Concepts by Most Recent Year of Graduation ............................................................... 66
TABLE 9, Percentage of Courses With Different Types of Learning in Undergraduate and Graduate Programs.......................................................... 68
TABLE 10, Experiences That Expanded Participants Cultural Awareness ............ 69
TABLE 11, Workshops That Expanded Participants Cultural Awareness ............. 69
TABLE 12, Means and Standard Deviations for Perceptions About Education by Type of Courses Taught.............................................................. 74
TABLE 13, Interview Themes ........................................................................ 83
FIGURE E1, Age Range of Participants .............................................................. 157
FIGURE E2, Years in Field of Music Therapy....................................................... 157
TABLE E1, Items in the Cultural Attitudes and Skills Perception Subscales......... 158
TABLE E2, Logistic Regression Predicting Educator Skills and Attitudes .......... 160
TABLE E3, Predictors of Educator Status: Partial Correlation Coefficients .......... 161
TABLE E12, Educators’ Section ...................................................................... 162
Abstract

This mixed-methods study examined music therapists’ experiences with, education regarding, and attitudes about music therapy with people who have multiple intersectional cultural perspectives. In the first phase, a survey created by the researcher was used to gather information about participants’ (n = 474) education, training, attitudes, and skills regarding culture. In the second phase, 7 individuals were interviewed to learn about their experiences regarding multicultural education.

Survey data was analyzed to compare the attitudes/skills of participants. On average, participants were more confident in their ability to work with adults and people with disability than they were in their ability to work with children and adolescents. Participants were least confident in their ability to work with people who are lesbian, gay, bisexual, transgendered, and queer/questioning (LGBTQ), or people whose religion or language was different than their own. Scores on some attitudes and skills differed among participants according to demographic factors: those who identified as bisexual, non-binary gender, a person of color, an educator, or as having graduated in the past 10 years, indicated significantly greater skills and/or cultural awareness on several measures. On all items, scores were higher for those who held a master’s degree than for those who only held a bachelor’s degree.

Qualitative analysis of the interviews revealed participants’ concerns regarding a lack of research about how to teach about cultural perspectives in music therapy; a Eurocentric approach that minimizes, whitewashes, or erases non-White experiences; a question of whether the topic can be adequately addressed in the undergraduate curriculum; and the silencing or marginalizing of minority experiences within the field.
Many participants expressed the need to increase music therapists’ understanding of cultural humility, and to include a greater diversity of voices framing the conversation about diversity and inclusion. One participant’s interview was analyzed with respect to White fragility. Several participants stated that although there is still work to be done, the field of music therapy is moving in the right direction with respect to multicultural orientations. Implications and limitations of this study are discussed and future research is suggested.
CHAPTER 1

Introduction

The United States Census Bureau (Vespa et al., 2018) has projected that beginning in the year 2045, more than half of all Americans will belong to a minority group (a group other than non-Hispanic Whites). The United States is a “nation of immigrants” (Vespa et al., 2018, p. 8), meaning that the majority of Americans can trace at least part of their family history to people who were immigrants from another country. Many Americans do not have to look beyond a few generations to find that immigrant ancestor. Among citizens below the age of 18, the United States may already be a nation in which a majority of citizens belong to a minority group. In 2018, the United States Census Bureau (Vespa et al., 2018) projected that by 2020 a majority of children will be a race other than non-Hispanic White, a trend that is expected to rise so that by 2060 two in three American children will be a race other than non-Hispanic White. The United States is rapidly becoming a more pluralistic country, both racially and ethnically. Furthermore, starting in 2030, net international immigration is projected to become the largest driver of population growth in the United States. Thus, healthcare providers and therapists who work within the United States are very likely to serve clients who have a variety of cultures and worldviews, some of which will be different than that of the provider.

In the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, culture was defined as “the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics” (Department of Health and
Human Services [DHHS], 2013, p. 10). It was further noted that individuals may identify with several intersectional cultures over their lifetimes. In these standards DHHS suggested that ethical healthcare providers should be able to appropriately serve people who identify with different intersecting cultures, and should strive to eliminate the disparities that exist in the health and healthcare status of people according to racial, ethnic, and/or cultural backgrounds. Since these inequities impact both communities and the broader society, DHHS stated that culturally appropriate services are not just an individual concern, they are a public health concern. Thus, serving clients with multiple cultural identities is both a practical business reality, and an ethical imperative, the latter which pertains to social justice (DHHS, 2013).

The presence of multiple cultural identities might suggest an approach of multiculturalism (Ratts & Pedersen, 2014). Multiculturalism was defined by Merriam-Webster ("Multiculturalism", n.d.) as “cultural pluralism or diversity (as within a society, and organization, or an educational institution),” that is, to acknowledge multiculturalism is to acknowledge demographic and cultural differences. The phrase Multicultural competence has been used to describe competent work with culturally diverse clients; however, Hook et al. (2017) noted that use of this phrase has been questioned as it may imply that there is an end point at which a therapist achieves a desired level of competence with culturally diverse clients. Rather, Hook et al. suggested an approach of multicultural humility which encourages therapists to approach each client with an attitude of openess and a continual desire/willingness to learn. These authors positioned multicultural humility within a multicultural orientation which also includes a therapist’s comfort with and desire to learn more about diversity. Hook et al. explained that
**multicultural competence** focuses how to do therapeutic work with diverse clients, whereas a **multicultural orientation** refers to how a therapist thinks about and values diversity.

Ratts and Pedersen (2014) suggested that all **multicultural approaches** encourage the therapist to view each client as existing within a unique socio-political context. **Structural competency** (Metzi & Hansen, 2014) is one such approach that has been discussed by educators in the field of medicine. Metzi and Hansen stated that this approach suggests that clinicians recognize that their own knowledge is a starting point for a conversation to gain greater understanding of the structural factors a client might face. Such structural factors might include access to fresh food or access to healthcare. However, whereas structural competency suggests that clinicians should gain an awareness of a client’s context, a stance of social justice goes beyond that. Ratts and Pedersen (2014) explained that a stance of **social justice** involves not just acknowledging a client’s culture and context, but also seeking to ensure that resources such as high-quality healthcare are equitable and accessible to everyone. From a social justice standpoint, a therapist seeks to understand a client’s communities and contextual/structural factors so that the therapist can then address change on both the individual and systemic/structural levels (Ratts & Pedersen, 2014).

In 1991 Pedersen suggested that multiculturalism is the “fourth force” (p. 6) of psychology. In 1992, Sue et al. published multicultural competencies and standards for the counseling profession. Since that time, the fields of counseling and psychology continued to expand their perspectives regarding culturally appropriate services, clients’ socio-political contexts, and the relationship of those to social justice. In 2014, Ratts and
Pedersen named social justice as the fifth force of counseling/psychology. However, they cautioned that labeling multiculturalism and social justice as the fourth and fifth forces in counseling and psychology should not imply that these approaches will replace or are in competition with psychotherapeutic, cognitive behavioral, humanistic, or existential approaches. Rather, they argued, multiculturalism and social justice must be a part of all counseling approaches. Ratts and Pedersen boldly suggested that professionals who are unable to see the relevance of multiculturalism and social justice in counseling may need to reconsider their commitment to that profession.

Recent guidelines for multicultural competencies have suggested that the therapist should examine the larger context of a person’s culture (American Dance Therapy Association [ADTA], 2009; American Psychological Association [APA], 2017; Gipson, 2015; Talwar, 2015). Expressive therapists and their governing organizations have stated that clinicians have an ethical responsibility to be culturally sensitive to clients’ worldviews (American Art Therapy Association [AATA], 2013; Hadley & Norris, 2016). Lack of such cultural sensitivity can lead to misunderstanding (Hadley & Norris, 2016; Moreno, 1988; Toppozada, 1995) and thus potential harm (Acton, 2001; Hadley, 2013; Ratts & Pedersen, 2014), as well as misdiagnoses and the underutilization of available services (American Psychological Association [APA], 2017). There is an increasing need for therapists, including music therapists, who can responsibly, competently and ethically work with the increasing diversity found within the population of the United States.

The language in the present study reflects a move in the field of music therapy from multicultural competence toward cultural humility and a multicultural orientation. This research was conducted as the field of music therapy was beginning to move away
from the language of multicultural competence. Thus, during the course of this research, some authors and participants wrote or spoke about multicultural competencies, whereas others spoke about multicultural humility, a stance of multicultural responsiveness, and/or a multicultural orientation. These phrases have different implications and are all used herein, with a recognition that they are not interchangeable.

**Purpose of Study**

The purpose of this exploratory study was to gain information about music therapists’ experiences with and attitudes about the concepts of multicultural competence, multicultural orientations, and cultural humility. In particular, the researcher sought to learn about what music therapists have been taught in music therapy curricula regarding culture and identity, where they gained information, what their current attitudes and skills are regarding culture, and educators’ experiences with teaching about culture. In the first phase of this study, information was gathered from 474 music therapists via a national study that was sent by email; in the second phase of this study, 7 participants were interviewed about their experiences with and perspectives on multicultural orientations in music therapy. The researcher sought to describe some of the current practices, knowledge, and experiences in the field of music therapy or music therapy education, with respect to a multicultural orientation and cultural humility.

**Research Questions**

The research questions guiding this study use the language of multicultural competence, as they reflect the researcher’s thoughts at the start of the research. The questions are:

1. What skills and knowledge do music therapists have with respect to culture?
2. How is the perception of the adequacy of a person’s multicultural competency training affected by that person’s worldview?

3. What training regarding multicultural competencies have music therapists and music therapy educators received? From where have they received this training?

4. What are music therapists’ experiences regarding multicultural competence?

**Researcher’s Identity and Assumptions**

As a White middle-class cisgender woman who is employed at a university and pursuing a PhD, I have a great deal of unearned privilege. I work in a field in which nearly 90% of the other professionals are also White, and nearly 90% of the other professionals have the same gender identity as I do (American Music Therapy Association [AMTA], 2018). Because I am White, some White people will listen to me. Thus, one thing I can do with my unearned privilege is question and disrupt the dominant narrative.

As a Jewish woman, and the grand-daughter of immigrants who escaped Germany during the Holocaust, discrimination is part of my family’s historical narrative, and I myself have experienced religious discrimination. I have also witnessed the importance and persistence of culture within my family, and I am keenly aware of how closely music and culture are connected for me and many Jewish people I know.

As someone who identifies as bisexual, I have been marginalized, and at times excluded, by members of both lesbian and straight communities. Now that I am married to a man, I am nearly invisible to the LGBTQ community. I am also the mother of a boy who, as a multi-racial adolescent, is growing up with two parents whose skin color is not
the same as his. I am watching (and trying to help) him create his own intersectional identity as he owns his African ancestry and claims his own culture at a time when it seems to me that the United States is becoming less tolerant of differences.

Two fundamental assumptions of this research were 1) that culture is a crucial element to consider in every interaction, and 2) that music itself is a cultural phenomenon. Thus, it is essential for therapists to take a multicultural orientation and continually learn more about their own and others’ cultures. In this research, I further assumed that during their education and/or in their practice, therapists had considered how culture would affect music and/or the therapeutic process. However, in my literature review, I found that the topics of culture and a multicultural orientation were more fully explored in other fields than in music therapy.

**Anticipated Contribution**

The United States is a nation with multiple intersectional cultural perspectives; music therapists have an ethical responsibility to serve clients who belong to a variety of cultures and hold various worldviews. It is anticipated that an analysis of music therapists’ current attitudes, knowledge, training, practices, and education will contribute to understanding the present status of the field with respect to multicultural orientations. In addition, a greater understanding of how a person’s sociocultural perspective affects their evaluation of their own multicultural training may help the field better understand how to educate music therapists, and may expand understanding of how to attract a greater diversity of therapists and educators.
CHAPTER 2

Literature Review

This review first examines multicultural guidelines that were published by counseling and expressive therapies organizations, including those for music therapy. The links among music, culture, and identity are also explored. Following that, several articles and chapters in the music therapy literature regarding culture and music therapy are reviewed: these report experiences, guidelines, and research regarding the uses of music with specific groups. Education in multicultural awareness relies on studies from other expressive therapies; this literature is also included. Five studies regarding music therapists’ multicultural attitudes and/or knowledge are reviewed; the most recent of which was conducted during the present study. This last set of studies provides the foundation for the present study.

Multicultural Guidelines

Guidelines regarding multicultural competencies continue to build on recommendations for multicultural counseling competencies that were first presented by Sue et al. (1992). Those recommendations suggested that culturally competent counselors are (a) actively learning about their own biases and assumptions, (b) actively learning about the worldviews of their clients, and (c) actively developing interventions that are appropriate for and relevant to their clients (p. 481). Within each of these three areas, Sue et al. suggested that counselors address their own beliefs and attitudes, increase their knowledge, and learn skills. Although these guidelines were written many years ago for counselors and psychologists, the language describing this ongoing process continues to
be relevant when addressing multicultural competencies and multicultural practice in psychology and the creative arts therapies.

In 2017, the American Psychological Association (APA) adopted a new set of multicultural guidelines that focused on intersectionality and the contextual aspects of identity. These guidelines gave a framework for providing multiculturally competent services, where multiculturally competent was understood to include both cultural humility and lifelong learning. APA additionally suggested a broad understanding of the term multicultural, acknowledging “intersectionality among and between reference group identities, including culture, language, gender, race, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables” (p. 8). The guidelines emphasized a stance of responsiveness to each person’s unique identity and cultural background; a stance which requires appreciating, understanding, and learning about the multicultural background of each person and their greater community. Furthermore, therapists should aspire to understand the interlocking systemic structures of power, privilege, and oppression that do exist and have existed in our society (APA, 2017).

**Expressive Therapies**

Art therapy (AT), dance/movement therapy (DMT), drama therapy (DT), and music therapy (MT) all published guidelines or standards for multicultural competence. Sajnani et al. (2015) wrote guidelines on cultural response/ability for the North American Drama Therapy Association (NADTA); these guidelines on cultural response/ability were published as a supplement to the NADTA Code of Ethics. The NADTA guidelines state that a core value of the organization is a commitment to championing the diversity and
dignity of its members and clients. Sajnani et al. introduced the concept of cultural
response/ability: a responsive and responsible stance of cultural humility that includes
continuous learning, self-reflection, and assessment of power dynamics in research,
practice, education, and advocacy.

Both the American Dance Therapy Association (ADTA, 2015) and the American
Art Therapy Association (AATA, 2013) include multicultural competency in their codes
of ethics; both describe that this requires continuous development of awareness and
knowledge about culture and diversity, and the use of those skills with their clients. The
ADTA also addresses cultural competency explicitly in their educational standards,
highlighting the impact of racial, cultural, and gender identity on one’s interactions. The
Code of Ethics for DMT is the only one that explicitly espoused a stance of social justice,
stating that DMT therapists should promote social justice with a recognition that this
contributes to the health of the individual, family, and community (ADTA, 2015).

The AMTA (2013) Professional Competencies are based on knowledge, skill, and
abilities. These suggest that in order to satisfy multicultural competencies, the therapist
will select and implement culturally appropriate assessment, have a repertoire of music
for culture and stylistic differences, and have skill with diverse populations. In addition,
the therapist will treat all persons with respect. In 2019, AMTA published an aspirational
Code of Ethics which states that a music therapist’s professional values should include
social responsibility; dignity and respect; and equality. The Code of Ethics further affirms
the dignity and rights of all, stating that the music therapist will act with compassion, and
therefore be aware and accepting of the client’s individual and cultural differences.
Unlike the fields of drama therapy and art therapy, music therapy does not have a specific set of multicultural guidelines.

These codes and guidelines each define what one field is striving to provide. Nonetheless, Chang (2016) suggested that colorblind racism and defensive attitudes are still pervasive in the field of DMT. Chang suggested that graduate DMT programs must continue to improve cultural competency in both syllabi and supervision, so that future therapists can practice with a greater awareness of the effects of culture on the individual and collective levels. Talwar (2015) gave similar warnings for art therapists, suggesting that the field still requires increased attention to the recruitment and retention of students of color and the recognition of intersectional identities. Furthermore, Talwar (2015) and Gipson (2015) both offer a strong caution that cultural competency frameworks often replicate the very arrangements that they intend to dismantle unless they are accompanied by a social justice framework.

These guidelines from the expressive therapies, counseling, and psychology all suggested that multicultural practice is ethical practice. In music therapy, such practice requires attention to music, multiple cultures, and the identities of both the therapist and client.

Music, Culture, and Identity

Music and Culture

In 1988, Moreno suggested music is a multicultural phenomenon that reflects and expresses multiple unique cultural traditions. At that time, he argued that music therapists must have a basic working knowledge of a variety of world music traditions and genres. However, therapists must recognize and understand the function of music from various
cultures, since a lack of such understanding or stereotypes of what type of music should be used based on ethnic and cultural backgrounds could lead to incorrect assumptions or disrespectful use of music (Hadley & Norris, 2016; Moreno, 1988; Toppozada, 1995).

Hadley and Norris (2016) suggested that culture impacts not only musical interactions, but all interactions between two people, since all people bring their own cultural context to every encounter with another. Thus, they suggest, all music therapists are multicultural therapists. They echoed other music therapists (Shapiro, 2005; Young, 2016) in emphasizing that being respectful and skillful when working with people from cultures different from one’s own requires much more than learning songs in different languages, studying traditional instruments, or studying different music cultures. Hadley and Norris (2016) suggested that therapists must also learn how music is understood by each client, and how that client formed his or her musical identity. This often requires that therapists step outside of an ethnocentric and Eurocentric approach to their use of music and therapy, seeking to understand not only the music, but also the role of music, ritual, and symbols in other cultures. Hadley and Norris further suggested that therapists need to recognize that the notion of therapy itself has grown out of Western patriarchal ideology. They recommend a multicultural counseling theoretical framework for music therapy, explaining that this approach acknowledges that each person has their own sociocultural context influencing who that person is in the world.

Identity and Creative Arts Therapies

According to the AMTA's (2018) workforce analysis, more than 88% of music therapists are White/Caucasian/European. This does not say everything about who those people are in the world, but their race and ethnicity are likely to affect their cultural
context. This context is based not only on identity, but also by dominant narratives—those stories that are told by the dominant culture about who one is and about what is normal (Hadley, 2013). Hadley explained that although people constantly create narratives about who they are and who others are, dominant narratives can become oppressive, especially when they give a flattened description of a person or create a prescribed narrative about what is normal or healthy. If therapists are not examining and questioning their own and others’ narratives, the therapists will (intentionally or unknowingly) reinforce the dominant narratives, thus disempowering and oppressing various groups of people. Hadley challenged educators of creative arts therapists to examine their pedagogy to ensure that their curricula are inclusive of non-dominant narratives. Young (2016) noted that increasing awareness of one’s own narratives, culture, and privilege must be a life-long endeavor for both educators and therapists.

In the United States, race is related to privilege. DiAngelo (2018) suggested that most White people in North America find it hard to talk about race; in an attempt to maintain their own story of not being racist, they have learned how to deflect and avoid conversations about race. This is due, in part, to the misconception that racism is a single event done by a bad person, when in fact, DiAngelo argues, racism is a whole system that White people benefit from. This misconception leads to an internal good/bad dichotomy: if it is suggested that a person did or said something that was racist, that person is likely to hear an accusation that they are bad and immoral. White fragility (DiAngelo, 2018) is a reaction to this perceived accusation, in the form of defensiveness, argumentation, indignation, anger, and/or guilt. White fragility thus shuts down that conversation in
particular and cross-racial dialog in general, while protecting racial inequality (DiAngelo, 2018).

Johnson (2006) explained that racism involves patterns of privilege and oppression, along with both intentional and unintentional actions or systems that create or perpetuate the patterns of privilege and oppression. One such action, whether intentional or unintentional, is the denial or minimization of the effects of power and oppression by people who have unearned privilege. DiAngelo (2018) named this pattern of denial with respect to race; Johnson (2006) further suggested that such denial occurs with regard to race, gender, ability, and any other marker of difference that might privilege one group over another. The unintentional nature of this is precisely why ethical multicultural practice must include therapists’ engagement in life-long learning and vigilance (Hadley, 2013; Young, 2016).

**Music Therapy With Specific Populations**

When Sue et al. (1992) wrote about multicultural counseling competencies, they suggested that counselors should increase their knowledge of and skills with people who have various cultural backgrounds. Hadley and Norris (2016) maintain that for music therapists these knowledge and skills must include not only counseling skills, but also an understanding of culturally appropriate music and the ability to provide musically relevant strategies and/or interventions. Multicultural competence cannot be achieved as a single destination, rather it will differ with each case, each client, each relationship, and within each “social-political-cultural-musical context” (Young, 2016, p. 127). As therapists seek to expand their own socially and culturally constructed tastes and
assumptions, every published study and shared experience will support a move toward increased multicultural awareness (Young, 2016).

Several music therapists have written about their experiences with clients whose culture and/or music cultures were different from the therapist’s (Behrens, 2012; Mondanaro, 2016; Shapiro, 2005; Viega, 2016; Yehuda, 2002). Others provided guidelines and suggestions for music therapy practice with specific groups: Mexican-American children (Rilinger, 2011) and LGBTQ clients (Whitehead-Pleaux et al., 2012). In addition, there has been research regarding the uses of music with specific groups: Darrow and Loomis (1999) examined media portrayals of students who are deaf; Froman (2009) surveyed music therapists who work with Jewish clients; Werner et al. (2009) studied differences in responses to music among African American, Asian American, and White students; and Bradt et al. (2016) examined the use of a particular music therapy protocol with African American clients. In addition, several studies have been published about the experiences of international students in the United States (Hsiao, 2011; Kim, 2011; Swamy, 2011) and of American students studying abroad (Keith, 2017). This literature is described in more detail below, serving to reinforce the notion that there are many different cultural factors that influence (or should influence) the practice of music therapy.

1 This document uses “Black” to refer to people of African ancestry unless replicating the term “African American” as used by a participant or other researcher. Similarly, “White” is used to refer to people of European ancestry unless replicating the term “Caucasian” as used by a participant or other researcher.
Descriptive Studies of Multicultural Music Therapy

Recent publications have included descriptive accounts by therapists who are working with several different cultures within a single setting. Shapiro (2005) presented one example of work with older adults in which he musically reflected important parts of clients’ identities and musical cultures. He additionally described how he conducted a drumming group at a shelter with men who had been born in Europe, South America, the Middle East, Asia, and the United States, claiming that in music the men could work together and contact each other while maintaining separate cultural identities. He also has intentionally used music from various cultures to help people move out of their own “musical comfort zone” (p. 31), perhaps aiding them to adjust to the diversity present in their living situations. He emphasized that in order to provide effective therapy it is essential to address the multiple cultural aspects of music therapy.

In presenting five case studies from his work as a music therapist in a New York City hospital, Mondanaro (2016) also emphasized the importance of recognizing clients’ cultures. Mondanaro presented vignettes of patients who were Romani, Orthodox Jewish, Haitian / African American, Chinese, and Latino; he emphasized that affirming a client’s cultural identity can optimize the client’s coping strategies, and thus enhance health. He noted that knowledge of the music and styles from clients’ cultures is not sufficient; music therapists also need knowledge of the social and cultural norms of those cultures.

Studies conducted by therapists outside of the United States also gave a valuable perspective on working with multiple cultures in a single setting. Yehuda (2002) and Behrens (2012) both wrote about finding a middle ground between two different musical languages. Yehuda practiced music therapy in Israel, working with Jews of a wide range
of observance, Arabs, and immigrants from all over the world. Seeking to investigate the difficulties of musicians and music therapists who are trying to speak a musical language other than the ones they learned at an early age, she interviewed music therapists and musicians who were playing, performing, or composing music that originated in a culture other than their own. Yehuda noted that both musicians and therapists found it difficult if not impossible to learn all the subtleties of a musical language if they had not been exposed to that language at an early age; yet the therapists asserted that it was important to use a client’s own music language. Yehuda found that clients and therapists sought commonalities of what was expressed in the music, and often met in the musical middle, with each client and therapist bringing their own musical heritage to the encounter.

Behrens (2012) discussed her experiences and use of instruments when working with children in the occupied Palestinian West Bank, noting that there is little written about what music therapists consider when they select instruments to use with clients from other cultures. When Behrens attempted to gather traditional Palestinian instruments, she encountered several obstacles, including difficulty in obtaining and learning the oud [string instrument], and difficulties in learning the traditional maqams [melodic modes or scales] used in Palestinian music. Behrens therefore created a “third space” (p. 198) between her clients’ Arabic styles and her own Western styles of music, based on the similarities in the music and several Arabic drumming patterns that she learned. This third space is similar to the musical middle that was described by Yehuda (2002).
Guidelines for Specific Populations

Thoughtful and respectful use of music requires knowledge of different cultures’ music and the appropriate uses of music without reliance on formulae or stereotypes (Shapiro, 2005). In Whitehead-Pleaux and Tan’s (2017) edited book about cultural intersections in music therapy, they presented many themes with respect to culture, including both the worldviews and the meaning / function of music for non-dominant populations. This edited volume includes experiences of music therapists’ own cultures of heritage (Hispanic / Latino, East & Southeast Asian, South Asian American Diaspora, Arab/Middle Eastern, African American, Native American / First Peoples, and multi-ethnic), religion (Muslim and Jewish), sexual orientation, gender, disability, and survivorship. In addition to guidelines, the chapters offer a rich resource for building the knowledge of social and cultural norms of various identities, knowledge that Mondanaro (2016) stated is essential for each therapist to build.

Focusing on a culture based on common heritage within the United States, Rilinger (2011) presented an overview of issues about which a music therapist should be aware in order to practice music therapy with Mexican-American children. Acknowledging that Mexican culture comprises a diverse set of traditions that could not be described or explained in a single article, Rilinger described the implications of several features associated with Mexican-American cultures. In addition, Rilinger noted culturally based uses of music and listed popular songs and artists, thus providing a useful resource to the therapist wanting to learn more about working with this population.

Mexican-American culture is based on a common heritage, but other cultures are formed through identification with groups that are not based on heritage, ethnicity, or
race. The LGBTQ community is one such group. The AMTA (2019) Code of Ethics and Standards of Professional Practice recommends a non-biased approach to working with LGBTQ individuals and their families, but does not address best practices. In 2012, Whitehead-Pleaux et al. conducted a review of LGBTQ best practices in other fields; the result is recommendations of how to serve this population with regard to assessment, support, treatment, research, community outreach, work environment, policies, training, supervision, and teaching. The authors gave a reminder that LGBTQ individuals come from all cultures: an individual’s age, race, ethnicity, religion, region in the United States, and identity with other cultures must all be considered as components of their intersectional identity.

**Studies Focused on Specific Populations**

Studies that are focused on specific populations provide music therapists with valuable knowledge of what might be considered regarding ethnicity or culture when working with people who identify with a particular population. The following studies emphasize that, although individuals respond to music differently, music is often culturally based or embedded.

The experience of listening to music was the focus of a study by Werner et al. (2009), who surveyed African American, Asian American, and White students at two different colleges. They examined the differences in self-reported experiences of music and of depression, finding statistically significant differences among groups. Several scales indicated differences among the groups in commitment to and reactions to music: Commitment to Music \( (p < .05) \), Affective Reactions \( (p < .001) \), Positive Psychotropic Effects \( (p < .01) \), Reactive Musical Behavior \( (p < .001) \), and Depression \( (p < .01) \).
Although the study examined college students who may have felt coerced to participate in a study for which they received extra credit for participation, the study emphasized the need for music therapists to acknowledge and understand that there may be a cultural basis to or reasons for clients’ differing responses to music.

While the study by Werner et al. (2009) examined a listening experience by comparing the effects among different populations, Bradt et al. (2016) studied the use of a vocal music therapy treatment with African American participants. The typical research for pain management has focused on listening to pre-recorded music, however the authors suggested that an intervention in which the participants are actively engaging in vocal music might be particularly appropriate for African American participants. The researchers found that the vocal music therapy protocol had a moderate treatment effect on pain interference and a large effect on self-efficacy. No conclusions could be drawn about the efficacy of this intervention in contrast to other music interventions for a similar demographic, and it is not clear if the intervention is more relevant to African Americans than it might be to other participants. Nonetheless, it is noteworthy that this study is one of very few studies that have investigated treatment for a single minority group.

Froman (2009) sought to describe the Jewish population served by music therapists and the practices employed for that population. She explained the importance of understanding cultural uses of music, giving an example of a case where the inappropriate use of music caused trauma for a client. In describing the diverse demographics of the Jewish population in the United States, Froman emphasized that individual definitions of “Jewish” may vary for each individual, and that there is not just
one specific Jewish music. Froman surveyed a sample of 38 credentialed music therapists who identified themselves as working with people of a Jewish background or Jewish religion. The majority of participants did not claim a personal connection to Judaism, and some who did identify as Jewish did not consider their background to be a source of knowledge about Judaism. A majority of therapists surveyed (54.1%) thought that a client’s Jewish background did impact the therapy process, and almost all of the respondents (94.7%) reported that they used music affiliated with Jewish religion or culture. Froman found that music therapists learned information through one or more sources: 89.5% learned information through Jewish friends/colleagues, 65.8% learned information from their clients, and 47.4% learned through reading books or finding information on the Internet. However only 7.9% had learned any information about Jewish clients or Jewish music from college courses. A majority of participants (69%) reported that their own lack of familiarity was a challenge to providing quality care to clients with strong Jewish affiliation. Participants also noted the importance of understanding which music can be used in a non-religious context.

**Student Experiences of Culture**

Students who are studying in a new country often find themselves to be a minority in their classroom, resulting in a unique perspective of the ways that cultural considerations impact music therapy. Hsiao (2011) focused on the transition for music therapy students who were returning to their home country in Asia after studying in the United States, noting that these students were hoping to re-integrate into a culture that may not be receptive to their new knowledge or their experiences. She recommended that music therapy programs include preparation for international students’ career planning
and return to their home country. Hsiao (2011) also suggested that the content of multicultural competencies should go beyond introducing different cultures and diverse music to “place diversity issues within a global context and to analyze the intersections of social categories across cultural, economic, social, and political institutions” (p. 437).

Examining international students’ learning from a different perspective, Keith (2017) studied the experiences of 8 American music therapy students who enrolled in a study-abroad course that took place in Germany. After interviewing the students and comparing this with coursework from the students, he concluded that the students gained awareness of their own culture and own definitions of music therapy because they were immersed in a culture that was different. Keith suggested that the experience was valuable in helping the students recognize themselves as culturally situated beings. This is a task that has been recommended as an important step in gaining cross-cultural skills (Hadley & Norris, 2016; Keith, 2017).

Addressing the ways that cultural differences may affect the relationship between student and supervisor, Swamy (2011) presented a culturally centered approach to supervision with a first-year music therapy student who was from Taiwan and studying in the United States. Swamy’s approach to supervision drew on a framework for supervising international students created by Nilsson (2004): the guidelines suggested assessing the student’s level of acculturation, addressing cultural differences, and fostering a relationship that supports a working partnership with explicit expectations. Swamy suggested that effective culturally centered supervision should acknowledge the cultural differences that are present and build on the strengths of the person being supervised. She also emphasized the importance of noting the student’s culturally based wisdom and
knowledge, rather than suggesting that a student’s cultural differences are a sign of pathology.

The above literature represents only a few of the relationships and cultural encounters a music therapist might encounter during practice in the United States, but it does provide a starting place for gaining the types of skills and knowledge that Sue et al. (1992) suggested are needed to gain cross-cultural skills. The recent increase in the volume of literature about cross-cultural music therapy may represent an increased understanding of the need for such information. Nonetheless, the field of music therapy has only begun to examine best practices in multicultural work. It is not clear how, or if, this material is being taught to future music therapists.

**Education in Multicultural Awareness**

Music therapy education in the United States should include multicultural competence training since this education is preparing therapists to work and live in a country that is increasingly diverse (Hadley & Norris, 2016). Failing to provide such training may result in therapists providing ineffective services, which becomes an ethical issue, as a misunderstanding about culture can lead a therapist to do harm despite the best intentions (APA, 2017; Doby-Copeland, 2006; Toppozada, 1995).

The training and education for music therapy is competence based (AMTA, 2013). Questions of how educators teach specific AMTA competencies have led to studies on teaching improvisation (Erkkilä, 2000; Gardstrom, 2001; Hiller, 2009), percussion skills (Knight & Matney, 2012, 2014; Scheffel & Matney, 2014), guitar skills (Gregory & Belgrave, 2009; Silverman, 2011), and technology skills (Crowe & Rio, 2004). Several studies have additionally focused on students’ experiences in practicums
and supervision (Abbott, 2015; Bae, 2012; Barry & O'Callaghan, 2008; Wheeler & Williams, 2012). However, no studies were found about pedagogy for, or the effectiveness of, teaching multicultural competencies in music therapy curricula. Indeed, it is not clear how these competencies are being approached in various music therapy curricula across the country.

Although no literature was found regarding this pedagogy in music therapy, one article (George et al., 2005) discussed the pedagogical tool of reflective writing as experienced by one art therapy professor and two students. George et al. found that although discussions existed regarding cultural competence in the context of therapist-client interactions, few could be found regarding cultural competence in a pedagogical framework or within the context of preparing students to work with culturally diverse people. The authors shared their experiences with reflective journaling as a pedagogical tool for exploring their own intersectional identities and their own privilege. They did not analyze the journals, but did note similarities present in all three. All three authors found that self-reflective narrative was a useful tool to facilitate self-discovery, noting that a key component in promoting increased cultural competence is to create a safe environment in the classroom for students to explore their cultural selves. This presentation of self-reflective writing was one of very few discussions about multicultural pedagogy in the expressive therapies.

In the field of DMT, Hervey and Stuart (2012) investigated how educational programs were meeting the multicultural standards of the ADTA. They interviewed a total of 10 instructors and/or administrators, thus interviewing at least one person from each of all six ADTA-approved DMT programs. The authors also looked at course syllabi
They reported that five of the six DMT programs had at least one discrete course designed to address multicultural competencies exclusively, while the sixth program addressed multicultural issues in a course that also addressed ethics.

All of the programs that Hervey and Stuart surveyed offered these courses early in the curriculum so the students’ awareness of multicultural issues could be developed at an early stage in their studies. Respondents reported having seen profound shifts in student self-awareness, while also having had challenges with teaching this material to students. Challenges common to all respondents included: students’ limited awareness of their own culture, values, biases, and privilege; students’ limited exposure to diverse cultures; and both students and instructors experiencing the topic as potentially volatile. In addition, many respondents to Hervey and Stuart’s survey asked a question that was echoed by other creative arts therapists (George et al., 2005; Talwar et al., 2011): How can instructors teach about cultures if they themselves have limited exposure to those cultures?

Hervey and Stuart (2012) found that the instructors used a wide variety of pedagogical methods, and they found little similarity across the courses at different schools. They suggested that this reflected the fact that there are different ways of approaching multicultural issues in DMT depending on the worldview and skills of the person teaching the course. The authors concluded that further multicultural and diversity training is needed for all DMT faculty, whether the faculty are teaching about these issues or not. They also noted that the competence of the faculty and students was not being formally assessed. In addition, the authors suggested that the diversity of the faculty and student body should be increased so that the field is better equipped to discuss
these issues and to support clients of diverse backgrounds. This study was the only recent study of educational programs in the expressive therapies.

In 2012, the same year as Hervey and Stuart’s study, Carmichael interviewed 4 dance/movement therapists who had each practiced for more than 10 years, hoping to understand the approach of and skills used by dance/movement therapists with respect to multicultural diversity. The dance/movement therapists shared that their multicultural diversity training was obtained by working in the field and actively educating oneself about a population, self-study and a commitment to exploring one’s own identity with the recognition that any learning about the client is done through the lens of oneself, and actively seeking conference presentations and education about diversity or specific populations. Participants also noted a bias toward Eurocentric movement in the assessment, therapeutic models, and education in the field of DMT.

Both music therapists and art therapists have asked whether educators are reaching a student body that is representative of today’s diverse and multicultural population (Ahessy, 2011; Awais & Yali, 2015; Shapiro, 2005). In 2018, 88.4% of current music therapists were White/Caucasian/European and 87.14% were female (AMTA, 2018a). As music therapists increasingly look toward evidence-based methods and best practices in therapy, there is some literature about best practices for working with diverse cultural populations (Froman, 2009; Rilinger, 2011; Whitehead-Pleaux et al., 2012, Whitehead-Pleaux & Tan, 2017). However, there is very little literature about best practices for teaching music therapists about these populations or teaching about multicultural awareness in music therapy. It is not clear how (or if) undergraduate programs are preparing music therapy students to work with diverse populations.
Studies of Music Therapists’ Multicultural Knowledge

Knowledge is one of the foundations of the AMTA (2013) competencies. However, since 1995, five studies have examined music therapists’ multicultural knowledge. These have focused on music therapists’ knowledge and attitudes (Toppozada, 1995); education (Darrow & Molloy, 1998; Gombert, 2017); cross-cultural empathy (Valentino, 2006); and competence (Whitehead-Pleaux et al., 2019) regarding multicultural issues. These studies form the rationale for the present survey; however, it should be noted that three of them are more than 20 years old (Toppozada, 1995; Darrow & Molloy, 1998; Valentino, 2006) and one was conducted during the time that the present study was underway (Whitehead-Pleaux et al., 2019).

Toppozada (1995) sought to determine whether there was a need to increase multicultural training for music therapists and, if so, in what areas. She surveyed 298 participants who ranged in age from 22 to 72 years and were described as: 82.9% women, 91% White, 4% Black, 2% Latino, and 2% Asian/Pacific Islander. Fifty percent of participants held a bachelor’s degree and 36% held a master’s degree; the remaining 14% held a doctorate or other advanced degree. Toppozada combined two existing scales (the California Ethnocentrism Scale and the Black Ethnocentrism Scale) to create a survey that included 22 statements, which participants rated on a 7-point Likert scale according to their agreement with each statement. Higher scores indicated greater knowledge and less ethnocentric attitudes. Toppozada tested for internal validity of the instrument by using the Spearman rank-order correlations technique, finding that all item scores were significantly correlated with the total score ($p < .001$). She examined differences in response according to demographic variables such as age, gender, ethnicity, level of
education, and geographical location. Participants from the New England region scored significantly higher than those from the South Central geographic region, and participants who held a PhD scored significantly higher than those with a bachelor’s degree \( (p < .05) \). Other differences in scores were not statically significant, indicating that those respondents had similar attitudes and knowledge sets about culture. Toppozada found that many participants received multicultural training as professionals, but few did as students. More than 78% of respondents in her research supported multicultural training for students, and 86.9% agreed that culture should be taken into consideration during music therapy.

In 1995, Toppozada wrote, “Given the resurgence of overt racism and hate crimes evident in media reports, multicultural education must be seen not just as important but as imperative” (p. 85). At the time of the present study, more than 20 years later, there has been a resurgence of White nationalism (Potok, 2017). The Southern Poverty Law Center (Beirich, 2019) reported a 30% increase in American hate groups from 2014 to 2018, and the Anti-Defamation League (2019) reported that FBI statistics show a corresponding increase of hate crimes. Perhaps these statistics indicate that multicultural education is even more imperative than it was in 1995. Despite music therapists’ understanding of the importance of culture in a therapeutic setting, the responses in Toppozada’s study indicated a lack of agreement of how to educate music therapists about culture. She suggested that music therapy programs across the country should be examined in order to further understand music therapists’ multicultural training.

Darrow and Molloy (1998) explained that Toppozada’s (1995) suggestion for further research influenced their study, in which they sought to examine the training and
experiences of music therapists with respect to multicultural issues. Darrow and Molloy used a questionnaire they developed based on their review of the literature, their own experience, and a questionnaire used by the Canadian Association for Music Therapy for a similar purpose. Of the music therapists surveyed ($N = 219$), most (68.1%) felt that coursework in multicultural music therapy was necessary, while some (12.9%) felt that their own training had been somewhat adequate. No respondents reported that their training had been very adequate. Indeed, most respondents to the survey (75%) indicated that their knowledge of multicultural issues was gained through experience rather than coursework. The authors concluded that more training was needed in music therapy programs.

There were no other studies regarding this topic until 2006, when Valentino examined the relationship between a therapist’s training and cross-cultural empathy; a construct that would be most closely related to cultural humility in the literature reviewed herein. Valentino explained that cross-cultural empathy requires that therapists understand their own culture, be aware of the client’s culture, and understand the role of music in the client’s culture. Valentino surveyed 78 music therapists from Australia ($n = 45$) and the United States ($n = 33$); each participant completed a survey that was developed by the researcher and had questions to measure cross-cultural empathy, social desirability, and training. Although the cross-cultural empathy scores were high for all participants, the music therapists who had received training in cross-cultural theory ($n = 38$; 49%) scored significantly higher on the cross-cultural empathy scale than those who had not ($n = 36$; 46%), regardless of clinical experience, country of residence, or degree level. Although the study measured the participants’ own definitions of cross-cultural
training and the participants’ self-report on measures of cross-cultural empathy, results indicated that cross-cultural empathy might be a learned skill (Valentino, 2006). This study adds to the call for increased multicultural training.

While the present study was being conducted, Whitehead-Pleaux et al. (2019) surveyed the cultural competence of music therapists in the United States. Their survey included demographic questions, as well as the Multicultural Counseling Inventory (MCI) and the California Brief Multicultural Competence Scale (CBMCS): two scales that were similar to those used by Toppozada (1995). These each contained sub-scales measuring cultural knowledge, sensitivity, awareness, and skills. The authors presented each score as a percentage of the total possible for that sub-scale; in each case 100% indicated the highest level attainable on that sub-scale. The median scores for the sub-scales were between 70% and 83%; the range of scores was from 20% to 100%. This indicated that participants had from 20% to 100% of the cultural knowledge, sensitivity, awareness, and skills measured by the scales; higher scores indicated greater competence.

Whitehead-Pleaux et al. (2019) found that the non-White respondents had significantly higher scores than the White respondents on two items: the CBMCS item for cultural knowledge and the MCI item for multicultural awareness. The non-heterosexual respondents scored significantly higher than the heterosexual respondents on four items: the CBMCS items of cultural knowledge, cultural awareness, and non-ethnic skill; and the MCI item of multicultural counseling skills. They also found that groups of respondents with master’s degrees and doctoral degrees scored significantly higher than respondents with bachelor’s degrees on several items: the CBMCS item of cultural knowledge, and the MCI items of multicultural awareness and multicultural
counseling knowledge. Significant differences were also found between respondents from some of the AMTA regions: respondents from the Midwest region scored significantly lower than respondents from the Mid-Atlantic or New England regions.

Music therapists serve a diverse set of clients. It is therefore concerning that music therapists did not indicate strong cultural competence on these scales overall: some participants’ scores were as low as 20% competence in cultural knowledge and 25% on non-ethnic skills (Whitehead-Pleaux et al., 2019). However, Whitehead-Pleaux et al. found significantly higher scores among music therapists who identified as belonging to marginalized populations within the United States or the field of music therapy. They also found that cultural competence rose with higher levels of education: music therapists who hold master’s or doctoral degrees scored significantly higher on some scales than those with a bachelor’s degrees.

Whitehead-Pleaux et al. (2019) suggested an overhaul of the educational system for music therapists and continuing education courses available for music therapists. Their recommendations for future research included suggestions to examine: music therapists’ implicit bias, the lack of cultural diversity among music therapists, and ways to increase fidelity within cultural competence education for students and professionals. They also suggested that music therapy policy be changed to include a cultural competence requirement for recertification, and that music therapy education be modified to include standards for cultural humility and for teaching a wider variety of genres of music. Whitehead-Pleaux et al. conducted their research during the same time frame as the present research was starting; their study addressed similar issues and had complimentary findings as this research.
In a pilot study, Gombert (2017) interviewed 3 educators and 3 recent graduates of undergraduate music therapy programs to learn how multicultural competencies were being addressed in some undergraduate music therapy programs. The interviews of educators investigated how those educators were addressing multicultural competencies, and what those educators understood “multicultural competence” to mean. The interviews of recent graduates investigated what each of them learned with respect to multicultural competencies, whether or not what they had learned was useful or helpful, and what they think should have been taught or otherwise addressed in the undergraduate curriculum. Gombert (2017) found no standard approach shared by the three educators or experienced by the recent graduates. This was similar to other findings of a lack of agreement pedagogy for multicultural education in the expressive therapies (Hervey & Stuart, 2012; Toppozada, 1995).

Analysis of the interviews also revealed possible differences in the perception of how culture was taught. One recent White graduate described that culture was “woven into everything,” while a Black graduate reported that culture was discussed for “one hot second” during her undergraduate education. This raised the question of whether non-White students perceive problems in the coverage of culture that White students are not aware of because non-White students are more aware of the complexity of the issue. The study raised similar questions about the ways in which the demographic of a professor affects their pedagogy.

**Summary**

Several music therapists (Hadley & Norris, 2016; Toppozada, 1995; Young, 2016) have suggested that there is a need for multicultural competency training for music
therapists. Although music therapists have reported on their use of music therapy with non-dominant or diverse populations within the United States, to date the field of music therapy does not have a clear mandate for what multicultural training should include or how it should be taught. While other creative arts therapies have begun to research the effectiveness of multicultural training for their therapists, the research that has been published about music therapy education has not examined how multicultural awareness and skills are addressed in music therapy education. In addition, at the time that the present study started, there had been no measure of the present cultural competence of music therapists. Given these gaps in the literature, the current study aimed to learn about music therapists’ training, their skills and knowledge, and how their perceptions of cultural humility are affected by their worldview.
CHAPTER 3

Methods

Design

This study examined the skills, knowledge, training, and experiences of music therapists with respect to culture. A mixed methods design was used to accomplish this. Creswell (2009) described a “sequential explanatory strategy” (p. 211) in which the first phase of research involves collecting and then analyzing quantitative data. The second phase of such a design is an explanatory qualitative phase, intended to explain or further interpret the results of the first phase. This sequential design was chosen because the literature review revealed very few recent studies about the education, attitudes, and skills of music therapists regarding multicultural music therapy. The exploratory quantitative data served as a foundation of information to guide the interview questions. In the present study, the results of the quantitative and qualitative phases were compared, and connections between the two were presented in the discussion section.

Participants

The only inclusion criterion for this study was that a potential participant must be over the age of 18 and hold a music therapy designation or credential. Participants for the survey portion of this study were recruited via an email list purchased by the researcher from the Certification Board of Music Therapists (CBMT). This list of 7,416 addresses included board certified music therapists who had opted to receive emails. The survey invitation was sent to everyone on the list in order to maximize participation; 64 were returned as being undeliverable. Of those 7,352 people who received an email, 538 responded by starting the survey. Six of those respondents declined to participate after
reading the informed consent in the survey; 58 people either did not complete or did not submit the survey. Thus, 474 surveys were completed, resulting in a response rate of 7.3%, and a completion rate of 88.1%. According to AMTA (n.d.), there were over 8000 board-certified music therapists at that time. A power analysis indicated that in order to achieve a 95% confidence level with a 5% margin of error, an ideal sample size for 8000 therapists is 370 (Qualtrics, 2019). The number of respondents exceeded this number.

Participants in the interview portion of the study were chosen from those who had completed the survey. At the end the survey, respondents were asked whether they would be willing to be interviewed by the researcher at a later date. If they answered “no,” the survey simply ended; if they answered “yes,” the survey ended and the participants were taken to a new form. There they were asked for their name and email, as well as brief professional and personal demographic information. In order to maintain confidentiality of the survey, the interview information was stored in a separate database that could not be linked to the survey. The number of participants who volunteered to be contacted for interviews was 263.

The 7 participants chosen for the interviews were a purposive sample of participants from a variety of demographic groups. The researcher used the information that the potential participants shared to determine demographic groupings. This sample was chosen so that a variety of experiences could be shared; however, not all demographic groups are represented in the interviews, nor are various groups represented equally. Additionally, the voice of any one participant should not be understood to represent the experiences of others who identify similarly. A description of the participants can be found in the Qualitative Results section.
Survey

The researcher created the survey used in this study, which is attached in Appendix A. The first section of the survey consisted of ten demographics questions about the participant’s age, populations worked with, what state the participant lived in, race, religion, gender, and sexual orientation. A large amount of demographic information was gathered so that the researcher could examine correlations between participants’ identification(s) with one or more minority groups and their answers on other parts of the survey.

The second section included 43 statements with which participants indicated agreement or disagreement using a Likert-type scale. These focused on the therapist’s attitudes, knowledge, and skills with respect to culture and cultural diversity; the section was largely based on other surveys as described herein. Toppozada (1995) used a survey to examine music therapists’ attitudes and knowledge about multicultural issues. Some of these survey items are used verbatim in this study, with the permission of the author. In addition, the researcher adapted questions from a survey that was designed to measure cultural competence among rehabilitation practitioners (Suarez-Balcazar et al., 2011), questions from the Australian Racism, Acceptance, and Cultural-Ethnocentrism Scale (Grigg & Manderson, 2016), a cultural-ethnocentrism scale that was designed specifically for use in Australia, and questions from the California Brief Multicultural Competence Scale (Gamst et al., 2004), a scale that was designed to examine psychologists’ preparedness to work with culturally diverse populations. The researcher also gained permission from the primary author of guidelines for best practices for LGBTQ clientele.
(Whitehead-Pleaux et al., 2012) to use ideas from a related survey designed by those authors and others.

The third section of the survey asked about a participant’s education. The same six questions were asked for each music therapy degree a participant had completed or was working on at the time of the survey (bachelor’s or equivalency, master’s degree, or PhD). Thus, if a participant completed three degrees, the participant answered this section three times. This section asked whether certain elements, such as songs in other languages or information about other cultures, were present in the participants’ education.

The final section of the survey was only presented to educators. This consisted of 18 statements regarding curriculum and education that the participant rated using a Likert-type scale. The questions in the third and fourth sections were prompted by the results of interviews in a pilot study (Gombert, 2017) in which educators and recent graduates were asked about their perspectives on multicultural education.

In order to pilot the survey, it was sent to one music therapist and one dance/movement therapist, who each completed the survey. Their comments were integrated into the survey. The survey was then sent to two other music therapists for further feedback.

**Interview**

The interview questions are attached as Appendix B. Open-ended questions were chosen to deepen the researcher’s understanding of the survey results regarding participants’ attitudes and experiences, as well as their experiences in teaching and/or learning about culture. The interview questions were piloted with one music therapist.
The researcher revised the questions after reviewing the interview and the participant’s comments.

During each interview the researcher included several types of questions, as described by Forinash (2012). These included: descriptive questions, follow-up questions that asked the participant to clarify terms or experiences, example questions that asked the participant for an example of a concept they mentioned, and closing questions that allowed the participant to add comments the researcher may not have sought.

**Procedure**

The survey was created in Qualtrics, an online tool for creating, sending, and analyzing survey data. Qualtrics’ survey design allowed for the gathering of demographic information, short answer responses, and Likert-type responses. It also included tools for branch logic; thus, only those participants who had advanced degrees saw questions about their advanced degree curriculum, and only those participants who were educators saw questions about their perspectives on education with respect to multicultural awareness.

The interviews were conducted and recorded via Zoom, an online video conferencing software. A backup was also recorded on the researcher’s iPad; this backup was deleted once it was confirmed that the recording using Zoom was successful.

**Protection of Participants**

This study was approved by the Lesley University Institutional Review Board (IRB; see Appendix C). The informed consent forms for the survey and interview are included in Appendix D. In order to start the survey, each participant had to click on the screen of the survey to indicate they had read and understood the informed consent, and
to indicate they understood they could stop the survey at any time. Survey data was not kept for those participants who did not complete the survey.

Participants who volunteered for interviews at the end of the survey were taken to a separate survey form to give their name, contact information, and demographic information. To maintain confidentiality of the survey, information was stored in a separate data set that was not linked to the survey. Before each interview, each participant received and returned a signed informed consent form.

**Data Analysis**

IBM’s Statistical Package for Social Sciences (SPSS) was used to analyze the survey results. Descriptive statistics were run for the demographics and education sections. Comparisons were calculated between the material covered in different levels of education. Differences in scores for the attitudes/skills section of the survey were examined, comparing scores among people with different demographic identifiers, among those with different levels of education, and between people who were educators versus non-educators. SPSS was used to run a factor analysis for the attitudes/skills section of the survey to validate the survey items.

The interview recordings were sent via a secure server to be transcribed by a third party, who had signed a confidentiality agreement. The analysis of the interviews was conducted using MAXQDA2018. To code the interviews, the researcher used an iterative inductive analysis (Brinkman & Kvale, 2015). In each iteration of the analysis, the goal was to generate meanings and identify patterns or relationships from the data. The researcher first read all of the interviews and found themes, which were reviewed, sorted, and combined into groups. The themes were entered in MAXQDA2018, and the software
was used to retrieve and analyze the themes before they were recoded and combined through several iterations.
CHAPTER 4

Results

Several questions, which are reviewed below, were investigated in this research. This review is followed by the quantitative analysis and results, and then the qualitative analysis and results.

The first question guiding the study was: *What skills and knowledge do music therapists have with respect to culture?* This was investigated in the attitudes and skills portion of the survey data analysis, which revealed several differences in attitudes and skills between participants based on various demographic variables. The second question was: *How is the perception of the adequacy of a person’s multicultural competency training affected by that person’s worldview?* This was closely related to the survey data analysis used to answer the first question; it was further investigated in the interview analysis. The third question had two parts: *What training regarding multicultural competencies have music therapists and music therapy educators received? From where have they received this training?* The results from the education portion of the survey indicated how much of various elements were included in each curriculum and gave information regarding experiences that expanded participants’ cultural awareness. The interview analysis provided additional information regarding this question. The fourth question was investigated in the interviews: *What are music therapists’ experiences regarding multicultural competence?*
Quantitative Results

Description of Respondents to Survey

Participants \((n = 474)\) provided personal demographic information about their gender, sexual orientation, ethnicity, religion, and age, as well as professional demographic information regarding number of years in the field, AMTA region, type of work, and education. Some of the demographic information was compared to information in the AMTA’s (2018) workforce analysis to provide a comparison of participants in the present study to music therapists in the field. Please note that the workforce analysis draws from AMTA members, whereas the present research sought responses from a mailing list from CBMT, the certifying organization for music therapists. Although these two groups have a large overlap, membership in one organization does not imply membership in the other.

Personal Demographics

Participants wrote in their gender: 83.8% female \((n = 397)\), 12.9% male \((n = 61)\), and 3.0% non-binary gender \((n = 14)\). The percentage of respondents who indicated a non-binary gender was almost three times the 1.04% reported by the AMTA (2018) workforce analysis, perhaps suggesting that this topic was of particular importance to this group. Participants chose an identifier for sexual orientation; 82% chose heterosexual. See Table 1 for frequencies of gender and sexual orientation.

Participants were asked to choose one or more descriptors for race/ethnicity. The four largest groups chosen were: White \((n = 386; 81.4\%)\); Asian \((n = 31; 6.5\%)\); Hispanic and Latinx \((n = 18; 3.8\%)\); and African American or Black \((n = 16; 3.4\%)\). For the statistical analyses, race/ethnicity was condensed into two groups: White and person...
of color, the latter which included Asian, Black/African American, Hispanic, Latinx, multiracial, and other persons of color. The percentage of participants who identified as being White in the AMTA (2018) workforce analysis was 88.4%; thus, the percentage of people from minority ethnicities who participated in the present survey was greater than expected. In particular, 1.8% of respondents to the workforce analysis were Black/African American, compared to 3.4% in the present study, again perhaps suggesting a particular interest in the topic of multicultural education to this group of respondents.

To indicate present religion, participants chose from one of several options or wrote in their religion. For statistical reasons, several religions were then grouped together to match the groupings used by the Pew Research Center (2015). Religion had no statistically significant correlations to other responses in this survey. Table 1 shows details regarding race/ethnicity and religion.

The age of participants ranged from 23 years old to 87 years old ($M = 38.6$, $SD = 13.1$). Over half of the participants (51.5%) were 23 to 34 years old. The number of years in the field ranged from less than one year to 58 years ($M = 11.7$, $SD = 11.1$) and was highly correlated to age ($p < .000; r^2 = .826$). This topic seemed to be of particular interest to newer therapists: 41.1% ($n = 195$) of the participants had worked in the field for 5 years or fewer. Charts showing the age ranges and number of years in the field are in Appendix E.
### Table 1

**Personal Demographic Information**

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>397</td>
<td>83.8</td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>12.9</td>
</tr>
<tr>
<td>Non-binary or other gender identification</td>
<td>14</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>387</td>
<td>81.6</td>
</tr>
<tr>
<td>Bisexual</td>
<td>30</td>
<td>6.3</td>
</tr>
<tr>
<td>Gay</td>
<td>12</td>
<td>2.5</td>
</tr>
<tr>
<td>Pansexual</td>
<td>11</td>
<td>2.3</td>
</tr>
<tr>
<td>Lesbian</td>
<td>7</td>
<td>1.5</td>
</tr>
<tr>
<td>Asexual</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>Queer</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>Other non-heterosexual identifier</td>
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<td>.8</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>11</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Identified Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>386</td>
<td>81.4</td>
</tr>
<tr>
<td>Asian or Asian American</td>
<td>31</td>
<td>6.5</td>
</tr>
<tr>
<td>Hispanic or Latinx</td>
<td>18</td>
<td>3.8</td>
</tr>
<tr>
<td>African American or Black</td>
<td>16</td>
<td>3.4</td>
</tr>
<tr>
<td>Other person of color</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>American Indian or Indigenous Population</td>
<td>4</td>
<td>.8</td>
</tr>
<tr>
<td>Multiracial or Biracial</td>
<td>3</td>
<td>.6</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>3</td>
<td>.6</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Present Religion, if Any</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant: (Anabaptist, Baptist, Lutheran, Methodist, New Testament Christian, Protestant, Quaker, Seventh-Day Adventist, United Church of Christ)</td>
<td>156</td>
<td>32.9</td>
</tr>
<tr>
<td>Catholic and other Christian religions: (Greek or Roman Orthodox, Member Church of Latter Day Saints, Other Christian Religions, Roman Catholic)</td>
<td>98</td>
<td>20.6</td>
</tr>
<tr>
<td>No Particular Religion</td>
<td>76</td>
<td>16.0</td>
</tr>
<tr>
<td>Atheist/Agnostic/Antitheist</td>
<td>50</td>
<td>10.5</td>
</tr>
<tr>
<td>Jewish</td>
<td>28</td>
<td>5.9</td>
</tr>
<tr>
<td>Other faiths: (Humanist and Free thinker, New Age, Spiritual, Unitarian Universalist, Wiccan)</td>
<td>26</td>
<td>5.5</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>20</td>
<td>4.2</td>
</tr>
<tr>
<td>Traditional Asian Religions: (Buddhist, Daoism, Hindu, Shintoism)</td>
<td>17</td>
<td>3.6</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>0.6</td>
</tr>
</tbody>
</table>

*Note. Religious groupings match those used by the Pew Research Center (2015) except for the category of Traditional Asian Religions.*
Professional Demographics

Responses were submitted from music therapists from all seven AMTA regions. The regions with the largest number of responses were the Mid-Atlantic Region \((n = 112; 23.8\%)\); Great Lakes Region \((n = 110; 23.2\%)\); Southeastern Region \((n = 73; 15.4\%)\), and the Western Region \((n = 64; 13.5\%)\). Most respondents \((n = 20; 4.2\%)\) who lived outside the United States lived in Canada \((n = 7)\), Japan \((n = 3)\), or Taiwan \((n = 3)\). The percentage of responses by region matched that of the AMTA (2018) workforce analysis.

Participants indicated one or more categories for the type of work they do: most respondents \((84.6\%; n = 401)\) were clinicians for at least part of their work. Respondents worked in a wide variety of settings and with a wide variety of populations. The response rate for all regions and categories of work are shown in Table 2.

Table 2

Professional Demographic Information: Region and Type of Work

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Music Therapy Association Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-Atlantic Region</td>
<td>112</td>
<td>23.6</td>
</tr>
<tr>
<td>Great Lakes Region</td>
<td>110</td>
<td>23.2</td>
</tr>
<tr>
<td>Southeastern Region</td>
<td>73</td>
<td>15.4</td>
</tr>
<tr>
<td>Western Region</td>
<td>64</td>
<td>13.5</td>
</tr>
<tr>
<td>Midwestern Region</td>
<td>36</td>
<td>7.6</td>
</tr>
<tr>
<td>Southwestern Region</td>
<td>35</td>
<td>7.4</td>
</tr>
<tr>
<td>New England Region</td>
<td>20</td>
<td>4.2</td>
</tr>
<tr>
<td>Outside of the US</td>
<td>20</td>
<td>4.2</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>.8</td>
</tr>
<tr>
<td><strong>Type of Work (Clinician, Supervisor, etc.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician practicing music therapy</td>
<td>401</td>
<td>84.6</td>
</tr>
<tr>
<td>Supervisor of students in internship site, or practicum/fieldwork</td>
<td>139</td>
<td>29.3</td>
</tr>
<tr>
<td>Professor/instructor of music therapy</td>
<td>54</td>
<td>11.4</td>
</tr>
<tr>
<td>Practitioner in other field with a degree/credential in music therapy</td>
<td>49</td>
<td>10.3</td>
</tr>
<tr>
<td>Graduate student in music therapy</td>
<td>38</td>
<td>8.0</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>6.5</td>
</tr>
<tr>
<td>Retiree from the field of music therapy</td>
<td>7</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Table 3

Professional Demographic Information: Degrees and Advanced Degrees

<table>
<thead>
<tr>
<th>Degree or Training</th>
<th>Completed</th>
<th>Pursuing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrees Completed or Pursuing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree in music therapy</td>
<td>321</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree in other field</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Equivalency degree in music therapy</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Master’s degree in music therapy, expressive therapies, or with</td>
<td>215</td>
<td>32</td>
</tr>
<tr>
<td>music/music therapy concentration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s degree in field other than music/music therapy/expressive</td>
<td>61</td>
<td>16</td>
</tr>
<tr>
<td>therapies (such as MBA, MSW, or other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD or doctoral degree in music therapy, expressive therapies, or</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>music education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD or doctoral degree in other field</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Advanced Trainings Completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic Music Therapy (NMT)</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Bonny Method – Guided Imagery in Music (BM-GIM)</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Neo-natal ICU Music Therapy (NICU MT)</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Nordoff-Robbins Music Therapy (NRMT)</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Hospice &amp; Palliative Care Music Therapist (HPMT)</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Vocal Psychotherapy</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Analytic Music Therapy</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Education and Advanced Training

Bachelor’s degrees or equivalency degrees in music therapy were held by 83.1% 

\( n = 394 \) of the participants. There was not a separate option for participants who 
pursued an equivalency and master’s in the same degree program. Nearly half (45.3%) of 
the participants had a master’s degree in music therapy or a related field, and 4% 

\( n = 19 \) of the participants held doctoral degrees in music therapy or a related field. In addition, at 
the time of the survey, 67 participants were pursuing an advanced degree in music 
therapy or a related field. In the AMTA (2018) workforce analysis, it was reported that 
42% of music therapists held master’s degrees and 6% held doctoral degrees; these 
percentages are close to the responses in the present survey. The number of people who
reported having completed an advanced training was close to half (47.4%). See Table 3 for details of participants’ education and advanced training.

**Data Analysis**

**Question 1: Differences in Attitudes and Skills**

A total of 41 items were used to measure the cultural attitudes and self-perceived skills of music therapists. A factor analysis was conducted to examine the psychometric properties of the survey questions for a more parsimonious analysis. Eight distinct concepts were identified with a Cronbach’s alpha ($\alpha$) higher than 0.7, indicating that the items in that concept are reliably testing the same construct. These concepts were: (1) *Effective Communication/Confidence With Adults & People Who Have a Disability* ($\alpha = .773$) combined measures of verbal and non-verbal communication with clients whose culture was different than the respondents’, confidence in working with adults, and confidence in working with people who have disabilities. (2) *Awareness of Effect of Culture* ($\alpha = .765$) combined measures of the respondents’ awareness of that cultural differences affect perceptions of and access to therapy. (3) *Confidence With Children and Adolescents* ($\alpha = .728$) combined measures of the respondents’ confidence in their ability to work with children and to work with adolescents. (4) *Self-Examination* ($\alpha = .853$) combined measures of the respondents’ report of their own background and values. (5) *Praxis* ($\alpha = .733$) combined measures of the respondents’ incorporation of elements from a client’s culture into practice with that client. (6) *Confidence With Difference* ($\alpha = .789$) combined measures of the respondents’ confidence in working with clients whose primary language, religion, economic status, gender, or sexual orientation were different from their own. (7) *Continuous Learning* ($\alpha = .718$) combined measures of the
respondents’ report of seeking continuing learning and supervision regarding their own and others’ cultural background. (8) *Belief in Stereotypes* (α = .724) combined measures of the respondents’ belief that culture and ethnicity are not relevant or belief in generalizations about groups. A list of all items in each concept is in Table E1 in Appendix E.

The factor analysis indicated that two items did not significantly load with other concepts. These were kept as individual items: (1) *Can Critique Assessment* measured the respondents’ confidence with critiquing assessment with respect to cultural aspects. (2) *Can Critique Research* measured the respondents’ confidence with critiquing music therapy research regarding cultural aspects. In addition, the scores for confidence with males, females, older adults, and those with disabilities indicated that those items should be in the concept group with *Effective Communication*. Since these constructs are distinct, the first concept will be broken into (1a) *Effective Communication*, and (1b) *Confidence With Adults & People Who Have a Disability*.

**Table 4**

*Means for Cultural Attitudes and Skills Subscale for all Participants*

*(Order: most confident/highest perceived skill, to least confident/lowest perceived skill)*

<table>
<thead>
<tr>
<th>Concept</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Communication/Confidence With Adults &amp; People Who Have a Disability</td>
<td>6.25</td>
<td>.56</td>
</tr>
<tr>
<td>Awareness of Effect of Culture</td>
<td>6.01</td>
<td>.78</td>
</tr>
<tr>
<td>Confidence With Children &amp; Adolescents</td>
<td>5.98</td>
<td>1.06</td>
</tr>
<tr>
<td>Self-Examination</td>
<td>5.90</td>
<td>.73</td>
</tr>
<tr>
<td>Praxis</td>
<td>5.82</td>
<td>.77</td>
</tr>
<tr>
<td>Confidence With Difference</td>
<td>5.77</td>
<td>.86</td>
</tr>
<tr>
<td>Continuous Learning</td>
<td>5.69</td>
<td>.93</td>
</tr>
<tr>
<td>Belief in Stereotypes</td>
<td>5.32</td>
<td>.99</td>
</tr>
<tr>
<td>Can Critique Assessment</td>
<td>5.19</td>
<td>1.23</td>
</tr>
<tr>
<td>Can Critique Research</td>
<td>4.81</td>
<td>1.39</td>
</tr>
</tbody>
</table>
The eight concepts and the overall means are displayed in Table 4. The scores for the concepts range from 1 to 7, with a score of 1 indicating Strongly Disagree and a score of 7 indicating Strongly Agree. Therefore, higher scores indicate stronger confidence, more awareness about culture, or a greater self-assessed skill in applying that knowledge. The scores for Effective Communication/Confidence With Adults and People who Have a Disability ($M = 6.25$), Confidence With Children and Adolescents ($M = 5.98$), and Confidence With Difference ($M = 5.77$) indicated that, on average, participants were more confident in their ability to work with adults and those with disability than they were in their ability to work with children and adolescents. On average, participants were least confident in their ability to work with people who are LGBTQ or people whose religion or language is different than the participants’. In addition, participants were less confident in their abilities to critique assessment with respect to culture than they were with the other skills. Participants were least confident in their ability to critique research with respect to cultural considerations. Analyses 2a, 2b, 2c, 2d, and 2e compared the scores of participants who belong to various demographic groupings.

**Question 2: Demographic Comparisons of Scores**

**Analysis 2a: What Differences Are There in Cultural Attitudes and Skills Between Participants Whose Identity Differs by Genders, Sexual Orientation, Ethnicity/Race, or Religion?** To answer this question, an ANOVA analysis was conducted to compare differences in cultural attitudes and skills between different genders (male, female, non-binary), sexuality (asexual, bisexual, gay, heterosexual, lesbian, pansexual, queer, other non-heterosexual identifier), religion (Atheist/Agnostic/Antithesist, Catholic and other Christian religions, Jewish, other faiths, ...
Protestant, Traditional Asian, no particular religion), and ethnicity/race (White, person of color).

Results revealed significant impact of sexual orientation $F(7, 461) = 2.48, \ p = .017$ and ethnicity/race $t(117.6) = 2.81, \ p = .031$ on Self-Examination. People who identified as bisexual scored significantly higher on measures of Self-Examination regarding culture than heterosexuals did ($p = .028$); people of color scored significantly higher on measures of self-examination than those who identified as White. When looking at Awareness of Effect of Culture, there was a significant impact of gender $F(2, 471) = 4.39, \ p < .05$; sexual orientation $F(7, 461) = 3.69, \ p = .001$; and religion $F(6, 450) = 2.29, \ p = .035$. More specifically, people who identified as bisexual scored higher on measures of Awareness of Effect of Culture than heterosexuals ($p = .039$) did. There were also significant differences between people who identified as non-binary gender in contrast to both male ($p < .001$) and female ($p < .001$); those whose gender was non-binary scored higher on measures of Awareness of Effect of Culture than both males and females. There were no significant differences among religious groups.

There was a significant effect of sexual orientation $F(7, 461) = 3.38, \ p = .002$ on measures of Belief in Stereotypes, but no significant differences among the groups. See Table 5 for the means and standard deviations. For measures of Continuous Learning, there were significant results for sexual orientation $F(7, 461) = 2.20, \ p = .003$ and ethnicity $t(116.3) = 2.78, \ p < .006$. There were no significant differences among sexual orientations, but there were differences between people of color and Whites with people of color more likely to pursue continuous learning about culture than Whites.
When comparing scores for genders $F(2, 470) = 6.97, p = .001$ on measures of confidence that one can critique research, there were significant differences between males and females ($p < .001$), with males being more confident in their ability to critique research. For the other measures, there were no significant differences among participants whose identity differed by gender, sexual orientation, ethnicity/race, or religion.

Table 5

Means and Standard Deviations for Attitudes and Skills by Gender, Ethnicity/Race, Sexual Orientation, and Religion (significant results only)

<table>
<thead>
<tr>
<th></th>
<th>Self-evaluation</th>
<th>Awareness</th>
<th>Stereotypes</th>
<th>Cont. learning</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>.62</td>
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<td>Ethnicity/Race</td>
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<td>5.11</td>
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<td>6.34*</td>
<td>.54</td>
<td>5.47†</td>
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<td>.41</td>
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<td>.58</td>
<td>6.36</td>
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<tr>
<td>Queer</td>
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<td>.36</td>
<td>6.67</td>
<td>.31</td>
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<tr>
<td>Other</td>
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<td>.93</td>
<td>6.25</td>
<td>.52</td>
<td>5.10†</td>
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<td>Religion</td>
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<td>.82</td>
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<td>.72</td>
<td>5.65</td>
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<td>.77</td>
<td>5.19</td>
</tr>
</tbody>
</table>

*significant at <.005; ‡significant at <.001
†significant effect, but not within groups
These results indicate that for some areas of attitudes and skills (Self-evaluation, Awareness of Effect of Culture, Belief in Stereotypes, Continuous Learning, and Can Critique Research), the average scores did differ based on the identities of participants. The means and standard deviations for all of the areas are displayed in Table 5.

**Analysis 2b: What Differences Are There in Cultural Attitudes and Skills Between Educators and Non-Educators?** An independent samples t-test was conducted to compare the cultural attitudes and self-perceived skills in music therapy between educators and non-educators. There was a significant difference in the scores for

- **Awareness of Effect of Culture** [educators ($M = 6.45, SD = .53$) and non-educators ($M = 6.02, SD = .70$): $t(435) = 3.31, p = .001$];
- **Praxis** [educators ($M = 6.16, SD = .72$); non-educators ($M = 5.83; SD = .71$)];
- **Continuous Learning** [educators ($M = 6.22, SD = .76$); non-educators ($M = 5.70; SD = .87$)];
- **Belief in Stereotypes** [educators ($M = 6.12, SD = .74$); non-educators ($M = 5.26; SD = .97$)];
- **Can Critique Assessment** [educators ($M = 5.77, SD = 1.18$); non-educators ($M = 5.20; SD = 1.14$)]; and
- **Can Critique Research** [educators ($M = 5.58, SD = 1.06$); non-educators ($M = 4.82; SD = 1.32$)].

These results suggest that music therapists in educator roles have more positive cultural attitudes and skills than those in non-educator roles. Furthermore, educators feel they are more skilled to critique assessments and research with respect to cultural considerations. Table 6 displays results for all items.
Table 6

*T-Test Comparison of Attitudes and Skills by Position*

<table>
<thead>
<tr>
<th>Group</th>
<th>Educator</th>
<th>Non-educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Communication / Confidence w Adults &amp; People who Have a Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>406</td>
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<tr>
<td>M</td>
<td>6.32</td>
<td>6.25</td>
</tr>
<tr>
<td>SD</td>
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<td>0.53</td>
</tr>
<tr>
<td>t</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Awareness of Effect of Culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>406</td>
</tr>
<tr>
<td>M</td>
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<td>6.02</td>
</tr>
<tr>
<td>SD</td>
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<td>0.7</td>
</tr>
<tr>
<td>t</td>
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<tr>
<td>Confidence With Children &amp; Adolescents</td>
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<tr>
<td>M</td>
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<td>5.99</td>
</tr>
<tr>
<td>SD</td>
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<td>1.02</td>
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<td>Self-Examination</td>
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</tr>
<tr>
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</tr>
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<td>0.71</td>
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<tr>
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<tr>
<td>Confidence With Difference</td>
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<tr>
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<td>31</td>
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<tr>
<td>M</td>
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<td>406</td>
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<td>M</td>
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<td>0.87</td>
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<tr>
<td>t</td>
<td>3.26*</td>
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<tr>
<td>Belief in Stereotypes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>406</td>
</tr>
<tr>
<td>M</td>
<td>6.12</td>
<td>5.26</td>
</tr>
<tr>
<td>SD</td>
<td>0.74</td>
<td>0.97</td>
</tr>
<tr>
<td>t</td>
<td>4.86*</td>
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<tr>
<td>Can Critique Assessment</td>
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<td></td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>406</td>
</tr>
<tr>
<td>M</td>
<td>5.77</td>
<td>5.20</td>
</tr>
<tr>
<td>SD</td>
<td>1.78</td>
<td>1.14</td>
</tr>
<tr>
<td>t</td>
<td>2.71*</td>
<td></td>
</tr>
<tr>
<td>Can Critique Research</td>
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<td></td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>406</td>
</tr>
<tr>
<td>M</td>
<td>5.58</td>
<td>4.82</td>
</tr>
<tr>
<td>SD</td>
<td>1.06</td>
<td>1.32</td>
</tr>
<tr>
<td>t</td>
<td>3.12*</td>
<td></td>
</tr>
</tbody>
</table>

*significant at p < 0.05

Analysis 2c: Do Measures of Attitudes and Skills Predict Position as Educator or Non-Educator? A forward logistic regression was conducted to determine which of the individual concept grouping scores are predictors of group membership (educator/non-educator). Data screening led to the elimination of 37 multivariate outliers. Results of the logistic regression indicate that the model provides a statistically significant improvement over the constant only model $\chi^2 (26, N = 406) = 65.75, p < .001$. The Nagelkerke pseudo $R^2$ indicated that the model accounted for 37% of the total variance. This suggests that the set of predictors does discriminate between educators and non-educators. Prediction of group membership was very high, with an overall prediction success rate of 94.1%. Table E2 in Appendix E shows the Wald statistics, significance level, and odds ratio $\beta$. Correlation coefficients are displayed in Table E3.

Controlling for gender, sexuality, ethnicity, and religion, the odds ratios were strong that educators scored better on *Awareness of Effect of Culture, Belief in*...
Stereotypes, and Can Critique Assessment. When compared to educators, non-educators have 2.75 times odds of being less aware of the effect of culture on therapy. This means that the odds of an educator having an awareness of the effect of culture on therapy is 1 to 2, while the odds of a non-educator having this same awareness is 3 to 2. In other words, for every 10 educators who do not have this awareness, there are 20 educators who will have it; but for every 10 non-educators who do not have this awareness, there are only 2 non-educators who will have it. In addition, educators are 3.33 times more likely to not believe in stereotypes, and 1.92 times more likely to consider culture in assessment. While results were also significant for Self-Examination, when compared with non-educators, educators are just .42 times more likely to participate in ongoing self-evaluation. Table E2 in Appendix E shows the logistic regression predicting educator skills and attitudes.

Analysis 2d: What Differences in Attitudes are There Between People With Different Levels of Education? A two-way MANOVA was conducted. The cultural attitudes and skills concept groupings and questions were the dependent variables; the highest level of education in music therapy was the independent variable. The MANOVA results indicated that the highest level of education in music therapy significantly impacted the following: Awareness of Effect of Culture, $F(3, 474) = 8.04, p < .001$, partial $\eta^2 = .053$; Self-Examination, $F(3, 474) = 3.54, p = .015$, partial $\eta^2 = .024$; Continuous Learning, $F(3, 474) = 7.46, p < .001$, partial $\eta^2 = .049$; Belief in Stereotypes, $F(3, 474) = 12.71, p < .001$ partial $\eta^2 = .081$; and Can Critique Research, $F(3, 474) = 8.83, p < .001$, partial $\eta^2 = .054$. 
Table 7

*Means and Standard Deviations for Cultural Attitudes and Skills Concepts*

*by Highest Level of Education*

<table>
<thead>
<tr>
<th></th>
<th>Bachelor</th>
<th>Master in MT</th>
<th>PhD in MT</th>
<th>PhD in other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Effective Communication/ Conf. w/ Adults &amp; People who Have a Disability</td>
<td>6.25</td>
<td>.55</td>
<td>6.27</td>
<td>.55</td>
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<tr>
<td>Awareness - Effect of Culture*</td>
<td>5.85</td>
<td>.81</td>
<td>6.12</td>
<td>.72</td>
</tr>
<tr>
<td>Conf. with Children</td>
<td>5.88</td>
<td>1.16</td>
<td>6.06</td>
<td>.97</td>
</tr>
<tr>
<td>Self-Examination *</td>
<td>5.82</td>
<td>.75</td>
<td>5.99</td>
<td>.68</td>
</tr>
<tr>
<td>Praxis</td>
<td>5.74</td>
<td>.79</td>
<td>5.88</td>
<td>.75</td>
</tr>
<tr>
<td>Conf. with Difference</td>
<td>5.71</td>
<td>.93</td>
<td>5.86</td>
<td>.80</td>
</tr>
<tr>
<td>Continuous Learning*</td>
<td>5.49</td>
<td>.99</td>
<td>5.81</td>
<td>.85</td>
</tr>
<tr>
<td>Belief in Stereotypes*</td>
<td>5.08</td>
<td>1.02</td>
<td>5.43</td>
<td>.92</td>
</tr>
<tr>
<td>Can Critique Assessment</td>
<td>5.14</td>
<td>1.23</td>
<td>5.18</td>
<td>1.89</td>
</tr>
<tr>
<td>Can Critique Research *</td>
<td>4.50</td>
<td>1.41</td>
<td>5.00</td>
<td>1.31</td>
</tr>
</tbody>
</table>

Note. Score of 1 indicates Strongly Disagree; score of 7 indicates Strongly Agree; scores closer to 7 indicate higher awareness/self-perception of skills.

*significant at p < .001

The Bonferroni post hoc analysis revealed that *Awareness of Effect of Culture* on therapy was significantly higher among those whose highest level of education was an advanced degree (master’s or PhD) in music therapy, when compared to those who only had a bachelor’s degree or equivalency degree in music therapy. For the items regarding belief in stereotypes, continuous learning, and ability to critique research, the statistical significance was additionally seen when participants who had a PhD in another field were compared to the others. That is, the attitudes and skills were significantly higher on those three items, for those who had an advanced degree in music therapy or a PhD in another field versus those who only had an undergraduate degree in music therapy.

On all items, the scores were higher for those whose highest degree was a master’s degree in music therapy than for those whose highest degree was a bachelor’s
degree in music therapy. This statistical significance on five items suggests that the master’s degree might be instrumental in impacting music therapists’ cultural attitudes and skills. Table 7 presents means and standard deviations on the Attitudes and Skills by highest level of education.

**Analysis 2e: What Differences in Attitudes Are There Based on Year of Graduation?** An ANOVA analysis was conducted to compare differences in cultural attitudes and skills when the participants were grouped by most recent year of graduation with any degree in music therapy using the following four ranges: 2014-2019, 2009-2013, 2004-2008, and 2003 or earlier.

**Table 8**

*Means and Standard Deviations for Cultural Attitudes and Skills Concepts by Most Recent Year of Graduation*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Commun. / Conf. w/ Adults &amp; People who Have a Disability</td>
<td>M = 6.19, SD = .55</td>
<td>M = 6.24, SD = .52</td>
<td>M = 6.31, SD = .59</td>
<td>M = 6.31, SD = .59, p = .239</td>
</tr>
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<td>Awareness of the Effect of Culture *</td>
<td>M = 6.11, SD = .64</td>
<td>M = 6.08, SD = .77</td>
<td>M = 5.93, SD = .89</td>
<td>M = 5.79, SD = .89, p = .004</td>
</tr>
<tr>
<td>Conf. with Children</td>
<td>M = 5.89, SD = 1.12</td>
<td>M = 6.05, SD = 1.07</td>
<td>M = 5.98, SD = 1.12</td>
<td>M = 6.04, SD = .95, p = .513</td>
</tr>
<tr>
<td>Self-Examination</td>
<td>M = 5.93, SD = .67</td>
<td>M = 5.87, SD = .76</td>
<td>M = 5.94, SD = .66</td>
<td>M = 5.83, SD = .82, p = .644</td>
</tr>
<tr>
<td>Praxis</td>
<td>M = 5.73, SD = .78</td>
<td>M = 5.82, SD = .80</td>
<td>M = 5.86, SD = .72</td>
<td>M = 5.89, SD = .75, p = .320</td>
</tr>
<tr>
<td>Conf. with Difference</td>
<td>M = 5.72, SD = .90</td>
<td>M = 5.73, SD = .76</td>
<td>M = 5.82, SD = .84</td>
<td>M = 5.85, SD = .94, p = .623</td>
</tr>
<tr>
<td>Continuous Learning</td>
<td>M = 5.63, SD = .94</td>
<td>M = 5.68, SD = .97</td>
<td>M = 5.67, SD = .96</td>
<td>M = 5.76, SD = .89, p = .725</td>
</tr>
<tr>
<td>Belief in Stereotypes</td>
<td>M = 5.39, SD = .90</td>
<td>M = 5.39, SD = .93</td>
<td>M = 5.31, SD = .99</td>
<td>M = 5.18, SD = 1.12, p = .283</td>
</tr>
</tbody>
</table>

*significant at p < .001

Results revealed significant differences among groups when considering *Awareness of Effect of Culture, F(3, 452) = 4.55, p = .004. Participants who received their most recent degree in music therapy in the time range 2014-2019 (M = 6.11, SD =
.64), or in 2009-2013 (M = 6.08, SD = .77), had significantly higher scores than those who received their most recent degrees in 2003 or earlier (M = 5.79, SD = .89). Table 8 shows the means and standard deviations for differences in cultural attitudes and skills by most recent year of graduation.

Question 3: Education

Analysis 3: How Does the Material Covered Differ Among Undergraduate and Graduate Coursework? What Was Present in Degree Programs? For each music therapy degree program (undergraduate, master’s, or doctoral) that a participant had completed or was enrolled in at the time of the survey, participants were asked to what extent various elements were included in each curriculum. These results are shown in Table 9 in this section, aggregated as percentages of respondents who reported that each element was present to some degree or was not present in the stated curricula.

It is noteworthy that there was a decrease in percentages of participants who reported the presence of the elements related to praxis (learning how to sing songs in different languages, learning about rhythms and scales relating to the music of non-Western cultures, and the introduction of songs relating to other religions). More than half of the respondents (67.23%) indicated that these four elements were present in their undergraduate curricula. On the other hand, 46.85% indicated that these elements were present in their master’s curricula and 12.95% indicated the elements were in their doctoral curricula. Conversely there was an increase in the presence of non-musical elements related to culture (immersion in a study of culture other than my own, examination of my own culture, non-musical information about groups). Less than half of the respondents (48.5%) indicated that these non-musical elements were present in their
undergraduate curricula, 55.73% indicated the elements were present in their master’s curricula, and 64.1% indicated that these elements were present in their doctoral curricula. These results give an indication of what type of information related to culture is learned at each degree level.

Table 9

Percentages of Coursework Elements present in each curriculum

<table>
<thead>
<tr>
<th>Element</th>
<th>% Reporting this present in curriculum</th>
<th>% Reporting none in curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to sing songs in different languages</td>
<td>UG 69.7, MA 41.2, PhD 14.8</td>
<td>UG 26.7, MA 52.1, PhD 81.5</td>
</tr>
<tr>
<td>Rhythms/scales relating to music of non-Western cultures</td>
<td>UG 85.3, MA 67.6, PhD 18.5</td>
<td>UG 12.9, MA 28.2, PhD 74.1</td>
</tr>
<tr>
<td>Introduction of songs relating to 1 non-Christian religion</td>
<td>UG 63.5, MA 43.7, PhD 11.1</td>
<td>UG 30.6, MA 48.3, PhD 81.5</td>
</tr>
<tr>
<td>Introduction of songs relating to several religions</td>
<td>UG 50.4, MA 34.9, PhD 7.4</td>
<td>UG 40.4, MA 55.0, PhD 85.2</td>
</tr>
<tr>
<td>Discussion about how to adapt specific interventions for clients with different backgrounds</td>
<td>UG 79.9, MA 80.2, PhD 57.7</td>
<td>UG 16.5, MA 14.8, PhD 42.3</td>
</tr>
<tr>
<td>Examination of the context or meaning of specific songs or music in different cultures/religions</td>
<td>UG 65.0, MA 65.8, PhD 53.8</td>
<td>UG 29.0, MA 27, PhD 46.2</td>
</tr>
<tr>
<td>Discussion of ways culture might impact music therapy</td>
<td>UG 81.7, MA 81.4, PhD 77.8</td>
<td>UG 14.7, MA 12.2, PhD 18.5</td>
</tr>
<tr>
<td>Immersion in a study of a culture other than my own (as part of my coursework)</td>
<td>UG 34.0, MA 39.2, PhD 50.0</td>
<td>UG 61.9, MA 56.1, PhD 46.2</td>
</tr>
<tr>
<td>Examination of my own culture</td>
<td>UG 53.2, MA 62.3, PhD 69.2</td>
<td>UG 40.4, MA 33.1, PhD 26.9</td>
</tr>
<tr>
<td>Non-musical information (such as beliefs, worldviews, customs, use of space) about specific cultural groups</td>
<td>UG 58.4, MA 65.7, PhD 73.1</td>
<td>UG 35.2, MA 27.1, PhD 26.9</td>
</tr>
<tr>
<td>An ethnomusicology perspective</td>
<td>UG 60.2, MA 53.4, PhD 53.8</td>
<td>UG 33.2, MA 36.4, PhD 42.3</td>
</tr>
<tr>
<td>A world music perspective</td>
<td>UG 75.1, MA 64.4, PhD 46.2</td>
<td>UG 21.6, MA 29.7, PhD 50.0</td>
</tr>
</tbody>
</table>

Experiences Outside of Classroom. A section of the survey asked participants about experiences that expanded their cultural awareness, regardless of what degree programs they completed. The experiences noted most frequently were work or research regarding clients, and working, living among, and being friends with people of different
backgrounds. The results and percentages are shown in Table 10. In addition, participants attended workshops that expanded their cultural awareness. The number of people who attended workshops at conferences and the average number of workshops attended are shown in Table 11. Close to half (48.9%) of all participants have attended workshops at AMTA conferences that have expanded their cultural awareness, and 40.9% have attended such workshops at regional or state conferences.

**Table 10**

*Experiences That Expanded Participants’ Cultural Awareness*

<table>
<thead>
<tr>
<th>Experience</th>
<th>Number who said it expanded their awareness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with clients of different backgrounds</td>
<td>415</td>
<td>87.6</td>
</tr>
<tr>
<td>Diversity among friends</td>
<td>367</td>
<td>77.4</td>
</tr>
<tr>
<td>Research to support client</td>
<td>334</td>
<td>70.5</td>
</tr>
<tr>
<td>Research because of own interest</td>
<td>320</td>
<td>67.5</td>
</tr>
<tr>
<td>Live in culturally diverse city</td>
<td>316</td>
<td>66.7</td>
</tr>
<tr>
<td>Immersion in culture for personal reasons</td>
<td>231</td>
<td>48.7</td>
</tr>
<tr>
<td>Employee training</td>
<td>181</td>
<td>38.2</td>
</tr>
<tr>
<td>Teaching students/interns from other cultures</td>
<td>179</td>
<td>37.8</td>
</tr>
<tr>
<td>Diversity in family</td>
<td>134</td>
<td>28.3</td>
</tr>
<tr>
<td>Identify as a minority</td>
<td>110</td>
<td>23.2</td>
</tr>
</tbody>
</table>

**Table 11**

*Workshops That Expanded Participants’ Cultural Awareness*

<table>
<thead>
<tr>
<th>Where workshops occurred</th>
<th>How many people attended:</th>
<th>% of participants</th>
<th>Avg. number attended</th>
<th>Range of number attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMTA conferences</td>
<td>232</td>
<td>48.9%</td>
<td>3.8</td>
<td>1 to 25</td>
</tr>
<tr>
<td>Regional/state music therapy conferences</td>
<td>194</td>
<td>40.9%</td>
<td>3.6</td>
<td>1 to 50</td>
</tr>
<tr>
<td>Expressive therapy conferences</td>
<td>33</td>
<td>7.0%</td>
<td>2.4</td>
<td>1 to 8</td>
</tr>
<tr>
<td>Other professional conferences</td>
<td>97</td>
<td>20.5%</td>
<td>5.8</td>
<td>1 to 50 or more</td>
</tr>
<tr>
<td>Conference about specific culture/group</td>
<td>63</td>
<td>13.3%</td>
<td>3.8</td>
<td>1 to 20</td>
</tr>
<tr>
<td>Other workshops</td>
<td>92</td>
<td>19.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Educator Perceptions

Although it did not correspond to one of the original research questions, a separate section of the survey was presented to those 107 participants who indicated they were educators. Questions were then presented only to those respondents \( n = 59 \) who indicated they teach music therapy at an AMTA approved university. It is not known if the remaining 48 participants who said they were educators were supervisors, educators at non-AMTA approved universities, or educators of something other than music therapy. Of those 59 participants who indicated they do teach at an AMTA approved university, 45.8\% \( (n = 27) \) taught undergraduate courses only, and 18.6\% \( (n = 11) \) taught graduate courses only. The remaining participants \( (35.6\%; n = 21) \) taught a mixture of the two. Participants were given 18 statements and instructed to indicate their level of agreement or disagreement with a Likert-type scale (1 indicated strongly disagree; 7 indicated strongly agree).

In the following report of responses, the number of responses indicating strongly agree, agree, and somewhat agree were reported together as indicating agreement, and the number of responses indicating strongly disagree, disagree, and somewhat disagree were reported together as disagreement. Thus, in the following text, when it is reported that respondents agreed, they may have done so with a range of strongly agree to somewhat agree; when it is reported that respondents disagreed, they may have done so with a range of strongly disagree to somewhat disagree. This simplification of responses to three categories: agree, disagree, or neutral was done to ease reporting given a small number of responses and to add clarity in reporting. The means and standard deviations for the Likert-type responses to each survey statement are shown in Table E4 in
Appendix E; these means express the strength of the agreement or disagreement with the statement.

All of the respondents (100%) agreed that culture should be addressed in undergraduate coursework; regarding graduate coursework, 96.6% of participants agreed that culture should be addressed. Thus, the vast majority of educators agreed that culture should be addressed in music therapy coursework. Regarding how much of a course is required for this topic, only 28.8% of respondents ($n = 17$) agreed that the topic of culture can be sufficiently addressed as a small part of one or two courses in the undergraduate curriculum, and even fewer (22.0%, $n = 13$) agreed that this amount of time would be sufficient in the graduate curriculum.

Participants were asked to what extent culture should be addressed when teaching various parts of the curriculum. Nearly all of the participants (98%) agreed with each of the statements: that culture should be addressed when teaching music therapy repertoire, and that culture should be addressed in music therapy coursework regarding percussion. All of the participants (100%) agreed that culture should be discussed during coursework about both clinical training and research.

When asked whether they agree or disagree that it is essential to discuss culture in all music therapy courses, 94.8% ($n = 55$) agreed. On the other hand, 71% ($n = 41$) of respondents agreed that it is ideal to have a separate course on the topic of culture and/or multicultural awareness. These two approaches are not mutually exclusive as it is possible to have one course on multicultural awareness and have discussions of culture be present in all music therapy courses.
Discussions about culture might include aspects beyond music. Most respondents (90\%, $n = 52$) disagreed with the statement that non-musical elements of culture such as worldview, customs, history, beliefs, oppression, or acculturation are beyond the scope of music therapy curriculum; this implies that most respondents agreed that these elements are within the scope of the curriculum. Similarly, 95\% ($n = 55$) of educators thought that topics regarding race, religion, or sexuality are not too volatile to be discussed in the music therapy classroom, and 98\% of respondents strongly agreed that it is essential that students examine their own culture in at least one music therapy course. Although nothing was asked about the ways in which these topics should be addressed, most respondents thought that they should be present.

In order to understand what structural forces might prevent educators from discussing culture in their courses, respondents were asked whether they have enough time and resources to address issues of culture, and whether they would face retribution or resistance if they discussed culture. Responses about adequate time and resources were similar: 41.4\% ($n = 24$) of the respondents felt that they did not have adequate time, and 35\% ($n = 20$) felt that they did not have adequate resources. The majority of respondents (82.7\%, $n = 48$) disagreed that they would face retribution from their university, college, dean, or supervisor if they discussed culture in music therapy courses, and 72.4\% ($n = 42$) disagreed that they would face resistance from their students regarding this topic. These items do not indicate whether or not the respondents are actually discussing culture; the items only asked about the availability of resources and/or support for these topics.
Responses about adequate time, resources, and whether the educators would face retribution or resistance all received an average of 10% of neutral responses ($n = 5, 6, \text{or } 7$). It is possible that these responses indicate that those people had not thought about whether or not they have available time and resources. The mean and standard deviations are shown in Table E4 in Appendix E.

**Analysis 4: What Differences Are There Amongst Educators in Perceptions of Elements Related to Culture in Undergraduate and Graduate Education?** An ANOVA was conducted to compare means, using the 18 questions as the dependent variables and type of courses taught (undergraduate or graduate) as the independent variable. The ANOVA results indicated that the type of the majority of classes an educator teaches significantly impacts the perception of undergraduate students’ readiness to challenge cultural assumptions $F(4, 54) = 3.72, p = .010$; the belief that culture can be covered in a small part of one or two courses $F(4, 54) = 2.76, p = .037$; and the belief that culture should be addressed when teaching repertoire $F(4, 53) = 9.75, p < .001$. The Bonferroni post hoc analysis revealed that when considering whether undergraduates are ready to challenge their assumptions about culture, there are significant differences among the three groups of: those who teach only undergraduate courses ($M = 3.22, SD = 1.95$); those who teach an equal number of undergraduate and graduate courses ($M = 1.9, SD = 0.99$); and those who teach only graduate courses ($M = 1.73; SD = 0.91$). Those who teach more graduate courses felt more strongly that undergraduates are not ready to challenge their assumptions.

Those who teach only graduate level courses differed significantly ($p = .022$) in their perception of whether culture being covered as a small part of one or two courses is
sufficient; they had the strongest disagreement that this is sufficient. Those who teach mostly in graduate level courses disagreed most strongly with the statement that culture should be addressed when teaching music therapy repertoire to students; this differed significantly \((p < .001)\) from the other groups of respondents for that statement. It is important to note that although other questions did not have significant differences among the groups, there were similar perceptions by all educators. Table 12 presents means and standard deviations for each of the items, grouped by type of courses taught.

**Table 12**

*Perceptions About Education by Type of Courses Taught: Means and SD*

<table>
<thead>
<tr>
<th>Questions</th>
<th>All UG</th>
<th>Most UG</th>
<th>Equal</th>
<th>Most Grad</th>
<th>All Grad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture should be addressed in UG music therapy coursework.</td>
<td>6.85</td>
<td>0.36</td>
<td>6.75</td>
<td>0.46</td>
<td>7.00</td>
</tr>
<tr>
<td>In the UG music therapy curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses.</td>
<td>3.81</td>
<td>2.05</td>
<td>3.63</td>
<td>1.77</td>
<td>2.90</td>
</tr>
<tr>
<td>UG students are typically not ready to challenge their assumptions about culture.</td>
<td>3.22</td>
<td>1.95</td>
<td>1.88</td>
<td>0.99</td>
<td>1.90</td>
</tr>
<tr>
<td>Culture should be addressed in graduate music therapy coursework.</td>
<td>6.44</td>
<td>1.28</td>
<td>6.87</td>
<td>0.35</td>
<td>7.00</td>
</tr>
<tr>
<td>In the graduate music therapy curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses.</td>
<td>3.70</td>
<td>1.98</td>
<td>3.00</td>
<td>2.20</td>
<td>2.60</td>
</tr>
<tr>
<td>Culture should be addressed when teaching music therapy repertoire to students.</td>
<td>6.59</td>
<td>0.50</td>
<td>6.62</td>
<td>0.52</td>
<td>6.80</td>
</tr>
<tr>
<td>Culture should be addressed in music therapy coursework regarding percussion.</td>
<td>6.52</td>
<td>0.70</td>
<td>6.5</td>
<td>0.54</td>
<td>6.80</td>
</tr>
<tr>
<td>Culture should be discussed during coursework about clinical training.</td>
<td>6.78</td>
<td>0.42</td>
<td>6.75</td>
<td>0.46</td>
<td>6.80</td>
</tr>
</tbody>
</table>
### Perceptions About Education by Type of Courses Taught: Means and SD

<table>
<thead>
<tr>
<th>Questions</th>
<th>All UG</th>
<th>Most UG</th>
<th>Equal</th>
<th>Most Grad</th>
<th>All Grad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture should be discussed with respect to music therapy research.</td>
<td>6.63</td>
<td>6.75</td>
<td>0.46</td>
<td>6.80</td>
<td>6.50</td>
</tr>
<tr>
<td>It is essential to discuss culture in all music therapy courses.</td>
<td>6.26</td>
<td>7.0</td>
<td>0.00</td>
<td>6.50</td>
<td>6.00</td>
</tr>
<tr>
<td>In order to adequately address culture, it is ideal to have a separate course on the topic of culture &amp;/or multicultural awareness.</td>
<td>5.15</td>
<td>5.5</td>
<td>1.31</td>
<td>6.40</td>
<td>5.00</td>
</tr>
<tr>
<td>Non-musical elements of culture, such as worldview, customs, history, beliefs, oppression, or acculturation, are beyond the scope of the music therapy curriculum.</td>
<td>2.37</td>
<td>1.36</td>
<td>1.93</td>
<td>1.60</td>
<td>1.70</td>
</tr>
<tr>
<td>Topics regarding race, religion, or sexuality are too volatile to be discussed in the music therapy classroom.</td>
<td>1.67</td>
<td>0.92</td>
<td>2.13</td>
<td>1.70</td>
<td>1.89</td>
</tr>
<tr>
<td>It is essential that students examine their own culture in at least one music therapy course.</td>
<td>6.41</td>
<td>6.75</td>
<td>0.71</td>
<td>6.90</td>
<td>7.00</td>
</tr>
<tr>
<td>I have adequate time in the courses I teach to address issues of culture in music therapy.</td>
<td>4.33</td>
<td>4.00</td>
<td>1.41</td>
<td>4.10</td>
<td>2.13</td>
</tr>
<tr>
<td>I have adequate resources to address issues of culture in music therapy courses.</td>
<td>4.7</td>
<td>4.12</td>
<td>1.55</td>
<td>4.60</td>
<td>3.00</td>
</tr>
<tr>
<td>I fear that I would face retribution from my university/college/dean/supervisor if I discussed culture in music therapy courses.</td>
<td>1.85</td>
<td>2.62</td>
<td>1.69</td>
<td>2.50</td>
<td>2.01</td>
</tr>
<tr>
<td>I believe that I would face resistance from my students if I discussed culture in music therapy courses.</td>
<td>2.04</td>
<td>3.62</td>
<td>1.85</td>
<td>3.20</td>
<td>2.50</td>
</tr>
</tbody>
</table>
Summary of Quantitative Results

Analysis revealed several differences in the overall scores for cultural attitudes and skills. Participants were considerably less confident about their skills with clients who do not have a shared culture than they were with children and adolescents; they were most confident about their skills with cisgendered adults and with people who have a disability. Participants were least confident about their ability to critique assessment or research with respect to cultural considerations. These results indicate areas of growth for music therapists’ skills with people who are different from themselves.

Analysis also indicated that cultural attitudes and skills differed among participants according to various demographic factors. Those who identified as bisexual, non-binary gender, or person of color indicated greater skills and cultural awareness on several attitudes and skills (Self-Evaluation, Awareness of Effect of Culture, Belief in Stereotypes, Continuous Learning, and Can Critique Research). The scores on all items were higher for those whose highest degree was a master’s degree in music therapy than for those whose highest degree was a bachelor’s degree in music therapy. Statistical significance on five of the items suggests that the master’s degree might be instrumental in impacting music therapists’ cultural attitudes and skills. Educators were significantly more likely than non-educators to score better on Awareness of Effect of Culture, Belief in Stereotypes, and Can Critique Assessment. In fact, analysis indicated that scores on these items could identify whether or not a person was an educator.

Analysis of what participants reported learning in undergraduate and graduate curricula revealed that undergraduate curricula contained more coursework related to praxis regarding culture, whereas graduate curricula had more coursework related to non-
musical elements related to culture. Participants indicated that a wide range of experiences and workshops significantly impacted their understanding of cultural factors. Responses by educators indicated agreement that culture should be addressed in music therapy curricula, although there were differences regarding the context and delivery of this education. These quantitative results are further examined in the discussion section, following the qualitative results.
Qualitative Results

Description of Participants

Using the demographic information provided by those who wanted to be interviewed, the interview participants were chosen via purposive sampling to include a variety of perspectives and identities. The demographics of the participants are presented as a group description in order to maintain the confidentiality of those who might be identifiable by individual information. This is followed by individual descriptions.

Group Description

Seven participants were interviewed: three identified as male, three as female, and one as having a non-binary gender. One male and two females specified that they were cisgender. Of those who stated their sexual orientation, three identified as straight or heterosexual, one as pansexual, and one self-identified as a “dyke.” Three participants were White, one was Latinx, one was Black, and two were Chinese. One additionally identified as South East Asian. Two participants stated that their family is bicultural or biracial. Two stated a religious affiliation: one was Protestant-raised, and one identified as atheist, from a Christian family, with strong ties to the Jewish community. One person identified as university educated. Two people included dis/ability in their description: one person as non-disabled and one as learning disabled. Three people included economic indicators: two stated middle class and one stated both affluent and capitalist. Their ages at the time of the interview ranged from 30 to 51 ($M = 37.66, SD = 9.64$).

All of the participants lived in the eastern United States. The participants reported working with: women in recovery from substance abuse, adolescents with emotional disorders, patients in medical settings, people who have autism, hospice clients, adults
with intellectual disabilities, and children who have developmental delays. Four participants were music therapy educators; one was a full-time professor. All participants had supervisory experience, having supervised music therapy students, interns, or music therapists. There was no inquiry into the length of time in the profession.

**Individual Participants**

The participants are introduced with a gender-neutral pseudonym followed by quotes and paraphrased ideas from their interview to give the reader a sense of that person as an individual.

**Alex.** “[I] learned a lot from different work-based trainings around culture… My education has been informal education” and on-the-job training. “I would love to see more of this education [regarding culture] formally done in classes,” but too often people “… don’t see how all these [issues regarding cultural responsiveness] affect them and they don’t see how it affects their students, because they have … power and privilege and they are able to just to overlook it.” So, what is the next step? I think that “the next step … is teaching educators” how to be more effective at introducing cultural humility.

**Amari.** This topic is “dear to me because I’ve seen where we fall short in addressing issues of culture, diversity, and inclusion in music therapy.” In particular, “I think in music therapy when we talk about culture, we’re still at the individual level”; instead we need to look at how we each influence each other as part of a system. As a field, I believe we have to be cautious if we “set Western Classical Music as the standard for music” because that makes music from other cultures “an accessory and elective… this exotic little thing.” If we have that attitude “we’re going to be putting our students, our clinicians, and our clients, ultimately at a disadvantage.”
Bei. In my opinion, we should be “moving away from the word multiculturalism, moving into cultural reflexivity or cultural humility”; because multiculturalism implies “awareness and tolerance of other races and cultures within the demographic, but … no acceptance or celebration or even representation or inclusion of minority races where it counts.” I find that our education in the United States is very Eurocentric, so we have to guard against “a White gaze towards other cultures… putting on White labels upon the other cultures.” Yet, I am optimistic because “I think that people want to go in the right direction [even if] that involves acknowledging that we are not perfect.”

Francis. When I was a music therapy student, about 5 years ago, “I always felt as though everyone had good intentions; I just think the field as a whole was lagging a little bit behind other fields that are in that similar area.” However, in therapy “everything is related to culture … it’s going to impact the relationship and at the end of the day, your relationships are everything.” I would love to see more diversity in the field, but in order to successfully pursue a degree and career in music therapy “that is a reflection of tremendous economic privilege.”

Logan. Although “I live in a … small town, and it’s pretty homogenous and people that I work with are very homogenous. … Even when I work with someone who is from a different class, or different educational background, or political background …ultimately, it comes down to the individual and I just have to get to know the individual. … I’m an individualist.” So, even though “I really haven’t had to deal with it as much as probably some other music therapists in the field,” I did feel “motivated to kind of continue a conversation” and explore this topic.
Morgan. I believe that “we each have multicultural aspects to our identity,” so “every interaction that we have is a cross-cultural interaction.” As educators and clinicians, we need to constantly be learning about the impact of culture on our work. We are all “people working with people, and the people that we are working with are disabled by many aspects of the way our society is… so I can’t look at the world without having that critical lens, because I can’t divorce the ways in which we interact [from] the ways in which we might continue to marginalize people.”

Quinn. In my perspective, I want to see music therapists “go beyond the music … Is this therapeutic, is this purposeful?” I think that cultural humility is just the start of a process in which music therapists examine the meaning and context of the music for both themselves and the client. Yet, I find that there is a lack of research about how to address this. I am also hesitant sometimes because anything I say “…becomes this Bible of like, oh, because that person said it, that’s the right way.” I want to see more people engaging in the conversation about cultural humility, so that we have more “voices to help frame that a bit more.”

Interview Questions

The interview consisted of open-ended questions. Participants were asked about: their training and experiences with respect to learning about culture; whether, and to what extent, their work has been impacted by considerations of culture; and how they think the field of music therapy is progressing with addressing multicultural music therapy. Educators were additionally asked how they teach about and challenges they have faced regarding multicultural music therapy. The full interview script is in Appendix B.
Themes

During analysis, nine themes were found. The first two themes, *Personal Connection to Conversation* and *Silenced Minority Experiences*, arose from participants’ discussion of their personal experiences and training. The next three themes related to the education of music therapists. The theme *Teaching – Where to Start?* captured concerns regarding the scope, depth, and/or approaches appropriate when talking about culture in the classroom. *A Master’s Level of Knowledge* captured participants’ concerns about the amount of space in the undergraduate curriculum for courses or discussions about culture. The final theme related to education, *A Very White Lens*, included participants’ concerns about a Eurocentric bias in many music therapy programs.

There were three themes regarding participants’ reflections about whether, to what extent, and in what ways—music therapists need to bring an awareness of culture. *When Does Culture Matter?* includes two opposing ideas: the notion that culture is in every single interaction, versus the belief that culture is not a necessary consideration for someone working in a homogenous town. The statement, *I’m not Racist! I’m a Good Person*, is the title of the theme that captures the false dichotomy that if someone is a good person, they are not racist (and conversely, if they appear racist they are bad). This theme further explores participants’ reflections on stepping into the uncomfortable space of examining themselves. The theme *What Do We Know?* relates to cultural humility and captures participants’ explanations of a stance of humility and respect.

The last theme, *Toward a More Diverse Profession*, captures participants’ statements about diversity in the field of music therapy and the importance of AMTA and CBMT requirements. The themes are shown in Table 13.
Table 13

*Interview Themes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Connection to Conversation</td>
<td>I wanted to add my two cents.</td>
</tr>
<tr>
<td></td>
<td>Training? Even then I found it lacking.</td>
</tr>
<tr>
<td></td>
<td>My exposure outside classroom was beyond formative.</td>
</tr>
<tr>
<td>Silenced Minority Experiences</td>
<td>It is a very different experience being a minority person in AMTA.</td>
</tr>
<tr>
<td></td>
<td>Usually it is the same people talking about culture.</td>
</tr>
<tr>
<td></td>
<td>I can’t teach the music without talking about privilege.</td>
</tr>
<tr>
<td>Teaching - Where to Start?</td>
<td>Important? Yes! But where do you even start?</td>
</tr>
<tr>
<td></td>
<td>There are several challenges.</td>
</tr>
<tr>
<td></td>
<td>A never-ending conversation.</td>
</tr>
<tr>
<td></td>
<td>Bringing other discourse to music therapy.</td>
</tr>
<tr>
<td></td>
<td>That is the approach I want to embody.</td>
</tr>
<tr>
<td></td>
<td>I think the next step is educating educators.</td>
</tr>
<tr>
<td>A Master’s Level of Knowledge</td>
<td>But how much can you expect from a BA program?</td>
</tr>
<tr>
<td></td>
<td>If we move to master’s level entry…</td>
</tr>
<tr>
<td>A Very White Lens</td>
<td>Whitewashing music, whitewashing therapy.</td>
</tr>
<tr>
<td></td>
<td>So much embedded cultural appropriation.</td>
</tr>
<tr>
<td></td>
<td>So then that person can’t audition for our programs.</td>
</tr>
<tr>
<td>When Does Culture Matter?</td>
<td>People like me? We don’t care about this culture stuff.</td>
</tr>
<tr>
<td></td>
<td>Everything is related to culture, everything.</td>
</tr>
<tr>
<td></td>
<td>Colorblind/client-centered approach.</td>
</tr>
<tr>
<td>I’m not Racist! I’m a Good Person</td>
<td>White fragility/Too much focus on diversity.</td>
</tr>
<tr>
<td></td>
<td>That uncomfortable space of examining ourselves.</td>
</tr>
<tr>
<td>What Do We Know?</td>
<td>Good intentions or microaggressions?</td>
</tr>
<tr>
<td></td>
<td>I still make mistakes.</td>
</tr>
<tr>
<td></td>
<td>We don’t know what we don’t know.</td>
</tr>
<tr>
<td></td>
<td>Bring humility, desire to learn, and respect.</td>
</tr>
<tr>
<td>Toward a More Diverse Profession</td>
<td>Diversity in the field of music therapy.</td>
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<td>Steering things in the right direction.</td>
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Theme 1: Personal Connection to Conversation

More than half of the interview participants ($n = 263$) stated that they wanted to be interviewed for this research. Even among people who were sorting out whether or how the topic of culture impacts them personally or professionally, everyone who was interviewed indicated a desire to engage in a conversation about culture. Some participants’ personal investment in the conversation was related to shortcomings they perceived in their own education; participants also noted that experiences outside the classroom were essential to their own understanding of culture. This theme revealed a personal investment in the topic for all 7 interview participants.

“I Wanted to Add My Two Cents.” All of the participants wanted to contribute to the conversation about culture, albeit for different reasons. Amari hoped to contribute to the conversation: “I’ve seen where we fall short in addressing issues of culture, diversity, and inclusion in music therapy.” Morgan stated that the topic is one they feel “really passionate about.” On the other hand, Logan seemed to be forming ideas during the interview, stating at one point, “I think culture and race at the moment are big, not so much race, … so I think it’s something that we should all be talking more about.” It seems that Logan was self-contradictory here, regarding whether race was significant or not (is race big, or not?), as well as in other parts of their interview, as they sorted out whether or not race and culture are in fact something we should be talking about, and if so, why. All participants suggested a need to expand the conversation about culture and diversity; one effect of doing so might be for people like Logan to explore their own experiences.
“Training? Even Then I Found it To Be Lacking.” All participants found something lacking in their formal education regarding culture; several participants reported it was nearly absent in their music therapy education. Frances, for instance, shared: “[I graduated in 2015], and when I was a student, I felt very frustrated, because I felt like it [culture] was discussed and considered so little.” Alex and Amari both found that much of their education contained overgeneralizations or lacked necessary context. Alex described “learning the music of cultures, and sort of learning like the Mexican hat dance, and how to do it and we got a book of different songs and different cultures, and I found it really quite useless.”

Bei also described a lack of context in their coursework, which included multicultural music therapy, as well as music and world cultures. However, Bei stated, it did not foster “understanding the essence [of the music] truly from that culture’s perspective,” since the discussions were “always coming from what is a White gaze toward cultures.” Concerns about this White gaze are discussed below. This sub-theme revealed several problems with participants’ training, although the interviewer did not investigate the details of participants’ training.

“My Exposure Outside the Classroom Was Beyond Formative.” Participants all noted that trainings at work, on-the-job experience, and personal engagement with people of different cultures were critical to their understanding about working with people from various cultures. Alex said: “I learned a lot from different work-based trainings around culture,” but “a lot of it is based in working with people from all over the world. … my education has been informal education mainly.” Three of the participants reflected on the critical impact of growing up in the presence of several
cultural backgrounds. Frances described growing up in a “very multicultural, multigenerational type of environment,” adding that they were “so blessed to have that.” For Amari, having grown up in the presence of several cultures “was beyond informative,” and later stated, “I would agree that people learn more about culture outside the classroom than in.”

**Theme 2: Silenced Minority Experiences**

Many of the participants have experienced being silenced or their ideas being discounted. This theme captured the fact that participants have experienced this, although an examination of these experiences in detail was beyond the scope of the present research. Participants shared experiences of being silenced or marginalized, as well as experiences of carrying the extra burden of being expected to educate others. This theme indicated that music therapists who belong to minority groups often feel marginalized within the field of music therapy, and it points to the need for all music therapists to acknowledge the effects of power and privilege. As Alex noted, often people “don’t see how all these [issues about diversity] affect them,” but they do.

*“It Is a Very Different Experience Being a Minority Person in AMTA.”*

Francis and Quinn both spoke about times that their knowledge was dismissed. As a student, Francis tried to share their perspective as a minority with the classroom but felt silenced, remembering, “… there's that power dynamic and I didn't want to say anything. … I did everything I could do that felt comfortable and relevant.” Quinn was aware of a different dynamic as a supervisor; they became apologetic for their minority status when students questioned feedback. The students were “… saying like, I belong in this, I know
more about White culture. I know more about what’s happening with the client than this … minority supervisor is telling me.”

Bei and Alex both mentioned the extra burden that marginalized music therapists carry: in addition to doing their work as a music therapist, they are often asked to educate others about difference and to help others with their discomfort about difference. Alex said, “You are choosing the minority to do the … work.” Bei explained that this is “a burden because sometimes it re-traumatizes people … [They have] the burden of educating and then also comforting other people where it’s not their responsibility … they [then] have to take care of the people who are marginalizing them.” Further, according to Amari, often therapists who identify with minority groups:

…don't feel like they fully belong to the field of music therapy. … Because there are always things that kind of make them recognize that their status is different or outsider. … like some of them have had their music kind of dismissed, or not recognized as valid, or some of their cultural knowledge has been dismissed or invalidated.

Alex also shared their experience, explaining:

It is a very different experience being a minority person in AMTA than the majority. … You know the way it is for those of us who are minorities … very aware of your differences every day and throughout the day. … people in the majority cultures don’t have that experience. They just glide through life and don’t have to think about those things [such as discrimination and being marginalized].
“Usually it Is the Same People Talking About Culture.” Several participants noted that more music therapists are talking about culture. Francis said: “I feel like it [culture] is on the radar more than it was before.” However, participants also noted that a small group of people seem to have taken on the responsibility for conversations about the intersections of culture and music therapy, a responsibility which they felt should be shared. Quinn stated that when “attending conference, the ones that are talking about culture issues are the same people [who were] talking about it [at the last conference].” Morgan suggested that “we need people … with various marginalized identities in the conversation and not just the same ones all the time.”

“I Can’t Teach the Music Without Talking About Privilege.” Several participants mentioned the importance of acknowledging one’s own privilege and being aware of the ways in which privilege impacts music therapy. They expressed that conversations about privilege should be part of the music therapy curriculum so that experiences of others are honored, not silenced. Amari spoke of educators who said “they couldn't continue to teach just the music without talking about power and privilege,” explaining that power and privilege affects why the music was written, what it means, and how it has been used. Several participants discussed the importance of understanding music within the context of particular music cultures.

Alex and Francis both noted the importance of acknowledging their own unearned privilege and of recognizing how their own intersectional identities are composed of both marginalized and privileged groups. Francis shared an awareness that because some of their differences are not visible, it affects “what I'm able to do, because of my race and presentation.” Alex stated, “I’m willing to spend my privilege to help others, so we can
all work together to change these systems … We need to not let the patriarchy and other systems keep us apart in organizing, and making things happen.” However, Morgan often found that students or therapists are not willing to acknowledge their unearned privilege: “It becomes more difficult when people really hold on to their oppressive stances, and unfortunately there’s more of that than we think within our communities in music therapy.”

**Theme 3: Teaching - Where to start?**

Aspects of teaching were mentioned by both educators and non-educators; this theme captures that a significant part of the interviews regarded participants’ reflections about the education of music therapists, and that there were various topics covered. Six of the participants spoke about the importance of discussing culture within the music therapy curriculum, but they noted various concerns including: lack of research about how to approach the topic, lack of clarity on what should be discussed, and the need to support educators regarding both of those. Many participants thought culture should be discussed throughout the curriculum. Some participants also shared their approaches or their use of discourse from other fields. This theme captures a range of ideas and concerns regarding teaching about this topic that, according to most participants, is essential.

“**Important? Yes! But Where Do You Even Start?**” Many participants agreed that although it is crucial to discuss cultural responsiveness, it is not always clear where to start the conversation. Quinn expressed this lack of clarity about how to start these discussions with students or colleagues, asking “Where do you even start to talk about it? Should it be awareness thing or should be like a self-discovery class [sic]?” Quinn found
that this is further complicated by a lack of research on best practices about how to teach cultural responsiveness in music therapy: “It’s hard because firstly there’s no research at all … and it’s hard to tackle those kinds of questions from a research perspective.”

“**There Are Several Challenges.**” Both educators and former students noticed challenges with teaching about culture in music therapy. Francis shared that as a student they found that not all of the professors agreed that we need to be talking about culture, and “that’s the biggest problem.” Another concern was a lack of clear definitions of culture and multiculturalism. Morgan stated: “one of the problems in music therapy is that I think we’ve got so many differing definitions of [culture] that I don’t think we’ve grasped it properly…” Quinn also noted that people are saying there is a need for cultural issues in music therapy: “But like okay, so, what should it be? … what I hear during class or whatever when these types of issues come up it’s like ‘oh yeah we should be thinking about it,’ but the conversation just stops there.”

If the conversation does start, several participants shared the challenge that people are often seeking a single correct answer. Students may offer the answer they think that the professor wants to hear, making it difficult to gauge students’ engagement. In addition, Quinn advised caution against reacting to a person’s identity in a fixed way: “It [can] become this almost rabbit hole/prescriptive thing where oh, if you see an Asian person do this and that’s it; or if you see a Black person do this and that’s it.”

Ultimately the information requires thoughtful application. Morgan mentioned: “When I introduce certain concepts [from a critical theory stance], sometimes what students would do is that they suddenly take it to an extreme.” Alex, also concerned about application, noted that not all educators have sufficient experience in applying the
information they have learned; if educators “didn’t spend a ton of time as clinicians… they don’t have that experience for years of working with all [kinds of] different people.” Alex wondered how those educators could then teach about working with diverse people.

Participants also noted the importance of having diverse faculty. Alex noted that each person can only speak about their own experience when teaching: “I can’t speak to everything, by any means. I try, but I can’t.” Amari, who is not White, shared a time when they spoke about racial differences, stating:

I know it made a difference for at least one African American student that I had because I'd heard from other professors before I had her that she tended to be guarded and withdrawn in classes. But, because I was talking about how cultures, some cultures are resistant to therapy as we do it in the West and that sort of a thing, she was able to jump right in there with her background. … and from the first day to the very last day of class she was in, she was involved.

“A Never-Ending Conversation.” Several participants noted that the topic of culture cannot be adequately addressed in one short conversation. Alex stated that if it is presented in a single class, “It’s just like a drive by of, like what is cultural responsiveness and the three different things of learning about yourself, learning about cultures, changing your practice … you can’t really do anything in-depth there.” Quinn found that people often do not recognize how much depth or time is required, stating that sometimes people “think that it’s an easy fix where is it, ‘Oh, let’s just talk about culture, oh, that’s easy;’” citing situations in which co-presenters wanted to add just one slide about culture and did not seem to understand the complexity of the topic: “Then my co-presenters were like, ‘… we should keep it generic.’”
Alex wondered aloud about how to further keep educators engaged in continual learning. “You want to be careful, you want them [the educators] to feel empowered, … but not so empowered that they just feel like they can teach this, and they don’t need any more help after one [Continuing Music Therapy Education course].” Francis suggested: “It’s just like a never-ending conversation.”

**“Bringing Other Discourse to Music Therapy.”** Several music therapy educators utilize concepts and frameworks from other disciplines. These included the concept of structural competence, a family dynamics perspective, and critical theories. Educators also noted the importance of being aware of the broader context of any music style. Amari suggested:

> Just because your clients like hip-hop, [it] is not enough to just learn the music without learning the sociopolitical context of the music, the cultural context of the music. How did this music come about? Why? Why does this still have this relevance for people now? Like it’s, it’s not just a trendy fad thing, but it serves as a voice of a culture. … what has happened to oppress and marginalize people who belong in hip-hop culture, and how that contributed to the development of the music.

Amari offered that another way to look at a client’s larger sociopolitical context is to take a view of “structural competence … recognizing that a person exists within a system. And that the system has been set up to advantage some over others.” On the other hand, Quinn uses a “family dynamics perspective.” When working, for example “with a Chinese family versus [an] African American family versus a White family, … [one should be attuned to the differences in] the dynamics between parent child interactions.”
Morgan and Bei each discussed how they bring critical race theory, feminist theory, dis/ability theory, and queer theory to conversations about culture in music therapy. Morgan said: “[I] can’t look at the world without having that critical lens, because I can’t divorce the ways in which we interact with the ways in which we might continue to marginalize people.” Both participants spoke about the value of critical discourse to music therapy.

Further talking about a dis/ability lens, Bei brought attention to “so much ableism that’s embedded within … the Nordoff Robbins literature in particular.” Morgan noted that many philosophies of therapy suggest an ableist stance; therapists “almost see themselves as subject, and the person that they are working with is an object to be worked on and to be fixed and normalized, and that sort of colonialist sense of coming in, and taking over.” Such an approach assumes a position of power on the part of the therapist.

Although Logan did not have a critical dis/ability viewpoint, they described the dis/ability culture within the autism community as: “the biggest cultural thing that I’ve experienced.” Logan is quoted in other themes as not finding culture relevant to music therapy practice because of living in a homogenous town; however, near the end of their interview, it seemed that they shifted their understanding of culture, recognizing dis/ability culture as an experience of culture.

“That Is the Approach I Want to Embody.” Educators shared their approaches to teaching about culture. Amari suggested: “Just bringing awareness to something and inviting conversation. I think that’s my approach or that’s the approach I want to embody.” Morgan brings humor, as well as: “A lot of vulnerability of my own, a lot of
self-disclosure, honesty and I have told them they can hold the mirror up to me…” Alex similarly found that self-disclosure works best: “My style or the way that I am is just to be open and authentic with people… being [willing to admit] ‘I struggled with this’…” Alex noted that some educators are more confrontive in their style “like in your face sort of way, of a very confrontive way of talking about things … and that’s cool … it’s just another style.”

“I Think the Next Step Is Educating Educators.” Several participants noted that teaching educators how to conduct difficult conversations about race, inclusion, equity, and diversity would cause change throughout the field. Alex stated: “The next step, I think, is educating educators,” suggesting that “it really needs to be a hands-on sort of thing because you [can] read about it [how to have these conversations], but that doesn’t mean that you understand it.” Morgan noted the difficulties when educators and therapists “are in dominant groups … it’s hard to be able to see [and understand] oppression if you haven’t had experiences with being marginalized in the past.”

**Theme 4: A Master’s Level of Knowledge**

This theme captured participants’ suggestion that a master’s level entry for music therapy is necessary in order to provide the necessary time and space to engage with topics regarding cultural humility and responsiveness. Participants’ primary concerns were: lack of space in the undergraduate curriculum, and undergraduates’ ability to grapple with topics regarding power, privilege, and oppression.

“But How Much Can You Expect from a BA Program?” Five of the participants voiced concerns about finding space in a bachelor’s program to discuss issues regarding culture. Francis noted that a lot of information “was squeezed into the
[music therapy] program.” With so much time spent on essential topics regarding musicianship and therapeutic presence, they found that discussions about the impact of culture were missing. Francis acknowledged that this would add a third area to the course of study and asked: “How much can you expect from a bachelor’s program?” Quinn had heard a similar explanation of why discussions about culture are omitted: “Undergrad students are overwhelmed with curriculum and then if [you] add culture… [it would add too much] to their plate.” Alex acknowledged that undergraduate educators are “focused on getting people graduated, or revamping the program or … CBMT scores,” and are often unable to see how they can add anything else.

Although Morgan believed that discussions about all of our multicultural aspects need to be introduced in the undergraduate curriculum, they suggested that the way undergraduates understand therapy may cause challenges in students’ readiness to grapple with aspects of the topic. Morgan explained that undergraduates are often:

So excited to be what they think a therapist should be, which is somebody who is helping somebody else, and in some ways fixing them. … [But if we examine] how we engage in keeping people disabled, rather than coming from an anti-oppressive stance, … [it] will put them [the students] into a real spin… they haven’t got enough grounding in it [music therapy] to deal with that tension.

In a similar vein, Bei questioned undergraduates’ ability to apply a critical lens to what they are learning, suggesting “if there are undergrad students who can do it, they are not being given the room for that because that’s not how an undergrad program curriculum is designed.”
“If We Move to Master’s Level Entry…” Six participants suggested that master’s level entry for music therapy would give space in the curriculum for this essential topic, while allowing students to gain the maturity to address it on a deeper level. Bei stated that this level of critical thought and maturity are needed because therapists are “in the place of privilege, power, and also the place of authority. That means that these therapists … [can] impose their own beliefs about music, culture, health upon their clients and what is the ideal goal for the clients.” Amari shared their personal experience of needing a master’s level of knowledge to comprehend the processes and “unanticipated reactions or untypical [sic] reactions” that were unfolding in their first music therapy job.

**Theme 5: A Very White Lens**

Bei used the phrase “a White lens” to describe a Eurocentric perspective. They suggested that this results in viewing both music and therapy through the lens of White standards being the norm. Several other participants shared concerns that a Eurocentric worldview affects the admissions standards to schools that teach music therapy, as well as how music therapy is taught, practiced, and even who enters into music therapy programs. Participants cautioned that this White lens fails to honor the experiences of many students, therapists, and clients. This theme captures their concerns about this White lens.

“Whitewashing Music, Whitewashing Therapy.” Bei, Amari, and Quinn articulated concerns that our education system whitewashes both music and therapy. Bei was most emphatic in explaining that schools are often:
acknowledging that there are different cultures outside White culture, but then it’s treated through a White lens. [There is] awareness and tolerance of other races and cultures, … [but] always coming from what is a White gaze towards other cultures… it doesn’t really talk about the intersectionality of different cultures… or understanding the essence from that culture’s perspective… [and this results in] putting on White labels upon other cultures… [and] imposing these White standards of aesthetics and health upon their clients, whether or not it is most culturally relevant for their clients. …

Participants noted that courses on music anthropology are not sufficient; music therapists need support in developing a clinical perspective about the music. Quinn said “topics in music and culture” courses had been offered as multicultural education courses, but “it was not related to music therapy… yeah you have the knowledge, but again how does it tie in with music therapy in the cultural context?” Amari noted that music from other cultures is often:

othered … like an accessory and elective, it’s like this exotic little thing that’s not given the same weight and consideration as classical music…. [That will] still keep a very skewed picture of what music is in the world. If we have that same kind of attitude in music therapy, then we’re going to be putting our students, our clinicians, and our clients, ultimately at disadvantages.

Quinn suggested that it is limiting to present White culture as the norm that everyone understands; rather there is a need to examine culture as a general construct:

[For] minority people or people from other countries, there’s no class on American culture [and] American music, but there’s class on like Chinese
music… we are so focused on, ‘Oh, we need to learn about other cultures’ but how open are we to letting other people learn about us?

“So Much Embedded Cultural Appropriation.” Cultural appropriation is an effect of whitewashing that was briefly mentioned only two times in the interviews. Bei noted that “there is so much cultural appropriation in the way they [Nordoff and Robbins] describe music.” Bei did not expand on this topic, only giving a short example about a case study in which the Chinese pentatonic was used to reach the “most unreachable child.” The other brief mention of cultural appropriation was from Morgan who mentioned that technology can lead to “a lot more appropriation … [because it] has increased … access to various music around the world,” Morgan suggested that greater understanding of music cultures is needed to mitigate this type of appropriation.

“So Then That Person Can’t Audition for Our Programs.” Amari and Francis suggested that placing European classical music as the standard of admission to music therapy programs may present a barrier to musicians who reach high standards by other measures. Amari noted:

There are so many musicians who come up in churches, or local bands and groups, who have phenomenal skills and probably have great presence and could be wonderful therapists. But, they never learned Beethoven on the piano, they never learned to sing an Italian Aria. So, they can't audition for our programs that way.

Francis further explained: “to study music therapy requires a tremendous amount of privilege,” since admissions to a school of music requires that you have had music lessons or lived in a school district that had a good music program. They further
suggested that “it would be one thing to pass an audition, but to have the finances to be a part of such a rigorous program to completion, especially during your internship, like all of that is a reflection of tremendous economic privilege.”

**Theme 6: When Does Culture Matter?**

This theme arose from analysis that suggested there is not agreement when culture matters for a music therapist. Logan stated an opinion that is likely shared by other music therapists: that culture is not important on a daily basis. On the other hand, many of the other participants spoke of culture being an ever-present phenomenon in music and all human interaction. Separate sub-themes contain participants’ explanations for each of these ideas; a third sub-theme presents contrasting views on a client-centered approach.

**“People Like Me? We Don’t Care About This Culture Stuff.”** Throughout the interview, Logan said they were “thinking out loud” about why, and to what extent, culture mattered in personal or professional spheres. They first stated that culture was not important on a day-to-day basis because they live in a homogenous town. Later they stated that they live in a diverse college town, but that culture was not important professionally. In other descriptions of the town, Logan did not acknowledge its diversity. Yet, the neighbor who babysits for their children is an immigrant from Africa; their best friend is Black; and they have a Hispanic client. Logan shared these contrasting views of their town:

I live in a pretty small city, small town, and it’s pretty homogenous and people that I work with are very homogenous. … [the] cultural sensitivity that needs to be present when you're living in a … different place than I live in, with different populations, and different people and different backgrounds. … I really haven’t
had to deal with that as much as probably some other music therapists in the field. … The whole concept and conversation about cultures is one that is increasingly strained and… if you look at your everyday Joe just walking around living their life doing their thing, including me, it’s not a big deal at all. Nobody cares about all this racial stuff. Nobody cares about all this culture stuff. … Nobody really cares about what language you speak, as long as you’re nice, as long as you are friendly and as long as you do your own thing and not harm anybody else.

Later Logan stated:

I live in a college town. So, there’s a significant number of people who are of different backgrounds, and from different countries … But when it comes to my professional life, everybody that I work with is White, except for one Hispanic family that I work with.

Yet Logan acknowledged the importance of music preferences related to religious holidays, adding, “I was glad that I looked into that…” because they further explained client preferences were not always predictable.

“Everything is Related to Culture, Everything.” On the other hand, five participants stated that culture touches all music therapists’ work since both music and people are shaped by culture. Alex explained that:

Music is a cultural phenomenon or artifact, and so we are working with a cultural thing, … there is a lot of emotions that are culturally based and also the way we express emotions is culturally based. So … then it’s all culture…
Francis additionally noted: “how close you’re sitting to somebody, what tone of voice you use, the eye contact, what level of formality you use, … everything is related to culture, everything.” Morgan suggested this is true even if when it is not obvious:

We might think that we are not having a cross-cultural interaction… but even the interaction between therapist and the minimally responsive client, there’s already going to have cross-cultural issues like that come out, and especially because if the person is minimally responsive and let’s say the therapist is so used to privileging verbal culture over non-verbal culture that would already be a cultural limitation.

Bei suggested the therapeutic process is: “A journey together that the client has to learn about us too, it’s a two-way process for that relationship to happen.” These participants all noted that both the client and the therapist bring their own unique culture to the encounter.

“Colorblind/Client-Centered Approach.” Participants shared different perspectives regarding a client-centered or person-centered approach. Logan suggested that an individual approach to therapy is best:

I'm an individualist, I see the person in front of me, and I treat him as a person with dignity and respect and that's how I work. I don't hold any allegiances to any race or anything like that. … I can try to be aware and be mindful, know a lot about certain cultures and whatnot. But ultimately, it comes down to the individual. … It’s all about person-centered [practice].

Amari, on the other hand, cautioned that culturally responsive music therapy is not the same as client-centered music therapy. In culturally responsive music therapy, they
explained, you also respond to the client’s context. Amari suggested that the problem of addressing culture on an individual level is that:

it runs into that place of being colorblind for lack of a better word, where all I see is people, and on the one hand that’s a beautiful sentiment, but on the other hand it dismisses a lot of the realities and nuances of someone’s experiences. … I mean yes, you still put the client at the focus, but it’s understanding the context of the client, and how that comes in to play in music therapy.

**Theme 7: I’m Not Racist! I’m a Good Person.**

Four of the participants noted that people often avoid conversations about difference because of fear of sounding racist or making a mistake, and therefore being seen as “bad.” Bei explained that:

there is that false dichotomy of good person, bad person linked with racism that exists. … So, people are hesitant, afraid, and defensive about going into that uncomfortable space of examining themselves. … People don’t know how to navigate through that discomfort and just either immediately shut down and stop the conversation or challenge it in ways that are not tactful [or productive].

Analysis of text for this theme suggested that these elements, the good/bad dichotomy, White fragility, concerns about so-called reverse discrimination, and the difficulties of navigating one’s discomfort, have stopped or limited conversations that the participants tried to conduct regarding diversity or inclusion.

“**White Fragility/Too Much Focus on Diversity.**” Several participants described experiences of “pushback” when discussing diversity: they had been told that they were
making other people uncomfortable; or that they were practicing so-called reverse-discrimination. Bei was told by co-participants in a music therapy organization that:

they think that we are focusing too much on diversity, race, or cultural type issues
… those are the times where I … question myself if what I’m noticing is wrong.
… it’s a silent form of gaslighting where their actions make me question myself.

Alex similarly found that:

White fragility and straight fragility and all of that is just so, it’s so pervasive and so hard to work around. Quickly people go to the idea of reverse discrimination and all that stuff … I wonder if maybe I’m not raising the conversations right because I see people get super defensive and then shut down to talk to me about this.

Logan on the other hand shared concerns about reverse-discrimination and “White views” not being respected. Logan spoke of:

a lot of anti-Christian, anti-conservative bias… the prevailing powerful in the society are of a certain globalist culture and they are not interested in respecting conservative or Christian or White views. … people on the left saying that … people cannot have a say if they are of a certain race, creed, color, perspective, background, privilege.

Although Logan was the only interview participant who expressed this concern, it is likely that other music therapists share Logan’s views. This theme captured the tensions and some of the difficulties that participants have encountered in conversations about race or difference. As Alex noted, White fragility and concerns about reverse-discrimination often shut down the conversation.
“That Uncomfortable Space of Examining Ourselves.” Several participants suggested that it is necessary to engage in self-examination, and to enter conversations with other people about race and other differences. However, rather than work through the discomfort that these conversations might bring, people often avoid them. Amari explained:

Race is still something we’re uncomfortable talking about, … but we need to know that it’s something we have to address, and we have to learn to navigate with this discomfort. … I think people are just afraid, because they don’t want to be seen as racist, so, they’re afraid to say anything. … [it is hard, but necessary] to find and create that environment where people will feel safe enough to express curiosity, and to recognize where that statement is coming from. And recognize that, yes, you may still offend and people’s feelings may still get hurt, but we can find ways together to address that.

Bei suggested that similar conversations are also necessary regarding other types of difference. However, “It gets really complicated because a lot of our conversations here in America are very Black/White focused and then people do not see [other types of diversity].” Regarding conversations about race, difference, or privilege, Morgan emphasized that “needing to sit in that discomfort is really important.”

**Theme 8: What Do We Know?**

This theme captured participants’ suggestion that a person needs to approach others with a stance of cultural humility, bringing openness and respect. Participants suggested we all need to be willing to admit we don’t know things, and to acknowledge we all make mistakes. Several participants suggested that cultural humility provides a
framework which allows space for our mistakes, and space for us to be continually learning.

“Good Intentions or Microaggressions?” Francis and Amari both spoke about the good intentions of others; Francis stated “there was always a good intention of being educated in relation to different cultures.” There were “… a lot of people who had good intentions, but didn't seem to have the awareness, or the ability” to follow through.

However, Amari cautioned that good intentions are not enough if the person does not further examine their actions. Amari remarked that often people are:

well-meaning but they’re really saying things and doing things that are micro-aggressions, and it’s happening on all levels. It’s happening for the students with their peers, it’s happening for some of the clinicians with their colleagues or work supervisors, and it’s happening for the educators with their colleagues and their supervisors.

“I Still Make Mistakes.” Both Francis and Morgan spoke about the importance of acknowledging their own mistakes and of learning from students. Morgan shared:

They [the students] said that’s really important that you told us that you still make mistakes … there was [sic] many times when I was corrected, and I had to really like think, ‘Oh my goodness, I just made a mistake again,’ but without like throwing it out of proportion and so that was a really great learning experience for all of us, because we were all going through that at the exact same time and all making mistakes and all falling into [old] patterns.

“We Don’t Know What We Don’t Know.” Several participants stated that it is crucial to come from a place of not knowing rather than making assumptions. They noted
that a person’s assumption of knowledge often decreases that person’s drive to seek knowledge about cultures and how to interact with people from other cultures. Bei found that too often “people are already assuming they know everything about other cultures and how to work with other cultures.” Amari suggested that continual, respectful learning is essential: “There’s like no hard and fast rule as to how to go about engaging in this work, I guess. Apart from just really coming to it with this ‘I don’t know’; [because] there’s so much to know.” Morgan suggested that admitting what we don’t know might be particularly challenging to music therapists because of:

   a need to claim competence because of a… defense mechanism against everyone who has ever probably challenged what kind of profession they are doing. … so there’s probably a heightened kind of ‘Yes, I’m competent, and I’m really good at what I do and my profession [of music therapy] is worth it.’

However, as Bei stated, if a person thinks they have reached multicultural competence, there is the danger that they “think they are not racist but then still perpetuate all of these [racist] behaviors or all these actions.”

“Bring Humility, Desire to Learn, and Respect.” All of the participants mentioned that one must approach clients with humility and respect. Participants described this as cultural humility, cultural responsiveness, or cultural reflexivity: coming to the client with genuine curiosity, a desire to understand, and the humility of assuming you know nothing about that client and their culture. Alex described the humility they bring to encounters with clients and families:

   cultural humility… being able to say I don’t know and to learn and to be strong enough to be able to say that to my client, to their families, to be like, all right so
I’m really good at music therapy, but I’m not very good at your culture. … I don’t know anything about your culture and these are the things that music therapy can do for your child. Can you tell me more about music and your culture so I can make this work for your child better? Being able to be in that space, and … more of a co-creating with my client, or with the family in therapy, and not having to be the one in charge.

Quinn described cultural responsiveness as responding rather than reacting to the client: Like again when you see a Black person is like, oh, hip-hop, Motown, gospel, [that would be] … reactive as opposed to … responding to what their preferences are and you’re responding to what needs arise as the session progresses.

Bei suggested that an approach of cultural humility is needed no matter where one practices, sharing that when traveling to the country where they were born:

I would have to do my homework in cultural humility. … about how to approach maybe your own community… from a cultural humility viewpoint, [rather] than White healthcare system viewpoints. … [This is] not an international student specific problem; we are sending American music therapists out into the world to practice outside of America. Are we going to impose American health values upon South Africa?

Both Amari and Francis suggested that music therapists should be self-aware so that they know what cultural values and beliefs they are bringing into any relationship. Francis acknowledged that this can be challenging:

How much are we willing to put aside what we think we know, to listen to somebody else’s needs or experiences? And I think that can be, that can be hard
no matter where you started… a lot of times individuals have to do a lot of self-reflection to get to a point where they can have the I think, open mindedness, the awareness, the sensitivities to not put their agenda ahead of somebody else’s and I think that’s a lifelong challenge for everybody at varying degrees.

Theme 9: Toward a More Diverse Profession

This theme captures participants’ view that the field of music therapy is moving in the right direction with respect to diversity and inclusion.

“Diversity in the Field of Music Therapy.” Several people noted that the field of music therapy has recently increased its awareness of diversity and inclusion. However, participants noted that despite an increased awareness among therapists, there is also need for more diversity in the profession. Amari stated:

So, we’re not where we should be, but I think we’re taking our baby steps. … the more people who have these conversations the better we’ll be. … There’s a growing surge of people, like my generation of therapists and the ones coming up that are really committed to … expanding how we talk about culture, diversity, and inclusion. …

[Yet] we really have to commit to making the environments inclusive. … [It] is not enough to just have us, you have to involve us, you have to listen to us, like, we can’t just be good on paper. … Our ideas have merit as much as we have merit.

Morgan suggested that there is a need “to have a much more intentional process for having a more diverse profession, and that would then help us have a more diverse
understanding about culture, a richer understanding of what culture means and how to address it.”

“Steering Things in the Right Direction.” Several participants noted the significant influence that AMTA and CBMT have regarding culturally responsive and ethical practice. These participants shared their awareness and use of the guidelines, codes of practice, and competency requirements. Quinn is hopeful: “I think that AMTA put out a mandate of having culturally diverse presentations,” and because “there’s a new commission on education and training so hopefully that will steer things in the right direction in terms of … what to teach.” Morgan referred to CBMT’s requirements, suggesting: “ethical practice is culturally responsive and so, I think we should be mandating culturally responsive supervision. … people should have to show a certain number of hours in their 5-year period to get recertified.” Participants look to these organizations to help the field move toward greater inclusivity.

Summary of Qualitative Results

Participants all stated that this was an important conversation; they were each eager to talk about culture, cultural humility, and/or diversity in the field of music therapy. The number of responses to the initial survey, and number who wanted to be interviewed for this portion, indicate a great deal of interest in this topic.

Participants had several ideas, comments, and concerns about educating students and professional music therapists about cultural considerations. The most striking concerns that were raised include: a lack of research about how to teach about culture in music therapy; a Eurocentric approach that minimizes, whitewashes, or erases non-White experiences; a question of whether the topic can be adequately addressed in the
undergraduate curriculum; and the silencing or marginalizing of minority experiences within the field. Several participants stated that these issues significantly affect who enters the field of music therapy, as well as music therapists’ ability to ethically serve their clients.

Logan took time in the interview to consider whether or not race and diversity matter to their practice. By the end of the interview, they concluded that, respect for and knowledge of different cultures does matter. They stated: “I suppose with some reflection there’s a lot of differences that I experienced culturally… within the profession.” Logan found that “it’s very important to have these conversations… to at least have a broader understanding of what our current world is.” During the conversation Logan’s perspective shifted, and they seemed to benefit from the conversation “even if it’s with my own [sic] sort of thoughts.”

Analysis of the interviews indicated that these participants felt there was a need to include a greater diversity of voices framing the conversation about diversity and inclusion. Participants suggested that this would result in increased understanding of the need for cultural humility and continuing education. Alex suggested that the next step to facilitate this learning is to offer more education to educators about how to approach this topic. On the other hand, Morgan suggested that if the CBMT mandates training in culturally responsive supervision, it will result in greater knowledge and sensitivity among supervisors. Ultimately, they suggested, this will cause increased diversity in the profession, as well as an increased understanding of what culture means and how we might address it.
CHAPTER 5

Discussion

This study examined the attitudes and skills of music therapists and music therapy educators, with respect to cultural humility and a multicultural orientation. The following were examined: the training of music therapists, where they received that training, and the effects of a person’s worldview on their understanding of a multicultural orientation. In this chapter, the results are compared to the literature, future directions are suggested, and limitations are noted.

Interpretation of Survey Results

Demographics

There was some unexpected representation in demographic groups: when compared to the AMTA (2018) workforce analysis, percentages were higher than expected for people who identified as having a non-binary gender (3% in this study versus 1.04% in the workforce analysis), and for people who identified as African American/Black (3.4% in this study versus 1.8% in the workforce analysis). The percentage who identified as White was lower than expected (81.4% in this study versus 88.4%). Although it is possible that various groups are underreported in the workforce analysis, it is also possible that this topic had particular importance to people who are in non-majority groups.

The percentage of participants who identified as non-heterosexual in the present survey was on the high end when compared to results from the Pew Research Center (as cited in Morin, 2013), which indicated that the percentage of the United States population who is not heterosexual is likely to be between 11% and 19%. A separate Pew survey
(Pew Research Center, 2013) found people who identify as lesbian, gay, bisexual, or transgender (LGBT) are “more likely to perceive discrimination not just against themselves but also against other groups with a legacy of discrimination” (para. 8). It is possible that members of other non-majority groups are also more likely to perceive discrimination, and thus more likely to have an interest in multicultural awareness.

The present survey had a high response rate among newer therapists. In addition, several interview participants noted that there has been a recent increase in interest in the topic of culture and intersectionality within music therapy. While this may seem promising, DiAngelo (2018) cautioned that millennials often express a deep commitment to equality and fairness that covers a great deal of discomfort, confusion, and misinformation about racial inequality. In the context of this survey, it is not clear if a high level of interest indicates comfort or action regarding the topic.

**Concept Groups for Attitudes and Skills**

A factor analysis was conducted to examine the psychometric properties of the survey questions. This yielded eight distinct concepts, which are listed in Table E1 in Appendix E.

**Attitudes and Skills Regarding Adults, Children, and Difference.** Respondents had the highest level of confidence with clients who identify as male, identify as female, have a disability, or are an older adult. Confidence with this group was higher than confidence with children and adolescents, and this was higher than confidence with people whose language, socioeconomic background, or religion is different than their own; or who are LGBTQ. Although confidence does not imply competence, this result may indicate that respondents are receiving the most training about working with people
who have disabilities or are older adults, and the least training about people who are
members of other minority groups. The findings for comfort with people who are
LGBTQ are supported by Whitehead-Pleaux et al. (2013), who reported that more than
half of the music therapists they surveyed did not feel prepared to work with the LGBTQ
community, and that very few had received education about LGBTQ issues while in
school. Beauregard et al. (2016) found a similar lack of perceived level of preparedness
in the field of drama therapy where more than half of therapists surveyed felt they were
not adequately prepared with this community. There is no other research regarding the
amount of training people have acquired to work with any of the other groups.

**Self-Examination, Praxis, and Continuous Learning.** The scores for *Self-
Examination* ($M = 5.90$), *Praxis* ($M = 5.82$), and *Continuous Learning* ($M = 5.77$)
suggested that participants have engaged in experiences designed to raise their own self-
awareness at some point in time, but they are less likely to continually seek cultural
information about their clients or to engage in continuous learning. The AMTA (2019)
Code of Ethics stated that ethical practice requires a commitment to self-examination.
This is a critical component of the cultural competence and cultural reflexivity skills that
music therapists must continue to develop throughout their careers (Whitehead-Pleaux et
al., 2019). However, Young (2016) additionally suggested that music therapists must
continually seek to move beyond their socially constructed tastes and assumptions, and
that this requires more than self-reflective strategies. This process requires continuous
learning and engagement in cross-cultural interaction (Hadley & Norris, 2016). However,
the results indicate that such continuous learning may not be as strong for some
participants.
Critique of Assessment and Research. Participants expressed the lowest confidence in their abilities to critique assessment and research with respect to culture. However, the AMTA (2013) Professional Competencies specifically state that music therapists should be competent in selecting and implementing effective culturally-based methods to assess client needs, strengths, and development; the competencies also state that music therapists should be able to integrate the best available research with the needs, values, and preferences of the individual. Arguably both of these competencies require that therapists be able to critique both assessment and research with respect to cultural considerations; these findings may indicate an area for further education.

Differences in Cultural Attitudes and Skills.

In previous research, Gombert (2017) explored music therapy educators’ and clinicians’ understanding of multicultural competency. She noted that among those she interviewed, the non-White students seemed to be aware of deficits in the coverage of culture that White students were not aware of, and that the demographic of professors seemed to affect their pedagogy. Other studies (Topozada, 1995; Whitehead-Pleaux et al., 2019) similarly found differences in multicultural attitudes based on various demographic information. In addition, the Pew Research Center (2013) indicated that people who identify as LGBT are more likely to perceive discrimination against other groups. The present study built on these findings, examining whether there were differences in cultural attitudes and skills between participants in different demographic groups. Several were found, as follows.

Differences by Region. Topozada (1995) compared music therapists’ knowledge and attitudes using a tool similar to that used by Whitehead-Pleaux et al.
Although Toppozada did not find differences in attitudes among participants based on most demographic factors, she did find that participants from the New England geographic region scored significantly higher (indicating more knowledge and less ethnocentrism) than participants from the South Central geographic regions. Whitehead-Pleaux et al. (2019) also found statistically significant differences according to location: respondents from the Mid-Atlantic and New England regions scored significantly higher than respondents from the Midwest region. Unlike the studies by Toppozada or Whitehead-Pleaux et al., the present survey did not find statistically significant differences in scores between participants living in different regions.

**Differences Among Demographic Groups.** As was the case in the study conducted by Whitehead-Pleaux et al. (2019), gender, sexual orientation, and ethnicity/race all had a statistically significant impact on responses to awareness and skills. In the present study, individuals who identified as bisexual, non-binary gender, and/or people of color had average scores that were statistically different for 5 of 8 of the concept groupings of attitudes and skills (*Self-Evaluation, Awareness of Effect of Culture, Belief in Stereotypes, Continuous Learning, and Can Critique Research*); this indicated higher awareness of culture and greater continuous learning by people in those groups. Additionally, interview participants spoke of the importance of the voices of educators and music therapists who are in minority populations; participants suggested that these people are able to share a more diverse set of experiences, ultimately leading to a more diverse profession and an increased ability to serve a diverse population. This is supported by Fansler et al. (2019), who stated that the overrepresentation of dominant identities in the field of music therapy indicates that the barriers to minority populations
are keeping these people out of the profession; furthermore, the authors argued, this overrepresentation is resulting in less access to role models who reflect the identities of many students and clients.

Gombert (2017) suggested that members of underrepresented groups may be more aware of the deficits in multicultural education than those in majority groups. In her research, she found that the recent graduate who was Black saw deficits in her education that the two recent graduates who were White did not see. Further, the Black educator perceived opportunities to discuss culture to be ever-present, whereas one of the White educators perceived it to be a topic that should be approached cautiously. According to Johnson (2006), people who have the unearned privilege that comes with membership in a majority group are able to, and often likely to, deny and minimize their own privilege while also doubting the extent of difficulty of others. These findings support the hypothesis that educators or therapists who additionally have majority privilege may inadvertently define an inappropriately low level of how much is “enough” multicultural education.

**Ability to Critique Research.** Participants expressed the lowest confidence in their ability to critique research with respect to cultural considerations. However, males were significantly more confident than other respondents in their ability to critique research. This finding could indicate that a) males in music therapy are more likely to be professors, researchers, or people with research experience; or b) males are more likely to express confidence in their abilities to critique research. Nonetheless, the low scores on this item overall may indicate that all participants are lacking in sufficient training to critique research with respect to cultural considerations.
**Master’s Prepared Participants.** Nearly half of the participants (45.3%, $n = 215$) held a master’s degree in music therapy or a related field, a percentage only slightly higher than that reported in the AMTA (2018) workforce analysis. The scores of participants whose highest degree was a master’s degree in music therapy were higher on all items than the scores of participants whose highest degree was a bachelor’s degree or equivalency. This difference was statistically significant for five of the concepts (*Awareness of Effect of Culture, Self-Examination, Continuous Learning, Belief in Stereotypes, and Can Critique Research*). These scores indicate that participants who had a master’s degree felt more aware of and more capable of responding to issues regarding culture in music therapy.

These findings match those of Toppozada (1995) and Whitehead-Pleaux et al. (2019): both reported that participants who held advanced degrees had scores indicating greater cultural awareness or skills. Toppozada found a statistical difference between those with a bachelor’s degree and those with a PhD; Whitehead-Pleaux et al. found a statistical difference between those who held a bachelor’s degree and those with either a master’s or doctoral degree. This finding also corresponded to the theme in the interviews, *A Master’s Level of Knowledge*, which reflected participants’ observation that some educators find it hard to adequately address culture in undergraduate curricula because of either time or undergraduates’ difficulty with examining their own culture and biases. If this is indeed a critical topic to ethical practice as the AMTA (2019) Code of Ethics implies, then it is worth examining this difference. The difference may be due to the timing of coursework in a master’s degree or to the increased maturity of master’s level students. On the other hand, this discrepancy may indicate that this missing
information should be added to the undergraduate curriculum so that this education is included for all music therapists.

**Educators’ Confidence With Difference.** The results indicated that music therapists who are in educator roles have higher scores for cultural attitudes and skills than those in non-educator roles; educators’ scores were higher than non-educators’ scores for every one of the concept groupings. In addition, participants’ scores on items for some attitudes and skills predicted a person’s position as an educator or non-educator. While this was a striking result, no other research was found that examined differences in attitudes and skills between educators and music therapists in the field.

However, when comparing the educators’ scores on each of the eight concept groups for attitudes and skills, educators’ scores were lowest on the concept group of *Confidence With Difference* ($M = 5.95$). The aggregate average of educators’ scores for the other seven concept groups was 6.22. The fact that this score is lower than the others indicates that educators have less experience or less confidence with the demographics in that grouping: people who differ from the respondent with respect to language, religion, socioeconomic background, or those who identify as LGBTQ. The questions about experience/confidence with these demographic groups were separate items in the survey, but were combined into the single item *Confidence With Difference* because a factor analysis indicated that participants’ scores were statistically similar on those items.

This finding can be compared to those of Whitehead-Pleaux et al. (2013), who reported that very few participants in their survey received education about LGBTQ issues, and more than half of those who did receive training did not feel prepared to work with members of the LGBTQ community. This particular result on the present survey
spoke to educators’ experience and comfort with several types of difference. Both educators and non-educators scored lower on *Confidence With Difference* than on some of the other concept groups. However, this was the lowest grouping for educators, indicating that educators have lower comfort with several types of difference. Educators’ reduced experience and/or comfort in working with people who differ from themselves is likely to have an impact on educators’ approaches to teaching about people in those demographics. The results suggest that this is an area in which educators need support so they can prepare therapists to work with several demographic groups.

**Educator Portion of Survey**

Among the educators (*n* = 59) who were asked about their perceptions of how and where issues related to culture should be addressed, the majority of educators agreed that culture should be addressed in at least some part of the music therapy coursework. This corresponds with the findings by Hervey and Stuart (2012) who found that all of the DMT programs integrate multicultural and diversity education in their curricula. Note however, there are only six DMT programs and these are all master’s degree programs.

Other findings in the educator portion of the present survey correlated with findings by Hervey and Stuart (2012). Educators agreed that non-musical elements such as other worldviews should be included in music therapy curricula, and that students should examine themselves in at least one course. Hervey and Stuart found that although some educators struggled with how to expose students to the worldviews of others, this element was included in all DMT programs. They also agreed that DMT students have to explore their own cultural, racial, and gender identities since that informs how they approach clients. This indicates that both music therapy educators and DMT educators
believe that exposure to other worldviews and an examination of one’s own culture are important elements in a therapist’s education. Although the fields use different art forms, the field of DMT may provide insight about this education.

**What Was Present in Individuals’ Education**

**Self-examination.** Survey results indicated that undergraduate coursework had the greatest amount of information related to praxis that is specific songs or rhythms. There was an increase in the presence of non-musical elements related to culture in advanced degrees, including an increase in self-examination. In addition, participants who held a master’s degree scored significantly higher on *Self-Examination* than those who held a bachelor’s degree. In the interviews, respondents suggested that graduate students are more capable than undergraduates of critical thought and self-examination, and that this level of thought is required for multicultural humility. Indeed, in the AMTA Code of Ethics (2019), self-examination is mentioned as one of the cornerstones of ethical practice. Since self-examination is more present in advanced degrees, this might further strengthen the suggestion that a master’s degree should be required for practice of music therapy. No other research was found about the extent to which these elements are in various music therapy curricula; the sister creative arts fields require a master’s degree for practice as a therapist.

**Ethnomusicology Perspective.** Many respondents did indicate that during their undergraduate education there was an ethnomusicology perspective (60.2%) or a world music perspective (75.1%). These were also present in education at the master’s level at lower levels (53.4% and 64.4%, respectively) and at the doctoral level (53.8 and 46.2%, respectively). Over 30 years ago, Moreno (1988) suggested that a knowledge of world
music is necessary so that therapists can musically communicate to a wide range of people. He further suggested that knowing a few songs or idioms is often sufficient knowledge for the music therapist. However, participants in the present research questioned whether this is truly sufficient, suggesting that knowing a genre or style of music does not tell music therapists how or when to use that music. The interview participants suggested that often music therapists have a course in world music or know songs in other languages, but are missing a broader context: the knowledge of how to be present with the client in therapy. Hook et al. (2017) stated that moving from multicultural competency to a multicultural orientation involves a shift away from teaching what to do in therapy, toward a focus on how to be in therapy. The prevalence of world music courses in the present curriculum does not indicate whether that coursework moves beyond presenting the world music or ethnomusicology perspective that Moreno suggested (what music to do in therapy), to giving the needed context for how to be in music with that client.

**Experiences Outside of Classroom.** Respondents noted a wide range of experiences that expanded their cultural awareness, and many commented that an experience outside of the classroom was most valuable to their understanding of other cultures. This supports the findings of several other studies. Twenty years prior to this research, Darrow and Molloy (1998) found that 75% of respondents to their survey gained knowledge of multicultural issues through experience rather than through coursework. Froman (2009) surveyed music therapists who worked with Jewish clients and found that 89.5% learned information for their clients from Jewish friends or colleagues, 65.8% learned from their clients, and only 7.9% had learned information
about Jewish clients or Jewish music from college courses. A similar importance of experience was reported by Carmichael (2012) who found that dance movement therapists’ immersion in a client’s culture was a critical way for a therapist to learn about that culture. Looking at experiential learning from a different angle, Keith (2017) found that the experience of living abroad increased students’ cross-cultural skills as they became more aware of their own cultural background.

These findings support the need to expand what is taught in the classroom about how to be culturally responsive. If therapists are learning more from experiences than from their classes, then educators and leaders of workshops should be teaching therapists how to seek out these experiences, recognize how to critically analyze and apply their knowledge, recognize when more information or supervision is needed, and recognize the need for continual education.

**Relationships Between Survey and Interview Results**

The data from the survey indicated a high level of confidence in many areas of cultural attitudes and skills; however, respondents to the survey and in the interviews suggested that music therapy is lagging behind related fields in this work. The results of the survey thus reflected a level of confidence with this topic that the interviews did not support. One area in particular where there was an apparent discrepancy was in participants’ skills with disability. Results indicated that participants have a high level of confidence about their skills with people who have a disability; however, several interviewees noted that there is a strong underlying ableist notion in the foundational literature of music therapy. Participants’ confidence in their skills may not indicate an anti-oppressive stance for clients.
Interview Results

Participants in the interviews wanted to engage in the conversation about culture. Many expressed that despite the importance of this topic to the field of music therapy, they found their formal training to be inadequate. In addition, several participants stated that music therapists who are in non-majority populations often do not feel fully included in the field; that it is a different experience being a minority person in music therapy. They also noted that the same people within the field of music therapy are talking about culture, yet if music is a cultural phenomenon, they thought that conversations about culture would be ever-present.

Many of the interview themes were related to education. The expansion of this area of the interviews expanded on results from in the survey. Participants stated that it is essential for educators to teach about culture in the music therapy classroom. However, interviewees articulated challenges with this, including a lack of research into how to best do this. The literature review in this present study showed that there is a gap in the literature regarding pedagogy for teaching multicultural competencies in music therapy.

Interviewees suggested more education and resources are needed for educators, empowering them to discuss a topic that, according to the survey, most educators believe is important. Therapists from both AT and DMT (Hervey & Stuart, 2012; Talwar et al. 2011) asked how instructors can teach about cultures if they themselves have limited exposure to those cultures. Hervey and Stuart (2012) found that more multicultural and diversity training was needed for all DMT faculty, regardless of whether the faculty were teaching about those issues. This may likewise be true for the field of music therapy.
Other concerns voiced by participants about the current education system included a lack of adequate time in the undergraduate curriculum, and a very Eurocentric approach to music therapy, the later which affects who is able to even enter the field. This supports concerns about a Eurocentric approach, as stated by Fansler et al. (2019) who suggested that training in European classical music acts as a gatekeeper, prioritizing some types of knowledge over others. Although participants in the present study acknowledged that the field still has work to do, they expressed that the field as a whole is moving in the right direction regarding diversity and inclusion.

White Fragility

Several aspects of the interview results can be examined through DiAngelo’s (2018) explanations of White people’s responses to race. DiAngelo (2018) described “color-celebrate” (p. 78) statements a person might make in order to claim they see and embrace racial difference. She also described a colorblind stance, which allows a person to claim they do not see race and therefore cannot be racist. DiAngelo suggested that both color-celebrate and colorblind statements can serve to exempt the person from responsibility for any participation in racism. The interview theme I’m Not Racist! I’m a Good Person captured several such statements made by one participant in the interviews: the participant shared details about the Black people who they interact with and stated that their best friend is Black. They also stated that since they have a person-centered approach to therapy, they do not need to worry about culture within their own practice. In the interview, the researcher did not seek to examine this position, but rather allowed the participant to think out loud about why and if race mattered to them.
Another aspect of the *I'm Not Racist! I'm a Good Person* theme was mentioned by two participants who spoke about the good/bad binary. DiAngelo (2018) explained that the good/bad binary is the belief that a person is either not racist and good, or racist and bad. DiAngelo suggested that well-intended, open-minded people are often the least likely to examine their racism because of this binary. She further explained that this good/bad binary offers no room for growth, and it serves to obscure the structural nature of racism: if a person sees themselves as good, they must not be racist, and they therefore do not have to examine the ways that they hold privilege within our society. Participants in the present study suggested that belief in this binary was preventing music therapists from openly examining their relationships and actions; that people were holding onto being good and thus hesitant or defensive about entering the uncomfortable space of examining themselves with respect to examining any structure of power and oppression.

One participant suggested that therapists in particular see themselves as doing “good” because they help others, and therefore as being “good.” According to DiAngelo (2018), this person might see themselves through the good/bad dichotomy, and thus be particularly surprised and defensive at the suggestion that they should examine their own racism and privilege. The argument might follow that being in a helping profession may make it harder to examine one’s racism or unearned privilege; as the interview participant suggested, some therapists so desperately want to hold onto being good.

Two other participants in the study mentioned that good intentions by music therapists in the field were not enough, as they do not stop the microaggressions that occur. DiAngelo (2018) wrote about aversive racism, the racism that is present when well-intentioned, educated, progressive people cite their good intentions, colorblindness,
or racially diverse friends as evidence that they are not racist. This type of aversive racism prevents those well-intentioned people from examining their racism because it sets an assumption that they are not racist. The concern about good intentions raised by the interviewees may suggest that they have encountered music therapists who are using their good intentions in this way.

An interview participant also expressed concerns about reverse-discrimination. Other interviewees mentioned that music therapists had reported concerns about reverse-discrimination to AMTA. However, as Johnson (2008) explained, people in privileged categories can certainly feel bad in ways that feel oppressive, but White people cannot be oppressed as Whites because there is not a group in the United States that exists with the power to oppress them. The mention of music therapists being concerned about reverse-discrimination suggests that other music therapists may not understand how oppression and discrimination work, and thus may not understand that reverse discrimination is impossible.

**Structural Competence**

One interviewee mentioned the importance of structural competence, a paradigm that Metzi and Hansen (2014) described as going beyond cultural competency. The paradigm of structural competence includes the element of critical thought: whereas cultural competency is the ability to identify issues of diversity, structural competency includes the ability to examine structural barriers to a person’s health. This paradigm encourages clinicians to examine the bias that is embedded in social structures and institutions. The mention of structural competence during the interviews was one of
several suggestions that music therapists should go beyond the concepts of cultural competency to examine the structures, factors or context that affect a client.

**Limitations**

There were several limitations to the present study. Although the survey yielded 474 complete responses, it represents a relatively small portion of the field. This return rate may have been negatively affected by the fact that just 7 months prior to this study, a survey (Whitehead-Pleaux et al., 2019) with a title of “Surveying the Cultural Competence of Music Therapists in the United States” was sent to the same email list, perhaps causing some participant fatigue. In addition, the return rate of the present survey may have been negatively affected by the length of the survey: participants were told that the survey would take 20 to 30 minutes of their time.

It is also likely that those participants who responded were those who were most interested in multicultural music therapy. Although this may have resulted in a higher response rate from individuals who identify with non-majority cultures within the United States, this also may have resulted in higher overall scores of awareness and skill with cultures than if the survey had been completed by participants who had not thought about multicultural music therapy. The survey results may not be representative of the field for that reason.

A large number of participants in the survey (41%) had worked in the field for 5 years or fewer. However, the researcher did not ask how long the interview participants had been working in the field or when they received their degree(s) in music therapy. Doing so might have revealed further differences in education over time. During analysis of the survey, the attitudes and skills scores for music therapists who graduated at
different times was not separated by degree. It is possible that investigation of degree programs over time would reveal further differences. It is a limitation to this study that this was not investigated in more detail.

In the survey, a separate section was presented to those 107 participants who indicated that they were educators. Only those respondents \((n = 59)\) who indicated that they teach music therapy at an AMTA approved university were then asked questions about their experiences. No information was gathered about the remaining 45\% \((n = 48)\) of the participants. It is not clear whether those participants were supervisors, educators at non-AMTA approved universities, or educators of something other than music therapy. It is a limitation to this study that further information was not asked about those 48 participants.

More than half (66.4\%) of the participants lived in areas of the United States that are in the New England, Mid-Atlantic, Great Lakes, and Southeastern regions of the AMTA. This is not surprising as it is similar to response rates for the AMTA’s (2018) workforce analysis. However, this may have affected the choice of interview participants. The researcher chose participants to interview based on a) participants’ stating they wanted to be contacted, and b) the participants’ self-described demographics. In an attempt to include various affinity groups and because some people who were contacted were unable to be interviewed, all of those who were interviewed lived east of the Mississippi river. Thus, interview participants did not come from the western two-thirds of the country.

The researcher attempted to speak to people who identify with several non-majority groups, but of course could not speak to people from every group that was
represented in the survey. The responses in the interviews represent the experiences of each individual, and therefore should not be extrapolated to represent all people of any particular description.

Finally, the researcher’s assumptions and biases were limitations to this study. Two fundamental assumptions of this research were 1) that culture is a crucial element to consider in every interaction, and 2) that music itself is a cultural phenomenon. The researcher’s belief was that it is essential for therapists to take a multicultural orientation and continually learn more about their own and others’ cultures, as well as their biases. Biases can alter anyone’s perception and interpretation.

**Future Studies**

The experiences of minority music therapists or the experiences of music therapists who belong to a particular minority group could be the sole topic of a single research study, such as Hsiao’s (2011) phenomenological study of re-entry transition for international music therapy students upon returning home after studying in the United States. In the interviews for the present study, many participants spoke briefly about their experiences as minority music therapists; however, these experiences were not the focus of the interviews. The researcher included them in the results, but did not inquire into further details or instances of these occurrences; this should be further researched.

The areas of culturally appropriate assessment and the ability to critique research with respect to research were both reported to be areas where therapists had less confidence; these would also be fruitful areas for future research.

An investigation into the significance of travel or living abroad experiences would seem to be a fruitful area of investigation. In the fill-in-the-blank portion of the survey,
many people reported that they learned more about cultural responsiveness from experiences outside of the classroom than from formal coursework. In addition, several participants in the interviews indicated that their exposure outside of the classroom was informative. Future studies might investigate what people learned from such experiences and expand on Keith’s (2017) study about the effects of living abroad on a therapist’s responsiveness to cultural factors in music therapy.

Two interview participants noted that there is much cultural appropriation and ableism in the music therapy literature. This was reflective of our understanding of culture and disability at the time that various aspects of music therapy were developed. Tracing the roots of and problems with appropriation and ableism in the music therapy literature could form topics for future research.

In the interviews, most participants noted ways in which their formal education had been lacking with respect to multicultural education. However, the researcher did not examine specific curricula or programs. Neither did the researcher investigate specifically what individuals wished they had learned. Future studies might examine either of these topics, in addition to several other topics regarding education.

As mentioned in the limitations, the researcher did not ask interview participants when they had earned their degree(s) in music therapy. Doing so might have revealed details about some of the ways culture and intersectionality have been addressed in education over time. In addition, a deeper analysis of differences in attitudes and skills by year of graduation with specific degrees may yield more information about differences in those degree programs over time.
Results indicated that educators were more likely than non-educators to have an awareness of the effect of culture on therapy, more likely to not believe in stereotypes, and more confident in their ability to critique assessment with respect to culture. However, it is unknown if or how educators are imparting these skills to their students. An area of future study is to examine educators’ skill in teaching about cultural humility and responsiveness.

Most of the educators (88.1%) indicated that non-musical elements about culture, such as worldview, customs, beliefs, and oppression, are not beyond the scope of the music therapy curriculum, implying that these should be included. However, nothing was asked about the extent to which or how the educators were addressing these topics at the time of the survey. In addition, roughly half of the responses indicated that educators felt they did not have adequate time or adequate resources to adequately teach about topics relating to culture. The survey did not investigate what time or resources educators have or what they feel they need. These are both areas for future study.

Of the educators surveyed, 86.4% were heterosexual and 74.6% identified as White. One question that was not explored herein, but might be a question for future study, is: “Are majority-population educators likely to perceive less of a need of multicultural education than non-majority educators?” Johnson (2006) suggested that those with unearned privilege or in majority populations are likely to minimize the impact and reality of the oppression faced by non-majority populations. To what extent does this extend to educators?

The present study also did not examine the importance of culture in supervision, or the experiences of supervisors/supervisees with respect to cultural humility. Swamy
(2011) described a culturally-centered music therapy approach to supervision. This important topic could be more fully explored.

Several interviewees spoke of the need for increased education for educators and supervisors regarding: approaching classroom discussions about multicultural humility, leading classroom exercises to examine their own and their students’ biases, and cultural sensitivity in supervision. Future studies might focus on this aspect of education: investigating how this is implemented in other fields, what has been done in music therapy, and evaluating how to move forward with this aspect of multicultural education.

**Recommendations**

It is recommended that the education standards for music therapists include standards for cultural humility, cultural responsiveness, and understanding of intersectional cultural perspectives, as well as standards for understanding research and music therapy assessment with respect to cultural considerations. Extending these standards to the undergraduate curriculum would ensure that bachelor’s prepared therapists are introduced to these topics. This would necessitate increased training for educators to expand their understanding of and approaches to these topics. This also points to the need for more research and education about the best way to teach these topics within the music therapy classroom.

It is recommended that music therapy education emphasize the value of music other than European art music, giving other music cultures the same consideration and respect as the music traditionally taught in music school. Students should be learning how to approach music therapy from a multicultural standpoint: no one can predict what songs or styles will be needed for one’s future clients. It serves students to learn how to
approach each client as a cultural being and to expect to continually learn about new music and new cultures.

It is recommended that the professional organizations within music therapy and current music therapists listen to and value the voices and experiences of minoritized members. The field also needs to understand why people are leaving or staying in the field of music therapy. Research should be conducted to understand how we can attract and maintain greater diversity among therapists so that we can better serve our clients.

Just as music therapists have a continuing education requirement to spend a certain number of hours learning about ethics, it is recommended that music therapists have a similar continuing education requirement devoted to multicultural awareness, and/or multicultural humility. Approaching all clients as culturally situated beings and understanding that every interaction is a cross-cultural interaction will benefit therapists and clients alike.

The AMTA Code of Ethics (AMTA, 2018) recommends that practicing music therapists engage in continuous self-examination and learning. This learning should include seeking to understand each client’s intersectional identity, culture and cultural/systemic context. It should also include seeking local opportunities to learn about culture, broadening one’s tastes, assumptions, and comfort with difference.

Finally, we all benefit from listening more, and continuing to examine our biases. Each one of the interview participants taught me something about my view of culture and difference; I learned the most from those who were the least like me.
Contribution to Expressive Therapies

Expressive Therapies include all of the arts therapies: art, dance, drama, expressive arts, and music therapy. Some of the findings of this study were unique to the education of music therapists. However, some of the quantitative findings can be generalized to other expressive therapies and the qualitative findings may be of interest to all expressive therapists, since all expressive therapists have an ethical responsibility to serve clients who belong to a variety of cultures and hold various worldviews.

This analysis of music therapists’ current attitudes, knowledge, training, practices, and education contributes to an understanding of the present status of the field of music therapy with respect to multicultural competencies and cultural humility. A greater understanding of how a person’s sociocultural perspective affects their evaluation of their own multicultural training may help the fields of music therapy and other expressive therapies better understand how to educate therapists, and may expand understanding of how to attract a greater diversity of therapists and educators. A greater diversity of therapists will then add to the knowledge base in the field of how to address and respond to a diverse set of clients. Educators are a critical piece to this growth, as they influence or control how therapists are educated, what is included in students’ education, and the perspectives revealed there. It is ethically responsible toward both clients and future therapists for educators to ensure that they have the tools to engage with questions of diversity and inclusion with a critical perspective. This perspective will serve all therapists whether they work abroad or within the changing demographics of the United States.
APPENDIX A

Survey Instrument
INSTRUCTIONS

Next screen:

This survey has 4 sections. Please fill out each section as indicated within the survey.

Section 1 consists of 10 questions about demographic information.  
Section 2 consists of 43 statements about music therapy and culture for you to rate on a scale from strongly disagree to strongly agree.  
Section 3 consists of 6 questions about your education, plus a set of questions about what elements were present in each degree program you completed in music therapy.  
Section 4 (only for educators), contains 18 statements about music therapy education for you to rate on a scale from strongly disagree to strongly agree.

The survey should take 20 to 30 minutes to complete.
Thank you!

SECTION 1: DEMOGRAPHICS QUESTIONS

1. Are you currently a (check all that apply):
   - Clinician practicing music therapy
   - Graduate student in music therapy
   - Supervisor of music therapy students in an internship site, or a practicum / fieldwork setting
   - Professor / instructor of music therapy
   - Practitioner in another field with a degree / credential in music therapy
   - Retiree from the field of music therapy
   - Practitioner who uses music as therapy but NOT a credentialed / Board-Certified Music Therapist  
     (The above answer would cause the survey to exit)
   - Other (please specify):__________________

2. In what year were you born?  
   (Dropdown menu of years.)

3. In which State or US Territory do you reside?  
   (Dropdown menu of US States / Territories)
   If you live outside of the United States, in what country do you reside? ____________________ (fill in the blank)  
   (Only use this question if above was answered as living outside the US.)

4. How many years have you been in the field of music therapy as a clinician, therapist, professor, researcher, or in another professional role?
5. In which setting(s) do you currently work? (check all that apply)

- Adult Day Services / Day Care
- Child / Adolescent Treatment Center
- Children’s Day Care / Preschool
- Children’s Hospital or Unit
- Community Based Service
- Drug / Alcohol Program
- Early Intervention Program
- Forensic Facility
- General Hospital
- Geriatric Facility – not nursing
- Group Home
- Hospice / Bereavement Services
- Inpatient Psychiatric Unit
- Nursing Home / Assisted Living
- Outpatient Clinic
- Private Music Therapy Agency
- School (K-12)
- Self-Employed / Private Practice
- University / College
- Other (please specify): __________

6. With what population(s) do you currently work? (check all that apply)

   People who have / People who are diagnosed as / People who fit in the category of:

- Abused / Sexually Abused
- Alzheimer’s / Dementia
- Autism Spectrum Disorders
- Behavioral Disorder(s)
- Bereavement / Grief
- Cancer
- Chronic Pain
- Intellectually / Developmentally Disabled
- Dual Diagnosed
- Early Childhood
- Elderly Persons
- Emotionally Disturbed
- Forensic
- Head Injured
- Hearing Impaired
- Hospice / Palliative Care
- Learning Disabled
- Medical / Surgical
- Mental Health
- Multiply Disabled
- Neurologically Impaired
- Parkinson’s Disease
- Physically Disabled
- Post-Traumatic Stress Disorder
- School Age Population
- Speech Impaired
- Stroke
- Substance Abuse
- Terminally Ill
- Visually Impaired
- Undergraduate students (As an instructor, not as a therapist)
- Graduate students (As an instructor, not as a therapist)
- Retired, or Not currently working as a music therapist
- Other (please specify): __________

7. How do you identify your gender? __________

8. How do you identify your sexual orientation?

- Asexual
- Bisexual
- Gay
- Heterosexual
- Lesbian
- Pansexual
- Queer
- You don’t have an option that applies to me. I identify as: __________
- Prefer not to answer
9. What is your present religion, if any?
   • Protestant
   • Roman Catholic
   • Mormon
   • Orthodox (such as Greek or Russian Orthodox)
   • Jewish
   • Muslim
   • Buddhist
   • Hindu
   • Atheist
   • Agnostic
   • Nothing in particular
   • You don’t have an option that applies to me. I identify as: _________________
   • Prefer not to answer

10. How do you identify your ethnicity? Please check all that apply:
   • Multiracial / Biracial
   • African American / African descent
   • Black
   • Asian
   • Caucasian / White
   • Hispanic / Latinx
   • Middle-Eastern
   • Native American / Alaskan Native / First Nations / Indigenous people
   • Pacific Islander
   • You don’t have an option that applies to me. I identify as: _________________
   • Prefer not to answer
Miriam-Webster ([https://www.merriam-webster.com/dictionary/culture](https://www.merriam-webster.com/dictionary/culture)) defines culture as:

"a: The customary beliefs, social forms, and material traits of a racial, religious or social group; also : the characteristic features of everyday existence (such as diversions or a way of life) shared by people in a place or time

b : the set of shared attitudes, values, goals, and practices that characterizes an institution or organization
c : the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic
d : the integrated pattern of human knowledge, belief, and behavior that depends upon the capacity for learning and transmitting knowledge to succeeding generations"

In the following questions, “culture” is used to include all of these diverse aspects of culture.

Using the 7-point Likert scale for each statement below, please indicate your agreement or disagreement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Agree Somewhat</th>
<th>Neutral</th>
<th>Disagree Somewhat</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am confident in my ability to provide music therapy to clients who identify as male.</td>
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<td>2. I am confident in my ability to provide music therapy to clients who identify as female.</td>
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<td>3. I am confident in my ability to provide music therapy to older adults.</td>
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<td>4. I am confident in my ability to provide music therapy to children.</td>
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<td>5. I am confident in my ability to provide music therapy to adolescents</td>
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<td>6. I am confident in my ability to provide music therapy to persons with disabilities.</td>
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<td>7. I am confident in my ability to provide music therapy to people whose religious / spiritual practice is significantly different from my own.</td>
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<td>8. I am confident in my ability to provide music therapy to clients whose primary language is not one I speak fluently.</td>
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<td>9. I am confident in my ability to provide music therapy to clients who come from very poor socioeconomic backgrounds.</td>
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<td>10. I am confident in my ability to provide music therapy to clients who identify as trans / transgender / gender non-conforming, or who have a non-binary gender identification.</td>
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<td>11. I am confident in my ability to provide music therapy to clients who identify as gay / lesbian / bisexual / or as being under the LGBQA umbrella.</td>
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</table>
12. I am effective in my **non-verbal** communication with clients whose culture is different from my own.

13. I am effective in my **verbal** communication with clients whose culture is different from my own.

14. Clients who share a language are likely to know the same set of songs.

15. In music therapy sessions, culture is irrelevant; music can transcend culture.

16. I try to learn how music plays a part in each client’s culture.

17. I attempt to play music that reflects the cultures and ethnic backgrounds of the clients with whom I work.

18. I attempt to use instruments that reflect the cultures and ethnic backgrounds of the clients with whom I work.

19. I seek to learn about the cultural values and cultural history of my clients.

20. When completing music therapy assessment, I am able to identify the strengths, weaknesses, and potential biases of different assessment tools in terms of their use with persons with different cultural/racial/ethnic backgrounds.

21. When determining appropriate goals and therapeutic/objective outcomes, culture and ethnicity are not relevant factors.

22. When evaluating my client’s behaviors, I should use my own cultural standards/norms, since I am most competent with those standards.

23. I can critique research regarding music therapy and culturally different populations.

24. Immigrants from the same country will share virtually the same values and beliefs as each other, regardless of how long they have lived in their new country.

25. I am aware of within group differences among ethnic groups (e.g., low socioeconomic status (SES) Puerto Rican clients vs. high SES Puerto Rican clients).

26. The way that “therapy” is perceived in some cultures may inhibit people from using music therapy services.

27. There are institutional barriers that may inhibit minorities from using music therapy services.

28. I encourage clients to use resources commonly used within their own culture.

29. Being born a white person in this society carries with it certain advantages.

30. Being born a minority in this society carries with it certain challenges that white people do not have to face.

31. Therapists frequently impose their own cultural values on their clients.

32. I have examined the ways that religious beliefs might influence how ethnic minorities respond to illness and disability.

33. I have examined how my own cultural background and experiences have influenced my attitudes about therapeutic processes.
34. I have examined how my own cultural background and experiences have influenced my attitudes about the use of music.

35. I have examined how my own values might affect my clients.

36. I can identify my own reactions that are based on stereotypical beliefs about different ethnic groups.

37. I frequently examine my own biases related to race and culture that may influence my behavior as a music therapist.

38. I seek supervision or support from others when I am working with clients whose music or culture is new to me.

39. There are people with whom I openly discuss issues I have in developing multicultural awareness.

40. I have sought opportunities to learn more about my own cultural background.

41. I continuously strive to learn about different ethnic cultures through educational methods and/or life experiences.

42. The education of music therapists should actively promote greater awareness of different cultures.
SECTION 3: EDUCATION / TRAINING

1. What degrees have you completed (check all that apply):
   (year of graduation will only come up if a respondent checks that degree):
   - Bachelor’s degree in music therapy; Year of graduation:______
   - Bachelor’s degree in other field; Year of graduation:______
   - Equivalency degree in music therapy; Year of graduation:______
   - Master’s degree in music therapy, expressive therapies, or with a music therapy concentration; Year of graduation:______
   - Master’s degree in field other than music therapy / expressive therapies (such as MBA, MSW or other); In what field? ______________
   - PhD or Doctoral degree in music therapy; Year of graduation:______
   - PhD or Doctoral degree in music education; Year of graduation:______
   - PhD or Doctoral degree in expressive therapies; Year of graduation:______
   - PhD or Doctoral degree in other field: In what field?___________

2. What specialized music therapy training(s) you have completed (if any):
   - Analytic Music Therapy
   - Bonny Method – Guided Imagery in Music (BM-GIM)
   - Neo-natal ICU Music Therapy (NICU MT)
   - Neurologic Music Therapy (NMT)
   - Nordoff-Robbins Music Therapy (NRMT)
   - Vocal Psychotherapy
   - Other (please specify): ______________
   - None

3. Are you currently studying toward an advanced degree? (Y/N)
   (Only if answered yes) What degree are you pursuing?
   - Master’s degree in music, music therapy or expressive therapies;
   - Master’s degree in field other than music / music therapy / expressive therapies (such as Special Ed, MBA, MSW or other) please specify:____________________;
   - PhD or Doctoral degree in music therapy
   - PhD or Doctoral degree in music education
   - PhD or Doctoral degree in expressive therapies
   - PhD or Doctoral degree in other field (please specify): __________

Questions about what was present in the respondents’ undergraduate and graduate curricula (the next questions 1-14) were asked as follows.

- only BA/BS in music therapy  ➔  one set of questions
- only Master’s degree in music therapy / expressive therapies  ➔  one set of questions
- BA/ BS plus Master’s degree  ➔  2 sets of questions
- Master’s and PhD at same place  ➔  questions about graduate curricula combined
- Master’s and PhD at different places  ➔  questions about graduate curricula separate; may have 3 sets of questions about curricula if have 3 degrees in MT from 3 different schools.
1. In your *undergraduate or equivalency music therapy curriculum / Master’s curriculum / PhD curriculum*, how much of the following was included? Note: items might have been included in BOTH one whole course and in parts of others. *(logic will allow several choices to be checked)*

<table>
<thead>
<tr>
<th>Extent to which each of the following was present in my music / music therapy courses.</th>
<th>No music or music therapy courses</th>
<th>Part of one music or music therapy course</th>
<th>It was the topic of one whole music or music therapy course</th>
<th>Present in several music or music therapy courses</th>
<th>All music or music therapy courses</th>
<th>Not sure</th>
</tr>
</thead>
</table>

2. How to sing songs in different languages
3. Rhythms or scales relating to the music of non-Western cultures
4. Introduction of songs relating to one non-Christian religion
5. Introduction of songs relating to several religions
6. Discussion about how to adapt specific interventions for clients with different backgrounds
7. Examination of the context or meaning of specific songs or music in different cultures / religions
8. Discussion of the ways that culture might impact music therapy
9. Immersion in a study of a culture other than my own (as part of my coursework)
10. Examination of my own culture
11. Non-musical information (such as beliefs, worldviews, customs, use of space) about specific cultural groups.
12. An ethnomusicology perspective
13. A world music perspective

14. Which of the following were included in your *undergraduate or equivalency music therapy curriculum / Master’s curriculum / PhD curriculum*:
   - One required non-music therapy course that specifically addressed culture
   - One elective non-music therapy course that specifically addressed culture
   - Workshop(s) about race and / or racism
   - Workshop(s) about discrimination and / or bias
   - None of the above
   - Other educational / experiential opportunity about culture / race / discrimination / bias or related topics. Please specify format and topic: ______________________
15. Which of the following experiences, if any, have expanded your knowledge of culture(s)? (check all that apply)
   - Life experience such as:
     - I identify as being in a racial, ethnic, or cultural minority
     - I live in a culturally diverse city
     - I have cultural diversity among my friends / acquaintances / peers
     - My family has several different cultural backgrounds represented
     - I have worked with clients of several cultural backgrounds
     - None of the above have particularly expanded my knowledge of culture

16. Which of the following experiences, if any, have expanded your knowledge of culture(s)? (check all that apply)
   - Attending workshops or sessions about culture at:
     - AMTA conferences; Approximately how many workshops / sessions?________
     - Regional or State music therapy conferences; Approximately how many workshops / sessions?________
     - Expressive Therapies conferences; Approximately how many workshops / sessions?________
     - Conferences for other therapies / other professional conferences; Approximately how many workshops / sessions?________
     - Conferences specifically about a culture or about a specific group; Approximately how many workshops / sessions?________
     - Other – please specify type of workshop or sessions:__________________
     - None of the above have particularly expanded my knowledge of culture

17. Which of the following experience, if any, have expanded your knowledge of culture(s)? (check all that apply)
   - Training module for an employer
   - Research because of own interest
   - Research to support a client
   - Teaching and/or supervising students or interns from other cultures
   - Immersion in a culture due to personal / extra-curricular non-MT experiences
   - Course specifically about culture outside of degree program
   - Other – please specify: __________________________
   - None of the above have particularly expanded my knowledge of culture

18. Which single experience (if any) was most impactful / meaningful to your understanding of the intersection of culture and music therapy? Was this during your graduate studies, undergraduate studies, or elsewhere in your experience? This may include one of the above, or a different experience.
SECTION 4: FOR EDUCATORS

This will appear only for people who said in the demographics that they are an educator (question 3). However, I want to verify that the person is an educator AND that they are at an AMTA approved school.

1. You arrived at this section because you indicated that you are an educator. Do you teach music therapy courses to either undergraduate or graduate students at an AMTA approved university?
   - Yes
   - No

The next section will appear only for the people who state that they are professors at AMTA approved universities.

2. Which is true of the courses you teach?
   - All of them are undergraduate courses
   - Most of them are undergraduate courses
   - The number of undergraduate and graduate courses is fairly even, or it varies.
   - Most of them are graduate courses
   - All of them are graduate courses

3. Please indicate to what extent you disagree or agree with the following:

   Note: The word “course” is defined here as a semester-long event, whereas “class” is defined as a single meeting during that semester.

<table>
<thead>
<tr>
<th>Question:</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Agree Somewhat</th>
<th>Neutral</th>
<th>Disagree Somewhat</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</thead>
<tbody>
<tr>
<td>4. Culture should be addressed in undergraduate music therapy coursework.</td>
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<tr>
<td>5. In the undergraduate music therapy curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses.</td>
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<tr>
<td>6. Undergraduate students are typically not ready to challenge their assumptions about culture.</td>
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<td>7. Culture should be addressed in graduate music therapy coursework.</td>
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<tr>
<td>8. In the graduate music therapy curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses.</td>
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<td>9. Culture should be addressed when teaching music therapy repertoire to students.</td>
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<tr>
<td>10. Culture should be addressed in music therapy coursework regarding percussion.</td>
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<td>11.</td>
<td>Culture should be discussed during coursework about clinical training.</td>
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<td>12.</td>
<td>Culture should be discussed with respect to music therapy research.</td>
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<td>13.</td>
<td>It is essential to discuss culture in all music therapy courses.</td>
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<td>14.</td>
<td>In order to adequately address culture, it is ideal to have a separate course on the topic of culture and / or multicultural awareness.</td>
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<td>15.</td>
<td>Non-musical elements of culture such as worldview, customs, history, beliefs, oppression, or acculturation are beyond the scope of the music therapy curriculum.</td>
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<td>16.</td>
<td>Topics regarding race, religion, or sexuality are too volatile to be discussed in the music therapy classroom.</td>
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<td>17.</td>
<td>It is essential that students examine their own culture in at least one music therapy course.</td>
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<td>18.</td>
<td>I have adequate time in the courses I teach to address issues of culture in music therapy.</td>
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<td>19.</td>
<td>I have adequate resources to address issues of culture in music therapy courses.</td>
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<td>20.</td>
<td>I fear that I would face retribution from my University / College / Dean / supervisor / students if I discussed culture in music therapy courses.</td>
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<td>21.</td>
<td>I believe that I would face resistance from my students if I discussed culture in music therapy courses.</td>
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</table>

Do you have any comments about the survey, multicultural education, or music therapy & culture that you would like to share with the researcher?

---

Thank you for your time!!!

Your answers are confidential and will be stored separately from any further information you provide. As a thank you for your time, I am offering that your name be put into a raffle for one of five $20 gift certificates to amazon.com. Note: your email is required for you to enter into this raffle. If you choose to enter, you will be redirected to a separate survey so that your email address will be stored separately from any other information you have provided. After clicking "Next" below, you will leave this survey.

- Yes I DO want to enter the raffle.
- No thank you, I do NOT want to enter the raffle.

Please enter your email address for raffle entry for one of five $20 gift certificates:___________
The researcher who designed the study you just completed is hoping to interview music therapists in order to further understand how music therapists perceive multicultural education. If you would be willing to be contacted to speak to the researcher about your perspectives, please indicate that below. If you indicate “Yes” you will be taken to a separate survey form so that the information you provide CANNOT be linked to your answers in the previous survey. Your response here will not impact your eligibility to participate in the raffle for a gift certificate.

If you provide your name / contact information below, the researcher might contact you in a few months’ time. At that time, you would receive a new informed consent and may decline to participate.

- **YES**, I am willing to be contacted for an interview at a later date.
- **NO**, I am **NOT** willing to be contacted for an interview.

Thank you for your willingness to be interviewed about multicultural education in music therapy. Please provide the following information so that the researcher might contact you:

- **Name:**
- **Email address:**
- **Phone number:**

Information from the previous survey has been submitted and is stored in a separate database from any information given here. Thus this information cannot be linked to your answers from the previous survey. The demographic questions below are optional, but are asked to aid the researcher in interviewing a group of music therapists who represent a diverse population, several regions, and several areas of practice.

1. **US State/ US Territory / Country of residence?** ________________
2. **Year of birth:** ________________
3. **With whom do you practice music therapy?** ________________
4. **In what setting do you practice music therapy?** ________________
5. **Please list 3 or more terms that you use to identify yourself with respect to gender, race, ethnicity, religion, sexuality, SES, country of origin, or other cultural identifiers.** ________________
APPENDIX B

Interview Questions
First questions:

1. Why did you offer to be interviewed after taking my survey?  
   Is there anything in particular that you want me to know?
2. What kind of training in music therapy coursework did you receive with respect to culture in music therapy? Where did that training occur?
3. What are your own experiences with learning about culture?
4. Do you think that your training in music therapy regarding culture was adequate?  
   If inadequate, in what ways was it inadequate? If adequate, describe.
5. I asked questions on the survey from other developed scales regarding a person’s perceived confidence with certain populations. Do you think that your own confidence is related to competence?

For people in field:

6. Has culture been an important consideration to you as a music therapist? What is your experience of working with culture as a music therapist?
7. Is your practice impacted by an awareness of culture competence? How so?
8. What challenges have you faced with respect to culture, as a music therapist?

For educators:

9. How do you teach/talk about multicultural music therapy with your students/interns? Where did you gain background to talk about this topic?
10. Have you faced any difficulties or challenges in addressing this topic? Can you describe?

Last question for all:

11. How are we, as a field, doing with multicultural issues?
APPENDIX C

Internal Review Board Approval
DATE: 5/16/18

To: Debra Gombert

From: Dr. Robyn Flaum Cruz & Dr. Ulas Kaplan, Co-Chairs, Lesley IRB

RE: IRB Number: 17/18 - 052

The application for the research project, “An Examination of Multicultural Education in Music Therapy” provides a detailed description of the recruitment of participants, the method of the proposed research, the protection of participants' identities and the confidentiality of the data collected. The consent form is sufficient to ensure voluntary participation in the study and contains the appropriate contact information for the researcher and the IRB.

This application is approved for one calendar year from the date of approval.

You may conduct this project.

Date of approval of application: 5/16/18

Investigators shall immediately suspend an inquiry if they observe an adverse change in the health or behavior of a subject that may be attributable to the research. They shall promptly report the circumstances to the IRB. They shall not resume the use of human subjects without the approval of the IRB.
APPENDIX D

Initial Email and Informed Consent Forms
Hello!

You are invited to participate in a research study titled “Multicultural Education in Music Therapy”. This study is being conducted by Debra Jelinek Gombert in partial fulfillment of her PhD degree at Lesley University. You were selected to participate in this study because you are a board-certified music therapist (MT-BC).

**Purpose:** The purpose of this research study is to understand what training music therapists have received; what skills and knowledge music therapists have regarding culture and multicultural awareness; and Educator’s perspectives on multicultural education. If you agree to take part in this study, you will be asked to complete an online survey. The survey includes questions about demographic information, your education, and your perspectives on music therapy and culture.

**Time:** This survey will take you approximately 20 to 30 minutes to complete.

**Option to enter a Raffle:** Upon completion of the survey, all participants are invited to provide an email address so that they can be entered into a raffle to receive one of five $20 gift certificates to amazon.com. Your choice to enter this raffle is completely optional; the email address you provide will not be linked to your survey answers in any way.

**Willingness to be interviewed at a later date:** The researcher is hoping to interview people in order to further understand how music therapists perceive multicultural education. At the end of the survey there will be an option to indicate your willingness to be contacted to speak to the researcher about your perspectives. If you agree to be contacted, the contact information that you provide will be stored separately from your survey and cannot be linked to your survey answers. Whether you agree or decline to be contacted does not affect your ability to enter into the raffle.

**Benefit:** You may not directly benefit from this research; however, we hope that your participation in the study may increase understanding about how music therapists are being educated about multicultural perspectives.

**Risks:** We believe there are no known risks associated with this research study; however, as with any online related activity the risk of a breach of confidentiality is always possible. To minimize this risk, the researcher will receive the responses anonymously and will not track individual responses. To the best of our ability, your answers in this study will remain confidential.

**Storage of Data and Privacy:**

- Computer IP addresses will not be stored or collected.
- Any information that participants give in order to enter into the raffle will be stored separately from the survey results or potential interview information.
- If a participant agrees to be contacted for an interview, an email address and brief demographic information will be collected for that participant. This information will be stored separately from the survey results or raffle information.
- Data will be stored on a password-protected external drive. The drive will be stored in a locked file cabinet in the researcher’s office. All data will be destroyed after 5 years.
- Qualtrics (the software used for the survey) will not collect any data linking information for the raffle or potential interview to the survey, to each other, or to other information.
- If the results of this study are published or presented, every attempt will be made to protect subjects’ identities and private information. The researcher understands some participants may belong to a small group and might be traceable because of their demographics. Therefore when
reporting results of the study the researcher will aggregate any results that mention a small group.

**Voluntary Participation:** Your participation in this study is completely voluntary and you can withdraw at any time. You are free to skip any question that you choose.

**Questions?** If you have questions about this project or if you have a research-related problem, you may contact the researcher, Debra Jelinek Gombert, 734-622-0444, dgombert@lesley.edu In addition, there is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairpersons at irb@lesley.edu

Link for survey:  

**INFORMED CONSENT:**

The Front page of the Qualtrics survey included the same text as the recruitment email above followed by:

- I am at least 18 years of age
- I have read and understand the above consent form
- I understand that my answers are confidential and that I may stop at any time.

OR

- I disagree. I choose NOT to participate in this study.

Followed by “Thank you” screen.
You are invited to participate in a research study titled “Multicultural Education in Music Therapy”. This study is being conducted by Debra Jelinek Gombert in partial fulfillment of her PhD degree at Lesley University. You were selected to participate in this study because you are a board-certified music therapist (MT-BC).

**Purpose:** The purpose of this research study is to understand what training music therapists have received; what skills and knowledge music therapists have, regarding culture and multicultural awareness; and Educator’s perspectives on multicultural education.

**In this second part of the study,** if you agree to participate, you will be interviewed by the researcher via Zoom, an online teleconferencing software. The interview will be recorded and subsequently transcribed. Questions will pertain to your perspectives on music therapy, culture, and multicultural education in music therapy.

**Time:** The interview will take no more than 60 minutes to complete.

**Benefit:** You may not directly benefit from this research; however, we hope that your participation in the study may increase understanding about how music therapists are being educated about multicultural perspectives.

**Risks:** We believe there are no known risks associated with this research study; however, as with any study the risk of a breach of confidentiality is always possible. The interviews will be stored as described below to minimize this risk. To the best of our ability, your answers in this study will remain confidential.

**Storage of Data and Privacy:**
- Participant names will be stored separately from interview transcripts.
- Transcripts will be stored separately from recordings.
- Data will be stored on a password-protected external drive. The drive will be stored in a locked file cabinet in the researcher’s office. All data will be destroyed after 5 years.
- If the results of this study are published or presented, every attempt will be made to protect subjects’ identities and private information. The researcher understands some participants may belong to a small group and might be traceable because of their demographics. Therefore when reporting results of the study the researcher will aggregate any results that mention a small group.

**Voluntary Participation:** Your participation in this study is completely voluntary and you can withdraw at any time. You are free to skip any question that you choose.

**Questions?** If you have questions about this project or if you have a research-related problem, you may contact the researcher, Debra Jelinek Gombert, 734-622-0444, dgombert@lesley.edu

In addition, there is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairpersons at irb@lesley.edu

**INFORMED CONSENT:**
- ☐ I am at least 18 years of age
- ☐ I have read and understand the above consent form
- ☐ I understand that my answers are confidential and that I may stop at any time.

Signature: ___________________________ Date: ___________________
APPENDIX E

Tables and Figures
Figure E1

Figure 1. Age Range of Participants

Figure E2

Figure 2. Years in Field of Music Therapy
Table E1

*Items in the Cultural Attitudes and Skills Perception Subscale*

<table>
<thead>
<tr>
<th>Item #</th>
<th>Concept</th>
<th>Item</th>
</tr>
</thead>
</table>
| 1      | Effective Communication                      | I am effective in my verbal communication with clients whose culture is different from my own.  
I am effective in my non-verbal communication with clients whose culture is different from my own.  
Confidence With Adults & People Who have a Disability  
I am confident in my ability to provide music therapy to clients who identify as male.  
I am confident in my ability to provide music therapy to clients who identify as female.  
I am confident in my ability to provide music therapy to persons with disabilities.  
I am confident in my ability to provide music therapy to older adults. |
| 2      | Awareness of Effect of Culture               | The way that “therapy” is perceived in some cultures may inhibit people from using music therapy services.  
The education of music therapists should actively promote greater awareness of different cultures.  
Therapists frequently impose their own cultural values on their clients.  
There are institutional barriers that may inhibit minorities from using music therapy services.  
Being born a minority in this society carries with it certain challenges that white people do not have to face.  
Being born a white person in this society carries with it certain advantages. |
| 3      | Confidence With Children & Adolescents       | I am confident in my ability to provide music therapy to adolescents.  
I am confident in my ability to provide music therapy to children. |
| 4      | Self-Examination                             | I can identify my own reactions that are based on stereotypical beliefs about different ethnic groups.  
I frequently examine my own biases related to race and culture that may influence my behavior as a music therapist.  
I have examined how my own values might affect my clients.  
I have examined how my own cultural background and experiences have influenced my attitudes about the use of music.  
I have examined how my own cultural background and experiences have influenced my attitudes about therapeutic processes. |
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</table>
| **5** | **Praxis** | I seek to learn about the cultural values and cultural history of my clients.  
I try to learn how music plays a part in each client’s culture.  
I attempt to use instruments that reflect the cultures and ethnic backgrounds of the clients with whom I work.  
I attempt to play music that reflects the cultures and ethnic backgrounds of the clients with whom I work. |
| **6** | **Confidence With Difference** | I am confident in my ability to provide music therapy to clients whose primary language is not one I speak fluently.  
I am confident in my ability to provide music therapy to clients who come from very poor socioeconomic backgrounds.  
I am confident in my ability to provide music therapy to people whose religious/spiritual practice is significantly different from my own.  
I am confident in my ability to provide music therapy to clients who identify as gay/lesbian/bisexual/or as being under the LGBQ umbrella.  
I am confident in my ability to provide music therapy to clients who identify as trans/transgender/gender non-conforming, or who have a non-binary gender identification. |
| **7** | **Continuous Learning** | There are people with whom I openly discuss issues I have in developing multicultural awareness.  
I seek supervision or support from others when I am working with clients whose music or culture is new to me.  
I continuously strive to learn about different ethnic cultures through educational methods and/or life experiences.  
I have sought opportunities to learn more about my own cultural background. |
| **8** | **Belief in Stereotypes** | Clients who share a language are likely to know the same set of songs.  
In music therapy sessions, culture is irrelevant; music can transcend culture.  
When determining appropriate goals and therapeutic/objective outcomes, culture and ethnicity are not relevant. (reverse coded)  
When evaluating my client’s behaviors, I should use my own cultural standards/norms, since I am most competent with those. (reverse coded)  
Immigrants from the same country will share virtually the same values and beliefs as each other. (reverse coded) |
When completing music therapy assessment, I am able to identify the strengths, weaknesses, and potential biases of different assessment tools in terms of their use with persons with different cultural/racial/ethnic backgrounds.

I can critique research regarding music therapy and culturally different populations.

### Table E2

**Logistic Regression Predicting Educator Skills and Attitudes**

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<th>Demographic Variables</th>
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*significant at < 0.05

**significant at < 0.01
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</tbody>
</table>

*p < .05; ‡p < .01; †p < .001
Table E4

*Educators Section*

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture should be addressed in undergraduate MT coursework</td>
<td>6.83</td>
<td>0.38</td>
</tr>
<tr>
<td>In the undergraduate MT curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses</td>
<td>3.39</td>
<td>1.89</td>
</tr>
<tr>
<td>Undergraduate students are typically not ready to challenge their assumptions about culture</td>
<td>2.42</td>
<td>1.64</td>
</tr>
<tr>
<td>Culture should be addressed in graduate MT coursework</td>
<td>6.47</td>
<td>0.92</td>
</tr>
<tr>
<td>In the graduate MT curriculum, the topic of culture can be sufficiently addressed as a small part of one or two courses</td>
<td>2.97</td>
<td>1.9</td>
</tr>
<tr>
<td>Culture should be addressed when teaching MT repertoire to students</td>
<td>6.59</td>
<td>0.77</td>
</tr>
<tr>
<td>Culture should be addressed in MT coursework regarding percussion</td>
<td>6.62</td>
<td>0.58</td>
</tr>
<tr>
<td>Culture should be addressed during coursework about clinical training</td>
<td>6.76</td>
<td>0.43</td>
</tr>
<tr>
<td>Culture should be discussed with respect to music therapy research</td>
<td>6.69</td>
<td>0.47</td>
</tr>
<tr>
<td>It is essential to discuss culture in all music therapy courses</td>
<td>6.45</td>
<td>0.99</td>
</tr>
<tr>
<td>In order to adequately address culture, it is ideal to have a separate course on the topic of culture and/or multicultural awareness</td>
<td>5.48</td>
<td>1.47</td>
</tr>
<tr>
<td>Non-musical elements of culture such as worldview, customs, history, beliefs, oppression, or acculturation are beyond the scope of the music therapy curriculum</td>
<td>2.10</td>
<td>1.33</td>
</tr>
<tr>
<td>Topics regarding race, religion, or sexuality are too volatile to be discussed in the music therapy classroom</td>
<td>1.72</td>
<td>1.25</td>
</tr>
<tr>
<td>It is essential that students examine their own culture in at least one music therapy course</td>
<td>6.57</td>
<td>0.70</td>
</tr>
<tr>
<td>I have adequate time in the courses I teach to address issues of culture in music therapy</td>
<td>4.31</td>
<td>1.58</td>
</tr>
<tr>
<td>I have adequate resources in the courses I teach to address issues of culture in music therapy</td>
<td>4.45</td>
<td>1.71</td>
</tr>
<tr>
<td>I fear that I would face retribution from my university/college/dean/supervisor if I discussed culture in music therapy courses</td>
<td>1.98</td>
<td>1.42</td>
</tr>
<tr>
<td>I believe that I would face resistance from my students if I discussed culture in music therapy courses</td>
<td>2.48</td>
<td>1.63</td>
</tr>
</tbody>
</table>

*Note.* 7 = strongest agreement; 1 = strongest disagreement
https://doi.org/10.1093/mtp/miv037

https://doi.org/10.1080/07421656.2001.10129749


https://www.musictherapy.org/about/find/
http://www.musictherapy.org/about/competencies/

https://www.musictherapy.org/assets/1/7/18WorkforceAnalysis.pdf

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https://doi.org/10.1080/08098130009477982
https://doi.org/10.15845/voices.v19i3.2679


https://doi.org/10.1093/mtp/27.1.33


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