

ARTICLE

“Surprisingly helpful”: An exploration of trainee and registered music therapists’ perspectives on the current role of personal therapy in music therapy training in the United Kingdom

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ABSTRACT

Music therapy training programmes in the United Kingdom are accredited by the Health and Care Professions Council (HCPC). The HCPC requires registered music therapists to have experience and understanding of the value of therapy for developing insight and self-awareness. In practice, this currently translates into a requirement for personal therapy during training – working therapeutically and confidentially with a suitably qualified and registered therapist for a minimum number of hours – although the amount and type of therapy required varies between course providers. The aim of this study was to explore the perceived value and impact of mandatory personal therapy from the perspectives of trainee and HCPC-registered music therapists. Data were collected through a qualitative survey with open-ended questions exploring participants’ personal therapy experiences. Thirty-nine participants were recruited from across the various music therapy training institutions in the UK at the time of the research and from within the pool of registered music therapists. Thematic analysis was used to develop three themes from the data: “personal therapy is costly, but ultimately beneficial”; “personal therapy provides a supportive space separate from training”; and “personal therapy is part of becoming a music therapist.” We conclude with recommendations about how personal therapy can be most usefully incorporated into training programmes based on our interpretation of the participants’ responses.

KEYWORDS

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INTRODUCTION

Music therapy training programmes in the UK have been accredited by the Health and Care Professions Council (HCPC; formerly the Health Professions Council and before that the Council for Professions Supplementary to Medicine) since the music therapy profession achieved state registration in 1999 (Barrington, 2015). The HCPC Standards for Proficiency require registered music therapists to “understand the value of therapy in developing insight and self-awareness through their own personal experience” (HCPC, 2018). Currently, all HCPC-accredited programmes in the UK choose to meet this requirement by mandating personal therapy for trainees, although precise requirements for hours and types of therapy vary between course providers (see below). All training programmes currently require at least 30 hours of personal therapy during the training process - most require more - and the personal therapy is non-assessed, with costs covered by the student. Based on information gathered for the current research, only one course provider specifies the type of therapy as “talking therapy” (see below). Other training programmes define personal therapy more broadly, for example: “confidential personal therapy with a suitably qualified therapist, for example, a creative arts therapist, a counsellor or psychotherapist” (UWE, 2021).

As Barrington (2005) outlined, in the 1980s, when there were just three music therapy training programmes in the UK, course leaders collaborated to present the Government with information about the profession to help make a case for state registration. A Basic Module of Training was established by the Courses Liaison Committee (CLC) of the Association of Professional Music Therapists (APMT) in order to demonstrate that similar professional standards were evident across the three training programmes. In this document, there was a clear emphasis on the importance of “personal development” within training (Barrington, 2005). During this time, there was also a growing recognition of the importance of assessing and evaluating music therapy clinical work as the profession moved towards achieving State Registration with the Councils Supplementary to Medicine (CPSM) (Barrington, 2005). This did not appear to be extended to the direct evaluation of the efficacy of personal therapy in training. In the 1990s, three arts therapies (music, art and drama) joined to form the Joint Validation Board, the function of which was to define the levels of expertise offered by training courses (Barrington, 2005). Personal therapy for trainees was also an established, but not always mandatory, practice in art and drama therapy so this may have further strengthened the inclusion of personal therapy within music therapy training.

As a result of the considerable professional achievement of registration with the CPSM confirmed in the 1990s, a structured supervision scheme was established by the Association of Professional Music Therapists (APMT) to provide access to and evidence of continuing professional development opportunities across the profession. At this point there were not any formal requirements established in relation to personal therapy within training, but this continued to be standard training practice. In 2006, with the advent of entry level to the profession moving to Masters level and accreditation by the Health Professions Council (HCP), personal therapy was mandated in the UK as part of this process (Odell-Miller & Sandford, 2007), as in Denmark (although Danish music therapy was not legally registered). Since then the depth and range of practice covered by professional

standards within the HPC (later the HCPC) has been broadened. The original Courses Liaison Committee became the Training and Education Committee (TEC) where all UK course leaders continued to meet regularly to discuss and compare standards, thus providing an environment where practices relating to personal therapy in training could be sustained and kept relatively similar.

A key influence in the development of music therapy training in the UK and the emphasis both on personal development and personal therapy within training is the English music therapist Mary Priestley. Priestley developed the “Intertherap” method of experiential learning for analytic music therapy in the 1970s with her colleagues Marjorie Wardle and Peter Wright (Scheiby & Pedersen, 1999). As Scheiby (2018) outlined, this involves, as practiced today, a trainee music therapist working for 30 minutes with another trainee - one in the role of therapist, the other in that of client. After 30 minutes, they switch roles, and work together for another 30 minutes. A supervisor is present and takes notes, and shares feedback and recommends readings after the session. Priestley designed Intertherap as a 12-session programme and viewed it as essential for the training of the analytic music therapist: “only this will give him the empathy with his own patients and the right sensitivity in the therapeutic use of this powerful art form” (Priestley, 1980). This innovation underlined a belief in the importance of the “student client” (Bonde, 2007) experience during training. As well as the development of Intertherap, Priestley offered her students “group therapy,” which arguably evolved into the practice of experiential training groups, and she introduced personal therapy for students. This contributed to the evolving promotion and delivery of personal development within music therapy training in parts of Northern Europe, specifically Denmark and Germany (Bonde et al., 2019; Eschen, 2002), as well as the UK. In Priestley’s analytic music therapy training model, 48 hours of personal therapy with an analytical music therapist became the first stage of a music therapist’s training (Kim, 2021). Students were only able to progress onto the next phase with the approval of their therapist. This is not reflected in current training practice: across all UK training courses, mandatory personal therapy currently takes place outside of the training institution, and progression through the course does not rely on approval from a trainee’s therapist. Most courses require proof of therapy hours completed, signed by the therapist, such as a certificate of attendance or letter, because the therapy is mandatory.

There are many other elements of personal development and experiential learning that have since been embedded within training courses within and beyond the UK, particularly in Northern Europe and research is already well underway in this area. Lindvang (2013) makes the point that despite some unpublished surveys of students about the use of personal therapy in the 1990s there was little rigorous exploration in Europe or the US on whether or how personal therapy directly contributed to the development of therapeutic competence.

In this study, we focus specifically on the mandatory hours of personal therapy that trainees in the UK are required to undergo instead of the personal development opportunities provided as part of their training courses. Despite the mandatory nature of this personal therapy and the significant commitment it demands (Murphy et al., 2018), no research to date, to our knowledge, has examined its role in UK music therapy training, and how involvement in personal therapy contributes to the building of therapeutic competences (Lindvang, 2013). The current study begins this exploration.

RESEARCH ON PERSONAL THERAPY IN PSYCHOTHERAPY AND PSYCHOLOGY AND US MUSIC THERAPY TRAINING

Within the wider field of psychotherapy, personal therapy is generally regarded as a fundamental aspect of learning to be a therapist and has been described as: “the single most formative educational experience in learning how to conduct psychotherapy” (Bridges, 1993, p. 44; see also Norcross, 2005). Howell (2008, p. 29) went as far as to say: “to avoid the experience of what it is like to be a client is perverse, incongruent and, ultimately, disrespectful to those who seek our help,” suggesting that choosing not to experience personal therapy is bordering on professional negligence. Grimmer and Tribe’s 2001 study of counselling psychologists’ perceptions of the impact of mandatory personal therapy during training indicated various perceived benefits in relation to professional development, in addition to “validation of therapy as an effective psychological intervention” for participants who did not have substantial experience of personal therapy prior to training. Despite this, in 2005, the British Association for Counselling and Psychotherapy (BACP) removed the mandatory requirement for personal therapy during training, deciding that to “require” therapy was unethical, inconsistent with all psychotherapy models and could potentially cause harm (Atkinson, 2006). Trainees must engage in “personal development,” but the BACP no longer specifies what form this should take (BACP, 2012). Despite this, in 2013, Chaturvedi noted that just over 50% of BACP-accredited training courses still required personal therapy, suggesting that it was regarded by many as a significant aspect of training.

Similarly, within US music therapy, personal therapy is strongly advocated by some prominent music therapists, with Bruscia (1998, p. 116) asserting: “Any music therapist who has not, can not or will not experience music therapy as a client needs to change professions.” Dileo (2000) similarly argued that personal therapy for music therapists is important in order to confront the therapist’s own psychological vulnerabilities, avoid burn out and best serve clients. Fox and McKinney (2016), in their study of music therapy interns in the US, drew attention to the therapist’s responsibility towards the client, asking the question: “Is a student who has never experienced therapy as a client fully prepared to serve clients as a therapist?” (p. 97). As is apparent within the wider psychotherapy literature, a lack of personal therapy during music therapy training seems to be regarded as having negative implications both for therapist and client. However, personal therapy is not a requirement for music therapy training in the US, with only a small minority of programmes surveyed in Gardstrom and Jackson’s 2011 study requiring or encouraging personal therapy. Yet the American Music Therapy Association’s (AMTA, 2013) *Professional Competencies* include recognising the impact of one’s own feelings, attitudes, and actions on the client and the therapy process - competencies which are likely to be promoted through the experience of undertaking personal therapy. There is an even greater focus on the therapist’s own self-development within the *Advanced Competencies* (AMTA, 2009), which state that an advanced clinician should “develop self-awareness and insight through personal experiences in music therapy, other creative arts therapies, verbal therapy, and/or personal growth work” (7.1) and “identify, confront and work through personal issues” (7.2).

Some music therapy and psychotherapy scholars have questioned the ethics of requirements for mandatory personal therapy. In Chaturvedi’s (2013) study of mandatory personal therapy in psychotherapy training, the author concluded that choice and motivation are important if good therapeutic outcomes are to be achieved. A similar perspective is represented in So’s 2017 study,

which explored the role of personal therapy for East Asian students participating in US music therapy training programmes and referred to the American Psychological Association's (2010) principle that engaging in any type of therapy should be an option rather than a requirement. The APA's (2010) ethical principles and code of conduct states that: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (General Principle E). It should be noted, however, that the American Psychological Association (2017) does also acknowledge that mandatory therapy plays a role in some training programmes for psychologists (7.05).

A number of studies promote open discussion about the potential value of personal therapy alongside therapy training. Salter and Rhodes (2018) identified dissatisfaction amongst qualified clinical psychologists in Australia regarding the lack of focus on personal development and reflective practice during their training, with one participant reporting that the stress of training led her to engage in personal therapy outside of the training course, which helped with her own personal development as well as increasing the empathy she felt for her clients. Similarly, one of the conclusions of McMahon's (2018) research with qualified clinical psychologists and counsellors in Ireland was that teaching staff should discuss the potential value of personal therapy with trainees, as well as encouraging peer discussion on the topic.

Various suggestions are made within psychotherapy literature about managing the potential challenges of mandatory personal therapy. In their systematic review of qualitative research into mandatory personal therapy during counselling and psychotherapy training, Murphy et al. (2018) stated that psychotherapy courses must exercise care within this component of training, with ethics at the fore. In Edwards' (2017) critical interpretive synthesis of literature exploring mandatory therapy during psychotherapy training, she outlined the potential for personal therapy to be disruptive for trainees given the likely mental and emotional challenges of engaging in self-exploration at the same time as starting to work with clients, and suggested that engaging in personal therapy *prior* to training could be more beneficial for some individuals. McMahon (2018) proposed a limited mandate - where type, amount and timing of personal therapy are not dictated - would be the best option to balance ethical concerns and protect the rights of both clients and trainees.

Despite such endorsements of personal therapy, however, as Edwards (2017) pointed out, there is a lack of research evidence for the benefits of personal therapy during therapeutic training. With the cost of training already prohibitively expensive for many, leading to increasing concern about widening participation and access to higher education, Murphy et al. (2018) claimed that there is an "imperative for the professional and regulatory bodies, higher education institutions and private training organisations, to base requirements for training on research evidence over tradition" (p. 200). Developing the body of research in this area could, therefore, support institutions in justifying a personal therapy mandate.

THE CURRENT STUDY

This study considers the perspectives of current trainees, qualified music therapists and teaching staff on the role of personal therapy in UK-based music therapy training. Including the perspectives of current trainees within this study aligns with the recently adopted HCPC standard for training providers

in the UK: “Learners must be involved in the programme” (HCPC, 2017). The mandatory nature of personal therapy during training implies it is regarded as beneficial. We set out to examine if this is the case from the perspective of trainees and qualified music therapists, including those teaching on training courses. In the participant information sheet, the purpose of the study was described as follows:

Trainee music therapists are currently required by the Health and Care Professions Council to have a “substantive and sustained experience of personal therapy” (UWE, 2021) while training (40-60 hours is recommended). The confidential personal therapy must be with a suitably qualified and registered therapist (e.g., creative arts therapist, counsellor, psychotherapist, etc.).

The aim of this study is to gain an understanding of the perceived value of this mandatory personal therapy, explore its impact on the theoretical and practical elements of music therapy training and to assess the variation in experience across different types of personal therapy in the seven¹ UK training institutions for Music Therapy.

Thus, this study explores the perceived value of mandatory personal therapy, and its impact on the theoretical and practical elements of music therapy training.

RESEARCHER PERSONAL STATEMENT

The first author at the time of conducting this research was a music therapy trainee at the University of the West of England (UWE), the second author is a qualitative psychologist who teaches research methods and supervises student research projects on the music therapy programme at UWE, and the third author is an HCPC-registered music therapist and programme leader of the music therapy programme at UWE. As this is the first exploration of personal therapy within UK music therapy training, the intention was to offer a broad perspective on the experience of personal therapy across training courses. However, the authors acknowledge that they approached the research with personal experience of the UWE music therapy programme.

The first author had a predominantly positive experience of personal therapy during training and was conscious of the potential to use the study to present an argument for the benefits of mandatory personal therapy. To mitigate this possibility, principles of qualitative research were adopted throughout the research process: ensuring survey questions were open-ended, adopting a consistently reflexive approach including reflexive journaling, and using the data as a starting point for analysis. Data analysis was a collaborative process between authors, incorporating initial independent readings of the data, followed by detailed discussions of and reviewing themes to ensure they captured meaningful patterns across the whole data set.

¹ Since collecting the data for this study, an eighth training course has since been established at the University of Derby, with the first intake of students beginning their training in 2020.

METHOD

As the aim of the study was to consider the thoughts and experiences of a wide range of participants, we chose to collect data using an online, qualitative survey (Braun et al., 2020). Given the potentially sensitive nature of the research topic, use of an online survey was intended to provide participants with a high level of “felt anonymity” (Terry & Braun, 2017, p. 19). As this is the first study addressing the role of personal therapy in UK music therapy training, it was hoped that the qualitative survey data would: “provide useful ‘baseline’ knowledge about practices or experiences in an under-researched area, without delimiting the scope of response, as a quantitative survey would” (Terry & Braun, 2017, p. 23). The research was approved by the UWE Psychology Master’s Ethics Committee.

Recruitment

Participants were recruited in several ways – through emails to programme leaders, posts to *Facebook* pages set up by trainees at various institutions and in person at the annual British Association for Music Therapy (BAMT) conference. Details of the study were also posted on the BAMT research forum and we asked for this information to be shared with current members – both trainee and qualified – via BAMT e-newsletters and social media accounts.

Participants

Thirty-nine participants completed the survey in full. Of these, almost two-thirds ($n=23$) were trainees. The sixteen remaining participants were qualified music therapists, two of whom were currently teaching on music therapy training programmes. The participant groups will be referred to as “trainees” and “therapists” (noting when relevant where therapists are also “teachers”). However, where a particular participant group is not specified, it is because the data from across the participant group has been aggregated. Table 1 provides an overview of the participant demographics and Table 2 details the number of participants from each of the seven UK institutions offering HCPC-accredited music therapy training at the time of the study. Demographic data were collected in order to observe the qualitative quality practice of “situating the sample” (Elliott et al., 1999) and fulfil the British Psychological Society’s (BPS) (2014) ethical principle of showing “respect for difference”.

As we are based at UWE, this provided a recruitment advantage that is evident in the constitution of the participant group. The second-most-represented institution was Nordoff Robbins, which may have been particularly effective in recruiting qualified music therapists to participate in the study as they have a substantial body of employees in their organisation who undertook Nordoff Robbins music therapy training. Of the trainees, the majority were studying part-time ($n=18$) and there was an even spread across first-, second- and third-year students. Of the music therapists, the vast majority had qualified within the last ten years.

Demographic questions		Number of participants	
How would you describe your gender?	Female	35	
	Male	4	
Please write 5 words to describe yourself (e.g. mine would be “student, single, white, English, middle-class” and my supervisor’s would be “white, middle-class, disabled, queer, humanist”)	Responses relating to ethnicity/national identify	White	27
		English	8
		British	7
		European	4
		Asian	1
		Bristolian	1
		Greek	1
		Mixed ethnicity	1
	Responses related to social class/ socioeconomics	Middle class	18
		Educated class	1
		Working class	5
		Not specified	15
What type of personal therapy experienced? (participants were given the options in the next column)	Psychotherapy (general)	16	
	A particular kind of psychotherapy (e.g. psychoanalysis, please specify)	Psychodynamic	1
		Core process psychotherapy	1
		Psychoanalytic	2
		Integrative	1
	Counselling (general)	4	
	A particular kind of counselling (e.g. person-centred, please specify)	Integrative	2
		Humanistic	1
		Integrative humanistic	1
		Person-centred	5
	Creative therapy (e.g. music, art, drama, dance- please specify)	Art	3
	Cognitive behavioural therapy (CBT)		0
	Other		2

Table 1: Participant demographics

Training institution	Personal therapy requirement	Trainee (n=23) ²	Qualified music therapists (n=16)	Total number of participants (n=39)
University of the West of England	40+ hours “During the course, we ask you to be in confidential personal therapy with a suitably qualified therapist, for example, a creative therapist, a counsellor or psychotherapist. The number of hours is not specified, but the Health Professionals Council requires you to have had substantive and sustained experience of personal therapy during the three years of the course (40 to 60 hours is recommended). Please note, this cost is not included in the programme fee.” (UWE, 2021)	15	5	20
Nordoff Robbins (London & Manchester) ³	30+ hours of talking therapy “As a music therapy student, you are required to undertake a minimum number of hours of personal psychotherapy while training. We can help you find a therapist who suits you, but you have to pay for this yourself. We recommend budgeting around £1500 for this.” (Nordoff Robbins, 2018)	1	9	10
Roehampton University	Weekly individual personal therapy for at least one year of the training “Students must be prepared to enter mandatory weekly individual personal therapy for at least one year of the training (this is paid for by the student, in addition to the course fees). Full time year 1 and part time year 2. Support from tutors is given if students require help to find a suitable therapist. Personal therapy is mandatory for this training. The costs of this vary significantly and it is not helpful to state an amount here, however applicants may wish to research this in order to have awareness of the costs involved.” (Roehampton, 2021)	2	2	4
Anglia Ruskin University (ARU)	50+ hours Course information suggests budgeting £1500-£3000 for personal therapy. (ARU, 2021)	2	0	2
Queen Margaret University (QMU)	40+ hours of psychotherapy “Personal development is fundamental to therapeutic training and it is a requirement (Health and Care Professions Council) that students attend regular personal psychotherapy throughout the course, with a minimum of 40 hours attendance. Personal therapy is non-assessed and students are required to cover the cost.” (QMU, 2021)	2	0	2

(Table 2 continued)

² One trainee attended two institutions throughout their training and is represented in two rows of the table.

³ Since collecting the data for this study, a third Nordoff Robbins training programme was introduced in Newcastle, with the first intake of students beginning their training in 2018.

Guildhall	40+ hours	1	0	1
School of Music and Drama (GSMD)	“All Music Therapy students undertake their own personal therapy during the training. A high degree of self-reflection and self-awareness is required, and gaining experience of personal psychotherapy prior to training is highly recommended.” (GSMD, 2021)			
University of South Wales	45+ hours (15 per year of training)	1	0	1

Table 2: Number of participants from each training institution⁴

Survey design, data collection and analysis

For the purposes of this research, our definition of “personal therapy” reflects that used within training programmes (see Table 2), and is understood as distinct from other forms of “experiential learning” that may feature within training programmes. There was no expectation around type of personal therapy undertaken: the wording in the participant information, detailed above, simply stipulated: “The confidential personal therapy must be with a suitably qualified therapist (e.g., creative arts therapist, counsellor, psychotherapist, etc.)” This wording was taken from the course information on the University of the West of England website at the time. Types of therapy experienced by participants are detailed in Table 1. The survey was conducted via the online Qualtrics survey platform, with different pathways through the survey for trainees, therapists and teachers. We carried out a pilot survey with three members of the target population in order to ensure the survey was clear and accessible, and generated appropriate data (Terry & Braun, 2017). We made some minor changes to the survey design following piloting including re-wording questions and adding open text response boxes to closed questions. Table 3 includes examples of the open-ended main survey questions.

Information about informed consent was provided within the participant information at the beginning of the survey in adherence with the BPS *Code of Human Research Ethics* (2014). It was mandatory for the consent box to be ticked before participants were able to proceed with the survey.

Once the survey had been live for three months and we had received responses from participants across all seven training institutions, the survey was closed. The data were analysed using the reflexive thematic analysis (RTA) approach outlined by Braun and Clarke (2006, 2019). The end product of a RTA is a set of themes, with themes defined as multifaceted patterns of meaning underpinned by a central concept or idea. Themes are not conceptualised as ontologically real things residing in data that the researcher extracts through the analytic process, rather themes are conceptualised as constructs created by the researcher through actively engaging with their data set, with all they bring to the analytic process, which provide a good “fit” with the data and allow the researcher to address their research question. As RTA is to some extent theoretically flexible, although underpinned by the assumptions of qualitative paradigm, Braun and Clarke (2006) recommend that authors specify their guiding theoretical assumptions. Our approach to TA is broadly critical realist in that we assume the

⁴ Given the low number of participants within the “teacher” category ($n=2$), this information has been incorporated within the “qualified music therapists” category to protect participant anonymity.

existence of a material reality but that human experience of this reality is mediated by language and culture (Maxwell, 2012). Our data orientation was broadly inductive, guided by our philosophical assumptions, but grounded in the accounts of participants. We began by familiarising ourselves with the data contents through reading and re-reading the data, reflecting on what we read, making notes on our initial observations and meeting to share and discuss our observations. The first author then led the processes of coding and theme development, meeting regularly with the second author to share and discuss her coding and potential themes. We discussed theme titles before and after writing up each theme in order to ensure that the themes and theme titles compellingly captured a “*patterned* response or meaning within the data set” (Braun & Clarke, 2006, p. 82). This analytic process resulted in three themes, which are now illustrated with relevant extracts from the survey responses.

Question no.	Survey questions
1	How do you feel about the personal therapy you have completed since beginning your training?
2	How has the personal therapy you have completed so far impacted on the practical elements of your courses? (e.g. placements, skills, practice)
3	How has the personal therapy you have completed so far impacted on the theoretical elements of your course? (e.g. written assignments, required reading)
4	i) To what extent is personal therapy discussed with staff or students on your course? ii) Do you think this is/would this be beneficial?
5	i) Do any of your assignments require you to draw on experience or learning from personal therapy? If so, please give details. ii) Do you think this is/would this be beneficial?
6	i) Does your personal therapist have a role in assessing you and your suitability for practice? ii) Do you think they should?
7	How does your experience of personal therapy sessions compare with other reflective opportunities within the course? (e.g. clinical supervision, experiential groups, tutorials, reflective journals)
8	Had you participated in therapy prior to starting the training? Yes No [<i>skip to question 10</i>]
9	i) Please give details of type/amount of therapy you experienced prior to starting the training. ii) How did the experience compare to therapy you have completed as part of your training?
10	Is there anything else you would like to say in relation to the role of personal therapy in music therapy training?

Table 3: Examples of survey questions – open-ended main questions from the trainee pathway through the survey

RESULTS

There was at least one participant from each of the seven training institutions (see Table 2), and there was consistency in responses across the institutions. As only three of the 39 participants undertook an arts therapy as their personal therapy, we acknowledge that our results and discussion are predominately based on participants who experienced talking therapy.

Theme 1: Personal therapy is costly, but ultimately beneficial

This theme captures the sense from across all three participant groups that personal therapy comes at a cost, both practically – specifically in relation to money and time – and emotionally. Many participants felt that more hours of personal therapy would have been beneficial but were prohibitively expensive, and some commented that the experience could have been more valuable if it had been possible to work with a more experienced – and therefore more expensive – therapist:

P24 (trainee): I finished after 46 sessions as I could no longer afford it – it is very expensive! If it wasn't so expensive I think I would have continued.

P31 (therapist): I feel that if I had the money to spend on an esteemed psychotherapist I may have felt more benefit but paying for life and the course left little money for the personal therapy which limited me.

This sense of the limitations of time-restricted therapy was reflected in a number of other responses, with questions being raised about how to use such a short period of therapy: “where do you even start when you know you're only going to have the 40 or so hours (because of money and time)” (P2, trainee). One member of music therapy teaching staff suggested that the process could be “deeper” for students if they had weekly personal therapy throughout the training, but went on to explain that the financial cost of this would exclude some people from training (P17, therapist). Given the number of participants who referenced the expense of personal therapy, this highlights the possibility that some potential music therapy trainees are already excluded from training due to the financial commitment required. One qualified therapist commented:

P22 (therapist): I found the additional cost rather crippling on top of course fees...I do wonder how colleagues on the full time courses manage to make ends meet. I certainly know that a couple of friends fell in to difficult financial situations whilst studying full time, trying to balance that with earning too.

Other participants expressed a more muted dissatisfaction about the financial cost of personal therapy, but also outlined the value they thought it provided: “Wish it was cheaper - but worth every penny” (P8, trainee).

Within the context of a participant group that was largely positive about mandatory personal therapy, there were trainees who discussed the possibility of financial support being made available in order to make it more accessible:

P12: I think it should be offered within the university for those who have less funding. I have no savings and no funding to pay for the therapy, therefore I had to take on extra work throughout my course which has been very tough to balance everything consistently. If we are to pay for it, it would be good for there to be a suggested organisation who offer discounted therapy when it is a compulsory requirement.

The challenge of “balancing everything” is also referenced by participants who discussed the time pressure experienced during training, with one therapist suggesting that learning about music therapy itself is the priority: “we needed as much course time focussed on the music therapy as possible” (P26).

In addition to the financial and time commitment of personal therapy, trainees and therapists discussed its emotional impact, with both groups using the term “difficult” in relation to their own therapy. In response to a question asking about what personal therapy offered, one therapist said: “What it feels like to be in therapy...to experience how difficult it can be to talk to a therapist” (P19). Others talked personally about how they responded to their own therapy:

P2 (trainee): Sometimes I will chat to my peers about my own experiences of personal therapy and theirs – but it’s usually to say that I’m finding it difficult, or to complain about it!

P1 (therapist): I initially found personal therapy very difficult and an uncomfortable experience.

In addition to the emotional cost implied by various participants, one trainee explicitly referenced the cost of personal therapy in terms of energy: “...due to sessions that have resulted in powerful emotional impact, I sometimes have found it hard to re-integrate into the focus of my life afterwards. It takes a lot of energy from within me” (P11).

Despite the emotional cost described, participants tended to also talk about the positive implications of “spending” the emotional energy. When providing their overall impressions of personal therapy, two trainees used the word “enriching” alongside the terms “difficult” and “emotional” (P15, P3), and one trainee expressed the value of personal therapy in professional development: “I feel it has been hard work, i.e. brought up difficult things to work through, but this has put me in a place to be a more effective therapist ultimately” (P14).

Throughout the data, the participants consistently referenced the financial and emotional costs of personal therapy, but these costs were ultimately outweighed by the emotional benefits of personal therapy. However, in many cases, it seems that the value of personal therapy could have been increased were it not for the practical constraints of money and time.

Theme 2: Personal therapy provides a supportive space separate from training

One of the teachers in the participant group described the main function of personal therapy as follows: “It is primarily there to be personally supportive – as a music therapy training can be

unexpectedly challenging, this is a means of helping students not just to survive the difficulties that arise but to thrive" (P30, therapist). Many participants confirmed that personal therapy did provide a supportive space that enabled them to manage the demands of training:

P1 (therapist): I found it an immense support for the pressures of the course. I spent a lot of time talking about how stressed I was and venting about workload!

Participants also refer to the value of personal therapy in discussing their responses to their course peers, tutors and placement colleagues:

P33 (trainee): For me, [personal therapy] stands alone and is more useful as a separate, private forum in which to [...] explore relationships with individuals that I study or work with.

P29 (therapist): It's easier to discuss group dynamics that took place on the course without other people from the course being there.

In addition to providing a sense of perspective on the course, personal therapy sometimes offered an external viewpoint on music therapy itself, with several participants mentioning the value of having personal therapy with a non-music therapist:

P1 (therapist): I sometimes found having to explain music therapy to a non-music therapist a useful experience and helped me see it from an outsider's perspective.

P7 (trainee): I feel that talking to someone in a confidential setting who doesn't know anything about music therapy apart from what I have discussed is quite refreshing. They don't assume anything, and through their curiosity and lack of knowledge of the subject, help me to discuss things simply.

When asked if personal therapy should be discussed with teaching staff and other trainees, the over-riding response was that this would not be appropriate and could affect the personal therapy process. The words "confidential," "personal" and "private" were used repeatedly across the data in relation to personal therapy. One trainee described personal therapy as offering the opportunity "to discuss adequately and openly the very real anxieties about practical ability that arise in training" (P33) and another trainee expressed: "boundaries around personal therapy should be respected" (P9), suggesting that it could be used most effectively when it was kept contained.

One of the features of personal therapy that was repeatedly mentioned is that it is not assessed, but instead functions as "a totally safe nonjudgmental 1:1 space" (P4, trainee). The absence of communication between personal therapists and the course team was also repeatedly highlighted:

P24 (trainee): There is no agenda, it is not marked or assessed in any way, I knew my therapist wasn't going to feed anything back to anyone on my course. This separateness from the course made it helpful.

Trainees talked about the impact it would have if personal therapy was assessed, with one participant commenting: “I get paranoid about saying things in therapy as it is. I feel like if they had a role in [assessment], I wouldn’t say anything” (P2). Although teachers in the participant group were clear that personal therapy is not assessed, one did explain that there might be certain situations in which personal therapy would be referred to:

P17 (therapist): If a student is struggling with the distinction between personal and professional boundaries, for example by overidentifying with a client, and is not using personal therapy to explore this, this may be commented upon in a placement appraisal.

Using personal therapy in this way was discussed by both trainees and therapists, who referred to the importance of “freeing up” supervision and other course activity for focusing on clients:

P28 (therapist): [Personal therapy] enables supervision to be focused on the CLIENT and music rather than our own “stuff”- it is useful to park things sometimes and take it to therapy at another time.

P9 (trainee): [Personal therapy provides a] chance to make sure my own emotions are effectively regulated in order that I can provide a safe space when I am working with clients.

“Safety” was often referenced within the data, with a number of participants noting that having a space devoted to personal reflection and development of self-awareness enabled them to be “safe and fit for practice” (P20, therapist). Participants talked about personal therapy as a private space to process and understand their responses and experiences:

P36 (trainee): A space just for you, not for your clients, or your training or your peers but a place where it’s ok to just be about you. The training is a period of enormous growth and change and I’ve found that therapy is the place where I can see it the clearest.

P31 (therapist): Space to process your own personal, emotional response to situations in a way that explores it within the context of your own history and “normals” and to feel like there’s space where it can be about you in a more abstract sense rather than it needing to be practical and work centred.

A small number of participants argued that there could be benefits to personal therapy being more integrated into the course, with two participants suggesting that more openness with fellow trainees and tutors may have allowed deeper exploration of experiences. One trainee described personal therapy as feeling “somewhat sidelined” (P14) and another expressed the importance of talking with course peers about problems they were having with their personal therapist. However, the overarching impression across the data was that, because personal therapy was separate from the training institution and from client work, it had a number of benefits for the trainee, both personally and professionally, such as those documented above.

Theme 3: Personal therapy is part of becoming a music therapist

Teaching staff cited the experience of being a client as a key purpose of personal therapy. This view seems to be shared by trainees and therapists who were not teachers, with one participant describing personal therapy as: “A real experience of how psychotherapy can work” (P39, trainee). Several therapists talked about the importance of understanding something of how it feels to be a client, and a number of trainees described this as being central to their learning. For example: “I think [personal therapy] is essential for understanding how it feels to be a client. [...] If trainees don't go through this learning, then I don't think they will be fully equipped for the work of a therapist” (P18).

Participants also referenced the benefit of observing a therapist at work: “it was a fantastic opportunity to see a therapist in action and to notice their approach and learn from it (whether this was aspects I might want to incorporate into my own practice or not)” (P1, therapist). One trainee explained it was through having therapy that they were motivated to train to be a therapist and, when describing the experience of personal therapy during training, this participant said: “I'm thinking about therapy on new levels i.e. analysing what the therapist is doing/might be doing since my own knowledge of therapy techniques is growing” (P18).

By being in the client role and making decisions about which elements of a therapist's approach to absorb into one's own practice, trainees experience their own individual “therapeutic journey” (P6, trainee), which had relevance both personally and professionally. Participants discussed variation in individuals' needs, with one trainee commenting that the number of hours of personal therapy required “probably depends on who you are” (P33). Other participants highlighted the different experiences trainees will have, while suggesting that personal therapy is generally useful and productive:

P30 (teacher): I think it is important that each student works with their therapist to find the role it most usefully plays for them. This will vary between students.

Despite this variation in needs, there was widespread agreement throughout the data that a key outcome of personal therapy is the development of self-awareness. Participants referred to overcoming potential barriers to being able to work as a therapist, with one trainee explaining that personal therapy provided: “A chance to go deep with your own process, and work through any issues that may affect your ability to be an effective therapist” (P14). Another trainee addressed one of these “issues” when they wrote: “[Personal therapy] is helping me to deal with issues of confidence. The ‘not good enough’ elements of how I view myself and how that may affect how I deliver therapy” (P13).

Participants also talked about the impact of personal therapy on the development of their professional skills: “Personal therapy allowed me to develop my reflective and observation skills. As my therapist made me more aware of my behaviours I became more attentive to clients whom I was working with on placement as well as becoming more confident working with other professionals” (P23, therapist).

Although the majority of participants described personal therapy as a useful experience, many experienced initial reservations. One participant described personal therapy as “surprisingly helpful” (P4, trainee), and a number of other participants referred to a gradual shift in their perceptions of personal therapy as its beneficial effects were experienced:

P1 (therapist): As the course went on and I got a better feel for how best to use the time with my counsellor, it was incredibly useful. It was a very supportive experience and I was relieved to have it. It provided support for things in my present and past that I had never considered getting support for, which was very useful.

P25 (therapist): At first, I felt forced into it [...] However, it soon became a bit of a life raft in terms of something I could look forward to - a safe space to voice my fears, insecurities and worries about the course as well as explore deep seated issues I didn't know were still under the surface.

Feeling “surprised” during the journey of personal therapy and becoming increasingly self-aware are potential features of the client experience. An additional feature encountered by music therapy trainees was the opportunity to develop professional skills. There was significant evidence within the data that participants felt this experiential element of music therapy training provided something of great value that is not otherwise available to the trainee therapist.

DISCUSSION

The data reflected a predominantly positive perception of personal therapy during music therapy training, although for many participants this positive perception developed over time, or even retrospectively, due to the costs of personal therapy outlined in theme 1. We chose to use P4's words “surprisingly helpful” in the title of the study as they captured the way in which many of the participants made sense of their personal therapy. Participants acknowledged a range of benefits, particularly in relation to the “separateness” of personal therapy from the rest of training - with this “separateness” seeming to alleviate concerns around the ethics of requiring personal therapy - and described it as an important part of becoming a therapist. Although many participants referred to the financial and emotional cost of therapy, these costs were largely described as being ultimately outweighed by the benefits. We recognise participants might have internalised professional discourses around the positive impact of personal therapy, but it was beyond the scope of this study to explore the extent to which this might have been the case. It is also possible that only participants with more positive views on personal therapy volunteered for the study. With these limitations acknowledged, we have focused on our interpretation of the meanings within the data in order to construct our discussion and recommendations.

When comparing the results of this study to those in the wider psychotherapy literature (e.g., McMahan, 2018; Messina et al., 2018; Moller et al., 2009; Murphy et al., 2018; Norcross, 2005; Rizq, 2011), it is clear that personal therapy is valued highly across both talking therapy and music therapy. The potential advantages of encouraging open discussion about experiences in personal therapy have been highlighted (McMahan, 2018; Rizq, 2011; Salter & Rhodes, 2018), and the results of this study underscore the importance of programme leaders and trainees optimising the value of personal therapy during training. We have used the data to derive a set of recommendations surrounding mandatory personal therapy by examining each of the three themes and considering how potential barriers - such as financial cost - could be lessened, and how benefits - such as understanding, and

therefore optimising, the impact of personal therapy during training - could be enhanced. Specifically, we argue the following are beneficial (and acknowledge these may reflect existing practice – so our intention here is not necessarily to make recommendations for changing current practice but to support the value of and enhance existing practice):

- Programme leaders, if they do not already, providing guidance to trainees as they search for *a personal therapist*. What are the different types of therapy that are available? Is there a database of local therapists? How do you choose which therapist to contact? Explain that it is normal to meet more than one therapist before deciding who might be most suitable (one trainee commented that “I think some documented guidelines would be useful though in funding and finding a therapist at the start”).
- Exploring potential *funding support*. Programme leaders highlighting when applications can be made to the BAMT Small Grants Fund (BAMT, 2017). Programme leaders and trainees investigating other sources of financial support or ways of accessing more affordable therapy.
- Tutors outlining the potential *benefits and challenges* of personal therapy, introducing this themselves and/or inviting final year trainees or qualified music therapists to share their experiences – both positive and negative.
- Trainees undertaking *background reading* on personal therapy, with guidance from tutors (e.g., Gardstrom & Jackson, 2011; Murphy et al., 2018; Yalom, 2009).
- Trainees setting aside *time to reflect* on their experiences in personal therapy throughout training, either through a private personal therapy journal or in discussion with tutors or course peers, at the discretion of the trainee.

Although these recommendations are already practised to some degree within all training institutions, we believe the data we have gathered suggests that there is the potential for the value of personal therapy for trainees to be further enhanced. The recommendations are intended to facilitate discussion about “best practice” amongst teaching staff and to give trainees ideas about how to approach personal therapy, and when to seek support or guidance from their tutors.

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

The recruitment aim was to achieve representation of all seven institutions offering music therapy training at the time of the study, and a spread of responses from trainees and qualified music therapists, including teaching staff. The participant group is limited by the disproportionate number of participants from the University of the West of England. However, the themes discussed above are representative of the responses of participants across all institutions, suggesting that the results have relevance beyond each participant’s respective training programme.

Most participants were either currently training, or had qualified in the last ten years, and there was no indication within the data that participants struggled to recall their experiences. However, the authors acknowledge that individuals’ perceptions may have altered over time. To give deeper insight, a possible approach for further research could be a longitudinal study exploring trainees’ reflections at different stages of training, and then again post-qualification.

Although much enthusiasm was expressed for the study at the point of recruitment, and those who did complete the survey provided rich reflections, we did not receive as many completed surveys as expected based on the number of people who initially expressed interest in taking part. This could be due to the potentially sensitive nature of the research topic, despite the anonymity of the online survey and the use of questions that were primarily exploring how personal therapy interacted with training, rather than the content of participants' therapy sessions. However, the challenge of recruiting participants could also reflect a lack of interest in the role of personal therapy during training – something that may be significant in itself – and also raises questions about the role of research in music therapy training. Lack of interest in research about something that was such a thought-provoking, relevant topic for the participants highlights a potential need to encourage further engagement within research culture in music therapy, particularly amongst trainees.

This research does not compare experiences across different training courses, but further investigations in this area could consider how personal therapy is positioned within each training institution, and the impact this has on trainees' experiences. Similarly, different types of personal therapy could be explored: The majority of music therapy trainees in this study chose not to have one of the arts therapies for their personal therapy. It would be interesting to explore the reasons behind this, in addition to considering how participation in an arts therapy could impact on a trainee's experience and what the potential impact could be of introducing mandatory music therapy for trainee music therapists.

It would be useful to expand upon this study's results relating to the financial cost of personal therapy. Further research could consider whether or not financial inaccessibility means that mandatory personal therapy is potentially an active obstacle to training, which may therefore be preventing a future change in the demographics of the music therapy profession.

CONCLUSION

This study goes some way to beginning the exploration of the role of personal therapy in music therapy training in the UK, and the depth of participants' responses shows that much insight could be gained from further research into this area. If personal therapy continues to be a mandatory requirement in UK music therapy training – and it seems there is a strong argument in support of this – more research is needed in order to justify its cost and optimise its value to trainees.

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Ελληνική περίληψη | Greek abstract

«Απροσδόκητα βοηθητική»: Διερεύνηση των απόψεων εκπαιδευόμενων και εγγεγραμμένων μουσικοθεραπευτών για τον σύγχρονο ρόλο της προσωπικής θεραπείας στη μουσικοθεραπευτική εκπαίδευση στο Ηνωμένο Βασίλειο

Megan Brand | Victoria Clarke | Catherine Warner

ΠΕΡΙΛΗΨΗ

Τα εκπαιδευτικά προγράμματα μουσικοθεραπείας στο Ηνωμένο Βασίλειο είναι διαπιστευμένα από το Συμβούλιο Επαγγελματιών Υγείας και Φροντίδας (Health and Care Professions Council, HCPC). Το HCPC απαιτεί οι εγγεγραμμένοι μουσικοθεραπευτές να έχουν εμπειρία και κατανόηση της αξίας της θεραπείας για την ανάπτυξη της διορατικότητας και της αυτεπίγνωσης. Σε πρακτικό επίπεδο, αυτό ερμηνεύεται σήμερα στην απαίτηση για προσωπική θεραπεία κατά τη διάρκεια των σπουδών – εντός ενός θεραπευτικού και εμπιστευτικού πλαισίου με έναν κατάλληλα καταρτισμένο και εγγεγραμμένο θεραπευτή για έναν ελάχιστο αριθμό ωρών – παρόλο που η συνολική διάρκεια και το είδος της θεραπείας ποικίλουν ανάμεσα στα διαφορετικά εκπαιδευτικά προγράμματα. Στόχος της παρούσας μελέτης είναι η διερεύνηση της αντιληπτής αξίας και του αντίκτυπου της υποχρεωτικής προσωπικής θεραπείας από τη σκοπιά των εκπαιδευόμενων, αλλά και των εγγεγραμμένων στο HCPC μουσικοθεραπευτών. Η συλλογή δεδομένων έγινε μέσω ενός ποιοτικού ερωτηματολογίου με ανοιχτού τύπου ερωτήσεις εξερευνώντας τις προσωπικές εμπειρίες θεραπείας των συμμετεχόντων. Έλαβαν μέρος 39 συμμετέχοντες από τα διάφορα εκπαιδευτικά προγράμματα μουσικοθεραπείας του Ηνωμένου Βασιλείου κατά την περίοδο της έρευνας, καθώς και από το μητρώο των εγγεγραμμένων μουσικοθεραπευτών. Θεματική ανάλυση χρησιμοποιήθηκε για την ανάπτυξη τριών θεματικών από τα δεδομένα: «η προσωπική θεραπεία είναι δαπανηρή, αλλά τελικά ωφέλιμη», «η προσωπική θεραπεία παρέχει έναν υποστηρικτικό χώρο χωριστά από την εκπαίδευση», και «η προσωπική

θεραπεία αποτελεί μέρος της διαδικασίας του να γίνει κανείς μουσικοθεραπευτής». Καταλήγουμε με προτάσεις σχετικά με τους τρόπους που η προσωπική θεραπεία μπορεί να ενταχθεί πιο χρήσιμα στα εκπαιδευτικά προγράμματα βασιζόμενες στην ερμηνεία των απαντήσεων των συμμετεχόντων.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ψυχοθεραπεία, ποιοτικό ερωτηματολόγιο, θεματική ανάλυση