Language Discordance in Music Therapy: Therapists' Experiences of Delivering Music Therapy Services with Interpreters

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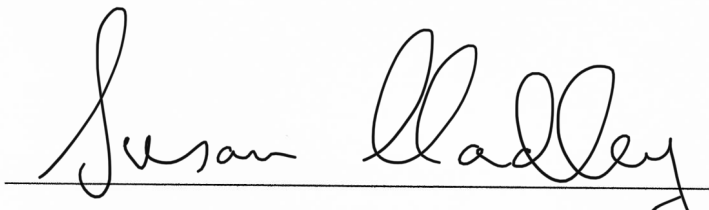

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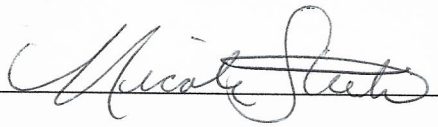

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Abstract

The following thesis is a culmination of an interpretative phenomenological analysis research study seeking to understand music therapists' experiences of delivering music therapy services with a language interpreter. The purpose of this study has four main tenets: 1) To understand the therapists' experiences of delivering music therapy services with interpreters, 2) To fill the gap in the music therapy literature on working with interpreters, 3) To serve as a resource for music therapists delivering music therapy services with interpreters, and 4) To combat the systemic issues of access and equity within the music therapy field. Data was collected through one-on-one semi-structured interviews with 5 music therapists. Data was then transcribed, coded, and thematized, resulting in 40 themes and seven domains: 1) Ways of working with interpreters, 2) Benefits of working with interpreters, 3) Drawbacks of working with interpreters, 4) Music therapists' feelings when working with interpreters, 5) Potential reasons for not working with interpreters, 6) Dangers of not working with interpreters, and 7) Considerations for music therapists working with interpreters. The findings indicate areas of growth and the need for increased education for music therapists when working with interpreters. Music therapists are also challenged to confront their own privileged stances on the issues of language and linguistic privilege within the U.S., as related to working with patients with limited English proficiency and from historically marginalized communities within music therapy.

Keywords: interpreters, language, linguistic privilege, music therapy

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Table of Contents

List of Tables and Figures

Tables

Figures

Introduction

Background

Motivation for research.

The motivation for this research stems from my direct clinical work as a board-certified music therapist at a public county medical hospital. The hospital is located in the mid-west and is unique in the sense that it serves individuals from all over the world, oftentimes individuals experiencing displacement or homelessness, incarceration, unemployment, being uninsured, and seeking refuge or asylum. Aside from English being the most spoken recipient care language, the subsequent five include Spanish, Haitian Creole, French, Arabic, and Kinyarwanda (R. Tardy, personal communication, January 12, 2023). Due to this high variance in patient language, I have experience delivering music therapy services with in-person interpreters, video interpreters, and phone interpreters in both one-on-one and group formats.

Throughout my undergraduate training and music therapy internship, the topic of working with language interpreters was never discussed. Perhaps this was due to the sociocultural locations of the professors and supervisors with whom I worked, who were all white, native-English speaking individuals, as well as their lack of education and awareness surrounding cultural reflexivity and multiculturalism. The topic of language and communication was ignored, and music was often regarded as a "universal language" and a "magical tool" for bridging language barriers. Upholding this type of thinking can be problematic as it dismisses an individual's entire language, culture, and ability to communicate, with the potential for harmful assumptions and stereotypes to be made.

As a student in a practicum placement, I had quite an unfortunate experience with a clinical supervisor who made it clear that they did not work with individuals who did not speak

English and “avoided those patient rooms.” As a student, I was utterly shocked to hear this and felt that I had no place to challenge this unjust, unfair, and discriminatory stance. I, as an Asian American student, had zero power in the supervisory relationship with my white supervisor who was responsible for my evaluation and semester grade. Later in the next semester, I shared this information with one of the music therapy professors, but it remains unclear if any steps were taken to address the discriminatory behavior and provide corrective action. I did not realize it at the time, but this experience left a hugely negative impression on me. Even though I am an English-speaking monolingual person, the supervisor’s biased behavior left me feeling angry and outraged. I do not know what it feels like to be discriminated against on the basis of language, but I can relate to the feelings of discrimination on the basis of race and gender. It is all too common for these types of discrimination to be dismissed or overlooked, ultimately heightening the experiences of othering, marginalization, and oppression. Throughout the early stages of my music therapy career, I started to unpack my own implicit bias against patients with LEP and my own discomfort with not being able to communicate in the “traditional” sense.

Significance of research.

When I began working at the public county hospital, I started to notice my own feelings of discomfort and nervousness when walking into a patient’s room for the first time when their natal language was not English. I felt my own insecurities and feelings of imposter syndrome when having another individual (i.e., interpreter) accompany me to the session. I wondered if the interpreter would judge me or question the validity of music therapy. I felt awkward and uncomfortable having to communicate with a third person because it was so unfamiliar to me at the time. Because of my upbringing, I had very little experience communicating with people who did not speak English. All these concerns centered myself and my own ego. At the same time, I

was battling the narratives in my head that told me, “Music is the universal language” and “When words fail, music speaks.” I was experiencing great dissonance between what I was taught as a music therapy student, and what I was actually experiencing and believed to be true as a music therapy clinician.

As I noticed my own bias, I thought to myself, I wish this was covered in the music therapy literature, other music therapists must be experiencing this too, right? I began to dive into the research and found very little on the topic of language interpreters in music therapy, yet related professions like counseling and psychotherapy held a plethora of research on this topic. I asked myself: Why aren’t music therapists talking about this? Are music therapists utilizing interpreters when they work with patients whose language is different from their own? Are music therapists believing in the illusion of music as a universal language? Perhaps the most daunting question of all - Are music therapists avoiding working with patients with LEP altogether? These questions led me to develop this thesis topic in hopes of shedding light on a much-needed issue within the music therapy field. I chose to conduct an interpretative phenomenological analysis to best answer these questions and understand the experiences of music therapists working with interpreters in music therapy.

Location of self.

I am an Asian American, Chinese, cis-woman, and I acknowledge the fact that my intersecting identities shape and influence the entirety of this research. Additionally, I am a transracial adoptee (TRA), which means that I was adopted by parents of a different racial group than my own (i.e., I am Asian, and my parents are white). I recognize the many privileges I hold as a college-educated, English-speaking, nondisabled, cis-woman in the United States. Especially as a monolingual, English-speaking individual, I hold linguistic privilege and power, which

continues to come up in how I work with patients. At the same time, I am working towards learning as much as I can to do less harm and uplift marginalized voices. The subjugated intersections of being an Asian woman, person of color, and foreign-born citizen lead me to have a unique relationship to this thesis topic, one with great empathy, connection, and emotional investment.

Aims of the Study

The contents of this research are situated within the context of music therapy practice in the United States. I acknowledge the many factors that play into this phenomenon, particularly those of race and class. Additionally, the aims of this research are centered on spoken language, rather than sign language. It would be interesting to conduct a similar study in the context of sign language, but such is beyond this research's scope. While the initial aim of this research was to understand the experiences of music therapists working with interpreters in music therapy, the focus evolved to include the systemic issues of accessibility and equity within music therapy, including the issue of music therapy access for individuals with limited English proficiency, as well as the biased stances of music therapy clinicians. Drawing from my own experiences, as well as literature from related professions, including psychotherapy and art therapy, it was important for me to highlight these issues in music therapy given the importance of this topic and limited research available.

There is a lack of research surrounding the experiences of music therapists working with interpreters. Relevant literature seeks to understand the experiences of therapists working with language interpreters within counseling, psychotherapy, and art therapy (Bird, 2008; Gerskowitch & Tribe, 2021; Hamerdinger & Karlin, 2019; Hama, 2015; Pugh & Vetere, 2009; Raval & Smith, 2003). I believe music therapists have uniquely shaped experiences that

influence the ways in which we work with language interpreters while delivering music therapy services, and as such, should be further explored. The purpose of this study has four main tenets: 1) To understand music therapists' experiences of delivering music therapy services with interpreters, 2) To fill the gap in the music therapy literature on working with interpreters, 3) To serve as a resource for music therapists delivering music therapy services with interpreters, and 4) To combat the systemic issues of accessibility and equity within the music therapy field related to language access/interpreters.

Literature Review

Defining Terms and Concepts

It is important to first define some key terms and concepts related to this research. I will discuss language statistics in the United States, define limited English proficiency, distinguish differences between interpreters and translators, and discuss language/linguistic privilege. I will also highlight important aspects of the AMTA Professional Competencies and Code of Ethics that make these issues relevant to the music therapy profession.

Language statistics.

According to Dietrich and Hernandez (2022), since 1890, the U.S. Census Bureau has collected data regarding languages spoken in the home. The first question in the U.S. census asks respondents, "Does this person speak a language other than English at home?" Those who answer yes are asked two subsequent questions: "What is this language?" and "How well does this person speak English?" (Dietrich & Hernandez, 2022, p. 1). The latter is answered from a choice of four options: very well, well, not well, or not at all. According to the 2019 U.S. Census, 67.8 million people speak a language other than English, and of those 67.8 million, 62% indicated that they spoke English very well, about 19% well, 13% not well, and 6% not at all (Dietrich & Hernandez, 2022).

Limited English Proficiency (LEP).

When a patient and health care provider speak different languages and have limited or zero proficiency of the other's language, language discordance occurs (John-Baptiste et al., 2004). In the context of the United States with the dominant language being English, this is often experienced with patients with limited English proficiency (LEP), which is defined as "the limited ability or inability to speak, read, write or understand the English language at a level that

permits the person to interact effectively with healthcare providers or social service agencies" (Divi et al, 2007, p. 60). Language discordance with patients with LEP may lead to provider miscommunication, lack of overall patient understanding and comprehension, and dismissal of patient needs, ultimately resulting in poorer care, inadequate use of medication, decreased patient satisfaction, increased adverse outcomes, increased length of stay, and higher hospital readmission rates (Divi et al., 2007; John-Baptiste et al., 2004; Walker-Cornetta, 2022). According to Title VI of the 1964 Civil Rights Act, discrimination is prohibited based on national origin and language and "individuals cannot be denied access to education, health care, or legal services because they do not speak English" (Searight & Searight, 2009, p. 445).

Interpreters versus translators.

It is important to distinguish between interpreters and translators, as they are often referred to interchangeably, when in fact, they are quite different. Interpreters deal with spoken language whereas translators deal with written language. "Interpreters convert one spoken language into another—or, in the case of sign-language interpreters, between spoken communication and sign language," which requires careful attention and exceptional memory (Jones, 2002, p.1). Translators on the other hand "convert written materials from one language into another," which requires excellent writing, editing, and analytical skills. (Jones, 2002, p. 1). Both interpreters and translators do more than convert language and text; they "relay concepts and ideas between languages...and must be sensitive to the cultures associated with their languages of expertise" (Jones, 2002, p.1).

The National Council on Interpreting in Healthcare (n.d.) has specific guidelines and ethics for healthcare interpreters and defines a qualified interpreter as an individual who:

> Demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care. (n.p.)

In contrast, "untrained interpreters or ad-hoc interpreters may be family members, bilingual staff, or volunteers with limited to no training in interpreting" (Villalobos et al., 2016, p. 4). Research repeatedly maintains that family members are not good options for interpretation, namely due to their lack of training and cultural understanding (Tribe & Morrissey, 2004), not to mention the proximity and emotional involvement they have to the patient.

Language/Linguistic privilege.

As a society and as individuals, we create dominant narratives about ourselves and others that become eventual truths in our own minds (Hadley, 2013). We are born into a "socio-cultural historical matrix of dominant narratives," some serve to oppress and others to empower (Hadley, 2013, p. 374). Over time, dominant narratives have placed the English language at the top of the hierarchy, with all other languages falling as less than (Gallagher-Geurtsen, 2007). Within the context of the U.S., there are two overarching grand narratives that result in linguistic privilege: "1) English is a naturally superior language; and 2) To be American is to speak only English" (Gallagher-Geurtsen, 2007, p. 43). In the context of university students, Vandrick (2015) created a list of invisible privileges from which many monolingual English-speaking students benefit. Like all other identities and privileges, an individual's experiences are also affected by their intersectional identities, such as race, gender, sexual orientation, class, etc. (Crenshaw, 1989). According to Vandrick (2015), some of the unearned linguistic privileges for monolingual English-speaking people include:

- I am not labeled “underprepared” because of my linguistic identity.
- Professors in my non-ESL classes do not immediately see me as a possible problem in their classes as soon as my language identity becomes apparent.
- When groups are formed in classes to do group projects, I can assume that my language identity will not cause people to resist or be uncomfortable having me in their group.
- People don’t say to me with surprise, “Oh, your English is so good!”
- I am able to make friends with a wide variety of others at my college and don’t feel that “Americans” don’t have time for me because of my linguistic or national identity or because they assume that communicating with me will be too challenging.
- Students who have been assigned as my roommates in dormitories do not ask to be reassigned, saying I “can’t communicate” or “can’t speak English.”
- People assume I know the standard costs of taxis and other services, and therefore don’t try to overcharge, cheat, or take advantage of me.
- I can get health care without worrying about being able to explain my concerns or symptoms clearly in English so the doctors and nurses can understand. (pp. 57-58)

Few music therapists have acknowledged linguistic privilege and the dominant narrative of the English language. Clements-Cortes and Yip (2022) reflected on the impacts of language in music therapy and the privileges of being white and a native-English speaker in Western healthcare systems. They discussed how Western English-speaking music therapists maintain power over their clients through pathologizing and ableist texts. Moonga (2022) discussed the ways in which the music therapy profession benefits from “the dominance of the English

language as a means of knowledge production, dissemination, and control," with virtually all means of communication defaulting to English (p. 2). This default benefits English speakers at the "logistical and emotional expense of non-native English speakers" (Moonga, 2022, p. 1).

AMTA Professional Competencies and Code of Ethics.

Music therapists in the U.S. work in various settings with various clientele. Music therapy research maintains that most clients "do not fit the typical Eurocentric ideal and are subject to systemic oppression and social microaggressions" (Baines, 2021, p. 3), and in many cases, music therapists are working with clients who speak languages different from their own (Hadar, 2022). The topic of language is referenced in the American Music Therapy Association (AMTA) Professional Competencies in two places: once in the clinical foundations section under therapeutic relationship and again in the music therapy section under professional role/ethics (AMTA, 2013):

> 9.5 Demonstrate awareness of the influence of race, ethnicity, *language*, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation on the therapeutic process.
>
> 17.10 Treat all persons with dignity and respect, regardless of differences in race, ethnicity, *language*, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation. (n.p., italics added)

These competencies imply that music therapists must demonstrate the awareness of the role that language plays in the therapeutic process and must also treat all persons with dignity and respect, regardless of their natal language. The AMTA Code of Ethics (AMTA, 2019) does not explicitly reference the intersection of language, however, under principle one, music therapists will:

> 1.1 Provide quality client care regardless of the client's race, religion, age, sex, sexual

> orientation, gender identity or gender expression, ethnic or national origin, disability, health status, socioeconomic status, marital status, or political affiliation. (n.p.)

The AMTA Code of Ethics (AMTA, 2019) also states that music therapists will "identify and recognize their personal biases, avoiding discrimination in relationships with clients, colleagues, and others in all settings" (n.p.). To combat personal biases and discrimination based on language, music therapists must ask themselves, "Are my clients with limited English proficiency being offered the same music therapy services and opportunities as my English-speaking clients?" and "Have I ever avoided or overlooked a client simply because of their natal language?"

Working With Interpreters in Related Professions

Psychotherapy/Counseling.

There is a plethora of research surrounding language interpreters in psychotherapy and counseling. Several publications focus on guidelines and recommendations when working with interpreters (Hamerdinger & Karlin, 2019; Hunt & Swartz, 2017; Martin et al., 2020; Searight & Searight, 2009; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2009a). General recommendations include keeping language short and succinct (Hunt & Swartz, 2017; Searight & Searight, 2009; Tribe & Morrissey, 2004), addressing the individual directly rather than the interpreter (Searight & Searight, 2009), and conversing with the interpreter before and after the session to discuss any relevant cultural issues, confidentiality, and boundaries (Hunt & Swartz, 2017; Searight & Searight, 2009). Hunt and Swartz (2017) also suggested the necessity for therapists to relinquish the need to be in control, as oftentimes, interpreters and clients form a unique bond that is separate from the therapist. Both Hunt and Swartz (2017) and Searight and Searight (2009) acknowledge that side conversations will likely occur between interpreter and

client, however, they suggest therapists politely request to join in the conversation, for example, “What you’re both saying sounds important. Could you please share it with me?” (Searight & Searight, 2009, p. 446).

Hamerdinger and Karlin (2019) described four factors that are key to the effectiveness of working with an interpreter: 1) Qualification of the interpreter, 2) Training and/or experience of the interpreter in the interpreting process, 3) Training of the interpreter to work in the specific clinical setting, and 4) Qualification of the therapist in working with an interpreter. Oftentimes, the research is focused on the skillset of the interpreter. However, Hunt and Swartz (2017) agreed with Hamerdinger and Karlin’s (2019) in that the attitudes and skillsets of the therapist are just as important, and failing to address these issues may be “tantamount to ignoring key social questions, notably questions of power, which may impact both on mental health and on the experience and conduct of psychotherapy” (Hunt & Swartz, 2017, p. 106). When faced with the potential for a dual relationship, Martin et al. (2020) suggested that therapists provide psychoeducation for interpreters to gain an understanding of boundaries and confidentiality. When transitioning from a dyadic to a triadic relationship, Martin et al. (2020) recommended therapists address and embrace the three-way relationship between therapist, interpreter, and client with honest and ongoing conversations. To combat therapists’ own ignorance and lack of knowledge, Martin et al. (2020) suggested the need for increased education and understanding of triadic relationships, ongoing cultural education and humility from the therapist, as well as seeking consultation and information from skilled interpreters when needed.

Several factors may prevent therapists from working with interpreters. These include feelings of anxiety, embarrassment, and inferiority regarding the interpreter (Gerskowitch & Tribe, 2021; Pugh & Vetere, 2009; Tribe & Tunariu, 2009). According to Smith (2008), “many

therapists deny clients therapy on the basis of language because they do not want to use an interpreter or worry that they don't have the necessary skills" (p. 21). It is imperative that therapists process and confront these feelings of anxiety, embarrassment, or inferiority to avoid this form of overt discrimination and consider the ethics surrounding withholding services based on personal biases.

Conversely, Tribe and Thompson (2009a) explored the positive aspects of working with interpreters in therapy. The interpreter's presence was found to "normalize psychotherapy to clients from cultures in which psychological and psychiatric services are unfamiliar, frightening or highly stigmatized" (Tribe and Thompson, 2009a, p. 5). Therapists also found that working with interpreters helped them to be "more reflective about their interventions," "more alert to non-verbal communication," and "simplify the language used, re-assessing how much they needed the jargon" (Tribe & Thompson, 2009a, p. 7). Working with interpreters may also aid in the enrichment of a therapist's practice, "requiring clinicians to question previously held assumptions and to widen their field of focus to appreciate other cultural constructions of behaviour, idioms of distress, contextual meanings and explanatory health beliefs" (Tribe & Lane, 2009, p. 235).

The ways in which therapists work with interpreters have evolved over the years. Traditionally, interpreters were viewed as "translation machines" (Hunt & Swartz, 2017, p. 99) or "black boxes," (Miller et al., 2020, p. 29) with the sole purpose of interpreting on a word-for-word basis. According to Tribe and Morrissey (2004), there are four basic models of interpreting: 1) Linguistic mode: The interpreter interprets "word-for-word and adopts a neutral and distanced position," 2) Psychotherapeutic or constructionist mode: "The interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation," 3) Advocate or

community interpreter: “The interpreter takes the role of advocate for the client, either at the individual or wider group or community level, and represents their interests beyond interpreting language for them,” and 4) Cultural broker/bicultural worker: “The interpreter interprets not only the spoken word but also relevant cultural and contextual variables” (p. 131). Many authors highlighted the importance of the cultural broker stance, (Gerskowitch & Tribe, 2021; Hunt & Swartz, 2017; Martin et al., 2020; Tribe & Thompson, 2009a), recognizing that important cultural, social, and political information can be interpreted and can enhance the therapist’s overall understanding of their client. When the interpreter is viewed as a cultural broker, there is a “powerful and unspoken acknowledgment of acceptance...shifting the perspective from ‘You use an interpreter’ to ‘The interpreter is here for us’” (Hammerdinger & Karlin, 2019, p. 2).

There are several studies within psychotherapy and counseling that seek to understand the therapists’ experiences of working with interpreters (Gerskowitch & Tribe, 2021; Pugh & Vetere, 2009; Raval & Smith, 2003). There are reported advantages, disadvantages, and mixed views when working with an interpreter. One of the advantages therapists have described is working with interpreters as a cultural broker to enhance their overall understanding of the client’s culture and context (Gerskowitch & Tribe, 2021). Other therapists viewed interpreters as an “unfortunate necessity,” due to the “intrusive” nature of an additional third party in the intimate therapeutic space (Gerskowitch & Tribe, 2021, p. 303). It is common for therapists to report anxiety when working with interpreters out of fear that the interpreter will misinterpret, miscommunicate empathy, or take over the session (Gerskowitch & Tribe, 2021). Therapists may also find the repetition of speech to be distracting and may feel excluded at times (Pugh & Vetere, 2009). Raval and Smith (2003) recommended therapists devote adequate time and energy

to creating a positive working alliance with the interpreter, including "briefing and debriefing interpreters [and] valuing and encouraging interpreters to take on a more active role" (p. 8).

Art Therapy.

Working with interpreters in art therapy is closely related to working with interpreters in music therapy, as both professions utilize creative arts as non-verbal mediums of communication. Music therapists use various forms of musical expression just as art therapists use "images and the creative process of image-making as a medium for expressing feelings and thoughts that one may find difficult to articulate" (Hama, 205, p. 5). Hama (2015) noted that even though art therapists primarily communicate through visual language, "verbal communication also remains an effective tool for the therapist to introduce the process as well as helps to establish a therapeutic relationship" (p. 4). Even more, it is common for art therapists to "ask questions during the art-making process as well as discussing the completed work with the client," thus it is the therapist's responsibility to include an interpreter when needed (Hama, 2015, p. 5). Some art therapists were reluctant to work with interpreters and preferred exhausting all other forms of communication before resorting to working with an interpreter (Hama, 2015). These therapists doubted "the effect of therapy when an interpreter is present and discussed how an interpreter could influence the therapeutic relationship, delay the process and mislead the therapist's understanding of the client" (Hama, 2015, p. 57-58). On the other hand, some art therapists believed the benefits of working with interpreters outweighed the potential issues, especially when working with "to establish a trusted and professional relationship...and addressing the issues with interpreters in advance" (p. 58).

Bird (2008) interviewed four art therapists to understand their experiences of working with clients in art therapy whose language was different from their own. As a result, Bird (2008) shared seven recommendations for working with interpreters in art therapy:

1. It should not be assumed that images automatically take the place of a shared first language.
2. Art Therapists should pay equal attention to the client's use of language and to the client's use of images.
3. Art Therapists need to take into account not only the languages they and their clients speak but also the cultural narratives that they bring to the therapeutic encounter.
4. Art Therapists should reflect upon the meaning of the words they and their clients use and not assume a common or shared sense of meaning to those words. Equally it should not be assumed that there is a common universal language of symbols, though that is not to discount the possibility of shared pre-existing meanings – it is the exploration of those assumptions and meanings which is of value.
5. Therapeutic relationships can be built and therapeutic benefits can be gained where the client and therapist do not share a common first language, and thus Art Therapists ought not to shy away from working with clients who they do not share a first language with.
6. Given the cultural and political aspects of language it is important that Art Therapists make themselves aware of the culture of the client and think about the potential political meanings of using one language or another, and of the meaning of silence within a political as well as psychological context.

7. Art Therapists share very similar experiences to psychotherapists when working with clients who they do not share a first language with. Consequently it would be valuable for Art Therapists to engage with psychotherapy research. (pp. 33-34)

In the instance of language discordance in art therapy, Bird (2008) ascertained that a working therapeutic alliance may be established when both the therapist and client have a willingness to understand and explore together.

Working With Interpreters in Music Therapy

While working with interpreters has been cited in the related professions of psychotherapy and art therapy, the mention of language discordance and language interpreters in music therapy literature is sparse. It is important to study this phenomenon in music therapy specifically due to the unique nature of our work and the nuances of music and language within an individual's everyday life and wellbeing. Schwantes (2015) shared about her experiences working with interpreters in both the U.S. and Czech Republic and categorized those experiences into three areas: 1) Interpreter as co-therapist, 2) Interpreter in a supportive role, and 3) Strict interpreter. Working with an interpreter as a co-therapist, Schwantes described the benefits of having more time to process experiences in the moment and increased client engagement within the sessions. Schwantes (2015) warned that roles can be blurred, and lines of communication must be "open, strong, and frequent" (n.p.). She noted that when working with an interpreter in a supportive role, interpreters were most helpful in "assisting with data collection, rapport building, and creating a positive atmosphere" (Schwantes, 2015, n.p.). She further explained that when interpreters and clients shared the same cultural background, the interpreter seemed to take a genuine interest in the personal challenges and political issues that the clients were also facing. When working with an interpreter as a strict interpreter, Schwantes (2015) described the

interpreter as an “essential bridge between the clients and me in the same way that music did” (n.p.).

Hadar (2022) reflected on her work as an Israeli music therapist working with a Chinese American family in the U.S. Hadar (2022) implored music therapists to consider contraindications for including an interpreter in music therapy services: “Prior to deciding whether to include an interpreter or not, music therapists should carefully consider the client’s level of mastery in the common spoken language. Rather than imposing a certain level of verbal communication” (p. 10). Hadar’s (2022) stance is rooted in the “dimensions of power and language in therapy, and specifically the notion of lingual plurality,” recognizing the fact that most academic debate is conducted in English (p. 9). Hadar (2022) argued that, in certain instances, “rejecting the use of an interpreter” would allow for a “relationship to be based on equity and acceptance, rather than one in which the therapist possesses the absolute truth” (p. 9).

Moonga (2022) also spoke to the notion of lingual plurality in music therapy: “The diversity of languages is something to be celebrated, except when language is used as a tool for dominance” (p. 1). There is a burden and expectation for non-native English folks to use English in everyday interactions, which is not acknowledged within the realm of music therapy. Moonga (2022) discussed the dynamics of language and power and posed the following questions: “In music therapy...little is written on the power of language. Could it be because of the assumption that music therapy relies less on spoken and written words as it clings to its relationship with music, which erroneously can be espoused as the universal language?” (p. 2). As a cross-language researcher and music therapist in Africa, Moonga (2022) also discussed the emotional labor of interpreting and translating in music therapy. Within the therapy space, “interpreters are

frequently forced to translate the client's story almost instantly, leaving them little time to think about the dialogue's emotional undertones or essential points" (p. 9).

Therapeutic Relationship in Music Therapy

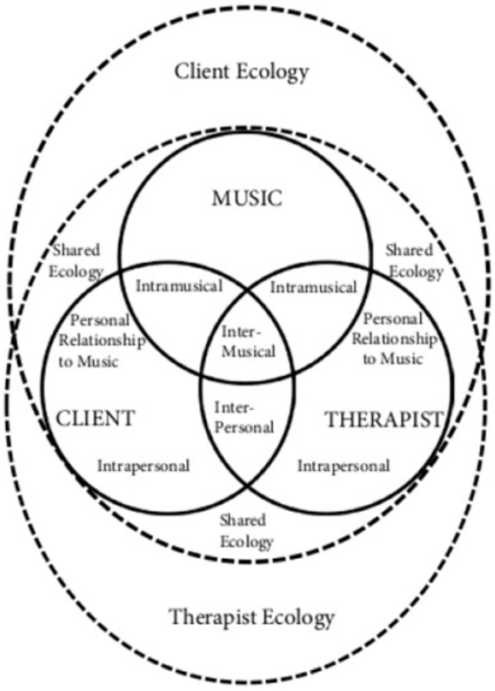
Several music therapy researchers and educators use a triangle to depict the multifaceted relationships within music therapy, with some form of therapist, client, and music at each point of the triangle. Garred (2001) conceptualized a triangle with therapist, client, and music at each point, indicating that "both the therapist and the client and the music are reciprocally interconnected, and thus a dynamic relation between each is made possible" (n.p.). Reciprocity is formed beyond just the client and therapist, but "between the two mediated by music" (Garred, 2001, n.p.). From a music-centered perspective, Brandalise (2004) illustrated the music therapy relationship in triangle form with music, the client's music, and the therapist's music at each point to form the "Triangle of Carpente & Brandalise" (n.p.). The entity of music is not between therapist and client but of equal importance within the triangular relationship. The triangle also includes two sided arrows between each point, representing the communication and relationship between the three agents. Brandalise (2009) expanded upon the "Triangle of Carpente & Brandalise" to include a "visual outline of the Music Therapy process using the song as a musical form functioning as a channel which supports the message between client-therapist-music" (n.p.). Here, the therapist and client may serve as either the transmitter or receiver of the message. Lastly, Murakami (2021) developed the Music Therapy and Harm Model (MTHM), using a triangle to depict the "means for conceptualizing potential sources of physical and/or psychological harm in music therapy practice" (n.p.). The music, client, and therapist are observed at each point of the triangle, with the therapeutic application of music between music and therapist, client-music associations between music and client, and therapeutic relationship

between therapist and client. The ecological factors of the client, therapist, and music are also acknowledged by three concentric circles, representing the micro-, meso-, and macro-dimensions at play.

Bruscia (2014) illustrated "The Client-Music-Therapist Constellation" (See Figure 1) to depict the varying relationships between client, music, therapist, and ecology (p. 174). Here, music is shown as its own entity existing "in and by itself, apart from the client and therapist," implying that the music can serve as therapist apart from the music therapist (Bruscia, 2014, p. 175). In this model, both client and therapist have intramusical relationships, that is, their own personal relationships to music, that eventually form together to create the intermusical relationship between client and therapist. The ecologies of both client and therapist are illustrated as overlapping circles that impact the therapeutic relationship.

Figure 1

The Client-Music-Therapist Constellation (Bruscia, 2014)



Bruscia (2014) also acknowledged the need for a "Client-Music-Therapist-Other Constellation," in the case of significant others or other professionals working with the client. With the additional presence of an interpreter, music therapists are working within the "Client-Music-Therapist-Other Constellation" (Bruscia, 2014). Several psychotherapy researchers note this shift in the therapeutic relationship, moving from a dyadic relationship between client and therapist into a triadic relationship between client, therapist, and interpreter (Hunt & Swartz, 2017; Miller et al., 2005; Pugh & Vetere, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2009b). For music therapists though, it is safe to assume that a four-way relationship exists between client, therapist, music, and interpreter.

Music as a Universal Language?

In the world of music therapy, the debate as to whether music serves as a universal language can be traced back to the 1980s when Moreno (1988) asserted that "no one music is a universal language" (p. 18). Bradt (1997) expanded upon Moreno's ideas nearly a decade later, urging music therapists to consider the ethical issues of music as a universal language:

> Music is often considered as being able to bypass language barriers and as a means for people from all over the world to communicate. But is there such a thing as a universal language? And, if so, what kind of music, which style, which culture is responsible for it? (p. 139)

In 2002, Brown asserted that "perceiving music as a universal language may give some practitioners a false sense of safety, believing that multicultural concerns are not necessarily an issue for music therapy" (n.p.). Some ethnomusicologists and music therapists argue that music is not even a language, as it is perceived symbolically rather than linguistically (Brown, 2002). Rolvsjord (2004) reflected on music as a poetic language, challenging the notion that music is a

universal language, one "that does not depend upon cultural[ly] mediated learning" (n.p.). Rolvsjord (2004) maintained that music has "biologically founded universal aspects" with "an inborn human musical communicative capacity," while also acknowledging "the cultural aspects of music, the mediated learning of music, and the connections between the cultural context and the way we use music in our lives and in therapy" (n.p.).

Following a critical examination of music therapy literature concerning working with refugees, Comte (2016) coined the term neo-colonial music therapist. The synthetic construct became evident through music therapists' "explicit or implicit cultural dominance, specifically relating to music therapy methods, orientations to practice, and understandings of health and trauma" (Comte, 2016, n.p.). These neo-colonial music therapists viewed music and more specifically, musical improvisation as a universal language, with the belief that music could transcend "traditional language barriers to find a common musical language through which the therapeutic dialogue could occur…and not only transcend the language barrier but also surpass a broader cultural barrier" (Comte, 2016, n.p.). Comte (2015) stated:

> By using improvisation as a means of therapeutic conversation with refugees without an awareness of this concept of culturally informed musical vocabularies, music therapists are advancing neo-colonial ideals...and imposing a set of Western values upon the therapeutic encounter…and in fact disempowering the refugee individual by misinterpreting their musical contributions to the therapeutic dialogue. (n.p.)

With this critical examination, Comte (2015) provided a real-life example of the dangers of viewing music as a universal language.

In a blog post that challenged the "helping" quality of music therapy as a helping profession, Young (2017) ascertained that "the 'miraculous' effects of music...along with the

widely accepted notion that music is a 'universal' medium can lead to false generalizations and over-simplification of how music can and should be used in healthcare or other psychosocial contexts" (n.p.). In a similar vein, Hiller & Gardstrom (2019) explained that this oversimplification may lead to the assumption that music is a "noninvasive and wholly-positive cure-all, and thus disregard the potential risks associated with music engagement," and urged music therapists to consider the contraindications and possible risks that come with engaging in music therapy (n.p.). Music and music therapy are not a prescriptive "'one size fits all' miracle cure," and music therapists should be actively working to dispel this myth (Young, 2017, n.p.).

Method

Epoche

I feel personally and emotionally invested in this topic, not because I identify as a bilingual individual, but because my sociocultural identities of being Asian American and a TRA. As a person of color, I have always felt a close connection with BIPOC patients and families in my music therapy work. Although I cannot relate to every BIPOC's specific struggle and hardship, I can empathize and understand the pain of everyday racial microaggressions, othering, and exclusion. As a TRA, I was separated and uprooted from everything I knew as a newborn infant - my birth family, culture, home, and language. The "what-ifs" and "what-could-have-beens" run through my mind as I work with patients and families who do not speak English. I see my own ancestors in some of my patients. Some of the Asian patients and families I work with see my face and automatically start talking to me in Mandarin, expecting me to reciprocate a language that was essentially taken away from me. I continue to grieve the loss of my birth culture, family, and language every day as an adult TRA. As a result, I feel a heightened sense of responsibility to conduct this research.

On the other hand, I was raised in a small, white, conservative town with two white parents. It was normal for me to grow up hearing racist and bigoted comments toward BIPOC communities, despite my own racial identity. Throughout childhood, I was never surrounded by any other languages aside from English. Even though I was foreign-born, I never had to sit with the discomfort of not speaking the dominant language. I was often shielded from harm under the protection of my white adoptive parents. I hold a different sense of privilege and power by being a POC raised by upper-middle class white parents. When I left home and went to college, I was forced to confront my own internalized biases from them and develop a greater sense of racial identity and adoptive identity apart from them.

Prior to conducting this research, I mostly viewed interpreters as "translation machines" (Hunt & Swartz, 2017, p. 99) or "black boxes," (Miller et al., 2020, p. 29), expecting them to interpret the spoken word and nothing else. I had never heard of or learned any other way of working with interpreters. My own biases and perceptions of working with interpreters prior to this research play a significant role in how the entirety of this research was conducted, analyzed, and presented.

Theoretical Framework

Epistemology is "the study of knowledge" and is concerned with how researchers seek to understand knowledge and truth, as well as what constitutes true knowledge (Matney, 2019, p. 4). The present research seeks to explore music therapists' experiences of delivering music therapy services with interpreters. For this research, the source of truth is based on the idea that there is no one single reality, but rather, multiple realities that are constructed through an individual's own lived experiences (Wheeler, 2016). The participants' realities are socially constructed; therefore, the researcher seeks to understand the world of their lived experience

through natural inquiry, emergent design, purposeful sampling, and reflexivity (Mertens, 2015; Wheeler, 2016).

Research methodology.

The research was conducted utilizing Interpretative Phenomenological Analysis (IPA), which aims to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2003, p. 53). In IPA, the researcher takes an active role in the unfolding and discovering of participant's experiences. A double hermeneutic occurs, where "participants are trying to make sense of their world" while simultaneously, "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 53). IPA researchers utilize their own lived experiences as ways to "enrich their interpretations, rather than them being an obstacle to making sense of the participant's experiences" (Peat et al., 2019, p. 8). Smith and Osborne (2013) suggest small sample sizes of 3-6 participants with a fairly homogenous participant pool, recruited primarily via purposive sampling. IPA requires flexible data collection and therefore suggests semi-structured interviews to engage participants in dialogue and probe any interesting areas that arise (Smith & Osborne, 2003). Interviews are recorded, transcribed, and thematized in a way that paints a picture of participants' overall experiences.

Recruitment.

Participants for this research were recruited via purposive and snowball sampling through my professional network. There were no conflicts of interest with any of the research participants. Interested participants filled out a Google Form to determine eligibility, as well as to answer demographic questions (e.g., race, gender, region, years in the field, native language). There was a total of seven participants eligible for this study, with six selected to complete the

study. The goal was to interview six music therapists across the U.S, with varying regional, racial, and gender identities, and therefore, a fairly heterogenous group of people were chosen to interview from the eligible participants. Five out of the six selected participants completed the study. One participant dropped out of the study prior to data collection for unknown reasons.

Participants.

Participants met the following criteria to be eligible for this study: 1) Hold the MT-BC credential, 2) Have experience working with clients in music therapy with the additional presence of an interpreter (e.g., in-person interpreter, video interpreter, or phone interpreter), and 3) Speak fluent English. Participant demographics were collected prior to conducting interviews and can be seen in a synthesized format in the table below.

Table 1

Participant Demographics

Variable	n=5
Gender Identity	
Cis-female	5
Ethnicity/Race	
South Asian	1
White	4
Native Language	
English	4
English and Hindi	1
Other Languages Spoken	
Hindi	1

Spanish	1
None (English only)	3
Years in the MT Field	
1-3 years	1
3-5 years	1
5-10 years	1
10+ years	2
Region	
Great Lakes	3
Southeastern	1
Western	1

There was great diversity in terms of number of years in the music therapy field and considerable diversity in geographical region. All five participants identified as cis-women and the majority of participants identified as white and native English speakers. Two participants identified as bilingual. Participants drew from their experiences working with interpreters in multiple settings, including pediatric medical, adult medical, adult psych, adult forensic psych, and community music therapy settings.

Data Collection

After eligible participants were identified using the Google Form, I set up an interview time via email and shared the informed consent form (See Appendix A). Data was collected through 1:1 semi-structured interviews recorded via Zoom, transcribed via Zoom and manual transcription, and further analyzed and coded via ATLAS.ti, a qualitative data analysis software program. I conducted 1:1 semi-structured interviews with seven open-ended questions (See

Appendix B). Throughout the interview process, I kept a reflexive journal to capture personal thoughts, reactions, and feelings. Excerpts from my journal are included in the discussion section to further support and contextualize the findings.

Data Analysis

I manually transcribed the audio content of participant interviews using the initial transcript saved by the Zoom platform. Completed transcripts were uploaded to ATLAS.ti. The participant transcripts were read and re-read, first notating my initial thoughts and reactions. Upon the second read through, codes and themes were written to transform the initial notes and reactions into more concrete ideas. In this analysis process, the aim is not to measure the frequency of particular themes and meanings, but rather, "to try to understand the content and complexity of those meanings" (Smith & Osborne, 2003, p. 66). Within the IPA framework, the researcher engages in an "interpretative relationship with the transcript," making it a highly personal process (Smith & Osborne, 2003, p. 66). The analysis process is interpretive, meaning my own pre-conceived assumptions and biases shape the analysis and findings. After reading and re-reading transcripts line-by-line, I connected the themes to accurately represent a complete data set.

Confidentiality

All data remained confidential throughout the research process. Throughout the data analysis process, participants were referred to as Participant A, B, C, E, and F. Files and data pertaining to this research remained in a password-protected file on my personal computer. For the interviews, confidentiality was ensured through Zoom's end-to-end encryption, maintaining that communication between researcher and participant is encrypted, using keys only known to

the devices of those involved. Select demographic information of participants is included in a synthesized format to protect individual participant identities.

Trustworthiness

Several measures were taken to ensure the trustworthiness of this research. Susan Hadley served as an internal auditor, providing guidance and oversight of analysis and writing processes, as well as triangulation of the data. Two additional readers provided insight and perspective into the discussion of data and final write-up. Participant transcripts were read and re-read as codes and themes were developed. To ensure accuracy and validity of data, member checking was utilized with each of the participants. I sent direct quotes and summarizations of data and asked participants to confirm or deny the accuracy and provide any additional thoughts, feelings, or viewpoints. All five participants confirmed the validity of their quotations. My own personal biases are disclosed throughout the research to ensure greater confirmability and credibility of the data.

Findings

Data was consolidated into 40 themes and further grouped into seven organizing domains: 1) Ways of working with interpreters, 2) Benefits of working with interpreters, 3) Drawbacks of working with interpreters, 4) Music therapists' feelings when working with interpreters, 5) Potential reasons for not working with interpreters, 6) Dangers of not working with interpreters, and 7) Considerations for music therapists working with interpreters. The table below outlines the domains and themes and the number of participants who endorsed each theme. Descriptions for each domain and theme are provided, along with participant quotations.

Table 2

Outline of Domains and Themes

Domain/Theme	n=5
Ways of working with interpreters	
Various interpreter backgrounds	5
Medium of interpretation	5
Interpreters as humans, not black boxes	3
Interpreters as collaborators	1
Interpreters as cultural brokers	4
Benefits of working with interpreters	
Family connections	3
Cultural connections	1
Increased access to care	1
Increased processing time	1
Increased patient comfortability	2
Stronger therapeutic alliance	3
Musical benefits	3
Drawbacks of working with interpreters	
Disruption in flow and pacing	1
Interpreter oversteps	2
Increased paranoia as contraindication	1
Patient hesitant to disclose	2
Therapist's meaning/words lost in translation	3
Technology issues	3
Music therapists' feelings when working with interpreters	

Generally positive feelings	2
Generally difficult feelings	4
Imposter syndrome	3
Spotlight effect	2
Bilingual identity	2
Potential reasons for not working with interpreters	
Extra step and energy	3
Fear of inflicting harm	1
Lack of institution protocols	2
Lack of music therapy education and resources	5
Assume patient's English is "good enough"	1
Music is the "universal language"	4
Dangers of not working with interpreters	
Limited therapeutic relationship	3
Decreased socialization in an English dominated world	1
Discrimination by patient avoidance	2
Considerations for music therapists working with interpreters	
Decision making process	3
Establish boundaries	2
Ask for clarification	1
Debrief/process with interpreter	2
Emotional toll and ethics	3
Careful not to lump cultures as one	2

Practice working with interpreters	2
Reflexivity of therapist	2

Domain 1: Ways of working with interpreters

The experience of working with interpreters in music therapy is not homogenous. There are various mediums of interpretation, backgrounds and educations of interpreters, and ways of working with interpreters from a theoretical standpoint. The following themes detail the variety of experiences that participants reported in working with interpreters in music therapy.

Theme 1.1 Medium of interpretation. To be eligible to participate in this study, participants must have had experience working with live language interpreters. This may include in-person interpreters, video interpreters, or phone interpreters. The use of electronic applications such as Google Translate did not suffice. Four participants reported working with in-person interpreters, two participants with video interpreters, and four participants with over-the-phone interpreters. Three participants reported working with all three mediums and ranked them in order from best to worst: 1) In-person, 2) Video, 3) Phone. Over the phone interpreters proved to be the least effective medium for interpretation, as participants cited them as “awkward,” “not good at all,” “impersonal,” and “difficult to hear.” Video interpreters were a step up from phone interpreters, in that therapists and patients can actually see the interpreters face; however, participants still described the experience as “awkward” and “frustrating” because the iPads had to be charged and would oftentimes lose internet connection. Participant B described her preference for in-person interpreters:

> [In-person interpreters are] able to be completely present in the session and they're even able to engage with the patient with me, like whatever I'm trying to do, whether it's

> handing them instruments, whether it's having them make choices, whether it's communicating even the littlest things and songs. It's just so much more helpful to have in-person interpreters because I feel like patients just feel more engaged and understood in those sessions.

In-person interpreters proved to be the most effective and preferred medium for interpretation in music therapy, as participants reported appreciation of the live, interactive, connective relationship with an actual human being.

Theme 1.2 Various interpreter backgrounds. Participants reported working with interpreters with various backgrounds and educations. One participant reflected on her music therapy internship in 2001, a "pre-interpreter era" of sorts:

> It's been over 20 years and we did not have any interpreters at all. It was not part of medical practice during that time, so I did the best that I could with the Spanish that I had, and sometimes I made mistakes.

Times have since changed, as many hospital organizations and other healthcare settings are required to have language and interpretation services. Two participants recalled instances of working with ad-hoc interpreters in music therapy, ad-hoc meaning individuals without official training in interpretation. These included case managers, family members, other therapists, and volunteers. Four participants reported working with professionally trained interpreters within the context of their work environment, most often a medical setting or psychiatric setting.

Theme 1.3 Interpreters as humans, not black boxes. Three participants spoke out against the "black box" approach and emphasized the importance of working with interpreters and seeing them as human beings (Miller et al., 2020, p. 29). To recall, working with interpreters

from a black box approach views the interpreter's sole purpose as interpreting on a word-for-word basis without any interference or subjectivity. Participant A stated:

> I do consider the interpreter to be a person in the room and it's way easier for me to do my sessions if I think of them as being a part of it in a way...I think there's a huge value in those little nuances. I can't imagine just thinking of a person as a black box.

Participant B further emphasized the importance of humanity and empathy within the therapist-interpreter relationship:

> [The black box approach is] so black and white like...we're just going to use them as a robot, but they're not a robot, it's an actual person, even if it's on audio or video...I feel like that just would not be helpful for working with patients and like being empathetic with them and understanding them. I think that wouldn't be helpful seeing them as robots.

Participants stressed the importance of empathy and humanity in music therapy work and therefore rejected the black box approach when working with interpreters.

Theme 1.4 Interpreters as collaborators. One participant specifically defined her orientation of working with interpreters as collaboration. Participant E stated:

> I would consider [interpreters] to be more collaborators than anything else...In my case, it was very positive because it felt like collaborative group music making the whole time, and we use this phrase, it's called *placticar* in Spanish. It means, "to hang out and chat," and that's how it felt all the time.

It is important to note that this participant was providing music therapy services from a community music therapy model and working with ad-hoc interpreters.

Theme 1.5 Interpreters as cultural brokers. Four participants alluded to the idea of working with interpreters as cultural brokers, meaning that the interpreter "interprets not only the

spoken word but also relevant cultural and contextual variables" (Tribe and Morrissey, 2004, p. 131). Participant A spoke to the difference between speaking a language and actually belonging to the culture behind the language:

> I'm really drawn to this idea of a cultural broker, especially in thinking of all the things that we will just never know...Even if you speak a language that's not your primary...native language, there's so many things that we can miss, and I mean so often. I find a lot of our like parents really bond with a huge majority of our environmental care staff who are Spanish-speaking, and I see them having these rich conversations.

Participant A did not identify as Bilingual but did report having some basic limited Spanish proficiency. Despite this ability, Participant A highlighted the difference between belonging to a culture and language and acquiring the language second hand later in life.

Participant B recalled an instance where working with an Arabic interpreter assisted in learning more about the patient's culture:

> With Arabic speaking people that we've worked with, the interpreters might not be from the same area or same country, but they at least know the same dialect. So, they're able to communicate, and they know at least some things about the culture or they're able to learn with me about their culture and that's really helpful. I think having that language there is so extremely beneficial for all of us to understand each other.

Participant B also called attention to the importance of different dialects and subcultures within a language and culture, and even if the interpreter may not be from the exact same subculture as the patient, there is still a benefit in having that shared language for increased understanding and communication.

Participant F spoke to the importance of cultural brokers as bridging gaps between patients and therapists, especially in providing greater insight into cultural norms and contexts surrounding care:

> I think [cultural brokers] really would [create a] bridge between a patient and English-speaking therapist because [even though] you can interpret what someone is saying, there's so many nuances to that and how someone may experience their care. I think that kind of goes into the social justice perspective and how someone's background really influences the way they perceive care and perceive their experience throughout therapy. I think that's why it's so important to have therapists that are the same culture and background of the patient or the person receiving care.

The nuances of language and culture are important to consider when communicating cross lingually. Participant F pointed out that working with interpreters can help with verbal communication and non-verbal communication, providing greater insight into cultural norms and values.

Domain 2: Benefits of working with interpreters

Participants reported several benefits of working with language interpreters in music therapy. These reported benefits were consolidated into seven themes. Several of the benefits reported by participants align with the benefits outlined in the relevant psychotherapy and counseling literature. Benefits range from therapeutic, to emotional, to societal, to musical in nature.

Theme 2.1 Family connections. Interpreters are utilized in music therapy sessions to enable communication between therapist and patient and between therapist and family members as well. Participant C stated, “I don't think I would have been able to connect with those families

at all in the same way if I hadn't had the interpreter." Participant A explained that about 90% of the time, her pediatric patients speak and understand proficient English, and instead, "it's the parent and the caregiver who would benefit from the support." With interpreter services, music therapists can better share updates and connect with the family members of patients, connections that may otherwise not be possible.

Theme 2.2 Cultural connections. When interpreters belong to the same cultural background as patients, a cultural connection may be established. Participant C pointed out this specific benefit to working with interpreters: "[An interpreter is] somebody that [patients] can identify with right there and that's huge...Any amount of cultural connection that people can have is important to preserve." In many instances, patients can feel seen and represented within the interpreter, whereas they may not feel that way with the music therapist.

Theme 2.3 Increased access to care. One of the benefits of working with interpreters in music therapy is increased access and increased quality of care. Participant A stated:

> I think the good things that come with this are access for our patients, especially when you have languages that are harder to find interpreters for...The way that technology has been able to really bridge that gap...So I think it's allowed more people to receive the same access to care.

With increased technology, music therapists can work and communicate with more patients and therefore increase patient access to music therapy services.

Theme 2.4 Increased processing time. One participant spoke about the potential benefit of increased processing time when working with an interpreter. Participant E stated:

> Some of the folks that I worked with had pretty active psychosis and may not have had enough volition to respond. So having that space for the interpreter to interpret and then

> someone else respond, and they would interpret that back to me, and then maybe someone could say, "Oh, wait. I have something I want to contribute," and they've had that time to sit there and think...Sometimes it feels like it's a longer amount of time and you might not get to so much. But it's like you still have the possibility of contributing, and more people can participate because it forces you to slow down.

Working with interpreters in music therapy essentially doubles the amount of time taken, as everything is said twice. This may work in both the therapist's and the patient's favor to increase processing time.

Theme 2.5 Increased patient comfortability. Two participants described increased patient comfortability as a direct benefit of working with interpreters. Participant C described an increased comfort level for patients when introducing music therapy services for the first time:

> I think the interpreter really makes a huge difference in [patients'] comfortability. I think coming in and trying to explain what we do without words is really difficult and doesn't really make sense and totally impacts the treatment. So, having somebody there who can actually explain why I'm there and what I'm doing is really crucial.

Participant F described the already stressful situation that patients are often in within the context of hospitalization and how working with interpreters can help to alleviate some of that stress and increase comfort:

> For me, it feels comforting to have the interpreter there because you have more context and you're not going in blindly...Thinking of it in terms of the comfort, comfortability of the patient, like they're already in a stressful situation to have to communicate with someone that doesn't speak [their] language like, that's just like a whole other added stress.

Theme 2.6 Stronger therapeutic alliance. Three participants reported developing a stronger therapeutic alliance with patients when working with an interpreter. Participant B highlighted the level of increased understanding and communication, which further leads to stronger therapeutic rapport:

> Having the interpreter there makes it stronger, the therapeutic alliance. I think it helps the patient understand, even if it's a little child...that I'm here to try to understand what they're doing and what they're communicating...especially when we are all in-person, I feel like it helps the child understand that we're really learning from them.

Participant F also spoke to a greater level of understanding, as well as lessened anxiety: "There's greater rapport built just because we're able to understand each other more and there isn't that like anxiety on both parties of, 'Are they not going to understand what I mean or what I'm saying?'"

Participant C highlighted the importance of working with interpreters for therapists to communicate a message of respect and investment in the patient's care and overall wellbeing: "I really feel like...the act of using the interpreter communicates to [patients], 'You're important to me. This is important that you understand,' and that's a huge part." Participant C described greater therapeutic rapport from utilizing interpreter services.

Theme 2.7 Musical benefits. Three participants cited specific musical benefits to working with interpreters in music therapy. Participant F described having a greater and deeper understanding of the lyrics and music within a session:

> [Working with an interpreter] is a huge benefit musically because...you might not always understand what the lyrics are saying. So, having an interpreter...explain what the lyrics

> mean, or bridge the meaning...You would be able to dig more into what the meaning would be to the patient.

Participant C also reflected on a greater understanding of the music, as well as the benefit of increasing patient self-expression:

> I think that [working with an interpreter] just frees up the self-expression so much, giving and opening that door for people to be able to talk about their own music, whether it's music they're making or music you're listening to...[The interpreter] could translate lyrics...and explain what the song means. Without the interpreter, you might be able to find a song in their language that they connect to, but [the patient] can't really talk about it at all.

Participant B recalled a situation where an Arabic interpreter assisted in the interpretation of words and lyrics, as well as offered word suggestions for the therapist to use within the session:

> [Interpreters] are able to interpret everything for me and it's so helpful having them right there because whatever I'm trying to communicate...they're able to translate. And with singing songs, like an animal song let's say, they're able to even tell me animals in Arabic that I could sing or that [patients] could sing.

Domain 3: Drawbacks of working with interpreters

Just as participants reported the benefits of working with language interpreters in music therapy, participants also reflected on drawbacks and potential contraindications to consider when working with interpreters. These reported drawbacks were consolidated into six themes. Again, many of the drawbacks reported by participants are reflected in the relevant psychotherapy and counseling literature. Drawbacks range from therapeutic, to relational, to technical in nature.

Theme 3.1 Disruption in flow and pacing. One participant cited a disruption in session flow and pacing when working with language interpreters. Participant A stated:

> A huge part of my practice is humor and laughter. It's a big part of how I engage with children...with some of the adolescents and young adults, it's really hard, like my natural flow and the timing of how I say things and what I pick up on, it really changes...I don't think that I fully have nailed it down...I don't know you're kind of pacing your session to include this other person and the space of interpretation becomes part of it, like the music is part of it, but the interpretation is also part of it.

Because of this disruption in typical session flow and pacing, as well as an additional person in the room and the barrier through which information is transmitted and received, the participant described a different dynamic surrounding therapeutic rapport with patients.

Theme 3.2 Interpreter oversteps. Participants cited a common worry of the interpreter overstepping and crossing boundaries within a music therapy session. Participant B discussed physical oversteps: “If [interpreters] get too involved in the session where it starts affecting what you are doing in the session...like too much hand over hand, or something...that could be a drawback.” Participant C discussed emotional and therapeutic oversteps: “It could be potentially dangerous because the [interpreter] is seeing themselves as some party that can affect change in the therapeutic relationship, and maybe unethically.” Participant C elaborated on the unethical aspect of this theme. She described a situation when working with an interpreter “confuse[d] the relationship a bit because [the interpreter was] not being objective.” It was a situation where the participant (music therapist) was encouraged to get a heartbeat from a pediatric patient who was nearing death, but the patient’s mother was adamant about not doing a heartbeat recording and refused to consent. Essentially, the interpreter had a private conversation with the mother in

Vietnamese and likely coerced the mother into agreeing to give consent. This is an example of how the interpreter overstep can be potentially harmful and highly unethical.

Theme 3.3 Increased paranoia as contraindication. One participant discussed a possible contraindication for working with interpreters in music therapy. From the context of a forensic psychiatric setting, Participant C stated, "Working with a person with psychosis, [interpreters] could sometimes increase paranoia. Having other people listening...you can see patients get a little squirrely about hearing that somebody's on the phone like, 'Someone's listening, but I can't see you.'" It is important to consider all possibilities of harm and exacerbation of symptoms. Patients with increased paranoia may not be suitable to have conversations with an interpreter, specifically with over the phone interpreters whom they cannot see.

Theme 3.4 Patient hesitant to disclose. Two participants wondered about patients' willingness to disclose in music therapy with the added presence of a language interpreter. Participant F stated, "I could see the patient potentially feeling like they wouldn't be able to open up with another person there...They might want to quicken the therapeutic experience because it may feel unnatural to communicate through an interpreter." Participant C stated:

> I think it could cause some discomfort, or maybe some reticence to disclose things from the receiver's end. I could imagine if I was using interpreter services [as a client] and I was sharing something that was really intense and deep, now I'm sharing it with somebody who I don't know and I don't have a relationship with, and so it might make me more hesitant to share certain things about myself or my situation.

If patients are indeed more hesitant to disclose information with the addition of an interpreter, therapists may not be able to fully access or understand patients' experiences and in turn may not be able to provide the best treatment and care possible.

Theme 3.5 Therapist's meaning/words lost in translation. Several participants spoke to the common worry that their own words and the meaning behind their words may get lost in translation. Participant B stated, "Sometimes I'm worried like, what if they're not actually interpreting it correctly, or if they are, maybe it's not fully what the patient or the mom was trying to say." Participant E went a step further and questioned the trust between therapist and interpreter: "I would also wonder if the therapist would trust the interpreter in terms of what they interpret...I wonder if that's something that the therapist would worry about like if they're getting an accurate reflection of what the client said."

Theme 3.6 Technology issues. The last drawback surrounds issues with technology. In instances where music therapists are working with video or phone interpreters, there are several technological and logistical barriers. Participant B described these situations as "inconvenient," oftentimes with the inability to even hear the interpreter. Participant C described it as "awkward" and "tricky," especially when the videos would die or cut off in the middle of a session. Participant E did not have direct experience with video or phone interpreters, but she questioned the quality of the music in these instances: "If you have a video interpreter there, how does the music come through the video?...I know with Zoom, it sounds terrible and it condenses it, or you don't hear it...What gets lost in that piece?" If the interpreter is serving as a cultural broker or collaborator, it would be important for them to hear and understand what is going on in the session musically, just as much as verbal conversation. With unreliable connection and unpredictable technology, this may create a barrier to music therapy treatment.

Domain 4: Music therapist's feelings when working with interpreters

To fully understand the experiences of music therapists working with interpreters, it was important to highlight the specific feelings that arise when working with interpreters. Most

participants reported generally difficult feelings when working with interpreters. At the same time, two participants did report generally positive feelings. Other phenomenon experienced when working with interpreters include imposter syndrome, spotlight effect, and bilingual identity. Each of these feelings related to working with interpreters are explored within this domain.

Theme 4.1 Generally positive feelings. Two participants reported generally positive feelings regarding working with interpreters in music therapy. This reported feeling was one of excitement. In addition to some difficult feelings, Participant E stated, "I was also grateful and excited...[working with interpreters] was a really fun challenge." This is similar to Tribe and Lane's (2009) description of clinicians feeling a personally enriched sense of practice through working with interpreters working. Participant C stated, "I actually get really excited when I use interpreter services because it's like, yes, this is a chance for me to unlock something or to help this person to share more. Maybe I can learn some more about him."

Theme 4.2 Generally difficult feelings. Contrasted to generally positive feelings, four participants reported generally difficult feelings regarding working with interpreters in music therapy. Reported difficult feelings included anxiety, frustration, hesitance, nervousness, and timidness. Regarding feelings of anxiety, Participant A shared a snippet of her own internal dialogue when working with interpreters:

> I definitely build it up beforehand and I'm like, "Oh, my God! Oh, my God! I have to do this extra thing"...It is kind of like, "Oh, God! Oh, God!" is what goes through my head...I do have to take an extra breath and...at the same time I'm doing a session.

Participant B reported feelings of nervousness and fear with doing something for the first time: "I think initially...when I first started working here, it was slightly scary because I've never really

[worked with interpreters] before." Participant E also spoke to the feeling of nervousness and the feeling of being an outsider: "I was a little bit nervous because I felt less comfortable across the board in that situation it was because my language was limited in that way, because I was an outsider coming in."

Theme 4.3 Imposter syndrome. Imposter syndrome is experienced when individuals have a difficult time attributing their success to their own accolades and competence, and instead, crediting external factors, leaving them to feel like a fraud or imposter (Shah, 2022). When thinking about imposter syndrome while working with interpreters in music therapy, Participant F described questioning her ability to meet the needs of her patients. Similarly, Participant A shared imposter-like thoughts, "'Am I doing this right? Am I supposed to be taking up this space?'"

Participants also reported feelings of incompetence and anxiety around not knowing what to do. Participant A stated:

> I don't know what to do, and I usually know what to do. And so really having to educate yourself, having to learn the tools and techniques in a way that works for you...that's the hardest part, is not really knowing. It's like working with a whole new population, even though it's not a new like disease population. But it's like, I have to learn how to do this, and I don't know what to do. And I still have that feeling. After 10 years of using interpreter services on and off.

Participant F shared about the feelings of inadequacy within imposter syndrome and not feeling good enough:

> Yeah, there's definitely more hesitance when I see a patient that doesn't speak English, just because I mean, there's not any guidance as to like what those experiences should

> look like or how to approach those scenarios. Which I don't like I don't like to feel that way, because I want to meet the patient where they're at and provide care...But there's so many things you don't know and then to add the communication barrier. I think it adds that anxiety and makes...me feel like I couldn't do enough.

Theme 4.4 Spotlight effect. Two participants described the notion of the spotlight effect when working with interpreters in music therapy. The spotlight effect refers to the tendency to "overestimate the extent to which behavior and appearance are noticed and evaluated by others" (Gilovich & Savitsky, 1999, p. 165). With the addition of a language interpreter in a music therapy session, Participant A described questioning the thoughts and experiences of everyone else in the room, including the interpreter:

> I'm also thinking, what is everyone else's experience of this moment? That is really what's running through my head, like not only what is the patient's experience? What is the interpreter's experience now of this?...So I'm constantly thinking of not only what I'm doing but how it's being perceived, and an extra layer.

Participant F also described the spotlight effect and fear of messing up or embarrassing herself when working with interpreters.

Theme 4.5 Bilingual identity. A unique theme surfaced from the two participants who identified as Bilingual. Both participants reported an increased comfort level in working with interpreters, as well as increased empathy and a personal investment in the topic. Participant B stated:

> I definitely think more about cultural considerations in general when I'm working with people, and I feel like I've worked from a more cultural lens myself. And I value the

> importance of having interpreters and having the ability to have them talk in their language...I feel like maybe my cultural background and bilingualism has to do with it.

Participant C also felt that her bilingual identity plays a role in this topic:

> I think my experience as a bilingual person definitely plays a role in how I view working with interpreters. I think it does make me more comfortable working with interpreters in that I am comfortable speaking frequently with people who do not speak English. Mostly I think my experience as a bilingual person makes me more passionate about the use of interpreters.

Participant B described her personal investment to the topic, specifically regarding her grandparents:

> If my grandparents were working with a therapist here...I feel like they would...have a hard time understanding some concepts that we have here, because they're very different from the concepts in India and they might actually not understand certain words. So, I feel like still having interpreters for them would be much better and...more comforting to have someone there who spoke Hindi with them, than to have someone there who was constantly speaking in English with them because I feel like they would just feel more comfortable sharing in that way...I think I'm able to be more empathetic in that way of why we need interpreters because if I think of my grandparents or if I think of some family from India like I would want them to have interpreters. I would want them to feel more comfortable.

Participant C described her personal investment to the topic, specifically surrounding her husband and mother-in-law:

> My husband...learned English quickly when he went to school but was forced to translate for his mom at his medical appointments throughout his childhood. So, you have a 5-year-old with congenital heart disease translating to his mom information about whether or not he is going to need a third open heart surgery, after he had to navigate talking to taxi drivers and bus drivers and reading signs to get them to the hospital in the first place...all while learning the language himself and having a shaky grasp of it. The amount of pressure that put both of them through is wild to me. If there had been an interpreter at least present during his medical appointments he wouldn't have had to be parentified in that manner, and his mom would have actually understood everything that was happening...My mother-in-law doesn't speak English, and I have seen first-hand many times how upsetting it is for her when people don't provide materials or information in her language, Spanish. I never want someone to have to go through a situation where they are unable to understand what's happening, especially around intense matters such as medical situations.

The experiences of music therapists working with interpreters are inevitably varied depending on the therapists' intersectional identities and lived experiences. Participant C shared a poignant statement about what it means to be Bilingual:

> Being Bilingual is more than just a skill that I have, it's actually deeply personal because my family is a family of immigration. My husband is a first-generation American citizen, and my family has been personally affected by the lack of resources available for people who need interpreters. This part of my identity influences me as a clinician in that it makes me want even more to provide those services for people I work with, in part

> because I want to make sure situations like what happened to my husband and what happens all the time to my mother-in-law don't happen to my patients.

For these two participants, the topic of working with language interpreters is deeply personal and a matter of equity and justice.

Domain 5: Potential reasons for not working with interpreters

While all five participants had direct experience working with interpreters in music therapy, participants also acknowledged that this topic is rarely discussed in music therapy education and research. Participants discussed potential reasons that music therapists may be resistant to working with interpreters. Five themes were found in their reflections, including personal, professional, and institutional issues.

Theme 5.1 Extra step and energy. A few of the participants described the extra energy exerted when working with an interpreter and having to go through that extra step. Participant F stated, "I've noticed from doctors or other providers who don't take the time to call the interpreter, or just you don't get to know the patient, because it's an extra step." Participant A described her own feelings surrounding this added layer and extra step:

> I think it's always a different experience to have someone else in their room, because their energy, the way that they speak, the way that they take the information that you're saying, it's going to change. So, I think it takes a little bit more energy for me personally because it's sort of like if you have a student with you.

If the process of working with interpreter is viewed as an extra step or expending unnecessary energy, music therapists may inadvertently bypass the patient altogether.

Theme 5.2 Fear of inflicting harm. One participant discussed the potential fear of

inflicting harm when working with patients with limited English proficiency. Participant F stated:

> I think that's why a lot of therapists feel hesitant with the potential doing harm unintentionally. I could see that to be true, like the fear of doing harm and not having all the information and feeling out of place and in a potentially uncomfortable situation where you can't understand each other...I guess what I'm trying to say is that the therapist may have hesitance doing an assessment with a patient that doesn't speak English because of fear of doing harm.

Again, if therapists enter these spaces and situations with fear and lack of information, they may disregard the patient altogether, rather than turn to interpreter services as a resource.

Theme 5.3 Lack of institution protocols. As stated in the 1964 Civil Rights Act, discrimination is prohibited based on national origin and language and "individuals cannot be denied access to education, health care, or legal services because they do not speak English" (Searight & Searight, 2009, p. 445). However, institutions each have their own policies for interpreter and translation services. Some participants reported a lack of institution protocols surrounding interpreter services, making it difficult for them to even utilize the services. Participant A stated, "There's no protocol even in the hospital setting for psychological safety [for interpreters and patients]." Participant A also pointed out that most in-person interpreters are reserved and prioritized for traditional medical staff, in which music therapists are often not included. Working in several different healthcare facilities, Participant C stated, "With the interpreter services, it's been frustrating for me at every place that I've worked at that there haven't been more in-person services...There's a lot of barriers to getting the interpreters there bedside." Some of these barriers include scheduling conflicts, staffing shortages, and budgets.

Without institutional protocols, it is near impossible for music therapists to successfully work with interpreters in music therapy.

Theme 5.4 Lack of music therapy education and resources. In addition to institutional shortcomings, all five participants pointed out the lack of education and resources for music therapists specifically within the music therapy profession. Participant F stated, “I think there's such a gap of education and knowledge and resources available for, and just in general, in the medical field and health care for non-English speaking patients to have accessible and fair care.” Participant A also pointed out the lack of education and resources within the field: “It's just because you don't have access either to the services you need, or the training needed to be able to do this. And so, I think that we have a long way to go [in] music therapy.” Without the proper support, music therapists may refrain from working with language interpreters. Participant E highlighted the importance of understanding roles and collaboration with interpreters:

> The training piece is important, like how to work with an interpreter. But I think because I've never had to deal with the video thing, it’s just like, “Oh, my gosh! That seems like a nightmare.” But how to collaborate with someone in general, I think would be really helpful, like, what is their role? What is your role? What is your responsibility? How are you all going to work together? But when you have just that video interpreter, I think that would require...some kind of like [guide on] how to navigate that.

Participant A also spoke to the culturally reflexive aspect of this work:

> [Music therapists] talk about being culturally competent, but we don't have anything in place that's getting us there. I mean, we don't even have anything about supervision. It's just like, if you are someone working with interpreters, unless we meet each other like this, where are you getting your help and information?

Not only is there a responsibility to become more culturally competent and culturally reflexive within the field, but even within this context of working with language interpreters, Participant A emphasized that music therapists have nowhere to turn regarding seeking supervision or even debriefing working with interpreters. Participant A also reflected on times where she wished she would have had more education and access to interpreter services:

> There were times where I think I could have been more effective if I had known better how to use the services I did have access to, or had access to, like the video interpreter. And that's something that's kind of sad to think about.

Participant B also recalled several instances where having an interpreter would have benefited her music therapy practice, especially in her internship in hospice. Without proper education and resources, it is nearly impossible for music therapists to utilize interpreter services appropriately, consistently, and effectively with their patients.

Theme 5.5 Assume patient's English is "good enough." Many therapists and providers may make the mistake of assuming the patient's English is "good enough" to get by without an interpreter. Participant C described a situation where the treatment team made this incorrect assumption: "The treatment team didn't think we needed to use the interpreter, or thought, 'It's not a big deal. She speaks enough English or whatever.'" Many patients may have a varying level of English proficiency in terms of receptive language and expressive language, meaning that patients may understand more than they can speak, or vice versa. Participant C described a revelation of sorts where when the interpreter was brought in, they suddenly realized how much the patient actually did not understand.:

> There are times where I would think that [patients] are understanding something about the treatment or something I'm communicating to them...But then when we brought the

> interpreter in, it's like they were not understanding, or they were not on the same page at all.

Music therapists may conduct sessions with patients with LEP assuming their English is "good enough" and subsequently incorrectly assume the patient fully understands what the therapist is communicating to them.

Theme 5.6 Music is the "universal language." As discussed previously, music therapists have been debating the notion of music being the "universal language." There are many dangers when operating with this rose-colored lens, including privileging certain music cultures over others, operating under a "false sense of safety," and disregarding multicultural considerations altogether (Brown, 2002, n.p), and reinforcing neo-colonial, anti-oppressive rhetoric (Comte, 2016). Four out of the five participants referenced the notion of "music as a universal language," some upheld the idea, and some opposed the idea. Participant C stated:

> If you don't have [interpreter] services, how do you provide access to your music therapy services without being able to speak to someone? I think an advantage of music therapy is that we do have the musical modality, and it's the whole [idea of] "you don't need words to communicate with music" or "music goes over words," or whatever they say.

Participant E pointed out some of the dangers of thinking in this lens:

> I could also see therapists thinking..."Oh, yeah, I can totally do music because music is a universal language and everybody loves music, and you know, everyone likes the Beatles, or whatever kind of generic white Western music." So, I could see that as being problematic too, just like assuming it's okay.

Participant B recalled a situation where one of her non-music therapy co-workers questioned the need for interpreters during the music therapy session, assuming they were "just going to be

singing and playing instruments." Even professionals outside of the music therapy field uphold this narrative of "music as a universal language." Participant F explicitly named this narrative as discriminatory:

> Just because "music is a universal language" doesn't mean that that's [the patient's] language or how they show up in the world. You can't just rely on music...I'm not saying that music isn't helpful, but "music is a universal language" is a cop-out.

Music therapists operating under the "music as a universal language" mindset and neglecting to work with interpreters are "copping out," as Participant F stated, of their ethical duty to provide quality service to patients whose language is different from theirs.

Domain 6: Dangers of not working with interpreters

After discussing potential reasons for why music therapists may not work with language interpreters, it is important to discuss the clear dangers and consequences of not working with interpreters. This section outlines three themes that participants identified as negative consequences of not working with interpreters.

Theme 6.1 Limited therapeutic relationship. Working with patients with limited English proficiency without the addition of a language interpreter may limit the therapeutic relationship and therapeutic alliance. Participants described a "one-way," "surface level" relationship. Participant C stated:

> The person receiving services can't communicate back to you. Not only can we not communicate to them what we're doing or what the point of our you know what our thoughts are about what's happening, but they can't have an authentic reaction if they can't use words to react...You can like kind of engage in the music. But the relationship is so much more surface level if you don't have an interpreter.

Participant C also spoke to the relationship-oriented aspect of rapport building:

> I feel like a huge part of a lot of music therapy is a verbal component, at least in forming the relationship. And without someone being able to speak or understand it, you just lose that whole part of the treatment and working from a relationship-oriented perspective, you lose the relationship. You have nothing but like your facial expression, to go off of and that's not enough.

Several participants voiced that the benefits of working with interpreters strongly outweighed the drawbacks, especially regarding building the therapeutic relationship. Despite some initial feelings of nervousness, Participant B said, “Really it was more scary to not have an interpreter there...I think that felt more unsettling to me.”

Theme 6.2 Decreased socialization in an English dominated world. One participant discussed the ripple effects of living in an English dominated world. In most hospitals and mental health settings, the programming and activities offered to patients are all in English. Participant C shared about a patient who displayed significantly decreased socialization, which she believed to be a result of his inability to communicate and converse in his native tongue:

> He will all the time just use very short responses, even in Spanish. He doesn't talk more. He doesn't share of himself in the same way that other like English-speaking patients do, and I don't think it's necessarily related to his symptoms or his treatment. I really feel that it's related to him not being able to have consistent conversations where he's actually understood so it's almost like he's learned to not engage even when somebody's speaking to him in a language that he's fluent [in].

Theme 6.3 Discrimination by patient avoidance. As indicated by the findings within this

domain, perhaps one of the most dangerous consequences of not working with language interpreters in music therapy is discrimination by patient avoidance. Participant E stated:

> I think access is a huge [factor]. I could imagine that some clients might not get referred to music therapy if they don't speak the therapist's language...The music therapist may inadvertently...if they have a [full] case load, that [patient] may be put at the bottom of the case load because [the music therapist doesn't] know what to do.

Participant C recalled a negative experience with a music therapy supervisor in her undergraduate practicum where the supervisor exhibited discrimination by patient avoidance:

> [The supervisor said], "I don't take...referrals when people don't speak English, I just avoid that room...I find reasons not to go to that room until they discharge"...I remember it was said by the supervisor, "You can take that one if you want because I'm not going to do it."

Domain 7: Considerations for music therapists working with interpreters

The final domain includes considerations for music therapists when working with language interpreters in music therapy. Participants reflected on their own lack of education surrounding this topic and gathered valuable information to consider when working with interpreters for the first time, as well as maintaining best practice. Eight themes emerged from this domain, including logistical, ethical, and emotional considerations.

Theme 7.1 Decision making process. Several participants discussed the decision-making process when deciding whether to work with an interpreter. In some instances, it is appropriate to ask the patient directly if they want an interpreter present for the music therapy session, giving them full autonomy to choose. Participant A shared about this approach working in a hospital:

> My decision making...would be a person-centered approach because it varies based on each person. If I am meeting an adolescent that I know speaks English, but their caregiver does not, I'll typically ask them their comfort level, how much they want me to tell their parents, and if they want me to use an interpreter.

In addition to reading the patient's chart, Participant B explained that she typically looks to her co-workers for advice on whether an interpreter is needed.

Participant A described instances where the patient and family speak a different language from her, yet there is no need for an interpreter:

> Once I get to know a particular patient and family and their specific needs for language services, I'll modify what I'm doing...It depends on the type of session, so like for receptive music therapy work, let's say, in the PICU and I know their favorite songs already, depending on their state of awareness, I might not need an interpreter at all. If I know that...we're not going to be speaking outside of very simple, because I do have like very basic Spanish proficiency.

Depending on the context and content of a music therapy session and the music therapist's proficiency in said language, an interpreter may not be needed.

Participant F described a situation where she worked without an interpreter because the phone interpreter was unavailable:

> I would stay and have a session...I worked on a lot of nonverbal communication with him just because he had a lot of anxiety, understandably with staff like trying to get him to speak English...It would get him worked up, and he'd have more like aggressive behaviors towards staff as a result...I think in those situations, music was just a great way for him to engage in a positive way because it was nonverbal.

In some instances, music therapists may have a plan going in to work with a patient with an interpreter, but for whatever reason, that may not be possible. In those instances, the music therapist must decide whether they will continue with the music therapy session without the interpreter.

Theme 7.2 Establish boundaries. Two participants stressed the importance of establishing boundaries with language interpreters, including the navigation of roles, responsibilities, and collaboration between interpreter and therapist. Participant C stated:

> [Interpreters are] not understanding the situation from the therapist's standpoint. So, I could see where, if it's a smaller community, or it's a language where somebody works with the in-person interpreter for a long time, boundaries are really important...I think it just goes back to the checks and balances that the interpreter has because I could see it turning into a situation...where it gets blurred...people bring in their own agendas - things like that.

It is the music therapist's responsibility to initiate conversations with the interpreter regarding these issues and set clear boundaries.

*Theme 7.3 Ask for clarification. T*o decrease any feelings of unsureness or distrust with the interpreter, one participant reported asking for clarification from the interpreter:

> I think just like checking in with interpreters like, "What did the patient say?" or "What did the mom say?" like really trying to understand what they're communicating...Just checking in and asking, "Are you sure that's all they said?" or like, "Can you tell me more?"

It is appropriate to ask the interpreter a direct question within a session if you are unsure about something the patient said, or even if you are unsure of what the interpreter communicated to the patient.

Theme 7.4 Debrief and process with interpreter. Some participants discussed the importance of debriefing and processing with the interpreter post-music therapy session. This may vary depending on the setting. Participant E described what the debrief process looked like for her within a community music therapy setting:

> We don't always have opportunities to co-treat with people depending on where you are, and so for me, having the interpreters there was really helpful to process through after sessions what had happened, and so I had that luxury in my case...I think there was a piece of that like being able to process through what happened, and to be able to hear from their perspectives like, because there were some places that we went that were really rough in terms of like the facilities and what was there, and to be able to talk through those experiences with them, and how they felt about it, and what could they do to help and what was not was outside of their scope of practice. So, I think that was helpful.

Other forms of debriefing and processing may look like staying on the phone with the interpreter to ask any follow up questions or speaking with a video interpreter after the session to debrief any necessary content.

Theme 7.5 Emotional toll on interpreters and ethics. A few of the participants acknowledged the emotional toll of language interpretation work and wondered about the music therapist's ethical responsibility to care for the interpreter. Participant A stated:

> I often wonder like, it weighs on my heart a bit - Do interpreters, especially in [a medical] environment, get the support they need from their managers? And like, do they have a therapist because they're hearing some really hard stuff...I worry about it because oftentimes they're getting calls for the hardest conversations, like conversations that can't be had [without them.]

Participant E also asked the question, “If the person I'm working with has experienced traumas, how is this interpreter going to process that if they've experienced the same things?" The question remains unanswered; however, it is important for music therapists to consider this emotional toll and to be mindful of how they treat and communicate with interpreters, especially in virtual situations.

Theme 7.6 Careful not to lump cultures as one. Two participants warned music therapists to be careful when working with language interpreters and avoid lumping cultures into one. Just because a patient and interpreter speak the same language does not mean they are from the same cultural background or even share cultural values. Participant E posed the question, “What if [patients] have different value systems and it's hard for the interpreter to translate it? Like that whole thing just makes my brain want to explode with like, "Oh, this can't be helpful’.” Participant C shared concerns surrounding the cultural broker lens:

> I would think that if interpreters are being asked to step into that cultural bridging type of position, they would definitely need a lot of training around that and education around how to do that appropriately, because I could see it becoming a problem in the therapeutic relationship for a bunch of different reasons. But you know, even in cultures, there's like micro cultures. So, it just gets a little tricky, I think, when it is all lumped into one.

It is important for music therapists to remember that culture and language are not synonymous, and many sub-cultures can exist within a culture at large.

Theme 7.7 Practice working with interpreters. Two participants identified as educators in the field of music therapy in addition to practicing music therapists. Participant A connected the conversation to her own work with students and interns: “We practice how we lead sessions in practicum...This is giving me inspiration on making sure that our interns and our students get to practice at least once with the [interpretation] devices if it doesn't naturally occur in their learning.” Participant E also reflected on her role as educator in helping students to better understand these processes:

> That gives me so much to think about in terms of preparing my students for those environments, like going back to that question you had about education and how to train people to work with interpreters because...I have a lot of students whose knowledge comes from a feeling deep within them and that is sometimes hard to capture over video, especially with an interpreter who you don't have a relationship with...like how would my students process those moments and be present for their clients?

Taking the time to introduce these topics to students and interns gives them the opportunity to practice while they are still in their educational phase of learning, rather than fumbling with real life clients and potentially causing undue harm.

Theme 7.8 Reflexivity of therapist. Two participants highlighted the importance of therapist reflexivity when working with interpreters in music therapy. Reflexivity refers to the constant awareness, evaluation, and modification of one’s work with a client (Bruscia, 2014). Participant A stated:

> Yeah, I think [language discordance] has always been part of my practice. Whether I really, consciously, was aware of it or not. And it's something that I had to work on my own to be like, "Oh, yes, you are providing this service, and you have to be aware of the different languages that your clients are speaking."

Participant F acknowledged the importance of having therapists who align with patient identity and culture, while also acknowledging that it is not always possible:

> It's so important to have therapists that are the same culture and background of the patient or the person receiving care. But I'm the only music therapist in the hospital and I need to be able to serve the needs of every patient that I get a referral for. So, having that broker would be so helpful to like, understand where the patient is coming from, and be able to provide care that makes sense for them.

When working with interpreters, it is vital that music therapists practice reflexivity, before, during, and after music therapy sessions, in order to provide the best care for their patients.

Discussion

To my knowledge, the present study is the only one of its kind to investigate the experiences of music therapists working with interpreters in music therapy. Using interpretative phenomenological analysis, a total of 40 themes emerged from the data and were further categorized into seven main domains. An in-depth discussion is provided for each domain. Excerpts from my reflexive journal are also included to provide greater context and enrich the discussion.

Domain 1: Ways of working with interpreters

Participants described their experiences working with language interpreters with various backgrounds (i.e., qualified and ad-hoc) and through various mediums of interpretation (i.e., in-

person, video, and over the phone). Three participants reported working with all three mediums and ranked them in order from most ideal to least ideal: 1) In-person, 2) Video, 3) Phone. Even though in-person interpreters may be preferred over remote interpreters, they may not always be possible for music therapists, especially when in-person interpreters are reserved for medical necessity in hospital settings. It is crucial for music therapists to learn the different means of interpretation services and how to work with the various mediums while delivering music therapy services.

There are different considerations for different types of interpretation services. General recommendations with in-person interpreters remain the same, including keeping language short and succinct (Hunt & Swartz, 2017; Searight & Searight, 2009; Tribe & Morrissey, 2004) and addressing the patient directly, just as they would if the patient spoke the same language (Searight & Searight, 2009). When working with remote interpreters in music therapy, additional considerations include making sure the remote device is fully charged with a strong internet connection. If music therapists are utilizing a video interpreter on an iPad or other remote device, it may be useful to position the interpreter in the room so that the interpreter can see both the patient and the music therapist on the screen, including any other family members in the room, as applicable.

While conducting this research on the use of language interpreters in music therapy, I have been able to personally reflect on my own ways of working with interpreters and widen my own lens. After talking with Participant C, I wrote in my reflexive journal:

> I realized that I was operating from the black box approach prior to all of this reading and understanding about interpreters. I really went into rooms with the iPad believing the interpreter should interpret what I say, interpret what the patient said back to me, and

> really nothing else. But through some recent sessions, I've been able to experiment with that cultural broker lens and really have some fruitful and meaningful outcomes.

To reiterate, working with interpreters from a cultural broker lens implies that the therapist views the interpreter as having rich cultural, social, and political information to strengthen the context of the patient's situatedness (Tribe & Morrissey, 2004). There is a shift in language and perspective from *using* an interpreter, to *working with* an interpreter (Hammerdinger & Karlin, 2019). Four of the five participants described working with interpreters as cultural brokers. Participants may have felt a stronger therapeutic relationship with patients with the addition of the interpreter, along with their background and lived experience. Especially when working from a cultural broker lens, the interpreter's values, thoughts, feelings, and lived experience certainly plays a role in the music therapy space. By forming a solid working alliance with the interpreter, music therapists may create stronger relationships overall with the patient, the music, and the interpreter. It has been a humbling experience to be able to conduct this research while also reflexively adjusting my own practice in working with interpreters in music therapy. In a work journal dated January 23, 2023, I reflected on working with a patient from a cultural broker lens:

> I found myself feeling nervous and anxious prior to meeting J for the same reason as always, the language barrier/discordance. Additionally, he had a trach and was not able to verbalize, so I knew communication would be extra difficult. There was an AMN interpreter in the room, so I introduced myself first and asked [the patient] if he would like me to use the interpreter, he said yes, so I pulled it up. It was a little awkward at first because he wanted to be repositioned and we had to wait for the RN to arrive. Once we got started though, things seemed to flow. He chose a song to listen to on my iPad and

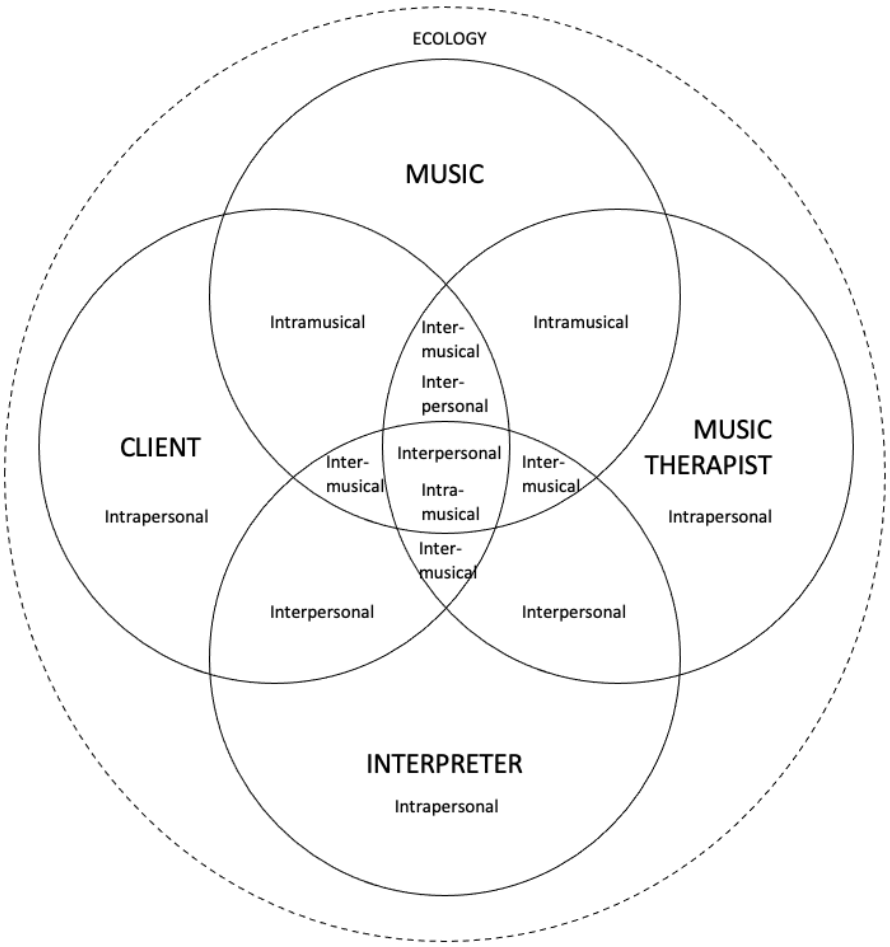
> throughout the 5-minute song, he closed his eyes, lifted his left hand up in praise, and swayed back and forth. I noticed the interpreter was also singing along quietly on the screen. After the song ended, I turned to the interpreter and asked if she would be willing to provide some cultural background and context of the song. She seemed happy to do so. I was able to learn the name of the song, the content, and the overall meaning. It was a really beautiful moment because it felt so natural, and the interpreter really seemed happy to share this information with me. I can't believe I've never thought to do this before.

If students and interns were taught the cultural broker lens, more music therapists could engage in richer practice with their patients, taking a step away from the "expert" role and engaging in a more collaborative, culturally reflexive approach.

To revisit Bruscia's (2014) "Client-Music-Therapist-Other Constellation," the therapeutic relationship when working with interpreters consists of four parts: the client, the therapist, the music, and the interpreter, each coming into the space with their own histories, lived experiences, and ecological contexts. Psychotherapy literature recognizes this shift from a dyadic relationship between client and therapist to a triadic relationship between client, therapist, and interpreter (Hunt & Swartz, 2017; Miller et al., 2005; Pugh & Vetere, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2009b). For music therapists, there appears to be a four-way relationship when working with interpreters. Working with interpreters in music therapy then may result in a "Client-Music-Therapist-Other Constellation," with four overlapping circles (Bruscia, 2014).

Figure 2

The Client-Music-Therapist-Interpreter Constellation



In this figure, there are four overlapping circles, each representing the music, the client, the music therapist, and the interpreter. An intramusical relationship exists within each person (client, therapist, and interpreter). An intrapersonal relationship also exists within each person. An intermusical relationship exists between client-interpreter, therapist-client, and therapist-interpreter, and client-interpreter-therapist. An interpersonal relationship also exists between client-interpreter, therapist-client, therapist-interpreter, and client-interpreter-therapist. There is a small space in between where all four parts overlap with one another, creating a strong therapeutic relationship as described by participants.

Domain 2: Benefits of working with interpreters

There are many benefits to working with interpreters in music therapy. Aside from being able to better communicate with the patient, participants also cited increased processing time, increased access to care, and increased patient comfortability, which is consistent with related research in psychotherapy (Tribe & Lane, 2009; Tribe & Thompson 2009a). In situations where patients themselves may be fluently bilingual, but their family members are not, working with interpreters can help to build greater bonds and connections with the patient's family. Participants working with children reported this as helpful when conducting assessments for the first time and learning more about a patient's background from their family members, as well as providing updates and communicating patient's progress in music therapy sessions.

The added presence of an interpreter offers musical benefits as well, which is important to highlight as this cannot be found in related literature in psychotherapy and art therapy. Participants described having a greater understanding of the music within a session and the ability to dive deeper into lyrics and analysis. In doing so, participants also noted an increase in patient's self-expression, which may be a common goal in music therapy. Recently, I was working with a patient with a video interpreter who helped me to ascertain the patient's music preferences. The patient was unable to vocalize and unable to write. Her primary means for communication was using gestures and head nods. The interpreter offered several popular musicians and groups of their shared culture, to which the patient was able to nod yes or no to indicate her preference. It seems quite simple, but before conducting this research, I never would have thought to include the interpreter in on the conversation to better understand the patient's world. It is important to remember that music therapists are not the experts in all musics, nor are we the experts in all cultures. It is completely acceptable and even necessary to take a step back,

accept what we do not know, and utilize our resources, working collaboratively with interpreters and acknowledging their wealth of cultural knowledge and information.

Domain 3: Drawbacks of working with interpreters

The drawbacks reported by participants are aligned with many of the drawbacks discussed in related psychotherapy literature, including disruption in flow and pacing, interpreters overstepping, and fear of therapist's words being lost in translation (Gerskowitch & Tribe, 2021; Pugh & Vetere, 2009; Tribe & Tunariu, 2009). One participant discussed increased paranoia as a result of working with an interpreter and therefore cited it as a contraindication for some patients. In the context of psychiatric work, it may be contraindicated to involve an interpreter, especially if the interpreter is only available over the phone or video. Participant C described patients becoming "a little squirrely" when they can hear the interpreter's voice but not necessarily see them. This can lead to increased feelings of paranoia and delusion. It may be important to assess the patient's cognitive state and orientation to reality prior to involving interpreters.

With any additional presence, be it family members, observers, or interpreters, the therapeutic relationship is inevitably affected. Some participants worried about patients being hesitant to disclose information with an extra person in the room. One participant also wondered if patients may "quicken the therapeutic experience" to avoid feelings of discomfort or uneasiness. It is the therapist's responsibility then to help establish a safe and welcoming space for patients to feel comfortable sharing. It may be beneficial for the music therapist to state the obvious and acknowledge the addition of a third person in the room, and though it may not be ideal, that the patient's confidentiality and privacy are still top priority. Raval and Smith (2003)

suggested that therapists address the "power imbalances and social inequalities" to facilitate a better therapeutic outcome overall, leaving all parties feeling more empowered (p. 24).

Three of the five participants described working with interpreters in music therapy as an "extra step" requiring "extra energy." Bilingual readers or readers with limited English proficiency may find this to be offensive and harmful. A single aspect of their identity and lived experience may cause them to feel like a burden or internalize these feelings. Perhaps the "extra step" and "extra energy" cited by participants is a by-product of the lack of institutional resources for music therapists to work with interpreters, rather than individuals with LEP themselves. I acknowledge the fact that this domain in particular may be difficult to read. At the same time, it is a harsh reality that music therapists identified several drawbacks to working with interpreters in music therapy. Perhaps greater education, awareness, and resources may serve to combat some of these drawbacks or perceived drawbacks.

In alignment with related psychotherapy IPA literature, participants' experiences of describing both benefits and drawbacks of working with an interpreter seemed "somewhat paradoxical", describing the "interpreter as both an obstacle and a facilitator of the empathic process, helping them to develop, and at times inhibiting, a sense of empathic connectivity with the client" (Pugh & Vetere, 2009, p. 317). This paradox confirms that working with interpreters can be a complex experience and depending upon the therapists' own sociocultural location, background, and lived experience, the comfort levels will be highly varied, as evidenced in the findings of this research.

Domain 4: Music therapist's feelings when working with interpreters

The generally difficult feelings outweighed the generally positive feelings reflected by participants when working with language interpreters. Just two of the participants reported a

positive feeling of excitement when having the opportunity to work with interpreters in music therapy, while four of the five participants cited generally difficult feelings. This uneven ratio may indicate the glaring lack of education and discussion surrounding working with interpreters in music therapy. This reveals the need for increased education and resources on the topic. This skew may also in part be due to the majority of participants identifying as white and monolingual English-speakers.

In grappling with my own feelings related to working with interpreters, I wrote in my journal:

> [Participant B's comments] make me second guess my own experiences and feelings with interpreters. There is a little bit of shame associated with my own feelings of nervousness and anxiety. But I think that's just the white supremacy that is engrained in my upbringing and society, as well as the experience I had at [the children's hospital].

Participants' generally difficult feelings of anxiety, nervousness, and imposter syndrome reflected similar findings in related literature (Gerskowitch & Tribe, 2021; Pugh & Vetere, 2009; Tribe & Tunariu, 2009). As participants shared their generally difficult feelings with working with interpreters, I felt validated because I experienced a lot of the same feelings of nervousness, anxiety, and frustration. However, as other participants shared their generally positive feelings with working with interpreters, I found myself experiencing feelings of shame and guilt for not having a more positive and excited outlook. Engaging in reflexivity enables music therapists to acknowledge that their individual reactions and feelings to a situation are deeply complex. The dominant narratives and systems of white supremacy and linguistic privilege are embedded in U.S. society to create division and hegemony (Hadley, 2013). It is the privileged music therapists' responsibility to actively work to confront these biases and dismantle them.

The experience of imposter syndrome has been researched within the field of music therapy (Pickett, 2020; Shah, 2022; Sims, 2017). When music therapists experience imposter syndrome and spotlight effect while working with patients with LEP, they run the risk of shifting the attention to themselves, rather than on the patient. Instead of focusing on the patient's needs, the therapist may find themselves stuck in their own thoughts, worrying about how others are perceiving them, or questioning their every action. It is important for music therapists to first become aware of these feelings, and then work to combat them. It may be useful for music therapists to dig deeper and question why they have feelings of imposter syndrome and spotlight effect in the first place. Perhaps their view of music therapy is coming from a stance of being the "expert" or having all the answers. When operating from this perspective, it would be quite impossible to feel secure when working with interpreters because the music therapist is not able to have all the answers and must work in collaboration with another individual to deliver services. Cultivating a practice of professional humility allows music therapists to free themselves from the unrealistic expectation of having all the answers. Feelings of imposter syndrome and spotlight effect may also reveal deep insecurities within the music therapist that would be beneficial to work through in clinical supervision or even personal therapy.

Two of the participants identified as bilingual, one brought up in bilingualism from childhood and one acquired bilingualism in adulthood. This aspect of their identity became crucial to reflecting on their experiences working with interpreters in music therapy. After speaking with these participants, I realized the profound impact of bilingualism to this topic, and I wrote in my journal:

> I am starting to notice that the white native English-speaking MTs seem to report this feeling of nervousness (at least initially) when working with interpreters. But both

> participant B and C had not really expressed those feelings. And those are the two participants who are fluently bilingual, even if not from birth. I do feel that that plays a role in comfortability in working with interpreters and just in general, working with people with whom you may not be able to communicate in "traditional ways."

After speaking with one of the bilingual participants, I found myself feeling sadness and despair, longing for more racial, ethnic, and language diversity:

> After doing this interview, I wish I had more variety/diversity in my participant pool in terms of race and language spoken. This participant was the only BIPOC participant. She had such a different outlook...and I truly believe her lived experience played a role. She didn't express the same feelings of nervousness, imposter syndrome, spotlighting, etc. that [other] participants felt (and me as well). She clearly sees the need for and importance of language services and really only views interpreters as beneficial.

The experiences of first-generation music therapists, bilingual music therapists, BIPOC music therapists, and non-native English-speaking music therapists would greatly enrich these discussions on working with interpreters in music therapy. Based on this small sample of participants, the participants with bilingual identities reported less generally difficult feelings and more generally positive feelings, as well as increased empathy and understanding when working with patients with LEP. To the researcher's knowledge, there are no research studies on the experiences of bilingual music therapists.

Domain 5: Potential reasons for not working with interpreters

There are many reasons why music therapists may demonstrate resistance to working with language interpreters, the most common reason being lack of music therapy resources and education. All five participants reported having no education whatsoever on the use of language

interpreters in their music therapy undergraduate and internship curriculum. All five participants reported having to “learn on their own” once they became faced with language discordance as music therapy professionals. Participant C stated:

> There's such a deficit in our ability to communicate with people and it's not being addressed in undergrad. As far as I know, all of the music therapists that I work with have had similar experiences because we've talked about these things, too, and I don't know anybody who really was educated on that at all in undergrad or graduate studies honestly.

Music therapists may be neglecting the utilization of interpretation services, or even disregarding working with patients with LEP altogether due to the lack of education and resources surrounding this topic. It is imperative that music therapy educators and supervisors increase their awareness and knowledge on working with interpreters in music therapy in order to educate students and interns.

One participant discussed the incorrect assumption of a patient’s English as “good enough” to get by without an interpreter. I have personally witnessed other therapists and clinicians disregarding the use of an interpreter, simply because it felt like an inconvenience to them. In a work journal dated March 21, 2023, I recalled working with a patient whose native language is Burmese:

> I’ve been working with Ms. H for several months at this point, but her orientation status and communication levels recently changed, so I thought it was time to reassess MT services. Initially, I was not working with an interpreter because she had demonstrated English proficiency in our previous sessions by nodding/shaking her head and using hand gestures (since her verbal communication was limited due to being vented and trached). When I saw her last week though, I heard her voice for the first time! I was co-treating

> with M to facilitate deep breathing and diaphragmatic breathing, as suggested by her OT. When we instructed her to place one hand on her chest and one hand on her belly, she smiled and nodded her head, but did not follow the instruction. We said it a few times, and still nothing, just smiles and nods. I thought to myself, "I need to find an interpreter." I pulled up the live Burmese interpreter via video and we were able to continue on with the session. I wrote and highlighted in my progress note that the patient's expressive English seems to be more advanced than her receptive English, and that an interpreter should be utilized for all interactions for optimal communication and success.

I share journal entries like these from my own clinical work to show real life examples of how working with interpreters is a reflexive practice and that I am constantly learning and growing. Any music therapist, clinician, or provider may fall guilty of assuming a patient's English as "good enough." It is important to never assume a patient's English proficiency, while also never assuming lack thereof. One way to address this issue is to ask the patient directly about their preference. It is appropriate for music therapists to ask the patient directly if they want an interpreter present for the session. If they are unable to answer this question when asked in English, then clearly an interpreter is indicated. Some participants discussed feeling awkward when they brought an interpreter to their music therapy session and it turned out that the patient spoke and understood English, and the interpreter was not needed after all. The findings in this study indicated that it is better to come prepared with an interpreter present rather than fumbling through a session and attempting to communicate with a patient who does not understand English and whose language you cannot understand yourself.

Four out of five participants alluded to the notion of music as a "universal language." After speaking with Participant E, I remembered a time when I also fell into this dangerous line of thinking:

> I remember in undergrad, writing a paper on CoMT and calling music the universal language. I remember Dr. X calling me out on it and challenging that idea. Ever since then, I've grown a lot in my understanding and worldview and feel very passionate about music *not* being a universal language. Not every culture experiences music in the same way. Not every culture even tolerates or accepts music as a permissible thing. It's so important not to generalize the human experience and to be careful of falling into the traps of hegemony and Eurocentric beliefs.

Music therapists must seriously challenge the notion that music is the "universal language." To assume that music breaks cultural and language barriers implies that verbal communication is not needed when language discordance exists. As Comte (2015) discussed, the belief that music can transcend verbal language barriers and become a language through which even cultural barriers may be overcome is a bold statement that upholds neo-colonial views. This is not to say that music is without meaning and expression. There are plenty of times when music, specifically music improvisation, can communicate thoughts, feelings, and behaviors that words simply cannot express. However, without a full awareness of language nuances and cultural values and norms, the neo-colonial music therapist upholds and imposes a set of white Western values, running the risk of misinterpreting and even disempowering the individual (Comte, 2015).

Participants discussed situations when interpreters may not necessarily be indicated, for example, if the session has little to no verbal interaction and music therapy serves as a more receptive experience. However, even if the music therapist is facilitating something receptive

with little verbal interaction, music assisted relaxation for example, what happens if the music elicits a specific trauma or intense emotional reaction? Without an interpreter there, the patient is unable to fully disclose their experience to the music therapist, and even if they did, the music therapist is unable to fully understand and therefore unable to provide adequate care and treatment, potentially risking emotional or psychological harm. Music therapists may be posing great harm to their patients with LEP by neglecting working with an interpreter.

Domain 6: Dangers of NOT working with interpreters

There are many consequences when choosing not work with interpreters. As Participant B stated, working *without* interpreters present can produce greater anxiety than working with them. One of the dangers of not working with interpreters is having an extremely limited therapeutic relationship, one that participants described as "one-way" and "surface level." Working with patients with LEP without interpreters quite literally prevents patients' ability to have an authentic, genuine relationship. In addition, restricting patients from access to an interpreter may result in a decreased level of socialization. One participant described a patient socially withdrawing on a psychiatric unit due to no one else speaking his native language and being unable to verbally and socially interact and engage with others. As music therapists continue to operate in an English dominated world in the U.S., conducting sessions strictly in English only serves to perpetuate and uphold dominant narratives of linguistic and language privilege.

Based on the findings, the most dangerous consequence of not working with interpreters is running the risk of discrimination by patient avoidance. Patients may not be referred to music therapy if it is the assumption that music therapists are only able to work with English-speaking patients. One participant recalled a negative experience with a music therapy supervisor who told

her, “I don't take...referrals when people don't speak English, I just avoid that room.” The supervisor even said to the participant, an undergraduate practicum student at the time, “You can take that [Spanish speaking patient] if you want because I'm not going to do it.” The supervisor was exhibiting not only bias and linguistic privilege, but blatant discrimination based on language.

It is disappointing but not shocking that some music therapists operate in this way. It may be easy in the situation described to point blame at the participant’s supervisor for engaging in such discriminatory acts and behavior. From a feminist perspective, Hadley (2013) wrote that “individual problems are related to the social and political context of the person” (p. 376). Therefore, to combat these issues, the music therapy supervisor must confront the social and political contexts through which she was raised and brought up. To enact change, music therapists are “expected to recognize the impact of our feelings, attitudes, and actions, in fact our very embodied being, on the client and the therapy process” (Hadley, 2013, p. 376). One way to do this is exploring the ways in which music therapy as a profession privileges certain groups in society over others. In this case, how did the music therapist privilege the English language over the Spanish language? In what ways does living in an English-dominated world privilege the English-speaking person and oppress the non-English speaking person? Additionally, how do we “cash in on unearned privileges,” especially those of linguistic privilege for the monolingual English-speaking music therapist, and “In what ways are those privileges invisible to us...and how are they “manifested in our profession and in our clinical practice in music therapy?” (Hadley, 2013, p. 379). The only way to combat language bias and prevent further harm and discrimination is to open the door for conversations surrounding working with interpreters,

linguistic privilege, and language bias. Without actively engaging in this type of work, music therapists are in direct violation of our professional code of ethics.

Domain 7: Considerations for music therapists working with interpreters

Many of the resistances and drawbacks to working with interpreters may be addressed in these considerations for music therapists when working with interpreters. Participants discussed the decision-making process surrounding when to utilize a language interpreter and how to navigate sessions when interpreters may not be available. Breaking down the decision-making process may help to combat feelings of imposter syndrome and spotlight effect. Participants also discussed the importance of establishing boundaries and having the space to debrief and process sessions with interpreters when applicable, which may help to reduce the possibility of the interpreter overstepping or blurring lines. It is important to remember patient confidentiality if music therapists do go on to debrief and process with the interpreter. Many participants cited the worry they feel of their own words and meaning being lost in translation. Taking the time to stop and ask for clarification may help to ease some of this worry and anxiety. It is appropriate for the music therapist to pause in conversation and ask the interpreter, "'What you're both saying sounds important. Could you please share it with me?'" (Searight & Searight, 2009, p. 446) or even something as simple as, "Sorry, I want to make sure the patient fully understands what I just said. Do you mind repeating it?" Other drawbacks and resistances discussed included technology issues and disruptions in flow and pacing of sessions. One of the recommendations for music therapists was to simply practice working with interpreters. The more music therapists become accustomed to communicating with a third party, the easier the technology and pacing will become. Practice working with interpreters starts at the educational level, calling upon

music therapy educators to increase their own knowledge and education with working with interpreters.

Two participants cited the importance of reflexivity of the therapist. It is important for the music therapist to become aware of the fact that not all patients speak English as a first language and that the English-speaking monolingual therapist holds a privileged position in an English-dominated society. While it is also important for patients to see themselves in their providers and have greater representation, this is not always possible or realistic. Therefore, the music therapist must be equipped with the knowledge and resources to be able to communicate with all patients, regardless of their natal language, English proficiency, or lack thereof.

Bruscia (2014) discussed five main ways to practice reflexivity: "1) Self-observation 2) Self-inquiry, 3) Collaboration with the client, 4), Consultation with others, and 5) Supervision." (p. 54). Music therapists may practice self-observation by reflecting on their own practice and instances when they may have avoided a patient due to their native language or instances when they were unable to communicate effectively with a patient and simply brushed off the need for verbal communication. Music therapists may practice self-inquiry by delving deeper into these issues and understanding the implicit biases they hold that perpetuate these instances of inequity and injustice. By collaborating with the client directly and understanding their individual needs surrounding language and communication, the music therapist places the power and autonomy back to the client. It is appropriate for the music therapist to ask the client directly if they would prefer utilizing an interpreter or not. If the patient is unable to answer that question, then it is safe to assume that you would need to work with an interpreter for optimal communication. Consulting with other professionals both inside and outside of the music therapy profession may be beneficial when working with interpreters. It is likely that other professionals are experiencing

or have experienced similar feelings that could be beneficial to work through together on a peer-to-peer support basis. Lastly, supervision remains a necessity for processing the ongoing dynamics of therapy and addressing any issues when working with interpreters. For the last strategy to be successful, it is imperative that music therapists, especially music therapy supervisors, increase their education and understanding of not only working with interpreters, but also of linguistic privilege, language inequities, and racial bias.

Clinical Implications

The present research is not intended to be a step-by-step guide on how to work with interpreters in music therapy. Rather, I hope to ignite further discussions on the issues of language and linguistic privilege, as well as to combat deeper systemic issues of equity and accessibility within the field of music therapy. I acknowledge how this research could be perceived by individuals with LEP. Various phrases used by participants as well as the names of themes, such as "extra step and energy," may be triggering to those who are personally impacted by LEP. Some of the language around drawbacks of working with interpreters and generally difficult feelings when working with interpreters may also be difficult to read, as it may suggest individuals with LEP are "difficult to work with" or an "extra chore." Additionally, anecdotes shared by me and some of the participants describe blatant discrimination, which is always painful to read. While I cannot change the attitudes and language of the participants' data, I can certainly acknowledge the emotional toll and impact this research has on bilingual individuals and anyone personally related to LEP, and further expose the unfair and biased stances many music therapists hold in regard to language.

Call for increased education.

Limited English proficiency (LEP) exists throughout the entire United States. According to the 2019 U.S. Census, 67.8 million people speak a language other than English, and of those 67.8 million, 19% reported that they speak English "not well" or "not at all" (Dietrich & Hernandez, 2022). Music therapists across all levels and across all settings have a responsibility to increase their awareness, knowledge, and education regarding working with individuals with LEP and working with interpreters. Additionally, music therapists must confront their own linguistic privilege and bias. Music therapy educators must begin to address these topics at the undergraduate level. Music therapy supervisors and internship directors must possess the skills and knowledge to facilitate students and interns in unpacking their own bias, as well as providing learning opportunities to address these biases. The combination of ongoing cultural humility and increased resources to working with interpreters is vital to address these issues and provide quality and equitable care for those with limited English proficiency.

As stated in the AMTA Professional Competencies (2013), music therapists will "demonstrate awareness of the influence of race, ethnicity, language…on the therapeutic process" and "treat all persons with dignity and respect, regardless of differences in race, ethnicity, language…" (n.p). The AMTA Code of Ethics (AMTA, 2019) states that music therapists will "identify and recognize their personal biases, avoiding discrimination in relationships with clients, colleagues, and others in all settings" (n.p.). Music therapy educators are called upon to foster this type of awareness and reflexivity in music therapy students. Music therapists are responsible for upholding the ongoing cultural humility and reflexive work that is required to meet these competencies and our professional code of ethics.

Limitations.

Primary limitations to this research include having limited participant diversity in terms of racial identity, languages spoken, and gender identity. The findings of this study may have been quite different had there been more non-white participants or more bilingual participants. However, in 2021, the American Music Therapy Association Workforce Analysis (AMTA, 2021) revealed that 88.34% of music therapists are white, from a total of 1,046 respondents; therefore, the racial makeup of this study's participant pool is representative of the music therapy profession.

As the researcher, I came to this study with my own background, biases, and opinions on the topic of working with interpreters in music therapy. Having had the experience of working with language interpreters in music therapy, I was able to pose thoughtful questions and elicit answers from participants that may have been difficult for someone who had not had that same experience of working with interpreters. On the other hand, having a proximity and an emotional investment to the topic may have biased the coding and analysis process, paying closer attention to certain themes that resonated with me and my own experiences. It was crucial to have an internal auditor and reviewer to limit this researcher bias.

As a monolingual, English-speaking music therapist and researcher, the ways in which I was able to address the emotional weight of this topic was limited. I shared similar feelings of discomfort and nervousness that were described by many of the participants, which is something that I could relate to and expand upon. A bilingual music therapy researcher or a music therapy researcher with limited English proficiency may have been able to draw out more nuanced experiences of this topic, especially in regard to the experiences of bilingual music therapists and the ways in which harm and discrimination unfold from monolingual music therapists.

Qualitative researchers may utilize self-disclosure and empathy to "level the playing field" and communicate respect to research participants (Dickson-Swift et al., 2007, p. 332). Self-disclosure may not always be appropriate, but feminist writers argue that self-disclosure helps to shift the power imbalance within the inherently hierarchical relationship (Reinharz, 1992). Throughout the participants' interviews, I was able to share my own experiences of working with interpreters, which at times led participants to share more or think more deeply about their own experiences. At the same time, this use of self-disclosure may have run the risk of participants sharing less than they would have with someone who had no experience working with interpreters, with the assumption that I as the researcher already had that implied knowledge.

Recommendations for future research.

To my knowledge, this is the only study of its kind to examine music therapists' experiences of working with interpreters in music therapy. It would be beneficial for music therapists to replicate this interpretative phenomenological analysis study to better understand music therapists' experiences of working with interpreters. Diversifying the participant pool in terms of race, language, and region would also be beneficial to having a greater understanding of this phenomenon. Additionally, music therapist researchers from various sociocultural locations would serve to expand the ways in which we understand music therapists working with interpreters, as the researchers' biases and lived experience would likely yield varied findings with different perspective.

It would be interesting to compare the experiences of bilingual music therapists with monolingual music therapists' experiences. This research suggests that bilingual music therapists have unique perspectives and life experiences that contribute to the overall experience of

working with interpreters, as well as with patients. It may also be useful to conduct a similar study with music therapy patients to understand their experience of being on the receiving end of music therapy services with an interpreter present. Additionally, it would be valuable to conduct a study with language interpreters to better understand their perspective and experiences of working with music therapists.

Conclusion

The present study sought to understand the experiences of music therapists delivering music therapy services with language interpreters. After interviewing five music therapists, a total of 40 themes emerged from the data analysis. Themes were further grouped into seven organizing domains, highlighting the many ways of working with interpreters, benefits and drawbacks of working with interpreters, feelings arisen when working with interpreters, potential reasons for not working with interpreters and subsequent dangers, and considerations.

The findings indicate the need for increased education for music therapists on the topic of working with interpreters. In order to prevent further harm and discriminatory practices, it is vital for music therapists to consider this research when working with patients with limited English proficiency. Music therapists are also challenged to confront their own privileged stances on the issues of language and linguistic privilege within the U.S. It is my hope that more music therapists begin this process of self-awareness, reflexivity, and culturally reflexive practice to better serve those with limited English proficiency.

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Appendix A

Informed Consent

CONSENT TO PARTICPATE IN RESEARCH

Therapists' Experiences of Delivering Music Therapy Services with Interpreters

Susan Hadley, PhD, MT-BC | susan.hadley@sru.edu | 724-738-2446

Victoria Obermeier, MT-BC | vxo1001@sru.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 1) A board-certified music therapist, 2) Have experience working with clients/patients in music therapy with the additional presence of an interpreter (e.g., may be in-person interpreter, video interpreter, or phone interpreter), and 3) Speak fluent English. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to investigate and understand the experiences of music therapists delivering music therapy services with interpreters. If you choose to participate, you will be asked to participate in an interview conducted via Zoom. This will take approximately 45-60 minutes.
- Risks from this research are limited but may include informational risks of breach of confidentiality.
- The study will contribute to a significant gap in music therapy literature and serve as a building block for future research in understanding the use of interpreters in music therapy services. The proposed research will also seek to combat systemic issues of access and equity within the field of music therapy.
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time.

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

What is the Study About and Why are We Doing it?

The purpose of the study has four main tenets: 1) To understand the therapists' experiences of delivering music therapy services with interpreters, 2) To fill the gap in the music therapy literature on working with interpreters, 3) To serve as a resource for music therapists delivering music therapy services with interpreters, and 4) To combat the systemic issues of access and equity within the music therapy field.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to participate in an individual interview conducted by the researchers via Zoom. The date/time of this interview will be determined upon both the participants' and researcher's availability. We expect this to take approximately 45-60 minutes. The audio from your interview will be recorded to assist researchers in transcribing and coding data for thematic analysis and review. Your data will be kept confidential and will not be linked to any identifying information. Data will be kept until 12/31/2024 for research purposes.

How Could You Benefit from This Study?

Although you will not directly benefit from being in this study, your participation in the study will assist in bridging the gap in music therapy literature and serve as a building block for future research in understanding the use of interpreters in music therapy services. By participating in this study, you will also aid in the efforts to combat systemic issues of access and equity within the field of music therapy.

What Risks Might Result from Being in This Study?

You may experience minimal risk from being in this study. Since interviews will be conducted using a third-party platform (i.e., Zoom), there may be informational risks of breach of confidentiality.

In order to prevent this type of risk, researchers will be conducting interviews on the Zoom platform. Zoom ensures End-to-end Encryption, maintaining that communication between all meeting participants in a given meeting is encrypted using cryptographic keys known only to the devices of those participants. This ensures that no third party, including Zoom, has access to the meeting's private keys. Content is protected during transit with 256-bit Advanced Encryption Standard (AES) using a one-time key for that specific session. Additionally, the transcription software (i.e., GoTranscript) ensures secure, encrypted audio translation.

How Will We Protect Your Information?

We plan to publish the results of this study. To protect your privacy, we will not include information that could directly identify you.

We will protect the confidentiality of your research records by removing personal information that could directly identify you. Your name and any other information that can directly identify you will be stored separately from the data collected as part of the project. All data will be stored on a password protected computer in a password protected file.

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

Your research data will be stored on researchers' password protected computers to use for future research purposes. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project. All data will be destroyed after 12/31/2023.

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

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

Your Participation in this Research is Voluntary

It is entirely up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed, your data will continue to be stored confidentially until the end of the research study. Participants are subject to termination by the PI without their consent if they miss their scheduled interview.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Susan Hadley, PhD, MT-BC at susan.hadley@sru.edu or 724-738-2446.

Contact Information for Questions about Your Rights as a Research Participant

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

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 302
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

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

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

_____	_____	_____
Printed Participant Name	Signature of Participant	Date

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

_____	_____	_____
Printed Name of Investigator	Signature of Investigator	Date

Photo/Audiotape/Videotape Release Form:
We request the use of audiotape material of you as part of our study. We specifically ask your consent to use this material, as we deem proper, specifically, for news releases, professional publications, websites and pictorial exhibits related to our study. We also emphasize that the appearance of these materials on certain media (websites, professional publication, news releases) may require transfer of copyright of the images. This means that other individuals may use your image. Regarding the use of your likeness in audiotape, please check one of the following boxes below:

- **I do...**
- **I do not...**

Give unconditional permission for the investigators to utilize audiotape of me.

_____	_____	_____
Print Name	**Participant Signature**	**Date**

Appendix B

Interview Script

Thank you for meeting with me to participate in my thesis research, "Therapists' Experiences of Delivering Music Therapy Services with Interpreters." I currently work in a public city hospital where I work with interpreters probably once a day, if not once every other day. I was shocked to see so little in the music therapy literature on this topic. My hope is to fill the gap in the and serve as a building block for future research in understanding the use of interpreters in music therapy services, as well as to combat systemic issues of access and privilege.

I have a series of interview questions to ask you during our time today. The interview audio will be recorded to assist in coding and analyzing the data. Your answers will be kept confidential, with any identifying information removed.

Before I start the recording, do you have any questions regarding the interview process or the informed consent?

Interview Questions:

1. Tell me about your current job. (i.e., Work setting, clientele, etc.).
2. What are your experiences in working with clients/patients who do not speak English?
3. What are your experiences in working with interpreters in music therapy? (I.e., in-person vs. remote, ad hoc vs. trained, black box vs. cultural brokers)
4. What are your overall feelings related to working with interpreters in music therapy?
5. Describe your comfort level in delivering music therapy services with the assistance of an interpreter?
6. How does the additional presence of an interpreter affect the therapeutic alliance with your client/patient, if at all?
7. Describe any benefits to working with an interpreter. Describe any drawbacks to working with an interpreter.
8. Is there anything else you would like to add about your experiences in working with interpreters in music therapy?