Music Therapists and Feelings of Clinical Inadequacy: A Narrative Analysis

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Abstract

In this narrative analysis, semi-structured interviews occurred with six music therapists to examine their experiences of feelings of clinical inadequacy in music therapy. Five themes with twenty-one subthemes emerged in the data: professional development (insufficient knowledge, lack of training, lack of experience in field/setting, lack of professional support), workspace issues (lack of knowledge of music therapy by others, feeling like an outsider, unrealistic expectations, unfair comparisons, pressure from unrealistic parental expectations), intrapersonal issues (historical wounds, personal vulnerabilities, personal traits), felt experiences (emotional, psychological, visceral, social, physiological, physical), and coping strategies (honest internal observation, professional vulnerability/humility, and compassion). The findings of this study hold implications for education, supervision, and further music therapy research.

Keywords: narrative analysis, clinical inadequacy, reflexivity, authenticity, music therapy, vulnerability, self-efficacy

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Introduction

Personal Context and Motivation for the Research

Being a product of culture and history in every space I'm in, it is important to reflect on systems in place that guide my thoughts and state of mind. It is through conscious observation of my role in each space, dialogue with brave colleagues and friends, and a continuous process of unlearning and taking responsibility that is required for my white, non-disabled, middle class, educated privilege to take less prominence in the ways in which I respond, while I also acknowledge that these systems position me regardless of my intentions. Therapy and a meditation practice have been spaces in which I explore constructs in my mind and concepts of self that have encouraged me to feel special, included, deserving, and to expect others to accept and love me unconditionally as well as spaces in which I explore my feelings of insecurity and inadequacy. Growing up, my mom would often ease my growing pains by telling me, "Oh they're just jealous of you, you're doing a great job." In high school theater productions, the director and my peers would tell me how amazing my talents were and that I really "have something." Then, after being rejected by eleven auditions to universities for further theater study, I began to feel angry with myself and the expectations I had developed, that others would perceive me as talented, and angry about my ingrained need to feel worthy, accepted, and actually praised by others.

These self-glorifying expectations and feelings of entitlement did not go away after naming them, however. Into my music therapy career, too, they trailed along and turned into what I refer to today as my understandings of myself as "helper," as I soaked up readings of successful case studies, marketing photographs that make the music therapist look so caring, and comments of praise for the "honorable career I was pursuing." This understanding was fostered by the discourse I was surrounded by and has been analyzed critically by Vee Gilman (2021). As

I progress, I have learned there is nothing wrong with balanced self-esteem, sharing how music affects others through case studies, being a caring person, or feeling honored to practice music therapy. What is troubling, is the systemic encouragement I've experienced to have an inflated ego, to really feel like a savior for someone, and to have your best intentions in mind, yet not recognize the position others are placed into as a result of the ever-present cultural and historical influences embedded in each interaction.

Simultaneous with these understandings of myself as good and entitled, I have struggled with feelings of inadequacy. In the context of this research, I have struggled specifically with feelings of clinical inadequacy. This may be due to other aspects of my sociocultural location, namely being a cis-woman in a profession that historically has been deemed less important than other health professions.

This research is inspired by my own feelings of clinical inadequacy, and a desire for connectedness, community, and a way of gently reminding other music therapists they are not alone in this deceivingly lonely space. I have become more and more aware that feeling like a fraud greatly influences not only my relationship with self, but my therapeutic presence, how clients and colleagues feel around me, and how my inner dialogue influences how I perceive and interact with others. When I started exploring this topic, however, emerging insights kept prolonging the writing of this work. It was as though this research was a glimpse into the fact that I cannot run from myself, from these limiting concepts regarding how life works and what it all has to do with creating spaces for connection.

I think that I had hopes that this research would rescue me from the narratives I had adopted, ones that I was hoping would hide my feelings of inadequacy. Somewhere in my survival toolbox, I decided it was necessary to earn the approval of those around me. I had a need to be constantly validated, appreciated, and ultimately loved by others. So when life happened,

for example when someone didn't find a joke funny, or when someone didn't assume innocence when they met me, or quite frankly wasn't finding me interesting, I tallied these instances up inside of me and they accumulated into a chameleon-esque personality. This ultimately led to deep self-rejection and self-hatred. When we add music into the mix—my music, my voice—learning in a conservatory atmosphere, a space of critique, these feelings of inadequacy grew. Many aspects of me were not ready to grow from advice from educators or opinions from professors. Within myself, I had to be perfect and any comment short of praise meant I had failed at something. As a result, I relentlessly held on to the mantra "I will be loved by everyone, even if it means abandoning myself."

Needless to say, I tried to hide my feelings of inadequacy both within a clinical space and outside of one. I hid from myself. I tried to fool others. But ultimately, acknowledging my feelings of inadequacy is what led me to this research. As mentioned above, I thought, felt, and hoped that after being rejected in theatrical studies that music therapy would be the field for me. I thought it could be a way to be in music somehow without all the judgement and auditions. What has been revealed since then, is that the filters of judgement and the ways I continued to feel like I was auditioning within client relationships, colleague interactions, and how I thought life *had* to be.

Although therapy and a meditation practice had profound healing qualities for me, works of Carolyn Kenny, especially the Field of Play (2006), seemed to communicate directly to me and gave a whole new understanding to what it means to be a music therapist. The following quote permits me to be in a process of change rather than perpetually striving for perfection. If I can allow myself to be the best that I can be given any circumstance, i.e., low self-esteem or needing to be loved, maybe I am acceptable to be in the role of a music therapist. She wrote:

> *"As music therapists, we are greatly concerned with the phenomenon of change and innovation; the modification of attitudes, behaviors, and habits. We are concerned with rehabilitating and reforming, adapting and learning. We are concerned with people becoming the best of who they can be, given the circumstances of their lives"* (p. 77) - *Music & Life in The Field of Play: An Anthology*

Writing this research has not been easy for me. There is a voice inside my mind that says, "You are not wise enough to explore this topic, much less write a thesis on it." So, in an attempt to be very honest, I will start by claiming that voice as part of me. I will also work hard not only to acknowledge that voice, but to understand that I must proceed regardless. As a person often in the role of therapist, musician, and spiritual healer, I can easily describe moments where I feel like a fraud playing a role in a movie or a TV show. Even though there are degrees and certifications on my walls that show I've learned something, I am writing this research as someone that looks at these and still doesn't believe I deserve the titles I uphold in my daily professional life.

In order to get a sense of prior research conducted in this area, I reviewed the literature on imposter syndrome, imposter phenomenon, and feelings of inadequacy within education and health fields, as well as within the field of music therapy. It was my sense that feelings of being an imposter and feelings of clinical inadequacy were closely related. The next section provides a synopsis of the literature that I surveyed, which provides a context for the current study.

Review of the Literature

The impostor phenomenon, also known as impostor syndrome, is the inability to internalize accomplishments while experiencing the fear of being exposed as a fraud (Jöstl, G., 2012; Vergauwe, J., et al, 2015; Chromey, K.J., 2017; Abrams, A., 2018; Barr-Walker, J., et al, 2019;

Mak, K.K.L., et al, 2019; Rittenhouse, J.R., 2019). For example, Rittenhouse (2019) examined authentic leadership and the imposter syndrome, which notes how individuals suffering from the effects of the impostor phenomenon often get caught in the cycle of working excessively. This excessive work cycle leads to successful outcomes, and breeds outward recognition, which then leads a person to take on additional responsibilities.

The imposter phenomenon is not limited to any particular age, race, or gender and has been found to occur across a variety of skill sets (Clance, 1985; Bernard, et al., 2002; Thériault, et al., 2009; Thériault & Gazzola, 2008; Thériault & Gazzola, 2010; Young, 2011; Bernard, et al., 2017; Sims, 2017). Bernard, et al. (2002) conducted a study on imposter phenomenon in which they administered 190 college students (79 men, 111 women) the Clance Impostor Phenomenon Scale (Clance, 1985), the Perceived Fradulence Scale (Kolligian & Sternberg, 1991), and the NEO–Personality Inventory–Revised (Costa & McCrae, 1992). They found that correlational and regression analyses supported a connection between high neuroticism and low conscientiousness. They found that college students prone to depression, anxiety, and/or who demonstrate low self-discipline and perceived competence, often experience imposter feelings. Furthermore, they found that young African American college students experiencing discrimination at predominently White institutions exhibit even higher levels of the imposter phenomenon than college students as a whole (Bernard, et al., 2017). Young (2011) noted that, in the U.S., feeling inadequate as a woman is common and encouraged through marketing schemes. These examples point to how one's sociocultural context impacts their feelings of being an imposter in certain settings. This is important to note, because it has been found that the imposter syndrome often manifests in self-doubt and self-limiting behaviors (Rittenhouse, 2019).

Imposter phenomenon and imposter syndrome are also referred to as feelings of incompetence. In the field of psychotherapy, feelings of incompetence have been described as

moments where therapists' beliefs in their abilities, judgment, and/or effectiveness is diminished, reduced, or challenged internally (Thériault & Gazzola, 2010). Feelings of incompetence have been found to occur throughout a therapist's career, not just for those entering into clinical practice (Thériault & Gazzola, 2005; Thériault & Gazzola, 2006; Thériault & Gazzola, 2008; Thériault, et al., 2009; Thériault & Gazzola, 2010). Specifically, feelings of self-doubt and insecurity in one's effectiveness are frequently reported by mental health professionals, regardless of their experience or skill level (Thériault, et al., 2009). That being stated, feelings of incompetence are a central feature in the development of a novice therapist's identity (Thériault, et al., 2009) and have been revealed to be a serious hazard to the field of psychotherapy (Thériault & Gazzola, 2008), sometimes leading clinicians to leave the field.

To study the origins of feelings of incompetence, eight seasoned therapists were interviewed and analyzed within a grounded theory approach (Thériault & Gazzola, 2006). Findings showed there were four main themes of origin for seasoned therapists experiences of feelings of incompetence: permissible/conditionally positive aspects, professional aspects, process aspects, and personal aspects (Thériault & Gazzola, 2006). Permissible/conditionally positive aspects represented thoughts on human fallibility and aimed at normalizing and removing the stigma from feelings of inadequacy and doubt (Thériault & Gazzola, 2006). Professional aspects related to the acquired capacity to understand clients and their specific presenting concerns and to the possession of the necessary repertoire of skills to intervene therapeutically (Thériault & Gazzola, 2006). Process issues were conditions or situations that arose from direct contact with clients and occurred in the dynamic therapeutic exchange with them (Thériault & Gazzola, 2006). Lastly, personal elements summarized both the therapist's discussion and portrayal of how perturbed and deeply affected they became when feelings of incompetence reached far into their personalities and their personal experiences (Thériault &

Gazzola, 2006). In the field of psychotherapy, problems in describing therapists' feelings of inadequacy/incompetence have made it difficult to recognize the impact of these feelings on one's personal and professional lives, to mediate their effects, to create coping models, and to teach prophylactic therapist self-care (Thériault & Gazzola, 2006).

Similar to the field of psychotherapy, music therapy involves clinical situations in which the clinician may experience imposter syndrome, the imposter phenomenon, and/or feelings of clinical inadequacy throughout a therapist's career. In the literature to date, music therapy literature has only focused on novice practitioners. For example, while reflecting on the feelings of clinical vulnerability, Bove (2019), a first-year music therapist generated personal responses through stream-of-consciousness writing, which informed the composition of two original songs, "Impostor Syndrome" and "Breathe." In this study, clinical vulnerability included experiences of uncertainty, emotional exposure, risk, perceived inadequacy, and loss of control (Bove, 2019). In another study, Sims (2017) discovered that the imposter phenomenon begins before the practitioner enters the music therapy field as a professional. In an interpretive phenomenological analysis of transcripts of interviews conducted with music therapy students at the University of Oklahoma, Sims discovered themes of the imposter phenomenon. These included experiences of uncertainty in transitions, challenges of the music therapy profession, and awareness and impact of the imposter phenomenon's constructs and patterns (Sims, 2017).

Purpose Statement

From the literature, feelings of clinical inadequacy are experienced in clinicians from a wide variety of fields, such as in leadership, academia, and business. While this has been studied more widely in related fields, such as counseling and psychotherapy, there is a paucity of research within the music therapy literature focused on imposter syndrome, the imposter phenomenon, feelings of incompetence, and/or feelings of clinical inadequacy. Thus, the purpose of this study

was to gain a rich understanding of music therapists' experiences of feelings of inadequacy as practitioners with different lengths of clinical experience. I was particularly interested in the contexts in which music therapists experienced feelings of inadequacy and the possible origins of these feelings.

Methodology

Research Design

Narrative Analysis

In narrative inquiry, stories are regarded as rich communications of human experiences (Hadley & Edwards, 2016). Narratives are both the medium for exploring the phenomenon and the phenomenon itself (Creswell, 2014, p. 185-6). Researchers are not only attentive to the story's content, but also how it is communicated, which may shape and shift its meaning based on time, context(s), and listener(s). The listener, or researcher, also shapes the story's meaning as they perceive it based on their own cultural location (Creswell, 2014, p. 185-6). The storytelling process is dynamic and can be transformative, impacting researchers, participants, and even readers. What differs narrative analysis from narrative inquiry, is the data collected in narrative analysis often involves a cluster of analytic methods for interpreting texts or visual data that have a storied form (Wright, 2015). Analysis techniques vary in this approach, such as thematic analysis, but narratives are always read and reread in order to help the researcher gain a deeper understanding. Thematic analysis involves immersing oneself in the data in order to identify common ideas or *themes* that emerge based on the phenomenon under investigation and that resonate with the research question(s) posed in the study (Peterson, 2017).

Rationale for Narrative Analysis

Narrative analysis was chosen to address the research questions because of its focus on lived experience and constructed meanings. Feelings of inadequacy, incompetence, imposter syndrome, and self-doubt are complex sensations that influence various parts of the person as a therapist. Thus, to study them requires an in-depth witnessing and examination of these experiences. Narrative analysis was also chosen because of its potential to more profoundly influence the reader through individual's lived experiences, and make the role in which research is absorbed and applied compelling and relatable. Within this framework, I intended to provide a supportive space for participants to share their experiences openly, leading to potential for greater insight, community, and healing.

Data Collection Procedures

Recruitment Procedures

A request for participants was posted to Music Therapists Unite and Music Therapists for Social Justice Facebook pages. Contained in the body of the post was a link to a demographic questionnaire in the form of a Google Survey for interested participants to fill out. Participants were chosen from the group of respondents with the following criteria in mind:

a.) The participant is a music therapy clinician.

b.) The participant has had experiences of feelings of clinical inadequacy.

c.) The participant was willing to share lived experiences of feelings of clinical inadequacy in an interview style format.

d.) The participant did not directly know the author of this research.

e.) The participant has access to an internet connection and a device to utilize the interviewing platform.

f.) The participants represented as diverse a group as possible.

Participant Demographics

Participants were selected based on a number of considerations in order to have a diversity of experiences and worldviews. Each interested party filled out a demographic survey on Google Forms, disclosing responses to the following categories: name, age, race/ethnicity, gender identity, sexual orientation, residential region, highest level of education, years worked as a professional music therapist, and to list the populations with whom they've experienced working with. After reviewing the submitted materials, and debating over what criteria to choose for the selection process, given the lack of diversity in terms of sociocultural identities, it was decided that the most diversity would come from how long and in what clinical context they had been practicing in the field of music therapy. Thus, out of twenty-nine applicants, two participants who had been practicing for 1-3 years, three participants who had been practicing between 4-6 years, and three participants who had been practicing for 7 years or more were chosen to participate. Six out of these eight participants submitted consent forms and scheduled a time for a virtually recorded interview with the researcher. The following chart illustrates each selected participant's pseudonym (changed for confidentiality of this study), years of practice in the field of Music Therapy, current practice setting at time of interview, gender identity, race, sexual orientation, and highest level of education.

Pseudonym	Years in Field	Current Practice Setting	Gender Identity	Race	Sexual Orientation	Highest Level of Education
Mandy	1-3	Hospice	Female	Caucasion	N/a	Bachelor's MT
Amanda	1-3	Medical	Female	White	Straight	Master's MT
Tony	4-6	Medical	Male/Queer	White	Gay	Bachelor's MT

Brandy	4-6	School	Female	White	Straight	Master's MT
Tammy	7+	Assisted Living	Female	White	Straight	Master's MT
Amy	7+	Mental Health	Female	White	Straight	Master's MT

Pre-Interview Procedures

Following the selection, participants were informed they were chosen to participate in a virtual interview on Zoom with no time range presented. They were sent an informed consent form (see Appendix A) approved by Slippery Rock University's Institutional Review Board (IRB). Communication was available via email for any questions the participants had about the study. Once their questions were answered and consent forms signed and returned, participants were asked to prepare for the interview by preparing at least two experiences of feelings of clinical inadequacy to share during the time spent together.

Interview Procedures

Semi-structured interviews were conducted and recorded via Zoom and transcribed verbatim. The participants explored a minimum of two specific moments where they experienced feelings of clinical inadequacy, guided by the interview questions.

Data Analysis and Interpretation Procedures

Interpretivist data analysis is a cyclical and dynamic process (Creswell, 2014), and it can completely render any attempt at a procedural approach. Thus, throughout analysis, I attempted to remain grounded and aware of how my own lived experiences shape my interaction with the presented data. Getting to the stage of coding was a resistant path for me, I wasn't ready to face the data out of fear it would harm the safety of my internal landscape. It took encouragement from my supervisor and cohort to dive into the material and I am grateful for the support and

patience. Additionally, I spent more time really combing through the data, reading and rereading it until themes and subthemes clearly emerged and felt consistent.

To begin the analysis process, data in the form of the transcribed interviews were uploaded into ATLAS.ti, a qualitative research software program that was helpful in organizing and managing the codes. The interviews were manually coded by selecting significant quotes and using a word or phrase to denote their meaning. I also noted *how* stories were communicated, such as incorporating the use of humor or inflection. As I read and re-read the transcripts, patterns continued to become clearer and various codes were merged together. Lastly, the researcher consulted with their academic advisor to consolidate codes into sub-themes and create overarching themes.

Human Subjects Review

This study was approved by Slippery Rock University's Institutional Review Board (IRB): Protocol #: 2020-051-56-A.

Researcher Trustworthiness

This researcher selected direct quotes to support the analysis. On a regular basis, reflexive conversations took place with research supervisor.

Ethical Considerations

In addition to this study being approved by the IRB, the researchers took steps to minimize bias. Such as journaling, creative processing, and discussing codes/themes with research advisor and cohort.

Findings

Within the content of these six interviews participants shared various instances of feeling clinically inadequate. Some feelings of inadequacy seemed to be in response to external sources

and some from internal ones. Each participant revealed strategies they used to challenge their feelings of clinical inadequacy. Participants shared how these feelings impacted their clinical stamina, their relationship with clients, client families, and colleagues, as well as how these feelings revealed deeper personal insights that remained while within the clinical space. These findings also reveal the difficult aspects of what a real music therapy career might look like on a daily occurrence, one that balances out the success stories communicated in much of the literature. That is, the findings illuminate the humanity beneath the title and certification of the practitioner.

Five themes emerged in the data with twenty-one subthemes from seventy-seven final codes. The five main themes were: 1) professional development issues, 2) workspace issues, 3) intrapersonal issues, 4) felt experiences, and 5) coping strategies. Each theme and subtheme will be explored in detail throughout this section. Quotes will be provided as examples and will be in italics when given their own paragraph or placed in quotation marks when included in a paragraph. Quotes were taken directly from the participants at the time of their interviews. To distinguish between participants and to ensure continued confidentiality, each person was assigned a pseudonym and any identifying information was excluded from the quotes.

Table 1

Experiences of Feelings of Clinical Inadequacy

Theme	Example Quote
Professional Development Issues	"…we're not going to be equally competent in all these many many skills that we need and the many different strengths and challenges and the people we face. You know, they are going to be so varied."
Workspace Issues	"I don't think it helps that we're part of a practice that is incredibly broad. I mean, you're expected to know speech language concepts, cognitive behavioral

	concepts, psychodynamic concepts, behavioral concepts, etc. We're expected to draw on all these little bits of different professions and be competent in all of them and it's like, 'How do I even begin to feel adequately prepared in all of those things if I say a music therapist scope of practice is this big?"
Intrapersonal Issues	"I think some of that discomfort comes when you meet somebody for the first time or you know, you've only been working with somebody for a week or two and some of that just kind of comes with a new person of, "Alright" You want to make sure you're doing the best job and you want to make sure you're getting to know them by asking the right questions, but you know, I know there's a big difference of you know, different personalities too."
Felt Experiences	"I think it can become bad when I'm questioning, *'Am I a competent therapist? What am I even doing in this room?'* And that's getting in the way of the interaction between the client and me where my feelings are now the dominant thing in the therapy space, is my feelings of uncommon incompetence versus the clients feelings of whatever is going on that day."
Coping Strategies	"I think it (feeling clinically inadequate) can be good when it spurs us to reflective practice, *'Am I doing the right thing at this moment for this client?'*"

Professional Development Issues

Within this theme four subthemes emerged representing one hundred and fifty-six total codes shown in parentheses: Insufficient knowledge (81), lack of training (28), lack of experience in field/setting (39), lack of professional support (8).

Insufficient Knowledge. All six participants commented on the amount of knowledge, clinical situations, and skills necessary to be in the positions they were in. Amy (she/her), beginning her twentieth year of practice, said she went to graduate school for music therapy after

five years and said, *"it's almost like the more I learned, the more, just like anything, the more I realized I didn't know".*

Participants expressed how switching work environments and clientele elicited feelings of insecurity and self-doubt. Brandi shared about transiting to virtual music therapy in schools, *"I'm now fully virtual at my school and offer therapy to the children through Zoom instead of going into every classroom. So, now I'm working online and working with parents, no teachers or aids, and there are language barriers. A lot of parents speak Spanish or Arabic, I don't speak either of those languages, yet I'm trying desperately to communicate what I need them to do because they're my co-therapist now."*

Tim shared how it is possible for him to feel inadequate without being incompetent, *"I can feel like I don't have what that client needs and still be competent within my scope of practice. I can still be competent within my area of work."* Tim and Mandy both acknowledge knowing where the practitioner's scope of practice begins and ends is important and can either prevent or add to feelings of clinical inadequacy. Mandy shared, *"I find myself leaning into playing it safe, which I think is good because I've learned to kind of stay within my scope of practice."* (Nods head. Deep breath). *"I think that feels comfortable but at the same time, when I think of music therapy as my job, I want to be able to do more I suppose."*

Three participants commented on how musical competence influenced a feeling of clinical inadequacy. Amanda reflected on feeling inadequate in music theory competence, *"Every choir I've always been in, I learned everything by ear so I guess I'm your typical vocalist where 'oh you learn everything by ear anyway, you don't really have to read music. Ha-ha.' But ya know it's like any choir you're in it's like, 'you'll learn music eventually'. And it's like, 'When's eventually? I kinda need to know that..'"* Tim shared, *"I need to be on it with my music*

and I think that adds another layer of inadequacy because it's not just myself, the client, and our relationship, we also have my relationship to music, the clients relationship to the music, and our shared relationship to the music. So I think when you add in a third force, suddenly there's a whole new realm to feel inadequate about." Amy shared how different instruments bring different feelings for her, *"If I make a mistake on the guitar, I just keep rolling. Nobody's going to know. If I make a mistake on the piano, I might have a much more difficult time recovering."*

Lack of Training. One participant, Amy, reflected on the inadequacy that arises due to lack of licensure, *"So there's that not having a license. I did the Masters and I could have been a couple more credits and then be able to graduate and then do the what I needed to do for the Pennsylvania LPC afterwards and I was like in a really solid state hospital job and I was like, "I just need to finish" and I didn't worry about it."* Two participants reflected on the concept of having enough competence, education, and presence in the clinical space. For example, Tim shared, *"I think it can become bad when I'm questioning 'am I a competent therapist? What am I even doing in this room?' And that's getting in the way of the interaction between the client and me where my feelings are now the dominant thing in the therapy space. My feelings of incompetence versus the clients feelings of whatever is going on that day."*

Amanda shared that her feelings of clinical inadequacy began in the beginning of music therapy coursework that involved music theory. She did not know how to read music before college. *"It was all 'can't be a music major if you don't know how to read', and I knew I didn't want to teach music, I knew I didn't want to be a performer because I hate the spotlight. So I knew I wanted to be a music therapist after seeing it and then I came in and was like, 'wow these people are trying to do so much in a short amount of time.'"* Amy shared, *"I took, you know all the lessons through college and I did everything. You know, everything is wrong. You need to*

make sure by a millimeter that your pinky is in the right place and I had never told him (instructor) *that I was also playing bass which is about here* (gestures with first two fingers widened) *instead of violin, which is here* (gestures with fingers closer to together) *and you know, just taking violin lessons or any instrument classical training in college is being told how terrible you're doing. Then as a music therapy major, you know, you have these like master performance majors turn around and glare at you. So, there's the musicianship piece."*

Mandy reflected on when the expectations of what the music therapy training would be like began to form:

> *"I think it might have started in undergrad. I think, well, I definitely think it happened before I got into my undergrad because I think that was part of the reason why I wanted to go into the field was because of what I saw, but I think it really cemented in undergrad through doing the Labs that we would do in the classroom. I felt a lot of it was very, at least in my program, it felt a bit staged and it felt a bit of 'best scenario'."*

Mandy also shared how the internship experience contributed to feelings of clinical inadequacy sharing, "*I think some of my inadequacy feelings came from my internship and I think it's very important to have internship supervisors, who are giving feedback in a good way, having really good expectations about music therapy as a field and um, yeah, I guess my point there is I think mine … I think inadequacy at least for me stemmed from internship."*

Participants also shared how the relationship to the instrument of choice impacted feelings of clinical inadequacy. Specifically Amanda was confident on the instrument she trained with in her undergraduate program, and when she played another instrument she was not as comfortable with, she noticed a direct impact on her presence in the session. Similarly, Tammy

felt it to be easy to connect with the voice as instrument, however when it came to the guitar and piano, she felt incompetent. This is reflected in the following thought Tammy shared, *"So I am a really good vocalist. And I feel really good about my vocal skills, and I am a hack pianist and I'm even worse on the guitar. So I would have my electric keyboard and my laptop and my 472 wires everywhere with me because I feel like I just can't do anything with guitar, and my skills are not good enough to be able to exist on the guitar. And I can hack on my keyboard."*

Lack of Experience in Field/Setting. In addition to feeling a lack of training, three participants reflected on feelings of clinical inadequacy being rooted in lack of professional experience. Mandy shared, *"I've had moments in group settings where I sense that there needs to be some verbal processing done and I have found that that is a time when I become nervous when I become anxious about making sure I'm saying the right thing."* Tammy explained how feelings of clinical inadequacy imerges when the data reported from sessions is arbitrary and specific to the therapist, eluding to a sense of 'making it up'. She shares, *"There isn't some outside standard there isn't some agreed-upon thing. So literally anybody else who came in and made a judgment about the decisions that I've made. They would be making it up to write like … we're all just making it up. But that doesn't make me feel better about the fact that I'm just making it up."*

Lack of Professional Support. One participant explained how feelings of clinical inadequacy were also apparent when concerning rates for services in a private practice setting. Amy shared, *"So right when I tell someone my rate, I know what kind of the going rate is and I'm not trying to undercut people not price-fixing, but I don't want to undercut or devalue what I'm doing, but I'll be like, "This is the rate but I can go down," and so I don't always say that anymore. But I am just dying to say, "but I can go down." It's tricky in part of that is, you know,*

I don't take insurance and I want healthcare to be accessible to everybody. I don't want to just see people who can afford tons of money to get therapy. So that comes into play with doing Private Practice." Amanda commented on the pressures from the field of music therapy by stating, "*I think it's kind of put on you at such a young start in your career of, 'you have to be a big name, everybody needs to know who you are, in order for you to count.'"*

Workspace Issues

Within this theme rose five subthemes representing one hundred and ten total codes, shown in parentheses. Lack of knowledge of music therapy by others (9), feeling like an outsider (49), unrealistic expectations (34), unfair comparisons (14), pressure from unrealistic parental expectations (4). The following graph illustrates this specific theme, its subthemes, and the combined codes contained within each subtheme.

Lack of Knowledge of Music Therapy by Others. Three participants reflected on educating friends and other professionals of what music therapy is. Brandi shared how music therapy is a mystery to others and how that impacts the ways in which she shares with others outside of the clinical space, *"... it's just hard when you talk about your job with people and no one gets it."* Mandy reflected, *"I think some of the inadequacy comes from our music therapy's reputation in the medical field. I would say, um,* (pauses and looks away) *I think with just the way we are prioritized; for example, I've seen in the children's hospital I work at how maybe we're not as prioritized as other therapies…"*

Feeling Like an Outsider. Three participants described feelings of clinical inadequacy having to do with letting others or self down and feeling left out. Tim shared an internal dialogue when a patient had a seizure after a music therapy intervention was implemented with a music therapy student observing,*"You over stimulated that child and he had a seizure and on top of*

that you had students watching and participating in the session. So like you have not only like quote-unquote failed as a therapist you have also failed as a supervisor." Amanda reflected on transitioning to tele-health during the COVID-19 pandemic, *"...switching to tele-health is a big one too* (source of feeling clinically inadequate), *I learned the hard way. There's not as much safety as we have when we're face-to-face and there's a lot of rejection."* Amanda expressed a lack of belonging as a music therapist within her physical location of the United States (location has been omitted to protect participant confidentiality), *"And the only place I know of where they do have music therapy that's nearest to here is two hours away. So I drive that distance to work."*

Unrealistic Expectations. Three participants revealed feelings of clinical inadequacy can occur in conjuct and as a result of feelings of helplessness, unattainable expectation, exhaustion, and being overwhelmed. While explaining the intricacy of feelings of clinical inadequacy, Brandi shared, *"I took a day off because this morning I was just like, "I can't do this today. Like I really just can't do it today." It's like I took a mental health day, but it's just like it's kind of that. It's that like that feeling of like I can't do it today."* Mandy explained, *"...(from what I experience) the idea of not being enough is because I had different expectations going into music therapy than maybe what I have (experienced)."* During the COVID-19 pandemic, Brandi shared an observation of how she is impacted within the clinical space due to how people are coping, "*Like everybody is just on their last bit of energy and understanding and everybody needs respect and understanding right now. And it's just a constant push and pull. It's just kind of weird. It's a weird time."* Feelings of clinical inadequacy can lead to burnout. Brandi articulated that *"it (feelings of inadequacy) steals all of my motivation from me."*

Unfair Comparisons. Social media plays a role in feelings of clinical inadequacy when collegues share educational advancement, licensure approval, and are focused on achievements. Mandy said, *"I think when I look at our Facebook music therapy groups I'm seeing so much, so many people in our field go on to pursue further education and I suppose like either social work. I see people doing music therapy master's, I see people becoming counselors or licensed counselors."* Amy noted, *"Facebook it doesn't help with adequacy at all for the most part unless you're commiserating with people who also feel less than."*

Tim shared the difference between incompetence and inadequacy being that which is measured by a sense of value: *"I think inadequacy falls below incompetency on the hierarchy. So I can feel inadequate without being incompetent. I can feel like I don't have what that client needs and still be competent within my scope of practice. I can still be competent within my area of work."* Mandy reflected on a tendency to trust colleagues in other fields during feelings of clinical inadequacy, *"I automatically think that people in other professionals can make better decisions and say better things than what I have to offer."*

Pressure from Unrealistic Parental Expectations. Brandi reflected on her experience within an elementary school setting and a projected expectation on parents of students, *"So I think parents come in with the expectation that maybe because they caught something early and they're going to a preschool that has all these therapists and all these resources that it will, not cure, but make their child just like more of a typical developing child, because they've caught something early."* Brandi also shared actual expectations of parents aiding in her susceptibilty to feelings of clinical inadequacy, *"So I get half the parents coming in thinking this (music therapy) is a godsend, that this is something that's going to help my child and fix my child in a way that I can't promise. Then there are parents that are like, "oh, she's just as good as a YouTube video*

like I'll plop my child in front of it (the screen) and they'll have fun." But I wonder, is it working on anything?"

Intrapersonal Issues

Within this theme rose three subthemes representing one hundred and twenty-eight total codes, shown in parentheses. Historical wounds (25), personal vulnerabilities (50), personal traits (53).

Historical Wounds. When pondering the cause of feelings of clinical inadequacy, one participant spoke of a culture that encourages specifically individuals identifying as a woman to doubt themselves in spaces they are labeled as the expert. Tammy reflected, *"maybe the useful thing to take out of that is to recognize that part of my own feelings of inadequacy are internalizing the cis hetero white patriarchy around me, you know, just like internalizing the fact that women get punished for the same behaviors that men get rewarded for."* Two participants theorized on the marginalized aspects of their worldview, i.e., gender, race, and age, and the internalization of feeling inadequate in spaces beyond only the clinical ones.

Personal Vulnerabilities. Uncertainty and feeling unsure were common ways all six participants explained feelings of clinical inadequacy. Brandi shared her thoughts after explaining the complexities of her current work transitioning to an online platform and how it feeds an uncertainty that she is on the right path as a music therapist, *"It's a whole mess of stuff and I was in a really good groove when we were in school. And now I'm kind of feeling that… kind of that pull to think, "Am I doing the right thing?"* Four participants shared how their inner dialogue goes. This tendency is reflected in the research as a "voice in one's head". This voice is specific to feelings of clinical inadequacy and was often portrayed in a question format.

Personal Traits. Personality played a role in participant's responses to the cause of feelings of clinical inadequacy. Brandi expressed a feeling of clinical inadequacy that lingers beyond the actual session and afterward when reflecting on the session:

> *"…you're left with those feelings (of inadequacy) afterwards. So I still have to be with myself the rest of the time, so even if I'm in sessions and I'm working with the kids and everything is going great, the kids are loving it, and I know that they love it; I know that it's helping the parents and I know that it's working… There is still that feeling of inadequacy when I leave the session of, 'did that really help?'"*

She and two other participants articulated a pressure they feel is self-inflicted. Brandi reflects, *"And I think it's even weirder when you're a mental health professional and you're struggling with your mental health, because you're helping others with their mental health. So like why are you struggling with it if you know exactly how to like work on it."* Tim candidly shared his internal narrative regarding an unexpected situation within a hospital unit, *"You over stimulated that child and he had a seizure and on top of that you had students watching and participating in the session. So like you have not only like quote-unquote failed as a therapist you have also failed as a supervisor."* This quote also reveals speech which illustrates a dichotomous concept of self and a perfectionism that was observed throughout dialogue of all six participants.

Felt Experiences

There were several felt responses when participants experienced feelings of clinical inadequacy. These included: emotional (8), psychological (6), visceral (13), social (5), physiological (9), and physical (7) responses.

Emotional. The most common emotional consequences of feelings of clinical inadequacy described by the participants were: depression, guilt, sadness, and shame. Tim, *"I get*

flushed. I get flustered. I think my brain goes to like 'escape, get out, preserve yourself,' and then the self critical voice starts going up like, 'What are other people thinking? Are other people judging? What are their thoughts about me? What's going on in the room right now?' The expression of 'putting on a face' came up in two interviews. Brandi shared, *"You put on this face and this understanding of, "I know what I'm doing, I'm a professional. Here's what I'm doing…" and "I thought inadequacy is just a personal thing, but no one sees you struggling with it because the faces that we tend to put on when we're working with people in general."*

Psychological. Two participants explained mental fatigue coupled with over-active mental activity and negative self-talk. Racing thoughts was mentioned at the same time as negative self-talk. Tim shared, *"And my mind goes round and round and round saying, 'What am I doing here? I think it can become bad when I'm questioning, 'Am I a competent therapist? What am I even doing in this room?'"* Tammy articulated how feelings of clinical inadequacy inspired a sense of pretending, *"There's a lot of ways the situation inspires to make you think that you're pretending to be good enough to deserve to have this job, good enough to deserve to have whatever position of authority or power, whatever, that you've got."*

Visceral Two participants described a result of feelings of clinical inadequacy being visceral, felt inside the body in the form of being in a state of survival due to feeling threatened. Mandy explained, *"So that's what I fall back on when the stress builds, then when I feel threatened then it's like oh, well, wait a minute. If things didn't go perfect, if I didn't do the right thing, the best thing that could have happened, well, what does that mean? Does that mean I'm bad? Does that mean I'm worthless? Does that mean I'm not a good therapist?"* and later on expressed how feelings of clinical inadequacy heightened her senses.

Social. Tim shared the impact on clients when he is feeling clinically inadequate:

*"That's (*feelings of clinical inadequacy*) getting in the way of the interaction between the client and me where my feelings are now the dominant thing in the therapy space, my feelings of uncommon incompetence versus the clients feelings of whatever is going on that day."*

Physiological. Mandy described feelings of clinical inadequacy being felt in the abdomen. Brandi shared low motivation as a result of feelings of clinical inadequacy. Mandy shared tension in her forehead and stuttering in her speech. Tim explained a flush feeling in his cheeks paired with rapid breathing patterns.

Physical. All participants described a lowered posture, being distracted, and overall physical tension when asked to describe how feelings of clinical inadequacy present themselves in the body. Mandy expressed, *"When I'm feeling inadequate I feel anxious, I feel nervous and I feel a bit tense."*

Coping Strategies

Reflecting on coping strategies, three subthemes were delineated from the total of one hundred and fifty codes: Honest Internal Observation (65), Professional Vulnerability/Humility (38), and Compassion (47). Honest Internal Observation included thoughts on self-exploration, self-care routines, awareness of feelings of clinical inadequacy, changing the focus, going to therapy, practicing authenticity, and being as present as possible. Professional Vulnerability/Humility encompassed seeking supervision, acknowledging what is within/out of one's scope of practice, expressing feelings of clinical inadequacy and sharing them with other professionals. Following this arose a need to normalize feelings of clinical inadequacy and to combat its isolating quality with a communal "everybody feels it" way of approaching it. Finally, strategies of generalizing the feeling, moving forward, pretending, having a plan, practicing musical authenticity, and practicing confidence are all within the Compassion subtheme.

Honest Internal Observation. Througout all interviews, some form of self-reflexivity was how feelings of clinical inadequacy were acknowledged and eventually integrated into the music therapist's practice. Tim shared, *"I think it (*feeling clinically inadequate) *can be good when it spurs us to reflective practice, 'Am I doing the right thing at this moment for this client?'"* Brandi said a self-care routine was crucial to her practice. She and Amy said therapy was immensely beneficial for both personal growth and therapeutic presence purposes. Amy shared how authenticity and, in a way, "owning the feelings" was how she managed feelings of clinical inadequacy.

Brandi, Tammy, Tim, and Mandy emphasized how changing the focus from therapist to client and the therapeutic goal lessened the influence of feelings of clinical inadequacy. Tammy shared, "*It's optional to attend my group and the purpose is enjoyment. The purpose is building something positive into the day. The purpose is making connections with everybody in the room and building a community, and so I'm not the focus. It's not about me. If it's not about me, then doesn't my success or lack of success with whatever it is that I'm trying to do, much less meaningful than what's happening towards the goals?"*

Professional Vulnerability/Humility. Throughout all interviews, vulnerability and humility within the clinical space allowed the music therapist to be honest and refine their scope of practice. Amy shared, *"It's important for us to be strengths-based…focus on our strengths, you know, be aware of our limitations; I think normalizing inadequacy is important because everybody feels it. I have friends with PhDs, who are psychologists and medical doctors and they feel inadequate too you know, I think it's it's just part of it."* Brandi shared, *"I wish there was more opportunity for music therapists to come together rather than National Conference where I have to pay so much money to get there and take days off of work and, not have any help. Some*

people's jobs pay for it, mine does not. Some people's job pays for the AMTA membership, mine does not, and I can't afford it. So, I wish that there was more opportunity for community where we didn't have to pay for it and maybe it was offered at a smaller rate that a music therapist could afford." Emphasis of supervision and scope of practice was mentioned by three participants.

Compassion. Overall, each participant offered some kind of self-compassionate strategy to cope with feelings of clinical inadequacy. Among them are generalization of feelings of clinical inadequacy, have a plan during sessions, be willing to move forward, commit to musical authenticity, and nourish confidence. Amy commented, *"How confident you are is a big part of whether or not you feel inadequate. If you believe in yourself that you can help the people reach their goals and be happy and healthy, you can overcome maybe some other things that you're lacking… We're trying to help people … I just don't believe that you do something a certain way and it's going to help so this, you know, just accepting that it's there and acknowledging it, and moving forward is important."*

Discussion

This research revealed how music therapists of varying lengths in careers experience feelings of clinical inadequacy. The following is an analysis of the findings, how these findings relate to the existing literature, and implications for the field of Music Therapy. Following this, I will discuss the limitations of this study and recommendations for future research.

The literature within the fields of psychotherapy and music therapy has shown that those who experience imposter phenomenon and feelings of clinical inadequacy have these sensations for a reason (Thériault & Gazzola, 2005; Clements-Cortes, 2006; Thériault & Gazzola, 2006; Thériault, et al, 2009; Thériault & Gazzola, 2010; Clements-Cortes, 2013; Sims, 2017). The

findings of this research revealed that the reasons for feelings of clinical inadequacy among music therapists are products of either external sources (systemic, within the field, or place of practice) or internal sources (self-doubt, personalities, and inner dialogue). For example, what was revealed in the themes of Professional Development and Workspace Issues were ways in which feelings of clinical inadequacy were credited to external sources. As an external source of feelings of clinical inadequacy, professional development included experiences of lack regarding knowledge, training, field experience, and support from other professionals. What these areas imply is that feelings of clinical inadequacy are avoidable. For example, should different knowledge be accumulated, training be modified for specific clinical skills, different field experience be attained, and if other professionals within music therapy provided spaces of support for one another, it is implied that a music therapist may be less prone to feelings of clinical inadequacy. Similarly, workspace issues revealed how the lack of knowledge of music therapy by other professionals, being the only music therapist within workspaces, in addition to there being unrealistic expectations placed upon either the music therapist or the results of music therapy, elicited feelings of clinical inadequacy. These issues being based upon a systemic lack of education implies that should there be more awareness of the clinical impact which music therapy practices offer, these feelings of clinical inadequacy could be avoided.

Within the field of music therapy, the existing research supports this finding that some causes of imposter syndrome and feelings of clinical inadequacy result from not being understood by other professionals, placing the source of these phenomena outside of one's inner landscape and self-concept (Clements-Cortes, 2006). The findings revealed that music therapists employed various coping strategies in response to external sources of feelings of clinical inadequacy. These were revealed in the theme of professional vulnerability/humility in which

there was emphasis on awareness of professional limitations. The findings indicated when there is an acceptance of where one's scope of practice starts and ends, the work the practitioner is offering makes for a more refined and effective service. This requires professional humility because it is inevitable that one practitioner will not be qualified or appropriate to treat a certain person for needs outside of their scope of practice.

External sources of feelings of clinical inadequacy seem to be things that could be addressed through education, within and outside of music therapy. Music therapy training may need to more adequately prepare future music therapists for the more mundane aspects of music therapy instead of highlighting substantial changes that, while inspirational, can set music therapists up to feel inadequate when they do not regularly observe such meaningful changes in their work with clients. In addition, there seems to be a need to more adequately educate people in related health professions about the scope of music therapy practice.

In contrast, what was revealed in the themes of Intrapersonal Issues and Honest Internal Observation were internal causes for feelings of clinical inadequacy. Some of the intrapersonal issues that lead to feelings of clinical inadequacy were experiences of limitation based on gender, and how those experiences lead to internalized narratives of self-doubt and insecurity regardless of education level or title. These findings support what has been discussed in the literature. For example, when studying imposter phenomenon and mental health, it was found that there may be an interaction with gender and racial discrimination experiences that influence one's academic performance (Bernard, et al, 2017). In terms of honest internal observation, some of the things that lead to feelings of clinical inadequacy include an absence of self-care and an unwillingness to self-reflect. These are also things that Thériault and Gazzola found in their study when interviewing eight seasoned therapists on feelings of incompetence (2006). As with the external

sources of feelings of clinical inadequacy, music therapists employed coping strategies in response to internal source of feelings of clinical inadequacy. These strategies involved self-compassion, which was a new finding that has yet to be reported in the literature. Within the field of psychotherapy, research supports and emphasizes how intrapersonal issues attribute to feelings of clinical inadequacy, indicating hope and power within the practitioner to lessen these phenomena with insight and self-inquiry (Thériault & Gazzola, 2006).

An interesting finding in this study was that the participants experienced a wide array of responses as illustrated within the Felt Experiences theme. Indeed, their experiences mirrored those of the domains listed in a music therapist's scope of practice (American Music Therapy Association, 2017). This suggests that feelings of clinical inadequacy impact the whole person of the music therapist, as the domains were created to cover all aspects of human experience. Some examples of how participants experiences mirrored these domains are as follows: psychological (dichotomous and limiting self-talk), emotional (depression, guilt, sadness, and shame), physical (low posture, tension, heightened senses, and distracted), musical (choosing a certain instrument over another, as a result of fear of messing up or not being able to be present with the client), and social (presence is directly affected). This indicates how feelings of clinical inadequacy affect a practitioner in a dynamic and prevalent way.

All interviews contained suggestions on how to deal with feelings of clinical inadequacy. These are presented within this research as Coping Strategies: honest internal observation, professional vulnerability/humility, and compassion. This provides us with useful data for music therapy educators and supervisors in terms of helping students and professionals navigate feelings of clinical inadequacy. Given that these feelings have been found to be experienced across one's clinical career (Thériault & Gazzola, 2005; Clements-Cortes, 2006; Thériault &

Gazzola, 2006; Thériault, et al, 2009; Thériault & Gazzola, 2010), feelings of clinical inadequacy should be addressed in undergraduate training, graduate training, pre-professional supervision, and professional supervision.

Feeling inadequate as a music therapist can impact not just the moment in a session when those feelings arise but can influence the therapeutic relationship if these feelings effect the therapist's ability to relate authentically. Feelings of clinical inadequacy can directly impact the client's experience if the therapist's feelings of inadequacy reduce the client's sense of trust in the therapist. Feelings of clinical inadequacy are present for clinicians at varying levels of experience and regardless of their longevity in the field. They are present at varying skill levels. Thus, feelings of clinical inadequacy cannot be equated with clinical incompetence.

Given that all participants, whether they had practiced for 1-3 years, 4-6 years, or 7+ years, experienced feelings of clinical inadequacy, it is important that we learn how to address these feelings when they arise. When discussing their coping strategies, participants provided useful information for us to consider. Interestingly, there was little focus on disciplinary practice in an effort to lessen these experiences. That is, there was little focus on improving musicianship skills through a practice routine or obtain more trainings in psychotherapy, behavioral therapy, or counseling, etc. Some participants expressed how feelings of clinical inadequacy cannot be irradicated with more practice or more certifications, because feelings of clinical inadequacy do not only pertain to skills or something that can be learned. As such, feelings of clinical inadequacy appear to be distinct from feelings of incompetence. In fact, Tim shared how it is possible for him to feel inadequate without being incompetent, *"I can feel like I don't have what that client needs and still be competent within my scope of practice. I can still be competent within my area of work."*

For the participants in this study, though, feelings of clinical inadequacy appeared to be a combination of feelings that include clinical inadequacy, imposter syndrome, and some feelings of incompetence. The imposter phenomenon has been referred to as a pervasive psychological experience of perceived intellectual and professional fraudulence (Mak, et al, 2019). Some participants seemed to feel as though they were not skilled enough in counseling techniques, musicianship skills, and administrative skills for private practice. Overall, not feeling adequately skilled seems to have led participants to feeling overwhelmed and out of their league professionally. Feelings of incompetence have been referred to as a reflection of sets of maladaptive cognitions (Bernard, et al, 2017). It seemed that three of the participants felt like they were "faking it until they made it" when their musical skills were not up to the task at hand. It seems what participants spoke of is a complex mixture of imposter syndrome, feelings of incompetence, and feelings of clinical inadequacy. This further emphasizes the need for coping mechanisms to begin within a music therapist's training and within clinical supervision contexts.

Limitations

The limitations of this study include the demographic of participants consisting of similar social location representations, all participants were white and middle class. Five out of six participants identified as cis women and heterosexual. It may have been that a more diverse group of participants would have provided even richer descriptions of feelings of clinical inadequacy and how these might be influenced by sociocultural factors.

Also, my qualitative interviewing skills were limited due to lack of research experience. There were times when I could have asked follow-up questions that could have revealed more about the participants experiences. I found that my ability to do this improved over time. It may have been good to have practiced interviewing a few people prior to interviewing the research

participants in order to refine this skill. There were many times in the process where I was dealing with my own feelings of inadequacy, as well as feelings of incompetence and imposter syndrome. Also, I did not go back to each participant to have them verify the data. This would have led to a higher trustworthiness of the findings.

Finally, I did not have a clear distinction of imposter syndrome, clinical inadequacy, and feelings of incompetence before and during this research process. As such, I did not provide the participants with a clear distinction of these prior to the interviews. Had this been more clear, my questions to participants could have helped to understand inadequacy more distinctly from these other experiences.

Recommendations for future research

The findings of this current study reveal personalized accounts of feelings of clinical inadequacy for music therapists of varying educational backgrounds, working in different clinical settings, spanning various years in the field. However, these findings are based on individual interviews with five white-cis-heterosexual women and one white-cis-gay man. Future research should seek to explore the impact of social location on these feelings of clinical inadequacy and explore in more depth the root of feelings of clinical inadequacy. Such findings could further elaborate on the constructs of feelings of clinical inadequacy for music therapists.

Another recommendation includes having an on-going dialogue with each participant every two years following up on their feelings of clinical inadequacy. This would allow for a more expanded and whole portrayal of a music therapist's experience of feelings of clinical inadequacy. It would also be suggested to provide a written assessment before interviewing to inquire on self-assessed levels of confidence/adequacy outside of the clinical space. This would

provide insight in whether feelings of clinical inadequacy relate or do not relate to feelings of inadequacy outside the clinical space.

Lastly, a future study which allows for a comparison between clinical inadequacy and feelings of incompetence and imposter syndrome would delineate what sets these phenomena apart from one another. This could help music therapists address each of these unique phenomena in education, training, and supervision.

Conclusion

From this study, feelings of clinical inadequacy in music therapy surfaced as professional development issues as insufficient knowledge, lack of training, lack of experience, and lack of professional support. Feelings of clinical inadequacy also emerged within the workspace as lack of knowledge of music therapy by others, feeling like an outsider, having unrealistic expectations, revealed in the projection of unfair comparisons, and pressures from unrealistic parental expectations. Intrapersonal issues housed feelings of clinical inadequacy in the forms of historical wounds, personal vulnerabilities, and personal traits. Furthermore, feelings of clinical inadequacy were felt experiences as emotions, psychological chatter, visceral sensations, physiological, and physical. These feelings of clinical inadequacy emerged for professionals not only as novices, but also well into their careers. Thus, more research should be done, and supervision should be encouraged. Additionally, feelings of clinical inadequacy should be discussed in undergraduate trainings, internships, graduate courses, continuing education credits, and within professional supervision.

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Appendix A.

Slippery Rock University

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Approved
6/19/2020
Slippery Rock University
Institutional Review Board

CONSENT TO PARTICPATE IN RESEARCH

Experiences of Feelings of Clinical Inadequacy as a Music Therapist: A narrative inquiry

Susan E-J. Dalessandro, MT-BC; sxd1040@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 a music therapist with years of practice ranging between 1-3 years, 5-8 years, or 10+ years and be prepared to share 2-3 experiences of feeling clinically inadequate. Access to internet connection is required. Taking part in this research project is voluntary. You can change your mind about participation at any point in the research.

Important Information about the Research Study

Things you should know:

The purpose of this study is to gather experiences of music therapists who have experienced of feelings of inadequacy in their practice at various points in their careers and to explore the possible origins of these feelings. The overall aim is to explore the implications of music therapy education on feelings of inadequacy, the possible impact of the music therapy work setting on feelings of inadequacy, and the possible impact of the music therapist's social location on feelings of inadequacy.

- The purpose of the study is to understand the experience of feeling inadequate as music therapists. If you choose to participate, you will be asked a series of questions regarding various aspects of your experience of feeling inadequate as a music therapist. Our conversation will be in the format of a semi-structured interview. This will take no longer than 2 hours in one day.
- There are no anticipated risks or discomforts as a result of participating in this research. There is a minimal chance that the experience may cause emotional or physical discomfort.
- The results of the study may provide a greater understanding of how and why we experience feelings of inadequacy as music therapists. There is no monetary incentive for participating. There is potential that participants will gain insight about their feelings of inadequacy not only limited to the role of music therapist.
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time.

Initials_____ * Every page must be initialed by research participant

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 this study is to gather experiences of music therapists who have experienced of feelings of inadequacy in their practice at various points in their careers and to explore the possible origins of these feelings. The overall aim is to explore the implications of music therapy education on feelings of inadequacy, the possible impact of the music therapy work setting on feelings of inadequacy, and the possible impact of the music therapist's social location on feelings of inadequacy.

What Will Happen if You Take Part in This Study?

If you choose to participate, you will be asked a series of questions regarding various aspects of your experience of feeling inadequate as a music therapist. Our conversation will be in the format of a semi-structured interview. This interview will be conducted on Zoom and will be recorded. The dialogue will then be transcribed once the interview is complete and the transcription will be sent to each participant to review. The interview will include the prepared two to four experiences of feeling incompetent as a music therapist from the participant, followed by questions exploring the possible impact of one's music therapy education, the music therapy work setting, and the music therapist's social location on feelings of clinical inadequacy. This will take no longer than 2 hours in one day.

How Could You Benefit From This Study?

The results of the study may provide a greater understanding of how and why we experience inadequacy as music therapists. There is no monetary incentive for participating. There is potential that participants will gain insight about their feelings of inadequacy not only limited to the role of music therapist. Various cultural perceptions and ways of being in the experience can be shared. There is the potential for personal growth through individual reflection and collaborative processing. The experience can provide a space where narratives of inadequacy can be explored and shared, and by doing so be more richly understood.

What Risks Might Result From Being in This Study?

There are no anticipated risks or discomforts as a result of participating in this research. There is a minimal chance that the experience may cause emotional or physical discomfort. Verballing processing feelings of inadequacy can bring up strong emotions, some of which may be uncomfortable or painful. The researcher will provide you with a list of accessible mental health resources in case such feelings arise.

How Will We Protect Your Information?

To protect your privacy, information that could directly identify you will not be included and pseudonyms will be created. Similarly, if the results of this study are published or presented at a professional conference, information that could directly identify you will not be included and the pseudonyms that were created will be used.

Initials_____ * Every page must be initialed by research participant

We will protect the confidentiality of your research records by storing research data on a password protected external drive which will be kept in a locked cabinet. Your name and any other information that can directly identify you will be stored separately from the data collected as part of the project.

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

We will not keep your research data to use for future research or other 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. Research materials will be kept for 2 years and then destroyed.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participation in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and may withdraw from participation at any time. If you decide to withdraw before this study is completed, any data collected during your participation will be destroyed. You do not have to answer any questions that you do not want to answer.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact me Susan Dalessandro at susan.ej.dalessandro@gmail.com or 915-203-7392, or my supervisor, Dr. Susan Hadley 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 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Initials_____ * Every page must be initialed by research participant

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. I will give you a copy of this document for your records. I 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 me 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

Audiotape/Videotape Release Form:
We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper. Regarding the use of your likeness in audiotape/videotape, please check one of the following boxes below:

☐ I do…

☐ I do not…

Give unconditional permission for the investigators to utilize audiotapes/videotapes of me.

_____ _____ _____
Print Name Participant Signature Date

PLEASE NOTE: Should you choose not to allow your audio or video to be used, we can still benefit from your inclusion as a research study participant.

Appendix B.

Research Guide Questions:

How are you? Thank you…

I'm really interested in the ways that Mts experience feelings of inadequacy.

Can you describe some moments when you have experienced feelings of inadequacy in your clinical work?

((After a rich description of an experience…))

What do you think contributed to these feelings of inadequacy?

Do you feel that your feelings of inadequacy had any impact on the therapeutic relationship? If so, how?

- Can you share with me a few experiences of clinical inadequacy?
- Would you describe moments, I know you've prepared two but are any others coming up?
- What are some of the things you feel have contributed to your feelings of clinical inadequacy?
- As a music therapist, how do you experience feelings of clinical inadequacy?
- How do you feel these feelings of clinical inadequacy manifest in music therapy contexts?
- What are the implications of music therapy education with these feelings of clinical inadequacy?
- How does your social location impact feeling clinically inadequate?
- What are the implications of the music therapy settings you've worked within on feelings of clinical inadequacy?

- **In your experience, what impact do these feelings of clinical inadequacy have on the therapeutic relationship, from the music therapist's perspective?**