

SURVEY RESULTS FOR THE CURRENT STATE OF CENSORSHIP IN ADULT  
PSYCHIATRIC MUSIC THERAPY SESSIONS

BY

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B.M. (Music Therapy), Sam Houston State University, 2014

Submitted to the graduate degree program in Music Education and Music Therapy and the  
Graduate Faculty of the University of Kansas in partial fulfillment of the requirements for the  
degree of Master of Music Education (Music Therapy)

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Date defended: April 29, 2016

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Date approved: May 11, 2016

## Abstract

The purpose of this study was to investigate current censorship practices and beliefs of music therapists working in adult mental health settings. The research questions are: (a) What music, or elements of music, do music therapists censor during music therapy sessions? (b) If music therapists censor, what are their reasons for censoring? The participants for this study were 42 board-certified music therapists who completed an online survey investigating their current censorship practices within sessions. Censorship was broadly defined as music therapists refraining from using, or redirecting clients away from using, certain lyrics, themes, songs, or genres of music during therapist planning and facilitation of sessions. The majority of respondents (78.57%) censor at least one musical element, including themes (69.05%), lyrics (66.67%), and genres (16.67%). Reasons for censorship revolved around issues with treatment, including other group members' responses, client comfortableness, emotional distress, self-esteem issues, and negative impact on the therapeutic relationship. However, about 25% reported personal beliefs affected censorship, such as their comfort with the content, religious beliefs, and believing the client cannot benefit in any way from hearing the music. Further research needs to be conducted on how lyrics, themes, and genres impact clients, and if these elements facilitated by a music therapist could be used to address and work through some of the issues and concerns presented by the music.

## Acknowledgements

Foremost I send my gratitude to my parents, Lynné and Rod Joplin, who have supported and encouraged me throughout my academic career since childhood. Without their unconditional love and support this journey would have been much more difficult. In addition, my many friends, who have provided the social support necessary to get through this and many other challenges.

I thank my wonderful thesis chair, Dr. Abbey Dvorak, for providing much needed guidance and patience. All the help and support she has provided has been invaluable, and the enthusiasm maintained for the topic helped keep me going. Her insight throughout this study has helped solidify my will to conduct research and make an impact on the music therapy profession.

Dr. Deanna Hanson-Abromeit and Dr. Colin Roust have wonderfully and graciously accepted to be committee members for this study, and deserve many thanks. Their passion, knowledge, and perspectives on the topic have served greatly to help improve this study in extraordinary ways.

Much of my growth the past two years as a researcher, professional, and individual can without a doubt be attributed to these individuals and the rest of the music education and music therapy faculty at The University of Kansas.

## Statements of Personal Bias

In my undergraduate training I was taught, “don’t open a can of worms you do not feel capable of closing,” and did not know exactly where the line should be drawn on topics to discuss in sessions. When I got into my internship I had supervisors who did not censor music, and discussed the importance of helping clients work through any major issues that were getting in the way of their treatment goals. Additionally, throughout my training, client preferred music has always been discussed as an important factor in music therapy sessions. I often felt as though I should address these issues through music my clients enjoy, but at times felt uncomfortable doing so. It seemed unprofessional to use certain words and talk about certain issues, even if I knew it might be beneficial for a client. I wondered what other professionals would think of the treatment I provide if they walked by and heard a rap or heavy metal song, even though I enjoy both rap and heavy metal, and know they could be powerful genres to work through issues. I sought answers to the questions I had regarding censorship and found there was no existing research. I am hoping this research study can begin a discussion in the field so music therapists can be reflective about their censorship practices. Lastly, I hope this research can lay the foundation for future research on the topic.

## Table of Contents

Abstract .....	iii
Acknowledgements .....	iv
Statement of Personal Bias .....	v
Table of Contents .....	vi
List of figures .....	ix
List of tables .....	x
Chapter 1: Introduction .....	1
Defining Censorship .....	1
Censorship of Various Musical Elements .....	2
The Third-Person Effect .....	5
The Therapeutic Relationship .....	6
Therapist Choices in Music Therapy.....	7
Mental Health Populations .....	8
Summary .....	9
Chapter 2: Review of Literature .....	10
Introduction .....	10
The Third-Person Effect .....	10
Impact of the Therapeutic Relationship .....	12
Profane Content .....	13
Thematic Content .....	15
Genres .....	17
Rap .....	17

Heavy Metal .....	19
House Music .....	21
Conclusion .....	22
Purpose Statement and Research Questions .....	23
Chapter 3: Method .....	24
Purpose Statement and Research Questions .....	24
Human Subjects Committee .....	24
Participants .....	24
Study Design .....	25
Procedure .....	26
Data Analysis .....	26
Chapter 4: Results .....	27
Participants .....	27
Demographic Information.....	29
Censorship of Music by Music Therapists .....	32
Lyrics (Warning: Explicit Content on p. 34).....	32
Thematic Content .....	35
Genres .....	36
Inconsistent Responses .....	37
Lyrics .....	37
Thematic Content .....	38
Genres .....	38
When Music Therapists Censor Musical Elements .....	39

Reasons for Censoring in Music Therapy .....	40
Summary .....	42
Chapter 5: Discussion .....	43
Findings .....	43
Limitations, Delimitations, and Assumptions.....	45
Clinical Implications .....	46
Future Recommendations .....	47
Conclusion .....	48
References (Warning: Explicit Content on p. 52).....	50
Appendices .....	58
Appendix A: Consent and Confidentiality Email Invitation .....	59
Appendix B: Censorship Survey (Warning: Explicit Content on p. 62-63).....	60



## List of Figures

Figure 1: Participant Flow Chart .....	27
Figure 2: Censored Lyrics .....	33
Figure 3: Censored Profane Words (Warning: Explicit Content) .....	34
Figure 4: How Music Therapist Censor Lyrics .....	35
Figure 5: Censored Thematic Content .....	36
Figure 6: Censored Genres .....	37

## List of Tables

Table 1: Demographic Information of Participants .....	29
Table 2: When Music Therapists (MT) Censor Musical Elements .....	39
Table 3: Reasons for Censoring Musical Elements.....	41

## Chapter 1: Introduction

### Defining Censorship

Defining censorship is difficult, and researchers have different perspectives on the defining parameters, specifically the timing of when it occurs. Cloonan (2004) even suggests that developing a definition for censorship is not possible due to the myriad of factors influencing censorship, including the level of the alteration of the material, when it occurs, and who can be a censoring entity. Merriam-Webster (2015) defines censoring as, “To examine books, movies, letters, etc., in order to remove things that are considered to be offensive, immoral, harmful to society, etc.” This definition means material has to be completely deleted for censorship to occur. Furthermore, this definition means censorship occurs after the expression of the material, and not before. Billiani (2003) also has a definition focused on “manipulative rewriting,” suggesting censorship happens *after* the fact (p. 3).

In contrast to outright elimination of material, many definitions describe a process through which censorship occurs on a continuum (Blom-Cooper, 1977; Cloonan, 2003; Hampshire and Nuzum, 2001; Jansen, 1991; O’Higgins, 1972). These authors describe censorship as a continuum from variations of any type of suppression (e.g., restriction, control) to any process in which the content is made less available (e.g., banning, elimination). This continuum suggests censorship may also occur *before* expression; thus, restricting or controlling what can even be expressed could be defined as censorship.

When defining censorship, other authors discuss a ruling power as being the censoring force (Hampshire and Blom-Cooper, 1977; Jansen, 1991; Marsh, 1991). In a therapeutic relationship, the power differential is skewed in favor of the therapist (Forrest, 2014; Llorens, 2009), and in a therapist-client relationship, the power of the therapist increases over time

(Gottlieb, 1993). Hill (2014) describes this power increase occurring over several stages in the helping process. In the first stage of the helping process, the therapist is mostly quiet and actively listens to anything the client is expressing. With each subsequent stage, the therapist takes on a bigger role by asking more questions, and eventually offering insights (Hill, 2014). In music therapy, this therapeutic relationship, and the resulting power shift could occur in a similar manner.

Music therapists develop a therapeutic relationship with clients and carefully choose music and music interventions to best meet the needs of the clients. In order to do this, music therapists may be considered a censoring force through decisions related to the suppression or availability of certain pieces of music used within the therapeutic setting. Therefore, censorship in music therapy practice may be defined as music therapists refraining from using, or redirecting clients away from using, certain lyrics, themes, songs, or genres of music before (i.e., therapist planning), during (i.e., therapist facilitating), and/or after (i.e. censoring clients' music or verbalizations after they have been stated) expression.

### **Censorship of Various Musical Elements**

When looking at the myriad of factors that lead to music censorship, therapists also need to consider all the different elements of music (e.g., melody, harmony, lyrics, rhythm, style), and the possibility of needing to censor any of them. Perceived negative effects of musical elements are documented throughout written history. Plato (360 B.C.E.) describes the need for banning Ionian and Lydian modes due to the wailing, drunken, soft, or idle nature of them that is unsuitable for decent women, let alone men who go to war. Following the notion of banning these modes, Plato states he does not want to support makers of instruments such as the harp, lute, or anything that can play many modes. Lastly, he touches on the need to find rhythms that

are appropriate for an, “orderly and courageous life,” (Plato, 360 B.C.E.). The censorship he describes appears to include melodic components, harmonic structure, style of music, and timbre of different instruments.

In today’s society, when thinking of censorship in music, obscene lyrics are a point of discussion. The use of profanity in language allows for emotional outlet, and can release anger or frustration without the use of physical violence (Jay & Janschewitz, 2007). This evolutionary step distinguishes humans from other animals, who may resort to physical aggression (Jay & Janschewitz, 2007). Some might say the use of profanity is a positive step toward expressing oneself; however, physiological responses and an increased state of arousal may manifest from hearing and using profanity (Jay & Janschewitz, 2007). Within a group setting, being aware of reactions to these words could be critical to ensure an escalation does not happen between individuals in the room. Profanity can express more positive forms of emotions as well, such as surprise and happiness. Appropriately experiencing and expressing different emotions, whether positive or negative, may be a goal within therapy.

Other than specific words, topics within songs could have the potential to elicit certain emotions or reactions detrimental to the therapy process. Many songs across genres are about violence, thug life (e.g., gun violence, belonging to a gang, hustling), drug usage, and unhealthy relationships. In their song, *Otherside*, Macklemore and Ryan Lewis (2010) state, “Us as rappers underestimate the power and the effects that we have on these kids.” This concern over the harmful societal effects of rap is heard in other rappers’ songs or interviews as well (B, 2015). However, when clients leave music therapy, they will be exposed to all types of music and need to have skills to manage negative thoughts and emotions appropriately. A therapy setting should be a safe place to have open conversations and explore different routes of coping with topics that

may be triggers. Horesh (2005) talks about using music that may trigger drug cravings in his clients as a way of opening verbal and musical discussions of emotions, behaviors, and consequences aroused by the music. Thus, the use of “harmful” music may be a beneficial tool to help clients work through issues and become equipped to handle similar situations outside of therapy.

Along with what is said, *how* something is said can express and evoke different emotions. If someone is screaming within a song there is perceived anger or frustration. Gowensmith & Bloom (1997) found heavy metal increased arousal of all participants. For anger levels in particular, Bloom found an increase for participants who do not regularly listen to the genre, but no affect those who self-reported enjoying the genre. In addition, siren sounds, gunshots and noises related to contemporary drug culture are commonly used in popular music. There is potential for these sounds to be associated with delinquent or defiant behaviors. Electronic timbres also have the potential to be perceived as club music, eliciting possible associations with alcohol and drug use (Hawkins, 2003; Kavanaugh & Anderson, 2008).

These different musical elements appear to be used either more or less frequently based upon the genre of the music. Hardcore, screamo and metal are examples of genres that use harsher timbres. Rap music is often criticized for its use of vulgar language and topics of misogyny and violence (Elligan, 2004). Psychedelic and house music are examples of genres one might associate with drug usage. While there is social criticism and speculation in how characteristics of different types of music may have the potential for negative or harmful outcomes, there is still little understanding of the relationship between the characteristics of the musical elements and the efficacious or harmful clinical outcomes. Therefore, some music therapists may censor entire genres of music within the clinical setting without having a

therapeutic rationale for censorship, or fully understanding the potential for therapeutic effectiveness.

### **The Third-Person Effect**

Music therapists need to consider why they are censoring. Personal beliefs and agendas typically cause censorship, and musical choices in therapy must generate from what is best for the clients in the moment, which could be different from what therapists would choose for themselves. The *third-person effect* was theorized by W. Phillips Davison in 1983 as a way to determine why censorship occurs. Rojas, Shah & Faber (1996) define this effect as believing media content has an impact on an unspecified “them,” but individuals themselves believe they are not as strongly influenced. In other words, individuals are either underestimating the effects of media on themselves or overestimating the effects of media on others. It is not known exactly why this occurs. Rojas, Shah, and Faber (1996) suggest this effect could coincide with the *attribution error*, in which people overestimate personal factors and underestimate environmental factors for others’ behaviors, while holding the opposite as true for themselves. If people follow this error, then they could believe that the negative intra- and interpersonal qualities profanity and lyrical content evoke in a person would not be balanced by other influences in their environment. This would make people more susceptible to believing others incapable of self-regulating the effects of musical content.

Researchers identify the third-person effect as occurring, and greater third-person perceptions correlate with greater support of censorship (Shah, Faber & Youn, 1999; Perloff, 2009; Park, Yun, Choi & Lee, 2012). Therapists could be unknowingly influenced by this phenomenon in their music choices with clients, and should take steps to ensure their biases are not impacting treatment. If music therapists are censoring due to these biases, they could be

prohibiting clients from working through musical triggers that music therapists could address, and creating a rupture in the therapeutic relationship.

### **The Therapeutic Relationship**

The therapeutic relationship is the interaction between the client and therapist. Across many different theoretical approaches it is accepted that this relationship is an important component for positive outcomes. Lower therapeutic relationship scores were found to significantly predict higher instances of voluntary and involuntary hospitalization, as well as more self-harm and suicide attempts in the next 18 months for clients experiencing psychosis (Farrelly et al., 2014). It is possible censorship could impact the therapeutic relationship between the therapist and client. In fact, Nuzum (2001) goes so far as to say that censorship is a discriminatory act, which therapists would want to avoid. Discriminatory acts, such as censorship, may decrease important aspects of the therapeutic relationship.

An important piece of a positive therapeutic relationship is *empathic resonance*. Empathic resonance is defined as the client feeling well understood by the therapist (Wiprovnick, Kuerbis, & Morgenstern, 2015). A component to clients feeling understood and accepted is for therapists to have a positive regard for them. *Positive regard* is defined as an unconditional acceptance of what the client presents, and was found to be a moderate factor in therapy outcomes in a meta-analysis of 18 psychotherapy studies (Farber & Doolin, 2011). Censorship of clients' musical expressions would not be considered positive regard. Creating an environment in which certain words and topics cannot be expressed may decrease the trust and openness between the client and therapist. Yet, perhaps not censoring these songs or genres could lead to outcomes opposite of treatment goals.



In music therapy, a way to build the therapeutic relationship is through the use of client-preferred music (Kim & Whitehead-Pleaux, 2015; Grocke & Wigram, 2007). There are times clients' preferences may include content that could be perceived as vulgar, or topics that appear to be in contrast to treatment goals. When this occurs, it is up to the therapist to determine if the positive outcomes of using client preference outweigh the potential negative effects of the musical elements when working towards these goals.

### **Therapist Choices in Music Therapy**

Censorship is prevalent throughout society. As a music therapist, it is important to think about the potential effects of every musical and verbal choice made in sessions, including whether or not to censor. Because music has the ability to engage others mentally, emotionally, spiritually, and physically, music therapists need to be careful of what they present in order to promote a safe environment for all clients to express and work through issues (Bruscia, 2014). It would be unethical for therapists to knowingly and purposefully expose clients to harmful situations, including situations that could arise from music. Safety is not only imperative in sessions, when clients leave the therapy session they need to be in a state of mind conducive to appropriately managing the following hours and days. This ensures they can remain in a state that is safe for themselves and others. The choice to censor could be an ethical decision to ensure healthy moods and actions.

Hill (2014) states sometimes the content of what is said in therapy is not as important as what is being emotionally felt about the topic. However, much of the literature on developing skills across many therapeutic fields consists of verbal techniques deemed either positive (e.g., avoiding "why" questions, asking open-ended questions, summarizing responses) or negative (e.g., using aggressive language, asking questions with a "right" answer, not giving time for

client responses) (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003; Hill, 2014; Nolan, 2005; Short, 2013). Within the scope of practice for music therapists, the Certification Board for Music Therapists (CBMT) and the American Music Therapy Association (AMTA) (2015) include recognizing the potential for harm that musical and verbal experiences can elicit, and making the choice to refrain from using such harmful material. It is imperative that music therapists research the effects of the different elements of music (e.g., genre, lyrical, and thematic content) to determine the most beneficial interventions. Currently, no research exists on the state of music censorship within music therapy sessions. Research needs to be conducted to determine if, why, and how music therapists are censoring music provided for, and created by, clients.

### **Mental Health Populations**

Within the mental health setting, common music therapy goals related to appropriate self-expression include: improving communication skills; promoting coping skills; decreasing tension, stress and anxiety; and expressing emotions. Bruscia (2014) defines self-expression as, “Merely the release of what is inside, without any concern for whether the expression is understood by the outside world and without any concern that it will offend or harm anyone or anything,” (p. 80). Healthily being able to self-express, however, would include being able to self-censor within public environments, and contain certain emotional responses until an appropriate time and means of release can be performed. In other words, there are times when it would be beneficial for clients to refrain from expressing intense emotions (e.g., crying in a business meeting, yelling during class) and find a healthy way of releasing these feelings when they are in a more appropriate environment for that expression (e.g., at home or with supportive friends).

To address self-expression goals, common music therapy interventions used in mental health settings include improvisation, lyric analysis, songwriting, music-assisted relaxation, and receptive music listening (Silverman, 2007; Silverman, 2015). In all types of interventions, therapists need to consider the therapeutic effects of all musical elements on client progress. Music is specifically used in therapy because of its ability to evoke emotions and allow clients to experience difficult topics in a safe environment. Consequently, every choice within music therapy needs to be made with purpose and intentionality.

### **Summary**

Musical elements may generate a variety of both positive and negative responses, and because of the potential deleterious effects of some music genres or characteristics, censorship is a common practice within the history of the music industry. In music therapy, in order to build a therapeutic relationships with clients which may increase progress toward treatment goals, preferred music is often used. To ensure quality and ethical practice, music therapists need to ask themselves about the appropriateness of their decisions to censor client preferences, and the potential ramifications of their choices. Due to a lack of research, the extent of censorship occurring in the profession of music therapy is currently unknown.

## Chapter 2: Review of Literature

### Introduction

Writers have discussed censorship of music throughout history (B, 2015; Blom-Cooper, 1977; Cloonan, 2003; Hampshire and Nuzum, 2001; Jansen, 1991; O'Higgins, 1972; Plato, 360 B.C.E.). However, the impact of profane content on individuals and the reason for censoring content are relatively unexplored. The third-person effect, and the causes of the effect, have the most research to date in the field as to why censorship occurs. However, within the context of therapy, the impact of profane content on the therapeutic relationship has minimal research. Other than the impact on the therapeutic relationship, the potential for causing harmful reactions in individuals is a necessary area for investigation, as avoiding harm is part of the code of ethics and competencies for music therapists (AMTA, 2015; CBMT, 2015). Looking into the impact of certain lyrics, themes, and genres warrants further study.

### The Third-Person Effect

The third-person effect is used to explain what may contribute to individual censorship views. The effect states people believe they are less affected by media influences than others are affected, and highlights the fact that individuals tend to overestimate the effects of socially unacceptable content and words on others' actions (Perloff, 2009; Rojas et al., 1996; Scherr and Reinemann, 2011). The three theories of projection, self-enhancement, and attribution error attempt to describe why the third-person effect occurs. Perloff (2009) suggests the third-person effect is related to the psychodynamic concept of *projection*; that is, the media influences people, but peoples' egos cannot consciously accept this, so instead they project the influential effects onto others. Others believe the third-person effect could stem from a human need to view the world in a way that puts oneself above, or better than, others; this *self-enhancement* theory is

believed to be the one with the most evidence (Perloff, 2009). Rojas, Shah & Faber (1996) highlighted the similarities of this effect with the fundamental attribution error. The *attribution error* states humans overestimate the influence of environmental factors on others' behavior, while underestimating a person's intrapersonal influences. The opposite holds true for themselves - they underestimate environmental factors and overestimate intrapersonal influences. These three theories of projection, self-enhancement, and attribution error have some similarities in the third person effect. They all relate to an individual's desire to place themselves above others, intentionally or unintentionally, causing individuals to believe they are better able to resist potential influences from their environment, including the media. Thus, these similarities allow individuals to subconsciously maintain the idea that they themselves are greater than others (Rojas, Shah & Faber, 1996).

Scherr and Reinemann (2011) tested the third-person effect on suicidal ideation in self and others with participants watching a rock music video with suicidal content. They found people with low depression scores perceived the effects of the video to be greater for others compared to them self. People with high depression scores rated suicidal ideation from the music video for both themselves and others the same. The rating they gave for themselves and others was about the same as the participants with low depression scores rated others. The content with suicidal themes more strongly influenced suicidal ideation for patients with high depression scores. This is vital to note for mental health settings, as the goal could be to decrease suicidal ideation, and therapists need to make conscious decisions based upon client diagnoses. Thus, music therapists may choose to censor music videos with suicidal content.

Within music, McLeod, Detenber, & Eveland (2001) suggest people are less likely to want censorship of obscene lyrics for their preferred musical genre, but support it for non-

preferred genres. This corresponds with the idea that increased exposure to a topic inhibits censorship beliefs (Rojas, Shah & Faber, 1996). In contrast, Eveland, Nathanson, Detenber, & McLeod (1999) found that participants believed with more exposure to violent and misogynistic, rap and death metal songs, the negative influence on others would increase. This highlights that although increase in exposure might actually decrease negative influences, individuals believe the opposite to be true.

### **Impact of the Therapeutic Relationship**

Relationships between client and therapist are a major indicator in client outcomes (Farrelly et al., 2014; Farber & Doolin, 2011; Lambert & Barley, 2001; McCabe & Priebe, 2004). Due to the importance of this relationship on client outcomes, it is imperative for therapists to build this therapeutic relationship. The relationship determines how the client perceives the therapist, provides the foundation for effective sessions, and motivates the client to work through problems with the therapist. To build the relationship, Hill (2014) describes the need for therapists to modify their grammatical style to match the clients' without compromising their own integrity. If a client uses more relaxed language the therapist should not necessarily match the style fully, but should also use language that is not too technical or clinical.

Sometimes building a therapeutic relationship with clients is difficult. At times, clients may express emotions such as anger or extreme excitement; profanity is one way for people to express such emotions without physical actions. When this happens, therapists make choices to address the language or the content of what is being expressed. If clients are expressing anger, therapists should listen empathetically and non-judgmentally, and should encourage clients to express that anger verbally rather than physically (Hill, 2014). Music therapists can also encourage clients to express this anger through songwriting. When expressing anger through

songwriting, clients may write lyrics containing profanity or themes that could have serious implications (e.g., show they are unable to appropriately manage anger, show cravings for drug use, show homicidal/suicidal ideation). The therapists could allow for this expression and use it as a tool to process those emotions. Furthermore, music therapy is unique in that it can actually allow for the expression of anger physically. Clients can play an improvisation or create a song that is in a genre or style typically viewed as angry or aggressive in order to release some of those emotions. For example, clients may play drums loudly or write or play a song in a heavy metal style. Censoring these forms of expression could prevent clients from working through issues and learning appropriate expressions of negative emotions.

Kottke & MacLeod (1989) found that when given audio of a session in which the client, therapist, both, or neither use profanity, college students rated both instances of the therapist using profanity as unprofessional, insensitive, and disrespectful. Participants were also significantly less likely to refer themselves to the therapist. In contrast, when the client used profanity the therapist was perceived as being more of an expert, more trustworthy, and more attractive. This leads to the question of who is truly speaking the profane words when re-creating a song (i.e., playing a previously recorded song live instead). It could be perceived the music therapist is merely recreating another's words, or that the therapist is personally using profanity. If the song is recorded, it is possible this perception could change when compared to live music.

### **Profane Content**

Although profanity may be viewed in a negative light, it may also have positive effects, including an increased pain tolerance (Stephens & Umland, 2011; Stephens, Atkins & Kingston, 2009; Vingerhoets, Bylsma & de Vlam, 2013). Jay and Janschewitz (2007) report the use of profanity as a positive step in human evolution to express high arousal states. This development

allows for expression of negative emotions in a manner that is not physically violent, and can be used to express positive emotions such as joy and surprise. Furthermore, Jay and Janschewitz (2007) state profane words have a gradability, with some being perceived as more obscene than others. The authors also describe the important role of relationship between speaker and listener in the perception of profanity. For example, depending on the relationship, racial slurs can be perceived as either negative or positive.

Profanity appears to have mixed results based on who is speaking. Looking at protagonist versus antagonist use of profanity, Ivory & Kaestle (2013) found profanity from either character increased hostile expectations, but did not impact the participants' accessibility of aggressive thoughts or perceived arousal. However, antagonist use of profanity decreased participants' aggressive affect. In other words, when the entity opposing the main character uses profanity, people had a decreased aggressive affect, indicating they were responding less aggressively to the situation.

In addition to the person speaking, the perception of profanity is affected by the situation. Vingerhoets, Bylsma & de Vlam (2013) analyzed research previously conducted on profanity and found that criminal testimonies that included those words were perceived as more credible. However, other circumstances in which profanity was used decreased credibility. Criticisms using profanity by a sports coach were less effective, but profanity used in positive statements in coaching led to greater effectiveness for male sports teams. Group use of profanity was found to increase group cohesion, and non-members of the group became more accepted with the use of profanity. In contrast, it can lead to fear and hostility, especially when the profanity is directed toward one another. There are myriad factors in language that elicit responses, and it appears that profanity is not the sole cause of negative outcomes (Vingerhoets, Bylsma & de Vlam, 2013).



Although profanity may have a positive effect on a group, lack of censorship may also have a negative effect on a group. When discussing political correctness within art therapy groups, Henley (2015) states art therapists have the responsibility to make sure clients are experiencing a secure environment, and to intervene in a client's personal expression when interpersonal relationships or the group integrity could be impacted. In a study by Gitter (2010), profanity was negatively correlated with self-control. Gitter (2010) suggests that the use of profane language leads to perceptions of less strictness of societal norms, which in turn leads to a decreased need to engage in self-control. Interestingly, for participants that reported they believe profanity is inappropriate, the exposure of profanity led to increased self-regulation. This could be due to an experience that goes against their perception of a social norm, so the profanity was more salient and led to an increase in control.

### **Thematic Content**

In addition to profanity, overall thematic content of the lyrics is important. A study with 160 college students found participants believed antisocial lyrics prompted antisocial behaviors regardless of the musical genre (Ballard, Dodson, & Bazzini, 1999). This could mean thematic content might be more important to consider than other musical elements, such as those that define different genres. This contradicts findings discussed earlier, which stated that the amount of negative influences perceived is correlated with one's preferred genre.

Research demonstrates that musical elements can affect emotional responses in individuals. Specifically, Lepping (2013) conducted fMRI scans of participants listening to music. These scans show activation of the cingulate cortex, amygdala, and hippocampus, which control emotion and memories. Depression also impacts these areas of the brain. When comparing fMRI scans of participants who have never had depression and scans of participants

with depression, those without depression had greater stimulation in these areas during positive musical elements (e.g., lyrics, consonance within the harmony). Those with depression had greater stimulation during negative lyrical and harmonic musical elements (Lepping, 2013). Because depression is a common diagnosis in mental health facilities, it should be taken into consideration that clients with depression could be more heavily impacted by negative thematic content.

Bodner & Bensimon (2015) found participants who preferred “problem music” (i.e. rap, hip hop, punk, rave [house and trance], heavy metal and alternative rock) self-reported their preferred music was important for mood regulation and tension alleviation more often than individuals who prefer non-problem music. Furthermore, researchers did not find any significant differences in personality traits including delinquency and psychopathology between non-problem and problem music listeners. This would indicate that music is a valuable tool for listeners to promote mood regulation, avoid externalizing negative emotions, and avoid promoting delinquency and psychopathology in the process.

A study in Israel by Horesh (2005) used what he described as “dangerous music” with clients who abused substances. He described addiction as being a culture; there is a certain way of thinking, talking, acting, valuing, and making music choices within the addiction of different substances. His clients described music being used “obsessively” during times of substance abstinence to fill an emotional void, but that music could also elicit cravings. Horesh (2005) used rap, heavy metal, Israeli Mediterranean music, and house music specifically because they were associated with substance abuse cravings in his clients. He was able to allow clients to verbally and musically process through the emotions and thoughts in a safe environment, so when they

encountered the triggering music in everyday life they had more insight and could better cope with cravings.

## **Genres**

Several books and research articles focus on the use and/or detriments of rap, heavy metal, and house music. When articles are written to discuss music that could be harmful, research often cites rap, heavy metal, and house. Therefore, these three genres are the genres of focus for this research study.

**Rap.** There are mixed findings on whether rap has negatives outcomes due to lyrical content or the musical style of the genre (Cobb & Boettcher, 2007; Fischhoff, 1999; Fried, 1999; Travis & Bowman, 2012). When given the same lyrics, participants who were told the lyrics they read were rap had significantly more negative views of the lyrics than participants told it was from a country song. Other factors, such as age, number of children, and music tastes also significantly correlated with the negative views (Fried, 1999). Fischhoff (1999) had participants give their views of the personality of a black male in a study using four groups, two of which included rap lyrics. One group was given information that the male was a high school senior doing well in school; the second group was given the same information, but that the male was charged with murdering an ex-girlfriend; the third group was given the same information as group one, and gangsta rap lyrics he was said to have written. The final group was given the same information as group two, and the same lyrics as group three. It was found that both groups given the lyrics had more negative views than the two groups not given lyrics. Even the third group rated him more highly negative than the second group, who were told that he was charged with murder. The negative views of the lyrics on personality suggest the participants thought

good men could not write such lyrics, and the fact that it was even more negative than being a murder defendant are surprising.

Elligan (2004) divided the thematic expressions of rap into six different categories: Gangsta Rap, Materialistic Rap, Political/Protest Rap, Positive Rap, Spiritual Rap, and Rap Not Otherwise Specified (NOS). Most of the critiques of rap would seem to center around gangsta, materialistic, and political/protest rap due to the lyrical content. It is, however, questionable if positive rap, spiritual rap, and rap-NOS can have negative impacts by being the same genre, and have associations with the more negative lyrical subcategories. In a pilot study comparing rap with misogynistic lyrics (i.e., prejudiced against women) and rap with non-misogynistic lyrics, neither type of rap was found to significantly increase sexist views in males or females. Interestingly, when the study was redone, rap with misogynistic lyrics was found to have no effect, and rap with non-misogynistic lyrics significantly increased sexist attitudes in both genders (Cobb & Boettcher, 2007). This indicated that musical elements of rap other than lyrics could have a negative influence on sexist attitudes, but it may not always elicit these responses.

Positive messages of rap music may include collaboration/community, identity formation/gender-role socialization, empowerment/equality, social transformation, social criticism, humanistic values, and negative behavior criticism (Tyson, Detchkov, Eastwood, Carver & Sehr, 2012; Veltre & Hadley, 2012). Travis & Bowman (2012) found listening to rap decreased depressive symptoms and increased self-esteem, but contributed minimally to undesirable behaviors. Furthermore, risk and empowerment were compared, and findings suggest empowerment did not positively or negatively influence risk. This would indicate rap empowered individuals, increased self-esteem, and decreased depression, while having no increase on negative behaviors.

Some subcategories of rap have lyrics about empowerment and self-esteem, which are common goals within music therapy (Elligan 2004; Tyson, et al., 2012; Veltre & Hadley, 2012). It needs to be determined if music therapists are utilizing the positive rap, or if the entire genre is censored due to its negative associations. Others believe exposing clients to the negatively themed rap can help create a dialect about what is wrong with the content, and ways of working through similar issues.

**Heavy Metal.** Compared to participants who do not listen to heavy metal, heavy metal fans of both genders were found to have decreased familial values, and survival and coping beliefs (Scheel & Westfeld, 1999). It was found that males also have a decreased moral objection to suicide. Using the Reasons for Living Inventory, male fans had weaker reasons to live compared to male non-fans (Scheel & Westfeld, 1999). Females who listened to heavy metal were found to have increased suicidal ideation compared to female non-listeners. However, findings show overall music listening of preferred genres had a positive effect on mood. Across all genres, only 1% of the participants reported being sadder and 9% reported being angrier after listening to their self-reported preferred genre (Scheel & Westfeld, 1999). This appears to support the notion that the music is not evoking the emotions or behaviors; instead people have the behaviors, then select musical preference. It also supports preferred music being utilized regardless of perceived harshness of the genre, as it does not appear to negatively affect mood.

To further support this, Gowensmith & Bloom (1997) found heavy metal increased anger in participants who do not regularly listen to heavy metal, but fans of the genre did not show increased anger. They also did not show significant differences in pre-test measures of traits of anger compared to fans of other genres. This further shows evidence that increased exposure neutralizes negative effects of “obscene” music. Censoring could increase the negative impacts

because individuals will have less exposure to the music. However, in a group setting it would be important to be aware of the potential effects for non-fans, such as decreased familial values, coping beliefs, and decreased objection to suicide.

Becknell, et al. (2008) studied physiological effects of heavy metal and found college females had significant differences in masseter muscle tension between silence and the initial exposure of heavy metal being played. Masseter muscle tension is the tightening of the jaw muscle, which can be an indicator of stress. The researchers cited decreased masseter muscle tension as an indicator of increased relaxation. There was, however, no significant difference found for all other stress related measures in the study including frontalis muscles, skin temperature, heart rate or electro-dermal activity. After the first exposure, the participants had less of a response to the music; this could be due to habituation to the music. The authors describe their findings as evidence of potentially unhealthy effects of heavy metal exposure. However, the data showed very little differences in all measured responses except masseter muscle tension, and that significantly decreased after the initial exposure. So it appears the physiological effects of heavy metal were minimal. Furthermore, the study only included 18 participants, so the sample size was very small.

For males, St. Lawrence and Joyner (1991) found individuals with an extrinsic religiosity had more negative views of women and more sexual stereotyping. On top of that, participants who listened to both sexually violent heavy metal and Christian heavy metal were found to have significantly increased sexual stereotyping and negative attitudes of women compared to the participants that listened to classical music. Interestingly, the group that listened to classical music had significantly increased self-reported arousal in response to the music compared to

both heavy metal groups. In both measures the two different groups of heavy metal fans did not have significant differences, indicating musical elements other than lyrics impacted the results.

Other than lyrics, heavy metal can be distinguished from other genres by the volume, intensity and speed of the accompaniment. When asked what draws fans to heavy metal, individuals cited these elements and the musical ability and performances of the artists. As with the appeal of rap, some discuss the “rare authenticity” that heavy metal portrays about a world that is often cruel and corrupt. This side of the human experience is one that listeners believe is not often addressed in life, so the music allows for that expression. All of these elements create a high sensation experience. In fact, male adolescent fans of the genre scored higher across the board for enjoying high sensation experiences, ranging from trying new foods to skydiving compared to non-fans of the same age and gender (Arnett, 1996). The same draw of high sensation experiences could explain the correlation between heavy metal and anti-social behaviors such as drug use, violence, promiscuity and vandalism, which have high sensation and thrilling aspects. Perhaps the music is meeting a need of the listeners.

**House Music.** House music, the third genre covered by this study, has associations with drug use and clubbing (Hawkins, 2003). Although rap and heavy metal are researched more thoroughly than house/electronic/rave music, it is important to look at the implications of therapy with this genre. House music may have negative connotations of sex, drug use (e.g., Ecstasy, LSD) and club scenes. If clients present house music, or a related genre, as their preferred music, the question becomes whether it can be used therapeutically. Due to the high amount of substance abuse in mental health, music therapists need to be aware of any triggering music for their clients. However, some music therapists believe exposing clients to triggering music and

working through the issues in a safe and therapeutic environment will better equip the client to handle cravings outside of therapy (Horesh, 2005).

Kavanaugh & Anderson (2008) state that it is not simply drug use, but the feelings of connectedness and spirituality associated with electronic dance music and dancing, that draw people to the genre. Interviewees mentioned the drugs just enhanced the experience of friendliness and connectedness that the music scene garnered, and that house music is about coming together, solidarity, and community bonding. Group cohesion and building strong interpersonal relationships can be a target area for individuals in mental health, so this genre could be utilized for important therapeutic goals. Hawkins (2003) describes house music as provocatively utilizing dynamics and rhythms to influence listeners to build toward arousal and passion. This arousal and passion build political, emotional, and erotic connections between individuals, and are enhanced by the use of Ecstasy within the subculture of this genre. Horesh (2005) discusses using house music as an opening to the sensitive topics described by Hawkins (2003), such as cravings and coping with them. Therapists need to take into consideration the amount of arousal and negative associations they want to evoke in clients, and determine the best music to reach those states.

## **Conclusion**

The third-person effect has shown that typically individuals believe media content has a greater impact on others than it does for themselves, which leads to becoming more pro-censorship. Several musical elements, including profane lyrics, thematic content, and genres associated with violence and/or drug usage could be media that is susceptible to this effect; the research that currently exists shows mixed findings on the impact of these different elements. Particularly the therapeutic relationship, an important indicator of therapeutic outcomes, has the



potential to be affected by censorship choices. To date, no research studies exist that focus on censorship practices of music therapists.

### **Purpose Statement and Research Questions**

The purpose of this study is to investigate current censorship practices and censorship beliefs of music therapists working in adult mental health settings regarding the lyrics, themes, and genres of music provided for, or created by, clients. The research questions are: (a) What music, or elements of music, do music therapists censor during music therapy sessions? (b) If music therapists censor, what are their reasons for censoring?

## **Chapter 3: Method**

### **Purpose Statement and Research Questions**

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### **Human Subjects Committee**

The University of Kansas Human Subjects Committee approved this study. Completion of the survey was considered consent of participation, and the total number to complete the survey was considered the total number of participants for the study. Participation was voluntary, and responses were confidential.

### **Participants**

Participants ( $N=42$ ) were board certified music therapists (MT-BC) who indicated as currently working in adult mental health settings through the Certification Board of Music Therapists (CBMT). To be included in the study, the participants had to be adults over age 18, board certified, and currently working within mental health settings with adult (over age 18) clients at the time of survey completion. The researcher purchased from CBMT the email addresses of participants that met the initial criteria. For the survey, mental health settings included the following populations: inpatient and outpatient mental health facilities, behavioral health facilities, community mental health, and mental health units within other settings. All participants resided in the United States.

## Study Design

The use of web-based survey research has been increasing steadily through the years; furthermore, web-based survey research is a cost efficient tool to reach people at far distances and conduct research about sensitive topics (Nair, 2013; Wright, 2005). Wigram (2005) explains survey research is used in music therapy research for its ability to obtain information about thoughts, feelings, plans, beliefs, and working methods. The researcher created an online survey (Appendix B) through FreeCap® to investigate the thoughts and beliefs of participants concerning censorship. FreeCap® is a non-HIPPA compliant version of REDCap® available to students at The University of Kansas. To ensure confidentiality, the program assigns participants a number so no identifying information is attached to the data.

Surveys that include the researcher's credentials, contact information, and information about the study and purpose obtain the most responses (Coughlan et al., 2008; Nair, 2013; Wright, 2005; Zhang, 2000). A link to the survey was emailed to all email addresses along with a cover letter including contact information, a confidentiality notice, and a brief overview of the purpose of the study (Appendix A). However, disadvantages associated with survey research include the possibility of having participants take the survey multiple times, systematic bias due to a portion of the sample possibly ignoring the invitation to participate, access to the internet, and computer literacy (Coughlan et al., 2008). Response rate tracking is a way to ensure participants do not take the survey more than once, as the program keeps track of when someone takes the survey using each particular email address. To ensure participants only take the survey one time, FreeCap® uses unique links and response rate tracking for each email.

In addition, ensuring validity of questions is a major concern for survey research. Closed-ended questions will only be truly valid if answer choices are comprehensive. The survey

included 22 close-ended questions with possible answer choices created through the research in the literature review in order to be as comprehensive as possible; fourteen short answer boxes for questions that have an “other” option; and nine Likert-type scales to assess views of censorship. The survey components were: (a) demographic information, (b) current practices of censorship, and (c) reasons for censorship.

### **Procedure**

The researcher sent the survey to three experts on survey design and music therapy in order to gain feedback, make changes, and increase validity. This pre-test to determine validity allowed feedback to be incorporated into the final questionnaire before sending it to potential participants (Zhang, 2000). Once the survey was finalized and approved by the human subjects committee, the researcher emailed the survey link to all email addresses along with a cover letter including contact information, a confidentiality notice, and a brief overview of the purpose of the study. Typically, several emails are sent throughout the duration of the study to encourage more responses, with research indicating peaks in response rates following reminder emails (Coughlan, Cronin, P., & Ryan, F., 2008; Nair, 2013). After four days, a reminder email was sent to those who had not taken the survey or opted out. The survey was open for one week to allow time for responses, then the research was concluded.

### **Data Analysis**

The researcher used descriptive statistics to describe the overall state of censorship within the field. This included percentages of any type of censorship; individually reporting on censorship of lyrics, genres, and topics; and number of responses for each reason for censorship.

## **Chapter 4: Results**

### **Participants**

Out of 480 emails purchased from CBMT, five sent back notices that the email was undeliverable, leaving a sample pool of 475. Out of those 475, one asked to be taken off the email list and 47 completed the survey, resulting in a return rate of 9.9%. Out of the 47 respondents, five currently did not work as music therapists with adults in mental health settings, leaving 42 participants included in the data analysis. See Figure 1 for a participant flow chart.

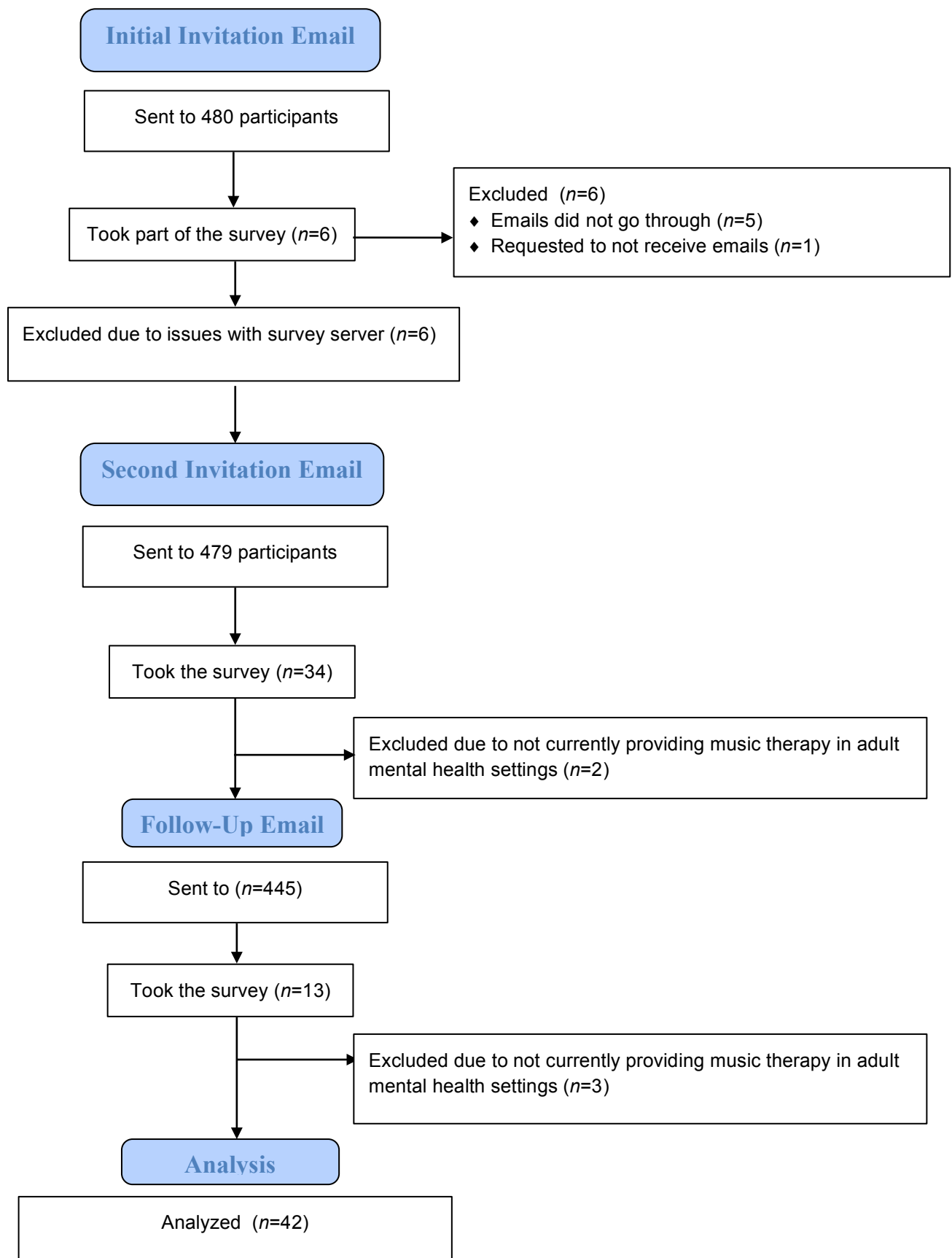


Figure 1. Participant Flow Chart

## Demographic Information

The total number of participants was comprised of nine males (21.4%), and 33 females (78.6%). The majority were between 26-35 years of age, ( $n=22$ , 52.4%), followed by 36-45 years, ( $n=7$ , 16.7%), and 46-55 years, ( $n=6$ , 14.3%). Three participants (7.1%) were 18-25 years, three participants (7.1%) were 56-65 years, and one participant (2.4%) was over the age of 65. Most had been working 0-4 years in the field, ( $n=15$ , 35.7%), followed by 5-9 years, ( $n=12$ , 28.6%), and 10-14 years, ( $n=7$ , 16.7%). Three people (7.1%) reported working in the field for 20-24 years, and three people (7.1%) reported more than 25 years. Lastly, two people (4.8%) reported working in the field 15-19 years. The top three regions represented were Mid-Atlantic, ( $n=17$ , 40.5%), Southeastern, ( $n=6$ , 14.3%), and Western, ( $n=6$ , 14.3%). The Midwestern region was represented by  $n=4$  (9.5%). The Great Lakes, New England, and Southwestern regions each had three participants (7.1%). All theoretical orientations except Biological and Transactional Analysis were included. The top five theoretical orientations were Humanistic/Existential, ( $n=27$ , 65.9%), Client-Centered, ( $n=25$ , 61%), Cognitive-Behavioral, ( $n=23$ , 56.1%), Holistic/Integrative, ( $n=14$ , 34.1%), and Psychodynamic/Insight-Oriented, ( $n=14$ , 34.1%). Table 1 includes demographic information of participants.

Table 1: Demographic Information of Participants

Gender	Number Reporting	Percentage
Female	33	78.6
Male	9	21.4

Table 1: Demographic Information of Participants

<b>Age</b>		
18-25 years	3	7.1
26-35 years	22	52.4
36-45 years	7	16.7
46-55 years	6	14.3
56-65 years	3	7.1
Over 65 years	1	2.4
<b>Years Working as a Music Therapist</b>		
0-4 years	15	35.7
5-9 years	12	28.6
10-14 years	7	16.7
15-19 years	2	4.8
20-24 years	3	7.1
More than 25 years	3	7.1
<b>Region Providing Services</b>		
Mid-Atlantic	17	40.5
Southeastern	6	14.3
Western	6	14.3
Midwestern	4	9.5
Great Lakes	3	7.1
New England	3	7.1
Southwestern	3	7.1
<b>Theoretical Orientation</b>		
Humanistic/Existential	27	65.9
Client-Centered	25	61
Cognitive-Behavioral	23	56.1



Table 1: Demographic Information of Participants

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**Theoretical Orientation Continued**

Holistic/Integrative	14	34.1
Psychodynamic/Insight-Oriented	14	34.1
Behavioral	12	29.3
Interpersonal	10	24.4
Dialectical Behavioral	9	22
Integrative	8	19.5
Cognitive	7	17.1
Jungian	6	14.6
Developmental	5	12.2
Positive Psychotherapies	4	9.8
Feminist Therapy	3	7.3
Gestalt	3	7.3
Post-Modern (Narrative, Solution-Focused, Collaborative Language)	3	7.3
Rational Emotive Therapy	3	7.3
Psychoanalytic	2	4.9
Other	2	4.9
Adlerian	1	2.4
Contemplative Psychotherapies	1	2.4
Family Systems	1	2.4
Biological	0	0
Transactional Analysis	0	0

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## **Censorship of Music by Music Therapists**

*Research Question 1: What music, or elements of music, do music therapists censor during music therapy sessions?*

Of the total number of participants ( $N=42$ ) who completed the survey, 21.43% of music therapists ( $n=9$ ) reported they do not censor at all in music therapy sessions, while 78.57% music therapists ( $n=33$ ) indicated they censor at least one type of lyric, thematic content, and/or genre.

**Lyrics.** Twenty-eight participants, 66.67%, reported censoring lyrics in sessions. The question on censoring lyrics was not answered by one of the participants. The top three most censored lyrics were profanity, ( $n=25$ , 59.52%), followed by drug references, ( $n=14$ , 33.33%), and alcohol references ( $n=12$ , 28.57%). Participants that selected “other” stated censoring lyrics that, “may trigger a negative response,” “glorifies the use of drugs/alcohol,” “glorifies violence and hatred of others,” “racial slurs,” “sexual references,” “explicit sexuality, abuse, suicide, self-harm, racism,” and “racial, gender stereotypes.” Figure 2 includes information about types of lyrics censored.

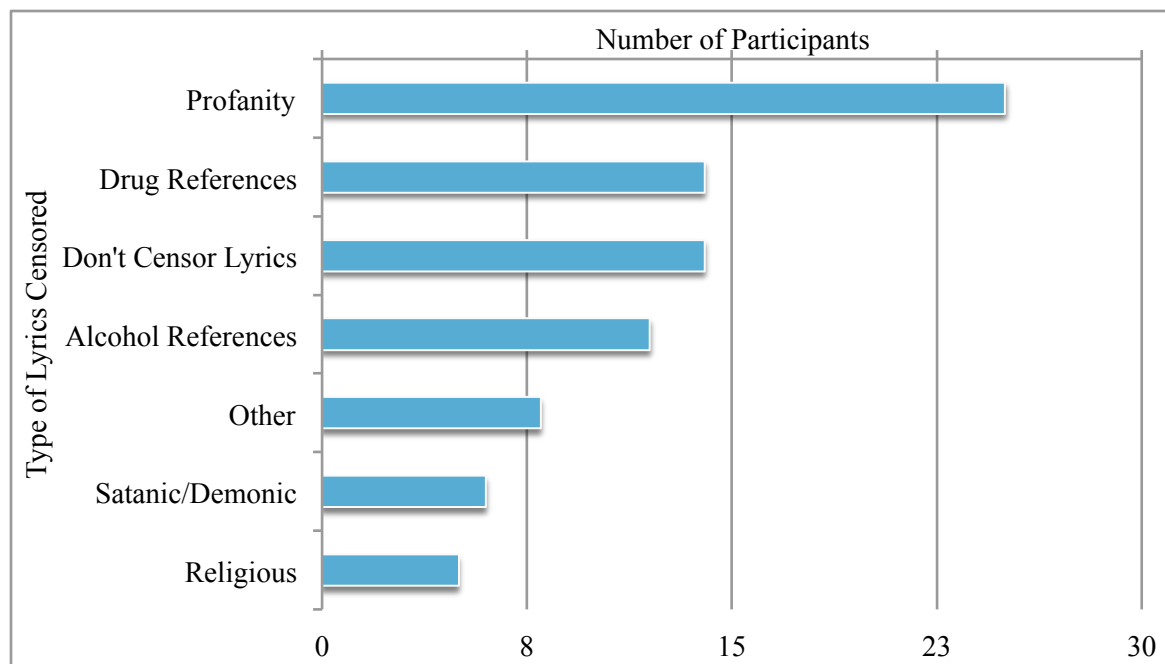
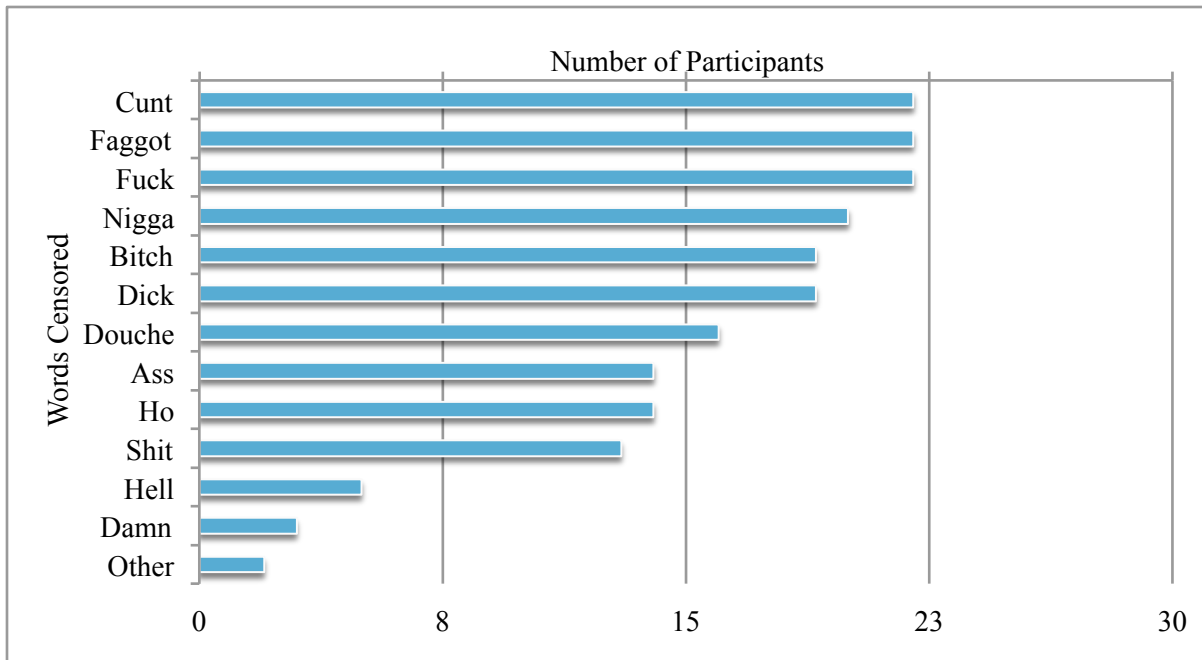


Figure 2. Censored Lyrics.

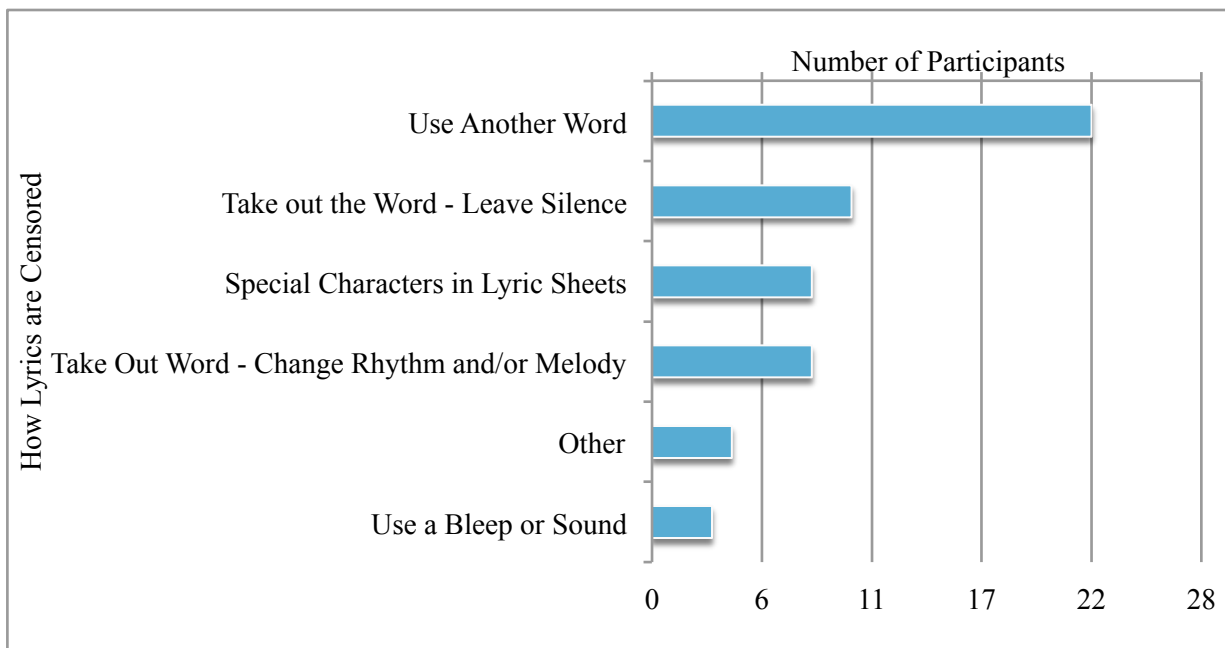
Participants ( $n=25$ ) who selected, “profanity,” as lyrics that they censored were directed to a question asking if they would respond to a question containing the specific words presented in Figure 3. One participant indicated they did not want to see a question containing specific profanity, and another participant did not answer this question. The remaining participants ( $n=23$ ) had variability in their responses, an indication that there is gradability of the profane words. The top six most censored words were, cunt, ( $n=22$ , 52.38%), faggot, ( $n=22$ , 52.38%), fuck, ( $n=22$ , 52.38%), nigga, ( $n=20$ , 47.62%), bitch, ( $n=19$ , 45.24%), and dick ( $n=19$ , 45.24%). One participant who selected “other” explained, “the context of ‘fuck’ makes a difference,” but did not explain in which context it would or would not be censored. One participant that selected “other” did not specify what other profanity they censor.



*Figure 3. Censored Profane Words*

Figure shows number of participants out of 23 who reported censoring profanity and agreed to answer this question.

Participants were then asked how they censor lyrics (Figure 4). Most participants reported they use another word in place of the censored material, ( $n=22$ , 52.38%), followed by taking out the word and leaving a silence, ( $n=10$ , 23.81%), taking out the word and changing melodic and/or rhythmic elements, ( $n=8$ , 19.05%), special characters on the lyric sheets (i.e., f@#k), ( $n=8$ , 19.05%), other, ( $n=4$ , 9.52%), and using a bleep or sound over the word, ( $n=3$ , 7.14%). Those that selected "other" stated they, “don’t play music with these lyrics,” “skip the verse that has the lyrics,” “use the ‘clean’ version of the song from YouTube or a recording,” or, “limit the quantity and timing of religious music and ask the group to ‘vote’ if the music is okay to use.”



*Figure 4.* How Music Therapists Censor Lyrics  
 Figure shows number of participants out of 28 who reported censoring lyrics.

**Thematic Content.** The majority of music therapists, ( $n=29$ , 69.05%) censor thematic content in their sessions, with themes more censored than lyrics or genres. The top five most censored themes (Figure 5) are misogyny, ( $n=22$ , 52.38%), violence, ( $n=20$ , 47.62%), sex, ( $n=19$ , 45.24%), gang related content, ( $n=19$ , 45.25%), and misandry, ( $n=18$ , 42.67%). The four least censored themes were clubbing ( $n=4$ , 9.52%), other ( $n=2$ , 4.76%), love relationships ( $n=1$ , 2.38%), and cigarette usage ( $n=1$ , 2.38%). The other themes participants stated they censor include, “self-harming content; hate themes.”

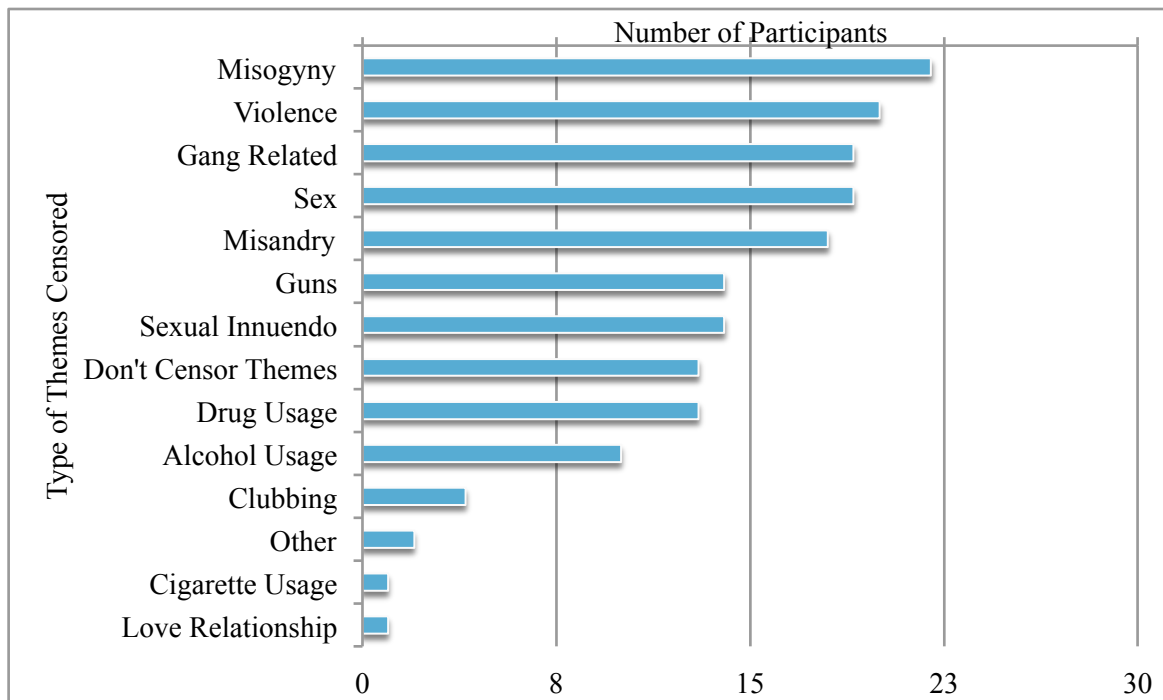


Figure 5. Censored Thematic Content

**Genres.** Compared to lyrics and themes, few participants ( $n=7$ , 16.67%) censor genres in their sessions. The question was not answered by 4.76% ( $n=2$ ). Rap was the most commonly censored ( $n=5$ , 11.9%), followed by heavy metal ( $n=2$ , 4.76%), other ( $n=2$ , 4.76%), and house/club ( $n=1$ , 2.38%) (Figure 6). One participant who selected "other" wrote, “religious themes (u)nless a group agrees to it, and possible songs that degrade women or are sexually explicit.”

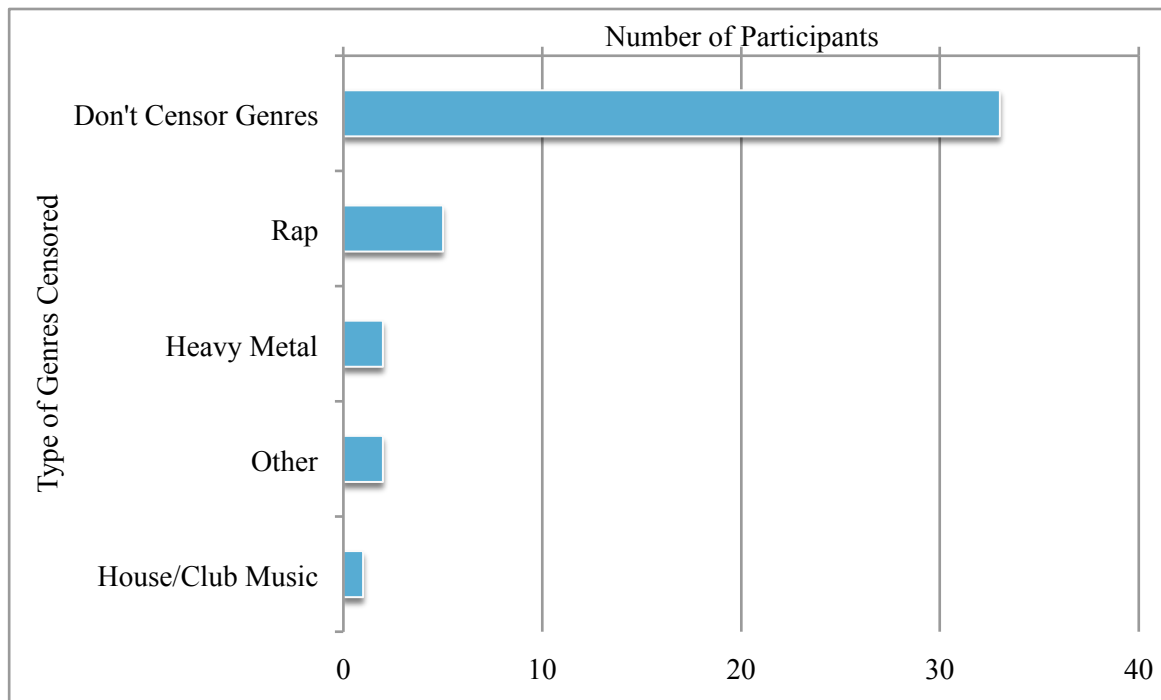


Figure 6. Censored Genres

### Inconsistent Responses

The definition of censorship given to participants for the survey was, “Censorship is broadly defined as music therapists refraining from using, or redirecting clients away from using, certain lyrics, themes, songs, or genres of music during therapist planning and facilitation of sessions.” Following this definition, some participants had inconsistencies between their selections for the close-ended questions and their written responses.

**Lyrics.** One participant selected, “demonic/satanic references,” and also selected, “I do not censor lyrics.” This participant stated, “I know it is inconsistent that I marked ‘satanic references’, as well as ‘I do not censor’.... I say this because while I do not censor the lyrics themselves during sessions, I encourage clients to choose better language, or at least discuss why profane language is not appropriate (at least in most circumstances). Also, I believe music is

‘food for the soul’, and I do not believe in feeding the soul demonic messages, so I do not use that music. Other than that, I do not censor.” Another participant did not select that they censor, “alcohol references,” or “drug references,” but wrote, “However, I do consider drug/alcohol references or sexual references when I choose songs (especially with my adolescent clients), and often just do not use a specific song if it has a lot of references, depending on my current clients and goals.” A third participant selected, “other,” but wrote, “If teens or younger, I try to find a healthier alternative to cursing or sexual content.” This survey was for music therapists’ censorship practices with their adult patients, so it is unknown if this would be the same with adult patients. Lastly, a fourth participant did not select “alcohol references,” or “drug references,” but wrote, “I censor drug and alcohol references except for during my MT and Addictions group, because it directly pertains to what we are working on/discussing.”

**Thematic Content.** One participant selected, “other,” and stated, “I am struggling to answer this question at all, because I simply do not find that I choose songs with these themes for the types of sessions I lead. I don't feel that it's because of censorship; they just don't tend to fit the goals I typically address.” This could be classified as censoring under the part of the definition stating, “music therapists refraining from using.”

**Genres.** One of the seven participants that indicated they censor genres selected, “other,” and also selected, “I do not censor genres.” This participant wrote, “Depending on my group members' history I may have to censor a genre if it could be an emotional trigger that they are not ready to process.” This participant may not consistently censor, but may censor at times as determined by their clinical wisdom.



## When Music Therapists Censor Musical Elements

Lastly, the researcher asked when the elements were censored (Table 2). For lyrics, the top five times censorship occurred were music the music therapist covers live, ( $n=21$ , 50%), recorded songs the music therapist chooses, ( $n=20$ , 47.62%), lyric sheets, ( $n=20$ , 47.62%), recorded songs clients request, ( $n=17$ , 40.48%), and songs the music therapist improvises or freestyles vocally, ( $n=12$ , 28.57%). For themes, the top five times censorship occurred were recorded songs the music therapist chooses, ( $n=22$ , 52.38%), music the music therapist covers live, ( $n=20$ , 47.62%), recorded songs clients request, ( $n=18$ , 42.86%), lyric sheets, ( $n=16$ , 38.1%), and clients' lyrics written during songwriting, ( $n=11$ , 26.19%). The top three times genres are censored were recorded songs clients request, ( $n=6$ , 14.29%), music the music therapist covers live, ( $n=4$ , 9.52%), and recorded songs the music therapist chooses, ( $n=4$ , 9.52%).

Table 2. When Music Therapists (MT) Censor Musical Elements (Number of Responses)

When Censorship Occurs	Lyrics	Themes	Genres
MT Cover Live	21	20	4
Recorded Song MT Chooses	20	22	4
Lyrics Sheets	20	16	3
Recorded Song Client Requests	17	18	6
MT Improvises	12	9	1
Clients' Songwriting Lyrics	6	11	1
Clients' Improvisation/Freestyle	5	7	1
Other	2	0	0

## **Reasons for Censoring in Music Therapy**

*Research Question 2: If music therapists censor, what are their reasons for censoring?*

The top five reasons for censoring lyrics include: it may negatively impact other group members, ( $n=24$ , 57.14%), the client may feel uncomfortable ( $n=14$ , 33.33%), the therapeutic relationship may be negatively impacted ( $n=13$ , 30.95%), the lyrics may incite self-esteem issues (e.g., racism, sexism), ( $n=13$ , 30.95%), and the lyrics may incite emotional distress, (e.g., depression, anxiety), ( $n=13$ , 30.95%). Participants who selected "other" gave reasons such as, "I believe music is 'food for the soul,' and I do not believe in feeding the soul demonic messages, so I do not use that music," "sexual lyrics have been observed to encourage sexual behaviors on the unit, so I always censor explicit material," "I personally feel uncomfortable using lyrics that incite demonic forces or possession," "I assess other patients' potential reactions, as well as the motive as to why a patient would request a particular song," and, "it doesn't benefit the patient in anyway."

The top five reasons for censoring themes include: it may negatively impact other group members, ( $n=24$ , 57.14%), the themes may incite emotional distress, (e.g., depression, anxiety), ( $n=17$ , 40.48%), the themes may incite self-esteem issues (e.g., racism, sexism), ( $n=15$ , 35.71%), the client may feel uncomfortable ( $n=15$ , 35.71%), and the therapeutic relationship may be negatively impacted ( $n=13$ , 30.95%). Participants who selected "other" reported reasons such as, "if the group is co-ed and there is a significant risk of overstimulation or re-traumatization," "censorship that occurs is almost always done with the consensus of the group. If one group member is uncomfortable with the theme, language, etc., the song will not be utilized but a group discussion may be had," "as a female in an all-male prison setting, working with sex offenders in some instances, I do not feel that it's appropriate to use songs with overly sexualized messages

for my own safety,” “the patients may not be ready to confront drug/alcohol issues,” “religious reasons for client,” and, “I work with all males in a forensic psychiatric hospital. It is often safer to choose songs that are not overtly sexual or violent.”

Participants did not censor genre as much as lyrics and thematic content. The top five reasons for censoring genres include: it may negatively impact other group members, ( $n=6$ , 14.29%), the client may feel uncomfortable ( $n=5$ , 11.9%), the therapeutic relationship may be negatively impacted ( $n=4$ , 9.52%), the genre may incite violence, ( $n=4$ , 9.52%), and the genres may incite emotional distress, (e.g., depression, anxiety), ( $n=4$ , 9.52%). No participants selected “other” for why they censor genres.

**Table 3. Reasons for Censoring Musical Elements (Number of Music Therapists Reporting)**

	Lyrics	Themes	Genres
May Negatively Impact Other Group Members	24	24	6
Client May Feel Uncomfortable	14	15	5
Therapeutic Relationship Negatively Impacted	13	13	4
May Incite Self-Esteem Issues (Racism, Sexism)	13	15	3
May Incite Emotional Distress (Depression, Anxiety)	13	17	4
The Music Therapist Feels Uncomfortable	10	7	3
Facility Required	9	10	2
Unit Required	9	9	2
May Incite Violence	8	10	4
Other Staff/Treatment Team Would Not Approve	7	9	2
Unprofessional	6	6	1
Music Therapy Training Indicated to Censor	3	1	0
Other	3	5	0

The researcher also investigated reasons for censorship that included the third-person effect and perceived affects on the therapeutic relationship. To test these two possible reasons, the researcher had questions with sliding scales ranging from strongly disagree (0), to neutral (50), to strongly agree (100). When asked if they believed hearing the different elements impacts their clients more than themselves, participants had a mean for lyrics at  $M=48.43$ , while themes were at  $M=63.16$ , and genres  $M=62.97$ . This data shows participants might be subject to the third-person effect for themes and genres, but not for lyrics. Interestingly, even though participants were likely to censor music, their responses on the sliding scales indicated the censorship of themes ( $M=56.13$ ) and genres ( $M=59.13$ ) has a negative impact on the therapeutic relationship, but less of a negative impact for lyrics ( $M=51.64$ ). On the other hand, many did not think that not censoring lyrics ( $M=41.95$ ), themes ( $M=46.85$ ), and genres ( $M=33.68$ ) had a negative impact on the therapeutic relationship.

### **Summary**

Overall, 78.57% ( $n=33$ ) of respondents censor at least one musical element, with 69.05% ( $n=29$ ) censoring themes, 66.67% ( $n=28$ ) censoring lyrics, and 16.67% ( $n=7$ ) censoring genres. Censorship within music therapy mental health settings is occurring, and for some musical elements at high levels. Reasons often stated for censorship revolved around issues with treatment including other group members' responses, client comfort level, emotional distress, self-esteem issues, and the therapeutic relationship being negatively impacted. However, about 25% reported personal reasons such as their comfort level with the content, religious beliefs, and believing the client cannot benefit in any way from hearing the content.

## Chapter 5: Discussion

### Findings

The majority of music therapists who participated in this study censored lyrics, themes, and/or genres in adult mental health settings ( $n=33$ , 78.57%). Most indicated they censor because of implications for their group; however, it is unknown if these implications are backed by research, or stem from the music therapist's personal beliefs of the possible impact of the musical elements. In addition, some people stated outright that their personal reasons and beliefs led to censorship. For example, one participant responded, "I do not believe in feeding the soul demonic messages," and another that wrote, "I personally feel uncomfortable using lyrics that incite demonic forces or possession." It is important for music therapists to maintain their personal values and beliefs while ensuring the best treatment for their clients. Other than personal beliefs, safety and clinical decision-making, were important issues brought up concerning censorship practices, such as safety. For example, one participant reported, "As a female in an all-male prison setting, working with sex offenders in some instances, I do not feel that it's appropriate to use songs with overly sexualized messages for my own safety."

Some participants were hesitant to define the limitations they place on musical elements as censorship, especially when involving clinical decision making and safety. It appears censorship may have negative connotations. For example, one participant stated, "I simply do not find that I choose songs with these themes for the types of sessions I lead. I don't feel that it's because of censorship; they just don't tend to fit the goals I typically address." Additionally, three other participants reported they do not censor a particular musical element in sessions, while simultaneously indicating censoring that same musical element.

Other notable findings include the fact that misogyny (i.e., hatred of women) was the number one censored theme, but misandry (i.e., hatred of men) was number five. This may be due to a higher rate of females within the field, as well as many reporting that they work with mostly males. Two participants reported not using overtly sexual or violent music because they work in forensic or correctional settings with all males. Other possible reasons could include the societal focus on decreasing misogyny being greater than the focus on decreasing misandry. Additionally, many rap and heavy metal artists are male, and relationships with women are common topics, so there may be more music available that is violent toward, or objectifies, women than there is music with the same themes directed toward men.

The third-person effect and the therapeutic relationship could be an additional reason for why censorship is occurring. Genres had a high score for the third-person effect, so music therapists believe that genres impact clients more than themselves. It also had the highest score indicating that censoring this music negatively impacts the therapeutic relationship. This could mean if music therapists believe genres impact clients more than themselves, but the therapeutic relationship would be the most affected by censorship of this element, the pros outweigh the cons of using the music. Therefore, they may be less likely to censor genres. Furthermore, the participants rated thematic content as having the highest score for the third-person effect, and they indicated censoring this element was slightly above neutral for negatively impacting the therapeutic relationship. This means the participants might believe the impact on the therapeutic relationship is not as consequential as the perceived negative impacts on goals, thoughts, behaviors, or emotions the themes could have on clients. This could be a reason for thematic content having the highest rate of being censored.

## **Limitations, Delimitations, and Assumptions**

When the survey was originally sent, the researcher was notified that there were technical issues with the survey platform causing all questions to be displayed, and random numbers and letters throughout the document. The researcher sent an email to all potential participants asking for them to ignore the invitation to the survey, and then closed the survey. Before the survey was taken down six participants took part of the survey. After fixing the issue with the survey platform those six participants' data were erased and a link to the survey was resent to all potential participants. While it is unlikely this impacted the data collected from the survey, it could have led to a lower number of participants.

Participants for this study were mostly 26-35 (52.4%), from the Mid-Atlantic region (40.5%), with a Humanistic/Existential theoretical orientation (65.9%). Perhaps one or more of these variables impacts the views of censorship within therapy sessions. It is important to note that individuals between the ages of 26-35 are much more likely to have lived most of their lives with music being censored than those in the other age groups due to the parental advisory label appearing on music in 1985 (Lewis, 2006). Furthermore, years of clinical practice, type of mental health setting, and how competent the therapist views themselves in terms of handling behaviors and difficult topics may impact their views on censorship, and should be explored.

The sliding scales used to ask participants how strongly they agreed or disagreed with statements regarding if they felt different musical elements affected their clients more than themselves did not indicate a positive or negative affect. They were left intentionally neutral because research indicated the third-person effect happens for both positive and negative media. However, participants may have answered differently depending on if they were thinking about the affects being positive, negative, or both.

Finally, one music therapist who received the survey link stated they left their job of 20 years due to issues with being censored. This study was investigating the current state of censorship; therefore, this person could not complete the survey because they did not currently work as a music therapist in mental health, but they may have valuable insights on the practice of censorship within music therapy.

### **Clinical Implications**

Clinically, censorship needs to be addressed. There is a lack of research on the censorship in music therapy, and in this study it was found there is disparity in the amount of censorship occurring within music therapy sessions in mental health settings. Many music therapists reported believing the examined musical elements have negative impacts on clients and treatment goals; however, others report not censoring at all. The participants in this study did not have a single element that everyone censored, or a single element that nobody censored. Additionally, related research findings of the effects of the musical elements have conflicting results (Becknell, et al., 2008; Eveland, Nathanson, Detenber, & McLeod, 1999; Gowensmith & Bloom, 1997; Hawkins, 2003; Horesh, 2005). More research needs to be conducted to determine the effects of these different musical elements, as well as the impact that censorship has on clients and treatment goals.

Participants voiced concerns for safety of both clients and themselves when writing responses explaining their censorship practices. Recognizing and avoiding the potential of harm are listed as part of the competencies and the code of ethics through the American Music Therapy Association and the Certification Board of Music Therapists, and must be a factor during clinical decisions (AMTA, 2015; CBMT, 2015). Therapists must also use reflective practice to determine if they have biases against certain music so they can control for these



biases to ensure the best therapeutic effectiveness for their clients. An example would be music therapists using clinical wisdom and decision making to ensure they are not providing triggering music that the clients are not ready to process, but considering if this music could be safely used to address and work through those triggers. Additionally, therapists need to ensure that they themselves are safe when in the clinical setting. Creating sexual, violent, or otherwise behaviorally inappropriate circumstances is not within the best interest of the therapist or client.

### **Future Recommendations**

This same, or a similar study, should be conducted with music therapists working in various populations. Many music therapists in this survey indicated mental health reasons and concerns about symptoms and recovery leading to censorship. Researchers should investigate if this is consistent for populations outside of mental health. In addition, future research could include music therapists who have previously worked in mental health to increase the data collected on music therapists' beliefs and views on the topic.

A qualitative study should be conducted to ensure participants have clarity on the definition of censorship and to gain further insights into music therapists beliefs and practices of censorship. Furthermore, a follow-up qualitative study could be conducted to investigate if music therapists have seen objective evidence of issues stemming from not censoring music, or if they are censoring a priori based on their beliefs that it might occur. Additionally, experimental research needs to be conducted on how exactly the musical elements in this study impact clients, and if these elements facilitated by a music therapist could be used to address and work through some of the issues and concerns presented by the music. In addition to finding out the impact each of these elements have on clients, research and practice should consider the effects on the therapeutic relationship when these elements are censored and uncensored. While it is important

to maintain personal identity and safety, therapists must also be aware of the implications of their biases and assumptions within treatment.

Within the survey, future research could include separate questions for both positive and negative affects regarding the third-person effect to determine if it changes participant response. Also, a common response to why participants censor included the idea of censoring music that “glorifies” different negative words or topics. The idea of glorification needs investigation to determine how current music therapists are defining the term, and to then create a conceptual definition. A conceptual definition will help ensure consistency for the research and clinical practice of this concept in music therapy. Interviews may be a practical way to investigate how music therapists are defining this and other key terms, and to explore the specifics of why they are censoring this material more in depth.

## **Conclusion**

This is the first study to examine censorship within the context of music therapy. The definition of censorship for this study was music therapists refraining from using, or redirecting clients away from using, certain lyrics, themes, songs, or genres of music before (i.e., therapist planning), during (i.e., therapist facilitating), and/or after (i.e. censoring clients’ music or verbalizations after they have been stated) expression. Findings from this research study indicate music censorship is occurring with music therapists ( $n=33$ , 78.57%) in mental health settings. Many reasons given for censorship related to not wanting to negatively impact group members or cause client distress, as clients may be triggered by certain musical elements. To develop the best interventions and provide the most ethical treatment of individuals, music therapists need to be clear on how their musical choices are affecting clients. These musical elements may be contraindicated for certain populations. However, music therapists were found to be subject to

the third-person effect regarding thematic content and genres. If these musical elements are in fact not contraindicated, music therapists might use the music to address important issues they have been censoring with their clients. Clinical research focused on censorship in music therapy would help therapists gain a better understanding of this controversial topic.

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## Appendices

**Appendix A**  
**Consent and Confidentiality Email Invitation**

**Dear Board-Certified Music Therapist:**

**Study Overview**

I apologize for the technical difficulties with the first invitation. You are invited to participate in a study about censorship practices in adult psychiatric music therapy services. For the purpose of this study, censorship is broadly defined as music therapists refraining from using, or redirecting clients away from using, certain lyrics, themes, songs, or genres of music during therapist planning and facilitation of sessions.

Kendall Joplin, MT-BC, is conducting this research project in partial fulfillment of the master's degree requirements at the University of Kansas.

**Procedure**

If you agree to participate, you will complete a 15-20 minute survey on your current censorship practices. Participation is voluntary, and you may choose to withdraw at any time. All information gathered is anonymous and will remain confidential. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. Completion of the survey indicates your willingness to take part in this study, and that you are at least 18 years old. Please submit your survey responses by April 8, 2016 by following the link below.

**Benefits and Risks**

Although you may not directly benefit from participating in this study, your responses will help us better understand current censorship practices within the field. There are no perceived risks involved in this study, and you will not be paid for participation.

**Questions**

If you have any questions, please contact Kendall Joplin using the contact information listed below. If you have additional questions regarding your rights as a research participant, please call (785) 864-7429 or (785) 864-7385, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email [irb@ku.edu](mailto:irb@ku.edu).

Sincerely,  
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## **Appendix B Censorship Survey**

### **Therapist Demographics**

1. Do you currently provide music therapy services in an adult mental health setting?

- Yes
- No

Unfortunately you do not meet the minimum participation requirements. Thank you for taking time to look at this survey.

2. Please indicate your gender.

- Female
- Male
- Transgender
- Other

3. What is your current age?

- 18-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- Over 65 years

4. How long have you worked as a music therapist?

- 0-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20-24 years
- More than 25 years

5. How long have you worked in your current position?

- 0-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20-24 years
- More than 25 years

6. Within which region do you currently provide mental health music therapy services?

- Great Lakes Region
- Mid-Atlantic Region
- Midwestern Region
- New England Region
- Southeastern Region

Southwestern Region  
Western Region  
International

7. What type of mental health setting do you work? Please check all that apply.

Community mental health facility  
Outpatient mental health  
Partial hospitalization  
Acute care psychiatric treatment  
Long-term psychiatric treatment  
Privately owned mental health hospital  
State owned mental health hospital  
Psychiatric unit(s) of a medical hospital  
Other

8. You selected other. Please provide information on what type of mental health facility you provide music therapy services in.

9. What type of services do you provide? Select all that apply.

Direct group music therapy services  
Direct individual music therapy services  
Consultative music therapy services  
Co-treatment with another therapist

10. With what diagnoses do you typically provide services? Please all that apply.

Neurodevelopmental Disorders  
Schizophrenia Spectrum and Other Psychotic Disorders  
Bipolar and Related Disorders  
Depressive Disorders  
Anxiety Disorders  
Obsessive-Compulsive and Related Disorders  
Disruptive, Impulse-Control, and Conduct Disorder  
Substance-Related and Addictive Disorders  
Trauma and Stressor-Related Disorders  
Feeding and Eating Disorders  
Personality Disorders  
Other

11. You selected other. Please indicate additional diagnoses you provide services for.

12. What is your theoretical orientation for music therapy? Select all that apply.

Adlerian  
Behavioral  
Biological  
Client-Centered

Cognitive  
Cognitive Behavioral  
Contemplative Psychotherapies  
Developmental  
Dialectical Behavioral  
Family Systems  
Feminist Therapy  
Gestalt  
Holistic/Integrative  
Humanistic/Existential  
Integrative  
Interpersonal  
Jungian  
Positive Psychotherapies  
Postmodern (Narrative, Solution-Focused, Collaborative Language)  
Psychoanalytic  
Psychodynamic/Insight-oriented  
Rational Emotive Therapy  
Transactional Analysis  
Other

13. You selected other. Please indicate your theoretical orientation.

Censorship of Lyrics

14. Do you censor any of the following types of lyrics in sessions? Please select all that apply.

Drug references  
Alcohol references Profanity  
Religious references Satanic/demonic references  
Other  
I do not censor lyrics

15. You selected other. Please describe what type of lyrics you censor.

16. The following question contains specific profane words. By selecting “Yes,” you indicate you are comfortable answering censorship questions containing profanity. By selecting “No,” you indicate you would like to skip this question.

Yes  
No

17. Please indicate which of the following lyrics you censor in sessions. Check all that apply.

Ass  
Bitch  
Cunt  
Damn  
Dick



Douche  
Faggot  
Fuck  
Hell  
Ho  
Nigga  
Shit  
Other

18. You selected other. Please indicate what other words you censor in sessions.
19. When do you censor specific words in songs for sessions? Please select all that apply.
- In songs I cover live
  - In songs I improvise/freestyle vocally
  - In recorded songs I choose/bring
  - In clients' lyrics during songwriting
  - In clients' lyrics during vocal improvisation/freestyle
  - In recorded songs clients request/bring
  - On written/typed lyric sheets provided for clients
  - Other
20. You selected other. Please describe when you censor specific lyrics.
21. How do you censor lyrics? Please select all that apply.
- I use another word in place of the profane word
  - I take the word out and leave silence
  - I take the word out and manipulate rhythmic and/or melodic elements to accommodate for less words
  - I use a bleep/sound to censor the word
  - I insert special characters on the lyric sheets (f@%\$ or f\*\*\*)
  - Other
22. You selected other. Please indicate how you censor lyrics.
23. Out of the following options, please indicate the reason(s) you censor lyrics. Select all that apply.
- The facility requires it
  - The unit requires it
  - The therapeutic relationship could be negatively impacted
  - Uncensored lyrics may incite violence
  - Uncensored lyrics may incite self-esteem issues (racism, sexism)
  - Uncensored lyrics may incite emotional distress (depression, anxiety)
  - Uncensored lyrics are unprofessional
  - Uncensored lyrics may negatively affect other group members
  - Other staff/treatment team members would not approve of the lyrics
  - Uncensored lyrics would make the client feel uncomfortable

I feel uncomfortable using the lyrics  
My music therapy training indicated not to use these lyrics  
Other

24. You selected other. Please indicate your reason for censoring lyrics.

25. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Hearing profane lyrics affects my clients more than it affects me.

Strongly Disagree - Neutral - Strongly Agree

26. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Censoring lyrics negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree

27. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Not censoring lyrics negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree

#### Censorship of Themes

28. Do you censor any of the following topics or themes in sessions? Please check all that apply.

Sex

Sexual innuendo

Love relationships

Drug usage

Cigarette usage

Alcohol usage

Clubbing

Misogyny (i.e., hatred of women)

Misandry (i.e., hatred of men)

Gang related content

Violence

Guns

Other

I do not censor thematic content of songs in sessions

29. You selected other. Please indicate what other topics you censor in sessions.

30. When do you censor specific themes in songs for sessions? Please select all that apply.

In songs I cover live

In songs I improvise/freestyle vocally

In recorded songs I choose/bring

In clients' songs during songwriting

In clients' songs during vocal improvisation/freestyle

In recorded songs clients request/bring

On written/typed lyric sheets provided for clients

Other

31. You selected other. Please indicate when you censor certain themes.

32. Out of the following options please indicate the reason(s) you censor thematic content. Select all that apply.

- The facility requires it
- The unit requires it
- The therapeutic relationship could be negatively impacted
- Uncensored themes may incite violence
- Uncensored themes may incite self-esteem issues (racism, sexism)
- Uncensored themes may incite emotional distress (depression, anxiety)
- Uncensored themes are unprofessional
- Uncensored themes may negatively affect other group members
- Other staff/treatment team members would not approve of the themes
- Uncensored themes would make the client feel uncomfortable
- I feel uncomfortable using the themes
- My music therapy training indicated not to use these themes
- Other

33. You selected other. Please indicate your reason for censoring certain themes.

34. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Hearing certain themes within music affects my clients more than it affects me.

Strongly Disagree - Neutral - Strongly Agree

35. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Censoring certain themes negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree

36. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Not censoring certain themes negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree

37. Do you censor any of the following genres in sessions? Please check all that apply.

- Rap
- Heavy metal
- House/Club music
- Other
- I do not censor genres in sessions

38. You selected other. Please indicate what other genres you censor in sessions.

39. When do you censor genres? Please select all that apply.

- In songs I cover live
- In songs I improvise/freestyle vocally

In recorded songs I choose/bring  
In clients' songs during songwriting  
In clients' songs during vocal improvisation/freestyle  
In recorded songs clients request/bring  
On written/typed lyric sheets provided for clients  
Other

40. You selected other. Please indicate when you censor certain genre(s).

41. Out of the following, please indicate your reason(s) for censoring certain genres. Select all that apply.

The facility requires it  
The unit requires it  
The therapeutic relationship could be negatively impacted  
Uncensored genres may incite violence  
Uncensored genres may incite self-esteem issues (racism, sexism)  
Uncensored genres may incite emotional distress (depression, anxiety)  
Uncensored genres are unprofessional  
Uncensored genres may negatively affect other group members  
Other staff/treatment team members would not approve of the genres  
Uncensored genres would make the client feel uncomfortable  
I feel uncomfortable using the genres  
My music therapy training indicated not to use these genres  
Other

42. You selected other. Please indicate your reason for censoring certain genre(s).

43. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Listening to certain genres affects my clients more than it affect me.

Strongly Disagree - Neutral - Strongly Agree

44. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Censoring certain genres negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree

45. Please use the sliding scale to indicate how strongly you agree or disagree with the following statement. Not censoring certain genres negatively impacts the therapeutic relationship.

Strongly Disagree - Neutral - Strongly Agree