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# The Role of Personal Therapy for Music Therapists: A Survey

Carla Debbane Chikhani

This research was completed as part of the degree requirements for the [Music Therapy](#) Department at Molloy College.

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THE ROLE OF PERSONAL THERAPY FOR MUSIC THERAPISTS

A SURVEY

A THESIS

Submitted in partial fulfillment of the requirements

For the degree of Master of Science

in Music Therapy

by

Carla Debbane Chikhani

Molloy College

Rockville Centre, NY

2015

MOLLOY COLLEGE

The Role of Personal Therapy for Music Therapists: A survey

by

Carla Debbane Chikhani

A Master's Thesis Submitted to the Faculty of

Molloy College

In Partial Fulfillment of the Requirements

For the Degree of

Masters of Science

May 2015

Thesis Committee:

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**Abstract**

The purpose of this study was to examine the attitudes toward and prevalence of use of personal therapy among music therapists. An online survey was conducted with a sample of 132 music therapists working per diem, part-time, and full-time in the United States. A total of 130 surveys were analyzed using quantitative methods. The study examined the prevalence of use of personal therapy among music therapists, the ways music therapists seek to increase their personal development, the reasons and importance of receiving personal therapy, and the benefits of receiving personal therapy. Prevalence of use of non-music personal therapy was 33.6%, at the time of the survey, while 60.3% had participated in personal therapy at some time during their career. Personal therapy was most often sought out by the participants to increase their personal development. It was considered by 96.3% of participants to be a valuable and beneficial experience for personal and professional growth; among the reasons cited were that it enables a music therapist to increase self-awareness, work through issues, and develop coping skills. Implications and future research are discussed.

**Keywords:** self-awareness; personal therapy; music psychotherapy; music therapists

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## **Introduction**

### **Personal Encounters**

I have long believed that one of the most transformative experiences for a music therapist is to receive therapy, whether on a personal level or in a group, regardless of the modality: music, verbal, or arts-based. Therapy has the potential to improve a music therapist's self-awareness, explore and expand his or her creative potential through music, and facilitate personal and professional growth.

When I began my graduate music therapy program, I quickly realized that going through personal therapy was not a requirement. It also appeared that other students did not seek out therapy for their own benefit. I feel that music therapists should experience the power of this kind of personal exploration first-hand. Personal therapy allows for deeper self-knowledge and aids in one's work.

The topic of personal therapy was not often addressed in my graduate music therapy program. Nordoff-Robbins Music Therapy does not require one to undergo personal therapy as part of training, though such therapy is thought to enhance one's experience and heighten and improve clinical practice. The only personal music therapy requirements for students I know of are for those training in Analytical Music Therapy (AMT) and Guided Imagery and Music (GIM).

I had had positive experiences with verbal therapy prior to entering the graduate program, and continued to participate in it as I pursued my degree. Many transferences and counter-transferences arose from classroom topics, fieldwork, and internship experiences. Therapy helped me note emotions and situations that reminded me of my past; I felt it was important to

explore these in order to understand clinical situations clearly. I felt this growing self-awareness was tied to my growth as a future music therapist.

In my opinion, personal therapy can enlighten a soon-to-be therapist and enable him or her to delve into the therapeutic process firsthand. I chose to use verbal therapy, but recognize there are benefits to participating in music therapy as well. Personal music therapy is a mode I greatly want to experience for my personal and clinical growth.

As both my graduate program and personal therapy progressed, I continued to think I might be one of the few students who sought out personal therapy. I felt that my peers could also benefit from personal therapy, both to enhance their self-awareness and analyze their thoughts about their training. Hence I decided to research the prevalence of use of personal therapy among music therapists.

Only a few advanced music therapy training institutes require their students to participate in extensive personal music therapy. Most schools and programs in the United States do not require, or even provide, personal [music] therapy services. This caused me to question how music therapists in the field develop self-awareness for their personal and professional growth.

### **Significance of the Study**

Self-awareness is a key component of work as a music therapist: it increases one's availability, empathy, presence, authenticity, and connection with patients. According to the American Music Therapy Association (AMTA) Advanced Competencies, music therapists need to consistently work on personal development and on their ability to empathize and connect with patients. Music therapists need to "utilize self-awareness and insight to deepen the client's process in music therapy" (AMTA, 2009a, 8.1). In order to achieve this, a therapist must identify and address his or her own personal issues before and while tackling a client's personal issues.

Hesser (2001) stated, “It is difficult to guide someone on the path of self-exploration through music if we are personally unfamiliar with the territory” (p. 163). Personal therapy can be a gateway to accessing one’s own emotional and personal process and enhance one’s self-awareness (Camilleri, 2001; Hesser, 2001; Jackson, 2008). Camilleri (2001) noted that personal therapy and self-reflection can help music therapists connect to their patients by adding depth and quality to their work. Jackson (2008) also believed that personal psychotherapy for music therapists could improve music therapists’ skills while increasing their awareness of feelings and attitudes, which may have a positive impact on their professional work.

In some mental health professions worldwide, personal therapy is mandatory for trainees and active therapists. Malikiosi-Loizos (2013) indicated, “The European Federation of Psychologists’ Associations (EFPA) requires at least 100 hours of personal therapy...In Greece...Postgraduate students are asked to have the experience of about 40 hours of personal development work as part of their training and self-awareness process” (pp. 34-35). In a semi-structured interview study, Kumari (2011) found that psychologists in training considered personal therapy to be a valuable experience that enhanced their personal and professional development. Through semi-structured interviews with Spanish psychotherapists, Oteiza (2010) found that most participants considered personal therapy to be a positive experience that provided a unique contribution to their development.

### **Need for the Study**

A search of databases including psycARTICLES, psycINFO, ProQuest, and EBSCO uncovered little literature on self-awareness and personal therapy among music therapists. It would therefore be advantageous to investigate how common personal therapy is among music therapists in the field today. This study will provide information on how and when personal

therapy is used by music therapists, as well as other ways in which they seek self-awareness. It may open doors to future research, and enlighten music therapy students, music therapists, teachers, psychologists, educators, and supervisors on the role personal therapy might have in their development. Data from a survey of music therapists currently working in the field will be used to evaluate attitudes toward and use of personal therapy.

## Literature Review

### Music Therapy

According to Bruscia (1998a), “*Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change*” (p. 20). Music therapy is used to assess, work through, and resolve therapeutic issues identified by the music therapist and client. Camilleri (2001) stated that the goal of music therapy is to make clear, informed clinical assessments and guide music interventions that allow clients to address issues and grow while working toward personal goals.

The American Music Therapy Association (AMTA) Education and Training Advisory Board defines two levels of practice within the profession. The first level is “based on the AMTA *Professional Competencies* acquired with a baccalaureate degree in music therapy or its equivalent, which leads to entrance into the profession and Board Certification in Music Therapy” (AMTA, 2009a). The second or Advanced level is defined “as the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs” (AMTA, 2009a).

A music therapist at the Advanced level must hold at least a bachelor’s degree or its equivalent in music therapy in order to obtain professional credentials such as Advanced Certified Music Therapist (ACMT), Certified Music Therapist (CMT), Music Therapist-Board Certified (MT-BC), Registered Music Therapist (RMT), Guided Imagery and Music (GIM) Therapist, Analytical Music Therapist (AMT), and Nordoff-Robbins Music Therapist (NRMT). The AMTA notes it is essential for music therapists to further their education through such

endeavors as receiving clinical supervision, pursuing a graduate degree, and receiving additional training. Music therapists at this level may also hold a master's degree, which includes advanced clinical education in understanding the foundations and principles of music, music therapy, treatment, and management in clinical, educational, research, and administrative settings (AMTA, 2009a).

The Advanced level of music therapy requires a level of awareness about psychodynamic and reconstructive work that is not addressed in the first level of practice. The AMTA explains that:

The *Advanced Competencies* also provide guidelines for the Advanced Level of Practice in clinical, supervisory, administrative, and research settings, as well as in government relations work dealing with such issues as state licensures and employment practices. Music therapists with master's degrees and other professional requirements are being granted state licensures in the creative arts therapies (music therapy) and related disciplines in some states. (AMTA, 2009a)

Entering this level opens the door to further professional growth and development, grants additional professional titles, allows for the acquisition of state licenses, and allows the therapist to enter into deeper therapeutic work with clients, such as exploring interpersonal psychodynamic relationships. For instance, a therapist can work towards becoming a Licensed Creative Arts Therapist (LCAT), which requires a graduate degree in a creative arts therapy, such as music therapy, in addition to 1,500 hours of post-degree supervised experience. The LCAT enables a creative arts therapist to work at a psychotherapeutic level, identifying, evaluating, assessing, and treating dysfunctions and disorders.

When taking a more interpersonal psychodynamic approach with clients, it is imperative for music therapists to be engaged in enhancing their own self-awareness. The AMTA outlines some of the areas in which personal/self-awareness is needed:

Utilize self awareness and insight to deepen the client's process in music therapy; identify and address one's personal issues; recognize limitations in competence and seek consultation; utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomatology, and prognosis in formulating treatment plans; utilize advanced music therapy methods (e.g., listening, improvising, performing, composing) within one or more theoretical frameworks to assess and evaluate clients' strengths, needs, and progress; employ one or more models of music therapy requiring advanced training; utilize advanced verbal and nonverbal interpersonal skills within a music therapy context. (AMTA, 2009a, II.B.)

As Camilleri (2001) noted, "Self-awareness also adds depth and quality to our work as therapists" (p. 81) because it allows us to recognize our own feelings and how they affect our role. This is vital to understanding what happens when the client transfers feelings onto the therapist (transferences) and the redirection of a psychotherapist's feeling towards a client (counter-transferences). Without self-awareness on the therapist's part, emotional entanglement with clients becomes possible. Music therapists must be aware of their feelings and reactions, and simultaneously aware, conscious, and mindful of the client's feelings and transferences, in order to create and protect a positive client-therapist relationship.

### **Music Therapy Education and Training**

The AMTA's Standards for Educational and Clinical Training (2009) are broken down into three educational levels: bachelor's, master's and doctoral degrees. The education provided

for each level must include a “defined organizational structure, with administrative officers who involve music therapy faculty at the appropriate level of decision making and who provide the necessary support systems for effective implementation of the program” (AMTA, 2009b, 1.3). Programs need to be regularly evaluated to make sure their educational objectives and curricular requirements are up to date, and must provide internships. Ultimately, all programs need to be approved by the AMTA.

Undergraduate programs have to have “professional competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles” (AMTA, 2009b, 3.1.1) in order to be approved by the AMTA. Each program must develop an individualized training plan for each student for all AMTA-specified aspects of clinical training, and all students must complete 1200 hours of clinical training in pre-internship and internship experiences.

Graduate-level curricula require experiences that surpass the undergraduate level, such as partaking in “small seminars and tutorials and ongoing consultation with faculty prior to and during preparation of a final project over an extended period of time” (AMTA, 2009b, 4.2.4). Master’s students have to develop advanced clinical skills, study music therapy theory, improve their musical development, show personal growth, and do work in clinical administration and research. Doctoral degree students must demonstrate advanced competencies in research, theory development, clinical practice, supervision, college teaching, and clinical administration. Exact requirements vary depending on the title and purpose of the program. Candidates for doctoral degrees delve into deeper psychotherapeutic work, which involves more advanced and self-aware thought processes.



## **Psychotherapy**

Psychotherapeutic work, which relies upon the therapist's self-awareness, can be a powerful component of music therapy. According to Corey (2013), "Psychotherapy is a process of engagement between two people, both of whom are bound to change through the therapeutic venture...this is a collaborative process that involves both the therapist and the client in co-constructing solutions to concerns" (p. 7). Clients undergoing psychotherapy hope to learn about their moods, feelings, thoughts, and behaviors, while also learning ways to take greater control of their lives and respond to challenges more effectively.

In psychotherapy the therapist and client discuss issues the client is facing, and explore the client's values, attitudes, and beliefs in order to increase his or her psychological awareness. Within music therapy, a master's degree and the AMTA advanced competencies (2009) are required to enable students to practice music psychotherapy.

## **Definition of Music Psychotherapy**

Music therapy aims to restore, maintain, and improve a client's mental and physical health. Music psychotherapy deepens the process and focuses more on "greater self-awareness, resolution of inner conflicts, emotional release, self-expression, changes in emotions and attitudes, improved interpersonal skills, resolution of interpersonal problems... reality orientation... behavioral change, greater meaning and fulfillment in life, or spiritual development" (Bruscia, 1998b, pp. 1-2).

Music psychotherapy uses music in addition to or in lieu of the verbal discourse used in psychotherapy. Bruscia (1998b) explained that music facilitates the relationship between the therapist and client in addition to enhancing the process of therapeutic change.

### **The Role of Self-Awareness for Music Therapists**

Like psychotherapists, music psychotherapists must cultivate a strong sense of self-awareness, so they are attuned to their own feelings as well as the client's feelings. According to Camilleri (2001), "As we become self-aware, we become more in tune with our patients, and therefore, more closely meet their needs" (p. 83). Camilleri (2001) also highlighted, "As our self-awareness increases, we better come to know ourselves and this knowledge informs us about our way of being, enabling us to be honest and genuine in our presence and interactions" (p. 82). Music enables music therapists to increase their self-awareness and reflect this process step-by-step to clients, deepening the quality of their work. The symbolic and abstract use of music can allow a therapist or client express and venture into how he or she feels in the moment without any limitations or barriers of meaning, creating numerous possibilities of inner exploration.

Therapists can increase self-awareness through numerous modalities, including personal therapy, supervision, musical improvisations, and peer supervision. Each of these methods helps raise awareness of issues that may interfere with professional practice. Gardstrom and Jackson (2012) researched the use of personal therapy among undergraduate students. Nine undergraduate students participated by undergoing three short-term personal music therapy sessions, and then responded to an online survey. All participants in this study indicated an increase in their self-awareness, as well as gaining insight in aspects of themselves; "It is interesting that the undergraduate participants in this study found their self-learning to be of paramount importance" (Jackson and Gardstrom, 2012, p. 72).

### **Music Therapy Supervision**

One way in which music therapists increase self-awareness is through supervision. According to Salmon (2013), "Clinical [music therapy] supervision is based on an important and

intimate relationship... this dyadic relationship is closely interconnected with a third party—the client—and can have a lasting impact on the developing professional” (p. 11). Jackson (2008) suggested that professional music therapy supervision allows supervisees to build a new or deeper understanding of themselves in relation to their work, since it provides a higher level of practice while increasing clinical skills.

For professional music therapists, supervision “ideally, moves beyond the education and management issues often involved in the supervision of student and intern supervisees, and moves into a process that might illuminate, develop, and redefine both parties involved in the supervisory relationship” (Jackson, 2008, p. 193). Jackson (2008) also found that the majority of practicing, professional music therapists do not seek or participate in supervision.

According to Kennelly, Baker, Morgan, and Daveson (2012), “Supervision can be successfully provided to a music therapist by a supervisor who does not have training in music therapy, and that supervision is generally useful to those who access it” (p. 49). The range of possible supervisors is broad; in Jackson’s (2008) study participants received supervision from people in fields which included: “art therapy, drama therapy, creative arts therapy, education and special education, social work, occupational therapy, physical therapy, therapeutic recreation, psychology, counseling or mental health, psychiatry, substance abuse, grief and bereavement, and nursing” (p. 201-202).

Jackson (2008) found that supervision had positive outcomes because it supported consistent growth and development, which benefitted music therapists personally and their therapeutic relationships with clients. In a congruent study, Stephens Langdon (2001) created group music therapy supervision to provide support and a safe environment for music therapists to share, analyze, and find solutions to their dilemmas. Group members were urged to be aware

of themselves, their process, and their therapeutic work through different modes of intervention. This enabled them to work through personal issues, regardless of whether they were in the early or advanced stages of their careers.

In Guided Imagery and Music (GIM), supervision has been used to re-imagine sessions with clients. This approach serves “to develop a form of experiential self-inquiry, to uncover unconscious dynamics that operate within the GIM experience, and to devise procedures for analyzing the transference and counter-transference material unearthed through such a self-inquiry” (Grocke, 2002, p. 520). Grocke (2002) personally found that this technique allowed her to have deeper empathy for her client’s sense of helplessness.

Analytical Music Therapy (AMT) also uses professional supervision to “expand on the participant’s experiential understanding and personal experience about the therapeutic relationship and its various aspects and elements about the therapeutic nature and elements of music and the musical relationship between the client and the therapist” (Ahonen-Eerikainen, 2013, pp. 398-399). Priestley (1994) described the use of supervision called Intertherapy, “the second part of the orientation training for analytical music therapists” (p. 297), in which two trainees take turns being the therapist and the client, while finding their own therapeutic style. During Intertherapy, the supervisor is a silent observer who provides “therapeutic discussion at the end of the sessions, or he may want to give some hints on technique and theory at the beginning as well” (Priestley, 1994, p. 300) to the trainee.

Additionally, when AMT trainees become supervisors, this process can help make the “therapist take a long, hard look at his own work ... [by] picking out some of his own worst faults in the therapist ... [that] may come to meet him when he goes back to his own patients” (Priestley, 1994, p. 305).

These types of supervision help professionals learn to notice and concentrate on their inner feelings, images, and sensations, thereby increasing their self-awareness as they work with their clients.

### **Personal Therapy and Mental Health Professions**

Studies within the field of psychology have explored whether or not personal therapy for trainees and professionals should be mandatory. Oteiza (2010) studied therapists' experiences through a qualitative study using individual semi-structured interviews and found that "personal therapy [is] important amongst therapists to increase effectiveness and maintain well-being" (p. 222). Further, Oteiza noted that most participants in her study felt personal therapy should be required for any therapist, since it enables them to identify personal emotions and avoid enmeshment with the feelings of clients. The value of personal therapy for professional development consists of a large range of benefits, including:

Learning about one's emotional blind spots and hypersensitivities, to extending one's awareness of personal impact one tends to have on another people, as well as increasing the ability to recognize, accept, and work to correct one's inevitable human weaknesses and limitations. (Oteiza, 2010, p. 227)

Gardstrom and Jackson (2011) found that "those who do agree that personal therapy is necessary are of the opinion that therapy can increase empathy and understanding of the client and can help students develop self-awareness, therapeutic skills, and insight into the therapy process" (p. 252). King (2011) investigated whether therapists in training encountered dilemmas while participating in personal therapy with psychodynamic therapists. Eight experienced psychotherapists were interviewed, using a semi-structured interview format. King (2011) found that mandatory therapy requirements could create dilemmas such as ambivalence, resistance,

inhibition, counter-transference reactions, and poor motivation. Despite these challenges, the participants regarded personal therapy “as ‘crucial’ and as important as supervision and teaching. Participants commented on the dangers of trainees not having therapy and of not being aware of their ‘shadow’” (King, 2011, p. 189). They also felt therapy taught them about their personal limitations, helped them develop self-awareness, and gave them a better understanding of how to be an effective therapist.

Counseling is another field that requires self-awareness and has similar educational requirements. Counselors may specialize in mental health, addictions and behavioral health, marriage and family, vocations, and schools and education. Kumari (2011) noted, “The British Psychological Society’s Division of Counselling Psychology currently requires trainees who undertake professional training in counselling psychology to complete 40 hours of personal therapy” (p. 211).

Kumari (2011) investigated the experiences trainee counselling psychologists had of personal therapy and the impact this therapy had on their personal and professional development. She found “that personal therapy can be a valuable experience for both personal and professional development of trainee counseling psychologists” (Kumari, 2011, p. 226) and concluded that it should be required or strongly recommended for trainees because of its beneficial role in raising awareness of counter-transference in response to client transferences projected onto the therapist.

### **Personal Therapy and Music Therapists**

Self-awareness is important in the field of music therapy as well. Gardstrom and Jackson (2011) wrote, “The authors defined personal music therapy as *a systematic process of intervention wherein a credentialed music therapist helps a client to access, work through, and*

*resolve personal/interpersonal issues primarily through music interventions”* (Gardstrom and Jackson, 2011, p. 232). They added that:

The value of personal psychotherapy for music therapists has been advanced by noted clinicians and scholars as a way to improvise therapy skills, increase awareness about feelings and attitudes that impact one’s work, and nurture oneself... to enhance clinical competence, prevent burnout, and stay in touch with the ‘power of music.’ (p. 229-230)

In countries outside of the United States, including Denmark and the United Kingdom, personal music therapy is mandated by the music therapy curricula. In contrast, “The American Music Therapy Association (AMTA) [in the U.S] neither requires therapy of any kind as a curricular feature of its approved training programs nor maintains statistics on how many program coordinators mandate or encourage it” (Gardstrom & Jackson, 2011, p. 227).

Gardstrom and Jackson (2011) surveyed 42 Board-certified music therapists who were program coordinators in the United States, and found that “only six respondents indicated that some form of personal therapy is required for their students ... four of these six require only music therapy, while the others require verbal and music therapy” (p. 239). Some participants believed that personal therapy should not be required or encouraged, due to ethical concerns, violating students’ legal rights, availabilities and costs, and that undergraduate students will not be providing in-depth therapy after graduating anyway. One third of the respondents said they encourage personal therapy when situations indicate a student has personal issues that are interfering with academic progress. Gardstrom and Jackson (2011) concluded that if personal therapy is considered inappropriate for undergraduates as a tool for increasing their self-awareness, then it could be considered inappropriate for those same students to enter internships that require a high level of self-awareness.

One form of music therapy does not require personal therapy during training, since the approach originated to treat non-verbal children with developmental disabilities, and verbal therapy would not provide insight into the client experience. With Nordoff-Robbins Music Therapy (NRMT) the therapeutic communication takes place through the music itself (Sorel, 2013). It is “the act of making music” (p. 304) that is “considered the primary process for developing a trainee’s self-growth, clinical awareness, resources, refining perception, and working through blocks and personal issues” (p. 310) within NRMT. This process, known as ‘musicing,’ is a tool that goes beyond verbal discourse, and is an essential part of training. Sorel (2013) argued that in certain cases ‘musicing’ can substitute for personal therapy, as the music can be the vehicle through which fear, preferences, and limitations are addressed; “What happens in Analytical Music Therapy and Guided Imagery and Music through “being the client” take places in NR through “musicing” (Sorel, 2013, p. 304).

Personal therapy is not mandated for Nordoff-Robbins music therapists since it “is not essential in attaining the musical and clinical skills necessary to become an NR therapist,” but personal therapy “could enhance, expedite, and facilitate this development” (Sorel, 2013, p. 325), especially since at the present time, “NRMT has expanded to a variety of populations and settings, including verbal adults with psychiatric illnesses and medical conditions” (Sorel, 2013, p. 304).

Sorel (2013) concluded that personal therapy should be considered as a requirement for trainees, in order to create deeper insight into their personal issues. It is unclear if this needs to be Nordoff-Robbins therapy for those preparing to work with certain populations.

Analytical Music Therapy (AMT) and Guided Imagery and Music (GIM) integrate talk therapy with musical elements, creating a need for greater familiarity with psychotherapy. Both



require personal therapy during training. Abrams (2013) discussed his experience of personal therapy during his AMT training:

I have come to believe with greater conviction than ever before, in the indispensable role of personal therapy as part of becoming and remaining a competent clinician...I can not express the indispensable role of personal work in music therapy training to students and others with a level of confident sincerity I have not experienced prior to my own personal work in AMT.” (p. 303)

Priestley (1994) clarified that AMT intentionally uses techniques that trainees need to explore personally with another analytical music therapist and cautioned, “To submit others to these techniques without having experienced anything of their power on oneself is irresponsible dabbling and could be dangerous” (Priestley, 1994, p. 6).

Helen Bonny, the developer of the Bonny Method of Guided Imagery and Music (GIM), believed:

That trainees must receive personal GIM sessions to understand fully and use the method...she intended for trainees to gain deep awareness of their own relationships with music and to engage in profound processes of self-exploration...[allowing] trainees to relate better to client music experiences and therapeutic processes. (Abbott, 2013, p. 361)

Abbott (2013) explained that personal GIM therapy sessions allow the trainee to learn the professional skills needed to administer this therapy, including how to engage clients in psychotherapeutic music-imagery processes. Trainees deepen their self-understanding, helping them to maintain therapeutic relationships with their clients.

The key difference between participating in supervision sessions and attending personal therapy sessions lies in the goals of each. Supervision’s primary goal is to assist a therapist in

becoming a better clinician by identifying personal issues that may inhibit the supervisee's music therapy process. Since supervision is not "therapy" it is up to the supervisee to work through these personal issues in some way. The goal of personal therapy is to help and individual resolve personal issues and increase insight and self-awareness. To the extent that these issues affect a therapist's development as a clinician, personal therapy may be warranted.

### **Problem Statement**

This study seeks to survey active board-certified music therapists about their attitudes toward and use of personal therapy, specifically with regard to their self-awareness and personal development. I will ask what the participants believe the role of personal therapy is for music therapists, and the ways in which the participants seek to increase their own self-awareness. The following research questions will guide the study:

- 1) What is the prevalence of use of personal therapy among music therapists?
- 2) In what ways do music therapists seek to increase their personal development?
- 3) What are the reasons and importance for receiving personal therapy?
- 4) What are the benefits of receiving personal therapy?

## **Method**

### **Design**

This study employed a survey design that made use of SurveyMonkey to collect data. SurveyMonkey is an online survey development cloud that provides customizable surveys, and includes data collection, data analysis, sample selection, bias elimination, and data representation tools.

### **Participants**

Criteria for inclusion in this study were that participants had to 1) be a current board-certified music therapist (MT-BC) in the U.S.; 2) be working full-time, per diem, or part-time as a music therapist in the U.S.; and 3) give informed consent. Approximately 900 board-certified music therapists in the U.S. met these criteria. This study was reviewed and approved by the Molloy Institutional Review Board for the Protection of Human Subjects (See Appendix A for IRB Approval Letter).

Participants were recruited via an invitational e-mail (see Appendix D) on January 28<sup>th</sup>, 2015, which was sent out to board-certified music therapists listed by the Certification Board for Music Therapy (CBMT). This included both American and international music therapists working in the United States at the time of the survey. If the participant met the inclusion criteria and gave informed consent, he or she filled out the survey forms on the SurveyMonkey website.

### **Measures**

Two instruments were used to gather data. These were:

- a) A Demographic Information Questionnaire (Appendix B)

This contained questions about the participant's age, gender, ethnicity/race, cultural identity, current working status (credentials), level of education, primary work

setting, primary work population, work hours, years of professional experience, and theoretical orientation from which they most often work.

b) Attitudes and Prevalence of Personal Therapy Questionnaire (Appendix C)

The survey contained closed- and open-ended questions about support methods participants use (supervision either with a music therapist or non-music therapist, personal therapy outside of music therapy, personal music therapy, and/or peer supervision), the methods from which they benefit the most and why, the methods they no longer use and why, and how important they think it is for professionals to participate in some form of support.

### **Procedures**

The researcher contacted the Certification Board for Music Therapy (CBMT) in order to obtain e-mails of potential participants for this study. The initial invitations to potential participants were sent on January 28<sup>th</sup>, 2015. Ten days later, on February 6<sup>th</sup>, 2015, a second e-mail was sent as a reminder to increase participation (see Appendix E). Once participants agreed to take part in the study and informed consent was obtained, participants filled out the two questionnaires on the SurveyMonkey weblink. Approximately fifteen minutes was required to complete the surveys. The time frame for the entire study was two weeks and six days. The survey weblink on SurveyMonkey operated from January 28<sup>th</sup>, 2015, to February 17<sup>th</sup>, 2015.

Using the weblink collector from the SurveyMonkey program, the data was aggregated anonymously. All information gathered was stored in a secure location on SurveyMonkey and in a locked computer in the researcher's home.

**Data Analysis**

An analytical tool embedded in SurveyMonkey was used to analyze the data. The number of participants and survey statistics were computed for data gathered through both surveys. Within the Demographic Information Survey and the Attitudes and Prevalence of Personal Therapy Survey, cross-tabs of data were done in Microsoft Excel, to examine differences in attitudes by demographic features. Answers to the open-ended questions in the Attitudes and Prevalence of Personal Therapy Survey were analyzed using qualitative methods by identifying and summarizing themes, ideas, and patterns found in the participants' responses.

## Results

### Recruitment

Of 900 potential participants, a total of 132 (14.6%) responded to the survey, leaving 85.3% of potential participants who did not submit survey responses. Two respondents did not meet the criteria for the study and were therefore excluded, leaving a total of 130 participants. One hundred and eleven surveys were completed, while 19 surveys were submitted as incomplete. Of the incomplete surveys (14.5%), one participant completed two questions in the Demographic Survey section, and one question in the Attitudes and Prevalence of Personal Therapy survey section. The other 18 incomplete surveys had the Demographic Survey filled out in full, but all the questions in the attitudes and prevalence of personal therapy survey sections were left blank.

### Demographic Information

Table 1 presents the demographic profile of participants, while Table 2 presents data on work hours, years of experience, number of facilities participants currently work in, primary work setting, and primary work population.

Within the Primary Work Setting, 21 participants selected “Other” and wrote in the following: adult medical in-patient, hospital, nursing homes, drug and alcohol programs, community centers, assisted living facilities, senior center, preschool, pediatric, adult inpatient hospital, universities, children hospitals, VA medical center and hospital, small practice, forensic psychiatric state hospital, bereavement, and day treatment facilities.

Within the Primary Work Population, 18 participants selected “Other.” Three participants said all ages/all of the above, and the remaining participants wrote neonatal through end of life, adolescents, disabilities, terminal ill, adults and children, birth-21, and family and preschools.

**Table 1.** Demographic Information I ( $N=130$ )

Variable	%	<i>N of participants</i>
Gender		
Female	89.3	116
Male	10.7	14
Age		
20-29	28.6	37
30-39	36.4	47
40-49	12.4	16
50-59	12.4	16
60 & Over	10.0	13
Race/Ethnicity		
American Indian or Alaska Native	0.8	1
African American/Black	0.8	1
Asian/Asian American	2.3	3
Caucasian/Latin	91.5	119
Hispanic or Latino	0.8	1
Multiracial	0.8	1
Other	3.0	4
If “Multiracial” or “Other”, specify*	3.0	4
Level of Education		
Post MT-BC Undergraduate Level	39.5	51
Equivalency Master’s	12.4	16
Post MT-BC Master’s Level	42.6	55
Doctoral Level	5.4	7

\*This question allowed participants to select more than one answer. The four who selected “Other” specified their answer.

Table 2. Demographic Information II ( $N=130$ )

Variable	%	<i>N of participants</i>
Work Hours		
Per Diem	7.0%	9
Part-Time up to 15 hours per week	14.8	19
Part-Time up to 30 hours per week	17.9	23
Full-Time	60.1	77
Years of Experience		
Under 1	6.9%	9
1-4	30.2	39
5-9	18.6	24
10-14	13.9	18
15-20	16.2	21
Over 20	13.9	18
Number of Facilities		
One	46.0%	59
Two	14.8	19
Three	3.9	5
More than three	35.1	45
Primary Work Population		
Children	28.6%	37
Adolescents	10.8	14
Adults	25.5	33
Older Adults	20.9	27
Other (please specify)	13.9	18
Primary Work Setting		
Psychiatric Hospital	8.5%	11
Rehabilitative Facility	1.5	2
Pediatric Medical In-Patient Hospital	5.4	7
Adult Medical In-Patient Hospital	4.6	6
Outpatient Clinic	3.1	4
Day Care Treatment Center	1.5	2
Agencies Serving Developmentally Disabled Persons	5.4	7
Community Mental Health Center	0.7	1
Drug and Alcohol Program	1.5	2
Senior Center	0.8	1
Nursing Home	8.5	11
Hospice Program	10.8	14
Correctional Facility	0.7	1
Early Intervention	2.3	3
School	13.1	17
Private Practice	14.7	19
Other (please specify)	16.2	21



**Results by Topic**

Participants’ responses were classified under four topics: Prevalence of use of personal therapy among music therapists, ways music therapists seek to increase their personal development, reasons for receiving personal therapy, and benefits of receiving personal therapy.

**Prevalence of use of personal therapy among music therapists.**

Table 3 refers to participants’ answers to question 16, “When was the last time you sought out any type of personal therapy?” The majority of participants (85.4%) who answered this question had received personal therapy at some point during their professional careers.

**Table 3.** Last Time Participants Sought Out Any Type of Personal Therapy

Answer Options	Response Percent	Response Count
<b>Within the past month</b>	30.9%	34
<b>1-6 months ago</b>	15.4	17
<b>7-12 months ago</b>	3.6	4
<b>12 + months ago</b>	32.7	36
<b>Other (please specify)</b>	17.2	19
	<i>answered question</i>	<b>110</b>
	<i>skipped question</i>	<b>20</b>

Of the 19 participants who selected “Other,” 10 indicated they had never sought out any type of therapy. One participant wrote, “Never, but would like to,” one indicated, “Two years as needed,” two said, “Several years ago,” one wrote, “Only therapy experiences have been through collegiate/internship supervision, not a traditional therapy,” another indicated, “No, but self-awareness is covered in supervision,” and three participants stated they sought out personal therapy 5, 15, or 30 years ago.

Table 4 summarizes responses to question 17, “How often do you participate in any type of personal therapy?” The most common answer (23.8%) was that at the present time they never seek out any type of personal therapy.

**Table 4.** How Often Participants Participate In Any Type of Personal Therapy

Answer Options	Response Percent	Response Count
<b>Once a day</b>	2.7%	3
<b>Once a week</b>	13.7	15
<b>Twice a week</b>	2.7	3
<b>Once every two weeks</b>	11.9	13
<b>Once every month</b>	10.0	11
<b>Once every two months</b>	4.5	5
<b>Once every six months</b>	6.4	7
<b>Once every year</b>	5.5	6
<b>Never</b>	23.8	26
<b>Other (please specify)</b>	18.3	20
<i>answered question</i>		<b>109</b>
<i>skipped question</i>		<b>21</b>

Responses of the 20 participants who selected “Other” provided details that included “weekly as needed,” “in the past,” “not currently, but will go back if need be,” “used to go weekly,” “on and off,” “depends on the situation,” “every few years,” and “used to be weekly.”

Fifty-six participants (43%) reported seeking out personal therapy weekly or monthly. Differences emerged, however, when the frequency with which they attended therapy was broken out by work hours. Of the 77 music therapists working full time, 30 (38.9%) sought out weekly or monthly personal therapy sessions, and among the 20 “part-time 30 hours” participants responding to this question, 14 indicated they sought therapy that frequently. Of the 19 “part-time 15 hours” music therapists, seven attended personal therapy on a weekly or monthly basis, and five of the nine “per diem” did the same.

Interestingly, 27 participants (20.7%) claimed that they never seek out personal therapy, while 19 participants (14.6%) stated they used to seek it out or they seek it out every 6 months or yearly. Additionally, when participants were asked how many facilities they work at, 72.5% of participants reported that they work at more than one setting and 46% report working at one facility (46%).

**How music therapists seek to increase their personal awareness.**

Questions 19, 20, 21, 22, 23, 24, 25, 26, and 27 related to ways therapists seek to increase self-awareness. Table 5 presents data on methods used. A high percentage of participants have used music as a vehicle in increasing self-awareness. The percentage who have used music therapy is less than half that of those who use music outside of therapy.

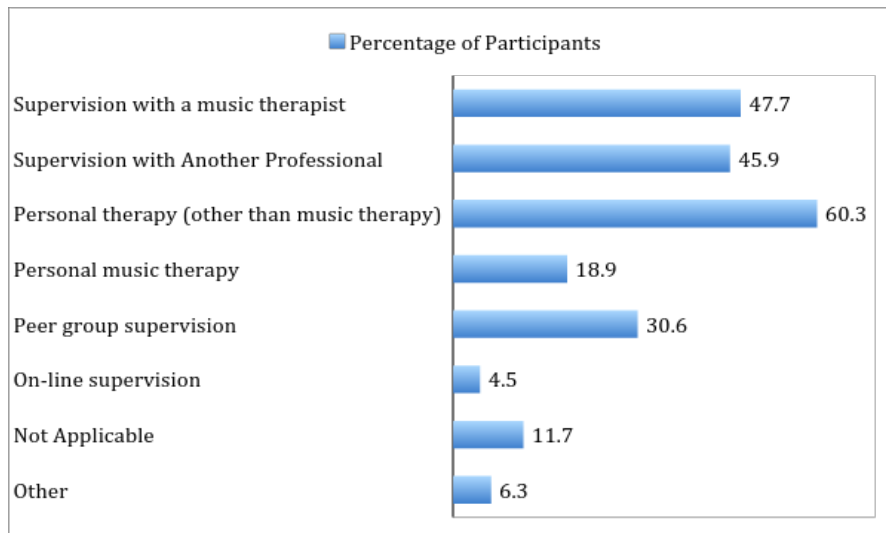
Table 5.

What methods do you use to increase your self-awareness? Check all that apply:		
Answer Options	Response Percent	Response Count
<b>Music Improvisation</b>	38.5%	42
<b>Supervision outside music therapy</b>	26.6	29
<b>Music therapy supervision</b>	14.6	16
<b>Music therapy peer supervision</b>	28.4	31
<b>Personal music therapy</b>	18.3	20
<b>Journaling</b>	39.4	43
<b>Spiritual support (including yoga, meditation)</b>	72.4	79
<b>Other personal therapy</b>	37.6	41
<b>Not Applicable</b>	2.7	3
<b>Other</b>	18.3	20
	<i>answered question</i>	<b>109</b>
	<i>skipped question</i>	<b>21</b>

Ninety-eight participants indicated they use more than one method for increasing their self-awareness; the average number of methods used was five. The 89 participants who selected “Personal music therapy,” “Other personal therapy,” “Spiritual support,” or “Other” were prompted to specify the type of method they used. Responses included yoga (31), meditation (24), verbal/talk therapy (18), prayer (18), church (11), GIM (10), musicing (the NRMT practice of making music by themselves or with others) (10), spiritual support (4), art therapy (3), and AMT (2).

Chart 1 refers to question 21, which asked participants to identify support systems they have used for their professional/personal development. Personal therapy (other than music therapy) was used by more participants than any other support system.

Chart 1. Support Systems Participants Have Used for Personal/Professional Development  
*n* = 113, with 80 participants providing multiple responses



Participants who selected “Personal music therapy,” “Other personal therapy,” “Spiritual support,” or “Other” were asked to specify the type of method they use. Sixty-four participants provided detail. Verbal/talk therapy psychotherapy (50%) was the most common support system used for personal or professional development.

In descending order, the other common support systems that were identified were prayer (28.1%), GIM (23.4%), musicing (17.1%), Cognitive Behavioral Therapy (10.9%), improvisational music therapy (7.8%), and AMT (4.6%).

Table 6 pertains to question 23, which asked participants to identify support systems currently being used for professional/personal development. Participants were allowed to select more than one answer.

Table 6.

Please identify any of the following support systems you are currently using for your own professional/personal development:		
Answer Options	Response Percent	Response Count
<b>Supervision with a Music Therapist</b>	15.4%	17
<b>Supervision with Another Professional</b>	30.9	34
<b>Personal therapy – other than music therapy</b>	33.6	37
<b>Personal music therapy</b>	4.5	5
<b>Peer supervision</b>	27.2	30
<b>Not Applicable</b>	26.3	29
<b>Other</b>	5.4	6
<i>answered question</i>		<b>110</b>
<i>skipped question</i>		<b>20</b>

Participants who selected “Personal music therapy,” “Other personal therapy,” “Spiritual support,” or “Other” were asked to specify the type of method they use. Forty-one participants answered this question. Responses included verbal/talk therapy or psychotherapy (19), music making by themselves or with friends and family, or in their bands (3), art therapy (2), GIM (2), spiritual support (2), yoga (2), prayer (1), and meditation (1).

Question 25 asked participants to explain how music is used within their music therapy supervision or personal music therapy. Twenty participants answered this question, while one hundred participants skipped it. Three participants wrote that they use music in GIM sessions, one used improvisational music therapy, two used AMT, and five participants use music in peer and clinical supervision. Participants also reported they use music in order to process what happened during their clinical work, to relax, and for support.

Table 7 refers to question 26, which asked participants which support system they feel they benefit from the most. Personal therapy other than music therapy rated high relative to the other support systems.

Table 7.

Which support system do you feel you benefit from the most?		
Answer Options	Response Percent	Response Count
<b>Supervision with a Music Therapist</b>	18.6%	20
<b>Supervision with Another Professional</b>	17.7	19
<b>Personal therapy – other than music therapy</b>	36.4	39
<b>Personal music therapy</b>	11.2	12
<b>Peer supervision</b>	19.6	21
<b>Not Applicable</b>	14.9	16
<b>Other</b>	11.2	12
	<i>answered question</i>	<b>107</b>
	<i>skipped question</i>	<b>23</b>

Participants who selected “Personal music therapy,” “Other personal therapy,” “Spiritual support,” or “Other” in question 26 were asked to specify the method they use. Fifty-three participants answered this question, while seventy-eight skipped it. Responses included verbal/talk therapy or psychotherapy (18), GIM (9), spiritual and family support (8), Cognitive Behavioral Therapy (3), music making either by themselves or with friends and family, or in their bands (3), improvisational music therapy (2), art therapy (2), and AMT (1).

Additionally, one participant shared, “It completely depends!! GIM is most beneficial for in depth seeking and personal growth; supervision with other therapists, with other professionals is necessary sometimes; personal MT is beneficial when dealing with areas that music can impact.”

**The reasons for and importance of receiving personal therapy.**

Question 15 asked participants “How important is self awareness to you?” Out of the 113 who answered, 72 participants (63.7%) indicated that it is extremely important, 27 participants (23.9%) said very important, 13 participants (11.5%) rated it as important, and one participant (0.9%) indicated it is not important. No one believed it is not important at all.

Table 8 represents question 18, which asked participants reasons why they seek personal therapy. The responses revealed a variety of reasons, and also that very few participants (6.1%, the lowest percentage on the table) received personal therapy as an educational requirement.

Table 8.

What are some reasons why you seek personal therapy? Check all that apply:		
Answer Options	Response Percent	Response Count
<b>Work through personal issues</b>	77.5%	76
<b>Manage personal problems</b>	44.8	44
<b>Receive support</b>	60.2	59
<b>Work through trauma</b>	27.5	27
<b>Develop coping strategies</b>	46.9	46
<b>Educational purpose</b>	18.3	18
<b>Required by school/training program</b>	6.1	6
<b>Other (please specify)</b>	14.2	14
	<i>answered question</i>	<b>98</b>
	<i>skipped question</i>	<b>32</b>

Of the 14 participants who selected “Other,” some participants indicated that “they don’t seek out personal therapy,” others wrote that it “helps them to understand their issues” and “increase self-awareness,” “spiritual growth,” “unbiased input,” “support,” “counseling skills,” “manage mental health,” and “disenfranchisement.”

Question 34 asked participants how important it is for a music therapist to receive personal music therapy rather than other forms of personal therapy. Of the 110 participants who answered this question, 13 participants (11.8%) indicated it is extremely important, 10 (9.0%) said very important, 30 (27.2%) said important, 26 participants (23.6%) believed it is not important, and four participants (3.6%) indicated it is not important at all. An additional 27 participants (24.5%) selected “Other.” Of these, 15 said the importance of personal music therapy “depends,” three had no opinion or were unsure, and one said that it is a good option.

Participants who selected “Not important” or “Not important at all” were prompted to explain their opinions. Write-in responses included “it may not be necessary for some,” that they

may “benefit from other types of personal therapy besides music therapy specifically,” that sometimes it is better to “get away from music,” “there are several types of personal therapy that can be useful,” “all forms of therapy are beneficial,” “I don’t believe any personal therapy is important,” “for the same reason it is not important for every child to receive music therapy,” and “it depends by the individual and what they feel most comfortable with.”

Table 9 summarizes responses to question 36, which asked participants how important it is for them to participate in some form of support.

Table 9.

How important is it for you to participate in some form of support?		
Answer Options	Response Percent	Response Count
<b>Extremely important</b>	53.2%	58
<b>Very important</b>	24.7	27
<b>Important</b>	16.5	18
<b>Not important</b>	4.5	5
<b>Not at all important</b>	0.9	1
<b>Additional Comments</b>		7
	<i>answered question</i>	<b>109</b>
	<i>skipped question</i>	<b>21</b>

Nearly all participants (103, or 94.5%) felt support was important, very important, or extremely important. In the additional comments sections, participants noted they receive support from friends and family, as well as peers, and that it helps to release stress.

Question 38 asked how important it is for other professional music therapists to receive some sort of personal therapy. Out of the 109 responses, 38 participants (34.8%) indicated it is extremely important, 25 (22.9%) said it is very important, and 43 (39.4%) considered it important. Two participants (1.8%) indicated personal therapy is not important, and one participant (0.9%) said it is not important at all. Six participants provided additional comments. Some wrote it “depends on the therapist and the therapy” and one said that it had a “good benefit.” Other comments included “it is important to be aware of countertransference,”



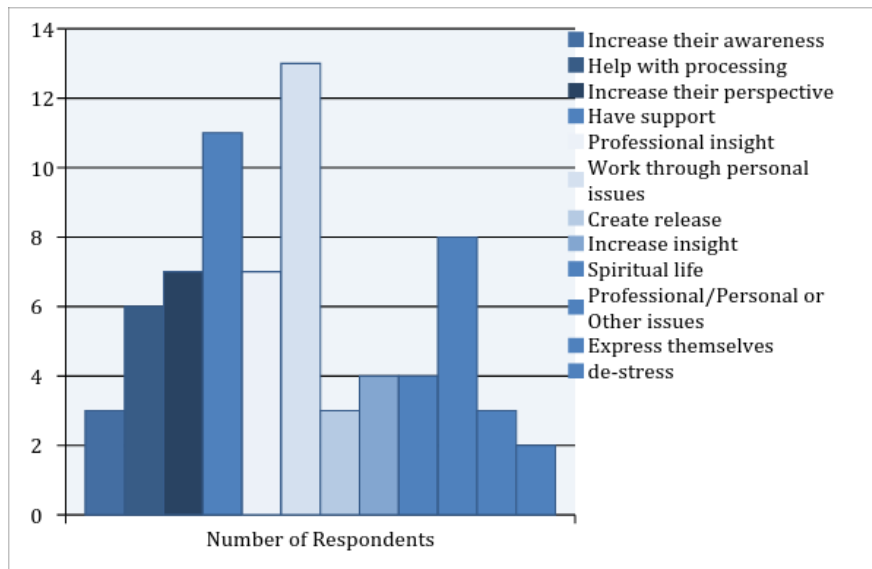
“important to develop self-awareness,” and “it is important to know how to take care of ourselves.”

A follow-up question was posed to those who said it was *not* important for professional music therapists to receive any type of personal therapy, asking them to elaborate on their opinion. Three participants answered saying “it is not necessary,” and another stated, “Just because they are a therapist, it doesn’t mean they need their own therapy.”

**The benefits of receiving personal therapy.**

Question 28 asked participants why they feel they benefit from their support system. Seventy-three participants answered this question, while 57 skipped it. The open-ended answers to this question were analyzed and are represented in Chart 2 below.

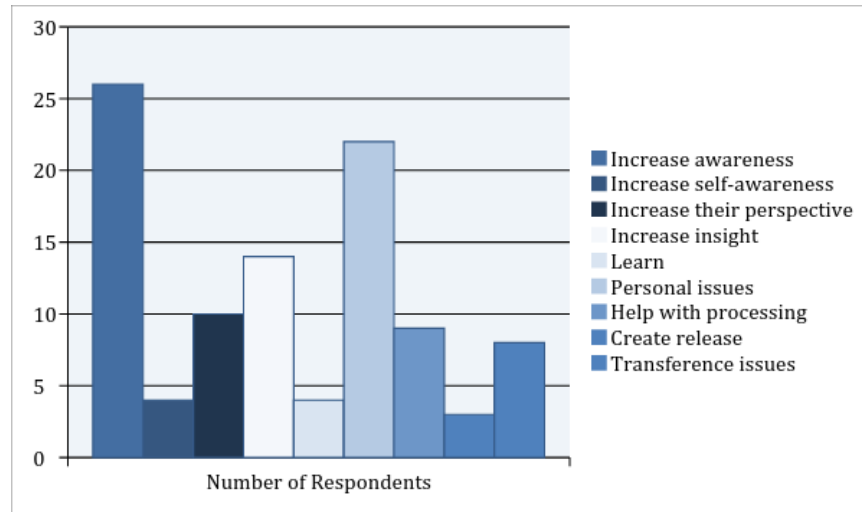
Chart 2. Reasons Why Participants Benefit From Their Support Systems



Question 40 asked participants if they believe personal therapy could increase their own self-awareness. One hundred and eleven participants answered this question, of whom 107 (96.3%) answered yes; 4 participants (3.6%) answered no. Participants who choose “yes” were then asked to explain why and how they believe personal therapy can increase their self-

awareness. Eighty-five participants responded; their answers were analyzed and are represented in Chart 3.

Chart 3. Reasons Why and How Participants Believe Personal Therapy Can Increase Self-Awareness



**Summary of Results**

Personal therapy was the most-used type of support system by participants, both currently and in the past. Participants believed that they benefit most from personal therapy and spiritual support. Plus 96.3% of participants consider personal therapy to be a valuable experience for personal and professional growth, while increasing one’s self-awareness.

### Discussion

The sample size of this study (N=130) was sufficient to generate significant results. Each participant was a Certified Music Therapist (MT-BC) working full-time, part-time, or per diem. The distribution of participants by gender closely paralleled national tendencies, with 89.3% of female participants and 10.7% male. The AMTA calculated that, in 2012, 89% of its members were female and 11% were male (AMTA, 2012).

The age range of participants was slightly older than the AMTA profile, with 36.4% falling between the ages of 30-39 and 28.6% between the ages of 20-29. The AMTA Workforce Analysis Survey (2012) reported the highest number of members (654) in the 20-29 year old range, and the second highest (350) in the 30-39 age range.

The ethnicity of participants was predominantly Caucasian (92.3%), a slightly higher rate than the AMTA's membership (87.9% Caucasian). Lack of participants from minority groups may have a bearing on results. Mori, Panova, and Keo (2007) surveyed Asian, Hispanic, and White American college students about their perceptions of mental illness and psychotherapy and found that "Asians are less likely to confide emotional problems to mental health professionals and other 'strangers' than are Whites" (Mori, Panova & Keo, 2007, p. 8). However, it was noted that Hispanics, predominantly Catholics, might feel more comfortable seeking therapy since "Catholics are encouraged to discuss their concerns with church officials, such as confessing their sins," (p. 8), though confessing in a church setting is quite different than working through personal issues in therapy. Ultimately, the authors concluded that psychological counseling might be a foreign concept to certain ethnical groups "due to perceived stigma or shame attached to disclosing emotional 'weaknesses' to an outsider" (Mori et al., 2007, p. 9).

These are concepts, however, that could be addressed in another study to fully grasp varying ethnic views on seeking personal therapy.

Of the 130 submitted surveys, 19 were incomplete. Eighteen of the incomplete surveys contained the Demographic Survey but were missing the entire second page on Attitudes and Prevalence of Personal Therapy. Since this was an anonymous survey, it is impossible to know for sure why this happened. According to SurveyMonkey, replies are recorded whenever a participant clicks the survey navigation buttons, “Next” or “Done.” Participants who completed the first page and clicked on the “Next” button but did not have time to complete the second page may have “timed out;” participants who exited without hitting the “Done” button would have lost the answers from the second page. It is also possible some participants decided not to continue beyond page one.

Even though 14.6% of participants did not submit the survey in its entirety, the completed surveys provided many insights into attitudes toward and prevalence of use of personal therapy for music therapists.

Interesting patterns emerged between number of work hours and use of personal therapy. The number of full-time music therapist participants, 30, reported a much higher rate of seeking out weekly or monthly therapy than the 14 participants who work “Part-time 30 hours,” the seven participants who work “Part-time 15 hours,” or the five per diem therapists who reported seeking personal therapy weekly or monthly. Since the participant pool of part-time and per diem music therapists is smaller than full-time music therapists, the percentage rates are higher, however the sample size for these categories may not be large enough to draw significant conclusions.

Possible explanations for the difference in usage of personal therapy between full-time and part-time therapists are that people working at more than one facility may not have as much time to participate in regular personal therapy, or those who work in multiple locations may have lower incomes and thus be unable to afford personal therapy. Alternatively, part-time or per diem therapists who work fewer hours than full-time music therapists, and may be less stressed by their job and therefore feel less need for therapy.

Although many participants in this study reported that they believe therapy is helpful (92.7%), not everyone believes one needs to be in therapy all the time in order to be self-aware. Many participants noted that seeking personal therapy and the type of personal therapy depends on the individual. The fact that many music therapists aren't currently seeking therapy may be due to many reasons. For instance, participants may have been in therapy in the past and now have sufficient insight into themselves that they no longer need to go; they have figured out multiple other support tools that work for them; they cannot afford it; there are no therapists in their vicinity; or they do not have enough time.

The most-frequent response to how participants increase self-awareness was spiritual support (72.4%), whether through prayer, church, meditation, or yoga. The least-reported support mechanisms were personal music therapy (18.3%) and music therapy supervision (14.6%). Music played a role in other ways, however; "Music improvisation" was used by 38.5% of participants, while 50% of those who selected "Other" indicated they used musicing. Journaling (39.4%) and "other personal therapy" (37.6%) shows a high percentage of use as well.

It was impressive and intriguing to see multiple methods currently being used. The majority of the participants (37.6%) who chose "Other personal therapy," for example, had experienced verbal/talk therapy. "Personal music therapy" and "Music therapy supervision" had

the lowest percentage rates, perhaps because music therapists do not want to seek support using the same method they use with their clients every day. They may need to take a break from listening or playing music. Alternatively, there may be a lack of professionals in the area for them to seek out.

In a question on the methods the participant benefits from the most, the highest rating was for “Personal therapy-other than music therapy” (36.4%); most of this “other” personal therapy used was verbal/talk therapy. Participants may lean more towards verbal/talk therapy for many of the same reasons they shun personal music therapy: because they need a break from therapeutic musical interactions, or welcome the chance to talk through feelings or problems, or have little access to other music therapists.

In noting that most participants sought out personal therapy instead of supervision, it is important to differentiate between the two modes of support. There is a fine line between supervision and therapy, and though struggles, insecurities, and personal issues can be discussed in both settings, the level at which they are discussed differs.

Salmon (2011) explained this difference by pointing out that clinical supervision can increase self-awareness, which can lead to deepened clinical understanding and the development of empathy for self and others. Through supervision, projection of personal issues can be identified, helping the music therapist become more aware of problem areas that affect interactions with clients. However, deeper explorations and working through personal issues should be undertaken during individual therapy sessions.

When asked about which support systems participants have used for their professional and personal progress, the most frequent response (60.3%) was “Personal therapy – other than music therapy.” The next most-used support systems were “Supervision with a music therapist”

(47.7%) and “Supervision with another professional” (45.9%). “Personal music therapy” had the one of the lowest rates of use at 18.9%.

When asked what modalities they are currently using, 30.9% of participants responded with “Supervision with another professional.” This brings to mind Kennelly, Baker, Morgan, and Daveson’s (2012) study; they found that 65% of music therapists had supervision from a non-music therapy supervisor, where “the cost of supervision was usually paid for by the employer and accessed at the place of work” (p. 48). Those who sought supervision from a music therapist “usually paid for the supervision [themselves] and accessed it away from the workplace” (p. 48). Lower cost may explain why many participants in this study reported seeking some form of supervision for support, either with a music therapist supervisor (15.4%) or a non-music therapy supervisor (30.9%), instead of seeking personal music therapy (4.5%).

Another common response on modalities used was “Personal therapy – other than music therapy” (33.6%). “Personal music therapy” again had the lowest percentage (4.5%) of respondents. Within this category, AMT and GIM were the music therapies most sought out, a pattern supported by Priestley (1994) and Abbott (2013), who noted that AMT and GIM both mandate that therapists undergo that specific type of personal therapy during training. Those who practice other modes of music therapy have choices about the type of therapy they would like to use, and non-GIM and non-AMT participants tend not to participate in personal music therapy.

Interestingly, 26.3% of participants replied “Not applicable” when asked to “Identify any of the following support systems you are currently using for your own professional/personal development,” without specifying why it was inapplicable. This may mean they were not currently seeking support for their development. Reasons provided for why participants do not participate in any type of personal therapy are: financial limitations (29.5%), lack of time

(16.3%), and lack of music therapy practitioners who work with music therapists (6.5%). Other reasons included “not necessary at the moment,” “never felt the need,” “achieved goals in recent therapy,” and “all of the above.”

Participants’ attitudes toward receiving support were explored separately from actual usage of support, since some participants may not have had a current need for therapy. The majority (53.2%) of the participants felt that it is “extremely important” to participate in some form of support. A few participants (4.5%) indicated that support is not important, as they do not need or require it.

When asked how important it is for music therapists to receive personal therapy, the most frequent response was “important” (39.4%). Within the additional comments section, many respondents indicated, “it depends on the therapist.” Three participants indicated that it is either “not important” or “not important at all,” and went on to specify that “I don’t see the need for personal therapy” and “I do not think NEEDING/benefiting from therapy is related to being a professional Music Therapist. If one needs therapy, they should get it. Just because they are a therapist, it doesn’t mean they need their own therapy.”

Each therapist is different and prefers different forms of support, and personal therapy may not necessarily be a universal need. However, personal therapy may, at some point in a music therapist’s career, be an important gateway to self-awareness and personal and professional growth. Abbott (2013) considered personal music therapy to have a positive impact on “the therapeutic stance [and] the therapeutic potentials of music” (p. 368), while also allowing client therapists to develop “deep awareness of their own relationships with music and to engage in profound processes of self-exploration” (361). Therapy for themselves allows many therapists to better serve their clients.



Personal therapy helps therapists gain awareness of and clarity around their own inter- and intrapersonal dynamics and thought processes, which then allows for greater openness and clarity when working with clients. Further, in personal therapy, a therapist can learn “experimentally about the therapy process...[an essential experience] in really understanding the nature of the work” (Daw & Joseph, 2007, p. 230). Through this first-hand experience, a therapist can learn “from being a client [about having] a deeper understanding of process issues, models, and techniques through actually experiencing them rather than merely reading about them” (Daw & Joseph, 2007, p. 230), providing more insight, awareness, and empathy with which to guide clients.

When gauging how important it is for a music therapist to receive music therapy rather than other forms of personal therapy, the three highest responses were “important” (27.2%), “not important” (23.6%), and “other” (24.5%). There is a wide divergence of opinion when music therapy is addressed specifically; perhaps this is because it is hard to generalize what might work for a particular therapist. The majority of participants who selected “Other” stated that it depends on the therapist and what type of therapy works for them. Some music therapists may want to shy away from music when working through personal issues in order to disconnect from “work” life, while others may find that music is the tool they prefer to use to work through their issues.

Only 20 participants answered question 25, which was about how music is used in supervision and personal music therapy. Considering that few participants use personal music therapy or music therapy supervision, it is understandable to have a lower response rate. Participants stated that music was used in GIM sessions, in improvisational music therapy, in AMT sessions, and with peers and clinical supervision sessions. Moreover, responders use music

in order to process what happened during their clinical work, to relax, for their own support, and to process their feelings.

Music can be useful in therapy and supervision, since it can transcend words and verbal constructs. Within supervision, music can help therapists explore what happened with a client, providing access to a range of emotions about the session. Argue (2013) shared her experience saying, “Music experiences during supervision also provided opportunities to relate with clients more fully. In order to address a specific clinical issue...I sometimes role-played a particular client [with the supervisor]” (p. 158).

Within therapy, music can also be used to explore feelings and issues. A therapist can experience what a client experiences in music, grasping the transformative power of the process on a personal level. Hesser (2001) stated, “personally experiencing music...deepens our understanding of our clinical work and changes our relationship to music permanently” (p. 163). It allows therapists to connect their intellectual beliefs about the power of using music in therapy to their own experience and growth.

The top reason participants seek out personal therapy is to work through personal issues (77.5%). The least common reason is “required by school/training program” (6.1%). This is consistent with Gardstrom and Jackson’s (2011) study, in which only six respondents indicated that some form of personal therapy was required by their program. “All respondents, however, indicated that development of the student’s self-awareness is the primary objective. It is important to question whether the classroom and other academic experiences mentioned are sufficient vehicles for increasing student self-awareness” (Gardstrom & Jackson, 2011, p. 243). Indeed, encouraging scholarly programs to require some form of personal therapy could have

long-term benefits to music therapists and to the profession as a whole. This would have to be researched in another study.

Most music therapists in this study had a positive experience of personal therapy, and most felt they benefited from it professionally and personally. This is congruent with what Malikiosi-Loizos (2013) found, which was that “personal therapy contributes to the greater effectiveness in the use of different skills, the possibility of a more authentic connectedness between therapists and clients” (p. 40). Participants appeared to believe personal therapy increases one’s self-awareness while developing one’s clinical relationships. It can also be an aid for learning what therapy is like, and what issues may arise during therapy with their clients.

The attitude of the majority of participants toward personal therapy is positive, with 97.1% saying it is “important,” “very important,” and “extremely important” to receive any type of personal therapy. They noted that personal therapy helps music therapists develop their awareness and clinical skills. Participants also believed that personal therapy can increase their self-awareness, increase their insight, help with processing, and improve their personal and professional lives.

## **Conclusion**

### **Summary**

The purpose of this study was to examine the role personal therapy plays in the lives of music therapists, and to explore attitudes toward and prevalence of use of personal therapy in the profession. Most participants indicated that while getting support is a clear need, the type of support systems used are subjective, multifaceted, and reflect current needs and budgetary constraints. Even though utilizing informal support systems, such as playing music and spiritual support, are important aspects in self-care, they may not provide the same benefits as personal therapy. Informal support systems tend to focus more on immediate release of stress; personal therapy explores and resolves deeper personal or professional issues. Overall, the majority of participants acknowledged that personal therapy can help music therapists increase their self-awareness and insight.

The vast majority of participants in this study believed that self-awareness is an essential component in developing as a music therapist. Indeed, 99% of participants who answered this question stated that it is either “important,” “very important,” or “extremely important.” Personal therapy is one of the most sought-out methods for increasing self-awareness, though many participants indicated it is not needed at all times. The use of personal therapy could prove extremely valuable to music therapists in their work with clients.

### **Limitations of the Study**

One aspect that limited my study was the lack of participants from members of the minority groups: 92.3% of the 130 participants were Caucasian. It would be helpful to conduct a survey with a more diverse population to analyze the differences between how music therapists use personal therapy based on their ethnic background.

The results of this study are subject to limitations due to the self-reporting nature of the questionnaire. Everyone has his or her thoughts and ideas about personal therapy, there is no right or wrong answer, and one cannot always be decisive about what a music therapist should or should not do. These personal opinions influence self-reported data and create biases. The data provided in this study can only be recommendations for current and future music therapists, teachers, and supervisors. A further limitation of this study is that participants' statements to the open-ended questions were fairly brief, and there were no possibilities to follow up on their thoughts. Therefore, future research using more in-depth interview techniques could provide richer results and data.

Another limitation is that the survey targeted practicing music therapists, not students, and the applicability of findings might differ. Financial considerations might be significantly more important for students, and since they are regularly receiving support via supervision, this may decrease or shift their need for other types of support.

This study did not explore beliefs on how frequently or for how long personal therapy is likely to be needed in order to improve self-awareness. Although personal therapy could be considered helpful for personal and professional development, the study did not delve into whether this means a) constant therapy is needed over the course of a career, b) occasional therapy should be accessed as needed, or c) a one-time experience is sufficient to expand one's self-awareness.

### **Implications for Music Therapy**

Limited research on personal therapy and music therapists is available, and it is hoped this study will be useful to music therapists, students, supervisors, parents, educators, and other therapists in the field in finding new ways to increase self-awareness while understanding the

potential significance of personal therapy. Only 6.1% of participants took part in personal therapy as “required by school/training program.” This seems to be a low percentage, since personal therapy can enable students to experience “being the client” while exploring skills and practice. Finding ways to integrate personal therapy in music therapy training programs without creating ethical dilemmas is an interesting challenge, as is finding ways to encourage music therapist to try personal therapy. In other countries personal therapy is incorporated into music therapy training, and programs in the United States would benefit from examining how this is done.

According to Gardstrom and Jackson (2011), “The American Music Therapy Association (AMTA) neither requires therapy of any kind as a curricular feature of its approval training programs nor maintains statistics on how many programs coordinators mandate or encourage it” (p. 227). Participants here suggested that personal therapy can be important, and that different types of personal therapy can benefit different types of individuals. The large majority agreed that personal therapy could enhance one’s professional and personal development while improving their self-awareness.

By experiencing personal therapy in school and training programs, students and music therapists could learn more about the process of how therapy works through supervisors, educators, and music therapists in a safe environment. In addition, they could explore personal issues that arise while learning new material, helping them process and understand why these feelings are emerging. Care must be taken to structure such programs so that ethical dilemmas are minimized, and there is a structure in place for promptly addressing any conflicts that arise.

**Future Research**

It would be advantageous to expand this study to include a greater number of music therapists, to gain greater insight into differences by ethnic background. Cultural influences or perceptions may affect views of personal therapy and the decision to become a music therapist. Expanding the participant pool to those working in other parts of the world would allow better understanding of the role, attitudes toward, and prevalence of use of personal therapy across cultures.

It would also be interesting to also delve into positive or negative experiences music therapists have had in personal therapy, to see how those experiences may have affected their outlook on therapy both for themselves and when working with their clients.

Further research could explore how personal therapy may be perceived within school and training programs. Future studies could ask educators and supervisors their thoughts about potentially mandating personal therapy, and how this mandate could be introduced with positive ramifications for students and music therapists.

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**APPENDIX A: IRB Review**

1000 Hempstead Avenue  
Rockville Centre, NY 11571  
www.molloy.edu  
**Tel. 516.323.3653**  
**Tel. 516.323.3801**

Date: December 3, 2014

To: Carla Debbane Chikhani/Suzanne Sorel

From: Kathleen Maurer Smith, PhD  
Co-Chair, Molloy College Institutional Review  
Veronica D. Feeg, PhD, RN, FAAN  
Co-Chair, Molloy College Institutional Review Board

**SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS**  
**Study Title: "The Role of Personal Therapy for Music Therapists"**

**Approved: December 3, 2014**

Dear Ms. Debbane Chikhani/Dr. Sorrel:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. With the approval you have received from the institution where the study will be conducted, it is EXEMPT from the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b) at the Molloy College IRB.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may disqualify the project from exempt status.

Sincerely,

Kathleen Maurer Smith, PhD

Veronica D. Feeg, PhD, RN, FAAN

## **APPENDIX B: DEMOGRAPHIC INFORMATION QUESTIONNAIRE**

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*Thank you for agreeing to participate in the study! You can complete the survey in one or more sittings. Please note that in order to access your responses over more than one sitting, you must use the same computer and be sure to NOT clear cookies from your browser response. It is the "Next" button or "Done" button that saves responses for each page.*

All responses will remain confidential and anonymous and personal identity will not be disclosed. Please reply to the following questions.

1. Your Gender

- Female  
 Male  
 Other: \_\_\_\_\_

2. Your Age

- 20-29  
 30-39  
 40-49  
 50-59  
 60 & Over

3. Your Race/Ethnicity

- American Indian or Alaska Native  
 African American/Black  
 Asian/Asian American  
 Caucasian/Latin  
 Hispanic or Latino  
 Middle Eastern  
 Pacific Islander (Guamanian, Chamorro, Native Hawaiian, Samoan, Other Pacific Islander)  
 Multiracial (please specify) \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_

4. Cultural Identity \_\_\_\_\_

(Please note the culture with which you identify most, such as French, German, American, Jewish, Christian, etc.)

5. Your Current Status – Check all that apply:

- Music Therapist  
 Educator  
 Administrator  
 Graduate Student  
 Other (please specify): \_\_\_\_\_

6. Level of Education

- Post MT-BC Undergraduate Level
- Equivalency Master's
- Post MT-BC Master's Level
- Doctoral Level

7. Please check your primary work setting

- Psychiatric Hospital
- Rehabilitative Facility
- Pediatric Medical In-Patient Hospital
- Adult Medical In-Patient Hospital
- Outpatient Clinic
- Day Care Treatment Center
- Agencies Serving Developmentally Disabled Persons
- Community Mental Health Center
- Drug and Alcohol Program
- Senior Center
- Nursing Home
- Hospice Program
- Correctional Facility
- Early Intervention
- School
- Clinic
- Private Practice
- Other (please specify): \_\_\_\_\_

8. Please check your primary work population

- Children
- Adolescents
- Adults
- Older Adults
- Other (please specify): \_\_\_\_\_

9. In how many facilities do you currently work?

- One
- Two
- Three
- More than three

10. Your Work Hours

- Per Diem
- Part-Time up to 15 hours per week
- Part-Time up to 30 hours per week
- Full-Time

11. Number of Years Work Experience

- Under 1
- 1-4
- 5-9
- 10-14
- 15-20
- Over 20

12. Your Primary Theoretical Orientation

- Music-Centered
- AMT
- GIM
- Nordoff-Robbins MT
- Humanistic
- Cognitive Behavioral MT
- Improvisational MT
- Other (please specify): \_\_\_\_\_

**APPENDIX C: ATTITUDES AND PREVALENCE OF  
PERSONAL THERAPY QUESTIONNAIRE**

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All responses will remain confidential and personal identity will not be disclosed. Please reply to the following questions.

*Self-awareness is defined as mindfulness, consciousness, and knowledge of one's own personality or individuality.*

13. Was developing self-awareness emphasized during your education and training?  
 Yes  
 No
14. Have you discussed topics related to self-awareness in your education and training? If so, in which setting:  
 Class  
 Supervision  
 Clinical Setting  
 Other (please specify): \_\_\_\_\_
15. How important is self-awareness to you?  
 Extremely important  
 Very important  
 Important  
 Not very important  
 Not at all important
16. When was the last time you sought any type of personal therapy?  
 Within the past month  
 1-6 months ago  
 6-12 months ago  
 12 + months ago  
 Other (please specify): \_\_\_\_\_
17. How often do you participate in any type of personal therapy?  
 Once a day  
 Once a week  
 Twice a week  
 Once every two weeks  
 Once every month  
 Once every two months  
 Once every six months  
 Once every year  
 Never  
 Other (please specify): \_\_\_\_\_



18. What are some reasons why you seek personal therapy -- check all that apply:
- Work through personal issues
  - Manage personal problems
  - Receive support
  - Work through trauma
  - Develop coping strategies
  - Educational purpose
  - Required by School/training program
  - Other (please specify): \_\_\_\_\_
19. What methods do you use to increase your self-awareness? Check all that apply:
- Music Improvisation
  - Supervision outside music therapy
  - Music therapy supervision
  - Music therapy peer supervision
  - Personal music therapy
  - Other personal therapy
  - Journaling
  - Spiritual support (including yoga, meditation, etc.)
  - On-line supervision
  - Not Applicable
  - Other
20. If you selected "Personal therapy," "Personal music therapy," or "Other," from the above question please specify the type of method you are *currently* using (e.g. GIM, AMT, verbal therapy...)
21. Please identify any of the following support systems you have used for your own professional/personal development:
- Supervision with a music therapist
  - Supervision with another professional
  - Personal therapy (other than music therapy)
  - Personal music therapy
  - Peer group supervision
  - On-line supervision
  - Not Applicable
  - Other
22. If you selected "Personal therapy," "Personal music therapy," or "Other," from the above question please specify the type of method you are *currently* using (e.g. GIM, AMT, verbal therapy...)

23. Please identify any of the following support systems you are *currently* using for your own professional/personal development:
- Supervision with a music therapist
  - Supervision with another professional
  - Personal therapy – other than music therapy
  - Personal music therapy
  - Peer supervision
  - Not Applicable
  - Other
24. If you selected "Personal therapy," "Personal music therapy," or "Other," from the above question please specify the type of method you are *currently* using (e.g. GIM, AMT, verbal therapy...)
25. If you do participate in music therapy supervision or personal music therapy, how is music used? \_\_\_\_\_
26. Which support system do you feel you benefit from the most?
- Supervision with a music therapist
  - Supervision with another professional
  - Personal therapy – other than music therapy
  - Personal music therapy
  - Peer supervision
  - Not Applicable
  - Other
27. If you selected "Personal therapy," "Personal music therapy," or "Other," from the above question please specify the type of method you benefit from the most (e.g. GIM, AMT, verbal therapy...)
28. Why do you feel you benefit most from this support system?  
\_\_\_\_\_
29. Have you received any type of personal therapy that was not helpful to you?
- Yes
  - No

Please explain the type of personal therapy you received and why it was not helpful to you: \_\_\_\_\_

30. Which support system do you no longer use?
- Supervision with a music therapist
  - Supervision with another professional
  - Personal therapy – other than music therapy
  - Personal music therapy
  - Peer supervision
  - Not Applicable
  - Other
31. If you selected "Personal therapy," "Personal music therapy," or "Other," from the above question please specify the type of method you no longer use (e.g. GIM, AMT, verbal therapy...)
32. For the support system you no longer use, why are you currently not using it?
- 
33. If you do not participate in any type of personal therapy, is it due to:
- Lack of time
  - Financial limitations
  - Lack of therapist in your area
  - Other (please specify): \_\_\_\_\_
34. How important is it for a music therapist to receive music therapy rather than other forms of personal therapy?
- Extremely important
  - Very important
  - Important
  - Not important
  - Not at all important
- Additional Comments: \_\_\_\_\_
35. If you selected not important or not at all important, please explain why.
- 
36. How important is it for you to participate in some form of support?
- Extremely important
  - Very important
  - Important
  - Not important
  - Not at all important
- Additional Comments: \_\_\_\_\_
37. If you selected not important or not at all important, please explain why.
-

38. How important do you think it is for other professional music therapists to receive any type of personal therapy?

- Extremely important
- Very important
- Important
- Not important
- Not at all important

Additional Comments: \_\_\_\_\_

39. If you selected not important or not at all important, please explain why.

\_\_\_\_\_

40. Do you believe personal therapy can increase your own self-awareness?

- Yes
- No

41. If you do believe personal therapy can increase your own self-awareness, why and how?

\_\_\_\_\_

**APPENDIX D: INVITATIONAL E-MAIL AND INFORMED CONSENT**

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*Title: The Role of Personal Therapy for Music Therapists*

Dear Music Therapist:

I am Carla Debbane Chikhani, a graduate student at Molloy College. I am currently conducting a survey on The Role of Personal Therapy for Music Therapists as part of my Master's program at Molloy College. The purpose of this study is to investigate trends in the field regarding both attitudes towards and the prevalence of personal therapy in music therapy. *If you are a current board certified music therapist (MT-BC), and working full-time, per diem, or part-time as a music therapist in the U.S., you are invited to participate in the study. Since there is little information on this topic in our field, your participation is very important, but entirely voluntary.*

You will be asked to fill out an on-line survey through SurveyMonkey. This web-based survey operates between *January 28th, 2015, and February 12th, 2015*. The survey will take 20-30 minutes to complete and can be completed twenty-four hours a day, in one or more sittings, at your convenience. The survey will consist of two short sections: Demographic Information and Attitudes and Prevalence of Personal Therapy. The researcher will be the only one to access all the data from the survey and all data will be kept in a secure and locked place. Your responses will be kept confidential and anonymous. In addition, if the data is published, no individual information will be disclosed. There is no foreseeable risk inherent with this study. This study was reviewed and approved by the Molloy Institutional Review Board; any questions about your rights as a research participant may be directed to the Institutional Review Board at Molloy College. They may be reached at (516) 323-3653.

By filling out and submitting the survey, you consent to participate in this study. If you wish to do so, please click on the following web-link:

<https://www.surveymonkey.com/s/HGVLYDL>.

If you have any questions about the study or wish to receive the results of the study after its completion, please feel free to contact me at [Cdebbane@lions.molloy.edu](mailto:Cdebbane@lions.molloy.edu), or to contact Dr. Seung-A Kim, my research advisor, at [Skim@molloy.edu](mailto:Skim@molloy.edu).

Thank you for your time and consideration.

Sincerely,  
Carla Debbane Chikhani

Student Investigator:  
Carla Debbane Chikhani  
M.S. student, Molloy College  
[Cdebbane@lions.molloy.edu](mailto:Cdebbane@lions.molloy.edu)

Faculty Advisor:  
Seung-A Kim, PhD, LCAT, MT-BC  
Music Therapy Program, Molloy College  
[Skim@molloy.edu](mailto:Skim@molloy.edu)

**APPENDIX E: REMINDER E-MAIL TO THE MUSIC THERAPIST**

---

*Title: The Role of Personal Therapy for Music Therapists*

Dear Music Therapist:

On January 28<sup>th</sup>, 2015, I sent an e-mail inviting you to participate in my survey research study, *The Role of Personal Therapy for Music Therapists*. This is a reminder that the survey will remain open until February 17<sup>th</sup>, 2015. For those who have already participated in my survey, I greatly appreciate your time and your contribution! *If you are a current board certified music therapist, and working full-time, per diem, or part-time as a music therapist in the U.S., and you have not yet participated in my study, I would greatly appreciate it if you could do so at your earliest convenience.* Since there is little information on this topic in our field, your participation is very important, but *entirely voluntary*.

You will be asked to fill out an online survey through SurveyMonkey. The survey will take approximately 15 minutes or less to complete. The survey consists of two short sections: a Demographic Survey Section and a Survey Section on Attitudes and Prevalence of Personal Therapy. The researcher will be the only one to access all the data from the survey and all data will be kept in a secure and locked place. Your responses will be kept confidential and anonymous. In addition, if the data is published, no individual information will be disclosed. There is no foreseeable risk inherent with this study. This study was reviewed and approved by the Molloy Institutional Review Board; any questions about your rights as a research participant may be directed to the Institutional Review Board at Molloy College. They may be reached at (516) 323-3653.

Since there is little information on this topic in our field, the current survey will provide significant information to MT students, MT professionals, advisors, school programs, educators, psychologists, and others about the trends in the field regarding attitudes towards and prevalence of personal therapy in music therapy.

By filling out and submitting the survey, you consent to participate in this study. If you wish to do so, please click on the following web-link:

<https://www.surveymonkey.com/s/HGVLYDL>

If you have any questions about the study or wish to receive the results of the study after its completion, please feel free to contact me at [Cdebbane@lions.molloy.edu](mailto:Cdebbane@lions.molloy.edu), or to contact Dr. Seung-A Kim, my research advisor, at [Skim@molloy.edu](mailto:Skim@molloy.edu).

Thank you for your time and consideration.

Sincerely,  
Carla Debbane Chikhani