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Running head: BURNOUT WITHIN VARIOUS MUSIC THERAPY METHODS

AN ANALYSIS OF BURNOUT AND MUSIC THERAPY METHODOLOGIES

A THESIS

Submitted in partial fulfillment of the requirements

For the degree of Master of Science

In Music Therapy

by

Samara Berry

Molloy College

Rockville Centre, NY 11570

2017

MOLLOY COLLEGE

An Analysis of Burnout and Music Therapy Methodologies

By

Samara Berry

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PhD, MT BC

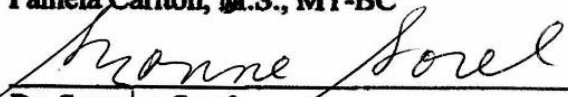
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Abstract

The purpose of this survey study was to explore professional burnout in music therapists and factors that may increase the likelihood of experiencing it. The *Maslach Burnout Inventory – Human Services Survey* (1981) and researcher-developed questions were used to test for burnout and variables among board-certified music therapists, such as demographics, longevity, and the music therapists' ideologies. The list of board-certified music therapists from 2017 was randomized and the survey was distributed to 1635 potential participants. Out of the 200 responses that were received, 199 agreed to participate in this study. On average, participants scored an average degree of burnout in emotional exhaustion and depersonalization, and a low degree of burnout in personal accomplishment. Overall, significance was found between the music therapist's methodology and the emotional exhaustion subscale. Results of this study also indicated that self-care and therapeutic approach alignment are factors that may lead to burnout.

Keywords: Burnout, career longevity, music therapy, self-care, therapeutic approach, music therapy methodology

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Background

This study investigated the relationship between burnout in music therapists and the methods they employ in their clinical work. Informing new and current music therapists about burnout will increase their awareness of what may cause them to be more susceptible to burnout based on their methods, levels of structure, approaches, and workplaces. This study employed quantitative methodologies and utilized a survey to collect data. Results obtained from the survey were analyzed using the *Statistical Package for the Social Sciences* (SPSS) computer program.

A music therapy “method” refers to the type of musical experience in which the client engages. There are four main methods of music therapy: improvisatory, re-creative, compositional, and receptive music experiences. Each method has the potential to evoke emotions, utilizes diverse cognitive skills, and varies in therapeutic applications and interpersonal processes. There are variations within each approach, which reflect a multitude of ways in which the therapist may engage the client (Bruscia, 2014).

The level of structure of a methodology defines how sessions are organized and led, depending upon the needs of the client and theoretical orientation of the therapist. The two levels of structure that this study explored are “nondirective” and “directive.” “Nondirective” refers to a less structured approach when facilitating sessions, allowing the client the opportunity to lead (Wheeler, Shultis, & Polen, 2005). “Directive,” a more structured style, is therapist-led and involves modeling and turn-taking within the client’s scope of attention, interests, and tolerance (Kim, Wigram, & Gold, 2009).

Burnout is associated with feelings of exhaustion and a cynical mindset toward one’s job and people at the job as well as a loss of concern for clients or patients (Keidel, 2002). It characterizes mental health professionals who have the psychological and somatic symptoms of

exhaustion (Papadatou, Anagnostopoulos, & Monos, 1994). Maslach and Jackson (1986) outline burnout in three categories: (1) depersonalization, (2) emotional exhaustion, and (3) lack of personal accomplishment.

Therapeutic approaches vary in the procedures the therapists employ in their practices such as the features, key concepts, and client-therapist relationships defined in each approach. Therapists choose an approach to achieve therapeutic change but may use various techniques from different approaches in their work based on presumptions and biases (Baker & Wigram, 2005; Corey, 2011). A few examples of therapeutic approaches are cognitive behavioral, psychoanalytical, existential, person-centered, and gestalt therapy (Corey, 2011).

Self-care has been found to increase career longevity and decrease risk of burnout. Some strategies for self-care include a healthy diet, exercise and/or adequate rest, and stress-reduction techniques (Fowler, 2006). Because self-care is a necessary factor in the music therapy profession, this variable was controlled for in order to determine if burnout is related to the methodologies employed in their practice or if it is related to insufficient self-care (Clements-Cortes, 2013).

Research questions for this study included:

1. How does burnout in music therapists relate to the methodologies that they employ in their practices?
2. What is the relationship between burnout in music therapists and the level of structure they employ in their practices?

Sub-questions that were examined include:

- a. How does burnout in music therapists relate to their workplaces?

- b. What is the relationship between burnout in music therapists and the theoretical approaches that they employ in their practices?
- c. What is the relationship between burnout in music therapists and the number of years they have been working as music therapists?
- d. How does self-care relate to burnout in music therapists?

Personal Rationale

Throughout the past six years, I have observed music therapists who could be described as “burned-out” according to current interpretations of this phenomenon. These therapists exhibited behaviors that reflected this sense of burnout: Perhaps they sang the same songs each week, dreaded going to the next session, facilitated music therapy sessions only once a week, or cancelled sessions because they were “too tired.” At the start of my observations during my third semester of college, I was excited and very eager to participate in music therapy sessions. After a few weeks of observations, however, I was easily stressed or tired and often did not want to go to my clinical site. Toward the end of the semester, I became worried, as I was not sure if these feelings were a result of my study of music therapy, my work with children, or the influence of the professionals at this site location. After reflecting upon this experience, I noticed that my feelings of stress and exhaustion were similar to those of the music therapist that I was observing at the time. In contrast, my emotions changed the following year during my fieldwork experience in which I was placed in a different location with a similar population. I began to look forward to session planning and was eager to share new musical experiences as well as to meet my clients in the music. This fieldwork experience solidified my conclusion that my reactions were not due to the population or thoughts about music therapy; rather, my feelings were entrained to those of

the music therapist. I realized that if I was experiencing the impact of these feelings and behaviors, it seemed likely that the clients and others in the workplace would also be affected.

Since being diagnosed with Juvenile Rheumatoid Arthritis at one year of age, I have been on and off medication throughout my life. Because my father is a pharmacist, my family is extremely careful when choosing a new medication; we research and study the different drug trials. I have grown to trust the numbers and facts. However, when choosing a doctor, I search for one with a person-centered approach in his or her practice because I am not defined by my disease and do not want to be treated as “just another patient.” This personal history informs my worldview, positivism.

Similarly, my personal approach to music therapy is relationship-based and client-led. This approach is informed by my past, how I was taught throughout my instruction through high school, and especially my education at Molloy College, which teaches within a person-centered approach. During my internship, however, I worked closely with the classroom teachers who did not agree with my method of following the client’s lead or improvising. These particular teachers operated from a cognitive-behavioral stance that focused on labeling objects, specific behaviors such as the students remaining seated in the chair, as well as more structured activities. Since I was a student intern, I had to change and adapt to various strategies to gain the respect of the teachers. When working within a cognitive-behavioral approach, which included following the pre-composed music strictly rather than following the client’s lead, I found myself not looking forward to sessions. I also felt less job satisfaction and more physically drained at the end of each day. In other words, I experienced feelings of burnout myself. During sessions, I felt as if I were trying to please the teachers first, then the clients. I focused on labeling instruments, determining what were “right” and “wrong” behaviors in sessions (i.e. sitting in the chair, raising your hand

before asking for something, etc.), and demonstrating the correct way to play an instrument as opposed to letting the child explore. Eventually, I adapted my approach to work in a humanistic manner, following the client's lead, while utilizing some cognitive-behavioral techniques as a compromise with the teachers. Although my feelings and exhaustion had changed, I recalled my thoughts being similar to previous observations. I began to research this "burned-out" feeling to learn how to prevent this from happening to me. I discovered the term "burnout" and some research articles that studied burnout in music therapy; however, I did not find studies examining the relationship between burnout and the music therapy theoretical approach or music therapy methods and strategies that would lead to such burnout.

Given my worldview and history, I concluded that a quantitative approach was the most reliable, generalizable, and cost-efficient way to research this topic. According to Abrams (2010), my worldview aligns with exterior-individual, which is rooted in positivism and conventional science. To explain further, Abrams (2010) states, "objective evidence is uncovered systematically through the precision, consistency, and neutrality of the scientific method, and accrues in an ever-growing repository of factual knowledge about the world" (p. 361). Therefore, the scientific method was utilized by conducting a cross-sectional survey design. This survey used subscales from the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) (1981) in addition to other survey questions specifically designed for this study. The purpose of this study was to explore professional burnout in music therapists and factors that may increase the likelihood of experiencing it.

Review of Literature

Music Therapy Methods and Levels of Structure

Because the terms “method” and “approach” are often used interchangeably, it is important to clarify what is meant by these terms for the purpose of this study. “Approach” refers to an overarching term that describes the techniques a music therapist aligns with or employs within an existing model or theoretical principles (Edwards, 2015). Bruscia (2014) defines “method” as “a particular type of music experience in which the client engages for therapeutic purposes” (p. 129). According to Baker and Wigram (2005), the therapist chooses a method within an approach to reach therapeutic goals or change. This study will focus on the methods that music therapists employ in their practices.

Within the field of music therapy, there are multiple methods utilized to address clinical need. Music therapists can do so by following a particular model of music therapy or by integrating elements of various approaches into their clinical work (Wheeler, 2015). The levels of structure to which this study refers are “non-directive” and “directive,” which describe who leads or initiates interactions in the music therapy session. This section of the literature review will further define various music therapy methods and levels of structure in a session.

Music therapy methods. As delineated by Bruscia (2014), there are four main methods in music therapy: improvisatory, re-creative, compositional, and receptive music experiences. Because there are different goals for each individual, each method varies in its therapeutic applications and techniques, evoking diverse emotions and utilizing different cognitive skills and sensorimotor behaviors. Further, they also have many variations, or different ways in which the therapist engages the client within that type of music therapy method (Bruscia, 2014).

Improvisatory experiences. “Improvisation” is defined as spontaneous and simultaneous actions of playing and creating (Bruscia, 1987). Improvisation may utilize a variety of musical elements, including, but not limited to, rhythm and melody. With the support and guidance from the music therapist, the client is encouraged to use his/her voice, body sounds, percussion or other instruments as a musical medium; either alone, with the music therapist, or through interaction with other clients (Bruscia, 2014). Improvisation in music therapy is very diverse, as it is used in a multitude of settings with a comprehensive range of clients. There are many specific models of improvisation in music therapy, each with its own goals to facilitate improvement of the client’s level of functioning or well-being. Goals may be general, population-specific, or individual, and can be the determining factor in how improvisation is used (Bruscia, 1987). Clinical goals may include, but are not limited to, bridging non-verbal communication to verbal communication, providing an outlet for expressivity, and exploring aspects of self in relation to others. According to Bruscia (2014), improvisation can take numerous forms. Some variations of improvisatory experiences include instrumental non-referential, instrumental referential, song improvisation, vocal non-referential improvisation, body improvisations, mixed media improvisations, and conducted improvisations.

Re-creative experiences. In re-creative experiences, the client learns or performs pre-composed music. This method also includes structured musical games and activities, as the client is realizing, interpreting, or reproducing music that already exists. Clinical goals may include improving attention span, group skills, communication of ideas and feelings, or memory skills. Variations of re-creative experiences include instrumental re-creation, vocal re-creation, musical productions, musical games and activities, and conducting (Bruscia, 2014).

Composition experiences. Composition experiences consist of the therapist supporting the client in writing songs, lyrics, or instrumental pieces (Bruscia, 2014). Songwriting is a process in which client(s) and therapist create, notate, and/or record lyrics and music to address needs of the client. These needs may include psychosocial, emotional, cognitive, or communication (Baker & Wigram, 2005). Although the therapist may be responsible for factors such as harmonizing or creating the music to the client's lyrics, this experience is takes place within a therapeutic relationship between the client(s) and therapist in order to address these clinical goals. These goals may include promoting self-responsibility, developing organization or planning skills, creative problem solving, and the ability to communicate inner experiences (Baker & Wigram, 2005; Bruscia, 2014).

Songwriting is used to express the client's thoughts and feelings as well as to enhance their self-esteem. It may be structured, involving filling in original keywords of a pre-composed song, or unstructured, which allows for more creativity, and the therapist supports the client in creating lyrics for a song (Baker & Wigram, 2005). Variations of compositional experiences include song parodies, song-writing, instrumental composition, notational activities, and music collages (Bruscia, 2014).

Receptive experiences. According to Bruscia (2014), receptive experiences in music therapy encompass the music listening experience through modalities such as silence or discussion. Live or recorded music is used and may consist of "live or recorded improvisations, performances, or compositions by the client or the therapist, or commercial recordings of music literature in various styles" (Bruscia, 2014, p. 134). Receptive music therapy, or listening experiences, are used to address various clinical goals that include promoting receptivity, stimulating or relaxing the client, exploring ideas or thoughts of others, or facilitating

reminiscence or memory, as well as evoking imagery or fantasies. These goals can be accomplished by focusing on spiritual, aesthetic, emotional, physical, or intellectual aspects of the music. There are many variations of receptive music therapy experiences, some of which include somatic listening, music anesthesia, music relaxation, meditative listening, song regression or reminiscence, song discussion, projective listening, and imaginal listening (Bruscia, 2014).

Music therapy level of structure. Music therapy sessions may be organized and led in various ways, depending on the needs of the client and the training and orientation of the music therapist. Wheeler, Shultis and Polen (2005) refer to these variations as differing “levels of structure” (p. 159). For the purposes of this study, non-directive (client-led) and directive (therapist-led) variations will be elucidated. The difference between the two levels refers to the therapist giving little direction and allowing client to establish the direction him/herself versus the therapist establishing the experience.

Nondirective (client-led). Wheeler, Shultis, and Polen (2005) describe the nondirective style as a less structured approach to facilitating sessions. In an effort to decode the premise of how clients perceive, interpret, and create music within musical-play, Carpenete (2013) provides significant insight into following the client’s lead: doing so allows the opportunity for the music therapist to begin understanding the client’s musical tendencies and preferred experiences that he/she finds pleasurable. The aim for the music therapist is to create an accepting (musical) environment and to build a relationship. Client-led music therapy begins by observing and listening to the client’s reactions to entering the session as well as the start of the music. During the music, the music therapist remains attentive to the client by adapting and reflecting the client’s affect through accompaniment and/or enhancing any responses the client may present

(Carpente, 2013). This non-directive style of leading sessions aligns with deeper levels of therapeutic exploration within music therapy (Unkefer & Thaut, 2002).

Directive (therapist-led). Directive, or therapist-led sessions, are characterized by a more structured style, with many of the group decisions made by the therapist in order to prompt responses. Kim, Wigram, and Gold (2009) described this as gently introducing activities that involve modeling and turn-taking within the client's scope of attention, interests, and tolerance. Therapists with a directive-style of leading sessions often fall under the supportive, activity-oriented level of music therapy (Unkefer & Thaut, 2002). Different kinds of clients may need varying levels of structure. For example, as a client grows older, the developmental level is likely to advance; the higher the developmental level, the less structure needed in the session (Wheeler, Shultis, & Polen, 2005). Thus, the levels of structure may be appropriate for different clientele and at different times in their development.

Burnout

The term "burnout," first used in 1974, was used to describe mental health professionals who had the psychological and somatic symptoms of exhaustion (Papadatou, Anagnostopoulos, & Monos, 1994). One definition, proposed by Greenberg (2002), describes burnout as extensive stress in the workplace that eventually results in emotional exhaustion. Keidel (2002) further developed this idea by defining burnout as "a syndrome of physical exhaustion including a negative self-concept, negative job attitude and loss of concern and feelings" (p. 200). According to Maslach and Jackson (1986), burnout is typically described as having symptoms in three categories: (1) depersonalization, (2) emotional exhaustion, and (3) a lack of personal accomplishment. The Maslach Burnout Inventory (1981) (MBI) is used to assess burnout as a factor of three subscales that are based upon these three categories of symptoms. Burnout is

associated with feelings of exhaustion and a cynical mindset toward one's job, people at the job, and a loss of concern for clients or patients. It is important to be educated about burnout, as it affects not only the therapist, but clients and co-workers as well (Keidel, 2002).

Impact of Burnout on Music Therapists

Clements-Cortes (2013) attempted to bridge the gap between health care professionals and music therapists by applying Keidel's (2002) research on various factors that caused burnout for hospice caregivers to the music therapy profession. The factors are as follows: (a) personal characteristics of the patient care staff, patient, and primary caregiver; (b) societal influences; (c) problems with the healthcare system; (d) institutional problems; (e) problems with the nursing system; (f) problems with the hospice system; and (g) stresses related to patient's family.

Clements-Cortes purported that these factors are parallel to music therapists because, similar to hospice caregivers, they also provide both compassion and care in their work.

Chang (2014) delved into the realm of burnout experiences of six music therapists who practiced in Canada. The participants' work experience ranged between one and over 15 years. In this qualitative study, the researcher described the participants' experiences of burnout and how it affected their work. Furthermore, the researcher explored their emotional, psychological, and physical beings, as well as how the participants recovered from and prevented burnout. The findings revealed a need for discussion about burnout and self-care during a music therapist's training process, thus allowing for the development of prevention and self-care practices. In addition, Chang found that support systems and resources should be established if symptoms occur.

Stress factors leading to music therapy burnout.

In addition to applying Keidel's (2002) research to burnout in music therapists, Clements-Cortes (2013) identified potential stress factors that contribute to professional burnout in music therapy. These potential stress factors include financial issues (low salary or high professional costs), personal issues, work overload, as well as isolation. Compassion fatigue, another stress factor experienced by persons providing care for others, may lead to reduced concern and empathy for clients. Additionally, Farber and Heifetz (1982) suggested that a primary factor leading to burnout in therapists is due to a lack of success in their therapeutic work. Therefore, it is important for music therapists to be aware of the stress factors that may lead to burnout, and the negative effects that burnout may have on the client and therapist (Clements-Cortes, 2013).

Oppenheim (1987) analyzed various stress factors that may have contributed to burnout to music therapists. Through the use of six subscales of the MBI, Oppenheim studied 239 music therapists' degree of burnout based on the following variables: hours worked per week, number of years as a registered music therapist, type of institution, gender, age, and number of years at current job. The researcher found that music therapists who worked for over five years at their current job scored in the medium range of the burnout subscales. In addition, 52 participants scored in the moderate range on at least one of the subscales, and 29 participants had a higher score of burnout on at least one subscale. Results of this study indicated that correlations were low, which showed that there was no established relationship between these predictor variables and the subscales used. This outcome may have been confounded due to the number of years that participants worked (76.9% worked five years or less). As a result of this, they may have not been in the working field long enough to experience burnout.

Some music therapists who participated in Oppenheim's (1987) study included comments concerning their music therapy work, most of which referred to insufficient pay, being required to engage in activities outside music therapy, and lack of respect and support from administrators. Moreover, because doctors and nurses may not understand the benefits and stressors of music therapy, music therapists can feel misunderstood in their workplace. In addition, music therapists can feel isolated due to the lack of other music therapists employed in that workplace (Rykov, 2001). It is recommended music therapists counteract negative statements towards them with positive self-talk statements to reduce anxiety and other implications of burnout (Clements-Cortes, 2013).

Self-care, longevity, and coping strategies for music therapy burnout.

Self-care and positive mental coping strategies have been found to correlate with longevity and burnout. For instance, Fowler (2006) conducted an unblinded survey, which consisted of American Music Therapy Association members from the Midwest who were working as music therapists at the time of the study. The researcher found that positive mental coping strategies and attitudes correlated with greater professional longevity within the field of music therapy. These coping factors included increasing positive appraisal and reducing threats or negative comments. Similarly, Rush, Schoel, and Barnard (1995) found that individuals who had positive coping skills and positive assessments of stressful situations were more likely to have positive professional longevity. In Fowler's (2006) questionnaire, she concluded, "Music therapists who have professional longevity can find a strong sense of personal accomplishment in their lives" (p. 193). Therefore, to increase professional longevity and reduce risk of burnout, self-care strategies are suggested in the helping professions. Some of these strategies for self-care

include a healthy diet, exercise and/or adequate rest, and stress-reduction techniques (Clements-Cortes, 2013; Fowler, 2006).

Additionally, Decuir and Vega (2010) utilized a survey to identify skills that are associated with career longevity in music therapists, which led to an analysis about burnout. The respondents revealed the primary factors that contributed to burnout were few employment and advancement opportunities, low salaries, and compensation (pricing, reimbursement, and health care). Geography also contributed to burnout, as there are more and better opportunities in urban areas than in rural areas.

Personality and employment factors in music therapy burnout.

Burnout is a concern for many professionals who work in human service fields, as it can lead to job withdrawal (i.e. missing work or leaving the job). For those who remain at their jobs, burnout can lead to a decrease in job productivity as well as affect their colleagues (Maslach, Schaufeli, & Leiter, 2001). To further explore personality, burnout, and longevity among music therapists, Vega (2010) surveyed 137 American music therapists (91% female, nine percent male). Overall, Vega found that low scores in vigilance, defined as those who trust and are accepting of others' motives, is the only predictive factor of longevity (Vega, 2010; Cattell & Mead, 2008). Factors such as gender and geographic location were not found to be statistically significant in relation to longevity. In addition, the researcher also found that the highest education degree earned by the music therapist was predictive of longevity.

Vega's (2010) findings from the MBI revealed that most music therapists scored in the "average" range of burnout (10% had a high degree of burnout, less than one percent had a low degree of burnout). The researcher also found a significant relationship between emotional exhaustion and the number of years in the profession, with anxiety as the factor that contributed

the most to emotional exhaustion. Even though sensitivity and tension were not found to be statistically significant, they still contributed to this prediction. Overall, this study confirmed that there is a strong relationship between personality, burnout, and career longevity (Vega, 2010).

Similarly, Kim (2012) examined personality and employment factors and found that music therapists who were older and earned a higher salary were likely to feel more confident within their work setting. Further, Kim found that higher job satisfaction significantly predicted lower levels of burnout. The researcher concluded that job satisfaction was an important factor when predicting music therapy professional burnout; thus, job satisfaction must be increased in order to decrease these burnout symptoms. The researcher also discovered a positive correlation between job satisfaction and collective self-esteem, as well as collective self-esteem and depersonalization. Promoting self-esteem plays an important role in preventing emotional symptoms of burnout (Kim, 2012).

Kim (2012) concluded that music therapists in Korea suffer from similar burnout symptoms to those that were observed in Vega's (2010) findings. The author also noted that Korean music therapists who participated in this study experienced higher levels of burnout symptoms when comparing the scores to mean samples in previous studies. A contributing factor to these higher levels might be related to the developmental stage of music therapists in Korea, a relatively new profession in this country (first developed in 1988). As a result, Korean music therapists often struggle with unsatisfactory employment conditions, short-term contracts, poor work conditions, and a low income. These are all factors that may lead to higher levels of burnout (Kim, 2007; 2011; 2012).

Overall, it is important for music therapists to be aware of their vulnerability to stress and the various factors that contribute to it. Not only does it affect the therapist negatively, but it may

affect the clients and others in the workplace as well. Recognition of these impacts and various stress factors would have a positive effect on the therapist's work and possibly reduce burnout (Clements-Cortes, 2013).

As elucidated above, there is a small body of literature examining burnout and music therapists, and there are many variables not yet explored. To add to the music therapy literature, the researcher investigated variables in music therapy practices that have not been studied previously in relation to professional burnout. These variables were music therapy methodology, level of structure, and theoretical approach.

Method

Participants

The criteria for inclusion in this research study were: (1) Board certified music therapists (MT-BCs) between the ages of 22 and 70 years, (2) English comprehension, and (3) previous or current practice in the United States. Following the Institutional Review Board approval (see Appendix A), the researcher contacted the Certification Board for Music Therapists (CBMT) and purchased the email addresses of 2016 MT-BCs. Surveys were sent to a randomly selected pool from the CBMT member list. The researcher randomized participants using the random number generator function in Microsoft Excel.

Research Design

This research design was influenced by Vega (2010), Fowler (2006), and Oppenheim (1987) who used quantitative measures to assess the data of burnout in music therapy. Vega (2010) used two standardized tests of the Sixteen Personality Factors (2002) and the MBI (1981). Oppenheim (1987) used a survey that she constructed as well as the MBI. Fowler (2006) created a questionnaire and utilized the MBI as well as the Stress Profile by Nowack (1999).

With these previous studies in mind, a quantitative survey design was employed for the current study. Measures included the MBI - HSS (1981) and researcher-developed questions (see Appendix B). The measures were chosen in order to examine professional burnout in music therapists in relation to the music therapy method and level of structure they employ in their practices.

Data collection.

Data collection took place from January 2017 to March 2017, followed by analysis of the data until April 2017. The target number of participants was 150-200 responses. The researcher randomized the list of MT-BCs and sent out 400 surveys followed by a reminder email two weeks after the initial recruitment date. Because the target number was not reached within two weeks of the reminder email, a second round of recruitment occurred, following the same procedures as the first. The first email recruitment resulted in a total of 50 responses, a 12.5% response rate. After the first week of recruiting for the second round of email recruitment, it appeared that the response rate for this round would also hover around 12%. Even with the reminder email, the number of responses tended to plateau after the first week. Therefore, the researcher decided to send out a third round of invitations to the study based upon the 12% response rate. With the predicted response rate, it was calculated that this study needed approximately 100 more responses to achieve the target range of 150-200 responses. Thus the researcher sent out 835 more invitations to reach the target range. After 200 responses were received, the survey was closed.

The survey was posted on the online survey website, Survey Monkey, and required a password. This was to ensure that only persons recruited via email could respond. All respondents' information and answers to the survey were anonymous. The survey began with a

consent form in which the respondents agreed or disagreed with the terms and conditions (Appendix C). By agreeing to the terms and conditions, the respondent confirmed that he/she met the inclusion criteria and was the person who received the invitation email (Appendix D). All data collected was exported from Survey Monkey and saved in an encrypted file that is on the researcher's personal, password-protected laptop accessible only by the researcher.

Procedures.

After the recruitment process outlined above, the researcher collected the data from Survey Monkey and exported it to an encrypted file, which was stored on the researcher's personal, password-protected laptop that was only accessible by the researcher.

Data analysis

To analyze the data, the researcher used *the Shapiro-Wilk* test to investigate normality in the data. When comparing two independent variables, the *Mann-Whitney U* test was utilized; for three or more independent variables the *Kruskal-Wallis* test was used; and when the independent variables were ordinal the *Jonckheere-Terpstra* test was employed. Distributions of the subgroup data were checked before any test was utilized and post hoc pairwise comparisons between independent variables were made when appropriate. To control for Type I error, Bonferroni correction was utilized in the post hoc cases. All statistics were performed using SPSS software.

Results

The first email recruitment sent out 400 surveys and had 50 total responses, which is a 12.5% response rate. Of the 50 total responses, six were partially completed surveys. The second email recruitment sent out 400 more surveys and had a total of 57 responses, which is a 14.25% response rate. Of the 57 responses, eight were partially completed surveys. The third email

recruitment sent out 835 more surveys and had 93 total responses, which is 11.14% response rate. Of these 93 responses, 11 were partially completed surveys.

In total, the researcher sent out 1635 surveys and received 200 total surveys. Of these 200 surveys, 199 participants agreed to the consent and moved on to take the survey. One respondent denied consent and was not able to move on to the survey. Due to the 25 partial responses, there are 174 completed surveys; however, responses of those who partially completed the survey were still analyzed when applicable.

Demographic Data

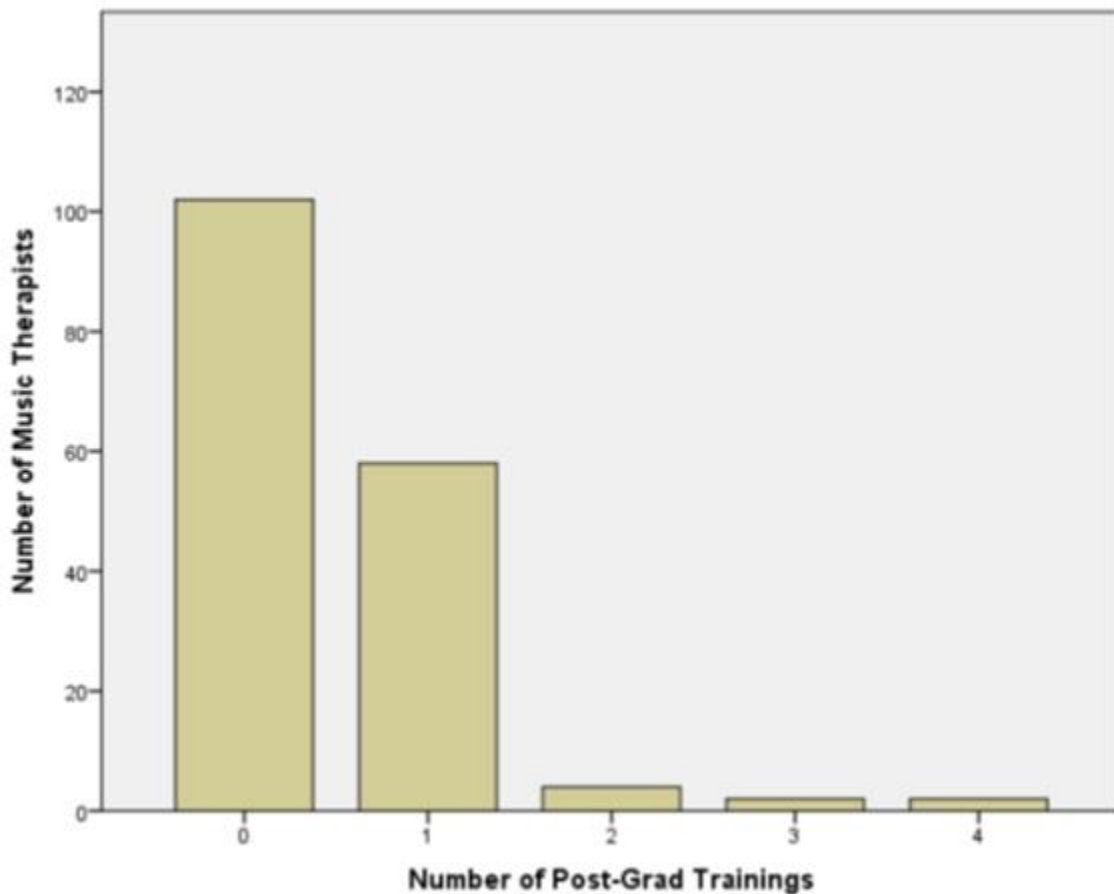
Out of the 176 participants that responded to the question about gender, 19 (10.8%) are male and 155 (77.9%) are female. Two participants preferred not to answer and no participants chose “other.” Further, of the 176 responses about the participants’ age, 74 (42%) reported to be between the ages of 20 and 30 years; 54 (30.7%) reported to be between the ages of 31 and 40 years; 11 (6.3%) reported to be between the ages of 41 and 50 years; 28 (15.9%) reported to be between the ages of 51 and 60 years; and 9 (5.1%) reported to be between the ages of 61 and 70 years.

The respondents who partook in this survey study were employed in 34 states. A majority of the respondents in these 34 states reported working in California (12 music therapists), Minnesota (10 music therapists), New York (11 music therapists), and Pennsylvania (11 music therapists). Additionally, 176 participants indicated their highest level of music therapy education completed: 52.8% held an undergraduate degree in music therapy, 45.5% held a master’s degree in music therapy, 1.1% held a doctoral degree in music therapy, and .5% did not complete their degree yet.

Music Therapy Reported Data

One key aspect on which the researcher wanted to gather data was post-graduate music therapy training. The trainings which the participants completed include: Guided Imagery in Music (7.5%); Nordoff-Robbins Music Therapy (3.5%); NICU Music Therapy (12.6%); Neurological Music Therapy (16.6%); and Analytical Music Therapy (0%). The number of participants reporting no post-graduate training was 51.3%. As Figure 1 indicates, some participants had more than one post-graduate training. Category “0” refers those with no post-graduate training.

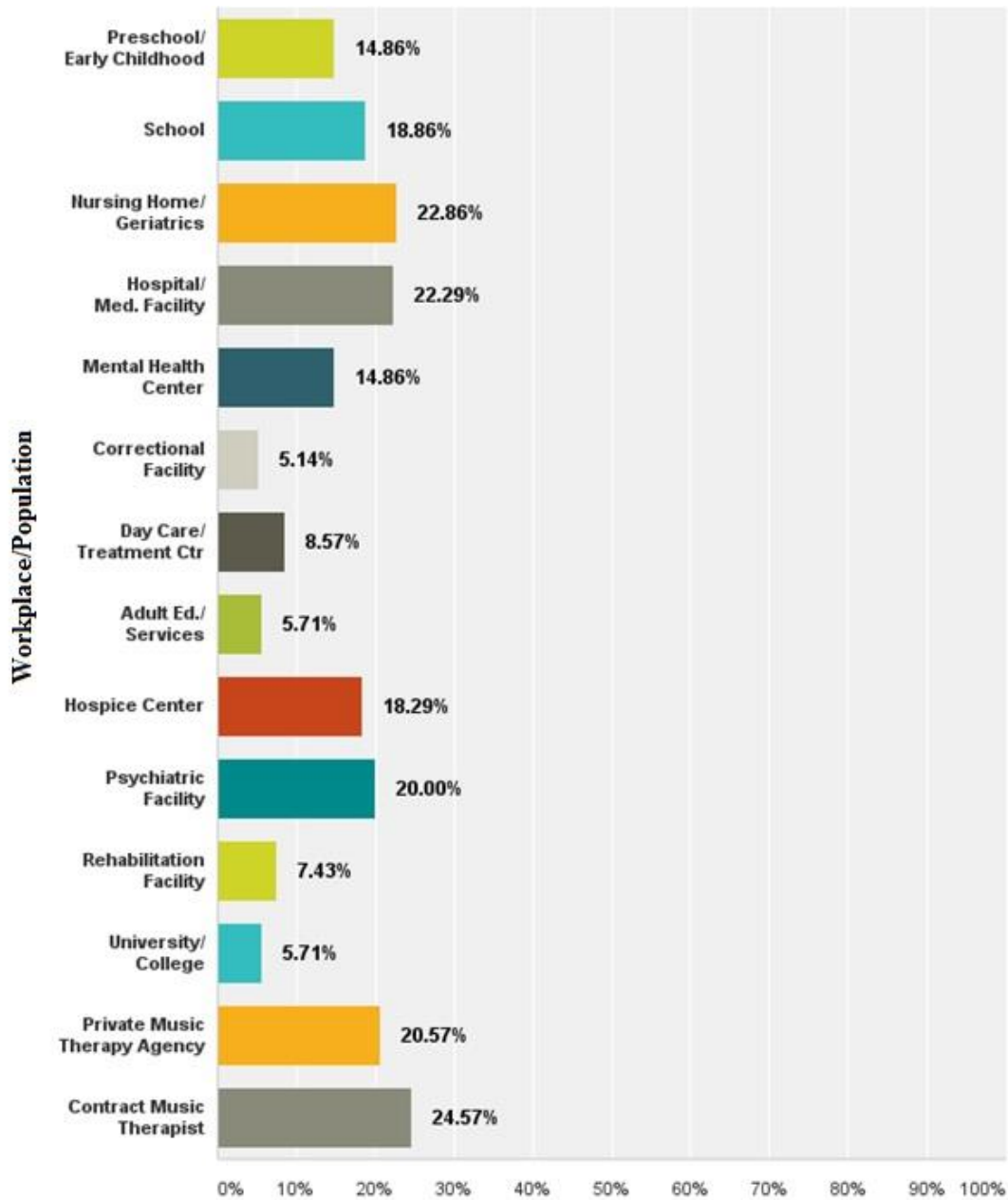
Figure 1. Post-Graduate Training Bar Graph



Similarly, some music therapists work in more than one clinical setting. The majority of participants who responded to this question work in one clinical setting (50.3%); however,

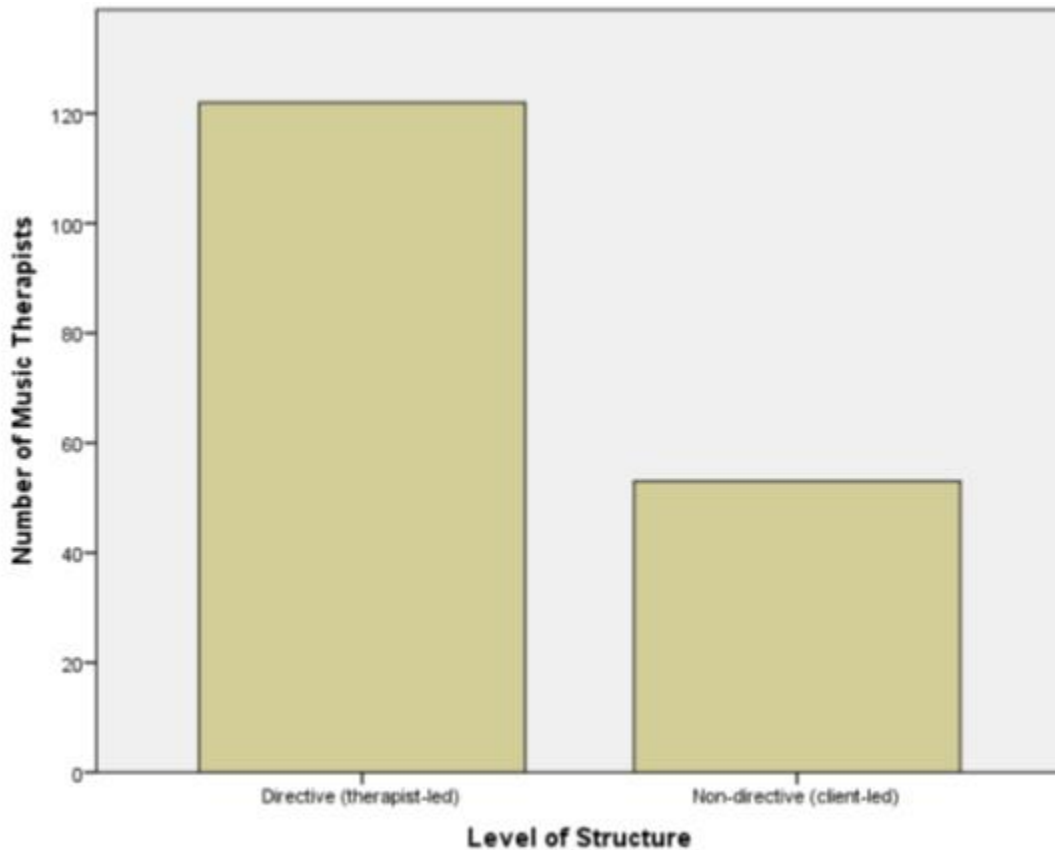
19.4% reported working in two different clinical settings, 13.1% work in three different clinical settings, 8.6% work in four different clinical settings, 5.7% work in five different clinical settings, 1.5% work in six different clinical settings, and 1.1% work in seven different clinical settings. The various populations and settings that participants in this study work with are noted in Figure 2.

Figure 2. Breakdown of Survey Sample by Workplace/Population

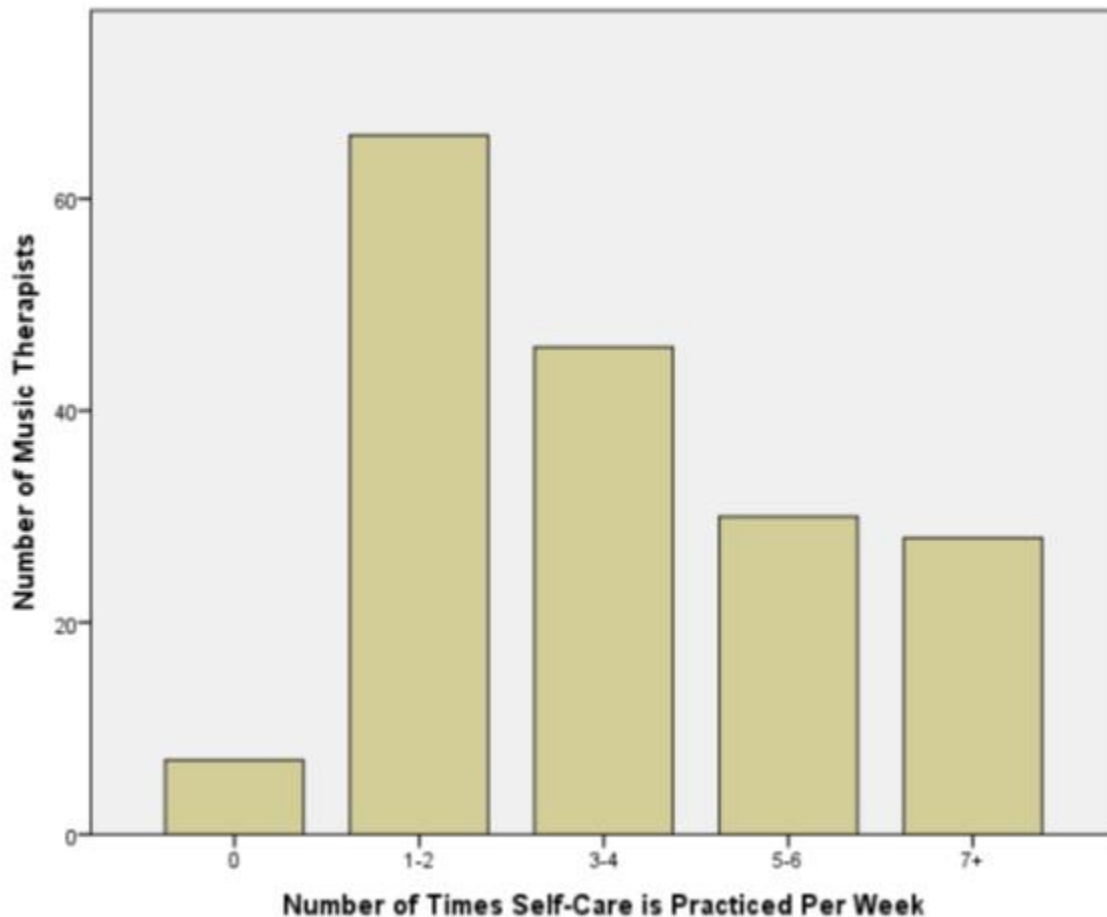


The participants in this study had a wide range in years of professional music therapy experience. Seventeen music therapists, or 9.7% of those who answered this question, had zero to one year of professional experience. The largest proportion of participants who answered this question (36.4% or 64 music therapists) worked in the field between two and five years. Almost one-fifth of the respondents (18.8% or 33 music therapists) have been in the field between six and ten years. Twenty-three music therapists (13.1%) reported they were in the field between 11 and 15 years. Only eleven music therapists (6.3%) had 16-20 years of professional experience, but twenty-eight music therapists (15.9%) were in the field for 20 years or more. Therefore, this study had a fairly even distribution of years of experience.

As seen in Figure 3, over half of the participants in this study (122 music therapists or 69.7%) responded that they employ a directive, or therapist-led, level of structure in their practice, while 53 music therapists (30.3%) responded that they employ a non-directive, or client-led, level of structure.

Figure 3. Level of Structure

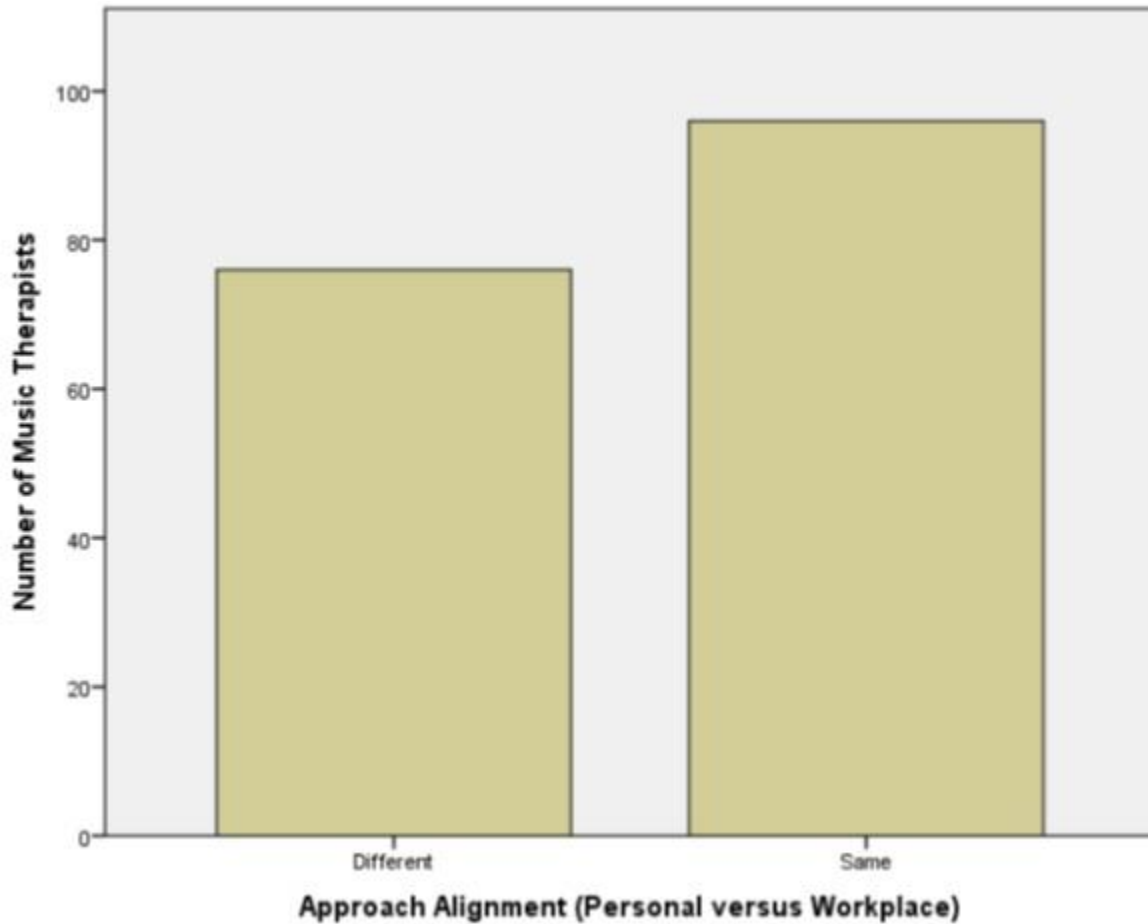
The number of times per week each music therapist reported to practice self-care varied widely among the participants. Seven respondents reported they do not practice self-care, sixty-six respondents (37.3%) practice self-care one to two times per week, forty-six respondents (26%) practice self-care three to four times per week, thirty respondents (16.9%) practice self-care five to six times per week, and twenty-eight respondents (15.8%) practice self-care seven or more times per week (see Figure 4).

Figure 4. How Often Self-Care is Practiced

Participants were asked to identify their therapeutic approaches both in their own practices and in their workplaces. As seen in Figure 5, 76 respondents reported that their personal clinical approach differed from the approaches of their workplaces. The raw data indicated that one music therapist practices in an analytical approach, 18 (10.3%) music therapists practice in a behavioral approach, 36 (20.7%) practice in a cognitive-behavioral approach, three (1.7%) practice in an existential approach, three (1.7%) practice in a gestalt approach, three (1.7%) practice in a transcendental approach, 85 (48.9%) practice in a humanistic approach, and 25 (14.4%) practice in a music-centered approach. In comparison, when reviewing the frequency of the respondents' approach in their workplace, four workplaces

(2.3%) align with the analytical approach, 36 (20.9%) align with the behavioral approach, 59 (34.3%) align with the cognitive-behavioral approach, one (0.6%) aligns with the existential approach, one (0.6%) aligns with the gestalt approach, 62 (36%) align with the humanistic approach, and 9 (5.2%) align with the music-centered approach.

Figure 5. Approach Alignment



In the researcher-developed questionnaire, the participants were asked to rank the music therapy methods they employ in their practice from most (1) to least (4). When analyzing the data overall, there was no clear most preferred or least preferred method. Each method averaged between two and three, indicating equal preference for all methods, as seen in Table 1.

Table 1.*Music Therapy Methodology Ranking*

Music Therapy Methodology	Mean	Std. Deviation
Improvisation	2.4852	1.02995
Re-creative	2.1221	1.02722
Composition	3.1512	.97354
Receptive	2.2011	1.14791

MBI-HSS Subscales Reported Data

The three subscales of the MBI-HSS were used to determine the level of burnout of each participant. The subscales are scored as low, average, and high in regard to burnout, and each subscale has a different numeric scale on which they are rated. As seen in Table 2 on the overall/general scoring of the MBI-HSS, emotional exhaustion (EE) is scored as low (0-16), average (17-26), and high (27+). Depersonalization (DP) is scored as low (0-6), average (7-12), and high (13+). The last subscale, personal accomplishment (PA), is scored as low (39+), average (32-38), and high (0-31).

Table 2.*MBI-HSS Overall Subscale Ranges (Maslach & Jackson, 1986)*

MBI Subscales	Range of Experienced Burnout		
	Low (lower third)	Average (middle third)	High (upper third)
Overall Sample			
EE ²	≤16	17–26	≥27
DP	≤6	7–12	≥13
PA	≥39	38–32	≤31

More specifically, there is a scale to score those in the mental health occupation that varies slightly from the overall scale, which is observable in Table 3. Emotional exhaustion is

scored as low (0-13), average (14-20), and high (21+). Depersonalization is scored as low (0-4), average (5-7), and high (8+), and personal accomplishment was scored as low (34+), average (29-33), and high (0-28). For the current research, the personal accomplishment subscale required an additional category, named low/average. This was due to an unintentionally omitted question in the online survey. Because each question could score between zero and six points, any total personal accomplishment score that was between 33 and 38 on the overall scale (29-33 for mental health occupation) had to be categorized in the new ranking. This is due to the possibility that the response to the missing question could have increased the individual's score from above average to the low range. A similar adjustment was also created for the high/average range, with scores between 26 and 31 being placed into this category (23-28 for mental health occupation).

Table 3.

MBI-HSS Mental Health Subscale Ranges (Maslach & Jackson, 1986)

<i>Mental Health</i>			
EE	≤13	14-20	≥21
DP	≤4	5-7	≥8
PA	≥34	33-29	≤28

Similar to analyzing the three subscales separately, the researcher was able to determine the participants' overall degree of burnout by assessing the subscales together. To determine a high degree of burnout, an individual must score a high number in emotional exhaustion and depersonalization as well as a low number score in personal accomplishment. In contrast, a low degree of burnout consists of a low score on the emotional exhaustion and depersonalization scales but a high score on the personal accomplishment scale.

Data was summarized in *SPSS* and can be seen in Table 4. Since the skewness for each subscale was not zero, the *Shapiro-Wilk* test was used to assess normality. The *p* values for all three measures were less than .05, indicating that the subgroups were, in fact, not normal. Therefore, the mean and median are both included in the analysis. Overall, the mean (25.94) and median (24.00) for emotional exhaustion resided in the average range of burnout in the overall scale. However, on the mental health scale, the mean and median for emotional exhaustion fell in the high range of burnout. For depersonalization, the mean (8.4) and median (7.0) also resided in the average range of the overall MBI-HSS scale. On the mental health scale, the median was still in the average range, however, the mean fell in the high range of experienced burnout. The mean and median of the personal accomplishment subscale, 41.06 and 43.00 respectively, fell in the low range of experienced burnout on both the overall and mental health scales. As explained previously, the mean value of personal accomplishment was slightly deflated because a technical issue resulted in one omitted question on the online survey.

Table 4.

Summary Statistics of MBI-HSS Subscales

MBI-HSS Subscale	Mean	Median	Std. Deviation	95% Confidence Interval	Skewness	Kurtosis
Emotional Exhaustion	25.94	24.00	10.97	(24.31, 27.57)	.566	-.168
Depersonalization	8.40	7.00	4.29	(7.77, 9.04)	1.06	.536
Personal Accomplishment	41.06	43.00	5.49	(40.25, 41.88)	-2.37	10.35

For the overall scoring on the emotional exhaustion scale, 72 (40.7%) scored high experience of burnout, 68 (38.4%) scored as an average experience of burnout, and 37 (20.9%) scored in the low experience of burnout. In contrast, the values for these three scoring categories

changed when utilizing the mental health subscale. A total of 119 music therapists (67.2%) resided in the high experience of burnout in emotional exhaustion, 39 (22%) scored in the moderate range, and 19 (10.7%) had a low experience of burnout in emotional exhaustion.

On the overall scale for depersonalization, 32 (18.1%) ranked high experience of burnout, 71 (40.1%) ranked average experience of burnout, and 74 (41.8%) ranked low experience of burnout. Similar to the emotional exhaustion scale, the frequencies in each range changed drastically when scoring the music therapists on the mental health scale. On the mental health scale, 84 (47.5%) experienced a high degree of burnout in depersonalization, 56 (31.6%) experienced an average degree, and 37 (20.9%) experienced a low degree of burnout in depersonalization.

In the overall scoring of personal accomplishment, two (1.1%) music therapists had a high experience of burnout, 9 (5.1%) had a moderate experience of burnout, 31 (17.5%) had a low/moderate experience of burnout, and 135 (76.3%) had a low experience of burnout in personal accomplishment. In comparison, the frequencies were similar when scoring the music therapists on the mental health scale for personal accomplishment. Two music therapists (1.1%) had a high experience of burnout in personal accomplishment, three (1.7%) had a moderate experience of burnout, 11 (6.2%) had a low/moderate degree of burnout, and 161 (91%) had a low experience of burnout in this personal accomplishment subscale. All of the above subscale frequencies are shown in Table 5.

Table 5.*MBI-HSS Ranking Frequencies*

MBI-HSS Subscale	Degree of Burnout	MBI-HSS Scale	
		Overall	Mental Health
Emotional Exhaustion	High	72	119
	Average	68	39
	Low	37	19
Depersonalization	High	32	84
	Average	71	56
	Low	74	37
Personal Accomplishment	High	2	2
	Average	9	3
	Low/Average	31	11
	Low	135	161

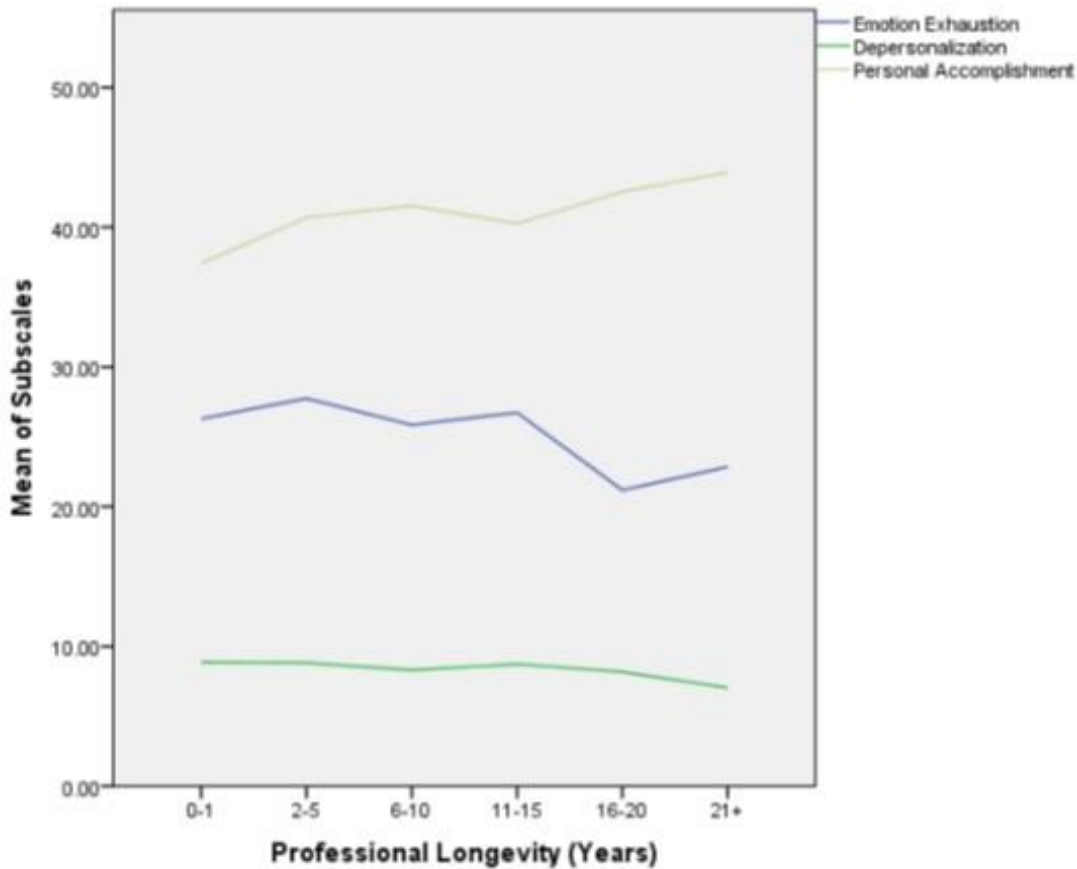
Overall, a limited number of participants in this study could be classified into one of the three categories for overall burnout. Of those categorized, 24 (12.1%) scored a low degree of burnout and one music therapist (.5%) scored a moderate degree of burnout. When determining burnout on the mental health scale, the frequencies changed slightly. One (.5%) music therapist had a high degree of burnout and 11 (5.5%) had a low degree of burnout.

MBI-HSS & Music Therapy Analysis

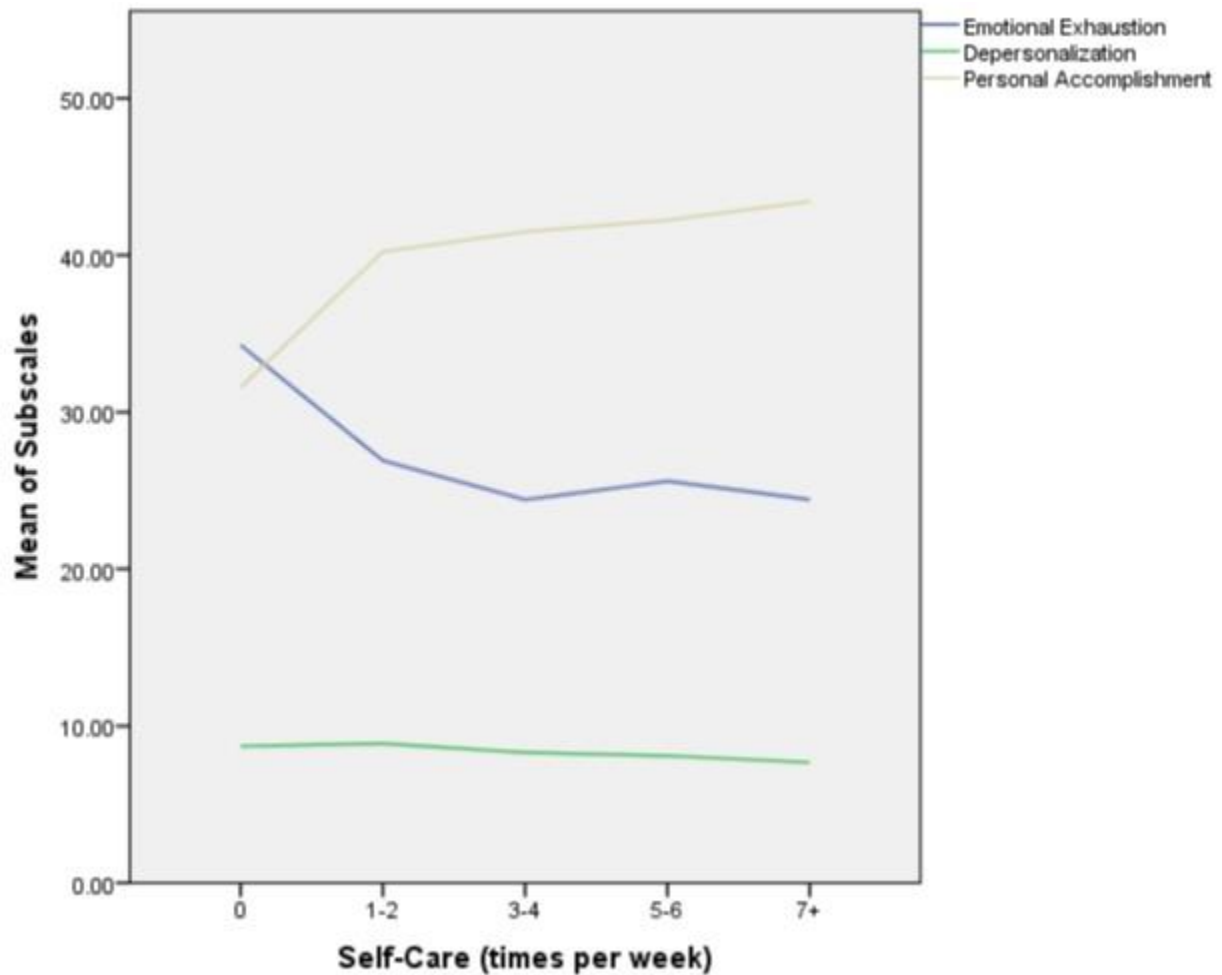
Due to the result that the three subscales were not normal, both alone and when subgroups were introduced, non-parametric statistical tests were used when analyzing the data. The data was analyzed at a significance level of 0.05, unless otherwise noted. To address the first research question, the *Kruskal-Wallis* test was used to determine any differences between the three subscales and the top ranked individual music therapy method for each participant. Because the distributions for the four methodologies were the same, the medians could be compared. Overall, the test indicated a statistically significant difference ($p = .044$) between the four methodologies and emotional exhaustion. However, a post hoc pairwise comparison with the use

of the Bonferroni correction, detected no pairwise significance between any of the methodologies. Statistical significance was not found when comparing the depersonalization and personal accomplishment subscales with the top-ranked music therapy method. Additionally, no statistical significance was found when investigating post-grad training and highest degree earned in relation to the burnout subscales.

The next analysis examined the relationship between primary level of structure employed in the music therapists' practices and the three subscales of the MBI-HSS. Through the use of the *Mann-Whitney U* Test, no statistical significance was found in any of the three subscales ($p \geq .05$). Comparing the years of professional music therapy experience (0-1, 2-5, 6-10, 11-15, 16-20, 21+ years), or longevity, alongside the MBI-HSS subscales resulted in a statistical difference in emotional exhaustion ($p = 0.023$) and personal accomplishment ($p < .001$) when using the *Jonckheere-Terpstra* test. When examining the post hoc pairwise comparison, no statistical differences were found for emotional exhaustion. For personal accomplishment, pairwise significance with the Bonferroni correction was found between 0-1 and 21+ years, 11-15 and 21+ years, and 2-5 and 21+ years, indicating a positive relationship between longevity and personal accomplishment. Similarly, when examining age, significant differences were found for both personal accomplishment ($p = .014$) and emotional exhaustion ($p = .016$). A display of the data is shown in Figure 6.

Figure 6. Longevity versus MBI-HSS Subscales

When analyzing the influence of self-care on the three subscales of the MBI-HSS (see Figure 7), personal accomplishment and depersonalization were found to be statistically significant when using the *Jonckheere-Terpstra* test. In the post hoc pairwise comparison, no statistical differences were found for depersonalization. However, pairwise significance for personal accomplishment was found for people who indicated engaging in self-care between 0 and 3-4 times per week ($p = .02$), 0 and 5-6 times per week ($p = .011$), 0 and 7+ times per week ($p = 0.004$), and 1-2 and 7+ times per week ($p = 0.013$). This indicates a positive relationship between reported frequency of self-care and personal accomplishment scores.

Figure 7. Self-Care versus MBI-HSS Subscales

The *Kruskal-Wallis* test detected no significant differences for the therapists' therapeutic approach alongside all three subscales. Similarly, this result was found for the workplace therapeutic approach. However, another interesting aspect explored in this study was the scores of three subscales when the music therapists' therapeutic approach did or did not align with the workplaces' therapeutic approach. The *Mann-Whitney U* Test detected a significant difference ($p = .008$) on the depersonalization scale. This indicates that individuals whose therapeutic approach did not align with their workplaces' approach had a statistically higher median depersonalization subscale score over those individuals whose approaches were the same.

Discussion

To summarize, the mean of the overall burnout subscales of this study are: 29.54 for emotional exhaustion (average), 8.4 for depersonalization (average), and 41.06 for personal accomplishment (low). These results differ from Vega's (2010) and Fowler's (2006) studies, in which participants had overall lower emotional exhaustion and depersonalization scores. Personal accomplishment, however, remained in the low range of burnout throughout all of these studies, indicating that music therapists tend to feel successful in their work.

Another observable difference is the representation of high to low degrees of burnout. Unlike Vega (2010) who reported 11% of the subjects had a high level of burnout, only .5% of participants in this study had a high level of burnout. Similarly, only .014% of Vega's participants had a low degree of burnout and 5.5% of participants in this study scored a low degree of burnout. One apparent limitation is that this data can only be generalized to music therapists that are low to moderate risks of burnout, and more data would need to be collected to understand high levels of burnout better. One possible explanation for the low representation of high degree of burnout could be related to the low response rate seen in this study. Overall, after sending out 1635 invitations to participate in this survey, only 200 responses were gathered within the allotted time frame, indicating a response rate of approximately 12.2 percent. There could be a relationship between those who did not participate in the survey and high degrees of burnout. According to Vega (2010), it is plausible that music therapists did not participate in this survey study because they are burned out and do not want to be involved in aspects dealing with music therapy outside of their workplace.

The researcher found a relationship between music therapists' highest ranked methodology and emotional exhaustion. When looking further into the data, improvisation had

the highest average emotional exhaustion and receptive had the lowest; however, the difference between the two methodologies was not found to be statistically significant. Therefore, future research should explore burnout in comparison to these methodologies further by obtaining a larger sample size. Because improvisation in music therapy had the highest average score in emotional exhaustion, it is possible that there are techniques used within improvisation that could trigger this response, or it could be related to socio-economic factors that were not captured by the current survey, as suggested by Decuir & Vega (2010) and Kim (2012).

Significance was found when analyzing professional longevity with emotional exhaustion and personal accomplishment. Although no discernable relationship could be detected within emotional exhaustion scores, as longevity increased, personal accomplishment scores did as well. This relationship aligns with the research conducted by Fowler (2006), whose study about professional well-being highlighted key characteristics such as positive attitude towards work. This factor is embedded within the personal accomplishment subscale, which could explain why this outcome of this research is similar to Fowler's study.

There is a positive relationship between the number of times self-care is practiced per week with depersonalization and personal accomplishment. Further, personal accomplishment scores tended to increase as the amount of times self-care was practiced per week increased. Similarly, Fowler (2006) found that positive coping strategies and attitudes relate to a higher score of longevity. This supports the findings of this study because depersonalization is the negative feeling or attitude towards one's clients; thus, a positive attitude and frequency of self-care can lead to a lower degree of burnout on the depersonalization subscale.

There was no correlation found between the music therapists' therapeutic approach and the three burnout subscales, but when their approach did not align with their workplace's

approach, there was an observable relationship with their depersonalization scores. Those whose therapeutic approach did not align had higher depersonalization scores, as opposed to those whose therapeutic approach matched their workplace's approach. It is possible that these results stemmed from other factors related to the workplace, as suggested by Kim (2007, 2011, 2012).

Limitations/Implications

A goal in designing a survey is to minimize the amount of time required for completion (Vega, 2010). Thus it is important to minimize unnecessary questions to ensure that respondents will answer as honestly as possible. Another goal of a survey is to formulate questions that will return the most pertinent responses. Some of the questions in this survey asked participants to "check all that apply" as opposed to selecting one answer. It is recommended that future research adjust these question-types so that the most relevant answer is gathered for clearer analysis by designing the survey with selecting one answer to questions and limiting multiple response questions. In addition, because this survey was password-protected, one potential participant claimed the password did not work for him/her. Along with this limitation, due to copyright reasons, the instructions of the MBI-HSS could not be altered in any way, which could have led to confusion in some participants. One participant commented feeling confused about the MBI-HSS instructions: when asked to "write numbers 1-6," there was no interface in which to write the number. Because of the electronic delivery of the survey, the respondents were meant to "click" the correct response. In addition, the survey did not have a numerical scale, as it only had a scale from "never" to "every day."

After utilizing and learning about the MBI-HSS, there appears to be some drawbacks. Though the MBI-HSS is designed to analyze burnout, in reality, only a small percentage of the overall participants fall into one of the three "burnout categories." The majority of the

participants have to be analyzed by the three subscales individually because the combination of the results of the scales falls into the grey area of burnout. For example, participants that ranked high in emotional exhaustion, high in depersonalization, and low in personal accomplishment could not have their degree of burnout clearly identified. Therefore, the researcher recommends using other potential predictors of burnout in addition to the MBI-HSS to get a more complete picture of the situation.

Some participants contacted the researcher to comment on potential factors that could lead to burnout and were not accounted for in this survey. One participant commented that finding jobs in his/her specific population is becoming more difficult due to state level budget cuts in mental health facilities. One potential participant who did not meet one of the inclusion criteria mentioned that in his/her area of the country, music therapy jobs are limited. Due to the limited job availability, s/he spent their career in special education; however, due to this potential participant's love for music therapy, s/he maintained their board certification. One participant of this study commented that his/her graduate trainings were not in the area of music therapy, but considers these other degrees as tools that has informed and advanced his/her music therapy work. This participant also noted that if s/he was not taking care of his/her self, s/he would be completely burned out. Some other suggestions for further research are to include survey questions regarding how many clients/groups per day, the number of clients in a group session, and how much paperwork is required, as well as safety factors within the workplace. These concerns of safety and limited job opportunities are similar observations that were made by Kim (2007, 2011, 2012).

Conclusion

This research indicates a need for further investigation into burnout identification within the field of music therapy. Based on the results of this study, it is recommended that music therapists practice self-care in order to prevent pessimistic feelings and attitudes towards one's clients and people at one's workplace, while also increasing proficiency and success in therapy sessions.

Another way to prevent burnout is to be more mindful to potential workplaces' therapeutic approach and to assess the alignment of that approach with the music therapist's approach. In addition, if the approach of the music therapist does not align with the workplace's approach, the music therapist can educate his/her peers or colleagues on his/her approach within music therapy to attempt to reduce risk factors that may lead to burnout.

Through this research study, those who use improvisation as their primary method had a higher degree of burnout in the emotional exhaustion subscale. It is recommended that those who choose to work within the improvisation methodology attempt to incorporate more self-care practices into their weekly routines.

Music therapists and student music therapists may not realize how common symptoms of burnout may be. The researcher was fortunate to study at a college that focuses on the psychodynamic approach and emphasizes the importance of self-care, analyzing sessions objectively and subjectively, and noticing transferences. If these tasks go unaddressed, as revealed in a study by Chang (2014), the therapist might be more prone to burnout.

The purpose of this survey study was to explore the relationship between burnout in music therapists and the methods they employ in their clinical work. In this study, self-care, longevity, therapeutic approach alignment, and music therapy methodology was found to be

statistically significant in relation to at least one of the three MBI-HSS subscales. The results of this study can inform new and current music therapists about factors that could lead to burnout and how to avoid it.

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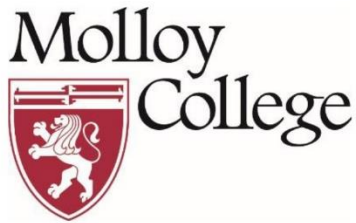
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Appendix A – IRB Approval Letter

1000 Hempstead Avenue
Rockville Centre, NY 11571
www.molloy.edu

Tel. 516.323.3801

Tel. 516.323.3711

Date: November 30, 2016
To: Professor Suzannel Sorel for Student: Samara Berry
From: Kathleen Maurer Smith, Ph.D.
Co-Chair, Molloy College Institutional Review Board
Patricia Eckardt, Ph.D., RN
Co-Chair, Molloy College Institutional Review Board

**SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS
(MUSIC THERAPY THESIS)**

Study Title: An Analysis of Burnout and Music Therapy Methodologies

Approved: November 30, 2016

Approval No.: 19011301-1130

Dear Professor Sorel for Samara Berry:

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. It is considered an EXEMPT review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b) and has met the conditions for conducting the research. The IRB approval is given to the faculty supervisor and agency supervisor who have given their signed approval to oversee the work and student compliance with appropriate norms and professional behaviors in carrying out the project.

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 change the project from EXPEDITED status that would require communication with the IRB.

Sincerely,

Kathleen Maurer Smith, Ph.D.

Patricia Eckardt, Ph.D., RN

Appendix B – Survey Questions Created by the Researcher

1. What is your gender?
 - a. Male
 - b. Female
 - c. Other _____
 - d. Prefer not to answer
2. What is your age?
 - a. 20-30 years
 - b. 31-40 years
 - c. 41-50 years
 - d. 51-60 years
 - e. 61-70 years
3. What state are you currently employed?
 - a. AL
 - b. AK
 - c. AS
 - d. AZ
 - e. AR
 - f. CA
 - g. CO
 - h. CT
 - i. DE
 - j. DC
 - k. FL
 - l. GA
 - m. GU
 - n. HI
 - o. ID
 - p. IL
 - q. IN
 - r. IA
 - s. KS
 - t. KY
 - u. LA
 - v. ME
 - w. MD
 - x. MA
 - y. MI
 - z. MN
 - aa. MS
 - bb. MO
 - cc. MT
 - dd. NE
 - ee. NV
 - ff. NH
 - gg. NJ

- hh. NM
 - ii. NY
 - jj. NC
 - kk. ND
 - ll. OH
 - mm. OK
 - nn. OR
 - oo. PA
 - pp. PR
 - qq. RI
 - rr. SC
 - ss. SD
 - tt. TN
 - uu. TX
 - vv. UT
 - ww. VT
 - xx. VA
 - yy. WA
 - zz. WV
 - aaa. WI
 - bbb. WY
4. What is your highest level of music therapy education completed?
 - a. Undergraduate Degree
 - b. Graduate degree
 - c. Doctoral Degree
 - d. Degree not yet completed
 5. Have you completed any of the following post-graduate music therapy training? (Please check all that apply)
 - a. Guided Imagery in Music (GIM)
 - b. Nordoff-Robbins Music Therapy
 - c. Analytical Music Therapy
 - d. Neonatal Intensive Care Unit
 - e. Neurological Music Therapy
 - f. None
 6. The clinical setting you work in is a: (Please check all that apply)
 - a. Preschool/Early Childhood Intervention
 - b. School
 - c. Nursing Home/Geriatric Facility
 - d. Hospital/Medical Facility
 - e. Mental Health Center
 - f. Correctional Facility
 - g. Day Care/Treatment Center
 - h. Adult Education/Services
 - i. Hospice Center
 - j. Psychiatric Facility
 - k. Rehabilitation Facility

- l. University/College
 - m. Private Music Therapy Agency
 - n. Contract Music Therapist
7. How many years of professional music therapy experience do you have?
- a. 0-1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-15 years
 - e. 16-20 years
 - f. 20+ years
8. My primary level of structure employed in my practice is _____.
- a. Directive (therapist-led)
 - b. Non-directive (client-led)
9. I practice self-care _____ times per week
- a. 0
 - b. 1 – 2
 - c. 3 - 4
 - d. 5 - 6
 - e. 7 +
10. Music therapists often incorporate techniques from various therapeutic approaches. The one music therapy therapeutic approach that best describes how you practice is:
- a. Analytical
 - b. Behavioral
 - c. Cognitive-behavioral
 - d. Existential
 - e. Gestalt
 - f. Transcendental
 - g. Humanistic
 - h. Music-Centered
11. The therapeutic approach of your workplace is best described as:
- a. Analytical
 - b. Behavioral
 - c. Cognitive-behavioral
 - d. Existential
 - e. Gestalt
 - f. Transcendental
 - g. Humanistic
 - h. Music-Centered
12. Rank the following music therapy methods employed in your practice from most (1) to least (4):
- a. Improvisation
 - b. Re-creative
 - c. Composition
 - d. Receptive
13. My improvisation method is best described in the following variation (please check all that apply):

- a. Instrumental Nonreferential
 - b. Instrumental Referential (musical improvisation to portray a feeling, idea or experience that is non-musical)
 - c. Song Improvisation
 - d. Vocal Nonreferential Improvisation
 - e. Body Improvisations
 - f. Mixed Media Improvisations (improvisation using any combination of sound sources)
 - g. Conducted Improvisations
 - h. None
14. My re-creative method is best described in the following variation (please check all that apply):
- a. Instrumental Re-creation
 - b. Vocal Re-creation
 - c. Musical Productions
 - d. Musical Games and Activities
 - e. Conducting
 - f. None
15. My composition method is best described in the following variation (please check all that apply):
- a. Song Transformation (also known as “Song Parodies”)
 - b. Song-Writing
 - c. Instrumental Composition
 - d. Notational Activities
 - e. Music Collages (using various songs or sounds to create a recording)
 - f. None
16. My receptive method is best described in the following variation (please check all that apply):
- a. Somatic Listening (this includes entrainment, resonance/toning, vibroacoustic music, and/or music biofeedback)
 - b. Music for Pain Management (also known as “Music Anesthesia”)
 - c. Music Relaxation
 - d. Meditative Listening
 - e. Subliminal Listening
 - f. Stimulative Listening
 - g. Eurhythmic Listening (music is used to regulate the client’s motor behaviors)
 - h. Perceptual Listening
 - i. Action Listening (evoking a specific behavior response through the use of musical cues or song lyrics)
 - j. Contingent Listening
 - k. Mediational Listening
 - l. Music Appreciation Activities
 - m. Song (Music) Reminiscence (client re-experiences past memories through music listening selected by either the client or therapist)
 - n. Song (Music) Regression (client re-experiences past events through the therapist’s song selection)

- o. Induced Song (Music) Recall
- p. Song (Music) Communication
- q. Song (Lyric) Discussion
- r. Projective Listening (this includes projective sound identification, free association, projective storytelling, music dramatization, song choices, projective movement to music, and/or projective drawing to music)
- s. Imaginal Listening (this includes directed music imaging, unguided music imaging, guided music imaging, and/or guided interactive music imaging)
- t. Self-Listening
- u. None

Appendix C – Survey Monkey Informed Consent Form

You are invited to participate in this online survey study because you are a board-certified music therapist. This study is being conducted by Samara Berry at Molloy College and has been approved by the Molloy College IRB committee for research involving human subjects. This study will investigate the relationship between burnout in music therapists and the methods and strategies they employ in their clinical work. The purpose of this thesis study is to educate music therapists on the reality of burnout and factors that may increase the likelihood of experiencing it.

Your participation is voluntary and you may withdraw at any time. You may choose not to participate. If you choose to not participate or decide to withdraw, you will not be penalized. The procedure involves filling an online survey that will take 10 minutes. Your responses will be confidential and no identifying information will be collected (i.e. your name, email address, or IP address). The survey questions will be about the music therapy method and level of structure you employ in your practice, demographic information, as well as include the Maslach Burnout Inventory - Human Services Survey. This will examine the relationship between burnout in music therapists and the methods and strategies they employ in their clinical work.

All data is stored in a password-protected electronic format. To further protect your confidentiality, the surveys will not contain information that will personally identify you. The results of this study will be used for scholarly purposes.

If you have any questions about the research study, please contact the researcher at sberry@lions.molloy.edu and/or the faculty advisor to this study at hwagner@molloy.edu.

ELECTRONIC CONSENT: Please select your choice below.

By selecting “agree,” this indicates that:

- You have read the information above
- You voluntarily agree to participate
- You are an MT-BC between the ages of 22 and 70 years
- You have practiced or are currently practicing in the United States

If you do not wish to participate in this research study, please decline participation by selecting the “disagree” button.

Appendix D – Invitational/Consent E-mail

Dear Music Therapist,

My name is Samara Berry, and I am a graduate music therapy student at Molloy College in New York. As part of the requirement for my program, I am conducting a research study titled, “*An Analysis of Burnout and Music Therapy Methodologies*” This study will investigate the relationship between burnout in music therapists and the music therapy methods and strategies they employ in their clinical work. The purpose of this thesis study is to explore professional burnout in music therapists and factors that may increase the likelihood of experiencing it.

You have been contacted and considered eligible for this study because you meet the following criteria:

1. You are a Board-Certified Music Therapist (MT-BC) between the ages of 22-70.
2. Have English comprehension.
3. Have practiced or are currently practicing in the United States.

Participation in this study will entail an online survey for approximately 10 minutes via SurveyMonkey. Survey questions will include demographic information, questions regarding your music therapy practices, as well as the Maslach Burnout Inventory (1981). All survey responses and data will remain anonymous. You do not have to submit your name and there will be no questions that will compromise your anonymity.

Your participation is completely voluntary and you may withdraw at any time. You may choose not to participate. If you choose to not participate or decide to withdraw, you will not be penalized.

Please click the link below to the survey if you would like to participate in this study; **the password is BurnoutMT**. The link will lead you to a consent form that will prompt you to agree or disagree. If you choose to agree, you will be guided to begin the survey questions. If you disagree, you will be directed to the end of the survey to thank you for your time.

If you have any questions about the study, please feel free to contact me or my faculty advisor. Thank you for your consideration.

Sincerely,

Researcher
Samara Berry
Molloy College
sberry@lions.molloy.edu

Faculty Advisor
Heather Wagner, Ph D., MT-BC
Molloy College
hwagner@molloy.edu