MUSIC THERAPISTS AND WORK: EXPERIENCES OF OCCUPATIONAL OPPRESSION IN THE PROFESSION OF MUSIC THERAPY

by

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Abstract

Occupational oppression is a system of invisible barriers created by those in power that reduces the professional's ability to perform work at the highest level. Barriers result from a combination of beliefs related to the value or worth of set occupations and their members. Occupational oppression is based on the assumption that certain professions are inherently superior or inferior. Barriers result from a combination of beliefs related to the value or worth of set occupations and their members. Oppressive experiences have been described within music therapy literature on burnout. However, the phenomenon of occupational oppression has not been explored within the profession of music therapy. The purpose of this mixed-method study was to establish and describe the phenomenon of occupational oppression within the profession of music therapy. Experiences of oppression were described using Young's five categories of oppression – marginalization, cultural imperialism, exploitation, violence, and powerlessness (1990). Participants, 634 currently practicing board-certified music therapists, completed an online survey that was comprised of multiple choice, Likert-scale, and short-answer questions. Results support the existence of occupational oppression within the profession of music therapy. A majority of participants identified as having experienced oppression within their workplaces (56%) and identified the profession as being oppressed (76.6%). All of Young's five categories of oppression (1990) were reported within participants' responses. Forms of cultural imperialism were described most frequently, followed by marginalization, exploitation, powerlessness, and violence. Descriptions of experienced oppression occurred both in respondents who did and did not identify as having experienced oppression, suggesting that music therapists may have difficulty labeling oppressive experiences. Acknowledging occupational oppression within the

profession of music therapy may be a critical first step towards developing solutions to improve workplace experiences for music therapists.

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Chapter 1

Introduction

"In order for the oppressed to be able to wage the struggle for their liberation, they must perceive the reality of oppression not as a closed world from which there is no exit, but as a limiting situation they can transform." – Freire, 1989

My interest in occupational oppression, as the researcher, emerged within the context of my feminist personal journey that began in 2015. I am a white, middle class, educated, able-bodied, heterosexual woman born in the early 1990's. As such, I have experienced certain advantages of dominant group membership, such as access to privileged places, people, and resources, including higher education. However, as a feminist I became increasingly aware of the disadvantages I experienced as a woman living in a patriarchal society. During my six-month music therapy internship, I encountered negative workplace experiences that gender group membership could not explain. Interest in occupational oppression within music therapy was a result. As a young professional, I continue to experience to oppression within the workplace. However, I strongly believe that by identifying negative workplace experiences for what they are, oppression, solutions can be developed.

Oppression is about power and privilege - the power one group has to influence or control a subordinate group and the privilege the powerful derive from said control (Cudd, 2005; Dominelli, 2002; Freire, 1989; Hardiman, Jackson, & Griffin, 2010; Johnson, 2010; Prilleltensky, 2003). Oppression is an umbrella term describing a wide range of systematic injustices and inequalities. Discrimination, prejudice, racism, sexism, ageism, ableism, and homophobia are all forms of oppression (Adams et al., 2010). While oppression can occur due to an overarching tyrannical power, it is not a requirement for oppression to occur. Rather

oppression is often more subtle, caused by regular people within a well-intentioned liberal society (Young, 1990). Arguably, one can be oppressed without acknowledging their oppression, just as one can serve as an oppressor without knowing it (Dominelli, 2002; Hardiman et al., 2010; Johnson, 2010; Young, 1990).

The social revolutions of the 1960s and 1970s promoted great achievements towards equality in the United States. Achievements included expanded access to employment, education, public spaces, civil rights, and creation of new family arrangements that had formerly been denied to racial minorities and women. The Equal Pay Act of 1963 made it illegal to pay different wages to men and women if they performed the same work. Title VII of the Civil Rights Act 1964 (Title VII) made it illegal to discriminate against a person on the basis of race, color, religion, nation of origin or sex. Title VII also made it illegal to retaliate against a person because they complained about discrimination, filed a charge against discrimination, or participated in an employment discrimination investigation lawsuit. Additionally, acts illegalizing discrimination against pregnancy (Pregnancy Discrimination Act of 1973) and age (Age Discrimination in Employment Act of 1967) were enacted during this period. These rights were later extended to qualified persons with a disability in national government positions in 1973 with Sections 501 and 505 of the Rehabilitation Act of 1973 and to all private sector and state and local government jobs in Title I of the Americans with Disabilities Act of 1990.

Furthermore, these discrimination laws protected against continued discrimination, which is known as harassment. Harassment is unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. Harassment becomes unlawful when (a) enduring the offensive conduct becomes a condition of continued employment, or (b) the conduct is severe or pervasive enough to create a work

environment that a reasonable person would consider intimidating, hostile, or abusive (U.S. Equal Employment Opportunities Commission, 2016).

Because of such massive gains, subsequent generations have often viewed equality as having been achieved. They argue that the United States has transitioned to a post-racial/post-feminist society based on the premise that overt racial and gender discriminations are a thing of the past (Roberts, 2015). While the social revolutions of the 1960s and 1970s certainly contributed greatly towards the progress of equality, current social movements such as the Black Lives Matter and the resurgence of popularity in the term 'feminism' has shown that equality has not, in fact, been achieved. Rather, post-racial and post-feminist ideologies such as color and gender blindness (the ability to completely ignore a person's race or gender (Roberts, 2015),) have provided superficial solutions without actually fixing the core problems.

One location in which oppression continues to occur, while in more subtle forms, is within the workplace. Today's women are more likely than men to complete college and attend graduate school, and make up nearly half of the workforce in the United States (Council of Economic Advisors, 2014). In fact, in 2013 women were 21 percent more likely than men to be college graduates (Council of Economic Advisors, 2014; U.S Bureau of Labor Statistics, 2015a). However, despite higher educational attainment, women consistently continue to earn less than their male counterparts (CONSAD, 2015; DeNavas-Walt & Proctor, 2015; U.S. Bureau of Labor Statistics, 2015a).

While the existence of wage differentials among men and women is not disputed, the causes and the numerical discrepancy among the salaries of men and women has been grounds for argument among various U.S governmental departments. The U.S. Census Bureau pegs the gap between men's and women's salaries to be 21 cents per dollar when looking at annual wages

(DeNavas-Walt & Proctor, 2015), while the U.S. Bureau of Labor Statistics (2015a) shows that the gap is 17 cents when looking at weekly wages. However, gender bias alone cannot account for the difference in earned salaries among women and men. In fact, after controlling for all other factors, such as educational attainment and occupational choice, gender bias was found to only account for 5 to 7 cents of the gap (CONSAD, 2015).

Women are also more likely to enter lower-paying occupations, a phenomenon referred to as occupational segregation (Carnavale, Strohl, & Melton, 2014; Cohen & Huffman, 2003; England, Allison, & Wu; 2007; Levanon, England, & Allison, 2009; Shauman, 2006). Nine out of the ten lowest-paying college majors are predominately female. These include, counseling psychology, early childhood education, human services and community organization, social work, drama and theatre arts, studio arts, communication disorders science and services, visual and performing arts, and health and medical preparatory programs (Carnevale et al., 2014). Conversely, only one of the top ten earning college majors – pharmacy pharmaceutical sciences and administration – is predominately female (Carnevale et al., 2014). Careers that are typically higher paying and male dominated display characteristics attributed as masculine – technical, scientific, or business-related. In contrast, careers that are lower paying and often predominately female have caring and creative characteristics that are often categorized as feminine (Shauman, 2006; England et al., 2007).

Three main influences impact occupational choice: (a) a person's background, including but not limited to gender, social status, racial/ethnic background, and age; (b) psychological and personal influences, such as attitudes and earlier experiences; and (c) cultural influences, such as societal norms, peer pressure, and the media (Farmer, 1985). However, gender stereotypes – commonly accepted beliefs about the activities, roles, physical attributes, and personality traits

that distinguish girls and women from boys and men – are predominately considered when career choices are made by individuals rather than ability (Francis, 2002). Gender stereotypes establish constraints on what kind of work is seen as appropriate for men and women. Young people (ages 14-16) indicate preferences for particular careers – often following gender norms – for which they have little knowledge of the adult workplace, the current demands for different occupations, and of the qualifications required for their preferred careers (Francis, 2002). These beliefs seem to emerge at a young age with girls opting for more creative and caring careers, and boys choosing occupations involving scientific, technical, or business-related skills (Francis, 2002).

In many ways occupational gender stereotypes continue to be defined by nineteenth century gender roles. During this period men were active in the public sphere, while women were relegated to the private sphere of the home (Bell, Michalec, & Arenson, 2014; Hall, 2005; Reverby, 1990; Valentine, 1996). This ideology supported the notion that there was a distinct contrast between the economic world outside the home, paralleling a sharp difference between male and female natures. This belief system promoted the idea that the home was the only proper place for women, that women were morally superior to men, and that a woman's greatest function was as a mother (Hall, 2005; Reverby, 1990; Valentine, 1996). While women were not seen as inferior per se, female segregation and subsequent subordination was believed necessary for societal stability. Consequently, feminine characteristics were devalued (Bell et al., 2014; Hall, 2005; Reverby, 1990; Valentine, 1996).

Within the public sphere, men served in professional roles, holding positions of authority and completing 'expert' tasks. In the healthcare setting, they provided 'cures.' Women, on the other hand, were praised for motherhood and domesticity (Bell et al., 2014; Hall, 2005; Reverby, 1990). Providing care for both the family and within healthcare settings was seen as a woman's

duty, rather than her job. Subsequently care was relegated to menial work. Care was believed to require little, if any, knowledge or skill and was deemed less valuable than masculine professional labor (Davies, 1996; Reverby, 1990; Valentine, 1996).

Current female dominated professions such as nursing, teaching and social work grew from within this ideology of the women's sphere (Bell et al., 2014; Hall, 2005; Reverby, 1990). These professions were not seen as 'real work' but rather as extensions of work inside the home. While this legitimized them as professions for single women, it diminished the worth of caring and nurturing within the workforce (Bell et al., 2014; Hall, 2005; Reverby, 1990; Valentine, 1996). Current gender stereotypes continue to promote women as caring and nurturing, which may account for the large proportion of women working in these professions.

Music therapy can be described as a 'caring' occupation. Music therapists provide holistic care, utilizing music as a modality within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals (AMTA, 2016b). Rather than providing a 'cure' or fixing an individual, music therapy places an emphasis upon improving the entire well-being of the individual. In this aspect, music therapy shares common characteristics with other caring occupations, such as nursing, teaching, and social work. Music therapists are predominately female – the profession is comprised of 89% women (AMTA, 2016a). Like similarly female-dominated occupations, music therapists report experiencing low wages, devaluation of work, and powerlessness in the workplace (Bitcon, 1981; Clements-Cortes, 2006; 2013; Decuir & Vega, 2010; Kim, Jeong, & Ko, 2013). However, the history of music therapy is much briefer and its population of practicing professionals much smaller than its caring occupation counterparts (AMTA, 2016c; Certification Board for Music Therapists, 2011b). The profession's holistic approach and brief history, combined with difficulties established within

caring occupations, can create unique challenges for music therapists as holistic practitioners establishing themselves within the medical-model health profession.

While the concept of music as therapy is an ancient practice, music therapy as a profession was not formalized until the early twentieth century. Initially, music therapy was conducted by community musicians. The first academic program in music therapy was not established until 1944. Furthermore, the national music therapy board certification test and subsequent credentialing were not implemented until 1983 (AMTA, 2016c). At this time, licensure is not a national requirement to practice music therapy. Eight states – Georgia, New York, Nevada. North Dakota, Oklahoma, Rhode Island, Utah, and Wisconsin – require licensure for music therapists (CBMT, 2011b). With the exclusion of New York, a music therapist qualifies for licensure when they have completed the requirements for the Music Therapy – Board Certified (MT-BC) credential (CBMT, 2011b). In New York, music therapists practicing Creative Arts Therapy and using the titles 'Creative Arts Therapist' and 'Licensed Creative Arts Therapist' or any derivative thereof practicing within New York must be licensed as a Creative Arts Therapist (LCAT) which requires a master's or doctoral degree and some training in psychotherapy. However, a LCAT is not required to practice music therapy with some positions. (CBMT, 2011b; Office of the Professions, 2016). While many facilities in states without required licensure recognize the MT-BC credential, board-certified music therapists in those states may compete with individuals lacking training for job positions. Furthermore, professional music therapists often have to differentiate themselves from volunteers who provide therapeutic music. As a young and relatively small profession, music therapy is at an earlier stage in the process of establishing itself as a health profession in comparison to other caring occupations.

Similar to music therapy, occupational therapy is relatively young and small, in contrast to other caring professions such as nursing, teaching, and social work. In comparison, nursing was established as a profession almost a hundred years before occupational therapy (Bell, Michalec, & Arenson, 2014; Hall, 2005) with approximately 2.5 million nurses currently practicing in the United States (U.S. Bureau of Labor Statistics, 2015b). Occupational therapy, as we know it, has its roots in the early nineteenth century, but was not established officially until 1917 (American Occupational Therapy Association, 2016). Comparatively, occupational therapy is a much larger profession than music therapy. Currently there are 110,052 occupational therapists practicing in the United States (U.S. Bureau of Labor Statistics, 2015b) compared to 6,500 music therapists (CBMT, 2011a). Furthermore, occupational therapy is in a much later stage in its establishment as a profession. Closely aligned with the medical model, educational guidelines and accreditation procedures were established by the early 1930s. Currently, to call oneself an occupational therapist, one must graduate from an accredited masters program and pass a board examination test (AOTA, 2016). While similar to music therapy, in that it is younger and smaller than other similar caring professions, advocacy and education is less integral for occupational therapy because it is a more established profession. However, as a predominately female occupation, occupational therapy experiences some of the same challenges as music therapy, such as low wages and devaluation of work.

Within music therapy, a small subset of music therapists have identified themselves as feminist music therapists, voicing their concern and the need to acknowledge gender inequalities within the profession (Curtis, 1990; 2006; 2013; Edwards & Hadley, 2007; Hadley, 2006a; Hadley & Edwards, 2004; Hahna, 2013; Hahna & Schwantes, 2011). Although men only account for 12% of the total population of music therapists, they hold a disproportionate number of

doctoral degrees, academic positions, seats on the *Journal of Music Therapy* (JMT) editorial board, and authorships in JMT (Curtis, 2013; Edwards & Hadley, 2007; Pasiali, Lin, & Noh, 2009). In 2004, the male music therapist's salary was on average $11,000 greater than that of female music therapists (Edwards & Hadley, 2007). The goal of feminist music therapy is to support personal and sociocultural transformation within the music therapy profession by accepting feminist theory in music therapy practice (Hadley, 2006a). Feminist music therapists acknowledge that women's experiences are different, but are to be valued the same as men's (Curtis, 2006). Through acknowledging and celebrating these differences, feminist music therapists hope to decrease oppression among all marginalized populations and promote equality.

Music therapy holds the potential to be marginalized as a profession. This may be due to the fact that the field is comprised of mostly females. Marginalization may also be higher because music therapists are often minority disciplines in their work facilities. Often they may be the only music therapist employed at their facility (Kim et al., 2013; Rykov, 2001). In addition, they make significantly less in comparison to similar occupations. The median salary of a music therapist with a master's degree in 2015 was $55,019 (AMTA, 2016a). In contrast, the average occupational therapist made $80,000 in the same year (U.S. Bureau of Labor Statistics, 2015b). Baines and Edwards (2015) have suggested that music therapy, as a creative and holistic modality may further experience oppression when working within the dominant medical model paradigm where the worth of providing care may be devalued. In addition to working outside the dominant model, as a female-dominated minority occupation, music therapists are at greater risk of experiencing marginalization.

When discussing workplace factors leading to burnout, music therapists have reported low autonomy and power, ambiguous job roles, an expectation to perform tasks outside their job

description, lack of respect and understanding from peers and supervisors, poor compensation for work, limited job and advancement opportunities, and low job security (Bitcon, 1981; Clements-Cortes, 2006; 2013; Decuir & Vega, 2010; Vega, 2010). These factors combined with high job demands have resulted in higher psychological stress and job strain (Clements-Cortes, 2013; Decuir & Vega, 2010; Vega, 2010). However, research has primarily focused on individual factors that can be changed to better combat high job demands and these workplace factors (Clements-Cortes, 2006; 2013; Decuir & Vega, 2010; Fowler, 2006; Murillo, 2013; Vega 2010). Little emphasis has been placed on what can be done to change these workplace factors.

By analyzing workplace factors through the lens of occupational oppression, any negative factors can be identified as limiting situations to be overcome, rather than adverse experiences music therapists should just expect to experience and endure. Unless the oppressed acknowledge their oppression and unite, the cycle of oppression will perpetuate (Freire, 1989).

Occupational oppression in professional music therapy has not been addressed within the published literature. If occupational oppression exists as an experienced phenomenon among music therapists, then such knowledge can be a catalyst for further research regarding the lived experiences of music therapists at work. A deeper understanding of these lived experiences could create solutions to reduce workplace factors resulting from oppression. Therefore, the purpose of this study is twofold: to use the lens of occupational oppression to determine if the aforementioned workplace factors that can lead to burnout exist and to explore the factors contributing to beliefs held by music therapists in relation to occupational oppression. The following research questions will be addressed:

1. How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?
2. What factors do music therapists identify that minimize or magnify experienced occupational oppression (i.e. gender, salary, primary population of clients served, membership in the professional organization, etc.)?
3. As individuals, do music therapists experience oppression in their workplace?
4. Do music therapists believe the profession of music therapy to be an oppressed occupation?
5. What factors contribute to a music therapist's belief that music therapy is or is not an oppressed occupation?

Chapter 2

Review of Literature

Defining Oppression

Oppression is the absence of choices (hooks, 1984) and has existed throughout history. Traditionally it exists within a binary depiction – those who oppress and those who are oppressed. In this depiction, there is a strong connotation of conquest and colonial domination with oppression being defined as "the exercise of power in a tyrannical manner; the cruel treatment of subjects and inferiors" (*The Shorter Oxford English Dictionary*, 1967).

This dichotomous interpretation of oppression continued through the 20th century until the social revolutions of the 1960s and 1970s. During this time a paradigm shift occurred. Rather than the former binary depiction – oppression occurring due to an overarching tyrannical power – the view of oppression shifted to a belief that it was caused by regular people and the everyday practices of a well-intentioned liberal society (Young, 1990). The definition of oppression was modified, becoming the "arbitrary and cruel exercise of authority or power; a feeling of being weighed down in mind or body" (*Merriam Webster*, 2015). Presently, oppression serves as an umbrella term for injustices and the lack of choice and power people experience in their daily lives due to others. Discrimination, prejudice, harassment, racism, sexism, ageism, homophobia, and bullying are all various forms of oppression (Adams et al., 2010). When one experiences oppression, their ability to choose freely is taken away by another with greater power. Contemporary theoretical researcher in oppression has adapted its explanations to accommodate this paradigm shift.

Modern researchers have defined oppression in a variety of ways, but with key components shared within the definition. Oppression is defined as a social injustice that is

pervasive and systematic within modern society (Bell, 2010; Cudd, 2005; Deutsch, 2006; Dominelli, 2002; Hardiman, Jackson, & Griffin, 2010) as a result of asymmetric power relations (Cudd, 2005; Dominelli, 2002; Freire, 1989; Hardiman et al., 2010; Johnson, 2010; Prilleltensky, 2003). Regular people within to the everyday processes of life perpetuate oppression (Deutsch, 2006; Young, 1990). Oppression is restrictive and hierarchical (Bell, 2010; Zutlevics, 2002). A person can both experience oppression and be an oppressor (Dominelli, 2002; Hardiman et al., 2010; Johnson, 2010; Young, 1990). While the definitions of oppression between modern researchers share key components, there are important differences among these current theories.

Current Theories on Oppression

A foundational theoretical text on oppression is Paulo Freire's *Pedagogy of Oppression* (1989). Freire argued that oppression is the dehumanization of individuals that can lead the oppressed to becoming fearful of freedom. It requires two groups, a dominant group and those 'outside' the dominant group deemed inferior. These 'inferior' or oppressed people feel devalued as result of the dominant culture promoting their group's attributes as the only valuable ones. Thus, the oppressed group develops both a disdain for themselves and a strong belief in their inferiority, potentially leading to a lack of pride and feelings of low self-esteem (Freire, 1989).

Members of the oppressed group who wish to succeed feel that they must adopt the attributes and values of the oppressor to be successful. In return for their support, the dominant group provides them with rewards and positions of relative power. Because of this, leaders in oppressed groups are more often supportive of the dominant group than their own culture. The lack of support of their leaders combined with their fear and low self-esteem causes the powerless to become submissive and silent, as well as unable to express their needs when confronted by authority. Unable to express this fear and anger towards the powerful, the

oppressed turn inwards, committing acts of horizontal violence: oppressive acts directed to others within the oppressed group by members of the same group (Freire, 1989). Horizontal violence results in a lack of solidarity within the group and perpetuates the oppression cycle. Until the oppressed acknowledge the cycle of oppression and unite, rejecting their negative beliefs and replacing them with a sense of pride in their own characteristics and abilities, the cycle of oppression will continue (Freire, 1989).

Modern researchers of oppression have expanded on Freire's (1989) theoretical framework. This expansion includes discussing the inclusionary criteria required to be an oppressor, the reasons why oppression perpetuates (Cudd, 2002; Deutsch, 2006; Prilleltensky, 2003), consequences of oppression (Deutsch, 2006; McDonald, Keys, & Balcazar, 2007; Prilleltensky, 2003), and common characteristics of minority groups that have successfully overcome oppression (Deutsch, 2006).

Modern researchers support Freire's argument that a dominant and an inferior group must exist for oppression to occur (Cudd, 2002; Deutsch, 2006; McDonald et al., 2007; Prilleltensky, 2003; Zutlevics, 2005). While criteria for membership in oppressed groups is generally agreed upon, there is less concurrence among researchers on the criteria for membership in oppressor groups (Cudd, 2002; Deutsch, 2006; Prilleltensky, 2003). One argument is that simple group membership and benefitting from group membership is not enough for membership in oppressor groups (Cudd, 2002). Individuals could fight against the social system from which they receive their privilege and diminish their role in the cycle of oppression. Consequently, in order to be an oppressor, one must deliberately intend to perpetuate oppression through their actions (or omissions) (Cudd, 2002). A second argument states that because an individual receives privilege at all and because oppression often occurs unintentionally, being a member of a privileged group

is synonymous with being a member of an oppressor group (Deutsch, 2006; Prilleltensky, 2003). In this argument, simple group membership meets criteria to be an oppressor. However, neither argument denies the material or psychological gains members of the privileged group receive from the oppression (Cudd, 2002; Deutsch, 2006; Prilleltensky, 2003). In other words, whether members of privileged groups intentionally, or unintentionally, perpetuate oppression, they benefit from their privileged group membership.

Often, members of both dominant and inferior groups are interested in maintaining the status quo (Cudd, 2002; Deutsch, 2006). Members of both groups know what to expect within their current relationship and feel anxious in the face of the unknown. In this new unclear relationship, both groups believe that they will appear foolish, or be humiliated or helpless (Deutsch, 2006). The oppressed fear that their rage will be released, while the oppressor fears the anger of the oppressed (Deutsch, 2006); yet members of both groups fear the consequences of change. Should the oppressed attempt to end the imbalanced relationship, they fear punishment by the privileged. The privileged fear that the oppressed will punish them in retaliation (Deutsch, 2006). Both groups anticipate a loss from the change as well. Members of the privileged group derive material or psychological gains from the oppression (Cudd, 2002; Deutsch, 2006; Prilleltensky, 2006), and their augmented power increases their chances of getting what they desire (Deutsch, 2006). With a relationship change, they would lose the respect and material benefits associated with being more powerful. While the oppressed tangibly gain nothing, the change in their relationship with the oppressors would cause them to lose their sense of moral superiority and the excuses afforded by victimhood (Deutsch, 2006). For the oppressed to end the status quo and overcome their oppression, their discontent and sense of injustice should be

strong enough to ensure that the gains achieved from ending the cycle of oppression are greater than the potential risks (Deutsch, 2006).

Oppression can lead to feelings of insecurity, shame, self-doubt, and anxiety within the oppressed (Prilleltensky, 2006). The oppressed internalize these feelings of inferiority and can become perpetuators of their own cycle of oppression. In this case, such feelings result in further exploitation, within-group violence, and isolation (Prilleltensky, 2006). Some individuals internalize these feelings of inferiority, accepting their social position as a natural outcome of their lack of worth and consequently out of their control. However, this is not the only pathway the oppressed group can take in response to oppression. Resistance can occur on both the individual and group-level (Deutsch, 2006; McDonald et al., 2007; Prilleltensky, 2006). On the individual level, psychological resources are used through the development of proactive strategies to resist oppression. Individual resistance can be expressed by simply removing oneself from an oppressive environment. This removal discounts the assumptions made by the norms of the dominant culture, replaces those negative messages with positive ones, and uses the negative messages as motivation to disprove the stereotype (McDonald et al., 2007). Challenging oppression on the individual level is likely a critical first step towards ending the cycle of oppression by requiring one to acknowledge that there is a problem. However, in order to end the cycle completely, group resistance demonstrated by social action and solidarity by the oppressed on the macro-level may be required. (Deutsch, 2006; Freire, 1989; McDonald et al., 2007; Prilleltensky, 2006). With power discrepancies disrupting the status quo, only through cohesion and organization can the oppressed gain enough power to promote effective change.

Researchers have applied the theoretical framework of oppression developed by Freire (1989) and subsequent researchers (Cudd, 2002; Deutsch, 2006; McDonald et al., 2007;

Prilleltensky, 2003; Zutlevics, 2002) to a wide variety of groups. This includes race (Elliott & Smith, 2004; Petrie & Roman, 2004), gender (Elliott & Smith, 2004; Hadley, 2006; Hillock, 2012; Petrie & Roman, 2004), ability (McDonald et al., 2007; Northway, 1997), as well as occupation (Cox, 1991; Matheson & Bombay, 2007; McKenna, Smith, Poole & Coverdale, 2003; Roberts, 1983; Roberts, Demarco, & Griffin, 2009; Rodwell & Demir 2012).

Minority groups that have been successful in overcoming oppression display a common set of characteristics. Successful minority groups display high social cohesion, effective social organization, and place an emphasis on the development of personal qualities such as skill, dedication, and discipline (Deutsch, 2006). These characteristics are necessary for the effective utilization of resources like money, votes, tools, and force to combat oppression. Unfortunately, such characteristics are often vastly undeveloped in victimized groups. However, discontent and injustice can amplify these characteristics and serve as catalysts for social action to promote change (Deutsch, 2006). In some populations, the discontent and sense of injustice may be latent, with the oppressed neither identifying as victimized or disadvantaged, nor being conscious of being a member of a disadvantaged group. In this case, consciousness-raising tactics are necessary precursors to developing group cohesion and social organization (Deutsch, 2006). Without the oppressed first acknowledging the oppression, they will not gain enough power through cohesion and organization to combat their oppressors and end the cycle of oppression (Deutsch, 2006; Freire, 1989). Acknowledging the existence of oppression within a population is necessary before change can occur for that group. Identifying characteristics of other oppressed groups may be helpful for the oppressed to acknowledge their own oppression.

How is Occupational Oppression Identified?

Occupational oppression refers to the system of invisible barriers that professionals experience in the workplace that reduce their ability to perform their jobs at the highest level. These barriers are based on the assumption that certain professions are inherently superior or inferior. These inequalities occur because of group membership. Occupational oppression is a result of multiple facets of oppression, such as sexism, racism, and ageism. Due to this combination, there is no attribute or set of attributes that oppressed occupational populations have directly in common. Each individual occupation experiences oppression differently (Young, 1990). Five broad categories or "faces" of occupational oppression have been described that, if present, are indicative of oppression. A profession does not need to experience all five categories to be considered oppressed, rather the presence of one category is sufficient to meet the oppressed threshold (Young, 1990). The categories are defined below:

1. *Exploitation* occurs when persons who control a resource enlist the effort of others in production of value by means of that resource, but exclude the others from the full value added by their effort. Exploited people do not receive adequate compensation for their labor.
2. *Marginalization* occurs through social exclusion. Marginalization involves excluding, not just merely discriminating against. Marginalized people are deprived of material goods and full participation in society, and are often seen as dependent on or a burden to society.
3. *Powerlessness* occurs when others have power over a group or groups of people. A small number of people make all of the decisions. Being powerless results in the inability to

make autonomous decisions in one's life, being inhibited from developing and improving oneself, and lack of respect from others.

4. *Cultural imperialism* occurs when the dominant or powerful group determines societal norms, and anyone outside the dominant group is seen as the 'other.' The 'other' group is then viewed as both different and invisible, and is devalued and objectified by the dominant group. Nearly all oppressed groups suffer from cultural imperialism.
5. *Violence* occurs through the application of physical or psychological force with the intent to hurt, damage, or kill someone or something. Violence does not only include experienced violence, but psychological implications of the potential of experiencing violence.

Occupational oppression occurs when a person experiences any of these five categories: marginalization, exploitation, powerlessness, cultural imperialism, and/or violence due to, or within, their occupation (Young, 1990). Occupational oppression is systematic and pervasive, and results from asymmetric power relations within hierarchical work structures (Bell, 2010; Cudd, 2005; Deutsch, 2006; Dominelli, 2002; Freire, 1989; Hardiman, Jackson & Griffin, 2010; Johnson, 2010; Prilleltensky, 2003). The oppressed group's power to choose is denied or limited due to a variety of factors, including but not limited to occupational choice, beliefs about chosen occupation, gender, race/ethnicity, educational level, or age. This denial of, or limitation on power can have adverse effects, resulting in the oppressed group feeling undervalued, unappreciated, fearful, and helpless (Freire, 1989; Deutsch, 2006; Prilleltensky, 2003). Some forms of oppression are quite visible, while others more subtle. Examples of occupational oppression include: wage gap (Black, Haviland, Sanders, & Taylor, 2006; CONSAD, 2015; DeNavas-Walt & Proctor, 2015; England, Allison, & Wu, 2007; Gaddis, 2015; Shauman, 2006;

U.S. Bureau of Labor Statistics, 2015a; 2016), occupational segregation (Carnevale, Strohl, & Melton, 2014; Cohen & Huffman, 2003; England, Allison, & Wu, 2007; Levanon, England, & Allison, 2009; Shauman, 2006; Women's Bureau, 2013), and the 'glass escalator' effect (Hultin, 2003; Karlsen, 2012; Simpson, 2004; Smith 2012; Williams, 1992; 2013; Wingfield, 2009). Each form will be described in more detail below.

Wage gap. A visible form of occupational oppression is the gender wage gap. Women who are employed full-time and year-round earn 79 cents for every dollar men earn according to the U.S Census Bureau (DeNavas-Walt & Proctor, 2015). The U.S. Bureau of Labor Statistics (2015a) identifies that figure slightly higher with median weekly earnings for women at 83 cents for every dollar earned by men. Despite numeric differences, disparities in wages between genders exist. However, gender bias alone cannot account fully for the wage gap. Women are more likely to enter lower-paying fields and take more time off from work due to pregnancy and childcare (Carnevale et al., 2014; Cohen & Huffman, 2003). Yet, when eliminating those factors and controlling for all outside variables, such as experience, education, skills, and responsibilities, the wage difference between men and women would still be greater than zero. In this case, the wage gap shrinks from between 21 or 17 cents to between 7 and 5 cents (CONSAD, 2015).

Similar disparities also exist across racial lines. White males make more than their black and Hispanic counterparts – approximately 28 cents more on every dollar (U.S. Bureau of Labor Statistics, 2016). While education levels can account for some of the difference, a wage gap still exists between college educated white and racial minority males (Black et al., 2006). White graduates from elite universities are more likely to receive interviews than their black equivalents when applying for similar positions. Furthermore, when employers respond to black

candidates, it is for jobs with lower starting salaries and inferior prestige (Gaddis, 2015). However when considering gender in addition to race/ethnicity, these trends do not necessarily hold true.

In 2014, median weekly earnings were higher for white women ($734), than for black ($611) and Hispanic ($548) women (U.S. Bureau of Labor Statistics, 2015a). This remains true without consideration of education levels. However, black women with a bachelor's degree reportedly earn more than their white or Hispanic counterparts (DeNavas-Walt & Proctor, 2015). Despite earning more than their female counterparts of the dominant group, black college educated women, on average, make less than black college educated men (DeNavas-Walt & Proctor, 2005; U.S. Bureau of Labor Statistics, 2016). It appears that gender has a greater impact on salary than race when considering wage differentials.

Occupational segregation. One factor leading to the wage gap is occupational segregation: the tendency for women to enter lower paying fields than men. Nine out of the ten lowest-paying college majors are predominately female. Conversely, only one of the ten highest-paying college majors – "pharmacy science and administration" – is predominately female (Carnevale et al., 2014). The U.S. Department of Labor (Women's Bureau, 2013) cites the top occupations for employed women as secretaries and administrative assistants, elementary and middle school educators, registered nurses, and home health aides. This list has changed little since post-World War II. These low paying occupations have been dubbed the "caring" industry and are overwhelmingly female dominated. Higher paying careers display technical, scientific, or business-related characteristics, which are characteristics generally attributed to men (England et al., 2007; Shauman, 2006).

While gender-related occupational segregation might suggest that women prefer lower paying occupations, occupations dominated by women might be devalued and paid less because cultural beliefs portray men as more competent and status-worthy than women. (Cohen & Huffman, 2003; England et al., 2007; Levanon et al., 2009). Women do not choose to work in occupations that pay less once occupations become predominately female, rather there exists a shift in how employers perceive an occupation as less valuable, demanding, or deserving of pay occurs once it becomes a predominately female occupation. Consequently, employers set a lower salary for both men and women than they would have done if the occupation had been predominately male. Similarly, when an increased number of men move into a female-dominated profession, the status of the occupation and the wages for all members of the occupation increase (England et al., 2007; Levanon et al., 2009).

The 'glass escalator' effect. When women work in male-dominated professions, they encounter a 'glass ceiling' that prevents their ascension into the top jobs (Hultin, 2003; Williams, 1992; 2013; Wingfield, 2009). However, when men enter female dominated professions they receive advantages and opportunities that promote them in their careers rather than encountering a glass ceiling due to their minority status. This is referred to as a 'glass escalator' effect, a label coined by sociologist Christine Williams (1992; 2013). According to this theory, men are assumed to be more competent and possess stronger leadership qualities than women. Therefore, they are ushered into higher-paying specialties and administrative positions, aided by stewardship from their female employees, collegial relationships with their superiors, lack of identification with the female aspects of their jobs, and meeting the gendered expectations of others (Hultin, 2003; Karlsen, 2012; Simpson, 2004; Smith, 2012; Snyder & Green, 2008;

Williams, 1992; 2013; Wingfield, 2009). However, the advantages gained by the 'glass escalator' effect do not apply toward all males.

The 'glass escalator' effect primarily applies to white males. Black males are less likely to receive the advantages of their peers, which suggests that the 'glass escalator' effect is both gendered and racialized (Wingfield, 2009). Black male nurses, instead of benefiting from the opportunities and advantages they should have received for being male were found to have encountered tense relationships with colleagues, supervisors' biases against them regarding promotions, negative stereotypes from patients that impeded caregiving, and a sense of comfort with some of the feminized aspects of the job that inhibited promotions (Wingfied, 2009). These challenges were suggested to be even greater when adding in the factor of sexuality on top of race (Wingfield, 2009). Such disparities among racial minorities and women, in comparison to white males, apply to the individual-level as well.

On the individual-level, both white and minority women experience a decrease in satisfaction with their work (Petrie & Roman, 2004). While all women report experiencing less workplace autonomy in comparison to men, black women report experiencing even less workplace autonomy than their white, female colleagues. This disparity occurs because black women experience the double jeopardy of both race and gender (Petrie & Roman, 2004). Women have less workplace power, less control over resources, people, and things (Elliott & Smith, 2004; Wolf & Fligstein, 1979). However, research suggests that black women experience this inequality because of direct discrimination (Elliott & Smith, 2004). Women report more obstacles to career success and satisfaction, such as having to work harder to be considered 'legitimate' (Shollen et al., 2009). The disadvantaged are more likely identify these incongruities in gender and racial occupational opportunities quicker than those who have privilege.

Historically, people who are privileged are slow to acknowledge their advantages. While men are more likely to acknowledge that women are disadvantaged, they struggle acknowledging their own unearned advantages (McIntosh, 2007). Men also experience greater challenges in identifying experiences of personal or professional oppression (Hillock, 2012) because they seldom experience oppression. Men, especially white men, struggle to identify oppression within other populations due to a lack of experienced oppression. In fact, men perceive greater strides towards gender equality than women (Tomer et al., 2015). Difficulty acknowledging their male privilege and the extent of oppression within others perpetuates the oppression cycle. This helps continue the oppression cycle by promoting inequality among genders and the oppression experienced by women in the workplace.

While occupational oppression occurs for a myriad of reason, gender is one of the most prevalent reasons. This is documented by differences in men's and women's wages, occupational segregation, and promotional inequalities. Women on average earn less than their male cohorts, even when performing the same job (CONSAD, 2015; DeNavas-Walt & Proctor, 2015; U.S. Bureau of Labor Statistics, 2015a). While women are more likely to enter lower-paying occupations (Carnevale et al., 2004; Shauman, 2006), research supports that female-dominated occupations experience devalued earning potentials (England et al., 2007; Levanon et al., 2009). White men within female-dominated professions encounter the 'glass escalator' effect and experience advantages towards occupational advancement unavailable to women (Hultin, 2003; Karlsen, 2012; Simpson, 2004; Smith, 2012; Snyder & Green, 2008; Williams, 1992; 2013). Women report a decrease in satisfaction in their work and report experiencing less workplace autonomy than their male counterparts (Petrie & Roman, 2004). These gender disadvantages are not unique to one single profession, but exist across occupations.

Where Does Occupational Oppression Exist?

Forms of occupational oppression such as the wage gap, occupational segregation, the 'glass ceiling' effect, and the 'glass escalator' effect have been well documented across professions (Hultin, 2003; Simpson, 2004; Smith, 2012; Williams, 1992; 2013; Wingfield, 2009). In many occupations, members of marginalized groups experience oppression on the individual level. However, for some professions, especially gender-segregated professions, oppression has been analyzed as a unique phenomenon due to occupational choice. This occupational oppression has been established and/or discussed as a phenomenon occurring within the entire profession (Chambers, 2011; Cox, 1991; Croom & Patton, 2011; Cushman, 2005; Daiski, 2004; Davis & Maldonado, 2015; Harley, 2008; Hart & Montague, 2015; Litosseliti & Leadbeater, 2013; Matheson & Bobay 2007; McKenna, Smith, Poole, & Coverdale, 2003; Roberts, 1983; 2000; Roberts et al., 2009; Rodwell & Demir, 2012; Sakamoto & Pitner, 2005; Truss, Alfes, Shantz, & Rosewarne, 2013; Watts, 2007; Werham, 2010). Examples of oppressed occupational groups include, but are not limited to, nursing, social work, and academia as experienced by minority women.

Nursing and oppressed group behaviors. Approximately 90% of registered nurses (RNs) in the United States are women (Women's Bureau, 2013). However, male nurses earn more than females; the gender gap for registered nurses' salaries amounts to a little over $5,000 yearly on average, a statistic that has not budged in 20 years (Muench et al., 2015). While gender differences explain a portion of oppression, the application of Freire's (1989) oppression framework identifies nursing, as a whole, as an oppressed group (Roberts, 1983) and has been actively discussed (Cox, 1991; Daiski, 2004; Dong & Temple, 2011; Duchscher & Myrick, 2008; Matheson & Bobay, 2007; McKenna et al., 2003; Roberts, 2000; Roberts et al., 2009;

Rodwell & Demir, 2012; Vessey et al., 2010). The presence of occupational oppression has been related to nurses' decreased self-advocacy or 'silencing,' horizontal violence, and other negative aspects of the nursing workplace (Budin, Brewer, Chao, & Kovner, 2013; Daiski, 2004; Duchscher & Myrick, 2008; Matheson & Bobay, 2007; McKenna et al., 2003; Roberts et al., 2009; Rodwell & Demir, 2012; Vessey et al., 2010).

Roberts (1983) argued that nursing has lacked power and control within the workplace since healthcare moved into the hospital. As hospitals became major care sites, a hierarchy developed with medicine on top, resulting in nursing being dominated by medicine (Matheson & Bobay, 2007; Roberts, 1983; 2000; Roberts & Demarco, 2009). This lack of control and autonomy benefitted physicians and hospitals, but created problems for nursing (Matheson & Bobay, 2007; Roberts, 1983; 2000). Despite supposed advancement in education and the practical foundations of both medicine and nursing, these hierarchical relationships and role distinctions between physicians and nurses continue to persist (Duchscher & Myrick, 2008). Nurses describe their anxiety-laden relationships with physicians frequently citing behaviors of yelling, displays of disrespect and condescension towards nursing staff, berating colleagues and patients, and the use of abusive language within the workplace (Duchscher & Myrick, 2008; Rosenstein, 2002). However, perhaps more disturbing is the reluctance of nurse leaders to address these problem behaviors (Duchscher & Myrick, 2008). Based on oppression theory, such reluctance may occur due to leaders from an oppressed group (nurses) adopting the values and norms of the more powerful group (physicians) to improve personal status and power (Duchscher & Myrick, 2008; Friere, 1989; Roberts, 1983; 2000; Roberts et al., 2009). Without the support of their leaders, nurses experience a reduction in empowerment and potentially a lack of collective self-esteem (Roberts, 1983; 2000). Consequently, while nurse managers report

higher levels of self-esteem, assertiveness, accountability, and control over practice, their staff nurses report higher levels of submissiveness and need for structure due to their perceived lack of power (Cox, 1991).

Due to this manifestation of submissiveness, nurses are often silent regarding their contributions to patient care. They report feeling unequal and having a lack of respect from physicians (Daiski, 2004; Duchscher & Myrick, 2008), and while they believe their work is important, it lacks appropriate recognition (Daiski, 2004). Consequently, the most common management styles utilized by nurses are 'avoiding and compromising,' with perceptions of 'silencing' resulting in diminished patient-care and lower self-worth of nurses as a whole (Roberts et al., 2009).

The disempowerment felt by lower ranked nursing staff often results in passive-aggressive behavior (Roberts, 1983; 2000; Vessey et al., 2010). For example, nurses will complain profusely about an offending physician, but will rarely confront the physician (Roberts, 1983). Nurses often lack organizational support and are unable to voice their frustrations alone about their lack of professional autonomy, decision making, and control over practice. As a result, nurses turn their anger inward towards nursing peers and themselves. Responding to this sense of powerlessness, these frustrations manifest themselves in peer-to-peer violence, referred to as 'horizontal violence.' (Deans, 2004; Myers et al., 2016; Roberts, 1983; 2000)

Horizontal violence is defined as anger and aggressive behaviors turned towards one's group members. Such aggressive behaviors have been well-documented in nursing (Daiski, 2004; Duchscher & Myrick, 2008; McKenna et al., 2003; Myers et al., 2016; Roberts et al., 2009; Rodwell & Demir, 2012). Often this violence takes place in the form of nurse-to-nurse incivility. Workplace 'bullying' among nurses is one of the most prevalently cited detractions to

nursing identified by those entering the profession (Duchscher & Myrick, 2008). Horizontal violence includes nurses abusing new graduates and resistance to new nurses' ideas for change (Daiski, 2004) One study found that over half of new graduates had experienced rudeness and humiliation across settings, and many had felt distress as a result of inappropriate supervision (Duchscher & Myrick, 2008; McKenna et al., 2003). Horizontal violence is an often-cited factor leading to the high attrition rate among newly graduated nurses (Duchscher & Myrick, 2008) and has been reported to lead to decreased morale, decreased productivity, decreased nursing care delivery, increased error rate, and increased absenteeism (Budin et al., 2013; Duchscher & Myrick, 2008).

Acknowledging the negative consequences of the disempowerment and disenfranchisement experienced by nurses, nursing literature has increasingly focused on developing practices that promotes a culture of empowerment and decreases occupational oppression (Deans, 2004; Duchscher & Myrick, 2008; Myers et al., 2016; Roberts et al., 2009; Vessey et al., 2009). These practices are often implemented top-down, with nursing leadership first analyzing the organizational culture and structures that promote nurse disempowerment (Deans, 2004; Duchscher & Myrick, 2008; Roberts et al., 2009). Further steps include fostering a culture where communication and positive feedback are encouraged (Duchscher & Myrick, 2008; Myers et al., 2016), increasing education on horizontal violence and bullying for nurses (Deans, 2004; Myers et al., 2016; Roberts et al., 2009; Vessey et al., 2009) and nurse leadership (Deans, 2004), and establishing a zero-tolerance policy on bullying (Duchscher & Myrick, 2008).

The nursing profession has recognized oppressive practices and the negative implications such practices had on the occupation. Subsequently, the profession took action to decrease such

practices by creating work environments where nurses feel valued, thus increasing work satisfaction and the level of patient-care (Budin et al., 2013; Duchscher & Myrick, 2008). While social work has not explored the implications of oppression experienced by their practitioners to the degree that nursing has, there has been a greater focus placed on the level of care patients receive due to oppression and ways to alleviate that oppression.

Social work and developing the anti-oppressive practitioner. Like nursing, social work is another predominately-female occupation. Women make up approximately 82% of the profession (U.S. Bureau of Labor Statistics, 2015a) but earn approximately $7,000 less annually, or 14% less, than their male cohorts (Whitaker, Weismiller & Clark, 2006). Furthermore, when comparing gender within the bottom 10% of wage earners and the top 10% of wage earners, 89% of the low earners are women, while only 57% of the top earners were women (NASW Center for Workforce Studies, 2007). Despite these disparities, there is little literature on how occupational oppression directly affects social workers. Rather a greater emphasis is placed on the effects of that oppression on interactions with clients.

One lens through which to view the effect of this oppression is anti-oppressive practice, which has been actively discussed in the social work literature (Hart & Montague, 2015; Sakamoto & Pitner, 2005; Strier & Binyamin, 2010; 2014; Wilson & Beresford, 2000). Anti-oppressive practice requires critical reflection and encourages the practitioner to be aware of power differentials, relying on their own intuition to create the best interventions for a diverse set of clients (Hart & Montague, 2015; Strier & Binyamin, 2010; 2014). Anti-oppressive practice acknowledges the requirement of different interventions for each client because each client has had different experiences. In other words, one set of solutions does not work for all clients, so practitioners are expected to challenge the status quo in order to best aid their clients (Hart &

Montague, 2015). While commonly taught in university-based training, anti-oppressive practice can be challenging for students to apply when entering work-based training, such as clinicals, internships, or practicums.

Work-based training is common practice within many health and social-care professions, and allows the student to apply classroom-based knowledge to real life situations. However, the workforce does not always mirror the educational setting, and can present several contradictory and competing demands to the developing anti-oppressive practitioner (Hart & Montague, 2015) due to their relatively limited power within organizational settings (Hart & Montague, 2015; Wilson & Beresford, 2000). While encouraged to develop reflexive artistry, become autonomous learners, and subsequently develop anti-oppressive practice, a greater emphasis is placed on the student's ability to follow rules and procedures within work-based training. Therefore, students wishing to identify with current practitioners are quick to adopt their values and beliefs (Hart & Montague, 2015), potentially abandoning anti-oppressive practices.

These power inequalities are further replicated, rather than challenged, through what Sakamoto and Pitner (2005) refer to as the 'teacher/student' trap. Helping professions generally practice a top-down approach. Knowledge, assistance, and expertise are dispensed from above: From the supervisor to the student, from the practitioner to the service user. Through this model, it is difficult for relatively powerless practitioners (students) to introduce new ideas into the organization (Sakamoto & Pitner, 2005). Instead of moving toward social justice and partnership, the teacher/student trap has a way of forcing social workers to perpetuate and re-inscribe power differentials and social injustice (Sakamoto & Pitner, 2005).

Paradoxically, while acknowledging the oppressive practices experienced by students, some researchers note that such personal experiences may also be considered a key strength of

work-based learning (Hart & Montague, 2015). By placing the student in such an ambiguous, fluid, and sometimes hostile environment, they may experience the discomfort necessary for the desired learning to take place (Sakamoto & Pitner, 2005). Moreover, in order for a developing therapist to recognize oppression and develop interventions to best combat it, they must first experience being oppressed (Hart & Montague, 2015).

However, interviewed social workers as a whole had difficulty acknowledging, or did not explicitly acknowledge positions of privilege and entitlement; furthermore they not articulate how these positions applied to their clinical and personal relationships (Hillock, 2012). Furthermore, male social workers, in comparison to their female peers, were less able to identify personal experiences of oppression, and had difficulty recognizing various sources, forms, and levels of oppression (Hillock, 2012). This finding is concerning because without explicit recognition and understanding of their own privileges and oppressive behaviors, social workers run the risk of continuing to perpetuate inequality and oppression (Hart & Montague, 2015; Hillock, 2012).

Black women in academia and intersectionality. Black women often experience 'double jeopardy' in relation to oppression; they experience the negative aspects of both being female and a minority. Despite these barriers, the educational achievement of black women in the United States has increased over the decades with a growing gap between the educational achievement of black females and males (Sharpe & Swinton, 2012). From the time period of 2000 to 2009 black women earned 8% of the total associate and master's degrees awarded, 6% of all bachelor's degrees awarded and 5% of all doctorate and professional degrees awarded. This is nearly twice as many degrees than what are awarded to black men. The professional progress of black women within academia has been positive as well, with data supporting greater

likelihood in advancement from assistant to full professor than in previous decades (Sharpe & Swinton, 2012).

Despite these positive advancements, black women in academia face challenges their fellow colleagues do not experience due to their blackness and womaness (Chambers, 2011; Croom & Patton, 2011; Davis & Maldonado, 2015; Harley, 2008; Howard-Baptiste, 2014). At the heart of these challenges are *microagressions,* a term coined by psychologist Chester M. Pierce in the 1970s. Microagressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative slights and insults towards minority populations (Chambers, 2011). Black female faculty members' microaggressions are presented by students questioning their knowledge or credentials, and the increased likelihood of being reprimanded by their dean and being criticized by colleagues based on suppositions, misperceptions, and on information without merit (Harley, 2008). They are often pegged to teach courses in diversity (Harley, 2008), and report being marginalized and their research devalued (Chambers, 2011). In order to feel success, black women in academia have to overcome both their female-ness and their black-ness.

These microaggressions are direct and indirect actions by others experienced by black female faculty. They occur due to a mix of ignorance, race-based stereotypes, and inaccurate misrepresentations of black women in higher education (Howard-Baptiste, 2014). Recommendations from African American faculty to address this problem focused on improving the campus climate (increase recruitment, improve racial climate, provide diversity training), increasing support (mentoring and valuing their input and contributions), modifying professional duties (reduce teaching load, provide assistance with research, reduce committee workload), providing compensation or other incentives (better salary, equitable pay), improving tenure and

promoting practices, respecting community service, and respecting African American faculty's work with African American students (Harley, 2008; Howard-Baptiste, 2014). However, until institutions of higher education critically examine the climate and commit to change, such microaggressions will perpetuate (Howard-Baptiste, 2014).

Occupational oppression within other professions. Occupational oppression has been explored to a lesser extent in other professions as well. Litosseliti and Leadbeater (2013) discuss the impact of speech language therapy/pathology being characterized as 'women's work,' a profession characterized by extreme occupational segregation. In addition to the inequality (in terms of pay, access to opportunities, and career progression) that accompanies sex-segregated occupations, labeling negatively impacts the discipline's clinical effectiveness. A majority of speech-language clients are male and attracting more men to serve these male clients has not yet been resolved (Litosseliti & Leadbeater, 2013). This discussion has also been reflected in other similar female dominated professions such as family and consumer science teachers (Werhan, 2010), primary school educators (Cushman, 2005), and secretaries (Truss et al., 2013). Furthermore, the challenges and hurdles women must overcome to be successful in male-dominated professions has also been discussed, such as the experiences of female civil engineers working in construction (Watts, 2007). When looking at qualities of value within the workforce, greater emphasis is placed on qualities exemplified by the dominant group, in this case white males. Historically male occupations are more respected, receive better wages, and are provide more opportunities for advancement.

Occupational oppression creates a workplace culture of hostility; it negatively influences all parties involved by adversely affecting their health and wellbeing. While different strategies among the various professions have been recommended, acknowledging the issue remains an

agreed upon essential first step in combatting oppression (Duchscher & Myrick, 2011; Harley, 2008; Hillock, 2012; Howard-Baptiste, 2014). If unaddressed, occupational oppression results in the oppressed experiencing decreased resources and low control in the workplace. Ultimately, it leads to high job strain, commonly referred to as high occupational stress.

What are the Consequences of Occupational Oppression?

Occupational oppression has adverse effects on the oppressed. Ultimately, it leads to high job strain and results in professional burnout and exiting the profession. Two theoretical models explaining factors leading to high job strain are the Job Demand-Control-(Support) (JDCS) model (Johnson & Hall, 1988) and the Conservation of Resources (COR) theory (Hobfoll, 1989).

Job Demand-Control-(Support) model. Karasek (1979) introduced the Job Demand-Control (JDC) model outlining the impact of adverse job characteristics on health and well-being. Two essential job characteristics influencing workplace well-being were identified, job demands and job control. In following years, social support was integrated into the model as a further fundamental characteristic of the work environment, thereafter being called the Job Demand-Control-(Support) (JCDS) model (Johnson & Hall, 1988). The expanded three-dimensional Job Demand-Control-(Support) model predicts that workers with jobs that have high demands, low control, and low support from supervisors and/or co-workers experience high occupational stress and are at the greatest risk for psychological or physical disorders (Figure 1) (adapted from Johnson & Hall, 1988).

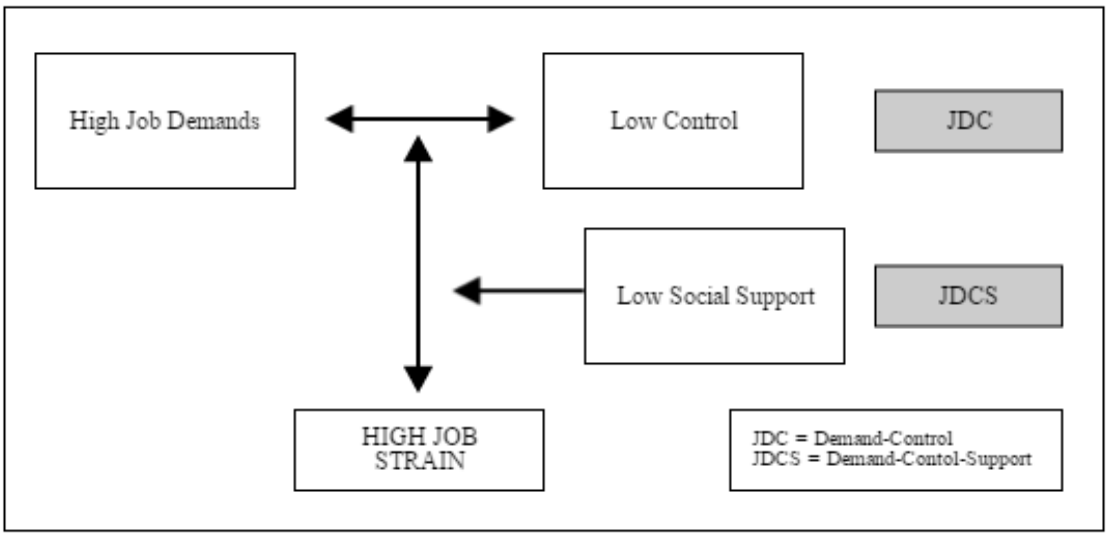

Figure 1. Job Demand-Control and Job Demand-Control-(Support) Models (adapted from Johnson & Hall, 1988)

Job demands can refer to aspects such as workload and time pressure, as well as physical and emotional demands. The second characteristic, job control, refers to the extent that a person is capable of controlling their tasks and general work activity. More specifically, job control is divided into two categories: skill discretion and decision authority. Skill discretion refers to a person's opportunity to use specific job skills in the working process. Decision authority refers to the extent in which a person is autonomous in task-related decisions, such as timing and control method (Häusser, Mojzisch, Nielsen, & Schulz-Hardt, 2010).

Combining the two dimensions of job demand and job control, Karasek (1979) stated that jobs high on demands and low on control ("high strain jobs") bear the highest risk of illness and reduced well-being. In contrast, jobs low on demand and high on control ("low strain jobs") are at little risk of illness and reduced well-being. With the addition of the third dimension, social support, Johnson & Hall (1988) argue that high positive social support can buffer the negative impact of high strain (high demand, low control). Subsequent studies have supported this model, finding a causal relationship between high strain (high demand, low control) and high

psychological stress (Haung, Chen, Du & Huang, 2012), and a positive longitudinal relationship between high job control and high social support in buffering psychological stressor jobs (Cheng, Mauno & Lee, 2014). These findings continue to be supported in systematic reviews (de Lange et al., 2003; Häusser et al., 2010).

Control of Resources theory. The Control of Resources (COR) theory is based on the idea that humans are motivated to protect their current resources and acquire new resources (Hobfoll, 1989; 2001). When valued resources are lost, threatened with loss, are inadequate to meet demands, or do not reap the anticipated level or return, negative outcomes such as burnout, turnover intentions, or health complaints are likely to occur (Hobfoll, 2001). Major work demands such as role ambiguity, work pressure, and workload, result in the threat of the loss of resources or the actual loss of resources. The COR theory acknowledges four types of resources: valued objects (e.g. housing, clothing, tangible benefits), stress-mediating conditions (job security, seniority, social support), stress-aiding personal characteristics (traits, skills), and resource generating energy (time, money, competence, knowledge (Hobfoll, 1989; 2001; Lee & Ashforth, 1996; Nevau, 2007).

In order to minimize or recover from resource loss and gain new resources, people must invest their current resources (Akhtar & Lee, 2010; Hobfoll, 2001). An adequate level of resources is necessary for both maintaining the status quo and improvement. When high job demands threaten a person's resources, it triggers stress. Confronted with this stress, people are expected to minimize the loss of resources by utilizing their current resources. In this respect, those who have greater resources at their disposal are at decreased risk of being adversely affected by resource loss created by high job demands (Lee & Ashforth, 1996). Furthermore,

those who have few initial resources are especially more vulnerable to experiencing further resource loss, and therefore high job strain (Hobfoll, 1989; 2001).

Resource loss is disproportionally more noticeable than resource gain. Given equal amounts of loss and gain, loss will have a significantly greater impact (Akhtar & Lee, 2010; Hobfoll, 2001). This implies that compared with known job resources, the effects of threats to resources posed by high job demands is greater with respect to job strain (Akhtar & Lee, 2010). Prolonged exposure to high job demands is thought to result in job strain in the form of emotional exhaustion (the core dimension of burnout). Low job resources are thought to be related to both emotional exhaustion and depersonalization (the second important dimension of burnout) (Taris, Schreurs & Van Iersel-Van Silfhout, 2001).

Combining the JDCS model and the COR theory. Karesek's (1979) Job Demand-Control-(Support) model and Hobfoll's (1989; 2001) Conservation of Resources theory are like two sides of a coin. The JDCS model explains what will happen – if "A" occurs, then it is likely "B" will occur – while the COR theory explains why. The JDCS model argues that high job demands combined with low job control and low social support will result in high job strain. When combined with the COR theory, it is assumed that people strive to obtain and maintain what they value. These resources include job control and social support, as well as job reinforcement (Hobfoll, 1989; 2010; Lee & Ashforth, 1996). High job demands threaten these resources and trigger stress. When confronted with stress, people utilize their resources to minimize the loss of future resources. If one already has few resources, such as little job control and no social support, the adverse impact of job demands will be greater in comparison to a person who has autonomy within the workplace and good social support (Akhtar & Lee, 2010; Hobfoll, 1989; 2010) (Figure 2).

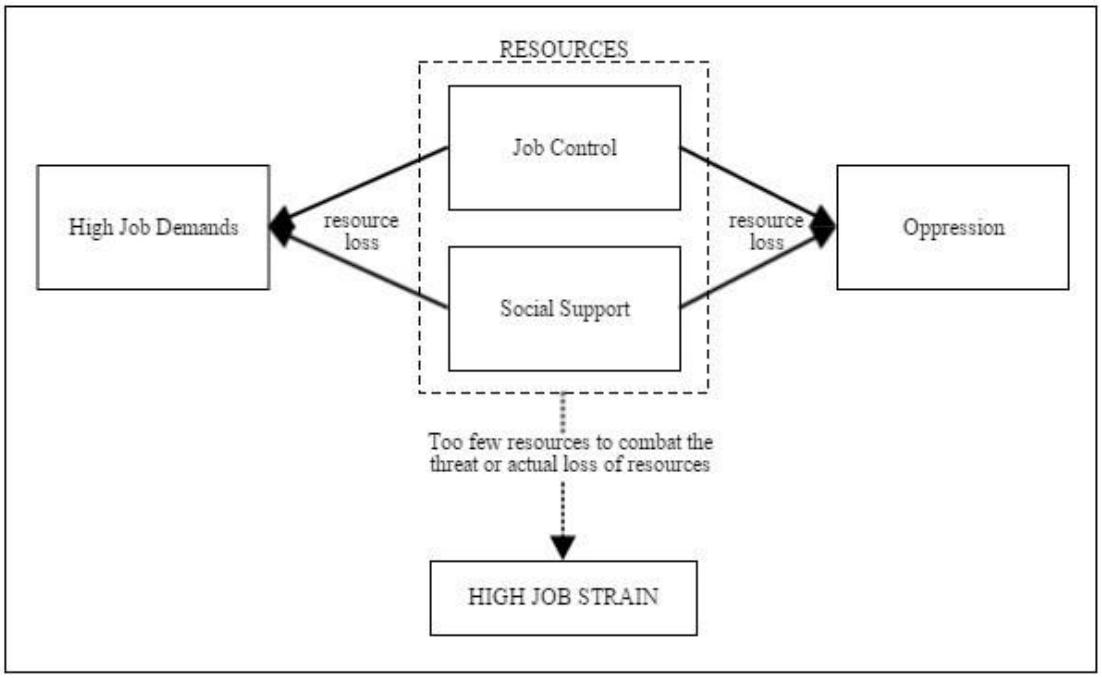

Figure 2. The Impact of Oppression within a Combined JCDS/COR Model

Occupational oppression results in the absence of choice within the workplace. This decreased autonomy places the individual at greater risk for high job strain. When the individual has little social support, due to horizontal violence or due to being a minority group member, the impact of these demands is expounded. Considering that many within helping professions experience high demands and lack resources, it is not surprising that many also experience high job strain.

Impact of high job strain. Experiencing high job strain is assumed to result in psychological stress reactions, such as high blood pressure and decreased work satisfaction (de Lange et al., 2003) and is one of the most prominent causes of reduced job involvement and increased absenteeism in the workplace (Häusser et al., 2010). When high job strain is experienced over an extended period of time, the professional can develop what is referred to as burnout. Burnout is frequently described as having three distinct categories of symptoms: depersonalization, emotional exhaustion, and reduced personal accomplishment (Maslach & Jackson, 1986). Depersonalization is described as a detachment or aloofness from other

individuals, particularly the ones who should be receiving care or services. Emotional exhaustion is the feeling of being overextended and depleted of emotional resources. Lack of personal accomplishment refers to the decline in one's own feelings of competence, as well as reduced productivity (Fowler, 2006). Ultimately, burnout can lead to the person leaving the job and/or the profession.

Burnout has been well-documented among female dominated professions including nursing (Bakker, Killmer, Siegrist & Schaufeli, 2000; Tummers, Janssen, Landeweerd & Houkes, 2001), education (Brunsting, Sreckovic & Lane, 2014; Farber, 2000), and social work (Kim, Ji & Kao, 2011; McFadden, Campbell & Taylor, 2015). Those who experience burnout demonstrate physical and mental exhaustion, find less enjoyment in their occupation, isolate themselves from others, have feelings of apathy or hopelessness, are more likely to call in sick or arrive late to work, and display a lack in productivity or a decreased performance. They may also exhibit increased mental and physical health issues (Johnson & Hall, 1988).

Occupational oppression and high job strain. Occupational oppression increases job strain because it reduces the number of resources a person has to combat high job demands. Oppressed group members lack autonomy. The oppressed feel powerless, unappreciated, and devalued. Rewards for job performance do not meet their expectations. The oppressed fear the repercussions should they speak their minds or promote change within the workplace. They may have few social supports because of marginalization or horizontal violence. These factors, combined with the fact that many female-dominated helping professions have high job demands – they are ambiguous, emotionally challenging, and time consuming – result in psychologically stressful professions.

Individual cognitive factors, such as beliefs towards control, commitment, and challenges, can contribute to or detract from resilience, the ability to overcome the negative effects of high job demands (McFadden et al., 2010). However, organizational factors play a greater role in contributing to burnout and turnover rates (McFadden et al., 2010). Oppressive experiences, such as inadequate manager or supervisor support, unmanageable workloads, poor social supports, and little workplace control/autonomy increase burnout and turnover rates. As evidenced in the nursing literature, occupational oppression therefore not only negatively affects the individual, but the profession as a whole (Budin et al., 2013; Daiski, 2004; Duchscher & Myrick, 2008; Matheson & Bobay, 2007; McKenna et al., 2003; Roberts et al., 2009; Rodwell & Demir, 2012; Vessey et al., 2010).

Trends in the Field of Music Therapy

Who are music therapists? According to the Certification Board for Music Therapists (CBMT), there are approximately 6,700 licensed music therapists currently practicing in the United States (Certification Board for Music Therapists, 2016). Of those, 3,957 music therapists belong to the American Music Therapy Association (AMTA), the professional organization for music therapy (AMTA, 2016a). In terms of gender and ethnic/racial diversity, a majority of music therapists are white females. The CBMT reports that 86.9% of credentialed music therapists (MT-BCs) are women. According to AMTA's *2016 Annual Member Survey and Workforce Analysis*, women comprised 88.6% of the 1,158 respondents. Similarly, Caucasian/Whites comprised the largest racial/ethnic group (89.3%), followed by Asian/Asian Americans (3.4%), Hispanic/Latino (2.3%), and African American/black (1.8%).

Music therapy requires at least bachelor's level degree to practice. Members who have completed their bachelor's accounted for the greatest amount of survey respondents (48%). Forty

percent of survey respondents held a degree at a master's level, while 7% have completed their doctoral degree. Five percent of respondents reported holding no degree, a majority of who were students or interns (AMTA, 2016a).

The average reported salary of a music therapist is $50,979, with the median salary being $47,000 (AMTA, 2016a). This median was below the 2014 national real median average salary for men ($50,838) and above the median average salary for women ($39,621) (DeNavas-Walt & Proctor, 2015). However, these national figures do not take into account education level. When accounting for at least a bachelor's level degree, music therapy with a median salary of $48,000 was below the national median salary for both men ($64,948) and women ($54,548) (AMTA, 2016a; U.S. Bureau of Labor Statistics, 2015a). Not accounting for gender differences within the profession, music therapists earn $6,548 less than the average woman with a bachelor's degree and $16,948 less than their similarly educated male counterparts (U.S. Bureau of Labor Statistics, 2015a).

Music therapy in comparison to other professions. In terms of gender equality, music therapy is similar to many female-dominated professions. Like many female-dominated professions, a vast majority of the occupation is comprised of women. Although more than 85% of board certified music therapists are women (CBMT, 2016), there is still a lower percentage of women in the occupation compared to women in registered nursing (90%), occupational therapy (92%), speech language pathology (99%), and preschool and kindergarten teachers (97%). The number of women in music therapy is higher than social workers (82%), physical therapists (70%), and college educators (50%) (U.S. Bureau of Labor Statistics, 2015a).

However, while being female-dominated, music therapists may not be compensated equal to that of other persons who work in similar female-dominated professions and have similar

educational requirements and work experience (e.g. occupational therapy, physical therapy, or speech language pathology). Music therapy requires a bachelor's level degree to practice, while occupational therapy and speech language pathology require a master's degree and physical therapy recently has transitioned to doctoral level entry. Music therapists with a master's degree earned on average $52,103 in 2015 (AMTA, 2016a). This was significantly less than median salaries found by the U.S. Bureau of Labor Statistics for occupational therapy ($80,000), physical therapy ($83,940), and speech language pathology ($74,900) in the same year (2015b). Registered nurses who have a bachelor's level entry earned ($69,700). However, music therapists had higher median salaries than social workers ($49,150) and recreation therapists ($46,060) (U.S. Bureau of Labor Statistics, 2015b).

There is also a significantly smaller population of music therapists than similarly compared professions. CBMT reports 6,696 licensed music therapists currently practicing in the United States (2016). In comparison, the U.S Bureau of Labor Statistics reported 110,520 occupational therapists, 200,670 physical therapists, 126,500 speech language pathologists, 2,687,310 registered nurses, 17,950 recreation therapists, and 603,300 social workers currently practicing (2015b).

Issues of gender equality in music therapy. Gender inequities within the music therapy profession often mirror inequities found among other female-dominated professions and has been previously noted within the literature (Edwards & Hadley, 2007). More than 10 years ago, using data from the *AMTA 2005 Member Source Book*, Edwards and Hadley (2007) examined the ratio of men to women in the profession, salary discrepancies, and potential gender publication bias. In 2004, the ratio of females to males in the AMTA membership was 88% to 12% (Edwards & Hadley, 2007), similar to the AMTA 2016 data. Of the 1314 board-certified

music therapists in 2004 with a master's degree, 88% were female and 12% male, again mirroring the ratio within the general AMTA membership. However, of the 148 board-certified music therapists with a doctoral degree, 74% were female and 24% were male. Similarly, of the 146 AMTA members who indicated their job titles as "Faculty (University/College)" 73% were female and 27% were male. In both cases, the ratio of females to males who had doctorates and those who held university position were disproportionate to the female to male ratio in the wider AMTA membership. In both instances, men comprised about a quarter of the population of those with a terminal degree and an academic position, while men only comprise 12% in the general membership (Edwards & Hadley, 2007).

Discrepancies among male to female salaries also appeared in the 2004 data. Survey respondents working full time at 34 hours or more indicated that the average salary for females was $41,265 yet $52,500 for males. For those who indicated their job title as Faculty (University/College), the average salary for females was $50,691 as opposed to $61,167 for males (Edwards & Hadley, 2007). From these figures, it appears that music therapist's average salary in 2004 for males exceeded that of females by about $11,000, outside and within academia in the United States (AMTA, 2005, as cited in Edwards & Hadley, 2007). Little has changed in subsequent years regarding the gender differences in music therapy. In a 2013 study, a greater proportion of men had further education than women, held more academic positions, and had salaries that were significantly greater than those of women music therapists (Curtis, 2013).

Gender discrepancies also exist in the publication records of women and men in music therapy. In 1985, Mark James noted that within the music therapy literature in the United States, women only authored 10% more articles than men in the period 1974-1984, despite there being a female to male ratio of 90:10 (cited in Edwards & Hadley, 2007). But between the periods of

2000-2005 the ratio more closely resembled the gender ratio of music therapy academics in the United States (Edwards & Hadley, 2007). The *Journal of Music Therapy* (JMT) published articles representing 164 authors from 2000-2005, 61.5% of authors were female and 30% were male, although 8.5% of the authors' gender could not be determined from name or affiliation.

Presently there are eight peer-reviewed journals publishing in English that have 'music therapy' in their title: *The Australian Journal of Music Therapy, The British Journal of Music Therapy, Canadian Journal of Music Therapy,* JMT, *Music Therapy Perspectives* (MTP), *The New Zealand Journal of Music Therapy,* and *Nordic Journal of Music Therapy*. Two of those, the JMT and MTP are published in the United States. Of these eight journals, six have female editors and two have male editors. The current editorial board (Winter 2016) for JMT boasts 32 members; 22 (68.75%) are female and 10 are male (31.25%). This distribution is a reduction in the ratio of women to men from 2007. Of the 25 editorial members on the Winter 2007 issue of JMT, 18 were female (72%) and 7 were male (28%). This ratio is equal to the percentage ratio of women to men on the editorial board from 1998-2007 and significantly closer to reflecting the AMTA member population than any decade since JMT's inception 1964-1977 (56:44), 1978-1987 (53:47), 1988-1997 (65:35) (Pasiali, Lin & Noh, 2009).

The presidency of AMTA has better reflected the AMTA member population as a whole. Since its foundation in 1998, eight of the nine AMTA presidents have been female (88.9%). Prior to AMTA, music therapy was divided between two professional organizations the National Association of Music Therapy (NAMT) and American Association of Music Therapy (AAMT). These organizations had predominately-male presidents. AAMT saw thirteen presidents from 1971-1997, five of which were women (38%). NAMT had 28 presidents, only ten of which were

women (35.7%). Examining the twenty-three presidents of the two organizations from the years 1951-1980, there were just five female presidents (21.7%) (AMTA, 2016d).

Results suggest that men have higher salaries and wages than women. Furthermore, there exists a disproportionate representation of men in educational achievement, employment in academia, article publication, and among the JMT editorial board. However, many music therapists feel that gender bias or discrimination does not have an impact on their daily or professional lives. Sandra Curtis (2013) found that 46% of female respondents and 42% of male respondents indicated that it had no impact. This is a significant decrease from 1990 where only 9% of female respondents reported feeling no impact of gender discrimination (Curtis, 1990). Those who felt no impact argued that gender discrimination did not affect them, that progress had been made, and that believing it had an impact was a self-fulfilling prophecy (Curtis, 2013). However, of the respondents who indicated that gender bias/discrimination did still have an impact, issues were raised on wage and status inequities, gender role stereotypes, access to services and opportunities, disproportionate representation of men in academic settings and the more covert nature of discrimination (Curtis, 2013). As one respondent wrote: "it [sexual discrimination] is more subtle than it once was. It can be equally dangerous, but harder to pin down and document" (Curtis, 2013, p. 391).

Why Might Music Therapists Experience Occupational Oppression?

Music therapy is a female-dominated profession, comprised of 86.9% women (CBMT, 2016). However, when looking at the number of men who earn doctoral degrees, hold academic positions, publish research articles, and serve on the editorial board for the *Journal of Music Therapy*, the ratio of men to women is disproportionate to the general population of credentialed music therapists (Curtis, 2013; Edwards & Hadley, 2007). Furthermore, Edwards and Hadley

(2007) found that in 2004 the average male music therapist earned $11,000 more annually than their female counterparts. Current data on salary based on gender was unavailable from the American Music Therapy Association.

When compared to similar health care occupations, music therapy has a significantly smaller population and receives compensation that is unequal to a person with equivalent education and work experience (AMTA, 2016a; CBMT, 2016; U.S. Bureau of Labor Statistics, 2015b). There are approximately 6,700 practicing music therapists in the United States (CBMT, 2016) who earn a median salary of $48,000 (AMTA, 2016a). In comparison, there are 110,520 occupational therapists and 126,700 speech language pathologists currently practice within the U.S., earning median salaries of $80,000 and $74,900 respectively (U.S. Bureau of Labor Statistics, 2015b). While occupational therapy and speech language pathology have higher educational requirements to practice than music therapy, music therapists who have a master's degree still make significantly less than related professions, earning only $55,019 (AMTA, 2016a). This data suggests that music therapists may not only experience oppression due to gender, but also may be undervalued in compensation within the healthcare setting

While oppression within the music therapy profession has not been explicitly studied, Baines and Edwards (2015) have suggested that music therapy as a creative, holistic modality may be oppressed within the dominant medical model paradigm. They write:

> it can be argued that where the state ignores the possible benefits for service users of certain treatments such as music therapy, oppression of the socially radical and creative is occurring in order to favor conservative and quieter traditions of therapy that have hitched themselves in tandem to the medical model. (p. 29).

One example of music therapy's struggle against the dominant medical-model paradigm is the difficulty music therapists have had in obtaining third-party reimbursement.

Oppression reduces the number of resources a person has to combat high job demands, resulting in elevated job strain and subsequent burnout. Oppression can be classified as such with the existence of any one of the five identified characteristics - exploitation, marginalization, powerlessness, and violence (Young, 1990) - thus contributing evidence to the potential of occupational oppression in professions that exhibit the presence of burnout. In a presidential column to the members of the National Association for Music Therapy, Carol Bitcon (1981) outlined a number of factors she believed contributed to burnout among music therapists, including:

> constant change and adaptation to the point of apathy; over-policing; unrealistic workloads with low pay; compromising ideals; lack of respect; continuous crisis intervention; 'going by the book' leadership attitudes; limited opportunities for sharing and contributing to decision making; and excessive control of emotional expression (p. 3).

While not explicitly stated, the extant literature has consistently described oppressive examples of marginalization, cultural imperialism, exploitation, violence, and powerlessness (Young, 1990) as factors leading to burnout within the profession (Bitcon, 1981; Clements-Cortes, 2006; 2013; Decuir & Vega, 2010; Fowler, 2006; Kim et al., 2013; Murillo, 2013; Vega, 2010). Currently, the focus of research has been to determine individual cognitive factors contributing to resilience, i.e. the personal ability to overcome the negative effects of high job demands, rather than the impact of low resources. However, there are trends in the literature to suggest an emerging identification of occupational oppression in the profession of music therapy,

particularly in the areas of exploitation, marginalization, powerlessness, and cultural imperialism.

Exploitation. There are significant compensation disparities between music therapists and similarly educated healthcare professions, with music therapists making approximately $25,000-$35,000 less annually than occupational therapists, physical therapists, and speech language pathologists (AMTA, 2016a; U.S. Bureau of Labor Statistics, 2015b). In a 2013 qualitative study on burnout, participants consistently reported they felt they were not adequately compensated for their work (Kim et al., 2013). Wage discrepancies among male and female music therapists have also raised concerns (Curtis, 2013; Edwards & Hadley, 2007).

Additionally, many workplaces (e.g. hospitals, nursing homes, rehabilitation, and day centers) may only employ one music therapist for the entire facility. Such solo work may result in the music therapist being stretched too thin and feeling stressed or overwhelmed because there are more clients who would benefit from services than there is availability, or because they are expected to see more clients than what is most therapeutically effective (Clements-Cortes, 2013; Kim et al., 2013). Moreover, music therapists are often asked, or may feel compelled, to perform tasks in addition to their heavy workloads that are not part of their specific job description. They may feel obligated to become involved in extracurricular activities related to music because of their special musical skills (Clements-Cortes, 2013; Kim et al., 2013). These tasks (e.g. providing background entertainment for employer events or coordinating guest artists to the facility) may simply be expected of the therapist and without compensation. In some settings, music therapists are expected to raise funds for their own position in addition to their other work responsibilities (Clements-Cortes, 2006).

Marginalization. Creative arts are often seen as a frill within healthcare and thus expendable when budgets become tight. Job security can be low (Clements-Cortes, 2013; Kim et al., 2013). Music therapists may experience economic marginalization; music therapy does not often receive third-party reimbursement by insurance providers. Furthermore, lack of reimbursement may result in unequal access to populations and facilities than other therapies; such inequality can contribute to occupational and social marginalization. Music therapists also report limited job and advancement opportunities (Decuir & Vega, 2010). A music therapist is often the only one in their facility, which can result in them feeling isolated and misunderstood (Kim et al., 2013; Rykov, 2001). Isolation may be further compounded when the music therapist is contracted to provide services rather than being hired at a facility. In many instances, contractual therapists are not considered staff and may not be part of the clinical team, having to deliver services without the fundamental support of an interdisciplinary team.

Powerlessness. Researchers have consistently listed lack of autonomy and control as a stressor leading to burnout among music therapists (Bitcon, 1981; Clements-Cortes, 2006; 2013; Kim et al., 2013). Administrators and supervisors are frequently non-music therapists and may not understand or value music therapy (Kim et al., 2013). Furthermore, fellow healthcare professionals may not understand or value music therapists, resulting in their voices being unheard and/or unheeded in interdisciplinary meetings. Music therapists may hold positions of relatively little power in the workplace. Music therapists have expressed their frustration at the lack of space for service provision, and their associated frustrations at being unable to do anything about it (Clements-Cortes, 2006; Kim et al., 2013). Available resources may also be limited, contributing to experiences of powerlessness. As part-time or contracted service providers, therapists' feelings of powerlessness may be compounded. This experience may be

particularly evident for those who have had experiences in which they are not seen as a member of staff or involved in interprofessional meetings (Clements-Cortes, 2006).

Cultural imperialism. As a care-emphasized profession, music therapy does not fit neatly into the dominant medical healthcare model. For this reason, other professionals may not understand or value the role of the music therapist. Music therapists across several studies have expressed frustration at being disrespected, unappreciated, and misunderstood by their peers (Bitcon, 1981; Clements-Cortes, 2006; Kim et al., 2013; Vega, 2010). Stories of nurses interrupting critical moments in therapy sessions to comment on the beautiful music being made, doctors mistaking therapists for a guest entertainer or volunteer, and people making comments like, "You are so lucky; you get to sing songs all day," (p. 43) filled the lives of the four participants in Clements-Cortes' (2006) qualitative study. Music therapists report the need to perpetually advocate the profession to other healthcare professionals in their work setting, as well as to their clients (Clements-Cortes, 2006; Kim et al., 2013). This constant need to educate and advocate to staff may result in the music therapists feeling isolated and without a support system.

Effects of occupational oppression on music therapists. Uncertain job security and isolation can create experiences of marginalization. Music therapy is a high-demand job. Music therapists are expected to work with a wide variety of clients with specific needs and backgrounds, which can be challenging when resources are limited. They may work with clients who have especially poor prognoses. Music, as a modality, can create spaces that are highly emotional for both clients and therapists. Solutions may be ambiguous. Occupational oppression can limit the amount of resources a music therapist has available to combat the high job demands of their profession. Occupational oppression can result in the therapist feeling unappreciated,

devalued, powerless, and lacking social support. Without resources to buffer the effects of high job demand, music therapists could experience high job strain leading to psychological stress reactions. When experienced over an extended period, burnout could develop.

Occupational oppression does not only negatively affect the individual music therapist, but also the entire profession as a whole. Previous research has focused primarily on the individual experiences of the music therapist and resulting burnout (Clements-Cortes, 2006; Kim et al., 2013). Few solutions have been offered beyond recognizing that working with other music therapists or knowledgeable others can improve job satisfaction (Vega, 2010). Acknowledging the existence of oppression within the music therapy profession and a clear description of it can offer the profession a catalyst for creating change. Such recognition may be an initial step towards reducing the negative organizational factors contributing to burnout and promote shifts in the profession amongst itself and other disciplines (Freire, 1989; Deutsch, 2006). Ignoring a problem does not make it disappear. As Freire (1989) argues, until the oppressed acknowledge the cycle of oppression and unite, the cycle will continue. Liberation is "acquired by conquest, not gift" (p. 29).

How has Occupational Oppression been Studied?

Research establishing oppression within occupations has been limited and has not been studied at all within the profession of music therapy. However, within the discipline of nursing a greater number of studies have been devoted to occupational oppression. Nursing has been described as an oppressed group (Roberts, 1983; 2000) and studies have described subsequent behavior resulting from this classification (Daiski, 2004; Dong & Temple, 2011; Duchscher & Myrick, 2008; Matheson & Bobay, 2007; Myers et al., 2016; Roberts et al., 2009; Rodwell & Demir, 2012; Wingfield, 2012). These studies have utilized systematic reviews of literature

(Dong & Temple, 2011; Matheson & Bobay, 2007; Roberts et al., 2009), in-depth interviews (Daiski, 2004; Wingfield, 2009), development of theoretical frameworks (Duchscher & Myrick, 2008) and surveys (McKenna et al., 2003; Myers et al., 2016; Rodwell & Demir, 2012). These studies explore Robert's (1983; 2000) theoretical framework establishing oppressed group behavior within nursing and describe the subsequent behavior such as silencing and horizontal violence.

In a number of studies, forms of occupational oppression (e.g. wage gap and occupational segregation) are established through quantitative studies examining large populations (Black et al., 2006; Cohen & Huffman, 2003; Gaddis, 2015; Levanon et al., 2009). These studies argue that the phenomenon of occupational oppression occurs, but do little to explain the impact of oppression on individuals or professions. Qualitative studies provide a more holistic picture, but are used to a lesser extent, often within populations where the existence of occupational oppression has been established. These qualitative studies often take the form of in-depth interviews, such as in Hillock's (2012) article exploring social workers' conceptualizations and experiences on oppression.

Within music therapy literature, the establishment of burnout, a potential result of occupational oppression, has been addressed. Using a "qualitative" methodological approach, Clements-Cortes (2006) conducted in-depth interviews with four music therapists working in palliative care to identify factors or stressors they experience in the work environment leading to burnout. Other studies have been descriptive. Clements-Cortes (2013) later conducted a review of literature to explain stressors experienced by music therapists that could result in burnout. Decuir and Vega (2010) utilized a "mixed-method" survey to determine skills and knowledge that experienced professionals perceived as important to career longevity. Quantitative surveys

have established burnout and factors contributing to it in music therapy (Fowler, 2006; Murillo, 2013; Vega, 2010). Demographic information in these studies identified number of years practicing, populations served, age, gender, and level of education in relation to the prevalence of burnout.

Baines and Edwards (2015) challenge researchers to apply anti-oppressive practices within their research. This ideology is based on the assumption that any intervention or research project, no matter the benevolent or progressive nature of its goals and intentions, can replicate the structural conditions that generate oppression (Strier, 2007). This requires critical reflection and encourages the practitioner to be aware of power differentials. Researchers can unintentionally incorporate elements of the dominant ideology. Anti-oppressive research promotes the production of knowledge that supports freedom for the oppressed (Strier, 2007). Subsequently, anti-oppressive research targets oppressed populations and has research goals that promote liberation within oppressed populations. In addition, anti-oppressive research combines epistemologies to holistically address the complex nature of oppression. Anti-oppressive studies (a) take place in safe environments for reflection and inquiry, (b) are participatory in nature, (c) promote an egalitarian power balance among researcher and participant, (d) reduce barriers to genuine participation, and (e) generate knowledge that promotes action (Strier, 2007). Integrating anti-oppressive practices within research processes can work to address oppression embedded within questions of participation, developing the research question, recruitment, consent, and further steps of the research process (Baines & Edwards, 2015).

Since the characteristics of oppression are complex and multifaceted, anti-oppressive research strives to combine methodologies that are able to address oppression's more objective structural aspects, as well as its subjective, phenomenological dimensions (Strier, 2007). Mixed

methods research offers unique opportunities for integrating multiple ways of knowing and forms of evidence (Bradt, Burns & Creswell, 2013). Selection of a mixed method research design is primarily dependent on the intent for mixing different methodologies to synthesize different types of data. This intent is to either merge datasets in order to compare them or to have one dataset build upon the other. Furthermore, research design is dependent upon the timing of the collection of each form of data, concurrently or sequentially (Bradt et al., 2013).

When looking at music therapy, there are four popular mixed method designs most suitable for music therapy: convergent parallel design, explanatory sequential design, exploratory sequential design, and embedded design (Bradt et al., 2013). The convergent parallel design lends itself well to descriptive research, especially when establishing and describing a phenomenon. In this research design, quantitative and qualitative data are collected simultaneously and both methods receive equal attention. The two data sets are analyzed independently and integration of the data occurs at the level of data interpretation. In the final step, the researcher examines in what ways the two data sets converge, diverge, or simply relate to one another (Bradt et al., 2013; Creswell, 2003; Fetters, Curry & Cresell, 2013).

By utilizing a mixed methodology, it is hoped that a more holistic vision of occupational oppression within music therapy will emerge. Separate quantitative and qualitative methods can be used as a means to offset the inherent weaknesses of one methodology with another. While a quantitative survey design provides numeric description of trends, attitudes, or opinions of an entire population, it excludes participants from actively contributing to the research and limits the research's scope. However, qualitative methodologies, while providing a more holistic view of the phenomenon are limited in their sample size. The purpose of this study is to both establish the existence of, and describe the phenomenon of, occupational oppression within music therapy.

Utilizing qualitative methods, in addition to quantitative methods, encourages active involvement by research participants and generates ownership of knowledge create by this research study. It is hoped that occupational oppression within music therapy can be established through objective data, while narrative data can allow music therapists to share their experiences in their own voice.

This descriptive mixed-method research project, utilizing a convergent parallel design seeks to achieve both objective and narrative results to establish and describe occupational oppression and beliefs held about it within the profession of music therapy. Five research questions will be addressed:

1.) How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization, cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?
2.) What factors do music therapists identify that minimize or magnify experienced occupational oppression (i.e. gender, salary, primary population of clients served, membership in the professional organization, etc.)?
3.) As individuals, do music therapists experience oppression in their workplace?
4.) Do music therapists believe the profession of music therapy to be an oppressed occupation?
5.) What factors contribute to a music therapist's belief that music therapy is or is not an oppressed occupation?

Chapter 3

Methods

Research Paradigm

Anti-oppressive research is a theoretical perspective that fosters the development of knowledge with marginalized populations in order to support freedom of the oppressed from their oppressors (Streir, 2007). Anti-oppressive research combines methodologies to holistically address the complex nature of oppression, is conducted in a safe environment for reflection and inquiry, is participatory in nature, promotes an egalitarian power balance among researcher and participant, reduces barriers to genuine participation, and generates knowledge that promotes action (Strier, 2007).

Research Design

This study was a mixed-method study that used the data-validation variant of a convergent parallel mixed method design (Creswell, 2011) as seen in Figure 3.

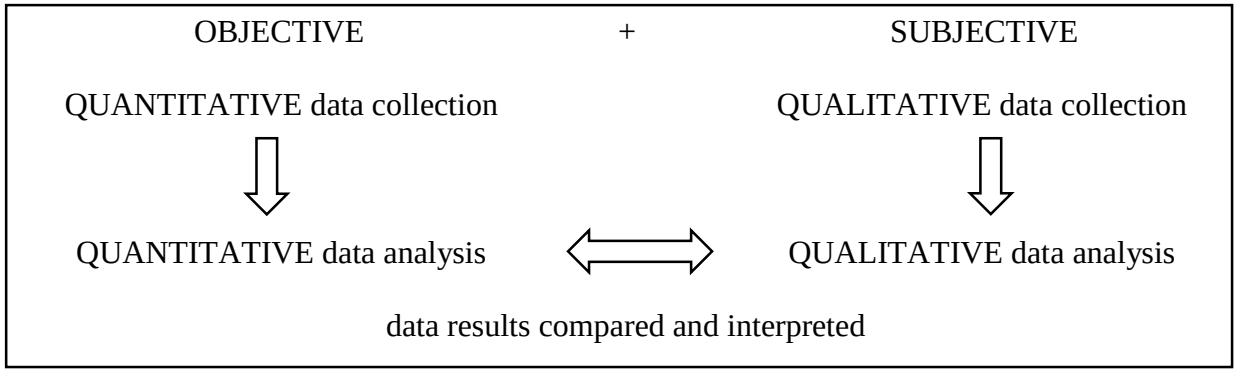

Figure 3. Convergent parallel study design.

The purpose of this design was to obtain different but complementary data on the same topic to better understand the research problem (Creswell, 2011). However, priority was given to the collection of the quantitative data. Qualitative data provided emergent themes that could be used to validate and embellish the statistical findings. Survey questionnaires provide objective sample

accounts of trends, attitudes, or opinions of a population. (Creswell, 2011). However, questionnaires limit active involvement among research participants, restricting them to a set of prescribed responses. This mixed method design involved the simultaneous but separate collection and analysis of qualitative and quantitative data through a descriptive survey questionnaire. Collecting quantitative and qualitative data served as a means to provide a holistic depiction of occupational oppression within music therapy, as well as allowed music therapists to actively voice their experiences in relation to occupational oppression. After separate data analysis, the data was merged and integrated in the interpretation of the overall results (Bradt, Burns & Creswell, 2013; Creswell, 2011; 2015; Fetters, Curry & Creswell, 2013). Data was gathered through closed and open-ended survey questions. Closed-ended questions were analyzed utilizing descriptive statistics and Chi-squared tests, while open-ended questions were analyzed using a thematic approach.

Participants

This study employed saturation sampling. Potential respondents included all actively practicing board-certified music therapists (MT-BCs) within the United States. Following Institutional Review Board (IRB) approval, a list of all current board-certified music therapists was obtained from the Certification Board for Music Therapists (CBMT) for a $100 fee paid by the researcher. The list of 6,759 anonymous email addresses was already filtered by CBMT to include only those music therapists who had given permission to release their email addresses. The list was delivered electronically to the researcher and was pre-sorted alphabetically by the first letter of the email address in an Excel spreadsheet. Participants were emailed on January 19, 2017 to partake in an online survey (Appendix A). A follow up invitation was emailed 7 days after the initial request to encourage participation (Appendix B).

Human Subjects Informed Consent

The information statement for participation in this study was included as part of the online survey, indicating that participation was voluntary, without compensation, and that no potential risks had identified as result of participation in the study. The statement informed participants that completion of the survey implied consent, they were able to withdraw from the survey at any time, and personal or identifying information would remain confidential. The last question of the survey asked the respondent to indicate whether they were interested in being part of a follow-up study should the results of this study indicate occupation oppression exists. If the respondent was interested, they were asked to indicate their email address; there was the potential these respondents' survey responses would not be confidential to the researcher.

Survey Instrument

An online questionnaire was developed and prepared by the researcher using Survey Monkey. The survey titled "Workplace Experiences of Music Therapists" was intended for currently practicing music therapists. In order to ensure that all survey participants were currently practicing music therapists, there was one qualifying question at the beginning of the survey, "Are you currently practicing music therapy?" Participants who responded, "No," completed the survey and were immediately directed to a Thank You page and exited from the survey. Participants who responded, "Yes," continued to the full survey.

Survey questions were formulated to determine music therapists' level of workplace resources, prevalence of oppressive workplace factors, perception of individual experiences of oppression, belief that music therapy is an oppressed occupation, and to examine personal anecdotes of experienced occupational oppression and beliefs about oppression of music therapy as a profession. The online survey consisted of five areas of focus:

1. Demographics, workplace climate, and resources
2. Work experiences in the last 6 months
3. Personal descriptions to support the belief that occupational oppression has or has not been experienced by the music therapist
4. Opportunity to identify/share personal experiences of occupational oppression
5. Opportunity to express beliefs as to why or why not music therapy is an oppressed occupation

Multiple choice and Likert-scale questions were included in the survey instrument, as well as two short answer questions at the conclusion of the survey.

Questions 2-24 assessed demographic information, workplace climate, and available resources in a multiple-choice format. The researcher intended to understand individualized work factors that could minimize or maximize oppressive experiences and help answer Research Question 2: "What factors do music therapists identify that minimize or magnify experienced occupational oppression (i.e. gender, salary, primary population of clients served, membership in the professional organization, etc.)?" The researcher developed questions from current music therapy literature on the topic, as well as interests of the researcher.

Survey questions examining workplace experiences within the last six months (Questions 25-30) were developed from current music therapy literature describing organizational factors leading to burnout and Iris Young's (1990) theoretical framework on the five faces of oppression. Young's five faces of oppression include: marginalization, cultural imperialism, exploitation, violence, and powerlessness. This theoretical framework argues that by experiencing at least one oppressive category, the entire experience can be described as oppression. Oppressive experiences described by music therapists from the literature were coded

and categorized as one of the five forms of oppression. A total of thirty statements were then developed from these factors. *Table 1. Form of Oppression* identifies each of Young's five faces, the corresponding described workplace experience, and the corresponding statement.

Table 1

Form of Oppression with Described Workplace Experience and Corresponding Statement

Marginalization
Limited job opportunities (Decuir & Vega, 2010)
I have opportunities for professional advancement within my organization.
Limited advancement opportunities (Decuir & Vega, 2010)
My position is secure should there be a budget cut
Expendable when budgets become tight (low job security) (Clements-Cortes, 2013; Kim, Jeong & Ko, 2013)
Access to populations that would benefit from music therapy services within my current organization are restricted from me due to lack of third-party reimbursement.
Not reimbursed through third-party reimbursement and therefore do not have equal access to populations and facilities that other therapies do (Decuir & Vega, 2010)
The number of music therapists employed at my current organization is adequate
Unwilling to hire multiple/adequate number of music therapists (Rykov, 2001; Vega, 2010)
I feel isolated in my workplace
Feelings of isolation (Rykov, 2001; Kim, Jeong & Ko, 2013)
There are others that understand my work with whom I can talk within my workplace
Cultural Imperialism
Lack of understanding and support by non-music therapy co-workers (Bitcon, 1981; Clements-Cortes, 2006; Kim, Jeong & Ko, 2013; Vega, 2010)
My team members support me
My team members demonstrate understanding of my work
My team members demonstrate respect for my work
Seen as a less valuable therapy in comparison to therapies that identify with the culturally dominant, medical model (Hadley & Edwards, 2015; Kim, Jeong & Ko, 2013)
Music therapy is seen as equally important in comparison to other therapies offered within my organization
Not seen as a healthcare professional (Clements-Cortes, 2006)
My team members mistake me as a volunteer or entertainer
My team members make statements undermining my role as a professional (i.e. "You're so lucky, you get to sing songs all day")
Need to perpetually advocate music therapy to peers (Clements-Cortes, 2006; Kim, Jeong & Ko, 2013)
I feel I have to advocate myself and my profession to my team members
Exploitation
Not adequately compensated for work – monetarily (Bitcon, 1981; Decuir &Vega, 2010; Kim, Jeong & Ko, 2013)
My salary is adequate for what I do
Not adequately compensated for work – psychologically (Bitcon, 1981; Clements-Cortes, 2006; Kim, Jeong & Ko, 2013)
My work is appreciated by others within my organization (i.e. clients, peers, supervisors)
My work is valued by others within my organization (i.e. clients, peers, supervisors)
My work is respected by others within my organization (i.e. clients, peers, supervisors)

Unable to provide music therapy services to all clients who would benefit from services due to time (Clements-Cortes, 2013)
Music therapy services are adequately provided to all clients who would benefit
Higher job demands than time (Clements-Cortes, 2013)
I work outside of work hours to complete all tasks expected of me
Expected to see more clients than beneficial (Clements-Cortes, 2013; Kim, Jeong & Ko, 2013)
The number of clients I am expected to serve is adequate
Expected to perform tasks outside of job description (Clements-Cortes, 2013; Kim, Jeong & Ko, 2013)
I am expected to perform tasks outside of my job description
Compelled to be involved in tasks related to music but not related to music therapy (Clements-Cortes, 2013)
I am asked to perform music-related activities (i.e. performances) that are unrelated to music therapy
Salary/position is dependent upon music therapist personally raising funds from donors, grants, etc. (Clements-Cortes, 2006)
My current position is dependent upon me personally raising funds for my salary
Violence
Bullying
I experience bullying in my workplace
Physical violence
I am concerned with being physically attacked in my workplace
Undue criticism
Feedback from other team members and/or my supervisor is appropriate, supportive and beneficial
Fear of repercussions
I can freely share my opinions/thoughts with others in my organization without fear of repercussions
Sabotage of work by others
Other team members sabotage my work
Powerlessness
Lack of autonomy in day-to-day activities (Bitcon, 1981; Clements-Cortes, 2006; 2013; Kim, Jeong & Ko)
I have adequate say in my day-to-day tasks
Inability to provide the best care due to organizational factors (Bitcon, 1981; Clements-Cortes, 2006; Kim, Jeong & Ko, 2013)
I have adequate power to make changes within my organization to consistently provide the best care for my clients
Unable to acquire adequate resources (Clements-Cortes, 2006; Kim, Jeong & Ko, 2013)
I have the necessary music therapy-related equipment (i.e. space, instruments) to satisfactorily do my job
Limited opportunities for sharing and contributing to decision making (Bitcon, 1981)
I have adequate opportunities to collaborate with others from different disciplines
I feel that my voice is unheard/unheeded when consulting with other professionals
Lack of understanding and support by non-music therapy supervisors (Bitcon, 1981; Clements-Cortes, 2006; Kim, Jeong & Ko)
My supervisor values music therapy
My supervisor demonstrates support for my work
My supervisor demonstrates understanding of music therapy
Limited opportunities to successfully self-advocate (Clements-Cortes, 2006)
I successfully advocate for myself

Statements were electronically randomized to decrease response bias. The thirty statements were then grouped into sets of five, creating six survey questions (Questions 25-30).

Statements were assessed on a Likert scale. Participants were asked to read each statement carefully and decide how strongly they agree or disagree based on their music therapy work experiences of the past six months. The levels are represented on a scale of 1-5 (1-Strongly Disagree; 2-Disagree; 3-Neutral; 4-Agree; 5-Strongly Agree). Statement responses were used to answer Research Question 1: "How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?"

Question 31 and 32 were intended to assess Research Question 3: "As individuals, do music therapists experience oppression in their workplace?" An operational definition of occupational oppression was presented (Appendix C) prior to Questions 31, 34, and 35. Participants were asked whether or not they believe they have experienced occupational oppression as a music therapist; this is presented as a dichotomous "yes/no" question. As a follow up question (Question 32), participants were asked in a short answer to describe a situation(s) with the workplace that supports their response. Responses describing experiences of occupational oppression from Question 32 were used to support and validate responses from Questions 25-30 in order to answer Research Question 1: "How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization, cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?"

Question 33 assessed whether music therapists believe music therapy to be an oppressed occupation. This corresponded with Research Question 4: "Do music therapists believe the profession of music therapy to be an oppressed occupation?" Presented as a dichotomous "yes/no" question, participants were asked, "Do you believe music therapy to be an oppressed occupation?" Question 33 was also used to assess the quantitative aspect of Research Question 5:

"What factors contribute to music therapist's belief that music therapy is or is not an oppressed occupation?" by associating responses with demographic information provided in Questions 2-24.

Questions 34 and 35 examined the specific factors that contribute to individual music therapists' beliefs that music therapy is or is not an oppressed occupation and was assessed through a short answer question. These questions correspond with Research Question 5: "What factors contribute to a music therapist's belief that music therapy is or is not an oppressed occupation?"

Each research question with its utilized research methodology and corresponding survey items can be identified in *Table 2. Research Questions, and Corresponding, Methodology and Survey Items.*

Table 2

Research Questions, and Corresponding Methodology and Survey Items

Research Question	Research Methodology	Item on Survey
Question 1: How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization, cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?	Mixed	See Questions 25, 26, 27, 28, 29, 30, and 32: agreeance/disagreeance on 5-point Likert scale of workplace experiences based on Young's (1990) framework and reports in music therapy literature, self-reported workplace experiences
Question 2: What factors do music therapists identify that minimize or magnify occupational oppression (i.e. gender, salary, primary population of clients served, membership in the professional organization, etc.)?	Quantitative	See Questions 2-24,and 31: Level of association between demographic and workplace information and identifying as having experienced oppression
Question 3: As individuals, do music therapists experience oppression in their workplace?	Mixed	See Question 31and 32: have you experienced occupational oppression as a music therapist (yes/no), self-report on workplace experiences to validate previous response
Question 4: Do music therapists believe the profession of music therapy to be an oppressed occupation?	Quantitative	See Question 33: music therapy an oppressed occupation (yes/no)
Question 5: What factors contribute to music therapists' belief that music therapy is or is not an oppressed occupation?	Mixed	See Questions 2-24, 33, 34 and 35: level of association between demographic and workplace information and identifying music therapy as an oppressed occupation beliefs as to why/why not music therapy is an oppressed occupation

The survey instrument was piloted with four graduate students and the thesis committee chair at a large Midwestern university to check content validity of the questions for the identified constructs of occupational oppression. Upon making edits, the survey instrument was then presented to the researcher's advisory committee and the Human Research Protection Program at the same large Midwestern university.

Procedure

Email invitations were sent to the population (N = 6,759) through Survey Monkey's website. Individual messages were sent without identifying information of the recipient or any other participants' email information. The messages explained the purpose of the study and directed participants to the online survey, where they were informed that their participation and completion of the study was their implied consent. Both the email and the cover letter of the survey indicated that the survey was intended for board-certified music therapists that were currently practicing music therapy. Prospective respondents were asked to complete the survey by February 2, 2017. Completion time for the survey was approximately 10 – 15 minutes.

Ethical Considerations

The survey was configured to collect anonymous responses. Only the researcher had access to aggregate data and individual responses were not identified. Data was encrypted, kept in the researcher's password-protected personal computer and will be destroyed five years after publication in a peer-reviewed journal.

The term "oppression" was not included in the email and the cover letter of the survey. The author purposefully omitted the term because of its potential to be highly polarizing. Including the term could lead to both response and responder bias. Participants were informed within the survey that the research study was intended to establish and describe the phenomenon of occupational oppression within the profession of music therapy. Upon conclusion of the survey, participants were provided a debriefing form explaining why the term oppression was withheld in the email and cover letter and provided the opportunity to withdraw data provided prior to debriefing.

Materials

Materials for this research included: (1) a list of current board-certified music therapists purchased from the Certification Board for Music Therapists for the research fee of $100; (2) access to the internet and Survey Monkey, an online survey administration company utilized for $200, (3) a secure laptop computer with Microsoft Word, Microsoft Excel, Dedoose, and SPSS Statistics 24 software.

Data Analysis

Completed survey responses were automatically compiled into aggregate form for analysis by Survey Monkey. The results in Survey Monkey's format, were converted to Excel and loaded into SPSS for data analysis of descriptive and nonparametric statistics. All survey responses were collapsed and examined to determine frequencies and percentages of responses. For several questions, respondents had the opportunity to select "Not Listed/Other" and provide a short answer response. These responses were read at least two times and coded into an existing or new response category or remained within the "Not Listed/Other" category as deemed appropriate by the researcher. "Varied" and "School age" were added as new response categories for Question 19 and "Educator" and "Administrator" were added for Question 23. Responses from Questions 5 and 6, Questions 16-18, and Questions 22 and 23 were combined to each describe one set of demographic information. When appropriate a Chi-square test of independence was applied to determine if responses occurred with equal probability. In some cases, responses were compared to each other and Cramer's V was applied to examine the level of association between variables. A .10 confidence level was determined to be appropriate due to the research being exploratory in nature.

Each statement response for Questions 25-30 was collapsed from a five-point Likert scale to a three-point scale and analyzed independently using a Chi-square test of independence. Responses from Questions 2-24 were analyzed in relation to Question 31: “Do you believe you have experienced occupational oppression as a music therapist?” using a Chi-square test to determine if a significant association between demographic/workplace information and identification of experienced oppression existed. Responses from Questions 2-24 were also analyzed similarly to Question 33: “Do you believe music therapy to be an oppressed occupation?”

Quantitative data extracted from Survey Monkey’s compiled responses included:

- Gender
- Sexual Orientation
- Age
- Race/Ethnicity
- Highest level of education
- Salary
- Current AMTA membership
- Membership in another professional music therapy organization
- Number of years in practice
- Length of current employment
- Numbers hours working per week in music therapy
- Position title
- Holding a supervision position at current organization
- Employment setting

- Age ranges of clients primarily served
- Number of full-time music therapist employed at current organization
- Number of part-time music therapists employed at current organization
- Profession of direct supervisor
- Gender of direct supervisor
- Workplace factors categorized as marginalization
- Workplace factors categorized as exploitation
- Workplace factors categorized as powerlessness
- Workplace factors categorized as cultural imperialism
- Workplace factors categorized as violence
- Identification as having experienced occupational oppression or not as a music therapist
- Identification as believing music therapy being an oppressed occupation or not

Qualitative thematic data was extracted and compiled from Questions 32, 34, and 35. Question 32 presents participants the opportunity to describe a workplace situation(s) which support their belief of having or not having experienced occupational oppression. Questions 34 and 35 request participants to share why they do or do not believe music therapy to be an oppressed occupation. These short answer questions provide participants opportunity to share their personal experiences and beliefs, rather than being restricted to prescribed responses developed by the researched. Responses from Question 32 were coded into two categories: supportive and non-supportive. Responses from Questions 34 and 35 were analyzed independently.

To analyze the narrative data and integrate it with the quantitative data, the research adapted Thematic Analysis (TA) approaches utilized by Braun & Clarke (2006) and Eyre & Lee (2015) to create 10 procedural steps, as follows:

1) All responses to each question were read and reread to obtain a general sense of the information and to reflect on its overall meaning
2) Categories that describe main factors were established
3) Each response was assigned to a category; where appropriate various segments of one response were assigned to different categories
4) The data included in each category was reviewed to ascertain their relevance and fit into assigned category
5) Data was sorted into subcategories or "themes" developed from review of literature and narrative responses
6) Data in each theme was read for consistency and reassigned if necessary
7) Narratives essences were created from each theme
8) Extracts from original participant comments were selected to illustrate the theme
9) Narrative essences were compared with quantitative data
10) All data was integrated to create a narrative revealed by the quantitative and qualitative data.

If necessary, any of these steps could be repeated parsing the data into smaller categories. A summary of these findings will be located in Chapter 4.

Chapter 4

Results

Participants were solicited through 6,759 email addresses of board certified music therapists purchased by the researcher from the Certification Board for Music Therapists. The survey was sent to each of the 6,759 email addresses via Survey Monkey. Figure 4 illustrates the number of participants and the reasons for enrollment changes or inclusion in data analysis. Approximately half of potential respondents (54.8%) opened the email invitation; 855 participants initiated the survey resulting in a 13.1% initial response rate. The survey required participants to be currently practicing music therapy. Survey participants were presented with a qualifying question upon initiating the survey. Those who did not meet survey inclusion criteria automatically completed and exited the survey. Participants who did not meet inclusion criteria were excluded from data analysis (n = 44). From the pool of participants who initiated the survey and met inclusion criteria (n = 811), 177 additional participants did not fully complete the survey and were excluded from the data analysis. The removal of those who did not meet survey inclusion criteria or did not fully complete the survey resulted in a total of 634 responses included within the data analysis; 78.2% of participants who began the survey and met survey inclusion criteria completed it. Of the total population (N = 6,759), the completed response rate was 9.7%.

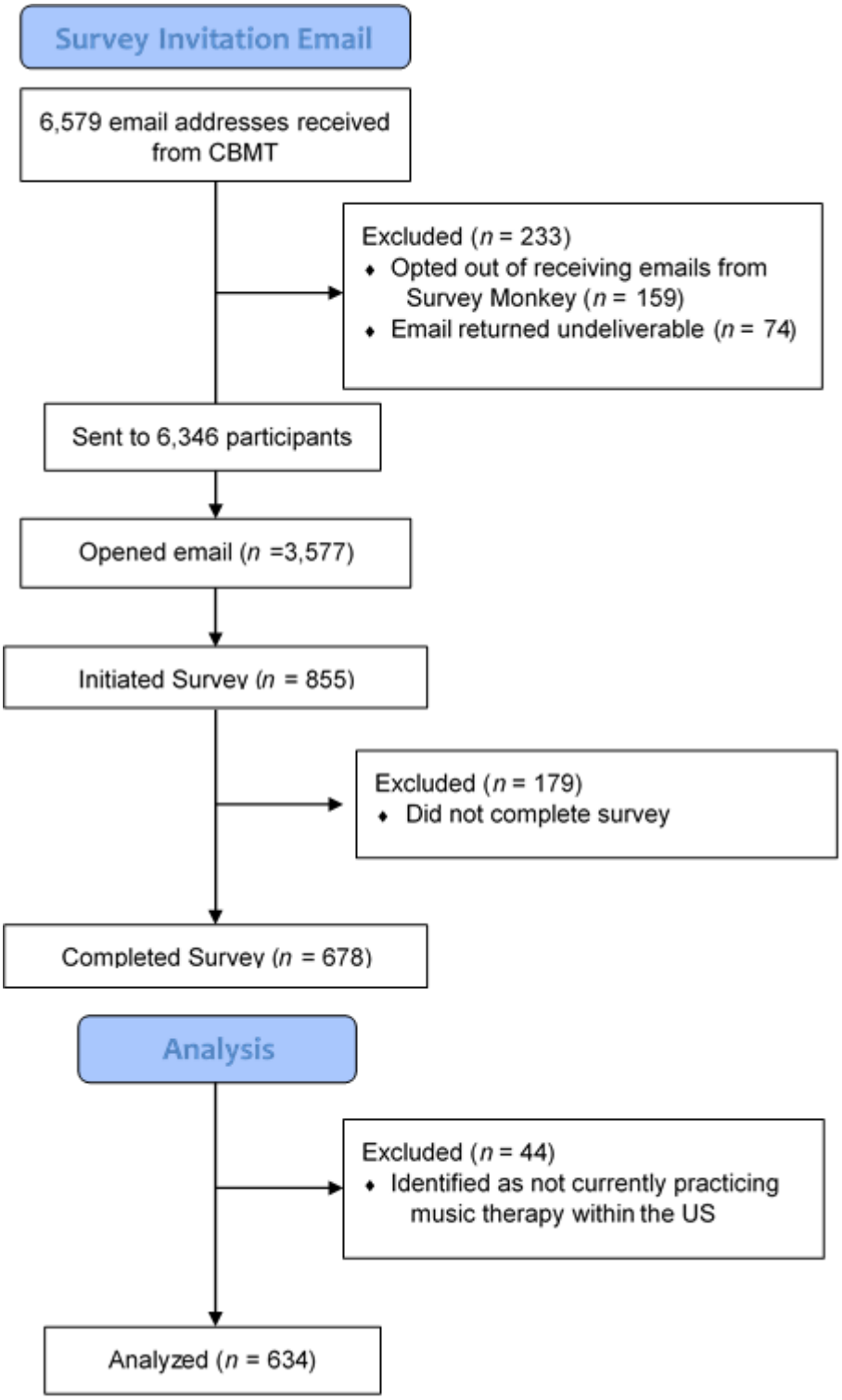

Figure 4. Participant Flow Chart

Demographic Information

Demographic information was collected to determine personal social factors that could minimize or magnify experienced occupational oppression. Tables 3 illustrates respondents' demographic characteristics by gender, sexual orientation, age, race/ethnicity, education level, and number of years of practice. A majority of the 634 respondents identified as female (86.1%), heterosexual (86.8%), Caucasian/white (86.6%) and under the age of 35 (65.6%). Half of participants (51.3%) had been practicing music therapy five years or less. Over half of participants (55.9%) identified a bachelor's degree as the highest level of education achieved. A lesser number of participants (42.3%) had completed their master's degree. Sixteen percent of participants had completed some education leading to the next degree.

Table 3

Survey Respondent Demographic Information

Variable	*N*	%
Gender		
Female	546	86.1
Male	77	12.1
Other	6	1.0
Decline to answer	5	0.8
Sexual Orientation		
Heterosexual	550	86.8
Bisexual	36	5.7
Homosexual	24	3.8
Other	8	1.3
Unsure	2	0.3
Decline to answer	14	2.2
Age		
25 years or younger	118	18.6
26-35	298	47.0
36-45	97	15.3
46-55	55	8.7
56-65	53	8.4
66 years or older	10	1.6
Decline to answer	3	0.5
Race/Ethnicity		
Caucasian/white	549	86.6
Hispanic/Latino	29	4.6
Asian	20	3.2
Two or more races	15	2.4
African-American/black	9	1.4
Other/Not listed	1	0.2
American Indian/Alaskan Native	0	0.0
Native Hawaiian/Other Pacific Islander	0	0.0
Decline to answer	11	2.7
Highest Level of Education Achieved		
Bachelor's degree	268	42.3
Some school leading towards Master's degree	86	13.6
Master's degree	255	40.2
Some school leading towards Doctoral degree	13	2.1
Doctorate degree	12	1.9
Years Certified		
0-5	325	51.3
6-10	123	19.4
11-15	62	9.8
16-20	42	6.6
21-25	25	3.9
26-30	18	2.8
31-35	21	3.3
36-40	8	1.3
Greater than 40 years	10	1.6

When asked about professional organization membership, 59% of respondents (*n* = 374) stated they belonged to AMTA; 39.3% (*n* = 249) were not members of AMTA. Nine respondents (1.4%) were unsure if they were AMTA members, and two participants declined to answer (.3%). A lesser number of participants were members of another professional association for music therapy, such as a local or regional chapter. These organizations could be affiliated with AMTA, but AMTA membership is less often a requirement. Some respondents (40.9%; *n* = 259) claimed they were members of another profession organization, while 55.2% of respondents (*n* = 350) did not. Twenty-one respondents (3.3%) were unsure and four declined to answer (.6%). When looking at AMTA and other professional organization membership, 66.4% of respondents (*n* = 421) were members of some music therapy professional association, while 31.2% of respondents (*n* = 198) did not belong to a professional association. Thirteen respondents were unsure if they belonged to a professional association (2%) and two declined to answer (.3%).

Workplace Resources and Climate

To help determine workplace climates or resources that could minimize or magnify the impact of experienced oppression, survey respondents were asked a series of questions related to their workplaces, such as number of years at current organization, annual salary, position title, and number of music therapists employed at current organization. Table 4 displays the distribution of years participants had been employed with their current organization. Most respondents had been with their current organization four years or less (64.7%), with 16.1% being employed at their current organization five to eight years. Respondents who had been with an organization greater than eight years were represented to a lesser extent; 7.4% at 9-12 years, 4.7% at 13-16 years, and only 2.8% and 4.1% respectively with 17-20 years and 21 years and greater.

Table 4

Number of Years Employed at Current Music Therapy Organization

Years	*N*	%
Less than 1 year	150	23.7
1-4 years	260	41.0
5-8 years	102	16.1
9-12 years	47	7.4
13-16 years	30	4.7
17-20 years	18	2.8
21 years and greater	26	4.1
Decline to answer	1	0.2

Over half of survey respondents were employed full-time (35 hours a week or greater) as music therapists (61.7%, $n = 315$). Of those working part-time, 17.8% of respondents ($n = 113$) were employed as music therapists 20-34 hours per week, while 20.5% were employed less than twenty hours per week ($n = 129$). One respondent declined to answer (.2%).

Respondents indicated a wide range in salaries extending from less than $10,000 earned annually to greater than $100,000 earned annually from their music therapy practice. The most commonly indicated salaries were $40,000-$49,999 (26.0%), $30,000-39,000 (22.9%), $50,000-$59,999 (12.6%), and $20,000-$29,999 (8.8%). Survey respondent's approximate annual music therapy salary is depicted in Table 5.

Table 5

Approximate Annual Music Therapy Salary

Salary	*N*	%
Less than $10,000	36	5.7
$10,000-$19,999	44	6.9
$20,000-$29,999	56	8.8
$30,000-$39,999	145	22.9
$40,000-$49,999	165	27.0
$50,000-$59,999	80	12.6
$60,000-$69,999	46	7.3
$70,000-$79,999	26	4.1
$80,000-$89,999	9	1.4
$90,000-$99,999	2	0.3
$100,000 and greater	2	0.3
Decline to answer	23	3.6

When analyzing for position title, the greatest number of respondents indicated that their position title was Music Therapist (70.0%), followed by Self-Employed/Consultant (3.9%), Director/Administrator/Supervisor (3.3%), Rehabilitation Therapist (3.2%), Creative Arts Therapist (2.8%), and Recreation Therapist (2.5%). A quarter of respondents (25.9%) indicated that they held supervisory positions within their current organization; 73.8% indicated that they did not. Two respondents declined to answer (.3%). Table 6 summarizes the distribution of position titles for respondents at their current organization.

Table 6

Position Title at Current Organization

Title	*N*	%
Music Therapist	444	70.0
Self-Employed/Consultant	25	3.9
Director/Administrator/Supervisor	21	3.3
Rehabilitation Therapist	20	3.2
Creative Arts Therapist	18	2.8
Recreation Therapist	16	2.5
Faculty/Professor	15	2.4
Activity Coordinator/Director	13	2.1
Activity Therapist	11	1.7
Expressive Arts Therapist	8	1.3
Music Educator	5	0.8
Adjunctive Therapist	5	0.8
Clinical Therapist	3	0.5
Special Educator	2	0.2
Other Title/Not Listed	28	4.4

Survey participants were asked to select the work setting in which they were primarily employed. Table 7 displays the distribution of these responses. The greatest number of respondents indicated that they were self-employed or owned a private practice (23.7%). This was followed by psychiatric/mental health facility (14.5%), medical hospital (11.5%), employed at a private practice (11.0%), educational (10.9%), hospice/bereavement services (9.0%), and nursing home/assisted living/rehab (8.5%).

Table 7

Current Primary Work Setting

Setting	*N*	%
Owner/Self-employed	150	23.7
Psychiatric/Mental health facility	92	14.5
Hospital	73	11.5
Employed at a private practice	70	11.0
Educational	69	10.9
Hospice/Bereavement services	57	9.0
Nursing home/Assisted living/Rehab	54	8.5
Community based services	23	3.6
Correctional facility	14	2.2
Multi-disciplinary therapy agency	9	1.4
University/College	8	1.3
Other/Not listed	14	2.2
Decline to answer	1	0.2

Respondents were asked to indicate the age range with which they mostly worked. The most common age ranges served were older adults (27.6%), adults (24.1%), children (22.7%), followed by pre-teens/teens/young adults (12.5%), other/not listed (9.9%), music therapy college students (1.6%), and pre-natal/infants (1.2%). One respondent declined to answer (.2%). Of those who selected other/not listed respondents indicated this was because they worked with school age children, ages 3-21 years (n = 16) or they worked equally with two or more age ranges (n = 44). Table 8 summarizes the distribution of ages served by survey respondents.

Table 8

Age Ranges Primarily Served

Age Ranges	*N*	%
Older Adults	175	27.6
Adults	153	24.1
Children	144	22.7
Pre-Teens/Teens/Young Adults	79	12.5
Music Therapy College Students	10	1.6
Pre-natal/Infants	9	1.4
Other/Not Listed	63	9.9
Decline to Answer	1	0.2

Survey respondents were asked about additional music therapist employed at their current organization. Survey respondents most commonly reported that there were no other full-time (44.0%) or part-time (61.8%) music therapists employed at their current organization, although some indicated at least one full-time (18.1%) or part-time (16.7%) music therapist. Fewer reported more than one music therapy colleague in their current organization.

When combining full-time and part-time music therapists, approximately one-third of respondents (33.9%) did not work with another music therapist; 19.2% of respondents had at least one additional music therapist employed at their current organization, 24.3% worked with 2-4 other music therapists, and 20.4% had five or more music therapist employed at their current organization. Fourteen respondents declined to answer if any part-time or full-time music therapists were employed at their current organization (2.2%).

Table 9

Number of Additional Music Therapists Employed at Current Organization Designated by Employment Category

	Full-Time		Part-Time	
Music Therapists	*N*	%	*N*	%
0	279	44.0	392	61.8
1	115	18.1	106	16.7
2	57	9.0	48	7.6
3	66	10.4	30	4.7
4	36	5.7	20	3.2
5 or more	74	11.7	25	3.9
Decline to Answer	7	1.1	13	2.1

Survey respondents also provided information about their direct supervisor. Sixty-eight respondents reported that they had no direct supervisor (10.7%). Of those who stated that they had a direct supervisor, a majority reported that their direct supervisor identified as female (81.2%), followed by 13.9% of respondents identifying their direct supervisor as male, 1.4% as other/not listed, and 1.6% as unsure. Eleven participants declined to answer (1.9%). Of those

who selected other/not listed, it was primarily because they had more than one direct supervisor. The most commonly reported direct supervisor profession was music therapy (27.3%), followed by social work (10.9%), recreational therapy (10.6%), nursing (9.9%), and education (7.6%). The full distribution of supervisor professions is displayed in Table 10.

Table 10

Profession of Direct Supervisor

Profession	*N*	%
Music Therapy	155	27.3
Social Work	63	10.9
Recreational Therapy	62	10.6
Nursing	56	9.9
Education	43	7.6
Administration (Unspecified)	23	4.8
Creative Arts Therapy	19	3.4
Psychology	18	3.2
Occupational Therapy	16	2.8
Child Life	12	2.1
Music-Related	12	2.1
Speech Language Pathology	8	1.4
Other Therapeutic Profession	40	7.1
Other Non-Therapeutic Profession	28	5.3
Decline to Answer	9	1.6

Description of Experienced Occupational Oppression

Research Question 1*: How do music therapists describe the potential of occupational oppression in their workplace (e.g. marginalization, cultural imperialism, violence, powerlessness, or exploitation) (Young, 1990)?*

As part of the survey, respondents were presented with 30 statements describing workplace experiences. These statements were developed from a review of the music therapy literature and corresponded with each of Iris Young's (1990) five categories of oppression (marginalization, cultural imperialism, exploitation, violence, and powerlessness). The statement,

its descriptive workplace experience and the corresponding category of oppression can been seen in Table 1. This research questions was analyzed utilizing a mixed methodology.

A one-sample chi-square test was applied to each individual statement to determine if responses occurred with equal probability. Each statement was found to be statistically significant at the .1 level ($p < .000$). Based on the statistical test, respondents were equally likely to select disagree/strongly disagree as agree/strongly agree. However, while responses were not found to be significantly different, analysis of statements using descriptive statistics can provide some insight on how music therapists describe the potential of oppression in their workplaces.

In addition to the workplace experiences statements, participants responded to an open-ended question (Question 32) that asked: "Please describe a situation(s) within your workplace that supports your response [in relation to having experienced occupational oppression]." Responses were coded into two categories, *supportive* and *non-supportive* and then supportive responses were analyzed utilizing an adapted Thematic Analysis (TA) approach.

Based on the thematic analysis, all of Young's five categories of oppression (1990) were described within participants' responses. Within the 357 responses categorized as supportive, the most commonly described form of oppression was cultural imperialism with 242 responses describing experiences of cultural imperialism. This was followed by powerlessness ($n = 115$), exploitation ($n = 113$), and marginalization ($n = 67$). The least described form of oppression was violence ($n = 17$). Responses could be assigned more than one form of oppression. The descriptive statistics and qualitative responses were merged for each of the five categories of oppression (Young, 1990) to determine how music therapists describe the potential of oppression within their workplaces.

Marginalization. Limited opportunities for professional advancement was cited as the most widely experienced form of marginalization with a mean score of 2.94 (disagreement). Respondents were almost equally divided on the adequate number of music therapists employed at their organization ($\bar{x}$ = 3.01). Respondents identified with oppressive experiences for all other marginalization statements. When looking at job security, "My position should be secure should there be a budget cut," had a mean score equaling 3.22. Restrictions to populations due to lack of third-party reimbursement had a mean score equaling 2.72. Respondents reported experiencing isolation minimally ($\bar{x}$ = 2.61, agreement), but a greater number of respondents reported that they felt there were not others who understood their work whom they could talk to within their workplace ($\bar{x}$ = 4.09). Complete response percentage to all statements is displayed in Table 11.

Table 11

Responses to Assessed Workplace Experiences (Questions 25-30) Describing Marginalization

Marginalization	Disagree	Neutral	Agree	N/A	$\bar{x}$	SD
I have opportunities for professional advancement within my current organization.	**40.9%**	**18.8%**	**38.7%**	**1.6%**	**2.94**	**1.24**
My position is secure should there be a budget cut.	29.0%	21.5%	47%	2.5%	3.22	1.18
* Access to populations that would benefit from music therapy services are within my current organization are restricted from me due to lack of third-party reimbursement.	46.5%	12.3%	30.1%	11.1%	2.72	1.53
The number of music therapists at my current organization is adequate.	40.6%	12.5%	44.5%	2.4%	3.01	1.34
* I feel isolated in my workplace.	53.8%	17.8%	27.9%	0.5%	2.61	1.24
There are others that understand my work with whom I can talk within my workplace.	7.4%	8.8%	82.1%	1.7%	4.09	1.03

***** Indicates response of "Agree" is supportive of oppression

Narrative description. Respondents often described experiences of marginalization within their workplace. They described a lack of opportunities for professional advancement within their organizations and the unwillingness of employers to hire music therapists. For some respondents, that meant they remained part-time despite showing "*strong need through increased*

census and referrals." For others, it meant their employers were unable to find funding to support an additional music therapy position despite hiring other clinical positions.

> *"While there is funding for many other research projects and positions in other areas, there is not any opportunity to grow the one person music therapy department."*

Respondents reported experiencing low job security, describing hours slashed, positions eliminated, and contracts not renewed due to budget cuts.

> *"Our team was cut down to three from five during a budget cut."*

> *"When my grant money ran out, another monetary source was secured but my hourly wage was cut in half."*

For a few respondents, the number of referrals received were limited.

> *"A contract that I have is very tight on their budget for music therapy. We are constantly educating and inquiring to see who might benefit to fill our load (within their budget) yet we are still not getting referrals."*

Cultural imperialism. The requirement of advocacy was cited as the most common form of cultural imperialism ($\bar{x}$ = 3.33). This was the only statement in which a greater number of participants indicated a response in support of oppressive experiences. The next cited form of cultural imperialism was being seen as less valuable in comparison to culturally dominant therapies ($\bar{x}$ = 3.16). "My team members make statements that undermine my role as a professional" had a mean score of 2.70. A lesser number of respondents agreed with not being seen as a healthcare profession, as evidenced by "My team members mistake me as a volunteer or entertainer ($\bar{x}$ = 2.19). As a whole, respondents felt that their team members supported them ($\bar{x}$ = 4.19) and demonstrated respect for work ($\bar{x}$ = 4.18). While still a majority, a lesser number

of respondents agreed that their team members demonstrated understanding of their work ($\bar{x}$ = 3.74). Complete statement percentages are presented in Table 12.

Table 12

Responses to Assessed Workplace Experiences (Questions 25-30) Describing Cultural Imperialism

Cultural Imperialism	Disagree	Neutral	Agree	N/A	$\bar{x}$	SD
My team members support me.	1.9%	10.1%	84.7%	3.3%	4.19	1.02
My team members demonstrate understanding of my work.	11.8%	19.2%	66.6%	2.4%	3.74	1.06
My team members demonstrate respect for my work.	4.3%	10.7%	82.0%	3.0%	4.18	1.08
Music therapy is seen as equally important in comparison to other therapies offered within my organization.	33.0%	16.8%	44.0%	6.2%	3.16	1.40
* My team members mistake me as a volunteer or entertainer.	66.4%	11.8%	17.6%	4.2%	2.19	1.20
* My team members make statements that undermine my role as a professional (i.e. "You're so lucky, you get to sing songs all day.")	49.5%	15.9%	30.1%	4.5%	2.70	1.33
*** I feel I have to advocate myself and my profession to my team members.**	**29.5%**	**14.0%**	**55.0%**	**1.5%**	**3.33**	**1.28**

* Indicates response of "Agree" is supportive of oppression

Narrative description. Cultural imperialism was the most described form of oppression experienced by respondents and often accompanied other forms of experienced oppression. A lack of understanding and support for music therapy from non-music therapy staff was consistently described. Participants described a preconceived notion held by those unfamiliar with music therapy that,

> "*Music and the arts are often seen as areas anyone with musical/creative ability can do rather than a specialized therapeutic profession*."

Respondents reported being seen as an "*optional service*" or "*less important*" in comparison to professions that identified more with the dominant healthcare model, such as physical, occupational, or speech therapy. Many participants expressed sentiments that they were not seen

as healthcare professionals but rather as "*entertainers*" or performers and were referred to as the "*music lady*" or "*song lady*" within their workplaces. One respondent wrote,

> *"In the correctional setting, music therapy groups are often mistaken for just 'social time' instead of meaningful therapeutic interventions."*

Respondents described sessions being interrupted by other treatment team members under the assumption that what they offered or was needed by the client was more important than music therapy.

> *"Frequently my groups are interrupted by other treatment team members so they can complete their work during my treatment time."*

> *"The psychiatrist often pulls patients out of groups as though it is a waiting room, without regard as to who is participating or not."*

> *"Music therapy feels like the bottom of the barrel. You are [seen as] just the person that is there to play, so your interactions are constantly interrupted."*

In addition, a consistent theme among respondents was the need to educate about and advocate for music therapy to others. This was described both by respondents who identified as having experienced occupational oppression, as well as by respondents who reported they had not experienced occupational oppression. For some, this advocacy resulted in greater understanding and support of the profession. However, others were faced with willful ignorance. Respondents described this required advocacy as draining.

> *"One not only has to serve clients but has to explain what and why we're doing what we're doing."*

Exploitation. A greater number of participants reported experiencing oppression for two statements: "I work outside of hours to complete all tasks expected of me," ($\bar{x}$ = 3.16); and "Music therapy services are provided to all clients who would benefit," ($\bar{x}$ = 2.97). While a slightly greater percent of respondents agreed that they were expected to perform music-related tasks (i.e. performances) that were unrelated to music therapy (43.3% agree; 42.9% disagree) the mean score equaled 2.95. Respondents were divided on salary adequacy ($\bar{x}$ = 3.02). Participants agreed that the number of clients they were expected to serve was adequate ($\bar{x}$ = 3.58) and more disagreed than agreed that they were expected to complete tasks outside their job description ($\bar{x}$ = 2.70). Respondents strongly agreed that that their work was appreciated ($\bar{x}$ = 4.32), valued ($\bar{x}$ = 4.21) and respected ($\bar{x}$ = 4.05) by others within their organization (i.e. clients, peers, supervisors). All responses and statements describing exploitation are displayed within Table 13.

Table 13

Responses to Assessed Workplace Experiences (Questions 25-30) Describing Exploitation

Exploitation	Disagree	Neutral	Agree	N/A	$\bar{x}$	SD
My salary is adequate for what I do.	36.9%	19.3%	43.3%	0.5%	3.02	1.19
My work is appreciated by others within my organization (i.e. clients, peers, supervisors)	2.8%	8.0%	88.7%	0.5%	4.32	0.81
My work is valued by others within my organization (i.e. clients, peers, supervisors)	3.0%	10.1%	86.4%	0.5%	4.21	0.79
My work is respected by others within my organization (i.e. clients, peers, supervisors)	4.0%	12.1%	83.1%	0.8%	4.05	0.83
Music therapy services are adequately provided to all clients who would benefit.	**40.6%**	**18.3%**	**39.1%**	**2.0%**	**2.97**	**1.29**
*** I work outside of hours to complete all tasks expected of me.**	**40.1%**	**9.6%**	**50.0%**	**0.3%**	**3.16**	**1.39**
The number of clients I am expected to serve is adequate.	18.3%	14.4%	64.5%	2.8%	3.58	1.20
* I am expected to perform tasks outside of my job description.	53.5%	14.4%	31.4%	0.7%	2.70	1.28
*** I am asked to perform music-related activities (i.e. performances) that are unrelated to music therapy.**	**42.9%**	**12.8%**	**43.3%**	**2.0%**	**2.95**	**1.30**
* My current position is dependent upon me personally raising funds for my salary.	84.7%	5.7%	6.9%	2.7%	1.67	0.99

* Indicates response of "Agree" is supportive of oppression

Narrative description. Respondents consistently reported that they felt their compensation was insufficient for the level of skill and high job demands required to conduct music therapy successfully. One respondent wrote:

> *"I've been asked and expected to perform duties outside of my title description such as office managerial work and bereavement coordinator duties. I've also been expected to market for the company via music performance at facilities within the city limits. Also, the funding is low, I was inadequately compensated for a full-time position and my hours were recently cut to part-time"*

These sentiments were echoed among other music therapists as they described excessive job demands and being expected to complete tasks outside their job descriptions that were unrelated to music therapy. Other respondents described experiencing exploitation in the form of unreasonable caseloads.

> *"I serve in a children's hospital with over 600 inpatients and am currently housed within the Child Life department. There are over 600 inpatients, with 47 child life specialists and 1 music therapist. The ratio is so significantly skewed and the caseload so unmanageable that it is alarming."*

> *"I am the only music therapist at my facility, expected to cover or be available to over 400 inpatient beds, plus outpatient and diagnostic/surgical services. I am regularly asked to see more patients in different areas and challenged as to why I have not seen any patients during the week/month in various areas (i.e. outpatient oncology, med/surg, intensive care, pre-surgery, etc.)"*

Others reported their workplace places an emphasis solely on client contact hours and they had inadequate time for paperwork or client projects/prep time.

> *"I feel that I am asked to fill my schedule with client contact hours and leave little to no time for paperwork or client project/prep-time."*

For some, this resulted in having to take projects home in order to provide the best services for their clients.

Violence. Respondents minimally identified as experiencing oppression in the form of violence. Most were not concerned with being physically attacked ($\bar{x}$ = 2.23). Respondents agreed that they could freely share their opinions/thoughts without fear of repercussion ($\bar{x}$ = 3.66) and even more so that feedback was appropriate, supportive, and beneficial ($\bar{x}$ = 3.88). Respondents minimally reported they experienced bullying ($\bar{x}$ = 1.72) and sabotage by others ($\bar{x}$ = 1.68). Full responses are depicted in Table 14.

Table 14

Responses to Assessed Workplace Experiences (Questions 25-30) Describing Violence

Violence	Disagree	Neutral	Agree	N/A	$\bar{x}$	SD
* I experience bullying in my workplace.	83.0%	6.8%	9.3%	0.9%	1.72	0.99
* I am concerned with being physically attacked within my workplace.	66.6%	15.7%	17.5%	0.2%	2.23	1.17
Feedback from my team members and/or supervisor is appropriate, supportive, and beneficial.	8.5%	15.9%	72.6%	3.0%	3.88	1.10
I can freely share my opinions/thoughts with others in my organization without fear of repercussion.	17.4%	16.4%	64.0%	2.2%	3.66	1.22
* Other team members sabotage my work.	82.0%	9.2%	5.7%	3.1%	1.68	0.92

* Indicates response of "Agree" is supportive of oppression

Narrative description. Violence was the least described form of occupational oppression. Respondents described experiencing sabotage and bullying in the forms of patronizing and sarcastic comments about their work from other professionals. Respondents wrote:

"I currently work in pediatrics through our Child Life department. Several members of the department have gone above and beyond to belittle what I do. And unfortunately some of these colleagues have also gone to nursing staff to belittle music therapy. As a result, several members of nursing staff [do] not support MT [music therapy], and are not interested in attending any in-services about MT."

"*The nursing and medical staff is passive aggressive or overtly demeaning [about music therapy] on a regular basis."*

"*She [my supervisor] was verbally abusive about music therapy."*

The intent to hurt or damage from these examples of violence were not directed towards the music therapist personally, but rather at the profession of music therapy as a whole. Colleagues attempted to damage the reputation and success of music therapy programs within their organization. Fear of repercussions and examples of physical violence were not described within survey responses.

Powerlessness. A majority of respondents did not identify in favor of having experienced oppression for any statement in the category of powerlessness. Inability to provide the best care for clients due to organizational factors was the highest cited form of powerlessness ($\bar{x}$ = 3.21). Respondents moderately felt that they had adequate opportunities to collaborate with other disciplines ($\bar{x}$ = 3.45) and were able to acquire necessary equipment to satisfactorily perform their jobs ($\bar{x}$ = 3.73). Respondents moderately disagreed that their voices were unheeded/unheard when consulting with other professionals ($\bar{x}$ = 2.27). As a whole, respondents did not report experiencing powerlessness due to their supervisors. Respondents strongly agreed that their supervisor valued music therapy ($\bar{x}$ = 4.38), demonstrated support ($\bar{x}$ = 4.37), and demonstrated

understanding ($\bar{x}$ = 4.05). Respondents reported they were able to successful advocate for themselves ($\bar{x}$ = 4.00). Full responses are displayed in Table 15.

Table 15

Responses to Assessed Workplace Experiences (Questions 25-30) Describing Powerlessness

Powerlessness	Disagree	Neutral	Agree	NA	$\bar{x}$	SD
I have enough power to make changes within my organization to consistently provide the best care for my clients.	29.2%	22.4%	47.3%	1.1%	3.21	1.16
I have necessary music therapy-related equipment (i.e. space, instruments) to satisfactorily perform my job.	18.6%	11.0%	69.9%	0.5%	3.73	1.12
I have adequate opportunities to collaborate with others from different disciplines.	24.6%	17.7%	56.6%	1.1%	3.45	1.21
* My voice is unheard/unheeded when consulting with other professionals.	64.1%	22.2%	10.7%	3.0%	2.27	0.99
My supervisor values music therapy.	3.6%	5.4%	83.9%	7.1%	4.38	1.37
My supervisor demonstrates support for my work.	4.8%	7.7%	78.8%	8.7%	4.37	1.51
My supervisor demonstrates understanding for my work.	8.0%	10.9%	74.1%	7.0%	4.05	1.40
I am able to successfully advocate for myself.	8.2%	13.6%	78.2%	0.0%	4.00	0.90

* Indicates response of "Agree" is supportive of oppression

Narrative description. The powerlessness participants described impacted their ability to conduct their jobs most efficiently or provide the highest level of care for their clients. They reported a lack of understanding and support from supervisors and upper management. In some, this took the form of "*micromanagement*," while others reported having their budgets or department slashed by those who had little understanding of music therapy.

> *"My immediate interdisciplinary team highly support music therapy, but my position is being eliminated because the higher administration does not see the value (not income generating)."*

Organizational factors inhibited providing the best services for respondent's clients.

> *"We need new/more musical instruments to support new techniques and have to get it approved by three different committees... as a I result I have yet to obtain the necessary equipment for my clients."*

Another wrote that it was a challenge to make even "*simple changes to enhance group therapy rooms*" and as a consequence continued to conduct sessions in inappropriate spaces. Others described difficulties, or even sometimes inability, in obtaining resources for new instruments or adequate space for sessions.

> *"I constantly fight for space to conduct my work."*

> *It's "difficult to get equipment when other departments can spend thousands of dollars on candy."*

Respondents described being denied opportunities to conduct in-services to educate staff and limited opportunities for contributing to decision making both in their professional lives and in the care for their clients.

> *"The other therapies [speech, occupational, and social work] are consulted about potential goals for the clients and I am not."*

Emerging themes from quantitative and qualitative analysis. Statistical results were compared to thematic subcategories and narrative descriptions derived from the qualitative analysis. Quantitative and qualitative data were integrated to develop themes describing experienced occupational oppression for each category of oppression (Young, 1990). Described themes identified by category of oppression are displayed in Table 16. Themes do not describe all forms of experienced oppression reported, but rather seek to describe those most commonly depicted within the data.

Table 16

Described Themes of Experienced Oppression by Survey Respondents

Cultural Imperialism
Lack of understanding of music therapy by others
Lack of support for music therapy by others
Need to perpetually advocate music therapy to others
Seen as a less valuable therapy in comparison to therapies that identify with the culturally dominant, medical model
Not seen as a healthcare professional
Marginalization
Limited job opportunities
Unwilling to hire multiple/adequate number of music therapists
Expendable when budgets are cut (low job security)
Limited advancement opportunities
Denied access to all clients that would benefit from music therapy services
Limited referrals
Exploitation
Not adequately compensated for work
Unreasonable caseloads
Expected to perform tasks outside of job description
Higher job demands than time
Compelled to be involved in tasks related to music but not related to music therapy
Powerlessness
Difficulties obtaining adequate resources – musical and space related
Inability to provide the best care due to organizational factors
Limited opportunities for sharing and contributing to decision making
Unable to conduct in-services to educate others due to organizational factors
Minimal professional support
Low autonomy
Violence
Bullying by other professionals
Undue criticism towards music therapists and music therapy

Research Question 2*: What factors do music therapists identify that minimize or magnify occupational oppression (i.e. gender, salary, primary population of clients served, membership in the professional organization, etc.)?*

Minimizing or magnifying factors of experienced occupational oppression. In order to identify factors that minimize or magnify occupational oppression, participants were asked a series of demographic questions intended to assess personal and workplace factors. These responses were analyzed using a Chi-squared test of independence with Question 31: "Do you believe you have experienced occupational oppression as a music therapist?" Table 17 displays

the probability of difference among responses and the level of association between those identifying as having or having not experienced oppression within Question 31 and the assessed personal and workplace factors.

Table 17

Level of Association between Personal/Workplace Factors and Identification of Experiencing Occupational Oppression

Variable	*n*	*df*	X^2	*p*-value
Gender	634	3	2.653	.448
Sexual Orientation	634	5	3.133	.680
Age	634	6	4.840	.564
Race/Ethnicity	634	6	1.974	.922
Education	634	4	6.326	.176
Years Practicing	634	8	5.877	.661
AMTA membership	634	3	4.412	.220
Other professional membership	634	3	1.894	.595
Years at Current Org	634	7	11.954	.449
Salary	634	11	11.019	.442
Weekly Hours	634	3	2.711	.744
Position Title	634	14	14.819	.391
Supervisory Position	634	2	2.676	.262
Workplace Setting	634	12	18.156	.108
Age Range Served	634	7	6.322	.707
Full-time MTs	634	6	8.993	.174
Part-time MTs	634	6	2.011	.919
Supervisor a MT	634	3	9.096	**.028**
Supervisor Profession	567	14	23.690	**.071**
Supervisor Gender	568	3	3.494	.624

Personal factors (i.e. gender, sexual orientation, age, etc.) did not have a statistically significant association with identifying as having experienced oppression. While not statistically significant, men (48.1%) reported experiencing occupational oppression less than women (57.3%). Those who identified as heterosexual or homosexual reported experiencing occupational oppression less (55.8%; 58.3%) than those who identified as bisexual (63.6%) or other/not listed (75.0%). Music therapists with greater education reported higher frequencies of experiencing occupational oppression; 58.3% with a Doctoral degree, 57.6% with a Master's,

and 51.5% with a Bachelor's stated they had experienced occupational oppression. Those who had completed some school leading to the next degree reported having experienced occupational oppression more than those who had not obtained further education. Sixty-five percent of respondents who had completed some graduate school leading to a Master's degree and 69.2% of respondents who had completed some graduate school leading to a Doctoral degree reported having experienced occupational oppression. There did not appear to be a statistical trend between occupational oppression identification and age, race/ethnicity, years practicing, AMTA membership, or other professional organization membership.

When analyzing workplace factors, those who experienced occupational oppression significantly differed by whether their direct supervisor was a music therapist (X^2 =9.096, p = .028) and the profession of your direct supervisor (X^2 =23.690, p = .071). Those who reported that their direct supervisor was a music therapist reported less frequently that they had experienced occupational oppression (47.7%) in comparison to those who reported having a direct supervisor who was not a music therapist (59.7%) or not having a direct supervisor at all (57.4%). When comparing all direct supervisors' professions (Table 18), those with social workers as direct supervisors reported the highest percentage of experiencing oppression (75.8%), followed by administrators (74.1%), and recreational therapists (60.0%). The number of music therapists with direct supervisors who had music-related professions (50.0%) or were occupational therapists (37.5%) reported to have experienced occupational oppression at a lower frequency that the response average (56.3%).

Table 18

Experienced Occupational Oppression Identification by Direct Supervisory Profession

		Music Therapy	Social Work	Nursing	Recreation Therapy	Education	Administration	Creative Arts Therapy	Psychology	Occupational Therapy	Child Life	Music-Related	Speech Language Pathology	Other therapeutic profession	Other non-therapeutic profession	I decline to answer	Total
Yes	*F*	74	47	33	36	23	20	10	10	6	7	6	4	22	18	3	319
	%	47.7%	75.8%	58.9%	60.0%	53.5%	74.1%	52.6%	55.6%	37.5%	58.3%	50.0%	50.0%	55.0%	60.0%	33.3%	56.3%
No	*F*	81	15	23	24	20	7	9	8	10	5	6	4	18	12	6	248
	%	52.3%	24.2%	41.1%	40.0%	46.5%	25.9%	47.4%	44.4%	62.5%	41.7%	50.0%	50.0%	45.0%	40.0%	66.7%	53.7%
Total	*N*	155	62	60	60	43	27	19	18	16	12	8	8	40	30	9	567

Workplace setting, years at current organization, salary, weekly hours, position title, holding a supervisory position, age ranges served, additional part-time or full-time music therapists, and supervisor gender were not found to be statistically significant.

Research Question 3: *As individuals, do music therapists experience oppression within their workplace?*

Individual identification of experiencing occupational oppression. Respondents were provided an operational definition of occupational oppression (Appendix C) and asked "Do you believe you have experienced occupational oppression as a music therapist?" Fifty-six percent of respondents (n = 357) reported that they had had experienced occupational oppression, while 44% of respondents (n = 277) reported that they had not experienced occupational oppression as a music therapist. Utilizing a one-sample Chi-squared test, significant differences between the yes and no responses were not found (X^2 = 10.095, p = .001).

As a follow up question, participants were asked to describe a situation(s) to validate their response in a short answer question. Responses were analyzed using an adapted Thematic

Analysis (TA) approach. Responses by those who identified, “Yes, I have experienced occupational oppression as a music therapist,” had been analyzed as part of Research Question 1 and were not analyzed in further detail for Research Question 3. Described workplace experiences of occupational oppression are displayed in Table 16. However, participants who identified, “No, I have not experienced occupational oppression as a music therapist,” were analyzed in greater detail to address this research question.

Participants who identified, “No, I have not experienced occupational oppression as a music therapist,” described experiences of occupational oppression within their workplace. While respondents often expressed experiencing a high level of support and understanding from immediate team members, they described a lack of understanding and support from those less familiar with music therapy, as well as the need to consistently advocate and educate.

> *“Within my company, staff understand music therapy, support it, and value the services it provides for families. Outside of the company, at facilities, it is sometimes devalued (seen as volunteer work), etc. It takes calm educated communication to teach others what it actually is and can provide.”*

> *“There are always people that you work with that do not understand what you do. I feel like for the most part I work for an organization that truly supports what I do and sees immediate changes for the residents, [but] I still get comments like ‘just go play for people, everybody loves music.”*

Some respondents reported that it was the job of music therapists to effectively advocate and educate others about the profession.

> *"I feel that it is our job as music therapists to be able to communicate with other professionals in a competent informed manner [and] advocate for ourselves as music therapists..."*
>
> "*The burden is on me to educate and demonstrate the effectiveness of what I do."*

In some instances, participants reported that they believed music therapy was simply "*misunderstood*" rather than oppressed.

> *"I think oppression is a strong word. I think music therapy is simply widely misunderstood."*

A majority of music therapists identified as having experienced occupational oppression within their workplace (56.3%). These participants described all of Young's five categories of oppression (1990) within their responses. While 43.7% of music therapists did not identify as having experienced occupational oppression within their workplace, some non-identifiers described oppressive experiences in their narrative responses. These descriptions were primarily located in the category of cultural imperialism (lack of understanding, lack of value, the need to perpetually advocate music therapy to others).

Beliefs Held in Regards to Music Therapy as an Oppressed Occupation

Research Question 4: *Do music therapists believe the profession of music therapy to be an oppressed occupation?*

Respondents were provided an operational definition of occupational oppression (Appendix C) and asked based on that definition whether they believed music therapy to be an oppressed occupation. A majority of respondents (77.6%, $n = 492$) supported the belief that the profession of music therapy is an oppressed occupation; 22.4% of respondents ($n = 142$)

reported that they did not believe music therapy to be an oppressed occupation. Utilizing a one-sample Chi-square test, differences between responses were not statistically different (X^2 = 193.218, p = .000).

Research Question 5*: What factors contribute to music therapists' belief that music therapy is or is not an oppressed occupation?*

Contributing factors to beliefs. In order to identify factors that contribute to music therapists' belief that music therapy is or is not an oppressed occupation participants were asked the same series of demographic questions utilized to assess Research Question 2. The author analyzed responses using a Chi-squared test with Question 33: "Do you believe music therapy to be an oppressed occupation?" Table 19 displays the probability of difference among responses and the level of association between the identification of music therapy as an oppressed occupation and the assessed personal and workplace factors.

Nine assessed personal and workplace factors were found to be statistically significant at the < .1 level when examining identification of music therapy as an oppressed occupation. Gender (X^2 = 8.146, p = .043), age (X^2 = 49.120, p = .000), years practicing (X^2 = 36.598, p = .000), years at current organization (X^2 = 28.206, p = .005), salary (X^2 = 33.732, p = .000), holding a supervisory position (X^2 = 9.401, p = .009), workplace setting (X^2 = 20.735, p = .054), music therapist as a direct supervisor (X^2 = 14.903, p = .002), and direct supervisor's profession (X^2 = 24.475, p = .025).

Younger respondents were more likely to identify music therapy as an oppressed occupation, as were respondents who had been practicing as music therapists for fewer years, been employed at their current organization for a shorter period, earned lower salaries, and did not hold supervisory positions within their current organization. Respondents who identified

their direct supervisors as music therapists or working within social work, administration, and nursing were more likely to identify music therapy as an oppressed occupation. Furthermore, participants who identified their direct supervisor as a music therapist were more likely to identify music therapy as an oppressed occupation as well; this is in direct contrast to identified experiences of oppression. Having a music therapist as a supervisor minimized identified experiences of oppression but magnified the belief that music therapy is an oppressed occupation. Respondents who held supervisory positions (69.5%) identified music therapy as an oppressed occupation less than respondents who did not hold supervisory positions (80.6%). Participants who identified as working for a private practice, nursing home/rehab, or hospice/bereavement services reported music therapy to be an oppressed occupation at higher frequencies.

Table 19

Level of Association between Personal/Workplace Factors and the Identification of Music Therapy as an Oppressed Occupation

Variable	*n*	*df*	X^2	*p*-value
Gender	634	3	8.146	**.043**
Sexual Orientation	634	5	6.539	.257
Age	634	6	49.120	**.000**
Race/Ethnicity	634	6	9.654	.140
Education	634	4	1.131	.889
Years Practicing	634	8	36.598	**.000**
AMTA membership	634	3	0.887	.829
Other professional membership	634	3	1.071	.784
Years at Current Org	634	7	28.204	**.005**
Salary	634	11	33.732	**.000**
Weekly Hours	634	3	3.837	.573
Position Title	634	14	20.101	.127
Supervisory Position	634	2	9.401	**.009**
Workplace Setting	632	12	20.735	**.054**
Age Range Served	634	7	4.326	.889
Full-time MTs	634	6	2.360	.884
Part-time MTs	634	6	4.971	.548
Supervisor a MT	634	3	14.903	**.002**
Supervisor Profession	567	14	24.475	**.025**
Supervisor Gender	568	3	2.847	.724

Narrative description of factors contributing to beliefs. To further explain what factors contribute to music therapists' beliefs about occupational oppression within the profession of music therapy, short answer responses from Question 34: "Why do you belief music therapy is an oppressed occupation?" and Question 35: "Why do you believe music therapy is not an oppressed occupation?" were thematically analyzed. All responses were read twice to obtain a sense of the information and reflect on its overall meaning. From this, themes were developed and responses were assigned.

Those who identified music therapy as an oppressed occupation often cited personal experiences in which they or a fellow music therapist had experienced occupational oppression and therefore led to their belief. Respondents described the lack of understanding and support for

the profession as a whole by others that results in preconceived notions and having to "*constantly fight and support the legitimacy*" of music therapy.

> *"I am constantly having to answer the question of what music therapy is, and even then, I feel it is hard for others to fully understand the depth of work we do."*

These preconceived notions result in a lack of value for music therapy and consequently many music therapists receive inadequate compensation.

> *"We are not valued as healthcare providers. We are not paid as healthcare providers."*

> *"[We're] Underpaid. Undervalued. Most people want it for free!"*

Three themes emerged from those who did not identify music therapy as an oppressed occupation: increased recognition/familiarity for the profession, personal experiences, and beliefs held about oppression. Respondents cited increased growth and understanding for the profession as support for their beliefs.

> *"There are new jobs emerging and new public awareness every year."*

> *"We seem to have an increase in opportunity for employment as compared to when I entered the field. There is a growing awareness so there is not the need to always define and advocate for music therapy like there was in the past."*

Respondents described experiences of support and understanding from colleagues.

> *"Music therapy is highly valued and sought after regularly."*

> *"I am a valued member of my organization."*

> *"Team members look to me for advice and insight [about] the patients."*

Beliefs held in regards to oppression influenced respondents' beliefs. Some respondents reported that they believed experienced oppression was self-imposed.

> *"I do not have the victim mindset."*
>
> *Oppression "stems from a lack of therapists advocating for and educating others [about music therapy]."*

Others shared that occupational oppression may be experienced by some music therapists but it did not occur throughout the population.

> *"There are some music therapists who experience in their workplaces, [but] others who receive a lot of support and understanding."*
>
> *"I believe it's sometimes an oppressed occupation."*

Synthesis of quantitative and qualitative factors contributing to beliefs. Synthesis of the data suggest that three broad categories influence music therapists' beliefs that music therapy is or is not an oppression occupation: level of resources, experiences, and beliefs held about oppression. Respondents who reported higher levels of resources (autonomy, adequate compensation, support from colleagues and supervisors, power to make change) were less likely to identify the profession as oppressed, while those who had lower levels of resources were more likely to identify the profession as oppression. Personal experiences influenced respondents' identification of music therapy as an oppressed occupation. Respondents who described being underpaid or not respected by colleagues were more likely to identify the profession as oppressed. Furthermore, respondents who reported they did not experience oppression but were aware of other music therapists' oppressive experiences identified the profession as oppressed. Participants who did not identify the profession as oppressed described experiences of

oppression within their responses with minimal frequencies. Finally, personal beliefs about oppression influenced respondents' identification of music therapy as an oppressed profession. Emerging factors that influence beliefs that music therapy is or is not an oppressed occupation are displayed in Table 20.

Table 20

Emerging Factors Contributing to Beliefs that Music Therapy is or is not an Oppressed Occupation

Level of Resources
Age
Gender
Salary
Number of years practicing
Number of years at current organization
Holding a supervisory position
Direct supervisor profession
Experiences
Workplace Setting
Music therapist as direct supervisor
Personal experiences
Awareness of other music therapists' experiences
Beliefs
Requirements to label group as oppressed
Personal bias to term oppression
Increased recognition of the profession

Chapter 5

Discussion

The present study was conducted to determine if the phenomenon of occupational oppression existed within the profession of music therapy, and to describe the beliefs of board-certified music therapists in regards to occupational oppression. Overall, music therapists identified music therapy as an oppressed occupation (76.6%). However, a lesser number identified as having experienced occupational oppression as a music therapist (56%). In their own words, music therapists describe workplace experiences depicting each of Young's five faces of oppression, with cultural imperialism most often described and violence the least described. Yet, these results were not mirrored within the quantitative data provided by thirty Likert-scale statements assessing workplace experiences. Respondents reported the need to advocate their profession to others, but often shared that their team members support, understand and respect their work. The contradictory nature of the results from this study provides interesting insights on the phenomenon of occupational oppression within music therapy and how music therapists view these experiences.

Description of Occupational Oppression within Music Therapy

Influence of cultural imperialism on subsequent oppressive experiences. Cultural imperialism occurs when the dominant or powerful group determines societal norms, and anyone outside the dominant group is seen as the 'other.' The 'other' group is then viewed as both different and invisible, and is devalued and objectified by the dominant group (Young, 1990). As a holistic, creative modality, music therapy is at risk of experiencing 'other-ization' within the dominant healthcare model (Baines & Edwards, 2015).While music therapy literature has often described cultural imperialism within the workplace (Bitcon, 1981; Clements-Cortes, 2006; Kim

et al., 2013; Vega, 2010), the extent to which cultural imperialism influences subsequent oppressive experiences has not been explored. A greater percentage of respondents agreed that they felt the need to continuously advocate for themselves and the profession of music therapy to their team members. In addition, descriptions of cultural imperialism were prevalent throughout participants' narrative responses whether the participant identified with the idea of occupational oppression or not. The creative arts are often regarded as superfluous within society (Baines & Edwards, 2015). In addition, the modality of music is readily available and frequently associated with entertainment. Music therapy does not fit neatly into the healthcare box. As a result, music therapy is viewed as different, invisible and devalued in comparison to more conservative forms of treatment that collectively integrated to the medical model paradigm. As one participant shared: *"Not everyone can be a physical therapist, speech therapist, or occupational therapist, so why does music therapist elicit others [non-music therapists] into thinking that they are as effective as a MT-BC?"*

Participants described the continual need to advocate and educate others about the profession in order to overcome lack of understanding, and subsequent incorrect assumptions, about music therapy. Such misunderstandings can be understood as a barrier, inhibiting music therapists from conducting their jobs at the highest level. In the words of one respondent: "*From the time we are in school we [sic] are trained that we need to fight for music therapy, that people will disregard us, that we are our own advocates*." While another respondent added: "*Music therapists must advocate intensely for themselves and consistently prove their worth in the workplace*." While many participants described advocacy and education successes in establishing understanding and support for the profession, the original incorrect assumptions of colleagues and those outside the profession often negatively influenced views on the worth and

value of music therapy as a healthcare modality. This frequently resulted in music therapy playing a diminished/devalued role within patient/client care and served as a precursor to other experienced forms of occupational oppression by music therapists.

Cultural imperialism and marginalization. The described devaluation of music therapy as a profession resulting from cultural imperialism led to experienced forms of marginalization. Marginalization occurs through social exclusion, and involves excluding, not just merely discriminating against. Consequently, marginalized populations are deprived full participation within society (Young, 1990). The lack of understanding and subsequent devaluation of music therapy results in the exclusion of music therapy from client care and facilities. CBMT reports that there are 6,696 licensed music therapists currently practicing in the United States (2016). In comparison, the U.S Bureau of Labor Statistics reported 110,520 occupational therapists, 200,670 physical therapists, and 126,500 speech language pathologists currently practicing (2015b). However, participants described difficulty in obtaining positions. One participant shared their difficulties in obtaining a position stating: "*It is not even close to protocol that a music therapist be staffed in every hospital or psychiatric unit*." Another participant, although they had not experienced it themselves, described their music therapy friends having to "*weasel their way into jobs*" or being "*overlooked*" for other professions during their job search.

As an additional consequence of the devaluation of music therapy, music therapists described experiences of low job security, unwillingness of employers to hire additional music therapists, lack of advancements opportunities, and limited referrals for music therapy services. Music therapy was described as a "*nonessentia*l" service and as a result, the first to go in a budget cut and valued at a lower worth than other professions. One participant wrote, "*Our*

hospice census continues to grow significantly, so a greater number of social workers and nurses are hired. Yet our music therapy staff has not been able to get funding approved from our foundation [for] an additional position." These accounts support existing depictions of marginalization within music therapy literature (Clements-Cortes, 2013; Decuir & Vega, 2010; Kim et al., 2013; Rykov, 2001).

Cultural imperialism and other forms of oppression. Cultural imperialism in the forms of low worth for the profession and lack of understanding, influenced experiences of exploitation and powerlessness for survey participants. The low worth of the profession was often reflected within experiences of exploitation. Exploited groups do not receive adequate compensation for their labor (Young, 1990). Participants described being underpaid for their level of education and job demands. One participant wrote:

> *I don't know many music therapists who are paid fairly, let alone adequately. After assuming (and paying for) a college education, MTs [music therapists] should be able to live and save, not live paycheck to paycheck. It should be assumed that we get benefits/PTO just like other professions. We sacrifice our job titles, pay, what population we want to work with, and dignity to just find a job. Many MTs have to work several separate music therapy jobs or supplement with non-therapy jobs.*

Furthermore, participants described high job demands and unreasonable caseloads due to organizations' reluctance to employ greater numbers of music therapists.

Powerlessness occurs when others have power over a group or groups of people. A small number of people make all the decisions (Young, 1990). The low census of music therapists within facilities resulting from marginalization is reflected in the number of music therapists in supervisory roles. A quarter of respondents (25.9%) indicated that they held supervisory

positions within their current organization, while 27.3% of respondents indicated that their direct supervisor was a music therapist. Those who reported that their direct supervisor was a music therapist were significantly less likely to identify as having experienced occupational oppression; 47% of participants who identified as having a music therapists as a direct supervisor identified as having experienced oppression. In comparison, 75.8% of participants who reported their direct supervisor was a social worker and 74.1% of participants who reported their direct supervisor was an administrator identified as having experienced oppression. Survey respondents described the lack of support and understanding from non-music therapist supervisors and upper management. They described difficulties obtaining resources for new instruments and appropriate spaces to conduct sessions, as well as acquiring approval to conduct in-services to educate. However, many identified that their direct supervisors valued and supported music therapy.

Music Therapy and the Cycle of Oppression

A majority of survey respondents indicated that they believed music therapy to be an oppressed occupation. Acknowledging the existence of oppression within a population is a critical first step for change to occur (Deutsch, 2006; Freire, 1989). However, music therapists were less inclined to identify as having experienced oppression within their workplaces (Tables 11-15).

Although acknowledging oppression is a necessary first step towards ending the cycle of oppression, group action is required to fully combat oppression and promote change. Often inferior group members are interested in maintaining the status quo due to being fearful of the unknown and the consequences of change should they attempt to end the cycle (Cudd, 2002; Deutsch, 2006). In order to attempt ending the cycle, the inferior group's level of discontentment

and sense of injustice needs to be strong enough to ensure that that gains achieved from ending the cycle of oppression are greater than the potential risks (Deutsch, 2006). While survey respondents acknowledged the existence of oppression within music therapy, the lack of identified experiences of oppression may reflect lower levels of discontentment within the profession. As a result, music therapists may not believe the potential risk of attempting change is worth the potential gains. Music therapists may have had difficulties identifying experiences as oppressive for several reasons: limited experiences, normalization, and personal/group discrimination discrepancy.

Survey respondents may have had difficulty labeling workplace experiences as oppressive due to limited experiences of oppression. As a primarily white, middle-class, heterosexual, college-educated population, survey respondents were more likely to be members of privileged groups than disadvantaged ones. However, members of disadvantaged groups more quickly acknowledge inequalities. As a result, due to their general lack of experience on the receiving end of oppression, music therapists may be slower to acknowledge experienced oppression.

In addition, survey respondents may have been less inclined to identify as having experienced oppression due to the normalization of experienced cultural imperialism within the profession. Consequently, respondents may have been hesitant to identify experiences of cultural imperialism, such as lack of understanding by others and the need to advocate, as oppressive. Music therapists expect that they will have to educate others about the profession. As one respondent wrote: *"Within my organization and among our community we believe we need to advocate and educate constantly. We often approach other professionals expecting to have to explain ourselves.*" The expectation of advocacy necessity is embedded within music therapy

education. CBMT's Board Certification Domains (2015), reflective of current practice, lists "serve as advocate for the profession of music therapy" under Professional Responsibilities. Several survey respondents expressed that they believed it was the job or duty of a music therapist to advocate for the profession, which further supports the normalization of cultural imperialism within the profession.

Furthermore, music therapists may have had difficulty labelling workplace experiences as oppressive due to the personal/group discrimination discrepancy phenomenon. Members of groups who are at risk of experiencing oppression/discrimination are more likely to perceive the group as experiencing oppression/discrimination, opposed to themselves personally experiencing oppression/discrimination (Crosby, 1984; Fuegan & Biernat, 2000; Hodson & Esses, 2002; Magallares, Luna, Garriga, Botella-Carretero & Morales, 2016). Researchers have argued this occurs for either two reasons: discriminations occur at higher frequencies within a group than as individuals and are more easily identified (Crosby, 1984; Fuegan & Biernat, 2000), or individuals minimize the effect of experienced discrimination as a form of self-protection (Crosby, 1984; Fuegan & Biernat, 2000; Hodson & Esses, 2002; Magallares et al., 2016). Personal discrimination has been found to be negatively associated with subjective well-being, whereas group discrimination as not (Magallares et al., 2016). Music therapists may not identify experiences as oppressive as a coping mechanism.

Music therapists engage in individual resistance from oppression through advocacy. Music therapists strive to disprove the negative assumptions held about the profession through education. Because of these advocacy efforts, survey respondents commonly described support from immediate colleagues and supervisors. However, survey respondents often described a continued lack of understanding from those outside their close work circle (i.e. administrators,

doctors, families, etc.). While individual resistance efforts through advocacy have increased knowledge and support for the profession, group cohesion and organization may be necessary to gain enough power to promote change effectively.

Minority groups that have been successful in overcoming oppression display high social cohesion and effective social organization. These characteristics are necessary for effective utilization of resources to combat oppression. However, group cohesion and organization are often undeveloped within oppressed groups (Deutsch, 2006). This is true within the profession of music therapy. Music therapists do not agree on the best theoretical approaches to practice. This results in (a) extensions of the profession promoting certain theoretical approaches and models as better than or worse than others, (b) a lack of solidarity among group members, and (c) an ambiguous definition of the profession. Such within profession debates makes the presentation of a unified front, in order to promote change, difficult. In addition, many music therapists are not members of the national professional organization, the American Music Therapy Association (AMTA). While there are approximately 6,700 music therapists practicing within the United States (CBMT, 2016), less than half are members of AMTA (AMTA, 2016a). Without effective social organization due to lack of national organization membership and cohesion impeded by in-group arguing, it could be difficult for music therapists to gain enough power to cause change. However, discontent and injustice can amplify these characteristics and serve as a catalyst to promote social action (Deutsch, 2006).

The described experiences of occupational oppression may have negatively affected the profession of music therapy and the lives of music therapists by creating barriers and limiting resources. While not actively discussed within this study, occupational oppression can lead to higher turnover rates and burnout among professionals. Describing the personal cost of

oppression a survey respondent wrote: "*I feel emotionally, physically, and spiritually exhausted when I leave work every day to the point that I can't make myself eat dinner*." Other professions have acknowledged oppressive practices and taken action to end the oppression cycle. The efforts of other professions to reduce experienced oppression can provide insight on steps the profession of music therapy can take to end their own oppression cycle.

Recommendations

Examples of overcoming oppression in other professions. Other professions have acknowledged oppressive experiences, such as nursing (Cox, 1991; Daiski, 2004; Dong & Temple, 2011; Deans, 2004; Duchscher & Myrick, 2008; Matheson & Bobay, 2007; Myers et al., 2016 ; Roberts, 1983; 2000; Roberts et al., 2009; Rodwell & Demir, 2012; Vessey et al., 2010) and black women in academia **(**Chambers, 2011; Croom & Patton, 2011; Davis & Maldonado, 2015; Harley, 2008; Howard-Baptiste, 2014). These professions have develop protocols and interventions to create organizational cultures that promote empowerment and decrease occupational oppression. Such developments can provide insight on how music therapists can combat their own oppression

Nursing. In order to combat the horizontal violence created by oppression, nurses implemented top-down interventions. Many interventions began with nursing leadership first analyzing the organizational culture and structures that promoted disempowerment (Deans, 2004; Duchscher & Myrick, 2008; Roberts et al., 2009). Further steps included fostering a culture where communication and positive feedback were encouraged (Duchscher & Myrick, 2008; Myers et al., 2016); increasing education about bullying and horizontal violence for nurses (Deans, 2004; Myers et al., 2016; Roberts et al., 2009; Vessey et al., 2009) and nurse leadership

(Deans, 2004); and establishing a zero-tolerance policy on bullying (Duchscher & Myrick, 2008).

Black women in academia. African American faculty challenged higher education institutions in which they were employed to critically examine their climates in order to decrease experienced oppression among black female faculty. Recommendations from faculty to address this problem focused on improving the campus climate through hiring more women of color and diversity training, increasing the level of support, modifying professional duties, providing adequate compensation or other incentives, and respecting African American faculty's work and space (Harley, 2008; Howard-Baptiste, 2014). The responsibility of promoting change was put on universities. Researchers argued that until institutions of higher education critically examine their climate and commit to change, oppression will perpetuate (Howard-Baptiste, 2014).

Recommendations for music therapy. There is no easy solution for ending the cycle of oppression within music therapy. Occupational oppression is a complex phenomenon and engrained within the culture of the profession. As a small and relatively unknown profession, music therapy holds little collective power in comparison to larger healthcare professions. At the foundation of experienced oppression by music therapists is cultural imperialism. There exists a lack of understanding about the profession of music therapy, which leads to incorrect assumptions about the profession, risking a subsequent lower worth as a whole for the profession in comparison to similar therapies. While music therapists engage in individual resistance through individual advocacy efforts, group action may be necessary to promote the change the profession desires. As steps towards positive professional change, increased membership in AMTA, an agreed upon definition of music therapy, uniformed degree requirements, state recognition and state licensure, and increased high quality research done by music therapists are

recommended. Such recommendations, were developed by the researcher both from extant literature and personal experiences.

Increased membership in AMTA. Music therapy is a small profession. Almost half of survey respondents (44%) were the only full-time music therapist employed within their facility. As a result, they may feel isolated from other music therapists, as well as unable to promote change within their organization due the lack of support from other professionals. Membership within a professional organization provides professional support (Esmaeili, Dehghan-Nayeri & Negarandeh, 2013). It also provides a group under which music therapists can unite; there is support in numbers. However, currently less than half of all music therapists belong to AMTA. This not only results in decreased social organization, but also reduces financial resources in which the profession can utilize to conduct national advocacy efforts (Sena Moore, 2015). Therefore, membership in the professional organization of AMTA is a critical component to increase positive efforts to minimize workplace oppression.

Agreed upon definition of music therapy. Music therapists often find themselves in debate with each other about best theoretical approaches to practice (Choi, 2008; Hillecke, Nickel & Bolay, 2005). As a result, the profession is unclear and not unified about the purpose of music therapy, which leads to an ambiguous definition of music therapy. Extensions of the profession promote their theoretical approach as better than other approaches. Not only does the in-group fighting impede cohesion among music therapists, a necessary component for effective social action (Deutsch, 2006), but also inhibits advocacy efforts for the profession as whole. If music therapists are unable to define the purpose of the profession, they cannot expect others to understand and value music therapy. The fissure between music therapists often originates within educational training (Choi, 2008).

Unifying degree requirements. The educational training of music therapists greatly varies by university. Within their education, music therapy students are introduced to the belief that one theoretical approach is better than others, as attended university most directly influences a music therapist's practiced theoretical approach (Choi, 2008). This can result in a diminished value for other theoretical approaches. This is turn leads to decreased cohesion among music therapists and an ambiguous definition of the profession. Furthermore, the varied curriculum requirements for music therapy degrees result in new music therapists with differing levels of competencies.

State recognition and licensure. State licensure has been a large focus of advocacy efforts by music therapists. This focus seeks to ensure that those who practice music therapy are in fact board-certified music therapists. Official state recognition may be the first step towards inclusion within health and education regulations. This would potentially allow for improved access reimbursement and state funding streams, such as private insurance, Medicaid waivers, and special education (Sena Moore, 2015).

Increased high quality research done by music therapists. Increased high quality research further promotes the efficacy of music therapy as an evidence based practice (Hillecke et al., 2005). For example, explicit intervention reporting to include clear and detailed explanations of the interventions used and why that intervention was selected (Robb, Burns & Carpenter, 2011) allows for study replication, as well as providing a better explanation for how the elements of music specifically influenced the results. Improved and increased research can serve as a resource to combat oppression in music therapy.

Limitations

One limitation to this study may have been the construction of the thirty Likert-scale statements intended to assess oppressive workplace experiences. These statements were constructed to be neutral in order to avoid bias. In result, participants' responses were neutral, with the exclusion of few statements. Had statements been more polarizing, results stemming from these statements may have been more significant.

A second limitation of this study may be the inclusion of the term "team members" within the wording of the thirty Likert-scale statements intended to assess oppressive workplace experiences (i.e. "My team members demonstrate understanding of my work."). "Team" was defined within the survey for participants as "the individuals with which you work closely." Results from this study indicate that music therapists minimally experience oppression at the hands of their immediate colleagues due to advocacy efforts. Rather they are more likely to experience oppression from those who have less contact with the profession such as doctors, administrators, or families. For many unfamiliar with the profession, seeing is believing. Respondents may have identified more statements as oppressive had this term been changed to encompass a broader circle of colleagues.

Another limitation of this study may be the research and survey questions construction. This research study was intended to establish and briefly describe the phenomenon of occupational oppression within the profession of music therapy. Research and survey questions were not designed to solicit deep insight into the effect of occupational oppression on the daily lives of music therapists. To better understand the effect of occupational oppression on the daily lives of music therapists, future research is necessary.

Potential researcher bias may have influenced results and served as a limitation for this study. The researcher's interest in occupational oppression within music therapy originated from personal experiences of oppression that occurred during clinical internship and within the first six months of employment. As a result, these personal experiences of oppression may have influenced thematic analysis results and subsequent interpretation of the data. It is difficult to remain completely unbiased within research, and especially so within qualitative research. Acknowledging this innate bias, the researcher attempted to present and analyze the results in the most unbiased manner possible.

Finally, it is the intent of the researcher to cut and revise this manuscript for publication. However, for the purpose of completing degree requirements, such revisions do not occur within this manuscript. Such revisions include, but are not limited to, conducting a factor analysis on the thirty Likert-scale statements related Iris Young's theoretical framework, statistical analysis utilizing a series of t-tests related to Questions 25-30, an in-depth discussion on the medical-model framework, and improved research-supported recommendations for the profession in order to overcome oppression.

Recommendations for Future Research

This research study established the existence and briefly described the phenomenon of occupational oppression within the profession of music therapy, as well as described the beliefs held about occupational oppression by music therapists. This study is the first to explore occupational oppression within the profession of music therapy and supports the existence of occupational oppression within the profession. However, descriptive methodologies can only provide a general awareness of the problem. A greater understanding of the lived experiences of music therapists in relation to this topic is a necessary step for developing solutions. Future

research on this topic should include constructivist and subjectivist methodologies. Such studies should examine music therapists' daily experiences of oppression in greater depth, as well as the resources employed to combat oppression and the cost of experienced oppression on job satisfaction and burnout. At the conclusion of this survey, participants indicated if they were interested in being contacted for a follow-up interview and provided an email address; 358 email addresses were collected. A follow-up study on this topic could provide a more complete framework for examining oppression within the profession, as well as establish a connection between experienced oppression and burnout. Through this enhanced understanding, music therapy as a profession can work towards developing solutions to decrease negative workplace experiences and ultimately end the cycle of oppression.

As a holistic, creative modality working within the dominant medical model, music therapy is at risk of experiencing oppression. However, this risk can apply to other creative arts therapies, such as art therapy or dance/movement therapy, as well. The survey from this study could be adapted to art or dance/movement therapy and a comparable study conducted to examine experiences of occupational oppression within these similar professions. Furthermore, results from both studies could be compared to highlight similarities and differences of experienced oppression between the professions. Such knowledge could lead to greater collaboration between the different creative arts therapy modalities within advocacy efforts, as well as to develop solutions to overcome occupational oppression.

Increased research in regards to AMTA and membership is an important additional step towards developing solutions. Effective social organization is a crucial component of successful social action. The profession would benefit from increased research on what influences a person to join or not join AMTA, as well as what members find beneficial within their membership. A

greater understanding of these influences could lead to more effective marketing campaigns and a higher percentage of music therapists belonging to the professional organization.

Finally, the review of literature discussed gender inequalities within music therapy that were not explored within this research study (Curtis, 1990; 2013; Edwards & Hadley, 2007; Pasaili, Lin & Noh, 2009). As a female-dominated profession, music therapists are at risk for experiencing oppression within their workplaces due to gender. Increased research examining occupational oppression and gender differences can provide greater knowledge on effect of gender on experienced oppression. This knowledge could promote practices to decrease gender inequalities within music therapy and decrease experienced oppression within the profession overall.

Conclusion

Occupational oppression is a system of invisible barriers created by those in power that reduces the professional's ability to perform at the highest level and is based on the assumption that certain professions are inherently superior or inferior. Prior to this research study, the potential of experienced oppression within the profession of music therapy had not been explored. However, findings from this research study indicate that occupational oppression exists within the profession of music therapy. A majority of music therapists believe the profession of music therapy to be oppressed (77.6%, $n = 492$) and identify as having experienced oppression within their current workplace (56%, $n = 357$). Furthermore, in their own words music therapists described experiencing each of Young's (1990) five faces of oppression – cultural imperialism, marginalization, exploitation, powerlessness, and violence. Music therapists described experiencing a lack of understanding and support for their work, a continual need to advocate, a lack of worth for the occupation by other professionals, difficulties obtaining a job, low job

security, inadequate compensation, lack of advancement opportunities, inadequate supervision, difficulties obtaining musical resources, plus many other negative workplace experiences.

Despite negative workplace experiences, the profession of music therapy is growing. There is increased recognition and support for the power of the arts within healthcare, and music therapists report more positive workplace experiences than in the past. As music therapy looks to the future, burnout and high turnover rates among music therapists will continue to be a concerning issue. Oppression contributes to burnout by depleting the resources necessary to combat high job strain. However, by viewing negative workplace experiences that contribute to burnout through the lens of occupational oppression, music therapy can begin to perceive these experiences as limiting situations that are transformable, rather than without solutions. Acknowledging the existence of oppression within music therapy is a critical first step towards liberation.

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Appendices

Appendix A

Email Invitation

Dear Music Therapy Colleague,

You are being invited to complete an online survey as part of my MME thesis research study that I am conducting under the supervision of Dr. Deanna Hanson-Abromeit of the Department of Music Education Music Therapy, University of Kansas. The Certification of Ethical Acceptability for Research Involving Human Subjects is #STUDY00140228.

The purpose of this research is to examine workplace factors and the perception of said workplace factors that affect the ability of music therapists to conduct their jobs at the highest level of performance. This survey, delivered by the online company Survey Monkey, contains several multiple choice and two short answer questions. It is expected to take 10 – 15 minutes to complete. This survey is intended for board-certified music therapists (MT-BCs) that are currently practicing music therapy.

You are free to choose not to participate in this study and you can withdraw from this study at any time while completing the survey without consequence. However, once survey data is submitted it cannot be removed from the study, as there is no means to differentiate individual participant responses, since these will be complete anonymous.

The results from this study may be used in reports, publications, or presentations.

If you have any questions please do not hesitate to contact the researcher or research advisor:

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If you have any additional questions about your rights as a research participant please call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Rd, Lawrence, Kansas 66045-7463, email irb@ku.edu.

If you wish to participate, please read the following "Informed Consent" document. The survey can be accessed through the "Begin Survey" button. Accessing and completing the survey will confirm your voluntary consent to participate.

Thank you for your time and consideration,

Molly Bybee, MT-BC
Music Education Music Therapy
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Appendix B

Reminder Email Invitation

Dear Music Therapy Colleague,

You recently received an invitation to complete an online survey as part of my MME thesis research study that I am conducting under the supervision of Dr. Deanna Hanson-Abromeit of the Department of Music Education Music Therapy, University of Kansas. This email serves as a reminder to participate. The survey will remain open until Feburary 2, 2017.

The purpose of this research is to examine workplace factors and the perception of said workplace factors that affect the ability of music therapists to conduct their jobs at the highest level of performance. This survey, delivered by the online company Survey Monkey, contains several multiple choice and two short answer questions. It is expected to take 10 – 15 minutes to complete. This survey is intended for board-certified music therapists (MT-BCs) that are currently practicing.

You are free to choose not to participate in this study and you can withdraw from this study at any time while completing the survey without consequence. However, once survey data is submitted it cannot be removed from the study, as there is no means to differentiate individual participant responses, since these will be complete anonymous.

The results from this study may be used in reports, publications, or presentations.

If you have any questions please do not hesitate to contact the researcher or research advisor:

Molly Bybee, MT-BC
Principal Investigator
Music Education Music Therapy
University of Kansas
m703b209@ku.edu

Dr. Deanna Hanson-Abromeit
Faculty Supervisor
Music Education Music Therapy
University of Kansas
dhansonabromeit@ku.edu
(785) 864-9632

If you have any additional questions about your rights as a research participant please call (785) 864-7429 or write the Human Research Protection Program, (HRPP), University of Kansas, 2385 Irving Hill Rd, Lawrence, Kansas 66045-7463, email irb@ku.edu.

If you wish to participate, please read the following “Informed Consent” document. The survey can be accessed through the "Begin Survey" button. Accessing and completing the survey will confirm your voluntary consent to participate.

Thank you for your time and consideration,

Molly Bybee, MT-BC
Music Education Music Therapy
University of Kansas

Appendix C

Operational Definition of Oppression

Occupational oppression is based on the assumption that certain professions are inherently superior or inferior. It is a system of invisible barriers created by those in power that reduces the professional's ability to perform work at the highest level. Barriers result from a combination of beliefs related to the value or worth of set occupations and their members. Occupational oppression is often experienced due to membership in marginalized occupations, but can also occur due to membership in other marginalized populations. Experienced workplace inequalities negatively affect the individual and the occupation.

Occupational oppression can manifest itself in a myriad of ways. Some examples of occupational oppression include, but are not limited to: low job resources, lack of understanding and support for work, low workplace autonomy, inadequate compensation (both monetarily and psychologically), unreasonable job demands, and low job security. (Cudd, 2002; Deutsch, 2006; Friere, 1989; McDonald, Keys & Balcazar, 2007; Prilleltensky, 2003; Young, 1990; Zutlevics, 2005).

Appendix D

Survey

Thank you for choosing to participate in this survey!

The Division of Music Therapy and Music Education at the University of Kansas supports the practice of the protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

The purpose of this research is to examine workplace factors and the perception of said workplace factors that affect the ability of music therapists to conduct their jobs at the highest level of performance. This survey is intended for board-certified music therapists (MT-BC's) that are currently practicing. The survey consists of several multiple choice and Likert-scale questions, and two short-answer questions and is expected to take approximately 15 minutes to complete.

Although participation may not help you directly, we believe the information obtained from this study will help us gain a better understanding of the lived experiences of music therapists at work and promote further research on this subject in order to create solutions to reduce the impact of negative workplace environments. Your participation is solicited, although strictly voluntary. Upon conclusion of the survey, you may be solicited for identifiable information in the form of email addresses as part of a follow-up study. Your name or email address will not be associated in any way with the research findings. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response.

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or email. Completion of this survey indicates your willingness to take part in this study and that you are at least 18 years old. If you have any additional questions about your rights as a research participant, please call (785) 864-7429 or write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Rd, Lawrence, KS 66045-7463, email irb@ku.edu.

Sincerely,

Molly Bybee, MT-BC
Principal Investigator
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Deanna Hanson-Abromeit, Ph.D, MM, MT-BC
Faculty Supervisor
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Demographics

* 1. Are you currently practicing music therapy in the United States?

- ◯ Yes
- ◯ No

Demographics

* 2. With which gender do you most identify?

- ◯ Female
- ◯ Male
- ◯ Transgender female
- ◯ Not Listed (please specify):
- ◯ Transgender male
- ◯ Gender variant/Non-conforming
- ◯ I decline to answer

* 3. With which sexual orientation do you most identify?

- ◯ Lesbian, gay or homosexual
- ◯ Straight or heterosexual
- ◯ Bisexual
- ◯ Not listed (please specify)
- ◯ Transgender, transsexual or gender non-conforming
- ◯ Unsure
- ◯ I decline to answer

* 4. What is your age?

- ◯ 25 years or younger
- ◯ 26 -35 years
- ◯ 36 - 45 years
- ◯ 46 - 55 years
- ◯ 56 - 65 years
- ◯ 66 years or older
- ◯ I decline to answer

* 5. Do you identify as Hispanic, Latino, or Spanish?

- ◯ Yes
- ◯ No
- ◯ I decline to answer

Demographics

* 6. Which of the following best describes your racial background?

- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White or Caucasian
- ◯ Two ore more races
- ◯ I decline to answer
- ◯ Not listed (please specify):

* 7. What is your highest level of education completed?

- ◯ Bachelor's degree or Bachelor's equivalency
- ◯ Some graduate school leading towards a Master's degree
- ◯ Master's degree
- ◯ Some graduate school leading towards a Doctorate degree
- ◯ Doctorate degree or higher
- ◯ I decline to answer.

* 8. What is your approximate annual music therapy salary?

- ◯ Less than $10,000
- ◯ $10,000 - $19,999
- ◯ $20,000 - $29,999
- ◯ $30,000 - $39,999
- ◯ $40,000 - $49,999
- ◯ $50,000 - $59,999
- ◯ $60,000 - $69,999
- ◯ $70,000 - $79,999
- ◯ $80,000 - $89,999
- ◯ $90,000 - $99,999
- ◯ Greater than $100,000
- ◯ I decline to answer.

* 9. Are you currently a member of the American Music Therapy Association (AMTA)?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ I decline to answer

* 10. Are you currently a member of another professional association for music therapy (e.g. international, regional, state, or city music therapy associations)? This does not include the Certification Board for Music Therapists (CBMT).

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ I decline to answer

* 11. How many years have you been practicing as a board-certified music therapist?

- ◯ 0 - 5 years
- ◯ 6 - 10 years
- ◯ 11 - 15 years
- ◯ 16 - 20 years
- ◯ 21 - 25 years
- ◯ 26 - 30 years
- ◯ 31 - 35 years
- ◯ 36 - 40 years
- ◯ 41 years and greater
- ◯ I decline to answer

Demographics

* 12. How long have you been employed at your current organization as a music therapist?

- ◯ Less than 1 year
- ◯ 1- 2 years
- ◯ 3 - 4 years
- ◯ 5 - 6 years
- ◯ 7 - 8 years
- ◯ 9 - 10 years
- ◯ 11 - 12 years
- ◯ 13 - 14 years
- ◯ 15 - 16 years
- ◯ 17 - 18 years
- ◯ 19 - 20 years
- ◯ 21 years and greater
- ◯ I decline to answer

* 13. Approximately how many hours a week do you work at your current organization as a music therapist?

- ◯ Less than 8 hours
- ◯ 8 - 19 hours
- ◯ 20 - 34 hours
- ◯ 35 - 40 hours
- ◯ More than 40 hours
- ◯ I decline to answer

* 14. What is your position title at your current organization

- ◯ Activity Coordinator/Director
- ◯ Activity Therapist
- ◯ Adjunctive Therapist
- ◯ Clinical Therapist
- ◯ Creative Arts Therapist
- ◯ Director/Administrator/Supervisor
- ◯ Expressive Arts Therapist
- ◯ Faculty/Professor
- ◯ Music Educator
- ◯ Music Therapist
- ◯ Recreation Therapist
- ◯ Rehabilitation Therapist
- ◯ Self-Employed/Consultant
- ◯ Special Educator
- ◯ I decline to answer
- ◯ Not Listed (please specify):

* 15. Do you hold a supervisory position within your current organization?

- ◯ Yes
- ◯ No
- ◯ I decline to answer

* 16. Do you own a private music therapy agency or consider yourself self-employed?

- ◯ Yes
- ◯ No
- ◯ I decline to answer

* 17. Are you employed at a private music therapy agency?

- ◯ Yes
- ◯ No
- ◯ I decline to answer

Demographics

* 18. Which setting best describes your current organization?

- ◯ Community Based Service
- ◯ Correctional Facility
- ◯ Educational (e.g. adult education, daycare, preschool, early intervention, special education)
- ◯ Hospital (e.g. children's hospital, general hospital, Veteran's Affairs)
- ◯ Hospice/Bereavement Services
- ◯ Other (please specify):
- ◯ Multi-Disciplinary Therapy Agency
- ◯ Nursing Home/Assisted Living/Rehab
- ◯ Psychiatric/Mental Health Facility (e.g. community mental health, outpatient clinic, inpatient psychiatric unit)
- ◯ University/College (e.g. faculty, graduate teaching assistant)
- ◯ I decline to answer

* 19. Please indicate the age range with which you work the most.

- ◯ Pre-natal/Infants
- ◯ Children
- ◯ Pre-Teens/Teens/Young Adults
- ◯ Adults
- ◯ Other (please specify)
- ◯ Older Adults
- ◯ Music Therapy College Students/I am a faculty member
- ◯ I decline to answer

* 20. How many music therapists, excluding yourself, are employed full-time at your current organization? (Full-time is considered equal to, or greater than, 35 hours/week.)

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5 or more
- ◯ I decline to answer

* 21. How many music therapists, excluding yourself, are employed part-time at your current organization? (Part-time is considered less than 35 hours/week.)

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5 or more
- ◯ I decline to answer

* 22. Is your direct supervisor a music therapist?

- ◯ Yes
- ◯ No
- ◯ I do not have a direct supervisor.
- ◯ I decline to answer

Demographics

* 23. What profession is your direct supervisor?

- ◯ Creative Arts
- ◯ Music-Related
- ◯ Nursing
- ◯ Occupational Therapy
- ◯ Physical Therapy
- ◯ Psychology
- ◯ Other Non-Therapeutic Profession (please specify):
- ◯ Recreational Therapy
- ◯ Social Work
- ◯ Speech/Language Pathology
- ◯ Other Therapeutic Profession
- ◯ I decline to answer

* 24. With which gender does your direct supervisor most identify?

- ◯ Female
- ◯ Male
- ◯ Transgender female
- ◯ Transgender male
- ◯ Not Listed (please specify)
- ◯ Gender variant/Non-conforming
- ◯ Unsure
- ◯ I decline to answer

Workplace Experiences

* 25.
The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you most work (i.e. hospital, school system, university, private practice); "team" is defined as the individuals with which you work closely (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I work outside of common work hours to complete all tasks expected of me.	○	○	○	○	○	○
The number of music therapists employed at my current organization is adequate.	○	○	○	○	○	○
Access to populations that would benefit from music therapy services within my current organization are restricted from me due to lack of third-party reimbursement.	○	○	○	○	○	○
My supervisor demonstrates support for my work.	○	○	○	○	○	○
Other team members sabotage my work.	○	○	○	○	○	○
My salary is adequate for what I do.	○	○	○	○	○	○

* 26.

The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you most work (i.e. hospital, school system, university, private practice); "team" will be defined as the individuals with which you work (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
My position is secure should there be a budget cut.	○	○	○	○	○	○
I have opportunities for professional advancement within my current organization.	○	○	○	○	○	○
I can freely share my thoughts/opinions with others in my organization without fear of repercussions.	○	○	○	○	○	○
My work is appreciated by others within my organization (e.g. clients, peers, supervisors).	○	○	○	○	○	○
I am able to successfully advocate for myself.	○	○	○	○	○	○
My team members demonstrate respect for my work.	○	○	○	○	○	○

* 27.

The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you most work (i.e. hospital, school system, university, private practice); "team" is defined as the individuals with which you work (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I have the necessary music therapy-related equipment (e.g. space, instruments) to satisfactorily do my job.	○	○	○	○	○	○
I am concerned with being physically attacked in my workplace.	○	○	○	○	○	○
My team members demonstrate understanding of my work.	○	○	○	○	○	○
Music therapy services are adequately provided to all clients who would benefit.	○	○	○	○	○	○
My supervisor demonstrates understanding for my work.	○	○	○	○	○	○
My work is valued by others within my organization (e.g. clients, peers, supervisor).	○	○	○	○	○	○

Workplace Experiences

* 28.
The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you most work (i.e. hospital, school system, university, private practice); "team" will be defined as the individuals with which you work (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
My supervisor values music therapy.	○	○	○	○	○	○
The number of clients I am expected to serve is adequate.	○	○	○	○	○	○
I experience bullying in my workplace.	○	○	○	○	○	○
I am expected to perform tasks outside of my job description.	○	○	○	○	○	○
I feel I have to advocate myself and my profession to my team members.	○	○	○	○	○	○
I feel isolated in my workplace.	○	○	○	○	○	○

* 29.

The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you most work (i.e. hospital, school system, university, private practice); "team" is defined as the individuals with which you work closely (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
Feedback from my team members and/or supervisor is appropriate, supportive, and beneficial.	○	○	○	○	○	○
My team members make statements undermining my role as a professional (e.g. "You're so lucky, you get to sing songs all day.")	○	○	○	○	○	○
My team members mistake me as a volunteer or entertainer.	○	○	○	○	○	○
Music therapy is seen as equally important in comparison to other therapies offered within my organization.	○	○	○	○	○	○
I have enough power to make changes within my organization to consistently provide the best care for my clients.	○	○	○	○	○	○
My work is respected by others within my organization (e.g. clients, peers, supervisors)	○	○	○	○	○	○

* 30.

The following are a list of statements related to music therapy workplace experiences. Please read each statement carefully then decide how strongly you agree or disagree with each statement based on your music therapy experiences in the PAST SIX MONTHS. Select ONLY ONE opinion that matches your level of agreement or disagreement with each statement.

For the purpose of this study "organization" is defined as the entire facility in which you work (i.e. hospital, school system, university, private practice); "team" is defined as the individuals with which you work closely (i.e. child life services, special education, school of music).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I have adequate opportunities to collaborate with other from different disciplines.	○	○	○	○	○	○
I am asked to perform music-related activities (i.e. performances) that are unrelated to music therapy.	○	○	○	○	○	○
There are others within my workplace that understand my work with whom I cam talk.	○	○	○	○	○	○
My current position is dependent upon me personally raising funds for my salary.	○	○	○	○	○	○
My team members support me.	○	○	○	○	○	○
My voice in unheard/unheeded when consulting with other professionals.	○	○	○	○	○	○

Beliefs of Occupational Oppression

* 31. Occupational oppression is based on the assumption that certain professions are inherently superior or inferior. It is a system of invisible barriers created by those in power that reduces the professional's ability to perform work at the highest level. Barriers result from a combination of beliefs related to the value or worth of set occupations and their members. Occupational oppression is often experienced due to membership in marginalized occupations, but can also occur due to membership in other marginalized populations. Experienced workplace inequalities negatively affect the individual and the occupation.

Occupational oppression can manifest itself in a myriad of ways. Some examples of occupational oppression include, but are not limited to: low job resources, lack of understanding and support for work, low workplace autonomy, inadequate compensation (both monetarily and psychologically), unreasonable job demands, and low job security.

Do you believe you have experienced occupational oppression as a music therapist?

◯ Yes ◯ No

* 32. Please describe a situation(s) within the workplace that supports your response:

* 33. Do you believe music therapy to be an oppressed occupation?

◯ Yes

◯ No

Beliefs of Occupational Oppression

* 34. Occupational oppression is based on the assumption that certain professions are inherently superior or inferior. It is a system of invisible barriers created by those in power that reduces the professional's ability to perform work at the highest level. Barriers result from a combination of beliefs related to the value or worth of set occupations and their members. Occupational oppression is often experienced due to membership in marginalized occupations, but can also occur due to membership in other marginalized populations. Experienced workplace inequalities negatively affect the individual and the occupation.

Occupational oppression can manifest itself in a myriad of ways. Some examples of occupational oppression include, but are not limited to: low job resources, lack of understanding and support for work, low workplace autonomy, inadequate compensation (both monetarily and psychologically), unreasonable job demands, and low job security.

Why do you believe music therapy to be an oppressed occupation?

Debriefing Form

Thank you for participating in this study. In order to get the information we were looking for, some information was withheld about some aspects of this study. Now that the survey is complete, we will describe the deception to you, answer any of your questions, and provide you with the opportunity to make a decision on whether you would like to have your data included in this study.

The purpose of this study was to determine the existence and describe the phenomenon of occupational oppression within the profession of music therapy by examining workplace factors and perception of said workplace factors that affect the ability of music therapists to conduct their jobs at the highest level of performance. The email invitation, consent form, and survey title omitted the term "oppression." This was done to decrease respondent and responder bias. Oppression is a polarizing term. By utilizing the term within the first parts of the survey, it was believed to potentially bias your willingness to respond to the survey invitation, as well as your responses. The omission does not affect the evaluation of the study results. Rather, it is believed that by omitting the word oppression from the title and description of the survey results will be more honest rather than being clouded by preconceived notions about oppression.

Although you have already completed the survey, your involvement is still voluntary, and you can choose to withdraw the data you provided prior to debriefing without consequence.

If you have later questions later or would like to know about the results of this study please do not hesitate to contact the researcher or the research advisor.

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If you have any additional questions about your rights as a research participant, please call (785) 864-7429 or write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Rd, Lawrence, KS 66045-7463, email irb@ku.edu.

Thank you again for you participation.

36. Would you be willing to be contacted within the next 6-12 months for a follow-up interview as part of an subsequent project, should the outcomes of this survey indicate that music therapy is an oppressed occupation?

- ◯ No
- ◯ Yes, I am interested in being contacted. My email address is provided below:

[ ]

Completion of Survey

This completes the survey.

Thank you for your participation!