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WHAT KEEPS US WELL? PROFESSIONAL QUALITY OF LIFE AND CAREER SUSTAINING BEHAVIORS OF MUSIC THERAPY PROFESSIONALS

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WHAT KEEPS US WELL? PROFESSIONAL QUALITY OF LIFE AND CAREER
SUSTAINING BEHAVIORS OF MUSIC THERAPY PROFESSIONALS

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THESIS

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A thesis submitted in partial fulfillment of the

requirements for the degree Master of Music in the

College of Fine Arts at the University of Kentucky

By

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2013

ABSTRACT OF THESIS

WHAT KEEPS US WELL? PROFESSIONAL QUALITY OF LIFE AND CAREER
SUSTAINING BEHAVIORS OF MUSIC THERAPY PROFESSIONALS

Self-care can be seen as not only critical for individual professionals, but also for the growth of the helping professions and the quality of care which clients receive. The purpose of this study was to investigate use of career-sustaining behaviors and the levels of professional quality of life in music therapy professionals. This study investigated research questions regarding use of career sustaining behaviors and levels of professional quality of life, the relationship between these variables, the differences in the use of career sustaining behavior by demographics, and the use of music as a self-care strategy.

An online survey was sent to all professional members of the American Music Therapy Association. A total of 403 participants were included in the study for the purposes of data analysis. Findings from the study indicate that music therapy professionals are in the average to low ranges for burnout and secondary traumatic stress. However, a portion of the sample was identified to be at risk for these factors. Differences existed in the use of career sustaining behaviors between demographic variables, indicating self-care behaviors vary among professionals. The field of music therapy should further investigate these areas to best provide opportunities for professional self-care.

KEYWORDS: Self-Care, Career Sustaining Behaviors, Professional Quality of Life, Burnout, Stress and Music Therapy

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WHAT KEEPS US WELL? PROFESSIONAL QUALITY OF LIFE AND CAREER
SUSTAINING BEHAVIORS OF MUSIC THERAPY PROFESSIONALS

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To my wife, Stephanie, for your unfailing support,

continuous encouragement, and boundless love.

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CHAPTER ONE

INTRODUCTION

As members of a helping profession, music therapy clinicians address the needs and emotions of others while balancing their own needs and quality of life (Cummins, Massey, & Jones, 2007). The challenges of working in a helping field have been shown to be emotionally draining and stressful (Balogun, Titiloye, Balogun, Oyeyemi, & Katz, 2001), deplete personal and professional health (Shanafelt, Bradley, Wipf, & Back,2002), and impact client care and the work environment (Skovholt, Grier, & Hanson, 2001). Self-care, defined as any strategy done to improve one's well-being (Richards, Campenni, & Muse-Burk, 2010), is not only vital for professional and personal well-being, but is also an ethical imperative in the field of music therapy. Lack of self-care can lead to decreased work performance, lack of emotional control, and poor interpersonal relationships that can negatively affect the client care provided in music therapy sessions (Clements-Cortes, 2006; Vega, 2010). The American Music Therapy Association (AMTA) code of ethics states that client welfare is of utmost importance in professional practice (AMTA, 2012). As such, AMTA notes that music therapists are expected to use every resource available to assist in best serving their clients. The practice of self-care can be seen as a research-informed strategy that can improve client care, as well as clinician health.

Self care has been defined in a variety of ways throughout the literature. Richards and colleagues developed the broad definition that the phenomenon of self-care is "any activity that one does to feel good about oneself" (Richards et al., 2010, p. 252). Further, the authors classify self-care into four domains: (a) psychological, which involves thoughts and cognitions; (b) support, consisting of relationships with others; (c) physical, seen as any physical activity or daily function; and (d) spiritual, encompassing the beliefs and values one has. Although

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researchers have examined and outlined many self-care strategies and behaviors, no standardized measure for self-care was identified as widely used in the literature. Brodie (1982) attempted to quantify self-care behaviors in a study of psychotherapists, and as a result established the term "career sustaining behaviors." These behaviors include both personal and professional activities engaged in by helping professionals.

Definitions of Terms

In addition to self-care, professional quality of life and career sustaining behaviors have been examined in this study. Definitions for the following terms are provided:

Burnout can be seen as "feelings of hopelessness and difficulties in dealing with work or in doing your job effectively" (Stamm, 2009, p. 13).

Career sustaining behaviors are "those behaviors used to enhance, prolong, and make more comfortable one's work experience" (Brodie, 1982, p. 1).

Compassion fatigue is "the negative aspect of our work as helpers" (Stamm, 2009, p. 12).

Compassion satisfaction is "the pleasure you derive from being able to do your work" (Stamm, 2009, p. 12).

Professional quality of life is "the quality one feels in relation to their work as a helper" (Stamm, 2009, p. 8).

Secondary traumatic stress is "work-related, secondary exposure to extremely stressful events" (Stamm, 2009, p. 13).

Self-care is "anything one does to feel good about oneself" (Richards et al, 2010, p. 252).

The importance of self-care practice has been stressed throughout the literature for maintaining physical and emotional health for helping professionals. Although it has been noted in the research literature that self-care is an essential tool to help professionals thrive in the

workplace, the nature of the outward-focused care provided by those in helping professions may place them at risk of not prioritizing self-care. One of the prominent figures in counseling, Carl Rogers, once noted that "I have always been better at caring for and looking after others than I have in caring for myself" (Rogers, 1995, p. 80). This focus on others at the expense of oneself appears to be common among professionals in helping fields. This claim is reiterated by others looking at self-care, who have stated that those trained to care for others often neglect themselves and ignore the same advice they give to their clients (Cummins et al., 2007; O'Halloran, 2000). Self-care has been suggested as a tool that may successfully prevent a variety of personal and professional impairments and improve job satisfaction (Figley, 2002), career length (Skovholt et al., 2001), and wellness (Connolly & Myers, 2003; Myers, Luecht, & Sweeney, 2004). Discussing the self-care imperative, Barnett and colleagues (2007) made the claim that failure to make ongoing efforts towards self-care may harm not only helping professionals themselves, but also their clients, their profession, and others in their lives.

Self-care has been shown to help prevent symptoms of burnout and fatigue, while allowing for more effective client treatment (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; O'Halloran, 2000), and has been recognized in some fields, including psychology, counseling, physical therapy, and music therapy, as an ethical behavior guided by outlined standards (Barnett et al., 2007; Dileo, 2000; Fereday, 2011). Fereday (2011) described recent research in which counselors who were viewed as competent and successful rated self-care practices as a vital part of maintaining ethical behavior and interactions in their work. Professionals stated difficulties in engaging consistently in self-care strategies, noting that other-care often took precedent, and that self-care subsequently became secondary. Fereday observed

that self-care behaviors were positively related to job satisfaction and compassion satisfaction, and negatively related to burnout (Fereday, 2011). Understanding self-care is imperative to help combat the difficulties common to the music therapy profession.

Common stressors identified by music therapists include those of dealing with loss, emotional exhaustion, juggling multiple roles, disappointment with clients' responses, lack of understanding of music therapy by others, education and advocacy responsibilities of the field, and economic challenges of the work (Clements-Cortes, 2006; Dileo, 2000; Vega, 2010). These factors can influence the professional quality of life and satisfaction of music therapy clinicians. In fact, burnout rates for music therapists have been found to be around 11-12% (Oppenheim, 1987; Vega, 2010). Additionally, one study found that less than 1% of clinicians had levels of burnout classified as "low", which may suggest that professional well-being is at risk for music therapists.

The American Music Therapy Association outlines the following standards of personal development as clinical competencies for the music therapy professional: (a) identify and address one's personal issues, (b) recognize limitations and seek consultation, and (c) practice strategies for self-care (AMTA, 2012). While the concepts of professional health and self-care are distinctly outlined as ethical responsibilities, there is little literature addressing these topics in the field of music therapy. Although various studies have looked at burnout in music therapy, no studies were found that examined the relationship between self-care practices, including career sustaining behaviors, of music therapists and professional quality of life. This gap in the literature provides a rationale for the current study.

Purpose

The purpose of this study was to investigate use of career-sustaining behaviors and the levels of professional quality of life in music therapy professionals. Specifically, this study investigated the following research questions:

1. Which career-sustaining behaviors are most commonly used by music therapy professionals and what are their levels of professional quality of life (burnout, secondary traumatic stress, and compassion satisfaction)?

2. Is there a relationship between use of career sustaining behaviors and levels of professional quality of life among music therapists?

3. Are there differences in music therapy professionals' use of career sustaining behaviors based on (a) gender, (b) age, (c) years of experience, (d) work setting, or (e) hours worked weekly?

4. In what ways and to what degree do music therapy professionals use participation in music as a career-sustaining behavior?

CHAPTER TWO

REVIEW OF LITERATURE

Challenges for Those in Helping Professions

Stress, defined as the perception of threat, with resulting anxiety, tension, and difficulty in adjustment (Selye, 1976), is a phenomenon that is increasingly common in our American society, is particularly prevalent in those who work in helping professions. A recent study by researchers at Carnegie Mellon University found that stress levels have increased in individuals in the U.S. by 30% over the last 30 years (Cohen & Jannicki-Deverts, 2012). This presence of stress, combined with the nature of the work, in which one must focus on the needs and emotions of others while balancing one's own well-being, causes individuals in helping professions to be particularly vulnerable to stress (Cummins et al., 2007).

The common challenges of work that involves helping others have been discussed extensively in the literature. Balogun and colleagues (2002), examining physical and occupational therapy, noted that challenges are inherent in helping professions because the close relationship between the provider and client is emotionally draining and stressful. Difficulties for social workers were identified as large and strenuous caseloads, time deadlines and constraints, crises and emergencies, and safety concerns. Additionally, therapeutic conversations with clients experiencing helplessness or traumatic events can be particularly taxing.

Skovholt and colleagues (2001) used the term "high touch" professions to better describe the challenges a variety of other-focused fields. Counselors, nurses, teachers, psychotherapists, and others can be seen as related in that their work emphasizes human interaction as a necessary means of improving health and well-being. These interactions all involve some level of attachment, empathy, and separation, all of which bring individual stresses and difficulties. To

combat these challenges, there has been an interest in identifying self-care strategies that have been utilized effectively by clinicians in helping professions.

Need for Self-Care among Helping Professionals

Self-care has been gaining increased focus in the professional arena, particularly in fields in which individuals consistently provide care to others. These fields include those of medicine, psychology/psychotherapy, rehabilitation, and counseling. Constant effort focused on others has been shown to put an individual at risk for depletion in professional and personal health, resources, and self-care behaviors (Shanafelt et al., 2002; Skovholt et al., 2001). Self-care can be seen as not only critical for individual professionals, but also for both the growth and survival of the helping professions and the quality of care which clients receive.

Self-care has increasingly become a practice seen as vital for competent caregiving. Factors related to lack of self-care, including burnout, compassion fatigue, secondary traumatic stress, decreased job satisfaction, and lowered wellness, can adversely affect the individual. Subsequently, client-care and the work environment may be negatively impacted by lack of self-care (Connolly & Myers, 2003; Figley, 2002; Skovholt et al.,2001). A statement by the National Association of Social Workers (NASW, 2009) provided a comprehensive outline for the importance of self-care, one that can be seen to address not only social work, but all helping professions. According to the NASW, developing a repertoire of self-care practices is essential for (a) competent, compassionate, and ethical practice; (b) overcoming the challenging nature of one's work; (c) the primary prevention of unwanted conditions; (d) maintaining ethical practice with clients in various settings and from diverse backgrounds; and (e) keeping valued professionals and maintaining professional integrity in the field. With an emphasis being placed

upon the need for self-care among helping professionals, it is important to first understand how self-care is defined.

What is Self-Care?

Self-care has been discussed and investigated quite frequently in the literature and various definitions of the term exist. Baker, who discussed self-care for psychotherapists, described self-care as the "processes of self-awareness and self-regulation and the balancing of connections among self […], others […], and the larger community" (Baker, 2003, p. 13-14). Other definitions speak more to the strategies that comprise self-care, including factors of intrapersonal work, interpersonal support, professional development and support, and physical activities (Carroll, Gilroy, & Murra, 1999). In discussing music therapy, Dileo (2000) describes self-care as something that is an ongoing behavior, which involves the therapist staying attuned to his or her needs, feelings, and values, as well as those of the client in each and every therapy session. Concerning self-care for counselors, Richards and colleagues defined the phenomenon of self-care as "any activity that one does to feel good about oneself" (Richards et al., 2010, p. 252). The authors further classified self-care through the components of psychological, support, physical, and spiritual wellbeing. These four domains will serve as the basis of self-care for the purpose of this study.

Self-Care Domains

Richards and colleagues (2010) defined self-care and wellness through four factors of the self, namely

- Psychological, which includes patterns of thoughts/cognitions and one's own personal counseling,
- Support, which includes relationships from professional and personal support systems,

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- Physical, which involves the utilization of energy through exercise, sports, household activities, and daily functioning, and

- Spiritual, which involves beliefs, values, and meaning of life.

It is important to note that both internal and external factors of the self are included in this model, suggesting self-care as a truly holistic practice. These domains are also strongly supported by the wellness model developed by Myers and colleagues (2004), which grouped behaviors by cognitive-emotional, relational, physical, and spiritual categories of the self.

Psychological self-care. Self-care techniques that have been discussed in the literature and appear to fall into the psychological domain as described by Richards and colleagues (2010) include (a) setting limits in the workplace (Myers et al., 2004); (b) positive self-talk (Shanafelt et al., 2005); (c) self-understanding/awareness (Baker, 2003; Cummins et al., 2007; Richards et al.,2010); and (e) using humor (Franzini, 2001; Myers et al., 2004). A study examining the self-care of nurses found that emotion-based strategies (endorsed by 43% of participants) were recognized most often as part of participants' wellness plans, with affirmations (36.5%) being the second most commonly utilized strategy (Kravits, McAllister-Black, Grant, & Kirk, 2010). Findings from the previously mentioned studies have emphasized that these psychological techniques should be used to provide a balance between personal and professional life, and are implemented most effectively when one uses ongoing personal assessment (Baker, 2003; Myers et al., 2004).

Support self-care. Aspects of self-care that fall into the supportive category include relationships with family and friends, social events, couple time, non-work related events, discussions with colleagues (Myers et al., 2004), engaging in personal therapy (Mahoney, 1997;

Jennings et al., 2005); and seeking supervision (Fereday, 2011). In studies of self-care practices, support or relational aspects have often been rated highly by participants surveyed. Stevanovic and Rupert (2004) found that the career-sustaining behavior of spending time with partner and/or family was both the highest rated and the strongest indicator of higher job satisfaction among psychotherapists. Findings from Kravits' and colleagues (2010) research support the emphasis that helping professionals place on relational support from family and friends. Eighty-two percent of nurses in Kravits' study noted time with family/friends as a self-care strategy, which was almost twice the number of participants who endorsed other self-care strategies. Quality relationships with co-workers (effective communication and management of conflicts) have been found to improve professional health by reducing the instances of burnout (Embriaco, Papazian, Kentish-Barnes, Pochard, & Azoulay, 2007; Poncet et al., 2007). Strong social supports in both personal and professional environments have been shown to solidify the quality of relational self-care, and help clinicians cope with the stresses of their demanding work (Hannigan, Edwards, & Burnard, 2004).

Physical self-care. Self-care behaviors in the physical domain include those for physical health and wellness, illness prevention, and active leisure engagement. Common to the literature are the physical strategies of

(a) proper nutrition (Kraus, 2005; Myers et al., 2004);

(b) sleep behaviors (Kraus, 2005);

(c) yoga and stretching (Valente & Marotta, 2005);

(d) deep breathing (Kravits et al., 2010); and

(e) physical exercise (Cohen-Katz et al., 2005; Myers et al., 2004).

Focus on physical self-care is vital not only for the wellness aspects of health, but also for the happiness that both rest and leisure activities can provide (Myers et al., 2004).

Spiritual self-care. Lastly, spirituality is included in the wellness model as a component of self-care practice. Baker described how spiritual practices can include anything from "involvement in traditional, formal, organized religion to more eclectic, informal, individualized versions" (2003, p. 96). Spirituality involves the general concept of finding one's meaning and purpose in life for personal growth, and it has been investigated through a plethora of different strategies. Spiritual practices cited in the research literature include

(a) mind-body practices such as hypnosis, visualization, and deep muscle relaxation (Baker, 2003);

(b) meditation or prayer (Baker, 2003; Richards et al., 2010; Valente & Marotta, 2005);

(c) spiritual journaling (Baker, 2003);

(d) pastoral care (Aycock & Boyle, 2009); and

(e) retreats (Baker, 2003; Aycock & Boyle, 2009).

These four domains—psychological, support, physical, and spiritual—help to define and categorize the strategies believed to constitute self-care. Whether consisting of behaviors related to one's own cognitive-emotional self, relationships, physical activity, or purpose of life, self-care strategies described in the literature often fall into these four areas of the self.

Self-Care Strategies

Several researchers have examined self-care practices in attempts to create research-informed strategies for professionals. Norcross listed ten self-care strategies for psychotherapists that he described as "clinician recommended, research informed, and practitioner practiced" (2000, p. 710). This compilation included

(a) recognize the hazards of practice;

(b) think strategies, as opposed to techniques or methods;

(c) begin with self-awareness;

(d) embrace multiple strategies traditionally associated with diverse theoretical

   orientations;

(e) employ stimulus control;

(f) emphasize the human element;

(g) seek personal therapy;

(h) avoid wishful thinking and self-blame;

(i) diversify; and

(j) appreciate the rewards.

Special attention is given to this last strategy, as the author emphasizes that the hazards of

practice must be counterbalanced by the rewarding, meaningful, and joyful aspects of the work.

Using a different taxonomy, Skovholt highlighted six self-care techniques for counselors:

(a) focusing on balanced wellness;

(b) increasing professional self-understanding;

(c) maximizing professional success;

(d) minimizing professional loss;

(e) active career development; and

(f) creating a "professional greenhouse" at work (Skovholt et al, 2001).

The term "professional greenhouse" stems from an environment where support from peers,

healthy leadership, and fun exists and allows for professional growth.

Three standardized measures of self-care behaviors were found by this researcher (Alkema, Linton, & Davies, 2008; Brodie, 1982; Fereday, 2011). Of these three, Brodie's has been used the most frequently in the research literature. Brodie (1982) researched and developed a questionnaire for psychotherapists to identify self-care strategies. This measure has been adapted into a version that is suitable in both admission and length for the present study. Therefore, the categorization of self-care strategies by Brodie, who uses the term "career sustaining behaviors," were used for this study.

Career-Sustaining Behaviors

In an attempt to better quantify aspects of self-care, Brodie (1982) coined the term "career sustaining behaviors" (CSBs) as behaviors that are used to enhance, prolong, and make the work experience more comfortable. Brodie's CSBs include both personal and professional activities engaged in by helping professionals. The value of these activities lies in the concept that they include positive and health-producing behaviors (Scholnik,1984). Information that guided the development of CSBs was collected from interviews with psychologists, all with over fifteen years of experience (Brodie, 1982).

In the initial interviews, Brodie posed a question, asking how psychotherapists kept themselves going in their work. Responses to this question, combined with background research Brodie conducted in areas of personality, gender, experience, and mental health, framed the main outline for the CSB makeup. These following question areas were initially identified for further study: (a) interpersonal support systems, (b) coping with specific situations, (c) leisure time use, (d) beliefs and attitudes, (e) gender influences on behavior, (f) career satisfaction, (g) implications for training, and (h) identification of available and unavailable supports.

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Originally a 17 page questionnaire developed for psychologists, the CSB form has been modified several times, resulting in its current version, which includes 34 questions. The questionnaire has participants rate the importance of specific strategies in helping them function effectively and maintain a healthy professional role, using a seven-point Likert-type scale, with one being *not important* and seven being *highly important*. Brodie's (1982) original observations found that *intra*personal supports (time to oneself, self-talk, supportive attitudes and internal beliefs) were rated higher by psychologists than *inter*personal supports (time with others, support by family and friends, discussions with colleagues).

In a later study of CSBs of 700 psychotherapists, results showed that the most frequently endorsed CSBs were maintaining a sense of humor, perceiving client's problems as interesting, leisure activities, utilizing case consultation, maintaining objectivity about clients, and use of solitary renewing activities (Kramen-Kahn & Hansen, 1998). Stevanovic and Rupert (2004) reported the highest rated CSBs among psychologists in their study to be very similar to those rated highly in the study by Kramen-Kahn and Hansen. The top CSBs were to maintain a sense of humor, perceive client problems as interesting, engage in leisure activities for renewal and relaxation, and seek case consultation. Rupert and Kent (2007) noted that the top three CSBs rated by the psychologists in their survey were (a) maintaining a sense of humor, (b) maintaining self-awareness, and (c) maintaining a balance between professional and personal lives. A study looking at counselor wellness found that the top five strategies endorsed by the 388 respondents were (a) maintain a sense of humor, (b) spend time with partner or family, (c) maintain balance between professional and personal life, (d) maintain self-awareness, and (e) maintain control over work responsibilities (Lawson, 2011). In comparing these four studies, it can be observed that maintaining a sense of humor was the most utilized CSB among participants in three

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different professions (psychiatry, psychology, and counseling). Perceiving a client's problem as interesting and seeking case consultation were frequently used by both psychiatrists and psychologists. Strategies of participating in peer support groups and receiving supervision—although often recommended in self-care literature—were found to be among the CSBs reported as being least important to professionals (Stevanovic & Rupert, 2004). Several studies of CSB use among psychologists have noted that participants tended to endorse a wide variety of CSBs, rather than relying primarily on one or two. In their study of CSB use among psychologists, Rupert and Kent (2007) found 17 strategies that were given mean ratings of over five (out of seven) and six strategies with ratings above six. These scores indicate that 68% of CSBs listed in the questionnaire were rated as either moderately or highly important. Rupert and Kent's observation that helping professionals find many of the career-sustaining behaviors to be important was supported by another survey of psychologists, where 76% of the behaviors received a mean score above four (Stevanovic & Rupert, 2004).

Trends in the Use of Career Sustaining Behaviors

Studies that have surveyed helping professionals on their use of CSBs have found differences related to demographic factors, including gender and years of experience. Significant differences have been identified between males and females in CSB use. Female psychologists and psychotherapists have been found to report a higher overall total score on CSBs than their male counterparts (Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Many strategies have been rated as being more important by women in these studies, showing that women are more likely to endorse these behaviors as being important to their well-being and professional health. Women have also been found to be more likely than men to use

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interpersonal or relational strategies and to identify the importance of self-awareness (Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004).

Rupert and Kent (2007) studied 595 psychologists and found seven CSBs that reached the level of statistically significant difference between genders ($p < .001$), many falling into the interpersonal strategy category. These behaviors were: (a) seek case consultation; (b) discuss work frustrations with colleagues; (c) spend time with friends; (d) maintain self-awareness; (e) maintain balance between personal and professional lives; (f) vary work responsibilities; and (g) try not to feel a sense of responsibility for client problems. Women were significantly more likely than men to rate these CSBs as important strategies. A study of psychologists found other CSBs reported more often by women to include continuing education, personal therapy, and positive self-talk (Coster & Schwebel, 1997). Taken together, the results of these studies may indicate that interpersonal strategies are more helpful or important for female helping professionals than for males.

Another factor which has been noted in the research to have a smaller effect on the use of CSBs is one's number of years of professional experience. In a study of psychotherapists, Briggs and Munley (2008) found that years of experience predicted 6.4% of the variance in use of CSBs. Kramen-Kahn and Hansen (1998) found that CSB use was weakly correlated with years of experience ($r = .19$), as well as age ($r = .13$). Although correlations in these areas were not particularly strong, even small effects on the use of CSBs in one's self-care practice may affect the professional quality of life of helping professionals over time.

Effects of Practicing Career Sustaining Behaviors

The utilization of CSBs has been shown to affect a variety of factors relating to both professional and personal domains. Those professionals who place a greater importance on CSBs

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tend to report a greater focus on occupational rewards, whereas those who view CSBs as less important report more focus on occupational hazards (Kramen-Kahn & Hansen, 1998). Likewise, Stevanovic and Rupert (2004) found that psychologists who had a higher level of professional satisfaction reported using CSBs to a greater degree. Additionally, another study found that more than half of CSBs were positively correlated with a sense of personal accomplishment, supporting the idea that CSBs help to create positivity toward one's career (Rupert & Kent, 2007). Lastly, a study examining therapists' stress and coping styles found that CSBs were positively correlated with scores on the Working Alliance Inventory, a measure of perceived alliance between therapist and client (Briggs & Munley, 2008). This seems to suggest that those therapists who reported using CSBs more often tended to have positive working alliances with their clients, even clients who were identified as stressful.

CSBs can be seen as analogous to self-care practices in many regards and have been investigated in several helping professions, including psychologists, counselors, and therapists. The endorsement and use of these behaviors have been linked to higher levels of accomplishment, satisfaction, and well-being.

Professional Quality of Life

Professional quality of life is a term to describe how one feels in relation to their work in a helping role. Helpers can be found in a range of different fields, from health care professionals to police officers and firefighters. Both the positive and negative aspects of the individual's job role influence professional quality of life. When creating a measure of professional quality of life, Stamm (2009) classified professional quality of life into two categories: positive, which consists of Compassion Satisfaction (CS), and negative, which is Compassion Fatigue (CF). Compassion Fatigue is then further separated into the aspects of Burnout (BO) and Secondary

Traumatic Stress (STS). Throughout the course of this paper, these abbreviations will be used in figures and tables. For clarity, the full terms will be used in text. Professional quality of life categories are illustrated by the figure below, created by Stamm (2009) and adapted for the purposes of clarity.

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                    ┌─────────────────────┐
                    │ Professional Quality│
                    │      of Life        │
                    └─────────────────────┘
                             │
              ┌──────────────┴──────────────┐
    ┌──────────────────┐          ┌──────────────────┐
    │   Compassion     │          │   Compassion     │
    │  Satisfaction    │          │    Fatigue       │
    └──────────────────┘          └──────────────────┘
                                           │
                               ┌───────────┴───────────┐
                      ┌─────────────┐        ┌──────────────────┐
                      │  Burnout    │        │    Secondary     │
                      │             │        │ Traumatic Stress │
                      └─────────────┘        └──────────────────┘
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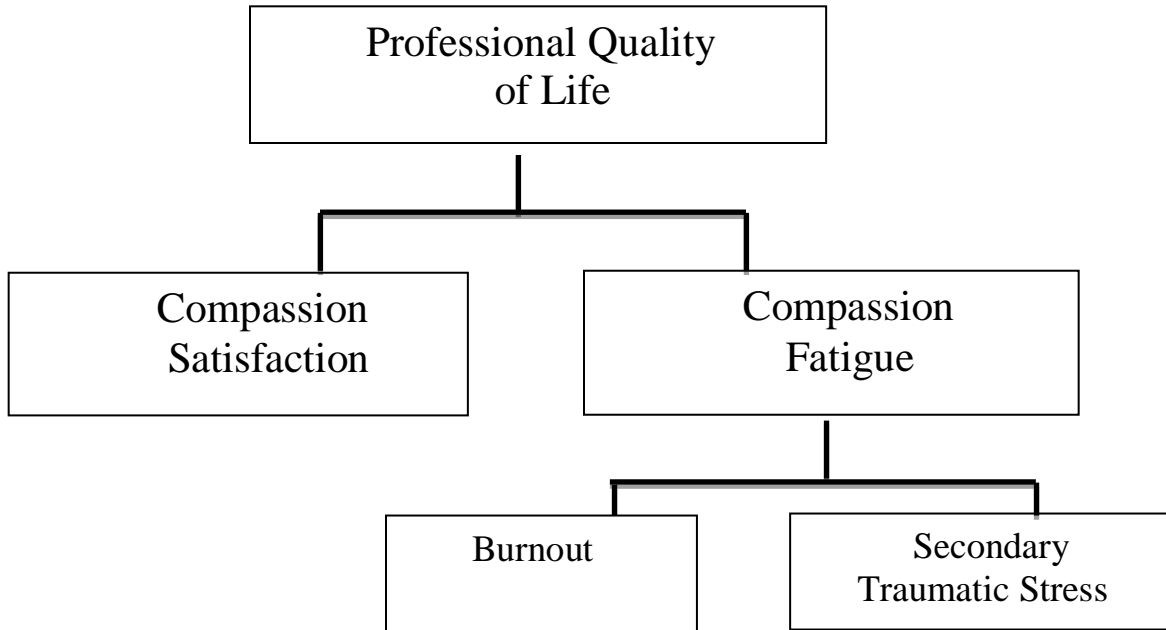
Figure 1. Professional Quality of Life categorization

To better understand the use of the ProQOL in the literature, it is important to define the terms used to quantify professional quality of life in this measure. According to Stamm (2009), compassion satisfaction is the satisfaction one derives from doing their work well, whereas compassion fatigue consists of the negative aspects of a helping profession and encompasses two categories. The first is burnout, which includes the exhaustion, anger, frustration, and depression that stems from job factors. Feelings of hopelessness and loss of motivation are common with burnout. The second factor of compassion fatigue is secondary traumatic stress, a negative feeling that stems from fear and work-related trauma. This fear arises from an exposure to people

(clients) who have experienced traumatic and stressful life events. This secondary exposure to trauma can cause problems with sleep, induce fearful thoughts and images, and impact responses to stressful events. The three subsets of the ProQOL have been studied in a number of professional fields. Although each subset can be found in other measurement tools, the ProQOL alone combines these factors when measuring professional health.

Compassion Satisfaction

While much of the literature has focused on the negative aspects of well-being, the ProQOL also includes a measure for compassion satisfaction. A sense of satisfaction from one's job and the helping of others comprise the feeling of compassion satisfaction (Stamm, 2009). According to Stamm (2009), those who have high levels of compassion satisfaction are notably happy, enjoy pleasant thoughts, are driven, and believe their work can make a difference. Feeling positively towards both colleagues and one's organization are also common in those who report high compassion satisfaction.

One of the strongest indicators of compassion satisfaction can be found in those who report seeing client change as a positive and can recognize their impact on their clients (Radey & Figley, 2007). Factors that have been shown to have a positive effect on compassion satisfaction include trauma training (Sprang, Clark, & Whitt-Woosley, 2007), sense of optimism, social resources available, positive affect, and a balance between professional and personal life (Radey & Figley, 2007). Also, those reporting higher levels of individual and organizational self-care showed greater compassion satisfaction (Jenaro, Flores, & Arias, 2007).

Compassion Fatigue

Compassion fatigue is a term that encompasses the construct of burnout, although the two terms are occasionally used synonymously. Whereas burnout relates to hopelessness, work

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problems, and feelings of insufficiency as a helper, compassion fatigue is more the result of the secondary exposure to traumatic events (Stamm, 2009). Unlike burnout, which often has a slow onset, symptoms of compassion fatigue can arise quite suddenly and are often linked to experiencing traumatic behaviors, stories, or events. And while burnout has been shown throughout the literature to be a general work-related hazard, compassion fatigue is a phenomenon isolated specifically to those professions that involve serving others (Alkema et al., 2008).

Compassion fatigue is used in the ProQOL measure as an overarching term that encompasses both factors of burnout and secondary traumatic stress. Factors that can lead to compassion fatigue include traumatic stories, stressful life events, lengthy exposure to these events, anxiety, and excessive empathy (Abendroth & Flannery, 2006; Figley, 1995; Sprang et al., 2007). Other than the stressors being indirect, compassion fatigue is quite similar in nature to post-traumatic stress disorder, and has been shown to impact individuals in much of the same manner (Bride, 2007).

Compassion fatigue levels have been studied in child protective workers (Cornille & Meyers, 1999; Dane, 2000), mental health workers (Meldrum, King, & Spooner, 2002), nurses (Abendroth & Flannery, 2006; Aycock & Boyle, 2009), social workers (Bride, 2007), trauma workers (Wee & Meyers, 2002), and psychotherapists (Brady, Guy, Poelstra, & Brokaw, 1999). Moderate to high levels of risk for compassion fatigue have been observed among 37% of child protective service workers (Cornille & Meyers, 1999), 64.7% of trauma workers (Meyers & Wee, 2002), 76.5% of counselors (Figley, 1995), 78% of hospice nurses (Abendroth & Flannery, 2006), and 86% of emergency nurses (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). The

risk of compassion fatigue has been shown to be offset by supervision, training, coping ability, and social supports (Chrestman, 1999; Follette, Polusny, & Milbeck, 1994)

Burnout. Burnout has been shown to affect clinicians through (a) lower job commitment (Bride, 2007); (b) decreased job performance (Figley, 1995); (c) low career satisfaction (Figley, 2002); and (d) stress-related health problems (Figley, 1999). DePanfilis (2006) discussed research which shows that burnout is affected by workload, social support, and isolation. Notable as well, staff members who left their jobs or reported a desire to leave had higher burnout levels (DePanfilis, 2006). Shenafelt, (2002) investigated levels of burnout in a sample of 115 medical residents. The responses to the designed questionnaire revealed that 76% of medical residents met the criteria for burnout. Residents found to be experiencing burnout were also seen providing suboptimal patient care at higher rates than residents without burnout (Shenafelt, 2002).

A study by Balogum (2002) examining burnout among physical and occupational therapists found high levels of burnout. Specifically, 58% reported being emotionally exhausted, while 94% had negative feelings regarding their work. Perhaps most revealing, only 1% of the therapists stated that they were satisfied with their personal accomplishments. While research in the area of burnout and professional impact has grown, there have been few solutions to the problem itself. Maslach and colleagues (2001) emphasized that further research should be conducted to discover and outline effective intervention strategies to prevent burnout.

Secondary traumatic stress. This factor of compassion fatigue is the negative feeling that can arise from both fear and trauma from incidents in one's work as a helping professional (Stamm, 2009). This trauma can be either primary (where an incident happens directly to the individual) or secondary (where hearing, discussing, or dealing with the trauma can cause stress).

Secondary traumatic stress consists of the latter. Helping professionals are at risk for secondary traumatic stress as the people they work with have often experienced violent or traumatic events in their lives. Negative effects of secondary traumatic stress may manifest as violent or disturbing images or dreams, difficulty with sleep, or being afraid of certain environmental triggers (Stamm, 2009). Some authors have used the term "vicarious trauma" when discussing these negative effects, which Stamm notes as being highly similar in quality. These ProQOL factors have been investigated throughout many helping professions and amongst a variety of demographics. Several factors have been found to influence the levels of these professional quality of life subscales.

Factors influencing Professional Quality of Life

The professional quality of life measure (ProQOL Scale) has been used to study the well-being of clinicians and professionals in nearly all the helping fields. Some differences have been noted across demographic categories in the ProQOL. Stamm (2009) compiled data from 1,289 studies to examine scores in the areas of gender, age, race, income, years with current employer, and years in the profession. Within these demographics, race was the only area where a statistically significant difference was observed. Burnout and secondary traumatic stress scores were significantly higher in non-whites compared to whites (Stamm, 2009).

Individual studies have found differences in several areas of the ProQOL measure. Alkema and colleagues (2008) found hospice workers to be at risk in the areas of compassion satisfaction and compassion fatigue. The study observed that age was positively correlated with burnout only, whereas years in the profession was negatively correlated with all measures. The authors suggested that those who start into the profession later in life are more susceptible to burnout and have not built up the self-care strategies of those in the field longer. Potter and

colleagues (2010) examined nurses in oncology units, finding that ProQOL measures were different with regard to education level. Nurses with associate's degrees had lower compassion satisfaction scores, those with bachelor's degrees had greater compassion fatigue, and those with advanced degrees reported the greatest levels of burnout (Potter et al., 2010).

A study of counselor self-care found significant differences between genders with regard to compassion fatigue (women reported greater levels). Significant differences in compassion fatigue were also found based on experience (less experience led to greater CF) and age (younger clinicians had greater CF) (Fereday, 2011). Sprang et al. (2007) conducted a large study investigating professional quality of life in over 1,000 mental health workers. Differences were noted in at least one of the ProQOL measures based on the following demographic variables: type of organization, licensure type, age, gender, education, and experience. Specifically, being female, younger, attaining a higher level of education, and having less experience all were associated with higher levels of burnout and compassion fatigue, while being older resulted in greater compassion satisfaction. Professional quality of life factors have not only been compared by demographics, but also with the use of self-care behaviors.

Relationships between Career Sustaining Behaviors and Professional Quality of Life

In examining self-care practices and the well-being of professionals in helping fields, several studies have used the Career Sustaining Behaviors questionnaire (CSBQ) in conjunction with the Professional Quality of Life (ProQOL) Scale. Two studies have been identified as having used these scales in a helping profession and with a large sample size. A national survey of counselors included the CSBQ, the ProQOL Version III, and some demographic questions (Lawson, 2007). Demographic profiles were ascertained through questions regarding (a) gender; (b) race; (c) age; (d) level of education; (e) professional licensing; (f) caseload variables, such as

size and work setting; (g) support, through supervision or personal counseling; (h) satisfaction; and (i) personal wellness. The levels of the fifteen CSBs most utilized by counselors were used to look more closely at ProQOL. Highest and lowest quartiles were established based upon CSB scores. Those in the highest quartile of CSB use had significantly greater compassion satisfaction and less burnout than the rest of participants. Several of the CSBs in the study that were the least endorsed (peer support groups, personal therapy, clinical supervision, relaxation activities) were behaviors that have been suggested in the literature as highly effective in promoting wellness and health (Lawson, 2007).

A more recent study of 506 professional counselors by Lawson and Myers (2011) used measures from the CSBQ and ProQOL Scale Version 5, along with the Five Factor Wellness Inventory (5F-Wel), to attempt to quantify the levels of these measures and their relationships with one another. Overall, participants in the study scored higher than the norm for wellness and compassion satisfaction and lower for burnout and compassion fatigue. The most commonly endorsed CSBs were found to be (a) spend time with family/partner; (b) maintain sense of humor; (c) maintain balance between professional and personal lives; (d) maintain self-awareness; and (e) reflect on positive experiences. Scores of wellness were significantly correlated with professional quality of life, both of which related to the reported CSBs of the participants. There were 19 CSBs rated higher by those with higher wellness and professional quality of life. From these findings, it is recommended that an emphasis be placed on CSBs to maintain professional and personal quality of life (Lawson & Myers, 2011). Before examining the music therapy self-care literature, it is important to note that music therapy, a helping profession within the healthcare field, has strong roots in music education. Looking closer at the professional well-being in the field of music education can help to inform the current study.

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Self-Care for Musicians (Music Educators and Therapists)

Burnout in Music Education

Several studies have explored burnout levels among music teachers in both secondary and post-secondary settings. Researchers have found incidences of burnout among music educators, which have been linked to the specific challenges of the work environment (i.e. administrative duties, heavy workload, and long hours), population, and training (Hamann & Gordon, 2000; Kelly, 1999; McLain, 2005). These rates of burnout could perhaps be the reason that music teachers have a slightly higher attrition rate than that of general educators (Hamann, 1990).

Hodge and colleagues (1994) found that music teachers were substantially more distressed and had greater burnout than mathematics teachers. A study by McLain of over 500 music educators teaching grades K to 12 revealed a moderate level of burnout as measured by the Maslach Burnout Inventory, with risk found particularly in the area of emotional exhaustion. However, this was balanced by high levels of personal accomplishment and few claims of depersonalization (McLain, 2005). Burnout is portrayed as a debilitating factor of a music teacher's life that "may be one of the leading causes of teacher ineffectiveness" (Hamann & Gordon, 2000, p. 34).

To help combat burnout, researchers in the field of music education have outlined several behaviors shown to be most effective to reduce stress and create a healthy balance. These behaviors include (a) professional development; (b) balance of professional and personal life; (c) exercise; (d) massage or yoga (Hamann & Gordon, 2000); (e) networking with other sufferers; (f) practicing relaxation (Hamann, 1990); and (g) time management (Hylton, 1989). As members of the helping professions, music educators (like music therapists) must develop a personal

system that reduces the effects of stress and helps to eliminate the occurrence of burnout to remain effective throughout their careers.

Another study in the music education literature investigated burnout levels of music therapy faculty members at institutions of higher education using the Maslach Burnout Inventory (Richardson-Delgado, 2006). As participants were both music therapy professionals and education faculty, this study has implications for both fields which will be discussed. Information was gained through a combination of mailed surveys and qualitative data taken from interviews, notes, and interactions. A total of 68 surveys were completed and seven interviews conducted. Music therapy faculty members were found to have significantly lower levels of burnout than the norm sample of higher education faculty. Richardson-Delgado found that older, more experienced individuals had lower emotional exhaustion, as well as overall burnout. No differences were observed between demographic variables of genders, having children, hours worked, or time in current position.

Qualitative data reported in Richardson-Delgado's study included some revelations concerning the use of different forms of self-care. Listening to music, composing and performing music, support systems, and engaging in self-awareness and contemplation were all discussed by music therapy faculty members as ways to combat burnout (Richardson-Delgado, 2006). These behaviors were reported by participants to decrease burnout symptoms. Research has shown that burnout in faculty can expose students to substandard teaching and lack of empathy, similar to the negative effects experienced by clients of helping professionals experiencing burnout (Maslach et al., 2001). Additionally, burnout experienced by music therapy faculty could affect the advancement of the music therapy profession as a whole, as the field needs strong, healthy educators to produce professionals who meet the rigorous standards of the work.

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Music Therapy Profession

According to the American Music Therapy Association (AMTA), music therapy is an evidence-based field in which a board-certified therapist uses music interventions to reach non-musical, individualized goals with clients of all ages and abilities. After assessing the needs of the individual, treatment is implemented through musical interactions such as singing, instrument play, movement to music, and music listening. Research has shown music therapy to be effective in addressing physical, cognitive, emotional, and social domains (AMTA, 2012).

Music has been described as a healing medium dating back to ancient times. While early literary references to music as therapy can be traced back to the 18th century, the field of music therapy began to form and grow during the times of WWI and WWII, with injured veterans receiving services after returning home. The establishment of the first college training programs in the 1940's, combined with a professional national organization in 1950, opened the door to an increase in education and training, and the field began to establish itself as a research-based profession in many settings (AMTA, 2012).

Music therapists work in medical, mental and behavioral health, community, nursing home, hospice, school, and private settings. In order to become a music therapist, one must complete an undergraduate degree in music therapy (or its equivalent) from an accredited university, 1,200 hours of clinical training culminating in a supervised music therapy internship, and a board-certification exam. AMTA specifies that music therapists' work requires versatility, patience, empathy, creativity and a desire to help others, all of which appear to impact one's professional well-being (AMTA 2012).

Burnout in Music Therapy

Few published articles could be found which focused on self-care in the field of music therapy. Although not specifically citing professional quality of life, much of the existing literature related to self-care for music therapists investigates burnout, a subscale of professional quality of life. As an established health profession in which music is used within a therapeutic relationship to address a variety of client goals, music therapy carries many of the same stressors and professional hazards which other healthcare professionals experience when caring for others. Common stressors identified by music therapists include (a) dealing with loss; (b) work environment; (c) difficult referrals; (d) emotional exhaustion; (e) juggling multiple roles; (f) relationships with team members; (g) feelings of professional competence; (h) disappointment with clients' responses; (i) salary; and (j) lack of opportunities for advancement (Clements-Cortes, 2006; Dileo, 2000; Ferrer, 2012; Oppenheim, 1987; Vega, 2010; West, 2009).

While these stressors have also been noted by professionals in other fields, there are some stressors that can be seen as more unique to music therapy. Lack of understanding of the field of music therapy, educating and advocating for music therapy, aspects of not feeling valued or appreciated, and economic challenges (discontinued contracts, low salaries, lack of funding) can be seen as profession-specific hazards that music therapists must cope with in their work (Clements-Cortes, 2006). The feelings of isolation that can arise when one's profession and job role are misunderstood can lead to burnout; however, working in facilities with knowledgeable staff or other music therapists may lead to increased job satisfaction (Vega, 2010).

Burnout rates for music therapists were first studied by Oppenheim (1987), who surveyed 239 music therapists and found nearly half of participants scored in the moderate range for burnout. Additionally, around 12% of therapists were found to have high levels of burnout, as measured by the Maslach Burnout Inventory. It was noted in the study that burnout levels

appeared to increase as therapists remained in the field longer. Also, salary and benefits were primary aspects of the work that led to job dissatisfaction, something that has been shown to affect career longevity and burnout (Decuir & Vega, 2010).

The burnout levels in Oppenheim's study are supported by a more recent study that examined personality, burnout, and longevity among music therapists (Vega, 2010). Results from the survey responses of 137 music therapy professionals indicated average levels of emotional exhaustion, and low levels of depersonalization and personal accomplishment. These three factors (emotional exhaustion, depersonalization, and personal accomplishment) are subsets of the Maslach Burnout Inventory (MBI) used in the study. Using the Maslach Burnout Inventory measure, Vega found that 11% of music therapists in the study scored high in burnout. Additionally, less than 1% of this sample had low levels of burnout, which may suggest that professional well-being is at risk for many music therapists.

Another finding related to burnout in Vega's study was a relationship between emotional exhaustion and years in the field. Vega also found that music therapists had greater emotional exhaustion, less depersonalization, and more sense of accomplishment than the average mental health worker. In addition, her study explored relationships between factors of burnout and personality, measured by the Sixteen Personality Factor Questionnaire. Analysis showed that anxiety, sensitivity, and tension were all predictive of emotional exhaustion, which is one factor of burnout. Vega's research recommendations included decreasing time needed for the survey and investigating whether case load is a factor in burnout. Both factors are addressed in the current study.

West (2009) investigated burnout and job satisfaction of music therapists across different work settings. A total of 116 credentialed music therapists who worked in a variety of settings

were surveyed in West's study. While no significant differences were found in burnout levels among therapists in different work settings, there were other notable findings. The study found that (a) those in the field longer have lower levels of emotional exhaustion, (b) advanced degrees did not increase job satisfaction; (c) job satisfaction was not correlated with years in the field; and (d) there are five areas music therapists most often seek for support. Specific areas were noted to provide support during difficult situations and can be seen as similar to aspects of self-care discussed in the current study. The five areas music therapists most identified in providing support were family, friends, hobbies, consulting supervisors or employers, and better time management by the therapist (West, 2009).

Self-Care in Music Therapy

Several studies have identified self-care attitudes and strategies endorsed by music therapists. Ferrer (2012) interviewed music therapy professionals to ascertain the current status and future direction of the field of music therapy. A total of 18 participants delivered comments regarding several important topics related to the professional and personal aspects of their work as a music therapist. Advice given by participants for burnout prevention included using music for self-care, having friends in music therapy, continuing education, variety in clinical practice, and seeking supervision as the most frequently endorsed behaviors. Other strategies provided during these interviews were to exercise, have outside hobbies, use family and friends for support, and seek personal therapy. One professor provided this insight into maintaining professional health:

> Burnout has never even occurred to me, even at this point in my career. My advice to young people is to do what you love to do and get somebody to pay you for it […] Avoid

the kinds of job situations that you don't enjoy and find the ones you really love. You

don't burnout when you are enjoying yourself (Ferrer, 2012, p. 91).

Participants also provided advice for young professional during the interview process,

when they were asked to name areas important for career health and burnout prevention.

Strategies named, among others, were to attend conferences, know the research, network, seek

supervision, and be creative and flexible.

Undergoing personal therapy is a recognized self-care practice for those in helping

professions (Norcross, 2000) and is an area addressed in some music therapy training programs.

Gardstrom and Jackson (2011) investigated how different modalities of personal therapy were

implemented in undergraduate education. In Gardstrom and Jackson's study, AMTA program

coordinators received a survey exploring attitudes towards verbal therapy, music therapy, and

expressive arts therapy for undergraduate students. Analysis of the 42 responses found that only

six programs (14%) required some type of personal therapy. An additional 27% stated that

personal therapy was recommended to students, with nearly three-quarters of these respondents

encouraging verbal therapy. A smaller portion noted that personal therapy was recommended,

but only if personal problems were identified. Ethical concerns, university guidelines, and course

design were some reasons noted by faculty as to why personal therapy was not encouraged.

Although there appears to be an increased emphasis on self-care in the music therapy literature

as of late, much remains to be investigated. Specifically, identifying not just specific areas of

self-care, but what comprises the whole of how music therapy professionals manage to function

effectively in their role as helping professionals.

Self-care is not only vital for professional and personal well-being; it is also an ethical

imperative in the field of music therapy. Symptoms of burnout in helping professionals such as

poor work performance, lack of emotional control, and poor interpersonal relationships can negatively affect the client care provided in music therapy sessions. The American Music Therapy Association (AMTA) code of ethics establishes that the welfare of the clients is of utmost importance, and that music therapists will use every available resource to best serve their clients. Self-care practices can be seen as a resource to better client care through professional quality of life.

Goodman (2011) discussed advanced competencies in education and training among music therapists. Using the guidelines established by the AMTA, the practice of self-care strategies is found under the aspects of personal development and professional role. Also, Goodman noted that an ethical therapist will "recognize limitations in competence and seek consultation" (Goodman, 2011, p.129). She deems personal monitoring and development necessary for one to conduct effective clinical care of clients. Dileo (2000) discussed professional self-care when exploring ethical thinking and behaviors in the music therapy field. Self-care is described as a professional necessity, even though it is stated that few music therapists may actually invest in these strategies fully. Dileo urged therapists not to avoid self-care, writing: "therapists need not feel compelled to choose between their clients and themselves. If this choice is made, the quality of therapy will undoubtedly suffer" (Dileo, 2000, p. 54).

Although music therapy researchers have looked at burnout and the quality of life of music therapy professionals, a gap exists in the literature regarding the investigation of these two factors in conjunction. It is important to fill this gap because self-care practices can help inform professional health, and vice-versa. As a helping profession, the literature has shown that music therapists are at risk for compassion fatigue and decreased compassion satisfaction. To help better understand self-care practices that combat these stressors, this study has identified CSBs as

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a means of quantifying these strategies. Professional quality of life is used to examine and measure the overall professional health of music therapy professionals. The purpose of this research study is to address the following:

1. Which career-sustaining behaviors are most commonly used by music therapy professionals and what are their levels of professional quality of life (burnout, secondary traumatic stress, and compassion satisfaction)?

2. Is there a relationship between use of career sustaining behaviors and levels of professional quality of life among music therapists?

3. Are there differences in music therapy professionals' use of career sustaining behaviors based on (a) gender, (b) age, (c) years of experience, (d) work setting, or (e) hours worked weekly?

4. In what ways and to what degree do music therapy professionals use participation in music as a career-sustaining behavior?

CHAPTER THREE

METHODOLOGY

Prior to conducting this study, an exemption for approval was received from the

University of Kentucky Institutional Review Board, Office of Research Integrity (Appendix E).

The study was determined to be exempt from Institutional Review Board approval because the

research used survey procedures where subjects could not be identified directly or through

identifiers, and disclosure of the subjects' responses provides no foreseeable risks.

Participants

A non-randomized, non-probability, total population sample of professional music

therapy members of the American Music Therapy Association (AMTA) was solicited to

participate in this study. The sample comprised the entire population of members of AMTA with

a particular set of characteristics. Due to the focus of the study and previous literature (Lawson,

2011; Stevanovic, 2004), only professional music therapists were recruited as participants.

Participants were also between the ages of 20-64 and located in the United States. As the study

was aimed at identifying the health and wellness behaviors of music therapy professionals, a

sample of these individuals was necessary to obtain the data. While this study included all

AMTA professional members, it should not be assumed that this includes all professional music

therapists in the United States, as professionals need not be AMTA members to practice.

The study was submitted to the Institutional Review Board (IRB) of the University of

Kentucky for exemption certification as the study posed no more than minimal risk, collected no

identifying information, and was in survey format. After receiving approval to conduct an

exempt study from the IRB, the principal investigator recruited participants for this study by

acquiring email addresses from the American Music Therapy Association. Email addresses were obtained using the standard AMTA Label Request Form requesting only email addresses of AMTA professional members. AMTA states: "Email addresses are provided for official AMTA business, research purposes, and special conference offers only" (Appendix F). This study met the research purposes criteria. The request form was submitted with IRB approval, per AMTA guidelines.

The email addresses were filtered by AMTA to meet the inclusion criteria noted above (music therapy professional members of AMTA ages 20-64 in the United States). Survey participation was requested through an email describing the purpose and nature of the project, and including the research survey through the REDCap data software. Study data were collected and managed using REDCap electronic data capture tools hosted at the University of Kentucky. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing: 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources. All professional members were encouraged to participate in the study to provide much needed information regarding self-care practices and professional well-being in the field of music therapy. The participants received no compensation or other incentive for their completion of the survey.

Professionals under the age of 20 or over 65 were excluded from the study. Because of the sex (89% women) and ethnicity (86% Caucasian) disparity amongst music therapy professionals, the demographics breakdown of this study were assessed to determine if it served

as a representative sample of the population, matching the AMTA membership. The terms "sex" and "ethnicity" were used in this study to maintain consistency with the categories supplied by AMTA in research. A total of 510 music therapy professionals completed the online survey. 107 people were excluded from data analyses due to any of the following criteria: (a) invalid email addresses, (b) incomplete survey resulting in non-submission, or (c) participants who were not currently practicing based upon session information provided. After elimination of these participants, the total sample size of this study was 403.

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Instrumentation

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The survey tool used in this study consisted of three different components—demographic information, career sustaining behaviors, and professional quality of life—which were utilized to collect information regarding self-care behaviors and professional wellness of music therapy professionals. These instruments were chosen due to their prevalence in the literature relevant to the focus of this study and their reliability and validity noted in the literature, which will be delineated when discussing each individual measure and their availability to the investigator. Further details of the instruments used in this study are discussed in the following section.

Demographic information

The survey began by collecting general information using a ten question demographic questionnaire designed by the researcher (Appendix B). Information was garnered regarding sex, age, ethnicity, highest level of education, professional credentials, hours worked weekly, number of individual and group sessions conducted weekly, years of experience, and work setting. The categories and response choices for these questions were based upon the AMTA 2012 Workforce Analysis, which is a survey of all members of the American Music Therapy Association. Age

ranges were adapted from AMTA's 10 year groupings (e.g. 20-29 years). With the exception of the 60-64 year age group, age range options were given in five year increments rather than ten, thus allowing for more detailed analysis. The 60-64 year age group was used in order to eliminate the option for participation by ages 65 and older due to study parameters. Individuals who are 65 and older can be classified as of retirement age. As such, they were excluded due to this additional uncontrolled variable. Age response for younger than twenty was not an option as it was assumed that professional music therapists would be over the age of 19 after factoring in schooling and internship requirements. Whereas age was a research focus, the principal investigator designed the survey to ask only for age ranges, helping to eliminate the possibility of indentifying participant's due to disclosure of their exact age.

The ranges for the question regarding hours worked weekly were also based upon AMTA research; however, an additional category of 30-34 hours was added to better delineate part-time and full-time clinicians. Analysis by the standard 10 hour range can still be achieved by combining two ranges, allowing for further comparison for the purposes of the study. Years of experience and work setting (including sub-settings) were also based upon AMTA groupings.

Career Sustaining Behaviors Questionnaire (CSBQ)

The CSBQ assesses the specific strategies participants use to function effectively and maintain a healthy professional role in their careers. The original questionnaire developed by Brodie was 17 pages in length. This was adapted into a 33 question version, which used a seven-point Likert-type scale and different anchors for each question (Scholnik, 1984). Kramen-Kahn and Hansen (1998) then modified that version into a 22 item revised questionnaire, the CSBQ-R. In a more recent study of psychologists, a version of the CSBQ was adopted and edited from

Kramen-Kahn and Hansen (1998) and Coster and Schwebel (1997) into a new list of 34 career-sustaining behaviors (Stevanovic, 2004). This 34 question form of the CSBQ was used in correlation with the ProQOL III by Lawson and Myers (2011). Internal consistency reliability coefficients for the CSBQ have been measured in its various versions at .78 (Scholnik, 1984), .71 (Kramen-Kahn & Hansen, 1998), and .89 (Lawson & Myers, 2011). As the highest Cronbach alpha was achieved in the study of career-sustaining behaviors by Lawson and Myers (2011), the CSBQ utilized in that study served as the basis for this research project. For the purposes of this study, as to eliminate confusion in different forms of this measure, the assessment tool to investigate career sustaining behaviors will be termed the "modified CSBQ."

There are 36 items in the modified CSBQ measure used for this study. Five items in the CSBQ were modified, deleted, and added for the purpose of this study aimed at behaviors among music therapy professionals. A question regarding the behavior of seeking case consultation was excluded from the study due to its lack of relevance to the practice of music therapy. Three questions were added to the measure, all regarding the use of music as a career sustaining behavior. The researcher felt that, due to the nature of the work and medium used in the profession, it was important to identify how professionals used music in their self-care practices. The three behaviors added to the CSBQ for use in this study were:

1. Active music participation outside of music therapy (playing, composing, etc.)

2. Passive music participation outside of music therapy (listening, relaxation, etc.)

3. Participate in personal music therapy sessions

Responses to items in the modified CSBQ were all based upon a seven-point Likert-type scale, which is the standard in the literature that has used this questionnaire. Anchors were not well-defined in previous studies so the researcher assigned them terms to align similarly to the

ProQOL measure. Previous studies had used both "how important" and "how important/likely" to assess the behaviors listed in the questionnaire. The decision was made to use the phrase "how likely," as it appeared to best capture behaviors, as opposed to feelings or attitudes. Anchors for the Likert-type scale were set as follows: 1 = Not Likely, 4 = Somewhat Likely, and 7 = Very Likely.

As no standard instruction prompt has been established for this measure, the researcher combined aspects of previous studies to best fit the current topic. The instructions to participants were as follows: "For the following professional behaviors, please rate how likely you are to practice each in helping you to function effectively and maintain a positive attitude. Select the number that best represents how likely you are to practice each behavior" (Appendix C). Responses to the modified CSBQ were made through single-choice checkboxes using the REDCap survey software utilized through the University of Kentucky. Scoring of the modified CSBQ relies upon mean numerical ratings of each behavior. As no subscales exist, the scores are simply the raw numerical ratings taken from the Likert-type scale. These scores can be compared to previous studies in other fields and with other professionals. Often, these mean scores are ranked to provide the most and least utilized behaviors identified by the study.

Professional Quality of Life Scale V (ProQOL)

The ProQOL measure is the most common tool used to examine the well-being of those in professional roles in which they work with people who have experienced extreme stress or trauma. The ProQOL has three subscale measurements: compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS). The latter two factors are subsets of compassion fatigue (CF). There are 30 items in this measure, with 10 in each subscale, all based upon a five-

point Likert-type scale. Anchors for the scale are as follows: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often. In the ProQOL, participants report information regarding their professional well-being within the last 30 days (Stamm, 2009).

There is good construct validity for the ProQOL, with over 200 articles published utilizing this measure. Nearly half (46%) of all research literature in the database of Published Literature in Posttraumatic Stress Disorder used a version of the ProQOL in their study (Stamm, 2010). The three scales of the ProQOL—CS, BO, STS—are separate and distinct measures. Higher scores on the CS subset indicate that one is more satisfied with their ability to provide care in their work environment. Higher scores on the STS subset indicate a greater risk for secondary traumatic stress. Scoring higher on the BO subset indicates a risk of experiencing burnout symptoms. Reliability scores are .72 for burnout, .80 for compassion fatigue, and .87 for compassion satisfaction, which shows an adequate level of internal consistency in the measures (Sprang, 2007).

A minor modification was made to the wording of original scale of the ProQOL for this study. As per the ProQOL administering instructions, the term *helper* was replaced with music therapist where applicable to better describe the appropriate target group. The standard instruction prompt for the measure was used in this study, and term *helper* was changed to music therapist where appropriate in the instructions. The instructions read as follows: "When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a music therapist. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*" (Stamm, 2009). Responses to the

ProQOL measure were made through single-choice checkboxes using the REDCap survey software utilized through the University of Kentucky.

There are three steps to scoring the ProQOL V. First, some items are reversed. Second, items are summed by subscale. Lastly, these raw scores are converted to a t-score. A detailed method of the scoring, as described in the ProQOL Manual (Stamm, 2009), can be found in the Appendices (Appendix D).

Procedure

The researcher obtained from AMTA the e-mail addresses for all professional members between the ages of 20 and 64 ($N = 1,469$) A cover letter was included as the initial page of the online survey and explained the nature of the survey, the instructions for survey participation, and terms of consent (See Appendix). Participants completed the survey by completing a demographic section, the modified CSBQ, and the ProQOL Scale Version 5. Whereas participants were allowed to skip questions, completion and submission of the survey was necessary for the data to be used for analysis. Surveys were classified into three categories: complete, partial, and unsubmitted. Partial surveys were submitted through RedCAP, but had question(s) that were unanswered. Unsubmitted surveys were ones that were not completed and submitted online. Completion and submission indicated consent for this study. For these reasons, surveys in the unsubmitted survey were excluded from data analysis to allow for participant withdrawal. Upon closure of the survey tool, there were a total of 403 completed surveys and 107 incomplete surveys. The survey ended with a statement of appreciation for participation in the study.

The REDCap survey tool was published online for a period of four weeks after the initial e-mail was sent to AMTA professional members. Two weeks after the initial e-mail, the

principal investigator sent a reminder e-mail to all potential participants, thanking those who had participated and reminding others that the survey would close after two more weeks. After the end of the four week period the survey was closed and no further responses were accepted into the database.

All surveys were submitted through REDCap using a non-identifying format. Data was compiled through the REDCap survey software, which was password protected and accessible only to the principal investigator.

<div align="center">

Data Analysis

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All statistical analyses were conducted using Statistics Program for the Social Sciences Version 21 (SPSS 21). Data were analyzed using descriptive measures of means, standard deviations, ranges, and percentages. A variety of statistical tests were used to analyze the data as well, including t-tests, chi-square tests, Spearman rho correlations, and One-Way Analysis of Variance (ANOVA). An alpha level of $p < .05$ was set as the threshold for statistical significance in each analysis conducted. Due to several tests being run simultaneously on a single data set, Bonferroni corrections were applied for Research Question 3, $p = .01$ ($p = .05/5$ independent variables = .01). Demographic variables were conveyed through descriptive statistics, as well as used in statistical analysis for their relation to both CSBs and ProQOL measures. The necessary descriptive statistics were conducted to maintain the certainty that data were normally distributed and not irregularly skewed. Data will be stored for a minimum of six years on password-protected files on the principal investigator's password-protected personal computer. After this period, data will be deleted from these files and permanently erased.

CHAPTER FOUR

RESULTS

In this study, the career sustaining behaviors and professional quality of life of professional members of the American Music Therapy Association were examined. Descriptive statistics were computed for all demographic variables in the survey tool and for scores on the modified CSBQ and ProQOL Scale Version 5. Preliminary analysis was conducted on all data to confirm it appropriate to continue with further statistical testing. The survey was sent to 1,496 individuals identified as professional members of the American Music Therapy Association. After the four week response period ended, a total of $N = 403$ individuals participated and submitted a completed survey, for a 27% response rate.

Sample Description

As previously noted in the discussion of participants, 510 individuals participate in the online survey through RedCAP. Informed consent for the study was outlined in the survey cover letter as completing and submitting the online survey. For this reason, 107 individual responses were excluded from the study for one or both of the following criteria: (a) a blank survey response or (b) a partial survey response that was not submitted. The remaining responses of 403 participants were included for data analysis in this study.

Of these participants, 92.7% were female ($n = 370$) and 7.3% were male ($n = 28$). A chi-square test for variance was conducted to compare these results to the American Music Therapy Association (AMTA) workforce breakdown, which lists a gender makeup of 89% female and 11% male among over 1,600 members. The results showed that this sample of music therapy

professionals did not significantly differ from the population, $X^2 = 0.82$, $p = .36$. Participants ranged from 20-64 years of age, with five individuals failing to provide an age range. The largest number of participants were between the ages of 25-29, accounting for 22.9% of all responses. The majority of participants (54.5%) were under the age of 40. See Figure 2 for the entire composition of age in this study.
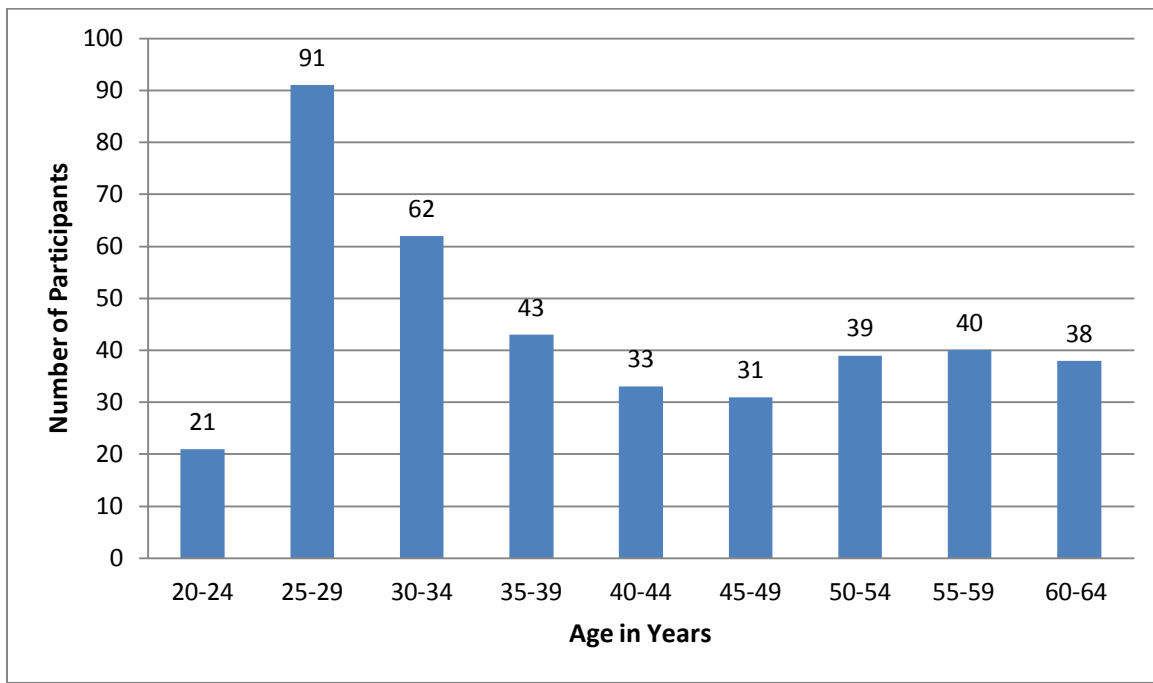

Figure 2. Ages of participants.

The majority of participants in the study were Caucasian (92.4%), with the remainder defining themselves as Asian (2.5%), Hispanic/Latino (2%), African American (1.8%), and Other (1.3%). The large percentage of Caucasian participants was anticipated and parallels the 87.9% found in the AMTA workforce analysis. Due to the small sample of participants from other races, statistical tests of correlation were not conducted between the modified CSBQ or ProQOL Scale Version 5.
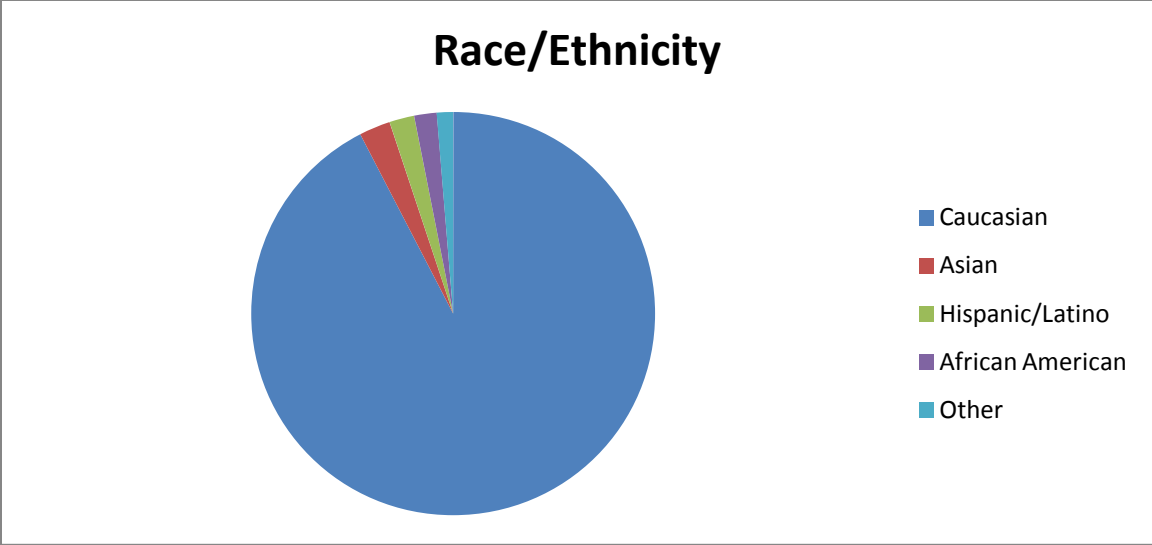
Race/Ethnicity

Legend:
- Caucasian
- Asian
- Hispanic/Latino
- African American
- Other

Figure 3. Race/ethnicity of participants

Nearly half of all participants (49.3%, *n* = 197) reported holding a master's degree. Another 44.8% (*n* = 179) had bachelor's degrees, with the remaining 6% (*n* = 24) of individuals reporting having doctoral degrees. The percentage of individuals with master's degrees in this study was much higher than the AMTA workforce analysis (38%). However, that analysis included students who had no college degree accounting for 10% of the sample. As this study included only professionals, results could be assumed to vary with regards to education.
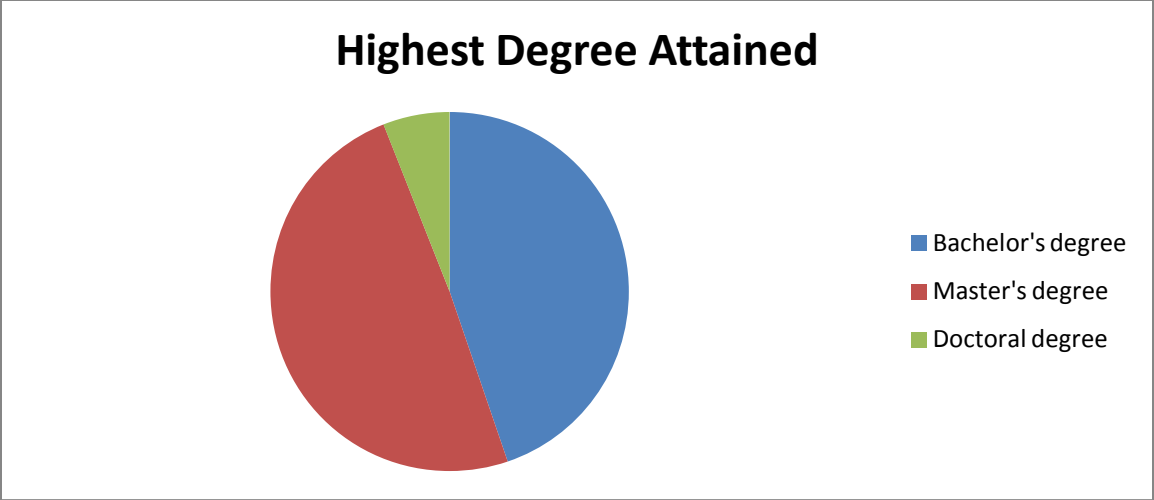
Highest Degree Attained

- Bachelor's degree
- Master's degree
- Doctoral degree

Figure 4. Highest education degree attained by participants

In terms of professional credentials, the overwhelming majority of respondents (93.7%, *n* = 374) were board-certified music therapists and held the MT-BC credential. Other credentials held included RMT (3.8%, *n* = 15), CMT (1.8%, *n* = 7), and Other (0.8%, *n* = 3).

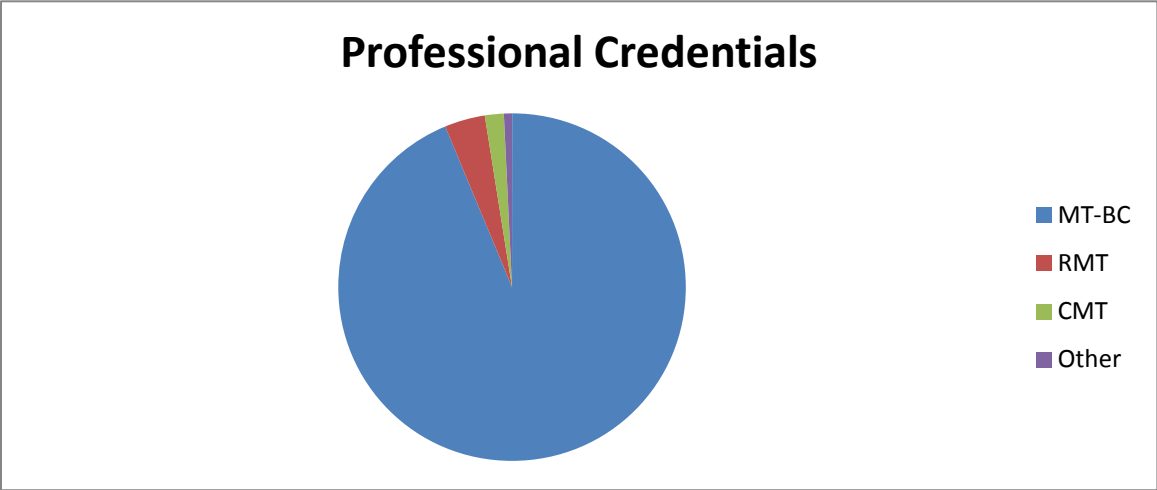**Professional Credentials**

- MT-BC
- RMT
- CMT
- Other

Figure 5. Professional music therapy credentials.

A total of 64% ($n = 296$) of individuals reported working full-time (34+ hours per week). Nearly one quarter (23.2%) reported working over 40 hours per week. See Figure 6 for frequency description of hours worked weekly.
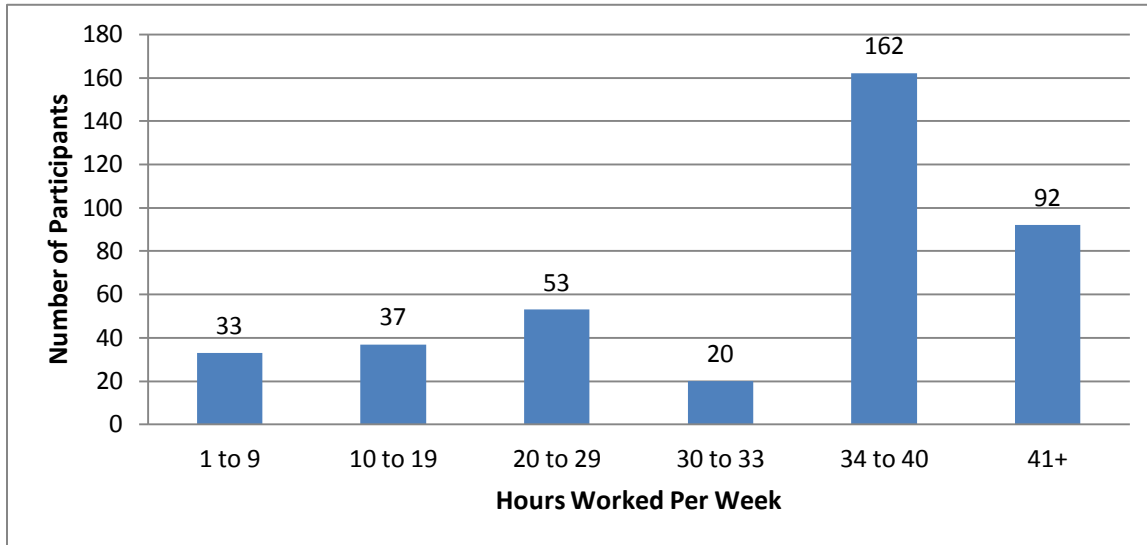

Figure 6. Hours worked per week

Study participants reported the number of both individual and group music therapy sessions they conduct weekly. There was a wide range for both questions, with the number of individual sessions varying from 0-50 per week and group sessions from 0-51 per week. The average number of sessions conducted weekly was 9.71 individual session and 6.49 group sessions. It is worth noting that 16.9% ($n = 66$) of participants reported conducting zero individual sessions per week, while nearly one quarter (22.3%, $n = 88$) had no group sessions weekly. See Figure 7 for a detailed description of music therapy sessions conducted weekly.
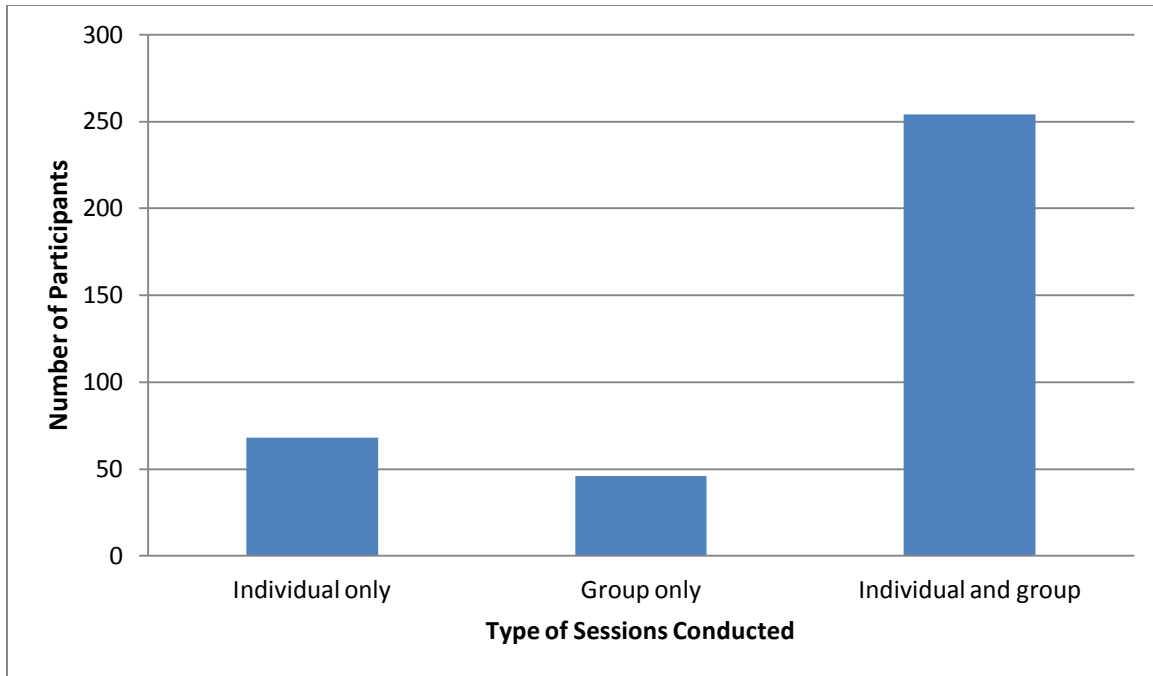
Figure 7. Music therapy sessions conducted by participants

Other demographic information gathered sought to capture experience in the music

therapy profession. Years of experience was presented in five year ranges. The most common

experience range of participants was zero to five years (29.2%, *n* = 117). Those with the least (0-

5 years) and most (21+ years) experience combined to make up the majority of responses. Also,

over half (51.4%) of participants reported having ten or fewer years of experience. For a

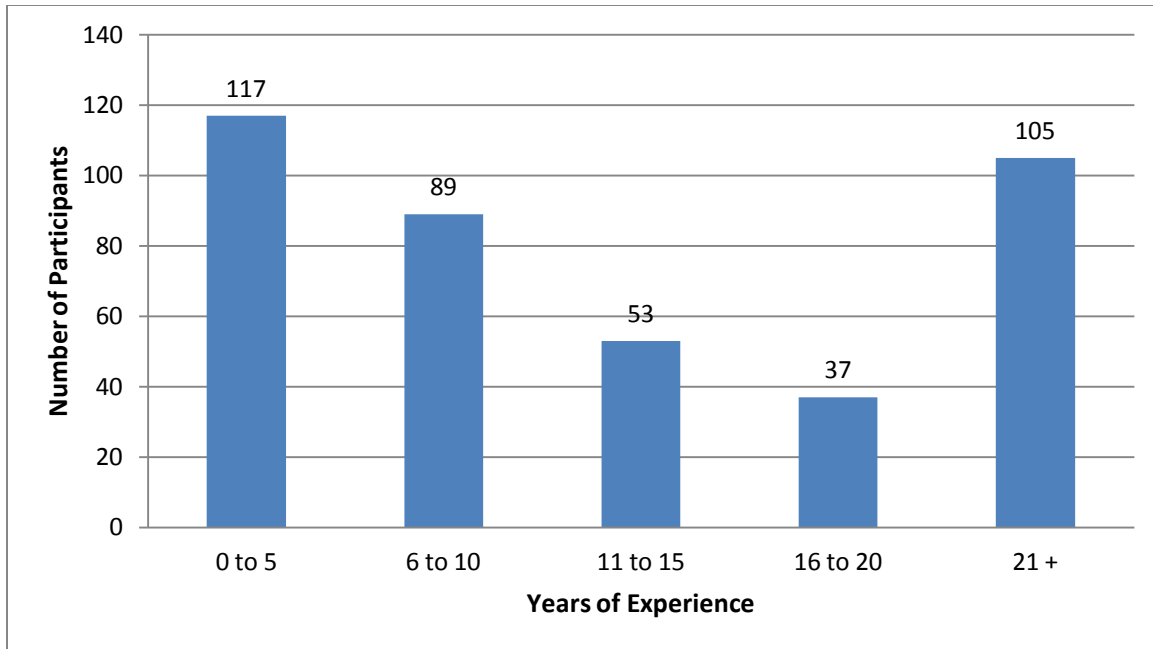complete description of experience see Figure 8.

Figure 8. Years of experience

Lastly, demographic information was obtained on the work setting(s) where participants provided services. The work setting options were taken from the AMTA workforce study and included: (a) children's facilities/schools, (b) geriatric facilities, (c) mental health setting, (d) medical setting, (e) self-employed/private practice, and (f) other. Descriptions were provided to clarify each setting. Self-employed/private practice was the most common work setting of this sample (36.2%, $n = 146$). This is much greater than the AMTA workforce description, which reported only 9% of members working in private practice. Possible reasons for this disparity will be discussed. "Other" comprised nearly one quarter of responses; however, this is less than the AMTA workforce analysis (36%). See Figure 9 below for a detailed description of work settings of music therapy professionals in this study.
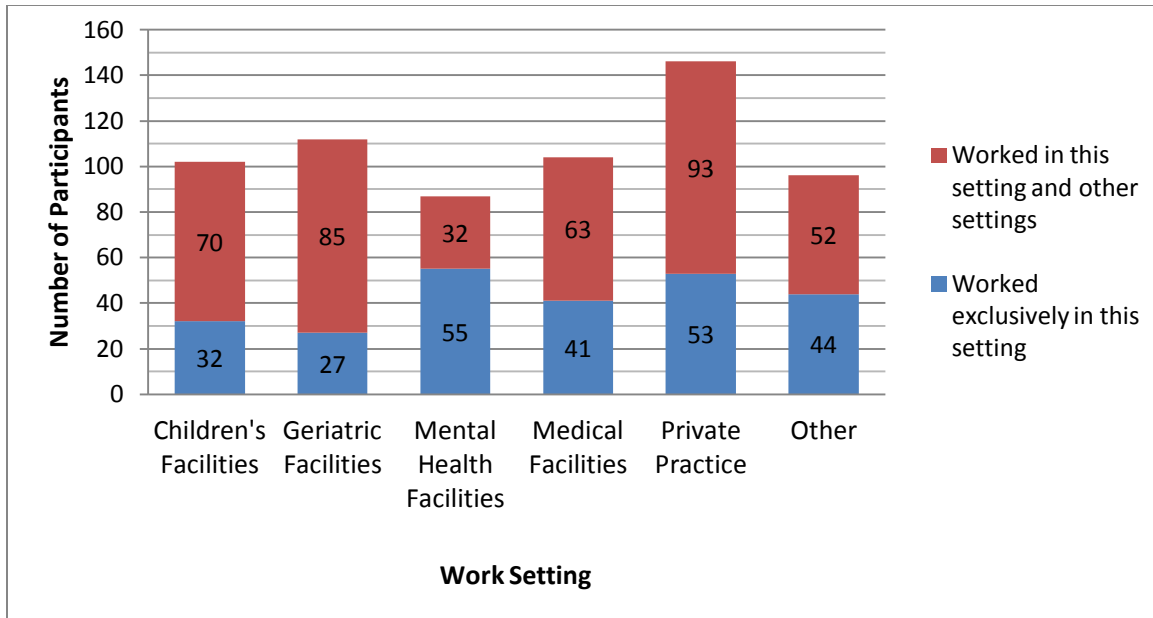
Figure 9. Work settings of participants

Note. Participants were allowed to select multiple work settings from the options above. The red bars account for music therapy professionals who worked in several different work settings in their current practice, therefore the total number of responses in the above table is greater than the number of participants.

Research Question 1

To investigate the career sustaining behaviors and levels of professional quality of life (burnout, compassion fatigue, and compassion satisfaction) of music therapy professionals

Descriptive statistics were produced for preliminary analysis of scores on the modified CSBQ and ProQOL V in this study. The CSBQ scores represented the participants' ratings of how likely they are to participate in each behavior. Higher mean scores indicate a greater reported use of that behavior. Table 1 provides a full description of the five most utilized career sustaining behaviors. Table 2 provides a description of the five least utilized career sustaining behaviors. See Appendix H for complete scored data for all CSBs measured.

Table 1

Highest Rated CSBs

	Mean	Median	Mode	*SD*
1. Maintain sense of humor	6.30	7.00	7.00	0.94
2. Spend time with partner/family	6.24	7.00	7.00	1.26
3. Maintain self-awareness	5.90	6.00	7.00	1.29
4. Reflect on positive experiences	5.81	6.00	7.00	1.13
5. Maintain professional identity	5.81	6.00	7.00	1.29

Note. Behaviors were rated on a seven point Likert-type scale. Items' scale, 1 = *Not Likely*, 4 = *Somewhat Likely*, 7 = *Very Likely*.

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Table 2

Lowest Rated CSBs

	Mean	Median	Mode	*SD*
1. Participate in personal music therapy sessions	1.85	1.00	1.00	1.40
2. Use substances to relax	1.93	1.00	1.00	1.41
3. Participate in peer support groups	2.95	2.00	1.00	1.83
4. Participate in personal therapy	3.14	3.00	1.00	2.01
5. Receive regular clinical supervision	3.32	3.00	2.00	1.92

Note. Behaviors were rated on a seven point Likert-type scale. Items' scale, 1 = *Not Likely*, 4 = *Somewhat Likely*, 7 = *Very Likely*.

The second self-care measure of professional quality of life was obtained using the ProQOL Scale Version 5. Table 3 shows the mean, minimum, and maximum scores for the ProQOL, as well as the standard deviations. Due to some incomplete or invalid responses on the ProQOL V Scale, the mean scores were based upon $n = 376$ for CS and STS, and $n = 385$ for BO.

Table 3

ProQOL Sum Scores

	Mean	Minimum	Maximum	*SD*	*n*
CS	42.46	27.00	50.00	4.89	376
BO	23.20	13.00	39.00	5.12	385
STS	17.90	10.00	34.00	4.43	376

For the purpose of further statistical analysis and scoring, conversion from sum scores to t-scores is recommended (Stamm, 2009). This was done by converting raw scores to z-scores, then converting these z-scores to t-scores using SPSS 21. As noted in the scoring protocol, the mean and standard deviation for this study were appropriate at 50 and 10, respectively. See Table 4 for a complete description of these scores. These scores will be discussed further in the bivariate correlations with the demographic survey and modified CSBQ.

Table 4

ProQOL T Scores

	Mean	Minimum	Maximum	*SD*
CS	50.00	18.37	65.43	10.00
BO	50.00	30.08	80.79	10.00
STS	50.00	32.18	86.31	10.00

Research Question 2

To investigate the relationship between professional quality of life and career sustaining

behaviors amongst music therapists

Initially, a Spearman's rho correlation test was conducted between the three subscales of

the ProQOL V Scale: burnout (BO), secondary traumatic stress (STS), and compassion

satisfaction (CS). Results were analyzed to look at the relationship amongst these three variables.

Table 5 displays the relation amongst these three subscales.

Table 5

ProQOL Subscale Correlations

	BO Score	CS Score
STS Score	.48	-.23
CS Score	-.62	--

Next, a series of Spearman's rho correlations were conducted to assess the relationship

between ProQOL subscale scores and the modified CSBQ data. See Table 6 for a detailed

description of correlation strengths between all 36 behaviors in the modified CSBQ and the three

professional quality of life subscales of Compassion Satisfaction (CS), Burnout (BO), and

Secondary Traumatic Stress (STS).

Table 6

ProQOL and CSB Correlations

	STS_Tscore	BO_Tscore	CS_Tscore
Maintain a sense of humor	-.14	-.22	**.33**
Spend time with partner/family	-.09	-.21	.13
Maintain balance...	-.29	**-.38**	.23
Maintain self-awareness	-.19	**-.38**	**.30**
Maintain sense of control over work...	**-.33**	**-.48**	**.39**
Reflect on positive experiences	-.14	**-.46**	**.52***
Try to maintain objectivity about clients	-.26	**-.39**	**.42**
Engage in quiet leisure activities	-.16	-.23	.19
Maintain professional identity	-.25	**-.37**	**.38**
Participate in continuing education	-.12	-.29	**.31**
Engage in physical activities	-.02	-.16	.16
Spend time with friends	-.02	-.22	.18
Not feel sense of responsibility...	-.27	**-.33**	.24
Put aside thoughts of the clients...	**-.31**	-.29	.17
Use positive self-talk	-.10	**-.34**	**.43**
Take regular vacations	-.17	**-.34**	**.32**
Spend time alone in self-reflection	-.02	-.29	**.30**
Turn to spiritual beliefs	-.03	-.29	.28
Maintain professional distance...	-.15	-.25	.28
Seek consultation	.06	-.14	.19
Read literature to keep current	-.09	-.29	**.33**
Discuss work frustrations with colleagues	.05	-.02	.18
Vary work responsibilities	-.12	-.29	**.30**
Limit time spent with clients	-.00	-.12	.13
Perceive clients problems as interesting	.07	-.17	.26
Take breaks between sessions	-.07	-.23	.17
Discuss work frustrations with	.06	.02	.12
Engage in formal relaxation exercises	.03	-.17	.14
Receive regular clinical supervision	.08	-.05	.09
Participate in personal therapy	.22	.05	-.03
Participate in peer support groups	.10	-.08	.08
Discuss work frustrations with friends	.16	.12	.08
Use substances to relax	.20	.23	-.05

Note. **Bold** = moderate correlation; * = strong correlation

Research Question 3

To investigate whether career sustaining behaviors of music therapy professionals differ based on (a) gender, (b) age, (c) years of experience, (d) work setting, or (e) hours worked weekly.

Gender

A series of 33 one-way ANOVAs were used to test for differences in career sustaining behaviors based on gender. Post-hoc analysis was not necessary due to the existence of only two variables (male and female). Results of ANOVAs for use of career-sustaining behaviors based on gender are shown in Table 7.

Table 7

ANOVA Results for use of Career-Sustaining Behaviors by Gender

	df	Mean Square	F	Sig.
Maintain a sense of humor	1	2.09	2.35	.13
Spend time with partner/family	1	0.04	0.02	.88
Maintain balance between professional and personal lives	1	1.80	0.98	.32
Maintain self-awareness	1	1.28	0.94	.33
Maintain sense of control over work responsibilities	1	0.60	0.37	.54
Reflect on positive experiences	1	5.08	3.97	.05
Try to maintain objectivity about clients	1	2.53	2.04	.15
Engage in quiet leisure activities	1	5.01	2.26	.13
Maintain professional identity	1	0.01	0.01	.94
Participate in continuing education	1	13.69	8.38	**.00**
Engage in physical activities	1	0.01	0.00	.96
Spend time with friends	1	0.00	0.00	.99
Not feel sense of responsibility for clients problems	1	2.33	1.01	.32
Put aside thoughts of the clients outside of work	1	3.23	1.28	.26
Use positive self-talk	1	0.62	0.26	.61
Take regular vacations	1	1.04	0.31	.58
Spend time alone in self-reflection	1	0.25	0.10	.76
Turn to spiritual beliefs	1	21.78	6.24	.01
Maintain professional distance from clients	1	3.01	2.00	.16
Seek consultation	1	6.63	2.27	.13
Read literature to keep current	1	16.92	7.40	**.01**

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Discuss work frustrations with colleagues	1	7.48	3.31	.07
Vary work responsibilities	1	1.82	0.67	.41
Limit time spent with clients	1	3.82	1.26	.26
Perceive clients problems as interesting	1	2.93	1.32	.25
Take breaks between sessions	1	0.02	0.01	.94
Discuss work frustrations with spouse/partner/family	1	6.22	2.11	.15
Engage in formal relaxation exercises	1	3.73	1.09	.30
Receive regular clinical supervision	1	0.12	0.03	.86
Participate in personal therapy	1	0.10	0.03	.87
Participate in peer support groups	1	0.08	0.02	.88
Discuss work frustrations with friends	1	16.49	4.92	.03
Use substances to relax	1	3.05	1.53	.22

Note. **Bold** indicates significance at $p = .01$

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "participate in continuing education" based on gender, $F(4, 397) = 8.38$, $p = .004$, $\eta_p^2 = .021$. Women were significantly more likely ($M = 5.85$, $SD = 1.27$) to use "participate in continuing education" then men ($M = 5.14$, $SD = 1.43$) in this study.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "read literature to keep current" based on gender, $F(4, 395) = 7.40$, $p = .007$, $\eta_p^2 = .018$. Women were significantly more likely ($M = 4.90$, $SD = 1.51$) to use "read literature to keep current" then men ($M = 4.10$, $SD = 1.59$) in this study. No other significant difference between gender were found in the use of career sustaining behaviors.

Age

A series of 33 one-way ANOVAs were used to test for differences in career sustaining behaviors based on age (20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49

years, 50-54 years, 55-59 years, or 60-64 years). Results of ANOVAs for use of career-sustaining behaviors based on age are shown in Table 8.

Table 8

ANOVA Results for Use of Career-Sustaining Behaviors by Age

	df	Mean Square	F	Sig.
Maintain a sense of humor	8	0.57	0.64	.75
Spend time with partner/family	8	0.76	0.47	.88
Maintain balance between professional and personal lives	8	2.12	1.15	.33
Maintain self-awareness	8	3.19	2.39	.02
Maintain sense of control over work responsibilities	8	4.48	2.81	**.01**
Reflect on positive experiences	8	3.50	2.80	**.01**
Try to maintain objectivity about clients	8	3.95	3.34	**.00**
Engage in quiet leisure activities	8	2.93	1.32	.23
Maintain professional identity	8	5.46	3.95	**.00**
Participate in continuing education	8	3.03	1.86	.07
Engage in physical activities	8	2.16	0.91	.51
Spend time with friends	8	3.49	1.58	.13
Not feel sense of responsibility for clients problems	8	9.27	4.29	**.00**
Put aside thoughts of the clients outside of work	8	9.73	4.10	**.00**
Use positive self-talk	8	6.96	3.12	**.00**
Take regular vacations	8	12.02	3.83	**.00**
Spend time alone in self-reflection	8	9.52	3.80	**.00**
Turn to spiritual beliefs	8	7.16	2.07	.04
Maintain professional distance from clients	8	0.71	0.47	.88
Seek consultation	8	1.29	0.43	.90
Read literature to keep current	8	7.06	3.18	**.00**
Discuss work frustrations with colleagues	8	2.46	1.09	.37
Vary work responsibilities	8	3.80	1.42	.19
Limit time spent with clients	8	5.65	1.89	.06
Perceive clients problems as interesting	8	4.80	2.20	.03
Take breaks between sessions	8	2.64	0.94	.49
Discuss work frustrations with spouse/partner/family	8	3.66	1.24	.27
Engage in formal relaxation exercises	8	13.10	4.07	**.00**
Receive regular clinical supervision	8	3.35	0.90	.52
Participate in personal therapy	8	0.93	0.23	.99

Participate in peer support groups	8	2.27	0.67	.72
Discuss work frustrations with friends	8	0.54	0.16	.10
Use substances to relax	8	3.78	1.93	.06

Note. **Bold** indicates significance at $p = .01$

Although significant main effects were found for several behaviors (maintain sense of control over work responsibilities, try to maintain objectivity about clients, maintain professional identity, use positive self-talk, take regular vacation) based on participants' age, Tamhane post-hoc comparisons indicated no significant differences ($p > .01$) in the use of these career-sustaining behaviors based on age when the Bonferroni correction was applied.

A significant difference was found in "reflect on positive experiences" based on age, $F (4, 396) = 2.80$, $p = .005$, $\eta_p^2 = .055$. Tamhane post-hoc comparisons indicated a significant difference ($p = .003$) between participants age 60-64 years ($M = 6.26$, $SD = 0.89$) and those age 25-29 years ($M = 5.45$, $SD = 1.30$).

A significant difference was found in "not feel a sense of responsibility for client's problems" based on age, $F (4, 393) = 4.29$, $p < .001$, $\eta_p^2 = .082$. Tamhane post-hoc comparisons indicated a significant difference ($p = .005$) between participants age 60-64 years ($M = 5.89$, $SD = 1.22$) and those age 25-29 years ($M = 4.82$, $SD = 1.70$). A significant difference ($p = .009$) was also found between those age 35-39 years ($M = 5.79$, $SD = 1.21$) and those age 25-29 years.

A significant difference was found in "put aside thoughts of clients outside of work" based on age, $F (4, 393) = 4.10$, $p < .001$, $\eta_p^2 = .078$. Tamhane post-hoc comparisons indicated a significant difference ($p = .002$) between participants age 50-54 years ($M = 5.44$, $SD = 1.17$) and those age 25-29 years ($M = 4.36$, $SD = 1.69$).

A significant difference was found in "spend time alone in self-reflection" based on age, $F(4, 394) = 3.80$, $p < .001$. $\eta_p^2 = .073$. Tamhane post-hoc comparisons indicated a significant difference ($p = .005$) between participants age 60-64 years ($M = 5.76$, $SD = 1.44$) and those age 25-29 years ($M = 4.58$, $SD = 1.62$). A significant difference ($p = .001$) was also found between participants age 60-64 and those age 30-34 ($M = 4.37$, $SD = 1.53$).

A significant difference was found in "read literature to keep current" based on age, $F(4, 395) = 3.18$, $p = .002$, $\eta_p^2 = .062$. Tamhane post-hoc comparisons for the nine categories of age indicated a significant difference ($p = .008$) between participants age 55-59 years ($M = 5.48$, $SD = 1.36$) and those age 30-34 years ($M = 4.31$, $SD = 1.69$).

A significant difference was found in "engage in formal relaxation exercise" based on age, $F(4, 394) = 4.07$, $p < .001$, $\eta_p^2 = .078$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants age 55-59 years ($M = 4.93$, $SD = 1.64$) and those age 25-29 years ($M = 3.35$, $SD = 1.59$). A significant difference ($p < .001$) was also found between participants age 55-59 and those age 30-34 ($M = 3.24$, $SD = 1.74$). Lastly, a significant difference $(p = .009)$ was also found between participants age 55-59 and those age 35-39 ($M = 3.42$, $SD = 1.75$).

Years of Experience

A series of 33 one-way ANOVAs were used to test for differences in career sustaining behaviors based on years of experience in music therapy practice (0-5 years, 6-10 years, 11-15 years, 16-20 years, or 21+ years). Results of ANOVAs for use of career-sustaining behaviors based on years of experience are shown in Table 9.

Table 9

ANOVA Results for Use of Career-Sustaining Behaviors by Years of Experience

	df	Mean Square	*F*	Sig.
Maintain a sense of humor	4	1.18	1.33	.26
Spend time with partner/family	4	0.92	0.58	.68
Maintain balance between professional and personal lives	4	0.67	0.36	.83
Maintain self-awareness	4	7.46	5.69	**.00**
Maintain sense of control over work responsibilities	4	4.68	2.88	.02
Reflect on positive experiences	4	6.37	5.13	**.00**
Try to maintain objectivity about clients	4	6.84	5.78	**.00**
Engage in quiet leisure activities	4	4.62	2.10	.08
Maintain professional identity	4	8.91	6.42	**.00**
Participate in continuing education	4	4.36	2.67	.03
Engage in physical activities	4	3.10	1.28	.28
Spend time with friends	4	4.85	2.20	.07
Not feel sense of responsibility for clients problems	4	10.17	4.59	**.00**
Put aside thoughts of the clients outside of work	4	16.11	6.75	**.00**
Use positive self-talk	4	8.98	3.91	**.00**
Take regular vacations	4	24.93	7.98	**.00**
Spend time alone in self-reflection	4	9.55	3.68	**.01**
Turn to spiritual beliefs	4	23.65	7.10	**.00**
Maintain professional distance from clients	4	1.34	0.89	.50
Seek consultation	4	3.67	1.26	.29
Read literature to keep current	4	8.50	3.76	**.01**
Discuss work frustrations with colleagues	4	2.09	0.92	.45
Vary work responsibilities	4	7.94	3.00	.02
Limit time spent with clients	4	6.44	2.14	.08
Perceive clients problems as interesting	4	4.51	2.05	.09
Take breaks between sessions	4	2.48	0.88	.48
Discuss work frustrations with spouse/partner/family	4	1.25	0.42	.80
Engage in formal relaxation exercises	4	10.60	3.13	.02
Receive regular clinical supervision	4	3.86	1.05	.38
Participate in personal therapy	4	1.52	0.37	.83
Participate in peer support groups	4	4.02	1.20	.31
Discuss work frustrations with friends	4	2.30	0.68	.61
Use substances to relax	4	0.68	0.34	.85

Note. **Bold** indicates significance at *p* = .01

Although a significant main effect was found for the behavior "read literature to keep current", Tamhane post-hoc comparisons indicated no significant differences ($p > .01$) in the use of this career-sustaining behavior based on years of experience when the Bonferroni correction was applied.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "maintaining self-awareness" based on years of experience, $F(4, 395) = 5.69$, $p < .001$, $\eta_p^2 = .054$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 6.30$, $SD = 0.94$) and those with 0-5 years of experience ($M = 5.56$, $SD = 1.36$).

A significant difference was found in "reflect on positive experiences" based on years of experience, $F(4, 395) = 5.13$, $p < .001$, $\eta_p^2 = .049$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 6.19$, $SD = 0.97$) and those with 0-5 years of experience ($M = 5.52$, $SD = 1.19$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "try to maintain objectivity about clients" based on years of experience, $F(4, 393) = 5.78$, $p < .001$, $\eta_p^2 = .056$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 6.22$, $SD = 1.01$) and those with 0-5 years of experience ($M = 5.54$, $SD = 1.06$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "maintain professional identity" based on years of experience, $F(4, 394) = 6.42$, $p < .001$, $\eta_p^2 = .061$. Tamhane post-hoc comparisons indicated a

significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 6.21$, $SD = 1.03$) and those with 0-5 years of experience ($M = 5.41$, $SD = 1.31$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "not feel sense of responsibility for client's problems" based on years of experience, $F (4, 392) = 4.59$, $p = .001$, $\eta_p^2 = .045$. Tamhane post-hoc comparisons indicated a significant difference ($p = .001$) between participants with 21 or more years of experience ($M = 5.67$, $SD = 1.29$) and those with 0-5 years of experience ($M = 4.88$, $SD = 1.66$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "put aside thoughts of clients outside of work" based on years of experience, $F (4, 392) = 6.75$, $p < .001$, $\eta_p^2 = .064$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 5.25$, $SD = 1.29$) and those with 0-5 years of experience ($M = 4.35$, $SD = 1.62$). A significant difference (p = .0010 was also found between those with 11-15 years of experience ($M = 5.34$, $SD = 1.44$) and those with 0-5 years of experience.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "use positive self-talk" based on years of experience, $F (4, 394) = 3.91$, $p = .004$, $\eta_p^2 = .038$. Tamhane post-hoc comparisons indicated a significant difference ($p = .004$) between participants with 21 or more years of experience ($M = 5.23$, $SD = 1.48$) and those with 0-5 years of experience ($M = 4.48$, $SD = 1.65$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "take regular vacations" based on years of experience, $F (4, 392)$

$= 7.98$, $p < .001$, $\eta_p^2 = .075$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 5.37$, $SD = 1.68$) and those with 0-5 years of experience ($M = 4.07$, $SD = 1.73$). A significant difference ($p = .002$) was also found between those with 21 or more years of experience and those with 6-10 years of experience ($M = 4.38$, $SD = 1.93$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "spend time alone in self-reflection" based on years of experience, $F (4, 393) = 3.68$, $p = .006$, $\eta_p^2 = .036$. Tamhane post-hoc comparisons indicated a significant difference ($p = .005$) between participants with 21 or more years of experience ($M = 5.37$, $SD = 1.56$) and those with 0-5 years of experience ($M = 4.60$, $SD = 1.663$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "turn to spiritual beliefs" based on years of experience, $F (4, 393) = 7.10$, $p < .001$, $\eta_p^2 = .067$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants with 21 or more years of experience ($M = 5.84$, $SD = 1.51$) and those with 0-5 years of experience ($M = 4.55$, $SD = 2.10$).

Hours Worked Weekly

A series of 33 one-way ANOVAs were used to test for differences in career sustaining behaviors based on hours worked weekly (1-9 hours, 10-19 hours, 20-29 hours, 30-33 hours, 34-40 hours, or 41+ hours). Results of ANOVAs for use of career-sustaining behaviors based on hours worked weekly are shown in Table 10.

Table 10

ANOVA Results for Use of Career-Sustaining Behaviors by Hours Worked Weekly

	df	Mean Square	F	Sig.
Maintain a sense of humor	5	0.91	1.02	.40
Spend time with partner/family	5	3.02	1.92	.09
Maintain balance between professional and personal lives	5	12.44	7.26	**.00**
Maintain self-awareness	5	0.67	0.48	.79
Maintain sense of control over work responsibilities	5	3.81	2.33	.04
Reflect on positive experiences	5	1.62	1.25	.28
Try to maintain objectivity about clients	5	0.48	0.39	.86
Engage in quiet leisure activities	5	6.87	3.17	**.01**
Maintain professional identity	5	1.21	0.83	.53
Participate in continuing education	5	0.39	0.23	.95
Engage in physical activities	5	3.76	1.56	.17
Spend time with friends	5	4.94	2.23	.05
Not feel sense of responsibility for clients problems	5	2.50	1.09	.37
Put aside thoughts of the clients outside of work	5	3.32	1.32	.26
Use positive self-talk	5	2.40	1.01	.41
Take regular vacations	5	1.77	0.53	.76
Spend time alone in self-reflection	5	1.77	0.66	.65
Turn to spiritual beliefs	5	4.45	1.27	.28
Maintain professional distance from clients	5	1.01	0.66	.65
Seek consultation	5	3.24	1.11	.35
Read literature to keep current	5	2.82	1.22	.30
Discuss work frustrations with colleagues	5	6.30	2.84	.02
Vary work responsibilities	5	1.04	0.38	.86
Limit time spent with clients	5	4.47	1.48	.19
Perceive clients problems as interesting	5	1.85	0.82	.54
Take breaks between sessions	5	6.06	2.20	.05
Discuss work frustrations with spouse/partner/family	5	2.28	0.77	.57
Engage in formal relaxation exercises	5	1.55	0.45	.82
Receive regular clinical supervision	5	3.41	0.92	.47
Participate in personal therapy	5	1.34	0.33	.90
Participate in peer support groups	5	3.45	1.04	.39
Discuss work frustrations with friends	5	2.35	0.70	.63
Use substances to relax	5	1.16	0.59	.71

Note. **Bold** indicates significance at *p* = .01

Although a significant main effect was found for the behavior "engage in quiet leisure activities", Tamhane post-hoc comparisons indicated no significant differences ($p > .01$) in the use of this career-sustaining behavior based on hours worked weekly when the Bonferroni correction was applied.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "maintaining balance between professional and personal lives" based on hours worked weekly, $F (4, 396) = 7.26$, $p < .001$, $\eta_p^2 = .085$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants who worked 41+ hours ($M = 4.96$, $SD = 1.93$) and those who worked 1-9 hours ($M = 6.06$, $SD = 1.14$). A significant difference ($p < .001$) was also found between those who worked 41+ hours and those who worked 10-19 hours ($M = 6.00$, $SD = 1.08$). A significant difference ($p < .001$) was also found between those worked 41+ hours and those who worked 20-29 hours ($M = 5.91$, $SD = 1.10$). Lastly, a significant difference ($p = .001$) was also found between those worked 41+ hours and those who worked 34-40 hours ($M = 5.76$, $SD = 1.32$).

Work Setting

A series of 33 one-way ANOVAs were used to test for differences in career sustaining behaviors based on work setting of music therapy practice (children's facilities, geriatric facilities, medical facilities, mental health facilities, private practice, or other). Although individuals were allowed to indicate working in multiple settings, only those participants who worked in only one setting were included for analysis. This allows the most accurate between-group comparison among work settings. Results of ANOVAs for use of career-sustaining behaviors based on work setting are shown in Table 11.

Table 11

ANOVA Results for Use of Career-Sustaining Behaviors by Work Setting

	df	Mean Square	F	Sig.
Maintain a sense of humor	5	0.50	0.66	.66
Spend time with partner/family	5	4.53	3.37	**.01**
Maintain balance between professional and personal lives	5	2.21	1.19	.32
Maintain self-awareness	5	0.24	0.18	.97
Maintain sense of control over work responsibilities	5	1.45	0.87	.51
Reflect on positive experiences	5	0.95	0.77	.57
Try to maintain objectivity about clients	5	1.05	0.83	.53
Engage in quiet leisure activities	5	1.84	0.78	.56
Maintain professional identity	5	1.00	0.62	.69
Participate in continuing education	5	1.58	0.98	.43
Engage in physical activities	5	0.57	0.23	.95
Spend time with friends	5	0.57	0.24	.95
Not feel sense of responsibility for clients problems	5	4.14	1.84	.11
Put aside thoughts of the clients outside of work	5	6.02	2.53	.03
Use positive self-talk	5	5.00	2.19	.06
Take regular vacations	5	5.64	1.75	.13
Spend time alone in self-reflection	5	5.98	2.31	.05
Turn to spiritual beliefs	5	2.59	0.79	.56
Maintain professional distance from clients	5	2.49	1.58	.17
Seek consultation	5	7.04	2.45	.03
Read literature to keep current	5	4.48	1.97	.08
Discuss work frustrations with colleagues	5	8.01	3.95	**.00**
Vary work responsibilities	5	1.27	0.54	.75
Limit time spent with clients	5	3.40	1.20	.31
Perceive clients problems as interesting	5	7.30	3.27	**.01**
Take breaks between sessions	5	2.78	1.06	.38
Discuss work frustrations with...	5	4.44	1.52	.18
Engage in formal relaxation exercises	5	11.62	3.75	**.00**
Receive regular clinical supervision	5	13.73	3.79	**.00**
Participate in personal therapy	5	14.39	3.53	**.00**
Participate in peer support groups	5	6.05	1.80	.11
Discuss work frustrations with friends	5	8.47	2.53	.03
Use substances to relax	5	1.52	0.71	.69

Note. **Bold** indicates significance at *p* = .01

Although significant main effects were found for the behaviors "discuss work frustrations with colleagues", "perceive client's problems as interesting," "participate in personal therapy" Tamhane post-hoc comparisons indicated no significant differences ($p > .01$) in the use of this career-sustaining behavior based on work setting when the Bonferroni correction was applied.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "spend time with partner and/or family" based on work setting, F (5, 251) = 3.37, $p = .006$, $\eta_p^2 = .065$. Tamhane post-hoc comparisons indicated a significant difference ($p = .004$) between participants in "other" work settings ($M = 5.95$, $SD = 1.46$) and those in children facilities ($M = 6.87$, $SD = 0.34$). A significant difference ($p = .007$) was found between participants in private practice ($M = 6.32$, $SD = 1.00$) and those in children facilities. Lastly, a significant difference ($p = .004$) was found between participants in medical facilities ($M = 5.88$, $SD = 1.55$) and those in children facilities.

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "engage in formal relaxation exercises" based on work setting, F (5, 248) = 3.75, $p = .003$, $\eta_p^2 = .072$. Tamhane post-hoc comparisons indicated a significant difference ($p = .003$) between participants in children's facilities ($M = 3.16$, $SD = 1.75$) and those in medical facilities ($M = 4.78$, $SD = 1.59$).

A significant difference was found in how likely participants reported they were to use the career-sustaining behavior "receive regular clinical supervision" based on work setting, F (5, 248) = 3.79, $p = .003$, $\eta_p^2 = .072$. Tamhane post-hoc comparisons indicated a significant difference ($p < .001$) between participants in geriatric facilities ($M = 2.30$, $SD = 0.87$) and those in mental health facilities ($M = 4.02$, $SD = 1.82$). A significant difference ($p = .001$) was also

found between participants in geriatric facilities and those in medical facilities ($M = 3.93$, $SD =$ 2.21).

Research Question 4

To investigate whether music therapists use participation in music as a career-sustaining behavior

Three self-care behaviors were added to the original CSBQ to better quantify the use of music as a career sustaining behavior by music therapy professionals. These behaviors were (a) active music participation, (b) passive music participation, and (c) participate in personal music therapy sessions. See Table 12 for descriptive statistics of these three behaviors.

Table 12

Music-Based CSBs

	Mean	Median	Mode	*SD*
Active music participation	4.70	5.00	7.00	1.56
Passive music participation	5.25	5.00	7.00	1.60
Participate in personal music therapy sessions	1.85	1.00	1.00	1.40

A Spearman rank order correlation was conducted to compare the three music-based CSBs and ProQOL subscales of CS, BO, and STS. See Table 13 for a detailed description of correlation strengths between these music-based behaviors in the modified CSBQ and the three professional quality of life subscales of Compassion Satisfaction (CS), Burnout (BO), and Secondary Traumatic Stress (STS).

Table 13

ProQOL and Music-Based CSB Correlations

	STS_Tscore	BO_Tscore	CS_Tscore
Active music participation	-.02	-.23	.19
Passive music participation	-.08	-.17	.20
Participate in personal music therapy sessions	.13	-.03	-.01

A series of three one-way ANOVAs were used to test for differences in career sustaining behaviors based on age and years of experience. Although significant main effects were found for the music-related behavior "active music participation" based on age and years of experience, Tamhane post-hoc comparisons indicated no significant differences (*p > .01)* in the use of this career-sustaining behavior based on years of experience when the Bonferroni correction was applied.

Table 14

ANOVA Results of Music-Based CSBs by Age

	df	Mean Square	*F*	Sig.
Active music participation outside of music therapy (playing, composing, etc.)	8	14.79	4.55	**.00**
Passive music participation outside of music therapy (listening, relaxation, etc.)	8	3.26	1.28	.25
Participate in personal music therapy sessions	8	2.89	1.49	.16

Note. **Bold** indicates significance at *p* = .01

Table 15

ANOVA Results of Music-Based CSBs by Years of Experience

	df	Mean Square	F	Sig.
Active music participation outside of music therapy (playing, composing, etc.)	4	13.98	4.15	**.00**
Passive music participation outside of music therapy (listening, relaxation, etc.)	4	7.57	3.02	.02
Participate in personal music therapy	4	5.63	2.92	.02

Note. **Bold** indicates significance at $p = .01$

A series of three one-way ANOVAs were also used to test for differences in music-related career sustaining behaviors based on gender, hours worked weekly, and work setting. No statistically significant differences were found among any of these variables.

Table 16

ANOVA Results of Music-Based CSBs by Gender

	df	Mean Square	F	Sig.
Active music participation outside of music therapy (playing, composing, etc.)	1	0.58	0.17	.68
Passive music participation outside of music therapy (listening, relaxation, etc.)	1	2.84	1.11	.29
Participate in personal music therapy sessions	1	2.22	1.17	.28

Table 17

ANOVA Results of Music-Based CSBs by Hours Worked Weekly

	df	Mean Square	F	Sig.
Active music participation outside of music therapy (playing, composing, etc.)	5	7.52	2.20	.05
Passive music participation outside of music therapy (listening, relaxation, etc.)	5	1.67	0.65	.66
Participate in personal music therapy sessions	5	1.46	0.73	.60

Table 18

ANOVA Results of Music-Based CSBS by Work Setting

	df	Mean Square	F	Sig.
Active music participation outside of music therapy (playing, composing, etc.)	5	2.37	0.69	.63
Passive music participation outside of music therapy (listening, relaxation, etc.)	5	2.01	0.81	.54
Participate in personal music therapy sessions	5	2.16	1.13	.34

CHAPTER FIVE

DISCUSSION

Research Question 1

1. Which career-sustaining behaviors are most commonly used by music therapy professionals and what are their levels of professional quality of life (burnout, secondary traumatic stress, and compassion satisfaction)?

Career Sustaining Behaviors

One of the exciting results of this study is the clearer picture regarding what behaviors music therapy professionals use in their self-care practice. The five most commonly used strategies were the career sustaining behaviors of maintain a sense of humor, spend time with partner and/or family, maintain self-awareness, try to maintain objectivity about clients, and reflect on positive experiences. Using Richards' domain classifications, the majority of these behaviors appear to be psychological in nature, rather than support, physical, or spiritual. No physical or spiritual self-care behaviors were found in the five most commonly used practices. Maintain a sense of humor was identified as the most used CSB, which is consistent with the findings of several other studies conducted on CSBs in helping professions (Kramen-Kahn & Hansen, 1998; Lawson, 2007; Stevanovic & Rupert, 2004).

These top-rated strategies were similar to other studies investigating helping professionals CSB use. Examining Lawson and Myers' (2011) study of counselor's self-care found that four of the top five CSBs (spend time with partner/family, maintain sense of humor, maintain self-awareness, and reflect on positive experiences) were shared by the current study. Similarly, comparing this study to Lawson's (2007) study of over 500 counselors finds that three of the five (maintain sense of humor, spend time with partner/family, and maintain self-

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awareness) most used CSBs are identical. On the other hand, comparing the current study to two studies of psychotherapists/psychologists found only one CSB that was shared as most utilized (Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004). This may suggest that the work of music therapists most closely relates to that of counselors, necessitating similar CSBs. Or it may be that schooling and training in music therapy is more similar to counseling than it is to psychotherapy, and students learn these self-care behaviors during their education.

The five least used CSBs in this study (excluding the music-based behaviors, which were added to the survey for this study and therefore cannot be compared to other studies) were use substances to relax, participate in peer support groups, participate in personal therapy, receive regular clinical supervision, and engage in formal relaxation exercises. Three of the least commonly used behaviors involved interaction with another professional (peer support groups, participation in personal therapy, and receiving regular clinical supervision). Using the self-care domains of Richards et al. (2010), these behaviors appear to fall into the support category. It may be that the support domain contains behaviors that are more difficult to utilize, since they mandate that others be involved in the self-care strategy. This is supported by Brodie (1982), who found that psychotherapists were more likely to use intrapersonal strategies than interpersonal one for self-care. Likewise, psychological-based CSBs may be reported as more utilized by individuals as they are solely intrapersonal activities. .

The present study's finding that peer support groups and clinical supervision were reported as being used so infrequently may be partially due to the large percentage of individuals (36.2%) who reported working in a self-employed/private practice setting. Perhaps these individuals do not have colleagues or supervisors readily available for support or supervision when needed. As it appears that many music therapy professionals are self-employed, options to

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meet these needs of supervision opportunities and peer support, which have been labeled as highly important for self-care (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Norcross, 2000) should be further investigated.

Overall, approximately half of the original 33 CSBs (51%) were given a rating of five or greater (on a seven point Likert-type scale). Additionally, 82% of CSBs were rated at four or greater. These scores show that music therapy professionals are likely to use a wide variety of the CSBs in their self-care practice, not solely relying on a select few. This finding is similar to Stevanovic and Rupert (2004), who noted that psychologists gave 76% of CSBs a rating of over four.

Professional Quality of Life

Professional quality of life was measured using the ProQOL Scale Version 5 developed by Stamm (2009). This scale determines scores for the subscales of compassion satisfaction, burnout, and secondary traumatic stress. There are several interesting findings worth further examination to understand professional well-being and self-care in the field of music therapy.

The compassion satisfaction mean score was 42.46 (on a scale of 1-50), which falls into the average range as delineated by Stamm (2009). Higher compassion satisfaction scores indicate higher levels of compassion satisfaction. Burnout, with a mean score of 23.20 (on a scale of 1-37), was also in the average range. Lastly, secondary traumatic stress, with a mean score of 17.90 (on a scale of 1-31), was in the low range for participants. Lower burnout and secondary traumatic stress scores indicate lower levels of these factors. These results are encouraging, as music therapy professionals' scores on the measure indicate the average individual in the study had normal levels of compassion satisfaction and burnout, and low levels of secondary traumatic stress. In comparing these results to recent studies of other helping professions, music therapy

professionals have a high average score for compassion satisfaction. This indicates that music

therapists are deriving pleasure and satisfaction from the work they are doing. Burnout and

secondary traumatic stress mean scores, while not at levels of risk, were higher than those of

counselors and mental health providers (Lawson, 2007; Lawson & Myers, 2011; Sprang, 2007).

Table 19 illustrates the average scores for each subscale of the ProQOL in four other large

studies of helping professionals. See Appendix G for ProQOL standard scoring range (Stamm,

2009).

Table 19

Average ProQOL Subscale Scores

	CS	BO	STS
Music therapists (current study)	42.46	23.20	17.90
Hospice professionals (Alkema, 2004)	40.5	23.8	17.50
Counselors (Lawson, 2007)	39.84	18.37	10.05
Counselors (Lawson & Myers, 2011)	40.53	19.93	10.32
Mental health workers (Sprang et al., 2007)	39.30	26.20	10.60

As portrayed above, in this study music therapy professionals had a slightly greater

compassion satisfaction level than other related helping professions. Yet, burnout levels were

higher than those of counselors, and although close to hospice professionals, secondary traumatic

stress levels are higher than all of the studies noted. Perhaps this level of greater compassion

satisfaction, resulting in a more positive view of one's work, leads to a greater difficulty in

identifying signs of burnout and stress. It may be easier for music therapists to ignore negative

symptoms within their professional lives if they are balanced by positive feelings of helping.

However, caution should be taken with aspects of burnout and secondary traumatic stress, as they have been shown to affect client care and job satisfaction. Caution should also be taken in interpreting these results as well, as it is unknown if the differences observed between professions are statistically significant.

Stamm (2009) provided cut scores to assist professionals in screening for relative risks in health. While noted as potentially overly inclusive due to its use as a screening tool, Stamm describes the bottom quartile of each subscale as a risk cut score. In this study, 25% of the sample was below the cut score for compassion satisfaction, 26.5% was below the cut score for burnout, and 23.9% was below the cut for secondary traumatic stress. This indicates that these professionals may have needs to address in terms of professional quality of life. However, these percentages are in line with the breakdown provided by the measure (Stamm, 2009).

Perhaps a better way to examine those who may be at risk in the current study is to look more closely at the ranges of scores for the subscales of burnout and secondary traumatic stress. Sum scores were transformed into t scores for the purposes of the study. The burnout t scores for this study ranged from 30.08 to 80.79. Stamm (2009) provides risk levels for the t scores for each subscale. For burnout, a score above 57 carries the warning that professionals reflect on their work and why they may feel ineffective in their jobs. However, as a screening measure, it is emphasized that this may just reflect an individual having a bad day or needing time off. There were music therapy professionals in this study who scored well over the risk cutoff, indicating they may need to assess their current status and ways to alleviate their burnout. Secondary traumatic stress t scores ranged from 32.18 to 86.21. Again, any score above 57 was considered high risk. There were music therapy professionals in this study who may have been affected by

trauma that their clients experienced. Examining their work environment and the effects of their therapeutic interactions may help these individuals in their professional and personal lives.

Research Question 2

2. Is there a relationship between use of career sustaining behaviors and levels of professional quality of life among music therapists?

This study attempted to identify relationships between music therapy professionals' quality of life and their use of career sustaining behaviors. Although there were many significant correlations between the ProQOL subscales and CSBs, most of these relationships were considered moderate or weak (Cohen, 1988). However, there were a few behaviors that had strong or high moderate correlations with ProQOL.

A strong positive correlation ($r = .52$) was found between compassion satisfaction and the career sustaining behavior of reflecting on positive experiences. Not altogether surprising, this seems to indicate that those who reflect on the positive aspects and interactions of their work derive more pleasure from their jobs. Whether those with greater compassion satisfaction think more positively of their work, or those who reflect on positive aspects of their work achieve greater compassion satisfaction is unclear. However, it is clear that this CSB is used most by those with the greatest levels of compassion satisfaction. This finding suggests that music therapy professionals would benefit from taking the time to notice the impact of one's work and how music therapy can help their clients.

High moderate negative correlations were found between burnout and the career sustaining behavior of maintaining a sense of control over work responsibilities ($r = -.49$), as well as between burnout and reflecting on positive experiences ($r = -.48$). A negative correlation

between burnout and maintaining a sense of control over work responsibilities indicates that those with difficulties balancing their work duties and roles had greater levels of burnout. Clements-Cortes (2006) discussed a lack of control over the work environment when identifying occupational stressors of music therapy. Juggling multiple roles, mainly seen in balancing direct client contact with non-direct work, was noted to be a struggle for music therapists in Clements-Cortes' study. It appears that having a lack of control over the multiple roles performed by music therapists may lead to increased burnout if work duties are not balanced effectively. Reflecting on positive experiences was a strategy which was related to having high levels of compassion satisfaction in the present study, and was also a strategy endorsed by those with lower burnout levels. This suggests that reflecting on positive experiences, which requires no resources or support from others, is highly beneficial in helping one combat work stressors and enjoy one's professional achievements. Perhaps future efforts should be made to better outline effective ways to set aside time to reflect on one's positive experiences.

Research Question 3

3. Are there differences in music therapy professionals' use of career sustaining behaviors based on (a) gender, (b) age, (c) years of experience, (d) work setting, or (e) hours worked weekly?

Gender

The findings of this study indicate that female music therapy professionals used CSBs more often than their male counterparts. Females had a greater total CSB score than males (161.76 > 156.08). This is consistent with findings in other helping professions (Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Additionally, each individual CSB was compared by gender. Women were more likely than men to read literature to keep current and participate in continuing education. This greater use of educational strategies by

women is consistent with other studies and the general coping literature (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998). Similar gender differences have been cited in a number of studies and beg for further examination, as previously stated by Stevanovic and Rupert (2004). Caution should be taken in drawing firm conclusions regarding gender differences from the present study, however, as the male group size was very small in this analysis ($n = 29$) relative to the number of female participants ($n = 370$).

Age

Upon examining the relationship between age and CSB use, it is apparent that age is related to how music therapy professionals implement CSBs in their practice. Older individuals used the following CSBs at greater levels than younger individuals: (a) reflect on positive experiences; (b) not feel sense of responsibility for clients problems; (c) put aside thoughts of the clients outside of work; (d) spend time alone in self-reflection; (e) read literature to keep current; and (f) engage in formal relaxation exercises.

Specifically, those individuals aged 55 to 64 are much more likely to use CSBs than those between the ages of 20 and 29. This finding indicates that as an individual ages, they may learn to more effectively incorporate CSBs into their professional practice. In fact, all significant differences in CSB scores by age found in the present study showed that those who were older scored greater than younger participants. Perhaps as one ages and matures, these behaviors are more easily utilized in maintaining well-being.

Years of Experience

Paralleling the findings of age, all significant differences between CSB scores and years of experience were found in those with more experience scoring higher than those with less experience. Individuals with more experience used the following CSBs at a greater level than

individuals with less experience: maintaining self-awareness, reflect on positive experiences, try to maintain objectivity about clients, maintain professional identity, not feel sense of responsibility for client's problems, put aside thoughts of clients outside of work, use positive self-talk, take regular vacations, spend time alone in self-reflection, and turn to spiritual beliefs

This suggests that more experienced music therapy professionals implemented CSBs at a greater level into their self-care practice. Specifically, those with 21 or more years of experience were most often found to use CSBs at a greater rate than those with 0-5 years of experience. This finding is consistent with other studies which have found that the longer an individual has been practicing, the more likely they are to report CSBs as vital to their professional health (Briggs & Munley, 2008; Kramen-Kahn & Hansen). There were no significant differences found in the least experienced professionals (0-5 years) and any of the other experience level groups (6-10 years, 11-15 years, or 16-20 years). This may suggest that CSB use is something that is gradually learned and implemented as a professional gains experience. It should be noted that 0-5 years of experience and 21+ years of experience were the two largest group sizes, making up 29.2% and 26.2%, respectively. Perhaps significant differences were most often found between these two groups due to their larger size. Also, as the category of 21+ years of experience could contain a larger range of years than other categories, this difference in the group may have affected comparisons.

Hours Worked Weekly

Results from this study indicated a significant difference in maintaining a balance between personal and professional life based on categories of hours worked weekly. Those individuals who reported working greater than 40 hours each week also reported maintaining balance at significantly greater rates than all other categories of hours worked. This suggests that

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those working the greatest amount of time may understand the need for balance and make it a priority in order to maintain healthy professional and personal lives. However, it may also be that those working fewer hours have less difficulty in achieving balance, resulting in less use of this CSB in their self-care practice.

Work Setting

A significant difference was found in how likely participants reported they were to spend time with their partner and/or family based on work setting. Individuals who worked only in children's facilities (day cares, preschools, early intervention facilities, or schools K-12) were significantly more likely to spend time with their partner and/or family than those working only in private practice (self-employed), medical facilities (general hospitals, oncology treatment centers, home health agencies, outpatient clinics, partial hospitalization settings, and children's hospital/unit), or other work settings not listed in the survey. With a mean score of 6.87 out of 7, nearly all of those participants who reported working solely in children's facilities gave "spend time with partner, spouse, or family" the highest score. This suggests that the self-care support domain of self-care is particularly important for music therapists who work with children.

Another significant finding regarding work setting can be observed in the CSB "engage in formal relaxation exercises." Music therapists who worked in children's facilities reported that they engaged in formal relaxation exercises significantly less than those in medical settings. Perhaps music therapists in children's facilities utilize this activity less frequently with their clients, affecting how often they utilize relaxation exercises for themselves. While formal relaxation is not specifically constrained to any specific setting, it often is used to combat pain and stress, something that would be considered more common for patients in medical facilities.

Lastly, an interesting finding was discovered when examining the relationship between the CSB "receive regular clinical supervision" and work settings. Music therapists working in geriatric facilities (adult day care facilities, assisted living facilities, or nursing homes) reported receiving clinical supervision significantly less than those working in mental health settings (child/adolescent treatment centers, community mental health centers, drug/alcohol programs, forensic facilities, or inpatient psychiatric units) or medical facilities. While this suggests that music therapists in geriatric settings used regular clinical supervision less frequently for sustaining their careers, it is unclear why this may be. Perhaps supervision is less available for these individuals due to facility resources or structure. Or it may be that supervision is simply more readily available in the mental health and medical settings. Regardless, future efforts should be made to further examine the need for and availability of clinical supervision for music therapy professionals in various work settings.

Research Question 4

4. In what ways and to what degree do music therapy professionals use participation in music as a career-sustaining behavior?

In addition to answering questions about their use of CSBs described previously in the self-care research literature, music therapy professionals in this study rated how likely they were to use three music-based behaviors for self-care. The mean score for active music participation (playing, composing, etc.) was 4.70 (on a seven point scale). Passive music participation (listening, relaxation, etc.) received a mean score of 5.25, while personal music therapy sessions were given a score of 1.85. To help give a better idea of where these fall among other CSBs in the study, all of the behaviors were ranked. Of the 36 total CSBs in the measure, passive music participation was ranked 16th, the highest of the three music-based behaviors. It appears that

music therapy professionals are more likely to use passive music strategies such as listening to music, music-assisted relaxation, or other similar activities than they are to use active music therapy strategies or personal music therapy as a means of self-care in their lives. Active music participation ranked 25th among CSBs yet still had a mean score above four, indicating music therapists were likely to use this behavior for their professional well-being. Using both active and passive music activities for self-care is supported by a recent study that identified maintaining a personal connection to music and using music for stress relief as ways music therapists help prevent burnout (Ferrer, 2012). Participating in personal music therapy sessions was ranked 36th, last of all the CSBs in the study. This strategy score ($M = 1.85$) was even lower than "use substances to relax" ($M = 1.93$). However, research has shown that the majority of music therapy programs do not mandate personal music therapy for their students (Gardstrom & Jackson, 2011). Only 14% of the music therapy academic preparation programs in the United States required personal music therapy in the educational curriculum; an additional 46% stated that personal music therapy was encouraged, but often only when signs of distress or need were noticed. It appears that participants in the present study did not use personal music therapy sessions often as a career sustaining behavior.

Correlations between the ProQOL subscales (compassion satisfaction, burnout, and secondary traumatic stress) and music-based CSBs were examined in this study. Although significant correlations were found, these were all weak in strength. A negative correlation ($r = -.23$) between active music participation and burnout was the strongest of all music-based CSBs. All other correlations were between -.20 and .20 for these music-based behaviors. This suggests that the use of active music participation is related to lower levels of burnout. Relationships between CSB use and areas of gender, age, years of experience, hours worked

weekly, and work settings were also studied. Results from one-way ANOVAs determined that no significant differences existed between any categories in these demographic areas based on use of CSBs.

Limitations

As with any research that attempts to ascertain such personal experiences as quality of life and self-care, there were limitations. First, research in which participants report their behaviors and feelings is reliant on accurate self-report by each individual. Although one hopes that music therapy professionals in the present study provided accurate assessments of their current well-being and strategies for self-care, there is no way to ensure that this is the case. Due to the nature of this topic it is difficult to garner information without relying heavily on the self-report of participants. Additionally, the stigma associated with stress and burnout may have caused participants to adjust their responses to avoid being seen as "unwell."

It is possible that only those music therapy professionals interested in the topic of self-care and/or with the time, energy, or resources to complete the survey were able to be examined for the factors of professional quality of life and career sustaining behaviors. Perhaps those music therapy professionals who were experiencing the greatest levels of burnout and/or secondary traumatic stress felt as if they were unable to take the time to complete the study, or were less interested due to their compromised professional health.

Ideally, several demographic groups would have had more evenly distributed participation. Although a similar response ratio to the American Music Therapy Association (AMTA), gender was predominantly female and left a smaller male sample for data analysis. The participants represented a narrow range of races, although again this was to be expected as seen in the AMTA analysis.

An additional limitation is that, while the study did look at the entire population of music therapy professional members of AMTA in the United States, the sample does not include those practicing as music therapists in the U.S. who are not registered members of AMTA. Perhaps these professionals exhibit different levels of professional quality of life or CSB utilization than the AMTA sample examined in this study.

The study would have benefited, in some regards, to adjustments to the question about work setting that asked for the primary setting in which an individual worked. This would have allowed a single response to the question and provided an opportunity to conduct a one-way ANOVA between each individual work setting. Also, a descriptive response opportunity following the "Other" choice for work setting would have been helpful to further look into differences among CSB use by professionals. Due to the current setup of the RedCAP software, this option was not possible at the time of survey creation.

Future Research

Replication of this study with additional samples of music therapy students, both at the undergraduate and graduate level, would be useful to further explore relationships between CSBs and professional quality of life in this population. Larger samples of ethnic minorities and males would help in making comparisons and help to inform the field regarding areas of differences and risk. Future research may benefit from collecting additional demographic information from participants. Identifying regions of the country where participants practice and their theoretical orientation could allow for interesting findings and discussion. While this study focused only on music therapy professionals in the United States, examining these areas of professional well-being in music therapists in other countries may prove beneficial, as cultural differences may exist in the training and workforce characteristics of music therapists worldwide.

Although the present study looked at CSB use based on demographic variables, comparisons in levels of professional quality of life among various demographic groups were not made. Past research has looked at burnout across various demographic areas in music therapists, but none have used the ProQOL Scale that the current study utilized. As subscales are provided for not only burnout, but also secondary traumatic stress and compassion satisfaction, using this tool to gain a clearer picture of how professional quality of life is affected by variables such as gender, age, experience, caseload, and work setting would be a logical next step.

As music therapists work in different work settings, it would be interesting to research professional quality of life and CSB use between music therapists and other professionals in the same work setting. For instance, investigating these levels between music therapists working in mental health and mental health professionals, or music therapists working in schools....

The study would have benefited, in some regards, to adjustments to the question about work setting that asked for the primary setting in which an individual worked. This would have allowed a single response to the question and provided an opportunity to conduct a one-way ANOVA between each individual work setting. Also, a descriptive response opportunity following the "Other" choice for work setting would have been helpful to further look into differences among CSB use by professionals. Due to the current setup of the RedCAP software, this option was not possible at the time of survey creation.

Music therapists who worked in private practice/self-employed settings reported receiving less clinical supervision and peer support. These strategies have been identified as greatly important for self-care and future research should perhaps investigate the levels of support received by music therapists working in private practice. Findings could inform the field

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of music therapy about possible ways or opportunities that could be provided to allow for supervision or support for these professionals.

Lastly, future research may benefit in investigating the career sustaining behaviors of music therapy professionals based upon the region in which these professionals practice or reside. As education, training, and theoretical orientation of practice often vary based upon geographic location in the United States, it may be beneficial to look more closely at self-care practices of professionals within each region. The AMTA delineates regions in the U.S. currently and these regions could be included in demographic information in future research. Perhaps some regions place more emphasis on certain self-care strategies such as personal therapy or supervision than do others. Further investigation into this area could provide valuable information to assess current trends and possible needs for future training.

Implications

It is recommended that music therapy professionals take the time to assess the stressors of their work and the strategies they utilize for their professional well-being. A portion of the music therapy field has been identified in this study as being at risk for burnout and secondary traumatic stress, both of which can affect stress, satisfaction, and client care. It is important for music therapists to use strategies in a variety of self-care domains, including psychological, support, physical, and spiritual. It may be beneficial for music therapists to have more options available for clinical supervision and peer support. As Clements-Cortes (2006) noted, perhaps a support network where music therapists could share and talk about experiences would be beneficial. The researcher has noted this trend among social media sites, but perhaps a standard resource maintained by AMTA would be helpful. Ferrer (2011) found that music therapy faculty and AMTA board members agreed that building professional communities was important to help

combat burnout and isolation. Providing more opportunities for peer-mentorship. collaboration, and clinical supervision would be a strong step towards addressing this need.

Additionally, new music therapy program graduates would appear to particularly benefit from self-care resources. Results of the study showed that younger and less experienced professionals used fewer CSBs in their self-care practice. An increased number of options regarding self-care for continuing education may help provide valuable learning opportunities. Also, reducing burnout and secondary traumatic stress, while increasing compassion satisfaction, may positively impact job satisfaction and help to reduce the attrition rate of music therapy professionals.

As music therapy continues to grow and becomes more integrated into the evolving healthcare environment, it will be vital to continue to monitor the professional quality of life and career sustaining behaviors of music therapists to meet the demands of managed care and successfully fulfill the needs of their clients. The researcher hopes that this study will aid in the continuing desire to better understand the state of the music therapy field and its professionals.

Appendix A: Survey Cover Letter

Dear AMTA Member,

Study Overview

You are being invited to take part in a research study about self-care practices and professionalhealth amongst music therapy professionals. You were selected as a representative sample of music therapy professional members of the American Music Therapy Association who reviewed this study and granted permission.

This study is a research project conducted by Shane Swezey, MT-BC to fulfill thesis requirements at the University of Kentucky.

Your helpful responses to this survey will provide our field with a better understanding of professional quality of life and career sustaining behaviors of music therapy professionals and the implications for future education and practice.

What will you be asked to do?

If you agree to participate, you will complete a brief survey about career sustaining behaviors, professional quality of life, and your professional background. The survey/questionnaire will take about **10-15** minutes to complete. Your participation, completion, and submission of this survey will indicate your consent to take part in this research study.

We hope to receive completed questionnaires from at least 306 people, so your answers are important to us. Of course, you have a choice about whether or not to complete the survey/questionnaire, but if you do participate, you are free to skip any questions or discontinue at any time.

Benefits

Although you may not get personal benefit from taking part in this research study, your responses may help us understand more about professional quality of life and career sustaining behaviors of professional music therapists. You will also have the opportunity to complete and score a questionnaire that will provide potentially helpful information about your current professional quality of life.

You will not be paid for taking part in this study

There are no known risks for participating in this study.

Your response to the survey is anonymous which means no names will appear or be used on research documents, or be used in presentations or publications. The research team will not know that any information you provided came from you, nor even whether you participated in the study.

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Contact

If you have questions about the study, please feel free to ask; my contact information is given below. If you have complaints, suggestions, or questions about your rights as a research volunteer, contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866-400-9428.

Thank you in advance for your assistance with this important project. To ensure your responses/opinions will be included, please submit your complete survey by **5-20-2013**.
To participate in the survey, please follow the link below:

[What Keeps Us Well? Professional Quality of Life and Career Sustaining Behaviors of Music Therapy Professionals](#)

Sincerely,

Shane Swezey, MT-BC
Department of Music Therapy
University of Kentucky
859-490-5482
shane.swezey@uky.edu

Olivia Yinger, PhD, MT-BC
Thesis Adviser
University of Kentucky
859-218-0997
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Appendix B: Demographic Survey Questionnaire

1. Sex

__ Male   __Female

2. Age

__20-24 __25-29 __ 30-34 __35-39 __40-44 __44-49 __50-54 __55-59 __60-64

3. Ethnicity

__ African American

__ Asian/ Asian American

__ Caucasian/White

__ Hispanic/Latino

__ Other

4. Highest level of education

__ Bachelor's degree   __ Master's degree   __ Doctoral degree

5. Professional Credential

__ MT-BC   __ RMT   __CMT   __ACMT   __ Other

6. Hours Worked Per Week

__ 1-9   __ 10-19   __ 20-29   __ 30-33   __ 34-40   __41+

7. Individual music therapy sessions conducted weekly _____

(please provide your best estimate)

8. Group music therapy sessions conducted weekly _____

(please provide your best estimate)

9. Years of Experience

__ 1-5   __ 6-10   __ 11-15   __ 16-20   __ 21+

(only include experience as a music therapy professional)

8. Work Setting

__ Children's Facilities/Schools *(Day Care, Preschool, Early Intervention, School K-12)*

__ Geriatric Facilities *(Adult Day Care, Assisted Living, Geriatric Facility, Nursing Home)*

__ Mental Health Setting *(Child/Adolescent Treatment Center, Community Mental Health Center, Drug/Alcohol Program, Forensic Facility, Inpatient Psychiatric Unit)*

__ Medical Setting *(General Hospital, Oncology, Home Health Agency, Outpatient Clinic, Partial Hospitalization, Children's Hospital/Unit)*

__ Self-Employed/Private Practice

__ Other

(check all that apply)

Appendix C: Modified Career Sustaining Behavior Questionnaire

Career Sustaining Behaviors Questionnaire

For the following professional behaviors, please rate how likely you are to practice each in helping you to function effectively and maintain a positive attitude. Select the number that best represents how likely you are to practice each behavior.

	Not Likely 1	2	3	Somewhat Likely 4	5	6	Very Likely 7
Maintain a sense of humor	☐	☐	☐	☐	☐	☐	☐
Spend time with partner/family	☐	☐	☐	☐	☐	☐	☐
Maintain balance between professional and personal lives	☐	☐	☐	☐	☐	☐	☐
Maintain self-awareness	☐	☐	☐	☐	☐	☐	☐
Maintain sense of control over work responsibilities	☐	☐	☐	☐	☐	☐	☐
Reflect on positive experiences	☐	☐	☐	☐	☐	☐	☐
Try to maintain objectivity about clients	☐	☐	☐	☐	☐	☐	☐
Engage in quiet leisure activities	☐	☐	☐	☐	☐	☐	☐
Maintain professional identity	☐	☐	☐	☐	☐	☐	☐
Participate in continuing education	☐	☐	☐	☐	☐	☐	☐
Engage in physical activities	☐	☐	☐	☐	☐	☐	☐
Spend time with friends	☐	☐	☐	☐	☐	☐	☐
Not feel sense of responsibility for clients' problems	☐	☐	☐	☐	☐	☐	☐
Put aside thoughts of the clients outside of work	☐	☐	☐	☐	☐	☐	☐
Use positive self-talk	☐	☐	☐	☐	☐	☐	☐
Take regular vacations	☐	☐	☐	☐	☐	☐	☐
Spend time alone in self-reflection	☐	☐	☐	☐	☐	☐	☐
Turn to spiritual beliefs	☐	☐	☐	☐	☐	☐	☐
Maintain professional distance from clients	☐	☐	☐	☐	☐	☐	☐
Seek consultation	☐	☐	☐	☐	☐	☐	☐
Read literature to keep current	☐	☐	☐	☐	☐	☐	☐
Discuss work frustrations with colleagues	☐	☐	☐	☐	☐	☐	☐
Vary work responsibilities	☐	☐	☐	☐	☐	☐	☐
Limit time spent with clients	☐	☐	☐	☐	☐	☐	☐
Perceive clients' problems as interesting	☐	☐	☐	☐	☐	☐	☐
Take breaks between sessions	☐	☐	☐	☐	☐	☐	☐

Discuss work frustrations with spouse/partner/family	☐	☐	☐	☐	☐	☐	☐
Engage in formal relaxation exercises	☐	☐	☐	☐	☐	☐	☐
Receive regular clinical supervision	☐	☐	☐	☐	☐	☐	☐
Participate in personal therapy	☐	☐	☐	☐	☐	☐	☐
Participate in peer support groups	☐	☐	☐	☐	☐	☐	☐
Discuss work frustrations with friends	☐	☐	☐	☐	☐	☐	☐
Use substances to relax	☐	☐	☐	☐	☐	☐	☐
Active music participation outside of music therapy (playing, composing,etc.)	☐	☐	☐	☐	☐	☐	☐
Passive music participation outside of music therapy (listening, relaxation, etc.)	☐	☐	☐	☐	☐	☐	☐
Participate in personal music therapy sessions	☐	☐	☐	☐	☐	☐	☐

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Professional Quality of Life Scale (PROQOL) VERSION 5 (2009)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a music therapist. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

© B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

	Never	Rarely	Sometimes	Often	Very Often
I am happy.	☐	☐	☐	☐	☐
I am preoccupied with more than one person I help.	☐	☐	☐	☐	☐
I get satisfaction from being able to help people.	☐	☐	☐	☐	☐
I feel connected to others.	☐	☐	☐	☐	☐
I jump or am startled by unexpected sounds.	☐	☐	☐	☐	☐
I feel invigorated after working with those I help.	☐	☐	☐	☐	☐
I find it difficult to separate my personal life from my life as a music therapist.	☐	☐	☐	☐	☐
I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	☐	☐	☐	☐	☐
I think that I might have been affected by the traumatic stress of those I help.	☐	☐	☐	☐	☐
I feel trapped by my job as a music therapist.	☐	☐	☐	☐	☐
Because of my helping, I have felt "on edge" about various things.	☐	☐	☐	☐	☐
I like my work as a music therapist.	☐	☐	☐	☐	☐
I feel depressed because of the traumatic experiences of the people I help.	☐	☐	☐	☐	☐
I feel as though I am experiencing the trauma of someone I have helped.	☐	☐	☐	☐	☐

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I have beliefs that sustain me.	☐	☐	☐	☐	☐
I am pleased with how I am able to keep up with helping techniques and protocols.	☐	☐	☐	☐	☐
I am the person I always wanted to be.	☐	☐	☐	☐	☐
My work makes me feel satisfied.	☐	☐	☐	☐	☐
I feel worn out because of my work as a music therapist.	☐	☐	☐	☐	☐
I have happy thoughts and feelings about those I help and how I could help them.	☐	☐	☐	☐	☐
I feel overwhelmed because my case [work] load seems endless.	☐	☐	☐	☐	☐
I believe I can make a difference through my work.	☐	☐	☐	☐	☐
I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	☐	☐	☐	☐	☐
I am proud of what I can do to help.	☐	☐	☐	☐	☐
As a result of my helping, I have intrusive, frightening thoughts.	☐	☐	☐	☐	☐
I feel "bogged down" by the system.	☐	☐	☐	☐	☐
I have thoughts that I am a "success" as a music therapist.	☐	☐	☐	☐	☐
I can't recall important parts of my work with trauma victims.	☐	☐	☐	☐	☐
I am a very caring person.	☐	☐	☐	☐	☐
I am happy that I chose to do this work.	☐	☐	☐	☐	☐

Appendix E: IRB Exemption Certification

UK KENTUCKY

EXEMPTION CERTIFICATION

MEMO: Shane Swezey
             Music Therapy
             H106: Chandler Hospital, Pavillion H
             PI phone #: 859-490-5482

FROM: Institutional Review Board
             c/o Office of Research Integrity

SUBJECT: Exemption Certification for Protocol No. 13-0111-X4B

DATE: March 26, 2013

On March 18, 2013, it was determined that your project entitled, *What Keeps Us Well? Professional Quality of Life and Career Sustaining Behaviors of Music Therapy Professionals*, meets federal criteria to qualify as an exempt study.

Because the study has been certified as exempt, you will not be required to complete continuation or final review reports. However, it is your responsibility to notify the IRB prior to making any changes to the study. Please note that changes made to an exempt protocol may disqualify it from exempt status and may require an expedited or full review.

The Office of Research Integrity will hold your exemption application for six years. Before the end of the sixth year, you will be notified that your file will be closed and the application destroyed. If your project is still ongoing, you will need to contact the Office of Research Integrity upon receipt of that letter and follow the instructions for completing a new exemption application. It is, therefore, important that you keep your address current with the Office of Research Integrity.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" from the Office of Research Integrity's Guidance and Policy Documents web page [http://www.research.uky.edu/ori/human/guidance/htm#PIresp]. Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI's web site [http://www.research.uke.edu/ori]. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at (859) 257-9428.

AMTA LABEL POLICY

Please note new label policy beginning December 1, 2012. We provide label rentals as a service to our members. Therefore, label rentals must be used for mailings that are consistent with the mission of AMTA: *to increase the public awareness of the benefits of Music Therapy and access to quality Music Therapy services throughout the United States and the world.* We respect the privacy of our members and have therefore placed the following restrictions on rentals:

Request labels in Writing:
You must request labels/lists in writing using the Label Request Form. The request must include a sample or copy of what is to be mailed or a detailed explanation of how the labels/lists will be used. No requests will be processed without this information or the completed request form.

Terms of Use:
You may use the labels/lists *one* time for the requested use *only*. This enables us to provide you with the most accurate addresses and membership list.

What You'll Get:
The lists you receive will contain **current AMTA members on the day the list is queried.** Because we add new members daily, the total number of current members will change daily. It is advisable to order labels as close to your expected mailing date as possible in order to get the most complete list. If you have any questions or to get an approximate number of labels before submitting a request form, please call the office.

Format:
We provide labels as electronic lists. Sticky labels are no longer provided except upon special request. If requesting an electronic version, you will receive all information in an MS Excel file (.xls or .csv) which can be opened in most word processing or spreadsheet programs. You are then responsible for formatting the data appropriate to your specific situation on your own. Because everyone's computer software and settings are different, you'll need to contact the applications' technical support or help desk for steps in doing this if you're not already familiar with the process.

Email Addresses:
Email addresses can be made available to AMTA members for research purposes only. For this service, members are charged a nominal fee of $.15 per address for the staff time involved (non-members pay the non-member price). Requests must be pre-approved by the AMTA Executive Director and you will need to provide a sample of the survey or mailing for pre-approval – this process may require additional time, so please plan ahead. An approval letter from the appropriate Institutional Review Board indicating that it has approved the study must accompany your request. In the event that an IRB approval letter is not possible, please provide an explanation. Once your project is complete, a copy of the final results would be very much appreciated and can be mailed to Angie Elkins at the AMTA National Office.

Processing Time:
We appreciate receiving your requests as far in advance as possible and process requests in the order they are received. A $10 rush fee will be added to your invoice if your labels are needed sooner than 2 weeks from the date your request is received. Due to the volume of requests we receive at the National Office, we cannot process orders in fewer than five working days.

Label Pricing:

Cost	*Price*	*Minimum*
AMTA Regions	$ .10	$ 10.00
Current AMTA Members	$ .15	$ 15.00
Non-Members	$ .25	$ 25.00

Shipping Costs are additional and are based on the shipping weight of your labels and the cost of shipping materials. If purchasing an electronic list, no shipping is charged if an email address is supplied for "shipping".

Thank you for your continued cooperation. As always, you may contact us with any questions or to obtain additional request forms at info@musictherapy.org, www.musictherapy.org, or at (301) 589-3300.

12/1/12

Frequently Asked Questions about AMTA Mailing Labels

If you have not ordered labels/lists before, please take a moment to familiarize yourself with some common questions and request process below. If you have questions not answered here, please contact us at the national office before you submit your request for labels. We will be happy to help you. To help you determine how to fill out your form, here are some things to remember about mailing lists:

How does AMTA receive addresses? Members provide their postal address when paying for membership and can update his/her contact information online at any time. Current AMTA Members are those people who have paid their membership dues for the calendar year. We make every effort to update and correct addresses, but need support from the membership to do this. If you notice an incorrect mailing address, please encourage that person to contact the AMTA national office with their updated information. Members may only make changes to their own personal contact information.

Which names are included? We've tried to reflect the varied needs for ordering labels on the request form. When Current AMTA Members are requested, only names of those people who have paid for their membership for the calendar year are included. Please be aware, that because many people wait to pay until later in the year, they may not be included in a list that is printed early in the year. We make every effort to respect the privacy wishes of our members and they may also opt out of inclusion in mailing lists. We also make an attempt to save you money and effort by excluding addresses which we know to be undeliverable (as determined by national mailings returned to us by the US Post Office.) If you have specific needs that aren't options on the request form, please call the national office before ordering to make sure that we understand your need and advise you.

Members vs. Non-members: Only AMTA Regions, as a part of AMTA, may request the information of those who are not currently AMTA members (e.g., non-members who were members last year). If you are requesting mailing addresses for upcoming regional conferences or regional membership drives, you may want to include non-members as well as members. Please keep in mind that addresses of non-members will not be as accurate as Current AMTA Members because these people have not contacted us recently with an updated address. Non-member information is only available for official AMTA business.

In what order should my labels be? The order of your labels may be very important to lower cost of your mailing. You may want to contact your mailing house to ask for their suggestion before filling out the request form or simply make that change in your electronic list. Labels will be in order of last name, then first name unless otherwise specified. Please be sure to fill out this section.

Email addresses are provided for official AMTA business, research purposes, and special conference offers only. As with any list request, they are available for one-time use only and may not be imported into address books or otherwise collected. A complete copy of what will be emailed (whether it's a notice, survey or announcement) must be provided and approved first. Please allow time for the approval process. Edits may be requested by AMTA before approval is granted. Requests may be denied. Please be aware that email addresses tend to change more frequently than mailing addresses and you may see a large contingent of "bounce backs" with emailed lists. Email addresses are not included with address labels, please specify which you request.

How are addresses updated? AMTA website users may update their own information at any time. When we are informed of a change in contact info (through mail, email, fax, or a phone call) we update our records within 7 business days. We also request address correction materials from the US Post Office. This process takes considerably more time and information is not always current. If we receive a piece of mail returned with a new forwarding address, we re-send the mail to the new address and update our records. However, we often receive returned mail that is simply marked "No Forwarding Order." In this case, it is not possible to re-send or update the address. Students typically change addresses more often. Please encourage members and non-members in your region to take a moment and update their contact info on the AMTA website so their mailings will be received.

How long are lists current? Given the changing nature of nearly 4,000 members' information, we receive address changes daily. In addition, people pay membership dues each day and are added to the list of Current AMTA Members. Therefore, lists are only as current as the day they are printed. Please keep this in mind when ordering labels in advance - members who have not paid for their membership at the time of the order may not be included.

How long does it take to process labels? Regional label requests are given priority. We fill other requests in the order that they are received. We request that you leave at least 2 weeks to allow for high volume during certain times throughout the year. Orders required in less than 2 weeks will be charged a rush fee and filled as time allows.

Usage Agreement: You may use the labels/lists one time and for the requested use only. This enables us to provide you with the most accurate addresses and membership list each time. As always, if you have any questions, please do not hesitate to call Angie Elkins or Cindy Smith at the national office at (301) 589-3300.

12/1/12

AMTA Mailing Label Request Form

Please fill out all sections of this form completely and mail, email or fax to AMTA at 301-589-3300.
Label requests cannot be filled without this completed form.

1. Bill to: *(for regions, your regional treasurer)*   **Ship (or Email) to:**

Shane Swezey

3650 Tates Creek Rd. #114

Lexington, KY 40517   *email address:* shane.swezey@uky.edu

2. Purpose of Mailing: Thesis Research Survey- "What Keeps Us Well? Career Sustaining Behaviors and Professional Quality of Life of Music Therapy Professionals"

(Please include a copy or sample of what you will be mailing. All requests are subject to approval by AMTA.)

3. Format: *(please check one)*
☐ Addresses in Electronic File
X Email addresses only - *for AMTA official business, research purposes, & special conference offers only*
☐ Addresses on Pre-printed Sticky Labels (special request; may require additional time)

4. Labels Requested:
REGION:

X Entire US	☐ Great Lakes	☐ Midwestern ☐
☐ Entire US & International	☐ New England	☐ Southwestern ☐
☐ Select States Only: _____	☐ Mid-Atlantic	☐ Southeastern ☐
☐ Other: _____	☐ Western	☐ AMTAS *(all students)*

CURRENT MEMBER TYPE:

☐ All Current AMTA Members   *Other Member Types:*
X Current Professional Members   ☐ Associate   ☐ Retired   ☐ Student only
☐ Current Grad & Student Members   ☐ Honorary Life & Life☐   ☐ Patron   ☐ Grad Student only
☐ Those with a MT designation/credential only   ☐ Educational Affiliate   ☐ Affiliate   ☐ All Affiliate
X Other _age 20-64_____   ☐ Other _____

For regional business only:
☐ Non-members who were members last year ☐   ☐ Non-member Music Therapists☐
* Please include all current professional members' email addresses for study
OTHER:
☐ AMTA Executive Director (1)   ☐ AMTA President (1)   ☐ Regional Newsletter Editors (10)

5. Sorted by: *(if nothing is checked default will be Last name, First name)*
☐ Last name, First name   ☐ Zip Code, Last, First   ☐ City, State   ☐ Other: _____

6. Date needed: _____4_____ (month) / ____1____ (day) / ___2013___ (year)   *"ASAP" will be disregarded.*

I have reviewed the label policy statement and agree to use these labels one time only:

Signature of person requesting labels: _____

Print full name: __Shane Swezey_____

Phone #: _859-490-5482_____   Date: _3-25-13_____

12/1/12

Appendix G: ProQOL Levels

Sum of Questions	T-Score	Level of BO/STS/CS
22 or less	43 or less	Low
23-41	Around 50	Average
42 or more	57 or more	High

Note. Table adapted from Stamm, 2009

Appendix H: Modified CSBQ Descriptive Scores

	N	Mean	*SD*
Maintain a sense of humor	401	6.30	.942
Spend time with partner/family	400	6.24	1.258
Maintain balance between professional and personal lives	402	5.65	1.357
Maintain self-awareness	402	5.90	1.171
Maintain sense of control over work responsibilities	400	5.53	1.286
Reflect on positive experiences	401	5.81	1.137
Try to maintain objectivity about clients	399	5.84	1.114
Engage in quiet leisure activities	400	5.50	1.490
Maintain professional identity	400	5.81	1.209
Participate in continuing education	402	5.80	1.288
Engage in physical activities	401	5.40	1.556
Spend time with friends	401	5.28	1.492
Not feel sense of responsibility for clients problems	398	5.35	1.516
Put aside thoughts of the clients outside of work	398	4.79	1.588
Use positive self-talk	400	4.91	1.536
Take regular vacations	400	4.56	1.826
Spend time alone in self-reflection	399	4.85	1.631
Turn to spiritual beliefs	399	5.18	1.878
Maintain professional distance from clients	399	5.80	1.227
Seek consultation	401	4.50	1.710
Read literature to keep current	400	4.84	1.523
Discuss work frustrations with colleagues	400	5.39	1.503
Vary work responsibilities	400	4.76	1.644
Limit time spent with clients	397	4.28	1.744
Perceive clients problems as interesting	397	4.86	1.491
Take breaks between sessions	399	4.57	1.677
Discuss work frustrations with spouse/partner/family	398	5.00	1.719
Engage in formal relaxation exercises	399	3.70	1.857
Receive regular clinical supervision	398	3.32	1.923
Participate in personal therapy	399	3.14	2.013
Participate in peer support groups	398	2.95	1.835
Discuss work frustrations with friends	401	3.72	1.836
Use substances to relax	398	1.93	1.410
Active music participation outside of music therapy	401	4.70	1.861
Passive music participation outside of music therapy	398	5.25	1.599
Participate in personal music therapy sessions	399	1.85	1.402

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    settings. Unpublished Master's Thesis. Michigan State University.

Shane Christopher Swezey

CURRICULUM VITAE

EDUCATION

Bachelor of Music   Florida State University, Tallahassee, FL   August 2011
                           Music Therapy, Magna Cum Laude

Masters of Music   University of Kentucky, Lexington, KY   August 2013
                           Music Therapy, Summa Cum Laude

PROFESSIONAL EXPERIENCE

UK HealthCare, Lexington, KY   2011-2013

Music Therapist/Research Assistant

Music Therapy Intern

PUBLICATIONS

Gooding, L., Swezey, S., & Zwischenberger, J. (2012). Using Music Interventions in
        Perioperative Care. *Southern Medical Journal, 105,* 486-90.

SCHOLASTIC AND PROFESSIONAL HONORS

National Institute on Aging Reseach Grant   2011-2012
Sanders- Brown Center on Aging ($40,000)
Funded research assistant
Music and Cognitive Reserve- Is There a Link?

Kentucky Opportunity Fellowship   2012-2013
University of Kentucky
School of Music
Graduate Student Academic Award