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MUSIC THERAPISTS' SELF-COMPASSION, COMPASSION FOR OTHERS, AND PROFESSIONAL QUALITY OF LIFE

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree Master of Music in Music Therapy in the College of Fine Arts at the University of Kentucky

By

Jamie Elisa Rushing

Lexington, Kentucky

Director: Dr. Olivia Yinger, Assistant Professor of Music Therapy

Lexington, Kentucky

2017

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ABSTRACT OF THESIS

MUSIC THERAPISTS' SELF-COMPASSION, COMPASSION FOR OTHERS,

AND PROFESSIONAL QUALITY OF LIFE

As helping professionals, music therapists show compassion to their clients but may lack necessary self-care skills to prevent burnout and promote well-being. Due to a lack of research in this area, this study investigated reported levels of compassion for others, self-compassion, burnout, secondary traumatic stress, and compassion satisfaction among music therapists in relation to age, gender, and years of professional experience. A survey of 575 board certified music therapists in the USA revealed higher levels of compassion for others than self-compassion, low levels of burnout and secondary traumatic stress, and high levels of compassion satisfaction. Burnout strongly negatively correlated with both self-compassion and compassion satisfaction and strongly positively correlated with secondary traumatic stress. A MANCOVA revealed significant differences in compassion for others and compassion satisfaction based on gender, with female participants reporting significantly higher scores for both constructs. Additionally, there was a trend related to self-compassion and compassion levels increasing over time. There were strong associations between compassion and self-compassion with burnout and secondary traumatic stress; therefore, it would benefit music therapists to cultivate compassion practices to lower burnout risk.

KEYWORDS: Burnout, Compassion, Music Therapy, Self-Care, Self-Compassion

Jamie Rushing

4-20-17

MUSIC THERAPISTS' SELF-COMPASSION, COMPASSION FOR OTHERS, AND PROFESSIONAL QUALITY OF LIFE

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To my mom, Jeanne Cobb; my siblings, David, Enid, and Sarah; my kids, Elliott, Even, Ethan, and Eric; and my BFF Libby. For always showing me compassion, encouragement, and unconditional love, I have the deepest love.

Without you, this would not be possible.

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When I was a senior in high school, Mr. Bob Kintner, a self-proclaimed “music scientist,” coached me through many hours of vocal training for my role as Eliza Doolittle in “My Fair Lady.” His training was my initial exposure to the science behind music and included progressive relaxation techniques, exercises for posture, stamina, and breath control, and some physiology behind vocal resonance and sound frequency. As I bowed on stage, I saw my dad beaming proudly from the audience with flowers in his hand. He passed away three weeks later.

Six months later, I arrived on the campus of my father’s alma mater, Transylvania University, wanting to major in music therapy. Since that was not an option, I studied psychology and earned my B.A. in music education. Three decades later, my dream of pursuing a career in music therapy has become a reality. Now that I am working in this profession, I have realized the importance of maintaining a balance of personal and professional well-being, through giving compassion to others and to myself. This is not easy for me, and as I have discovered, nor is it for many of my colleagues who also work in music therapy.

I hold deepest gratitude for those who have helped me along this journey of self-actualization: my mother, Jeanne; my four beautiful boys, Elliott, Evan, Ethan, and Eric; my siblings, David, Enid, and Sarah; my dear friend Libby; my coach Cindy Reed; my music therapy colleagues; my advisor, Dr. Olivia Yinger; and all of my friends. I dedicate this to the memory of my father, a musician and educator himself, Dr. William Daniel Cobb III, who instilled in me a profound appreciation for music and showed me its healing powers.

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CHAPTER ONE: INTRODUCTION

People in helping careers often show compassion for others but do not extend that same amount of compassion for themselves (Figley, 2002). This can lead to compassion fatigue and burnout, and it can negatively impact career longevity and client care (Decuir & Vega, 2010). Helping professionals often have high levels of compassion satisfaction, gaining pleasure from doing their work well and from helping those in need (Stamm, 2009). Altruism, or wanting to give to others with no expectation of a reward (Batson, 1991), and empathy, the understanding of another's pain (Davis, 1983), are common traits of helping professionals. But how often do helpers help themselves? Can helping professionals deliver quality care to their clients if their own well-being is compromised by neglect? What needs to happen to improve overall well-being personally and professionally for a helping professional to provide the best patient care?

According to Rutgers University-Newark School of Public Affairs and Administration, helping professionals "nurture the growth of, or address the problems of a person's physical, psychological, intellectual, emotional or spiritual well-being, including through medicine, nursing, psychotherapy, psychological counseling, social work, education, life coaching, and ministry" ("Social Work" n.d., para 1). Helping professions include teachers, doctors, nurses, social workers, psychologists, and even creative arts therapies like music therapy (Clements-Cortez, 2013). Compassion, kindness, and warmth are common personality traits among helping professionals and these traits often lead them into altruistic careers. Compassion is defined as the ability to recognize the suffering of others combined

with the desire to help alleviate it (Lunt, 2002). Self-compassion is “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one’s inadequacies and failures, and recognizing that one’s own experience is part of the common human experience” (Neff, 2003, p. 224). The ability to give and receive compassion can induce positive mental states and can also be a buffer against negative emotions (Pommier, 2010).

Helping professionals encounter stressful, and often traumatic, stories and situations regarding their clients. This can impact professional quality of life, which is how a helper feels about his/her work, and lead to symptoms of burnout (exhaustion) or secondary traumatic stress (fear) (Stamm, 2009). Helpers also experience positive feelings toward their work, which Stamm (2009) refers to as “compassion satisfaction”. The importance of self-care is becoming more prevalent among helping professionals as a way to combat burnout and improve professional quality of life. The helper needs to have self-care strategies and coping mechanisms in place for him/herself in order to create a professional boundary between work and personal life. Self-care has many forms: physical, psychological, social-emotional, and spiritual (Richards, Campenni, & Muse-Burke, 2010). It can be difficult for helping professionals to take the time and energy to practice personal and professional self-care; helpers place a high value on their service to others and believe in the impact their help has on clients. Indeed, helpers achieve a great deal of pleasure from doing their jobs well, which can be self-fulfilling for a long time. If helpers truly value giving and receiving help, they need to see the necessity of

performing self-compassionate acts to improve their own quality of life (Raab, 2014). While compassion studies have been conducted in other helping professions such as counseling, health care, and education (Neff 2003b), none have yet been conducted specific to music therapists.

Music therapy is an evidence-based helping profession that uses music as the tool to address a wide array of non-musical goals related to various conditions; it is used to address a wide array of issues presented by clients' needs in a variety of settings (e.g., educational, correctional, geriatric, medical, mental, and wellness) with clients of all ages (i.e., birth to end-of-life) where they encounter a wide range of potentially stressful or traumatic client problems and challenges. Although the American Music Therapy Association Code of Ethics 1.5 (2015) emphasizes that music therapists should be aware of personal limitations and take necessary actions to ensure client care is not negatively affected by the therapist's problems, the relationship between professional quality of life and compassion and its potential impact on career longevity has not been explored. This gap in the literature provides a rationale for the current study.

Operational Definitions

Burnout (BO) is defined as “feelings of hopelessness and difficulties in dealing with work or in doing your job effectively” (Stamm, 2009, p. 13).

Compassion is defined as the feeling or emotion present when a person is moved by the suffering or distress of another, combined with the desire to relieve that suffering (*Lunt, 2002*).

Compassion fatigue (CF) is the negative aspects of helping professions including burnout and secondary traumatic stress (Stamm, 2009).

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

Helping profession is a “profession that nurtures the growth of or addresses the problems of a person's physical, psychological, intellectual, emotional or spiritual well-being, including medicine, nursing, psychotherapy, psychological counseling, social work, education, life coaching and ministry” (“Social Work” n.d., para 1)

Music therapy is defined by the AMTA as the “clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (“What is Music Therapy”, 2017, para 1).

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

Secondary traumatic stress (STS) 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, Campenni, & Muse-Burk, 2010, p. 252).

Self-compassion (SC) is “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one’s inadequacies and failures, and recognizing that one’s own experience is part of the common human experience” (Neff, 2003a, p. 224).

Purpose

The concepts of professional quality of life and self-care are gaining popularity and are distinctly outlined as ethical responsibilities within health professions. Compassion for others and self-compassion as self-care are less frequently addressed, especially in the field of music therapy. Although various studies have looked at compassion satisfaction, compassion fatigue, and burnout in music therapy, no studies examine the relationship between professional quality of life factors and self-care (specifically, compassion for others and self-compassion). However, learning what professionals like about their jobs is just as important as knowing what they do not like; otherwise, how can a more comprehensive understanding of professional quality of life be measured and, in turn, be practiced. It is not enough to show compassion to others if helping professionals neglect giving themselves the same consideration. To achieve higher levels of compassion satisfaction and possibly help mitigate different effects of burnout like emotional exhaustion, depersonalization, and a sense of lower personal accomplishment it is important to understand the trauma factors of compassion fatigue and the risks for burnout (DePanfilis, 2006). If music therapists are not mindfully aware of their levels of compassion satisfaction and take steps to take care of themselves in terms of intentional self-care, compassion fatigue may set in which can lead directly to burnout.

Therefore, the purpose of this study is to investigate professional quality of life factors, compassion for others, and self-compassion in board certified music therapy

professionals in the United States. This study investigates the following research questions:

1. What are the perceived levels of self-compassion, compassion for others, and professional quality of life factors (compassion satisfaction, burnout, and secondary traumatic stress) in music therapy professionals?

2. Is there a relationship between levels of self-compassion and compassion for others?

3. Are there relationships between music therapy professionals' (a) compassion for others and self-compassion, (b) professional quality of life, and (c) age and years of music therapy experience?

4. Does gender have an effect on compassion for others, self-compassion, or compassion satisfaction?

These questions will be answered using the following validated measures: Professional Quality of Life (ProQOL), version 5, which includes subsets of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm, 2009); The Compassion Scale (Pommier, 2011); and The Self-Compassion Scale (Raes, Pommier, Neff, & Van Gucht, 2011).

CHAPTER TWO: REVIEW OF LITERATURE

Personality Traits of Helpers

People who choose to pursue work in helping professions tend to possess prosocial personality characteristics that naturally lead them into altruistic careers (Elsenberg et al., 1989). Altruism, the ability to give without looking for rewards (Ruppenthal, 1957), and prosocial behavior, acts made in favor of another person without awaiting material or social reward (Bierhoff, 2002), are common traits in helping professionals. These behavioral tendencies can be problematic because they can contribute to an emotional imbalance in helpers when they give more than they are receiving (Bierhoff, 2002). While possessing compassion, empathy, and kindness, helping professionals demonstrate a unique ability to understand and focus on improving the well-being of those who seek their help (Skovholt, Grier, & Hanson, 2001). Helpers derive a high level of compassion satisfaction as they gain pleasure from doing their work well (Stamm, 2005) and from seeing positive changes and impact on their clients (Radey & Figley, 2007). For example, research from The American Psychological Association suggests that, as helping professionals, psychotherapists' characteristics and actions are important for them to deliver effective treatment to patients. Characteristics include verbal fluency, interpersonal perception, affective modulation and expressiveness, and warmth and acceptance (Wampold, 2011).

Researchers have investigated personality characteristics of music therapists: emotional stability (Gilliland, 1952); integrity (Eustis, 1953); self-awareness and insightfulness (Sutton, 2002); good communication skills (Borczon,

2004);friendliness, responsibility, adaptability, initiative, versatility (Shatin et al., 1963); oriented toward social service (Shatin, Kotter, et al., 1964); prudent, sober, conscientious, and trusting (Shatin, et al., 1968a); and outgoing (Shatin, et al., 1968b). More recently, Vega (2010) identified music therapists' top self-reported personality traits using the tests "The Sixteen Personality Factor Questionnaire" and the "Maslach Burnout Inventory-Human Services Survey" (Cattell, Cattell, & Cattell, 1993) to examine possible relationships between personality, burnout level, longevity, and demographic variables among professional music therapists. Ranked in order from greatest to least, her findings revealed the following personality traits: Sensitivity–they tended to use personal beliefs and esthetic values in making judgments; reasoning–they tended to be logical, and solve problems efficiently; apprehension–they were highly sensitive and tended to be worriers; warmth–they were comfortable in social situations and tended to have a need to connect with others; openness to change–they tended to enjoy experimenting and looking at situations in non-traditional ways; self-reliance–they tended to make decisions on their own and may have difficulty working with others; extraversion–they tended to be people-oriented and likely to reach out to develop relationships with others; anxiety–they tended to be reactive and in a state of "fight-or-flight;" abstractedness–they tended to be lost in thought and were creative individuals; rule-consciousness–they tended to have high standards of right and wrong and respected cultural values; and self-control–they tended to inhibit their urges and are not impulsive individuals (Vega, 2010).

Professional Quality of Life

Aspects of professional quality of life have been studied in a number of helping fields to measure different facets of professional well-being. The Professional Quality of Life (ProQOL) scale, version 5 (Stamm, 2009), consists of three categories, and although each subset can be found in other measurement tools, the ProQOL combines these subsets to measure professional well-being in the categories of compassion satisfaction and compassion fatigue, which encompasses secondary traumatic stress and burnout. According to Stamm's Bibliography of Compassion Satisfaction, Compassion Fatigue, Secondary Trauma and Vicarious Trauma (2016), the ProQOL has been used in 667 studies across the globe, and referenced 2,017 times between 1984 and January 2016.

Professional quality of life is defined as "the quality one feels in relation to their work as a helper" (Stamm, 2010, p. 8). Helpers include various health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, mental health professionals, counselors, social workers, and art and music therapists. These are dedicated professionals who demonstrate high levels of compassion satisfaction, gaining pleasure as well as the payoffs from doing their jobs well. This concept of professional quality of life indicates how well people handle common stressors and potentially significant risks associated with job responsibilities that are inherent in the work of helping professionals (Lawson & Myers, 2011). According to Oxford Dictionaries online (2017), stress is defined as a state of mental or emotional strain or tension resulting from adverse or demanding circumstances. Selye (1976) defined stress as the perception of threat, with resulting anxiety, tension, and

difficulty in adjustment. Negative responses to stress can cause feelings of hopelessness, difficulties in job performance, frustration, exhaustion, or more severe symptoms like secondary traumatic stress, sleep disruption, fear, avoidance and depression.

Compassion satisfaction, burnout, and secondary traumatic stress are included in Stamm's (2009) Professional Quality of Life (ProQOL) scale, version 5, a validated self-report measure that poses questions about compassion satisfaction (CS)—the satisfaction one derives from doing his or her work well—and compassion fatigue (CF)— that consists of the negative aspects of a helping profession. For people working in helping professions such as music therapy, maintaining a professional quality of life that supports career satisfaction can be challenging, since compassion fatigue can lead to burnout, ultimately affecting a therapist's ability to treat clients effectively. To boost their professional quality of life, helpers need to adopt positive career sustaining behaviors, "those behaviors used to enhance, prolong, and make more comfortable one's work experience" (Brodie, 1982, p. 1).

Compassion Satisfaction

Many helping professionals experience positive feelings of fulfillment from the experience of helping others, and it is important that these positive effects of the work be recognized as meaningful and potentially sustaining (Radey & Figley, 2007). Compassion satisfaction relates to the pleasure one derives from doing his or her work effectively (Stamm, 2005). According to Stamm (2009), helping professionals with high levels of compassion satisfaction are notably happy, enjoy pleasant thoughts, are driven, and believe their work can make a difference. Those with high levels of compassion satisfaction may have positive feelings toward their colleagues or their organization; one

of the strongest indicators of compassion satisfaction has been found in those who recognize the positive impact on their clients (Radey & Figley, 2007). Other factors that have been shown to improve compassion satisfaction include trauma training (Sprang, Clark, & Whitt-Woosley, 2007), a sense of optimism, having social resources, displaying positive affect, and a balance between professional and personal life (Radey & Figley, 2007). Results of another study attributed greater compassion satisfaction to higher levels of individual and organizational self-care (Jenaro, Flores, & Arias, 2007).

Findings among licensed clinical social workers in Kentucky revealed significant, direct associations of higher mindfulness and emotional separation scores with higher compassion satisfaction scores while empathic concern had a significant, direct, positive association with compassion satisfaction (Thomas, 2011). Thomas concluded that mindfulness contributes to lower burnout and higher compassion satisfaction, including "higher-level processing of personal and interpersonal experiences in a way which allows for increased ability to deeply comprehend and interpret experiences both cognitively and emotionally" (2011, p. 175). Thus, cultivating mindfulness practices could be beneficial for music therapists' in regard to career longevity and client care.

Compassion Fatigue

Compassion fatigue is a term used to describe burnout symptoms and secondary stress reactions among helping professionals who treat clients who are suffering or have experienced trauma (Stamm, 2005). Since the 1970s, the term "burnout" was used for diagnosing doctors, nurses, and caregivers who invest a great deal of time and energy in their work at the expense of their own well-being. Freudenberger first used the term

"compassion fatigue" to replace burnout and this new term was officially attributed to health care workers, therapists, and helping professionals in 1981. Compassion fatigue was a term specific to burnout among psychotherapists but is now used for a multitude of other focused professions (Figley, 1995; Joinson, 1992). For example, one study has shown that 86% of ER nurses are in the moderate to high-risk range for compassion fatigue (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), while Hamann (1990) found music teachers to have a higher attrition rate than general education teachers due to higher burnout levels. Counselors, teachers, psychotherapists, nurses, and other professionals whose work emphasizes human interaction, all involve attachment, empathy, and separations, which can cause stress for the helper (Shanafelt, Bradley, Wipf, & Back, 2002).

While working with a range of clientele, helping professionals often hear painful and traumatic stories from those they help. Because of the emotional strain, professionals in these areas can find maintaining career satisfaction challenging, and they may reach a point at which the compassion fatigue is so overwhelming that they leave their jobs. It can occur gradually over time, suggesting that the very act of viewing others' suffering causes one to suffer. Common factors among helping professionals affected by compassion fatigue are an over-dedication to their jobs in the form of taking it home with them, and an overly emotional response to the traumatic issues they encounter on the job. This type of fatigue can decrease one's interest in carrying the suffering of others and, in turn, can decrease the helper's ability to effectively treat clients (Sprang et al., 2007).

There are two aspects of compassion fatigue that can result in emotional and physical reactions to work-related trauma. Burnout is fueled by a cumulative buildup of feelings of exhaustion, hopelessness, frustration, anger, and depression, and can have negative results like sleeplessness and difficulty coping with work. The second part, secondary traumatic stress, is a negative response driven by fear and direct work-related trauma (Stamm, 2010). This can result in more severe reactions like a preoccupation with traumatized clients by re-experiencing the traumatic events, or avoidance or numbing of reminders that cause persistent anxiety associated with the patient. This state of tension is a function of bearing witness to the suffering of others and is known as secondary exposure to trauma (Pearlman & Mac Ian, 1995). The very act of being compassionate and empathic extracts a cost under most circumstances. Compassion fatigue can be exacerbated by helpers' struggles to perform well in their careers while simultaneously dealing with potentially traumatic issues in the workplace (Korczak, Kister, & Huber, 2010).

Burnout. Burnout is characterized by a gradual onset of feelings of hopelessness, frustration, anger, and possibly depression stemming from work-related stress (Stamm, 2010). The impact of negative feelings varies greatly depending on individuals' experiences and their abilities to cope with stress. Helping professionals can be especially susceptible to burnout due to their kind, compassionate, and altruistic nature; according to Larson (1993), workers who are the most idealistic, altruistic, and committed are among the first to burnout. Over the last two decades, researchers have produced numerous writings on the subject of professional quality of life in relation to helper/caregiver experiences with their

clients (Figley, 1995b), with some suggesting a direct relationship between work-related stress and career longevity (Bride, 2007), or expressing concerns about the social, psychological, and economic costs of worker attrition rates (DePanfilis, 2006).

Many causes of career burnout have been identified in helping professionals who are particularly vulnerable to stress (Cummins, Massey, & Jones, 2007). Severe burnout among critical care doctors and nurses has been attributed to factors such as a high number of working hours, poor conflict management skills, and a lack of good communication between themselves and co-workers (Embriaco, Papazian, Kentish-Barnes, Pochard & Azoulay, 2007). In a study by Cohen-Katz, Wiley, Capuano, Baker, and Shapiro, nurses attributed burnout to "extended work hours, giving intense emotional support in the face of clients' suffering, having little power and control in physician-controlled work environments, and dealing daily with pain, loss, and traumatic illness events" (2005, p. 302). Among social workers, burnout factors include large and strenuous caseloads, time deadlines and constraints, crises and emergencies, and safety concerns (Adams, Boscarino, & Figley, 2006). Physical and occupational therapists reported that the close relationship between provider and client was inherently emotionally draining and stressful (Balogun, Titiloye, Balogun, Oyeyemi, & Katz, 2002). In these careers and others, Büssing and Glasser (2000) determined that a very high workload and a non-supportive work environment are factors for burnout. Additionally, Alkema et al. (2008) found that those starting a helping career later in life are more susceptible to burnout because they have not built up the self-care strategies of those who started young in the field who adopted

ways of coping early on. Finally, for music therapists, Decuir and Vega (2010) have shown that dissatisfaction with salary and benefits play a major role in burnout.

As a result of burnout, healthcare professionals may find it difficult to do their jobs effectively. Burnout can adversely affect the quality of decision-making and the capacity for developing or maintaining optimal client-worker relationships (Conrad & Kellar-Guenther, 2006). Negative feelings can cause helping professionals to believe that their efforts make no difference; thereby, they can "detach from work and other meaningful relationships" and have "lowered productivity, cynicism, confusion...a feeling of being drained, having nothing more to give" (Gorkin, 2010, para. 1). In 1987, Oppenheim reported that almost half of the music therapists who participated in that study were experiencing moderate levels of burnout and 12% reported high levels of burnout. However, another study found that despite reporting average levels of emotional exhaustion, music therapists had greater emotional exhaustion than the average mental health worker (Vega, 2010).

As helping professionals, it is imperative for music therapists to understand personal tendencies and recognize potential work-related causes and factors that lead to burnout. This can aid music therapists in "identifying warning signs, enable them to seek help, and understand their own professional development on a deeper level" (Clements-Cortéz, 2013, p. 167). Because compassion fatigue is a form of burnout affecting people in caregiving professions (Alkema et al., 2008), it is important for music therapists to consider this as a potential issue they may face and address it appropriately and preventatively. Deliberately putting strategies in place at the onset of a career will prevent getting caught by the gradual build up of potential career

ending factors. For music therapy faculty, self-awareness and contemplation have been identified as ways to combat burnout (Richardson-Delgado, 2006), and as Swezey (2013) stated, " ...burnout experienced by music therapy faculty could affect the advancement of the music therapy profession as a whole, as the field needs strong, health educators to produce professionals who meet the rigorous standards of the work" (p. 26).

Secondary traumatic stress. The second factor of compassion fatigue is secondary traumatic stress, which is defined by Stamm (2009) as "work-related, secondary exposure to extremely stressful events" (p. 13) among professionals who are empathically engaged with others who are traumatized or suffering. This fear-driven response arises from a helper's exposure to clients who have experienced traumatic or extreme life events and can create problems with sleep, induce fearful thoughts and images, cause avoidance of situations that could be reminders of the trauma, and impact responses to stressful events (Stamm, 2009).

Over the last two decades, a growing body of work on the effects of this secondary exposure on helping professionals has emerged (Figley, 1995; Sprang et al., 2007). In order to combat stressors and avoid burnout and compassion fatigue, it is important for professionals in helping careers to engage in career sustaining behaviors and self-care strategies to positively cope with their work and the associated emotional stress they harbor. If helping professionals only focus on the needs of others and neglect addressing their own needs, they risk burnout and compassion fatigue unless they practice coping strategies to maintain overall well-being.

Self-Care

In relation to music therapy and other helping professions, self-care is defined as any deliberate, ongoing action taken to improve one's physical and psychological well-being, and involves the therapist staying attuned to his or her needs, feelings, and values (Dileo, 2000). Counseling professionals in the past were trained to focus on others and their own self-care was secondary (Skovholt, et al., 2001), but as recent research has revealed the benefits of self-care practices, helpers have started developing a framework for self-care to carry throughout their careers. Carl Rogers, a prominent figure in counseling, once noted, "I have always been better at caring for and looking after others than I have in caring for myself" (1995, p. 80). This sentiment is echoed in subsequent research on self-care, which finds evidence that those trained to care for others generally neglect themselves, ignoring the same advice they give to their clients (Cummins et al., 2007; O'Halloran & Linton, 2000).

Self-Care Domains

Self-care practices are often grouped as one of the following domains: physical, psychological, support, and spiritual (Richards et al., 2010). Definitions of these self-care domains are as follows:

- Physical — any physical activity and daily functions;
- Psychological — involves thoughts and cognitions, and one's personal counseling;
- Support — consisting of relationships with personal and professional support systems;

- Spiritual — encompassing the beliefs and values one has (Richards et al., 2010, p. 252).

The literature on common physical self-care strategies names physical exercise (Cohen-Katz et al., 2005); proper nutrition (Myers, Luecht, & Sweeney, 2004); sleep behaviors (Kraus, 2005); yoga and stretching (Valente & Marotta, 2005); deep breathing (Kravits, McAllister-Black; Grant, & Kirk, 2010); and illness prevention and active leisure engagement (Myers, et al., 2004). Helpful psychological self-care strategies include setting limits in the workplace, engaging in positive self-talk, practicing self-understanding/awareness, and using humor (Baker, 2003; Cummins et al., 2007; Franzini, 2001; Myers et al., 2004; Richards et al., 2010; Shanafelt et al., 2005) and engaging in personal therapy (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Mahoney, 1997). Research regarding support as a self-care strategy suggests that relationships with family and friends are strong indicators of higher job satisfaction (Myers et al., 2004; Stevanovic & Rupert, 2004). Other support areas include going to? social events, having couple time, going to non-work related events, and having discussions with colleagues (Myers et al., 2004); seeking supervision (Fereday, 2011); and engaging in quality relationships with co-workers by having effective communication and management of conflicts (Embriaco et al., 2007; Poncet et al., 2007). Spiritual self-care can include an array of practices from traditional and organized religion, to more eclectic and individualized versions of spiritual practice (Baker, 2003). Other forms of spiritual care include meditation or prayer, mind-body practices like visualization and deep muscle relaxation, spiritual journaling, pastoral

care, and retreats (Aycock & Boyle, 2009; Baker, 2003; Richards et al., 2010; Valente & Marotta, 2005).

Benefits of Self-Care

Research on the value and benefits of regular self-care for helping professionals has increased over the last two decades as helpers and employers alike reap the benefits of improved career satisfaction, higher morale in the workplace, better? retention rates, and increased client care (Conrad & Kellar-Guenther, 2006). In "The Resilient Practitioner," Skovholt and Trotter-Mathison explored several strategies for self-care and burnout prevention in counseling and psychotherapy, offering ways to maintain personal and professional self, from novice to seasoned practitioner (2011). Other researchers have found that some areas benefitted by regular self-care include:

- Prevention of burnout and fatigue symptoms, (O'Halloran & Linton, 2000);
- Increased job satisfaction and compassion satisfaction (Fereday, 2011);
- Prevention of personal and professional impairments (Figley, 2002);
- Career longevity (Skovholt et al., 2001); and
- Wellness (Connolly & Myers, 2003; Myers, Luecht, & Sweeney, 2004).

Helpers need to have self-care strategies and coping mechanisms in place for themselves in order to create a professional boundary between work and personal life. It can be difficult to take time and energy to perform personal and professional self-care because helpers tend to give only to others, placing a high value on the help they give to others, and they believe in the impact that receiving their help has on their clients. Establishing which self-care strategies are most beneficial is imperative in combating

the challenges common in the music therapy profession. Ongoing self-care practices aid helping professionals in improving their quality of live and in turn the care for their clients (Barnett, Baker, Elman, & Schoener, 2007).

The responsibility of helpers to do what they can to ensure they are able to provide the best care possible to their clients is recognized as an important ethical guideline in many helping fields, including music therapy, and has been added to several professional codes of ethics (Barnett et al., 2007; Dileo, 2000; Fereday, 2011). For example, 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) having a competent, compassionate, and ethical practice; (b) overcoming the challenging nature of one's work; (c) preventing 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. The American Music Therapy Association (AMTA) outlined 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 (2012).

As quality client care is of paramount importance, many healthcare organizations and education programs are promoting the practice of self-care strategies such as self-compassion to help combat compassion fatigue in their workers and decrease professional burnout (Barnett et al., 2007). While there is ample research examining

levels of self-compassion, compassion for others, and quality of life within helping professions such as psychology, nursing, hospice care, occupational therapy, and physical therapy, there is limited research on this topic specific to music therapy (Alkema et al., 2008; Balogun et al., 2002; Hooper et al., 2010; LeFevre, 2012). It is important to have a deeper understanding of the positive and negative factors related to being a well-adjusted helping professional, for merely knowing what stressors to avoid is only half the story.

Self-Care via Mindfulness, Meditation, and Compassion

Researchers have studied physical, psycho-emotional, spiritual, and relational self-care practices of people working in a variety of helping professions (Richards et al., 2010). Much of this research has shown that to improve professional quality of life and increase career longevity, helping professionals in many industries would benefit from regularly practicing various forms of self-care (Barnett, et al., 2007). This also has an impact on their ability to treat clients more effectively (Jennings et al., 2005). Other forms of self-care are becoming more widely recognized as the evidence grows supporting its positive effects on well-being. Traditionally used in Eastern philosophies, the practices of mindfulness, meditation, yoga, breath work, and compassion have all gained popularity in Western culture (Armes, 2014). The concepts of compassion and self-compassion are being studied and used within helping professions, as recognition grows of their efficacy for reducing negative affect, emotional exhaustion, and depersonalization while increasing the ability to empathize with clients (May & O'Donovan, 2007). Measuring the quantitative effects from self-care strategies like exercise and proper nutrition is more reliable than measuring self-reported emotional

changes associated with more inwardly focused self-care strategies such as compassion cultivation, meditation, and/or mindfulness techniques; however, the body of empirical evidence supporting inwardly focused self-care practices is growing (Neff & Germer, 2013).

Mindfulness and meditation practices are being utilized in healthcare as effective stress-reduction measures for employees, and yoga and meditation are even being used in schools to improve emotional and physical well-being. For instance, a school in Baltimore offers meditation as an alternative to punishment of student misconduct. The "Mindful Moment Room" is a space where students can stretch, do yoga, breathe, and be calm, allowing students to become aware of their emotional and physical reactions to stress. This provides alternative and acceptable coping strategies to deal with extreme stressors the children may experience in their community or with peers (Bloom, 2016).

Compassion in Helpers

The word compassion is from the Latin derivatives *com* (with) and *pati* (to bear, suffer) (Compassion. (n.d.). To suffer with someone requires the ability to recognize another person's suffering, understand the shared nature of that suffering, and have a desire to alleviate it (Gilbert, 2010). Germer and Neff (2013) listed traits of compassion, such as basic kindness; an intimate awareness of human suffering that can build emotional resilience, life satisfaction, optimism, social connectedness, and happiness. Neff (2003) included three elements in compassion: common humanity, kindness, and mindfulness. Klich (2015) provided information on biofeedback treatment and recognized mindfulness-based meditation as a way to develop self-awareness and

improve the helper's ability to self-regulate. The objective of the biofeedback treatment discussed in Klich's (2015) research was to entrain successive changes in physiological responses like brain, nervous system, and immune function with self-regulation through increasing awareness of self in relation to the world and practicing non-judgment and acceptance.

For helping professionals, the practice of "Mindfulness-Based Stress Reduction," when combined with compassion, helped lower stress levels (Shapiro et al., 2005). Davidson's (2006) study of brain activity in monks who engaged in compassion meditation found activation in parts of the brain that are associated with positive emotion. Thus, this finding suggests that there may be a link between compassion and happiness. In the workplace, compassion can generate feelings of dignity, worth, value (Dutton, Workman, & Hardin 2012), increase gratitude and reduce anxiety (Lilius et al. 2008), and increase a worker's attachment and commitment to his or her organization (Grant et al. 2008). If evidence continues to grow showing measurable physiological benefits of deep breathing, meditation, mindfulness, and cultivating compassion for others and for self, these techniques are likely to become part of the mainstream Western philosophy for good health.

Self-Compassion in Helpers

Self-compassion as a practice for helping professionals has been given more attention in recent years as a means of resiliency against stress, burnout, and emotional exhaustion (Raab, 2014). Neff (2003) offered three components of self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over identification (Germer & Neff, 2013). Furthermore,

Germer and Neff? (2013) define kindness as “warmth”, which has been identified as a top personality trait among music therapists (Vega, 2010). Common personality traits of helping professionals like altruism, empathy, kindness, and compassion are all considered positive and even necessary in order to be effective as helpers. However, these outwardly focused tendencies can lead to compassion fatigue and burnout if helpers are not given the tools to cultivate compassion for themselves as well. Self-compassion requires one to respond to his or her own pain and suffering with the same kindness and understanding as he or she would give to others (Neff, 2003a). In order for music therapists to provide high quality care for clients, it is important to be mindful that empathetic ability can leave them susceptible to compassion fatigue and burnout.

Neff and Dahm (2014) explain that self-compassion is not self-indulgence or instant gratification, which may give immediate pleasure regardless of long-term goals; rather, self-compassion involves a level of mindfulness focused on overall happiness and well-being, even if it is difficult at times to practice. Nor is self-compassion the same as self-esteem, which is often based on a perception of self-worth fed by outside comparisons to others, ranking qualities and failures. Self-compassion can provide an intrinsic motivation for growth as opposed to approaching change through self-loathing, shame, or guilt (Neff, Hseih & Dejitthirat, 2005). It requires a mindful, non-judgmental recognition and acceptance of painful emotions as they arise. Instead of avoiding the pain, one needs to take a step back and create a space, whether it is in the form of time or actually walking away from a situation, in order to allow the brain to process and respond to the

feeling on a logical level, not from a purely emotional reaction (Brown, 2015). This process is the foundation in many compassion practices, from ancient Buddhism to the current work of Brene Brown (2015). Self-compassion starts with recognizing physiological responses to emotional triggers and then leaning into them to discover what they truly mean. Through this, one may deal with triggers rationally and constructively as opposed to reacting habitually with avoidance or lashing out (Germer & Neff, 2013). Through self-compassion, helpers can feel good and live with happiness, because all humans are worthy of experiencing loving kindness and compassion

Benefits of Compassion and Self-Compassion

Research on mindfulness, meditation, and compassion provides evidence of positive physiological and cognitive effects on helpers. Empirical research shows that practicing compassion can help people recover, both physically from illness and bodily harm and psychologically from grief (Brody 1992; Bento 1994; Doka 1989). Klimecki, Leiberg, Lamm, and Singer (2013) suggest that the development of compassion is important for successful social interaction and for maintaining mental and physical health. Using fMRI, Klimecki and colleagues (2013) measured neural changes in adults who were taught to cultivate compassion while observing the distress of others. The study found that deliberate cultivation of compassion offers helpers a coping strategy to foster positive affect when confronted with the suffering of others (Klimecki, et al., 2013). In a different study regarding social and psychological well-being, Kok and Fredrickson (2010) found that increased connectedness and positive emotions had positive effects on adults' parasympathetic

nervous systems. Others found evidence that with brief self-compassion exercises, cortisol levels and heart rate can decrease (Porges, 2007; Rockcliff, Gilbert, McEwan, Lightman, & Glover, 2008). Additionally, there is some evidence that increasing self-compassion increases insula activity, which is associated with empathy (Longe et al., 2009).

Canevello and Crocker (2011) suggested that growth in personal relationships could be shaped when setting compassionate goals for others and for oneself. Additionally, Kuyken et al. (2010) found that the correlation between depression and cognitive reactivity was reduced with increased self-compassion learned through a mindfulness-based cognitive therapy program. When a helping professional acts compassionately toward him/herself, it can build emotional resilience and decrease negative internal reactions like defensiveness, insecurity, and autonomic arousal, while activating the care-giving system including feelings of safety, secure attachments, and the release of oxytocin (Gilbert & Proctor, 2006; Neff, 2016). Neff's (2016) research also indicated that self-compassion is associated with more accurate self-concepts, more caring relationship behavior, as well as less narcissism and reactive anger, because the emphasis is on mindfully accepting the common imperfections shared by all humans and showing kindness and understanding toward the interconnected nature of humanity.

Conclusion

As helping professionals, music therapists focus on meeting the needs of those around them; putting others first is the nature of being a caregiver. Because of this trait, self-care is often neglected and finding a healthy balance between personal and professional well-being can be difficult. Common stressors identified by music

therapists can influence the professional quality of life and satisfaction of music therapy clinicians. Helping professionals are aware of the subject of self-care, but not many use compassion practices as part of their training or regular self-care regiment. Caring for the self is the foundation of being able to care for others. Whether other self-care methods are used, physical, psychological, support, or spiritual, self-compassion may be the foundation upon which overall well-being is built. It is through shared understanding, mindfulness, kindness, and acceptance that emotional resilience is nurtured. When helpers find an inner peace, they are better equipped to have career satisfaction and provide the quality of care they are intrinsically motivated to provide to others. No research exists concerning the relationship between professional quality of life and compassion levels among music therapists. Therefore, the purpose of this study was to investigate reported levels of self-compassion, compassion for others, compassion satisfaction, burnout, and secondary traumatic stress among board certified music therapists. This investigation also provides a baseline of the current levels of the aforementioned variables and any significant relationships with age, years of experience, and gender in order to glean insight into possible areas of improvement concerning personal and professional well-being.

CHAPTER THREE

METHODS

Prior to conducting this study, an exemption for approval was received from the University of Kentucky Institutional Review Board, Office of Research Integrity (Appendix F). Given that the participants were unidentifiable and that disclosure of the participants' responses provided no foreseeable risk, this study was determined to be exempt by the Institutional Review Board.

Participants

All board certified music therapists from across the United States who opted to receive emails through the Certification Board for Music Therapists (CBMT) were invited to take part in this research study via email. Of the 6,801 emails sent, 652 music therapists responded to the survey. Since 76 respondents did not complete and submit the survey, they were excluded from the results, resulting in a final sample size of 576. Four respondents stated they were not working as music therapists and two were in Canada so they did not participate in the survey.

Instrumentation

The survey tool used in this study was comprised of four sections: (a) nine questions created by the researcher about demographic information; (b) 24 questions regarding compassion for others using The Compassion Scale (Pommier, 2011); (c) 12 questions regarding self-compassion using The Self-Compassion Scale (Raes, Pommier, Neff, & Van Gucht, 2011); and (d) 30 questions about professional quality of life indicators using the Professional Quality of Life (ProQOL), version 5,

which includes subsets of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm, 2009).

This study reports the total scores of the three subsets of the ProQOL and the two compassion measures, the relationship between the two compassion scales, and analyzes correlations between the three measures and the above-mentioned demographics. The instruments are further detailed in Appendix B, C, D, and E.

The Compassion Scale and Self-Compassion Scale-SF are both based on a five-point scale. Subscale scores are computed by calculating the mean of subscale item responses. Since subscales were not examined separately, certain subscale scores were reverse scored, and then the total mean of each subscale was used to compute a total mean of each scale.

For the purpose of statistical analysis and scoring for the ProQOL, conversion from sum scores to t-scores is recommended (Stamm, 2009). Raw scores were converted to z-scores, then the z-scores were converted to t-scores using SPSS 21.

Demographic Information

The survey began by asking the participants to answer nine questions designed by the researcher that provided general information regarding their (a) gender; (b) ethnicity; (c) age; (d) years of professional music therapy experience; (e) clinical hours worked per week in music therapy; (f) highest level of music therapy education achieved; (g) age range of clientele served; (h) work settings; and (i) region of the United States in which they currently practice music therapy (See Appendix B).

ProQOL

"The Professional Quality of Life Scale V" (ProQOL is a valid 30-item self-report measure with three, distinct 10-item scales measuring compassion fatigue, compassion satisfaction, and risk of burnout. The scale examines the well-being of helping professionals working with people who have experienced extreme stress or trauma. Participants report information regarding their professional well-being within the last 30 days (Stamm, 2009). Answers are based on a 5-point Likert-type scale: 1 Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often.

Compassion Scale

The Compassion Scale has 24 questions asking: "HOW I TYPICALLY ACT TOWARDS OTHERS-Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale: 1 (Almost Never), 2, 3, 4, 5 (Almost always)." Results of the study by Pommier (2011) show that the Compassion Scale is a psychometrically valid and reliable measure of compassion.

Self-Compassion Scale-SF

The Self-Compassion Scale-Short Form has 12 questions asking, "HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES-Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale: 1 (Almost Never), 2, 3, 4, 5 (Almost Always)." The 12-item Self-Compassion Scale–Short Form (SCS–SF) is an alternative to the long Self-Compassion Scale and is reduced to half

the number of questions, The Self-Compassion Scale–SF is reliable and has the same factorial structure as the original scale. The short scale has a near-perfect correlation with the long scale when examining total scores. The authors do not recommend using the short form if interested in subscale scores, since they are less reliable with the short form.

Procedures

The researcher obtained e-mail addresses from the Certification Board for Music Therapists for all board-certified music therapists practicing in the United States (N = 6,801). A cover letter was included as the initial page of the online survey, explaining the nature of the survey, the instructions for survey participation, and terms of consent (See Appendix A). Participants completed the survey by completing a demographic section, the Compassion Scale, the Self-Compassion Scale-Short Form, 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 576 completed surveys and 76 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 three weeks after

the initial e-mail was sent to AMTA professional members. Two weeks after the initial e-mail, the principal investigator sent reminder e-mails to all potential participants, thanking those who had participated and reminding others that the survey would close after one more week. After the end of the three-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.

Data Analysis

All statistical analyses were conducted using Statistics Program for the Social Sciences Version 21 (SPSS 21). Data were reported using descriptive measures of means, standard deviations, ranges, and percentages. The data were analyzed using a multivariate analysis of covariance (MANCOVA), with gender as the independent variable (male or female) and compassion measures as dependent variables (compassion for others, self compassion, and compassion satisfaction). Age was treated as a covariate.

CHAPTER FOUR

RESULTS

This study examined the levels of board certified music therapists' compassion for others, self-compassion, and professional quality of life. The survey participants completed included the Compassion Scale, Self-Compassion Scale-Short Form, and the ProQOL Scale Version 5.

Sample Description

A total of 652 individuals responded to the email survey. The survey cover letter outlined that completing and submitting the survey constituted informed consent. Of the 652 respondents, 76 participants did not submit the survey; therefore, they were excluded per the cover letter's instructions. The remaining 576 surveys were descriptively and statistically analyzed. Some of these participants did not answer several of the questions, thus resulting in a slightly different "*n*" than the overall "*n*" of 576 for various questions, as unanswered questions were excluded.

Demographic Information

The majority of participants were female (90.3%, $n = 519$) with 9% of participants being male ($n = 52$), which is congruent with the statistics from the 2016 American Music Therapy Association's (AMTA) workforce analysis. Two participants were transgender, while one person indicated "other." One person did not provide an answer.

The racial breakdown of the survey respondents is as follows: 90.0% Caucasian/White ($n = 520$); 4.0% Hispanic/Latino ($n = 20$); 3.0%

Asian/Asian/American (n = 15); 0.3% African American (n = 2); and 3.0% Other (n = 18). These results closely mirror the 2016 AMTA workforce analysis.

Participants ranged from 22–85 years of age. Eight respondents did not answer this question. Most participants were 25 years of age, accounting for 6.3% of all participants. When grouped by age range, most participants (34.4%) were between the ages of 22–29. The percentage of participants in other age groups is as follows: 30–39 (24.2%); 40–49 (14.1%); 50–59 (13.1%); 60–69 (8.2%); and 70+ (1.5%). These percentages are similar to the 2016 AMTA Workforce Analysis. See Figure 1 for individual ages in this study and Figure 4 for details showing age groups.

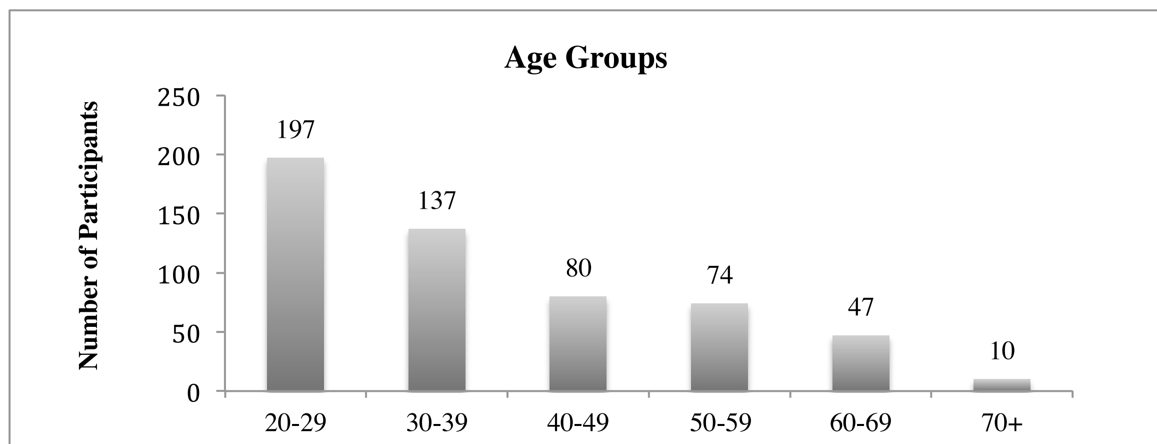

Figure 1. Age groups

Figure 2 shows results of years of experience grouped by five-year ranges. The majority of respondents reported having 1–5 years of professional music therapy experience.

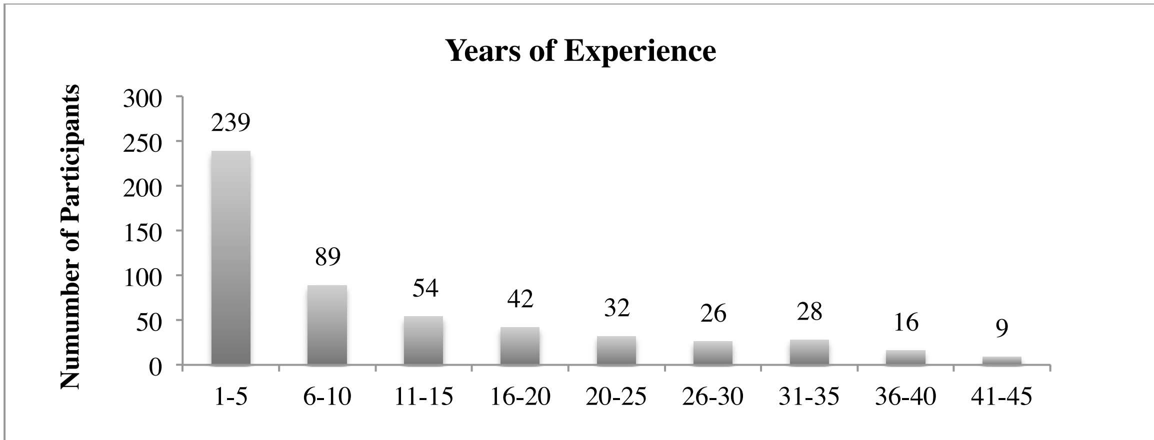

Figure 2. Years of experience by range

The largest percentage of respondents (*n* = 180, 31.3%) reported working in the 35–40 hours per week range. The smallest group (*n* = 22, 3.8%) reported zero clinical hours worked per week. The remaining hourly ranges can be seen in Figure 3.

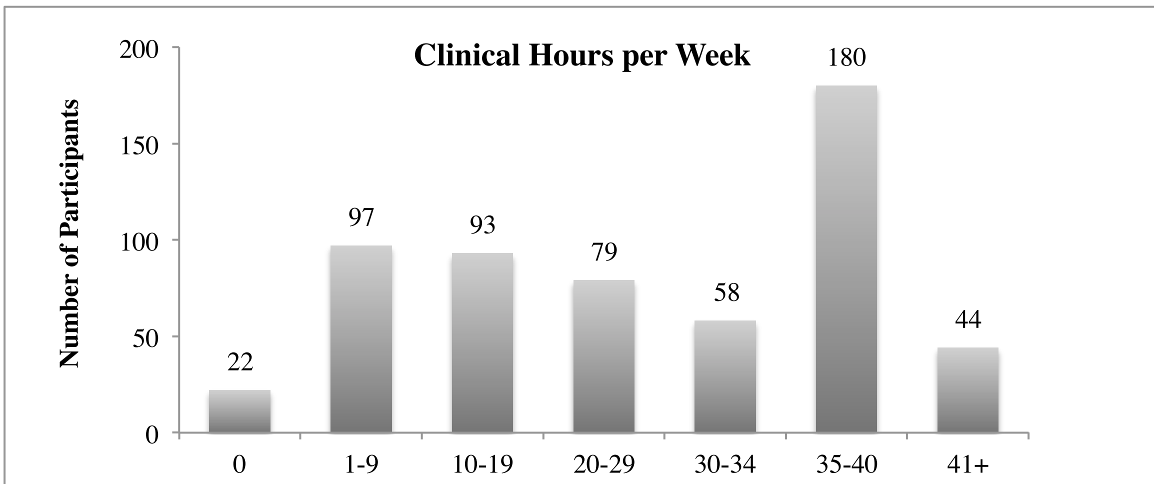

Figure 3. Clinical hours

Nearly half of all participants (48.3%, *n* = 278) reported holding a bachelor's degree as their highest level of educational attainment. Another 39.1% (*n* = 225) had master's degrees. The percentages of participants with bachelor's and master's degrees are almost identical to the 2016 AMTA workforce analysis. Of the remaining participants, 8.9% (*n* = 51) have their equivalency degree, and 3.1% (*n* = 18) reported

having doctoral degrees, which is lower than the 7% reported by the 2016 AMTA workforce analysis. The AMTA analysis included students who had no college degree, accounting for 10.0% of the sample, and it did not give a percentage of equivalency degrees earned. The current study included only professionals; hence, results could be assumed to vary in regard to education (see Figure 4).

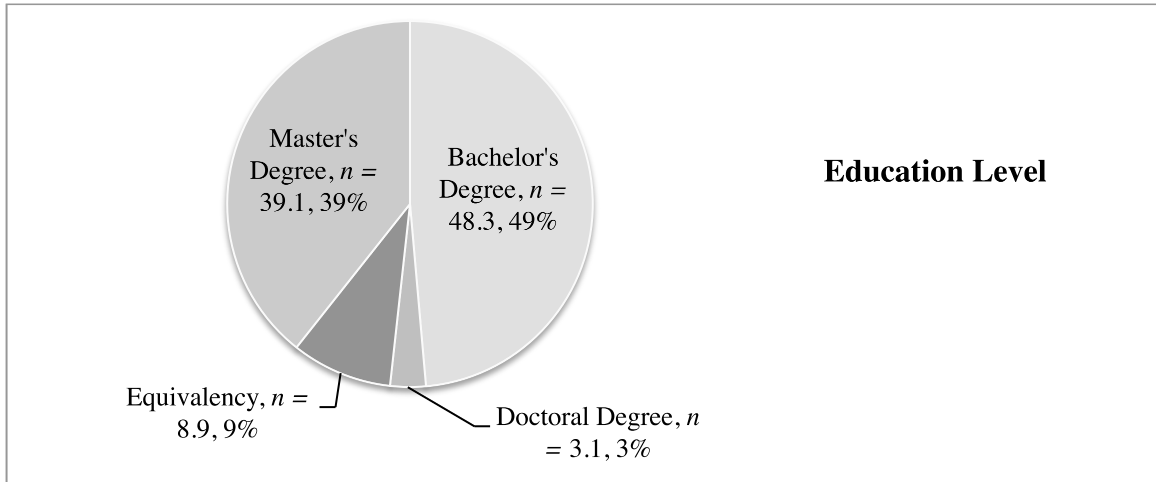

Figure 4. Education level

When asked to indicate which age groups participants work with, they were instructed to check all that apply, resulting in the number of responses being greater than the number of total respondents. Many respondents checked multiple age groups. The age group most frequently indicated was seniors (*n* = 329) and the least indicated was pre-natal (*n* = 24). The remaining numbers are reflected in Figure 5.

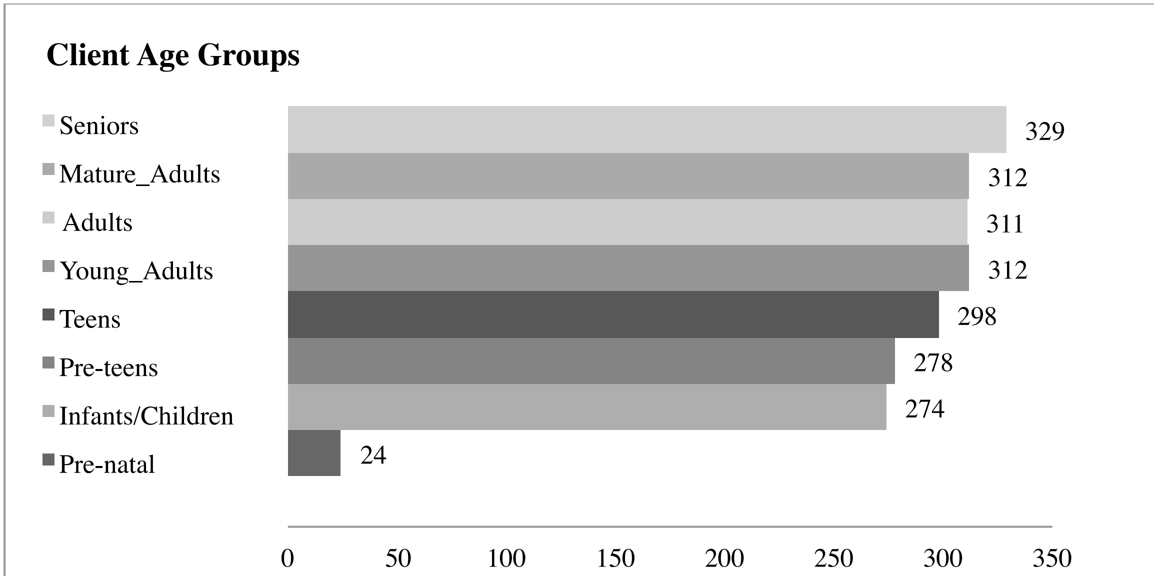

Figure 5. Client age groups

Additionally, participants were allowed to select multiple work settings from the options below; therefore, the total number of responses in Figure 6 is greater than the number of participants. Note: the category "Other Specified" includes responses that were written in. A complete list is provided in Appendix H.

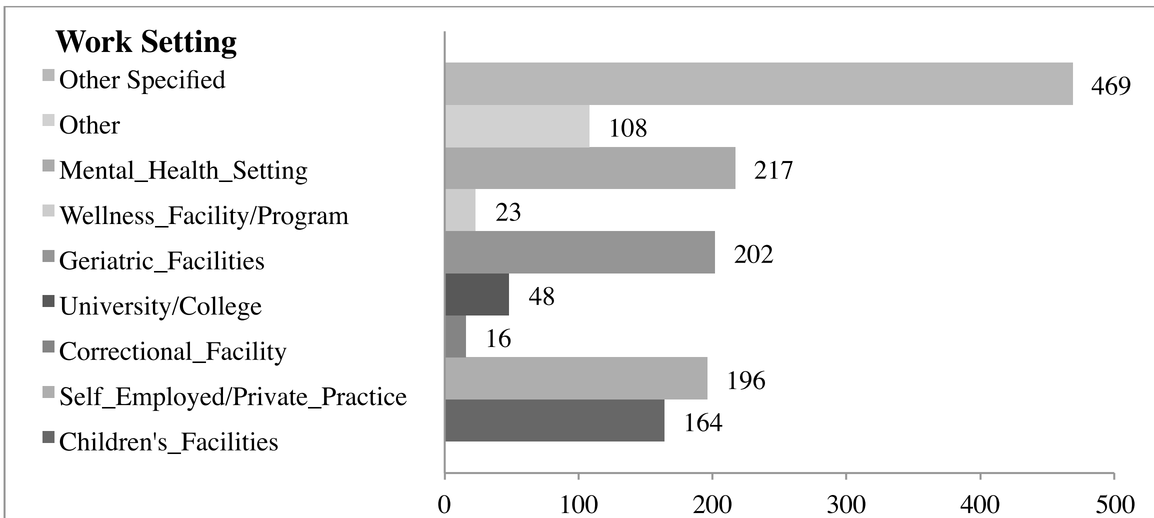

Figure 6. Work setting

The final demographic question asked for respondents to check the region in which they work. Great Lakes and Mid-Atlantic were the largest at 23.0% each. The remaining regions can be seen in Figure 7.

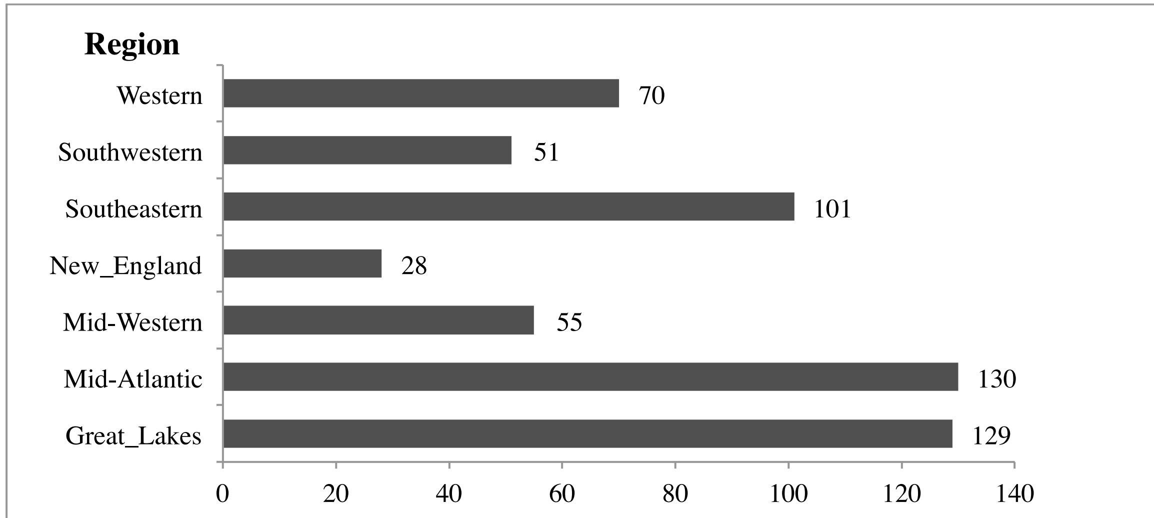

Figure 7. Region

Research Question 1

What are the perceived levels of self-compassion, compassion for others, and professional quality of life (burnout, secondary traumatic stress, and compassion satisfaction) in music therapy professionals?

A total of 549 respondents reported compassion scores, which ranged from 3.33 to 5.00 on a 5-point Likert-type scale (M = 4.37, SD = 0.36). A total of 560 respondents completed the self-compassion scale, with a minimum score of 1.33 and a maximum score of 4.92 on a 5-point Likert-type scale (M = 3.18, SD = 0.70). Professional quality of life indicators (measured on a 50-point scale) included compassion satisfaction (M = 42.15, SD, = 5.34), burnout (M = 20.80, SD = 5.19),

and secondary traumatic stress (M = 19.89, SD = 4.84). Table 1 shows minimum scores, maximum scores, means, and standard deviations for each variable.

Table 1

Descriptive Statistics of Compassion for Others, Self-Compassion, Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Scale	***n***	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Compassion Scale	549	3.33	5.00	4.37	0.36
Self-Compassion Scale	560	1.33	4.92	3.18	0.70
Compassion Satisfaction	563	23.00	50.00	42.15	5.34
Burnout	566	10.00	42.00	20.80	5.19
Secondary Traumatic Stress	553	10.00	44.00	19.89	4.84

Research Question 2

Is there a relationship between levels of self-compassion and compassion for others?

A Spearman's rank-order correlation revealed a weak positive association (r_s = .30, n = 540, $p < 0.001$) between compassion for others and self-compassion. A t-test revealed that there was a significant difference between the compassion for others score and the self-compassion score reported by the participants, t (837) = 35.87, $p < 0.001$. Levels of reported compassion for others were significantly higher than levels of reported self-compassion.

Research Question 3

Are there relationships between music therapy professionals' (a) compassion, (b) professional quality of life, and (c) age and years of music therapy experience?

A series of Spearman's rank-order correlation tests were used to compare the three subscales of the ProQOL V Scale (compassion satisfaction, burnout, secondary traumatic stress), the Compassion Scale, the Self-Compassion Scale-Short Form, age, and years of experience. Self-compassion was weakly positively correlated with compassion for others (r_s = .30, *n* = 540, p < .001), year of experience (*p* < .001, r_s = .27, *n* = 546), and age (*p* < .001, r_s = .28, *n* = 553). Compassion satisfaction was weakly positively correlated with year of experience (p<0.001, r = .22, *n* = 549), and age (p<0.001, r = .22, *n* = 557), and moderately positively correlated with compassion for others (p<0.001, r = .46, *n* = 543) and self-compassion (p<0.001, r = .39, *n* = 552). Burnout was weakly negatively correlated to age (p<0.001, r = -.27, *n* = 559) and years of experience (p<0.001, r = -.24, *n* = 552), moderately negatively correlated to compassion for others (p<0.001, r = -.38, *n* = 547), and strongly negatively correlated to self-compassion (p<0.001, r = -.52, *n* = 556) and compassion satisfaction (p<0.001, r = -.67, *n* = 560). Secondary traumatic stress was weakly negatively correlated with age (p<0.026, r = -.10, *n* = 546), compassion for others (p<0.004, r = -.12, *n* = 534), and compassion satisfaction (p<0.001, r = -.22, *n* = 546); moderately negatively correlated with self-compassion (p<0.001, r = -.33, *n* = 543); and strongly positively correlated with burnout (p<0.001, r = .50, *n* = 551). Correlations between variables are illustrated in Table 3.

Table 3

Spearman Rank-Order Correlations

	Compassion	Self Compassion	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Age	.21	.28	.22	-.27	-.10
Years of Experience	.18	.27	.22	-.24	-.05
Compassion for Others		.30	.46*	-.38*	-.12
Self Compassion			.39*	-.52**	-.33*
Compassion Satisfaction				-.67**	-.22
Burnout					.50**

Note: * = moderate correlation; ** = strong correlation

Research Question 4

Does gender have an effect on compassion for others, self-compassion, or compassion satisfaction?

A multivariate analysis of covariance (MANCOVA) was conducted to investigate the effects of gender on compassion satisfaction, compassion for others, and self-compassion in music therapists using age as a covariate. Wilks's Lambda criterion was used to assess the *F* statistic. When age was held constant, analyses revealed significant differences in between genders in compassion for others (F = 7.41, df = 1, 495, p = 0.007, $\eta_p^2 = 0.02$) and compassion satisfaction (F = 6.67, df = 1, 495, p = 0.010, $\eta_p^2 = 0.01$), but not self-compassion (p = .88). Female participants (n = 452) reported significantly greater compassion for others (M = 4.38, SD = 0.02) and compassion satisfaction (M = 42.23, SD = 0.25) than male participants (n = 46; M = 4.23, SD = 0.05 for compassion; M = 40.13, SD = 0.77 for compassion

satisfaction), whereas levels of self-compassion were similar for female (*M* = 3.15, *SD* = 0.03) and male (*M* = 3.16, *SD* = 0.10) participants.

CHAPTER FIVE

DISCUSSION

This study was the first to investigate relationships between compassion for others, self-compassion, and professional quality of life indicators among music therapists in the United States. While ProQOL indicators like compassion fatigue, burnout, and self-care strategies have received attention from the music therapy profession in the last several years, the potential application of intentional compassion practice as a clinical training tool for music therapists to mitigate burnout and compassion fatigue has not been studied. The purpose of this study was to investigate reported levels of compassion for others, self-compassion, compassion satisfaction, burnout, and secondary traumatic stress among board certified music therapists practicing in the United States. This study also looked at relationships between the aforementioned variables and age and years of professional music therapy experience. Further analyses were conducted to examine gender differences in compassion satisfaction, compassion for others, and self-compassion, with age as a constant.

Research Question 1

What are the perceived levels of self-compassion, compassion for others, and professional quality of life (burnout, secondary traumatic stress, and compassion satisfaction) in music therapy professionals?

Participants reported high levels of compassion for others ($M = 4.37$) and moderate levels of self-compassion ($M = 3.18$), and there was greater variability in self-

compassion (*SD* = 0.70) than compassion for others (*SD* = 0.36). Overall compassion satisfaction levels were high (M = 42.15), while burnout (M = 20.80) and secondary traumatic stress (M = 19.89) were in the low range (on a 50-point scale), according to Stamm's rating system. Table 2 illustrates how to interpret self-reported scores on each of the three sections of the ProQOL (compassion satisfaction, burnout, and secondary traumatic stress).

Table 2

ProQOL Score (Stamm, 2009)

The sum of my questions are:	**So My Score Equals:**	**And my levels are:**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Other studies have shown music therapists are at moderate to high risk for burnout (Oppenheim, 1987) and low risk for secondary traumatic stress (Swezey, 2013). This is common among many helping professionals due to factors like giving so much time and energy to others and not engaging in sufficient coping skills to ward off compassion fatigue. Many factors could account for this difference, like the number and variety of participants, the time in which the tests were conducted, or the knowledge and availability of coping strategies.

Research Question 2

Is there a relationship between levels of self-compassion and compassion for others?

In the present study, participants reported significantly higher levels of compassion for others (*M* = 4.37) than self-compassion (M = 3.18) on a scale of 1–5. The

discrepancy between levels of caring for others and caring for self is a typical finding among helping professionals due to common traits of empathy, kindness, altruism, and compassion for others (Neff & Pommier, 2013). As is typical with helpers, compassionate individuals tend to act more compassionately toward others than they do toward themselves (Neff, 2012). This tendency has been illustrated in many studies and the combination of a lack of self-care and low levels of self-compassion takes a toll on client care and career longevity.

Even though there was a statistically significant difference between self-compassion and compassion for others, the two variables were weakly positively correlated (r_s = .30), indicating a slight trend toward increased self-compassion as compassion increased. Future studies can be conducted to test if changes in self-compassion could have an impact on compassion for others. This would be helpful in developing valid and reliable evidence-based techniques to improve overall compassion levels and well-being. Studies have shown the positive outcomes associated with mindful compassion practices, including extending compassion to self in order for clinicians to manage reactivity in response to clients (Segal et al., 2002). Positive changes can happen when helpers are self-compassionate and they recognize common humanity, the fact that everyone suffers; when they extend the same kindness to themselves as they do to others; and they are mindful of accepting of their own imperfections. This awareness can build emotional resiliency that extends beyond self and out toward others, which ultimately can help them remain longer in a loved profession in spite of its being an emotionally taxing field.

Research Question 3

Are there relationships between music therapy professionals' (a) compassion, (b) professional quality of life, and (c) age and years of music therapy experience?

The initial results from the Spearman's rank-order correlation test revealed a strong negative association between self-compassion and burnout (r_s = -.52) and between compassion satisfaction and burnout (-.67), which shows that individuals who reported higher self-compassion and compassion satisfaction scores tended to report lower burnout scores. The strong positive association between burnout and secondary traumatic stress (.50) is an obvious relationship because burnout rates have been shown to be strongly associated with helpers taking on secondary traumatic stress. There were moderate positive associations between reported compassion for others and compassion satisfaction (.46) and self-compassion and compassion satisfaction (.39), which is perhaps unsurprising, since all of these variables relate to some aspect of compassion. Moderate negative associations were found between compassion for others and burnout (-.38) and self-compassion and secondary traumatic stress (-.33); nevertheless, according to Stamm's (2009) range delineations, reported scores of burnout and secondary traumatic stress fell within the low range.

Although Neff and Pommier (2013) suggested that compassion for self and others could be developed over time, in the present study, the correlation between age and self-compassion was weak, as were the correlations between age and compassion for others and between years of experience and self-compassion and

compassion for others. Additional studies could provide greater insight into the degree to which self-compassion and compassion for others may change over time.

Research Question 4

Does gender have an effect on compassion for others, self-compassion, or compassion satisfaction?

As mentioned in the results above, a multivariate analysis of covariance (MANCOVA) was conducted using age as a covariate and gender as the independent variable. Results indicated that, while small, there were significant differences between genders in compassion satisfaction and compassion for others, but not self-compassion. Although some studies have found that men showed slightly more self-compassion than women (Neff, 2003a; Neff & McGehee, 2010; Neff & Vonk, 2009), other studies found no difference in self-compassion between genders (Neff et al., 2007a; Neff et al., 2007b). Neff and Pommier's research also showed gender differences in constructs similar to compassion for others. As in the current study, women in a 2013 study by Pommier and Neff reported higher levels of compassion for others than men, as well as empathy, perspective taking, and forgiveness, but women also reported more personal distress in response to others' suffering, possibly due to greater sensitivity.

Limitations

Because this is the first study on the association between ProQOL, self-compassion, and compassion for others among current board certified music therapists in the U.S., there are gaps in the current study that will need to be filled by

future studies. As with any research that involves individual self-report concerning behaviors and feelings, findings are reliant on honest and unbiased answers from each participant. There is no way to ensure that the respondents provided accurate assessments of their current compassion levels and professional quality of life factors, nor is there a way to control for possible discrepancies and variance due to personal interpretation of survey questions. The possibility also exists that only those music therapists with the time, energy, resources, and/or interest in the topic of this study could be assessed for this study, which could bias the results toward including participants with lower levels of burnout.

The demographic groups were similar to the 2016 AMTA workforce analysis; however, to provide a more accurate data analysis, a larger sample size is needed. For instance, although gender percentage among music therapists in this study was congruent with the overall population of board certified music therapists in the U.S., the differences between compassion for others and self-compassion based on gender need to be further explored because there were so many more female participants than male participants. Because self-compassion is not necessarily a culturally valued trait, it may be subject to social bias and personal experience. Other demographics like work setting, region, and hours worked per week were not included as variables to be analyzed. There was no survey question regarding participants' theoretical orientation, which could be a factor that influences compassion practice. Nor was there an option to indicate AMTA membership, making it is impossible to investigate the various factor levels in this

study in relation to the support/resources available through the professional association.

Future Research

There are many opportunities for additional research to be conducted on this subject. As this study relied on subjective self-report measures, it would be beneficial to determine if more objective physiological measures (hormone levels, heart rate, and fMRI) would support the current findings regarding self-compassion, compassion for others, and professional quality of life. Changes in compassion for others, self-compassion, and compassion satisfaction over time could be better studied using longitudinal research. Additionally, specific interventions designed to increase compassion for others and self-compassion warrant investigation (e.g., Germer, 2009; Gilbert & Procter, 2006; Kyabgon, 2007). Other studies could explore potential effects of changes in levels of compassion for others and self-compassion on burnout, compassion satisfaction, and secondary traumatic stress. Findings could add to the growing evidence of effective mindful compassion practices.

Further research could explore differences between music therapy and other helping professions. The data in this study could inspire development of strategies for increasing compassion for others, self-compassion, and compassion satisfaction in order to support career longevity, as this study provides a baseline for these levels. This study only included board certified music therapists currently working in the United States, so expanding the survey to music therapists in other countries, where constructs of compassion may differ, could glean a broader understanding of cultural differences in the training and professional characteristics of music

therapists around the world. Self-care strategies could be included to assess the different techniques used by music therapists to cultivate compassion for others and self-compassion. It would also be beneficial to analyze compassion differences between specific work settings, client populations, and regions to ascertain the risk factors and professional well-being with various populations.

Implications

A therapist's most valuable instrument is the therapist's own self (Yalom, 2002). It is recommended that music therapy professionals cultivate consistent self-care practices to develop coping strategies to deal with personal and professional stressors. As a whole, the music therapists in this study reported lower levels of self-compassion than compassion for others. In order to provide the best care for clients, music therapy professionals need to seek help in areas where they to improve. The evidence is emerging surrounding the physiological, psychological, social, and professional benefits of mindfulness and compassion practices. Providing best practice starts with the therapist being at their best. Therefore, opportunities for music therapists to learn self-compassion practice during their training could help improve overall well-being and allow for longer careers with better client care.

Self-compassion and compassion are practices that bridge personal and professional life. These skills can be learned, cultivated, and practiced consistently in order to avoid burnout symptoms and improve professional quality of life. Self-compassion can serve as a mechanism of action in different types of therapy like psychodynamic, as it decreases psychiatric symptoms of anxiety, shame, and guilt, while increasing the willingness to experience painful emotions (Schanche, 2011). In

mindfulness-based cognitive therapy, self-compassion reduces stress levels and can be the key to changing habitual thought patterns (Shapiro, Astin, Bishop, and Cordova, 2005). Emotional resilience can be strengthened through inwardly focusing kindness, acceptance, common humanity, forgiveness, non-judgment, and mindfulness (Neff, 2012). Self-compassion can help mitigate symptoms of depression and anxiety and also increase motivation and emotional intelligence (Neff & Vonk, 2009).

Based on the results of the present study and investigations conducted in the past, it is clear that self-compassion levels need to improve in order to boost overall emotional and physical well-being and, in turn, cultivate more compassion within the workplace to ensure quality client care. The majority of respondents were in their mid-twenties with 1–5 years of experience and this study found that burnout levels decreased slightly as music therapists got older. Perhaps building a professional network for compassion and mindfulness practice that includes music therapy faculty and students could help combat burnout (Ferrer, 2011). Including practical compassion training in the music therapy curriculum could potentially have a positive effect on client care, career satisfaction, and career longevity. The researcher hopes that this study will help bring an awareness to the most basic form of self-care that music therapists could give themselves: self-compassion.

Appendix A: Survey Cover Letter

Dear CBMT Member,

Study Overview

You are being invited to take part in a research study about perceived compassion levels and professional quality of life indicators amongst music therapy professionals. You were selected because you are a board certified music therapist who opted to receive emails through the CBMT.

This study is a research project conducted by Jamie Rushing, MT-BC, to fulfill her master's thesis requirements as part of the master's degree program at the University of Kentucky.

Your helpful responses to this survey will provide our field with a better understanding of the relationship between professional quality of life and compassion levels of board certified music therapists, 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 self-compassion, CO, professional quality of life, and your demographic background. The survey/questionnaire will take approximately 10 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 1350 board certified music therapists, 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. Please complete the survey only if you are currently a board certified music therapist in the United States.

Benefits

Although you may not get personal benefit from taking part in this research study, your responses may help us understand more about professional well-being and levels of compassion of music therapy professionals at the time of this study.

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.

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 02/27/17.
To participate in the survey, please follow the link below:

Music Therapists' Self-Compassion, Compassion, and Professional Quality of Life

Sincerely,

Jamie Rushing, MT-BC
Department of Music Therapy
University of Kentucky
jamie.rushing@uky.edu

Olivia Yinger, PhD, MT-BC
Thesis Advisor
University of Kentucky
olivia.yinger@uky.edu

Appendix B: Demographic Survey Questionnaire

University of Kentucky

olivia.yinger@uky.edu

Gender

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Other

Gender Other

____

Race/Ethnicity

- ☐ African American
- ☐ Asian/Asian American
- ☐ Caucasian/White
- ☐ Hispanic/Latino
- ☐ Other

Race/Ethnicity Other

____

Age

____

Years of professional music therapy experience

____

Clinical hours worked per week in music therapy

- ◯ 0
- ◯ 1-9
- ◯ 10-19
- ◯ 20-29
- ◯ 30-34
- ◯ 35-40
- ◯ 41+

Highest level of music therapy education achieved

- ◯ Bachelor's Degree
- ◯ Equivalency
- ◯ Master's Degree
- ◯ Doctoral Degree

With what age range(s) do you provide music therapy services? (Check all that apply)

☐ Pre-natal
☐ Infants/Children (Birth-7)
☐ Pre-teens (8-12)
☐ Teens (13-19)
☐ Young Adults (20-29)
☐ Adults (30-49)
☐ Mature Adults (50-64)
☐ Seniors (65 and older)

Work Setting(s) (Check all that apply)

☐ Children's Facilities/Schools (Day Care, Preschool, Early Intervention, School K-12)
☐ Correctional Facility
☐ Geriatric Facilities (Adult Day Care, Assisted Living, Geriatric Facility, Nursing Home)
☐ Mental Health Setting (General Hospital, Oncology, Home Health Agency, Outpatient Clinic, Partial Hospitalization, Children's Hospital/Unit, Physical Rehabilitation)
☐ Self-Employed/Private Practice
☐ University/College
☐ Wellness Facility/Program
☐ Other

Work Setting Other

____

In what region of the United States do you currently practice music therapy?

◯ Great Lakes
◯ Mid-Atlantic
◯ Mid-Western
◯ New England
◯ Southeastern
◯ Southwestern
◯ Western

Appendix C: Professional Quality of Life Scale Version 5

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(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 *[helper]*. 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*.

1=Never	**2=Rarely**	**3=Sometimes**	**4=Often**	**5=Very Often**

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

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Appendix D: Compassion Scale (Pommier, 2010)

COMPASSION SCALE
How I Typically Act Towards Others

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				**Almost Always**
1	**2**	**3**	**4**	**5**

_____1. When people cry in front of me, I often don't feel anything at all.

_____2. Sometimes when people talk about their problems, I feel like I don't care.

_____3. I don't feel emotionally connected to people in pain.

_____4. I pay careful attention when other people talk to me.

_____5. I feel detached from others when they tell me their tales of woe.

_____6. If I see someone going through a difficult time, I try to be caring toward that person.

_____7. I often tune out when people tell me about their troubles.

_____8. I like to be there for others in times of difficulty.

_____9. I notice when people are upset, even if they don't say anything.

_____10. When I see someone feeling down, I feel like I can't relate to them.

_____11. Everyone feels down sometimes, it is part of being human.

_____12. Sometimes I am cold to others when they are down and out.

_____13. I tend to listen patiently when people tell me their problems.

_____14. I don't concern myself with other people's problems.

_____15. It's important to recognize that all people have weaknesses and no one's perfect.

_____16. My heart goes out to people who are unhappy.

_____17. Despite my differences with others, I know that everyone feels pain just like me.

_____18. When others are feeling troubled, I usually let someone else attend to them.

_____19. I don't think much about the concerns of others.

_____20. Suffering is just a part of the common human experience.

_____21. When people tell me about their problems, I try to keep a balanced perspective on the situation.

_____22. I can't really connect with other people when they're suffering.

_____23. I try to avoid people who are experiencing a lot of pain.

_____24. When others feel sadness, I try to comfort them.

Pommier, E. A. (2011). The compassion scale. Dissertation Abstracts International Section A: Humanities and Social Sciences, 72, 1174.

Appendix E: Self-Compassion Scale (Neff, 2003a)

Running head: SELF-COMPASSION SCALE–Short Form (SCS–SF) 1

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale – Short Form in your research (12 items instead of 26 items). The short scale has a near perfect correlation with the long scale when examining total scores. We do not recommend using the short form if you are interested in subscale scores, since they're less reliable with the short form. You can e-mail me with any questions you may have. The appropriate reference is listed below.

Best wishes,

Kristin Neff, Ph. D.

e-mail: kristin.neff@mail.utexas.edu

Reference:

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy. 18*, 250-255.

Coding Key:

Self-Kindness Items: 2, 6

Self-Judgment Items: 11, 12

Common Humanity Items: 5, 10

Isolation Items: 4, 8

Mindfulness Items: 3, 7

Over-identified Items: 1, 9

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a total mean.

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	**2**	**3**	**4**	**5**

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix F: IRB Exemption Certification

Office of Research Integrity
IRB, RDRC

EXEMPTION CERTIFICATION

MEMO: Jamie Rushing,
Fine Arts - Music
199 E. Louden Ave
Ste 101
Lexington, KY 40505
PI phone #: (859)983-6681

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

SUBJECT: Exemption Certification for Protocol No. 17-0118-X4B

DATE: February 8, 2017

On February 8, 2017, it was determined that your project entitled, *Music Therapists' Perceived Self-Compassion, Compassion for Others, and Professional Quality of Life*, 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 IRB Survival Handbook web page [http://www.research.uky.edu/ori/IRB-Survival-Handbook.html#PIresponsibilities]. 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.

see blue.

315 Kinkead Hall | Lexington, KY 40506-0057 | P: 859-257-9428 | F: 859-257-8995 | www.research.uky.edu/ori/

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170118X4B

Music Therapists' Perceived Self-Compassion, Compassion for Others, and Professional Quality of Life

Verified "Consent Authorized" N

			Trained:	Date:	DunnChad:	Citi:	Other Test	Authorized
PI	Rushing jamie.rushing@uky.edu	Jamie	Y	10/15/16	N	Y Unassigned	N	
KP	Yinger olivia.yinger@uky.edu	Olivia	Y	12/15/15	N	Y Faculty Advisor Ph.D.	N	Y

Appendix G: CBMT Email Invoice

February 6, 2017

Dear Jamie,

Please return the invoice below when mailing payment for the email addresses sent to you on February 6, 2017. If you have any questions about this invoice, please do not hesitate to contact the CBMT office.

Sincerely,

Hindi Burkett, MT-BC
CBMT Continuing Education Coordinator

*** Please return this slip when mailing payment to the CBMT office**.

Invoice #:
000236 Name:
Jamie Rushing
Item(s): 6,802 email addresses

Payment Due:

$100 Check

Enclosed [_]
Credit Card Payment:
On the CBMT website, click on the **Products and Services** tab, then scroll down to the bottom of the page and click the **Make a Payment** link to enter your credit card payment. Please reference the Invoice # above when entering your payment information.

Note: A 5% late fee will be added to balances that are not paid within 60 day

Appendix H: List of Other Work Settings Provided by Participants

Acute Inpatient Neurological Rehabilitation
Addictions
Adult Day Program
Adult day program and after school program
Adult day training
Adult DD day programs
Adult IDD day services
Adult residences - dev. disabilities
Adults with ID/DD Day Habilitation
Arts administration
Autism Clinic providing medical, behavioral, and clinical treamtent
Brain Injury Rehabilitation
Chemical dependency program
Children's hospital in addition to private practice
Children's Hospital, Adult Day Center
Children's hospital; Women and babies hospital
Client homes
Clients' Households; Hospice Inpatient Unit
Community agency supporting children, families, and adults with ID/DD
Community Center for the Arts
Community Music School
Community Music School Center for Music Therapy
Community Music School with MT program
Day habilitation programs with adults with IDD
Day program for adults with IDD
Day programs for DD
Day programs for people with developmental disabilities
Day services center for adults with developmental disabilities
Developmental Centre
Forensic Psychiatric Hospital
Group homes, private homes, day programs
Home and community services company
Home health agency
Home hospice
Home settings
Home-based
Home-based and inpatient hospice
Home-based services
Homes
Homes
Homes, Hospice Inpatient Unit
Hospice
Hospice Care
Hospice, Assisted Living for TBI patients, Community
Hospice, both community-based and inpatient
Hospice, personal homes
Hospice/Home Care, provide music therapy in many settings including private homes
Hospice/palliative care and bereavement
In home hospice
In Home Hospice
In home therapy
In Home/ Office Setting
Independent Care Facilities for Adults with Disabilities

Individual Homes

Individuals and small groups in home-based MT clinic, day camps, residential camps, after school art & science programs and jam sessions with some typical peers, etc.

Inpatient Psychiatric Facility

Medical

Medical - Hospice

Medical hospital (oncology)

Mental health-private practice

Military families -- community and on installations

Military Hospital

Music school

Music school in community

NICU

Non-profit creative arts therapy facility

On-campus music therapy clinic

Oncology/ Hospice

Private clients-in home

Private in-home

Residential/Group Homes

Residential program

Residential setting for adults with disabilities

Residential Substance Abuse Rehab

Seattle Symphony

Services for adults with developmental and intellectual disabilities

Sheltered workshop

State Institution for adults with IDD

Symphony

TBI rehabilitation unit

Therapeutic Day Program

Veterans Affairs

Waiver

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