The Role of Personal Music Therapy

for Music Therapists

by

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THE ROLE OF PERSONAL MUSIC THERAPY
FOR MUSIC THERAPISTS

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Abstract

The purpose of this paper is to examine whether or not music therapists engage in music therapy as personal therapy. A 32-question survey was electronically distributed to board-certified music therapists (MT-BC) who were working full-time, part-time, or per diem in the United States. Potential study participants were located through the Certification Board for Music Therapists (CBMT) database and contacted by the researcher. Of 177 participants, 55 (31.08%) have utilized music therapy as personal therapy. Music therapists have engaged in music therapy to explore personal issues, receive support, and strengthen professional competencies. For the 122 participants (68.92%) who have never engaged in music therapy as personal therapy, time, finances, engagement in other forms of therapy, and dual relationships within the music therapy profession were leading contributors that deterred music therapists from engaging in personal music therapy. Though a handful of participants believe music therapy is not beneficial for everyone, 95.15% of participants recommended that music therapists receive some sort of therapy. Results of this survey indicate that only a small percentage of music therapists are engaging in music therapy as personal therapy.

*Keywords:* personal music therapy, music therapists
The Role of Personal Music Therapy for Music Therapists

This quantitative research explores the engagement in music therapy as personal therapy by professional music therapists. By discovering how many music therapists are seeking music therapy as personal therapy, the study revealed benefits and limitations of music therapy services to the professional music therapy workforce. Research suggests that a majority of professional clinicians across orientations and disciplines seek personal therapy (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005; Orlinsky, Schofield, Schroder & Kazantzis, 2011). Norcross (2005) found that more than 90% of clinicians who have utilized personal therapy reported beneficial experiences, including personal growth and heightened empathy towards clients.

Chikahni (2015) surveyed music therapists and found that 96.3% of respondents considered personal therapy as a valuable and beneficial experience for personal and professional growth, especially covering topics such as self-awareness, developing coping skills, and working through personal issues. Music therapists have the ethical responsibility to stay well informed about their field and practice safe forms of self-care (Bruscia, 2014). Personal therapy can contribute to developing professional and personal self-awareness. However, it is the researcher's opinion that personal music therapy would allow music therapists to gain better insight on the intricacies of the therapeutic space within a music therapy session.

Stance of the Researcher

I am a graduate student in music therapy, yet I have never engaged in personal music therapy sessions. When I asked myself why I have not engaged in my own personal music therapy process, many factors arose including finances, availability, and
accessibility. Yet, as I delved deeper into my self-questioning, I was faced with the realization that I was not even sure what my own music therapy experience might entail. Which music therapist and what music therapy approach are best for me and my needs? Where do I begin to search for music therapists? Is engagement in verbal therapy already enough? It seemed obvious to me that music therapists should experience personal music therapy, to practice what we preach, so to speak. However, I was faced with the fear of not knowing how to begin personal music therapy, but also the realization that I do not understand the full extent of the music therapy field because I have never been a music therapy client.

As I experienced this professional crisis, I wondered if other music therapists have had similar experiences. My revelation inspired this research and I hope to gain a better understanding of the use of personal music therapy among music therapists.

**Need for Study**

After a thorough search through library databases including ProQuest, EBSCO, psycINFO, and psycARTICLES, no literature examining the utilization of music therapy as personal therapy for music therapists was found. To the researcher’s knowledge, this research would be the first of its kind and provide a foundation for further exploration and research on the topic of personal music therapy for professional music therapists. It may identify gaps in access of service and make determination regarding best practices for music therapists wishing to engage in personal therapy.
Literature Review

A Working Music Therapy Definition

Bruscia (2014) defines music therapy as “a reflexive process wherein the therapist helps the client to optimize the client’s health, using various facets of music experience and the relationships formed through them as the impetus of change” (p. 36). Bruscia offers this broad definition in order to respect the transdisciplinary aspect and continued evolution of the music therapy profession. Stige (2002) states that music therapy is a group of diverse practices that cater to diverse cultures and clients, and that one definition would not encompass all approaches. For instance, “one music therapist may work in schools pursuing educational or developmental goals… [while another] may work in a mental health setting pursuing psychotherapeutic goals” (Bruscia, 2014, p. 10). As a result of being a transdisciplinary practice, music therapy theory stems from disciplines of psychology, sociology, philosophy, medicine, and cultural anthropology. However, all disciplines and orientations of music therapy recognize professional uses of music as an integral part of the therapeutic process (Bruscia, 2014).

Music therapists have the ethical responsibility to stay well informed about their field, especially as it pertains to their work with clients (Bruscia, 2014; AMTA, 2019). This can be as simple as keeping up with relevant research, but also as complex as being self-aware, self-observant, and engaging in self-inquiry (Bruscia, 2014). Music therapists can work through the complexities of the profession through modalities such as personal therapy, supervision, and peer supervision (Chikhani, 2015).
Personal Therapy for Mental Health Professionals

There is significant research analyzing the utilization of personal therapy within the mental health profession. A majority of professional clinicians across orientations and disciplines seek personal therapy (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). The main reasons identified for clinicians entering therapy included working through personal issues and personal growth (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). In a review of seven studies, Norcross (2005) found that more than 90% of clinicians who have utilized personal therapy reported beneficial experiences. In a similar international study of 4000 psychotherapists, 88% reported positive personal benefit from therapy (Orlinsky & Rønnestad, 2005). Oteiza (2010) found that personal therapy for therapists was integral in personal and professional development, recognizing “emotional blind spots and hypersensitivities,” and developing empathy toward clients (p. 227). Bike, Norcross, and Schatz (2009) purport it is “virtually impossible to have undergone personal therapy without emerging with a heightened appreciation of the interpersonal relationship and the vulnerability of a patient” (p. 30).

Geller (2011) solicited essays from highly experienced clinical psychologists of varying theoretical backgrounds in order to gain a better understanding of the outcomes of personal therapy. All psychologists shared the view that personal therapy had a profound influence on the treatment of their own patients. On the other hand, recurrent themes of the problematic aspects of therapy became an important focus of the research. These problematic issues included personal boundaries, dual relationships, power differentials, and shame about being in therapy (Geller, 2011). Wilson, Weatherhead, and
Davies (2015) also found that clinical psychologists were shameful of attending therapy, due to fears of being inadequate or emotionally unstable therapists. Despite this, all of those participants stated that personal therapy was necessary due to the stressful and emotive nature of the profession.

Music Therapists Engagement in Personal Therapy

**Music therapists-in-training.** Gardstrom and Jackson (2011) examined how various modalities of therapy were being utilized by undergraduate music therapy students. The researchers surveyed AMTA program coordinators and only six of 41 respondents required their students to engage in some form of personal therapy. Additionally, one-third of the 41 respondents encouraged students to seek personal therapy in at least one modality, including music therapy, verbal therapy, or other creative arts therapies. Many respondents noted that personal therapy cannot be required as part of the academic program, especially considering the cost and availability of services.

**Professional music therapists.** Chikhani (2015) examined the use of personal therapy amongst music therapists. Of the 111 respondents, only 33.6% of music therapists were utilizing non-music therapy services, while 60.3% had participated in personal therapy at some point during their career. Even so, 96.3% of respondents considered that personal therapy is a valuable and beneficial experience for personal and professional growth, especially covering topics such as self-awareness, developing coping skills, and to work through personal issues (Chikhani, 2015).
Supervision for Professional Music Therapists

Forinash (2001) identified the goal of a supervisory relationship as “to address the complexities involved in helping supervisees in their ongoing (and never-ending) development as competent and compassionate professionals” (p. 1). Supervision provides a foundation for promoting professional growth in music therapy through enhancing and improving skills and competencies (Dileo, 2001). Though it is a requirement for music therapy students, interns, and trainees, there are no specific supervision requirements for professional clinicians (Forinash, 2001).

The role of a supervisor is often compared to that of a teacher, administrator, and evaluator, while still facilitating self-awareness in the supervisee (Dileo, 2001). While personal-growth is usually not the focus of supervision, it is often a by-product of the supervision process (Forinash, 2001). The thin line between professional supervision and personal music therapy brings up important ethical dilemmas.

**Ethical issues of supervision.** Supervision incorporates therapy-like qualities such as facilitating self-awareness and personal development (Dileo, 2001). Often supervisees bring to supervision personal problems or concerns that do not relate to their clinical work (Frohne-Hagemann, 2001). It is imperative that both the supervisor and supervisee remain mindful that the personal problems of the supervisee should only be explored to the extent as is helpful for the supervisee's work as a music therapist (Frohne-Hagemann, 2001). While supervision is an important part of a music therapist’s development, ethical issues such as power differentials and dual relationships may arise as a result of the supervision relationship.

**Peer supervision.** Austin and Dvorkin (2001) facilitated a monthly peer
supervision group to help integrate the knowledge obtained through advanced trainings, personal therapy, and experiences in music therapy of its participants. The peer group was comprised of five professional music therapists with diverse theoretical orientations. Participants brought clinical issues to the peer supervision that were explored through music and verbal processing. When personal issues arose, the group acknowledged them, but only focused on those personal issues that had an effect on clinical work.

Austin and Dvorkin (2001) reported that peer supervision was successful due to the fact that all participants had undergone (or continued) their own personal therapy. By engaging in personal therapy, they were able to allow themselves to be vulnerable in the group by sharing their problems, insecurities, and questions related to their clinical practice. While this peer supervision utilized music and verbal processing between professional music therapists, it did not serve as group music therapy. Rather, it provided a space for continuing education, reinforced how essential music is to the therapeutic process, supervision process, and to strengthen the therapists’ clinical developments (Austin & Dvorkin, 2001).

**Research regarding professional supervision.** There is substantial research regarding supervision for music therapy students and interns (Daveson, 2011; Odell-Miller & Richards, 2009; Summer, 2001; Tanguay, 2008), but research on professional music therapy supervision is not as rich. Jackson (2008) surveyed music therapy professionals and discovered that 62% of 667 respondents did not engage in clinical music therapy supervision. About half of the 62% instead received supervision from a non-music therapist. In these situations, the supervisors’ lack of understanding of music therapy theory, techniques, and materials and methods hindered the supervision process.
Those who received no supervision reported lack of access as the primary reason, with other factors including financial concerns, time, and location. The 36% of music therapists who participated in music therapy supervision advocated for supervision and believed it has the potential to support continued growth and development of music therapists and their clinical skills (Jackson, 2008).

Silverman and Hairston (2005) indicated that the number of music therapists who work in private practice has grown. Many music therapists who are employed through private practice and as private contractors stated they do not have access to supervision (Jackson, 2008). Amir (2001) encouraged music therapists who do not receive regular supervision from a music therapist to pursue it on their own terms. She expressed a belief that supervision is imperative in order to explore countertransference, client-related issues, and to prevent burnout (Amir, 2001).

**Music Therapy Postgraduate Trainings**

Many specialized music therapy training programs incorporate rigorous coursework and require mandatory personal music therapy as part of the training process (Scheiby, 2001; Ventre, 2001; Turry, 2001). This is based on the belief that it is important for trainees to have a full experience of depth-oriented music therapy in order to provide quality clinical work (Ventre, 2001). While the pursuance of personal music therapy is mandated in advance-practice music therapy trainings, the trainees do not accurately reflect the population of music therapists pursuing music therapy on their own terms. This section explores the trainings of Analytical Music Therapy, the Bonny Method of Guided Imagery and Music, and Nordoff-Robbins Music Therapy.
Analytical Music Therapy. Developed by primarily by Mary Priestley in the 1970s, Analytical Music Therapy (AMT) is an “analytically-informed symbolic use of improvised music by the music therapist and client… and is used as a creative tool with which to explore the client’s inner life so as to provide the way forward for growth and greater self-knowledge” (Priestley, 1994, p. 3). Analytical music therapists musically improvise with clients and use techniques of psychoanalysis to understand the content behind the music (Eschen, 2002).

Analytical Music Therapy training. The AMT training process incorporates a concept called Intertherapy training that provides opportunities for trainees to utilize their analytical skills on each other (Scheiby, 2001). Trainees are trained in pairs, each taking turns being the therapist and client (Eschen, 2002). Trainees are not role-playing in this training, rather bringing in authentic material from their personal lives to be explored in therapy (Scheiby, 2001). This blurs the line between training and therapy, as well as creates a dual relationship between the trainees. Because this training is intensively supervised, the trainees are able to make mistakes and explore their weaknesses without damaging the therapeutic process (Scheiby, 2001).

While this training provides a space for music therapy as personal therapy, trainees are in the process of developing their therapeutic identity, as well as being evaluated on their music therapy competencies. The trainees are required to receive up to a year’s worth of individual AMT supervision and weekly AMT supervision, but this supervision “straddles the gray area between clinical supervision and clinical music therapy” (Scheiby, 2001, p. 320). This boundary between supervision and therapy
becomes thin due to the trainee’s unresolved issues that are brought up in the training (Scheiby, 2001).

**Bonny Method of Guided Imagery and Music.** The Bonny Method of Guided Imagery and Music (Bonny Method of GIM) is “a music-centered, consciousness-expanding therapy developed by Helen Bonny” which utilizes “classical music sequences that stimulate journeys of the imagination” (Association for Music and Imagery, 2018, para. 1). It is a holistic process that may involve the exploration of a client’s unique physical, psychological, cognitive, social, and/or spiritual realms (Ventre, 2001). The GIM training is a rigorous training program incorporating coursework, personal GIM sessions, and client sessions (Ventre, 2001).

**Bonny Method of GIM training.** As a part of the training, Bonny Method of GIM trainees are “required to participate (as a client) in multiple Bonny Method of GIM sessions for the purpose of personal and practical learning” (Young, 2011, p. 107). Engaging in personal Bonny Method of GIM sessions ensures that trainees are actively pursuing Bonny Method of GIM as a primary therapeutic modality as well as provides trainees with a rich experience of their practice (Ventre, 2001). Supervision of Bonny Method of GIM practice sessions provides trainees with the ability to clarify professional issues, role-play, identifying mistakes, and alleviating stress accompanying clinical insecurities (Ventre, 2001).

Bonny Method of GIM sessions are most often conducted in private practice and access to supervision may not be readily available. Ventre (2001) holds that it is imperative that supervision is sought out in order to provide quality professional clinical work after training. Additionally, it is stressed that Bonny Method of GIM therapists
make a conscious effort to engage in personal therapy in order to address any personal problems (Ventre, 2001). Personal therapy for Bonny Method of GIM music therapists is not limited to Bonny Method of GIM, but encouraged.

**Nordoff-Robbins music therapy.** Nordoff-Robbins Music Therapy (NRMT) is an approach to music therapy “based on the belief that everyone possess a sensitivity to music that can be utilized for personal growth and development” (New York University, 2018, para. 1). This music-centered approach encourages clients to take an active role in the music-making process (Turry, 2018). NMRT training is musically advanced and the primary goal is the development of clinical musicianship and the release of creativity in the therapist (Turry, 2018).

**Nordoff-Robbins music therapy training.** Similar to other trainings, NRMT trainees must engage in clinical practice, coursework, and supervision. There are three levels of NRMT training and each level requires trainees to delve deeper in the therapeutic process (New York University, 2018). Supervision for NRMT training is multifaceted and the supervisory relationship often resembles a client-therapist relationship (Turry, 2001). Together the supervisor and trainee engage in music making to enhance clinical skills and increase self-awareness. By examining their own music played in supervision, trainees can gain further insight into themselves, as well as their clients (Turry, 2001). Though at times supervision may appear similar to personal therapy, the main goals of supervision include the cultivation of musical creativity and awareness, professional growth, and technical understanding of the NRMT philosophy (Turry, 2001). That being said, NRMT does not require trainees to pursue personal therapy.
Experiential Learning in Music Therapy Education

Experiential learning, or “engaging students in experiences related to education content,” is an important aspect of music therapy education (Murphy, 2012b, p. 28). In-class role playing offers students the opportunity to practice and refine music therapy methods in a controlled and less threatening environment, as well as allow students to experience music therapy techniques on a personal level (Murphy, 2012b). Students with high exposure to music therapy showed significantly increased analytical skills and perceived self-confidence (Gooding & Standley, 2010).

Experiential learning can turn into therapy if “the professor is not clear on the differences between the roles of instructor versus the therapist” (Murphy & Wheeler, 2005, p. 141). It is important that students understand that there will be some level of personal disclosure that may cause discomfort (Murphy, 2012a). However, ethical issues such as dual relationships, respecting boundaries, misuse of power, and access to students’ personal information are not uncommon during experiential learning and should be addressed if they arise (Murphy & Wheeler, 2005). While experiential learning may provide valuable experiences and practice to music therapists-in-training, it should not to be mistaken as a form of personal music therapy.

Music Therapists’ Engagement of Personal Music Therapy

Music therapists-in-training. Gardstrom and Jackson (2012) examined the use of group music therapy with music therapy students. Through a phenomenological analysis, their findings included student-reported increases in: emotional and psychological self-awareness; ability to connect with others; and empathy toward potential clients. The influence of the Bonny Method of Guided Imagery and Music on
music therapy interns included positive experiences in areas of personal and professional growth, including the importance of self-care, understanding the therapy process, and understanding the evocative nature of music (Bae, 2011; Fox & McKinney, 2015).

Hesser (2012) designed a music therapy group for students in a music therapy master’s program for the purpose of experiencing music therapy on a weekly basis. This group, known simply as the Music Therapy Group, is an ongoing part of master’s educational program. The focus of the music therapy group is to explore moment-to-moment feelings, thoughts, and experiences of the group members. Each year the students report that Music Therapy Group is one of the most important experiences in the program in regards to self-experience and growth (Hesser, 2012).

While there are many student-reported benefits of music therapy, Gardstrom and Jackson (2011) revealed that a majority of AMTA program coordinators do not require students to engage in personal therapy, let alone music therapy. Only four of 41 respondents required music therapy for their students, though it was believed by the authors that some of the respondents misinterpreted the definition of personal music therapy (Gardstrom & Jackson, 2011). Those who stated they required music therapy indicated that they engaged in experiential learning or provided therapy services themselves or through other music therapy faculty. This brings up important ethical considerations of dual relationships and personal boundaries (Gardstrom & Jackson, 2011).

Professional music therapists. After a thorough search of library databases, no published literature could be found that examined the utilization of personal music therapy for music therapists. Literature that incorporated music therapy supervision,
experiential learning, or mandatory music therapy engagement for specific trainings were excluded because it does not accurately reflect the pursuance of personal music therapy by music therapists based on their own terms.

**Problem Statement and Research Questions**

Clinical music therapy supervision and personal music therapy, though they may utilize some of the same techniques and experiences, are fundamentally different. The main difference is in the goals of each. The goal of supervision is to provide a music therapist with a space in which he/she can foster and expand upon clinical competencies, address client-related issues, and explore personal issues that may be hindering clinical work (Forinash, 2001). Personal music therapy aims to help an individual address and resolve personal issues, as well as provide an avenue for self-expression, self-awareness, and overall support (Austin & Dvorkin, 2001). Additionally, an important difference between personal music therapy and music therapy required by advanced trainings lies in the music therapist’s autonomous decision to pursue music therapy.

This research surveyed professional music therapists (MT-BC) on their experiences, or lack thereof, of music therapy as personal therapy. The following research questions guided this study:

1. How many music therapists engage in personal music therapy?
2. What are the benefits of receiving personal music therapy?
3. What is preventing music therapists from engaging in personal music therapy?
4. If music therapists do not utilize personal music therapy, are they engaging in other forms of personal therapy?
Method

Design

This study utilized SurveyMonkey for survey design and data analysis. This program provided customizable surveys that included data analysis, sample selection, bias elimination, and data representation tools.

Participants

Criteria for inclusion in this study were that participants must 1) be a current board-certified music therapist (MT-BC) in the United States; 2) be working full-time, part-time, or per-diem as a music therapist in the United States; 3) not currently enrolled in a graduate music therapy program; and 4) give informed consent.

Participants were recruited through an invitational e-mail based on a list provided by the Certification Board of Music Therapy (CBMT). The initial questions of the survey reflected the inclusion criteria (Appendix A) and if the participants met the inclusion criteria, they were redirected to the rest of the survey. Completion of the survey represented consent to participate in the study.

Measures

A questionnaire distributed to potential participants included demographic information (age, years of experience, current employment status, work hours, primary work setting, primary work population, and theoretical orientation), the utilization of support methods (supervision, peer-supervision, personal therapy, etc.), and engagement in personal music therapy (Appendix A).
Procedures

The researcher contacted the Certification Board of Music Therapy (CBMT) to obtain emails of potential participants. The invitational email sent to these participants included an explanation of the study, explanation of the survey process, and the timeframe in which the survey must be completed (Appendix B). The invitational email discussed the rights of the participants and provided a platform for informed consent. After participants agreed to partake in the study and provided informed consent, participants filled out the questionnaires by clicking on the SurveyMonkey link. The survey took approximately nine minutes to complete and the participants were able to complete the questionnaires in more than one sitting. The SurveyMonkey survey was active for four weeks. A reminder e-mail was sent two weeks after the initial e-mail to encourage survey response (Appendix C).

Data Analysis

The researcher utilized the analytical tools provided by SurveyMonkey to analyze the quantitative data of closed-questions. Answers to the few open-ended questions employed qualitative methods by the researcher to identify themes, ideas, and patterns found in the participants’ responses and were analyzed through a Microsoft Excel spreadsheet based on demographic.

Results

Recruitment

Of 1,300 potential participants, a total of 195 (13.6%) responded to the survey. Four respondents did not meet the criteria necessary for the study and were therefore excluded. Seventeen respondents submitted survey responses with no answers and were
therefore excluded. Out of the 177 completed surveys, nine respondents did not answer the last three questions in the survey, however the responses to the other survey questions were included in the data analysis.

Demographic Information

Table 1 presents the demographic profile of respondents. This includes identified gender, age, race/ethnicity, level of education, practiced music therapy approaches, and primary theoretical orientation.

Under music therapy approaches practiced by participants, the 49 participants that chose “Other” were prompted to specify which approaches they use (Table 2). The most common answers included “Holistic/mindfulness” (7 participants), “Humanistic” (6), “No approach” (7), “Eclectic approaches” (6), “Dialectical Behavioral Therapy” (3) and “Music psychotherapy” (2). Other answers included “Vocal psychotherapy,” “Existential music therapy,” “Hospice and palliative care music therapy” and “TaKeTiNa.”

Under primary theoretical orientation found in Table 1, the 23 participants that chose “Other” were asked to specify their orientation. Eleven participants identified themselves as practicing “eclectic” music therapy; four, “holistic/mindfulness”; one, “systems theory”; one, “intersectional feminist”; one, “Jungian”; one, “biopsychosocial”; and four, “not sure.” Table 2 represents respondents’ work environment and career experience.
Table 1

*Demographic Information (N=177)*

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<th>Responses</th>
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<tr>
<td>Primary Theoretical Orientation*</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td><em>Eclectic</em></td>
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*Respondents were able to choose more than one answer.*
Table 2

Work Environment (N=177)

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<thead>
<tr>
<th>Variable</th>
<th>%</th>
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<tr>
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<tr>
<td>Part-time up to 15 hours per week</td>
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<td>Part-time up to 30 hours per week</td>
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<td>1-4</td>
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<td>5-9</td>
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<td>4</td>
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<td>10-14</td>
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<tr>
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<td>Four or more</td>
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<td>Children’s Day Care/Preschool</td>
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</tr>
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<td>Children’s Hospital or Unit</td>
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<td>10</td>
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<td>Correctional Facility</td>
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<td>Drug/Alcohol Program</td>
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<td>12</td>
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<td>Early Intervention</td>
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<td>Forensic Facility</td>
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<td>4</td>
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<td>General Hospital</td>
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<td>Hospice/Bereavement Services</td>
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<td>Inpatient Psychiatric Unit</td>
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<td>Outpatient Clinic</td>
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<tr>
<td>Physical Rehabilitation</td>
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<td>12</td>
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<td>School (K-12)</td>
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<td>State Institution</td>
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<td>University/College</td>
<td>11.30</td>
<td>20</td>
</tr>
<tr>
<td>Veteran’s Affairs</td>
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<td>2</td>
</tr>
<tr>
<td>Wellness Program/Center</td>
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<td>10</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>16.39</td>
<td>29</td>
</tr>
</tbody>
</table>

*Respondents were able to choose more than one answer.
Music Therapists Who Have Not Engaged in Music Therapy

The heart of the survey focuses on whether or not music therapists are engaging in music therapy for personal therapy sessions (not as part of advanced music therapy trainings). When asked, 115 of 177 respondents (64.97%) reported that they have never personally utilized music therapy services. This does not include seven individuals who reported that they have engaged in music therapy, but then explained later in the survey that they have never. Total, 122 participants (68.92%) have never engaged in music therapy as personal therapy.

Two participants skipped the next question pertaining to interest in music therapy services. Of the 113 remaining, 57 (50.44%) reported they were not interested in receiving music therapy services. Figure 1 reflects factors that prohibit music therapists from utilizing music therapy as personal therapy. Thirteen individuals (22.81%) reported “time” as a factor; 10 (17.54%), “finances”; 7 (12.28%), “personal availability”; 18 (31.58%), “engagement in other forms of therapy is sufficient”; 16 (28.07%), simply “not interested”; and 22 (38.6%), “other.”

![Figure 1. Reasons why music therapists do not engage in music therapy services](image-url)
The 22 participants who chose “Other” were prompted to specify the reason(s) for their lack of interest in pursuing personal music therapy (Figure 2). Six respondents noted that dual relationships rendered it difficult to receive music therapy in their area. Five respondents reported that therapy was not needed. Four respondents reported that they didn’t want to receive music therapy since they spend all day providing services to other people, while two reported that they believed they would overanalyze the music and music therapist. Lastly, three never considered trying music therapy services, and two responded with “unsure.”

**Figure 2.** Reasons for lack of engagement in music therapy by music therapists.

Of the additional 113 who have not used music therapy services, 56 participants (49.56%) stated that they are interested in music therapy as personal therapy. Figure 3 reflects reasons these participants have never utilized music therapy, though they are interested. Participants were able to choose multiple responses. Eighteen individuals (31.58%) chose “lack of music therapist in the area”; 26 (45.61%) chose “finances”; 34 (59.65%), “time”; 26 (45.61%), “not sure who to reach out to”; 12 (21.05%), “not sure
which approach I would benefit from”; 15 (26.32%), “nervous about being the client”; and 10 (17.55%), “other.”

The 13 participants who chose “Other” were prompted to specify the reason(s) for not pursuing music therapy as personal therapy. Five reported that dual relationships rendered it difficult to receive music therapy in their area, three identified that engagement in other forms of therapy was beneficial for them, and two have never considered services until the survey. Three participants fell into the category “Lack of music therapist in my area” and were added accordingly.

![Figure 3](image_url)

_Figure 3._ Reasons why interested music therapists do not engage in music therapy

**Music Therapists Who Have Engaged in Music Therapy**

**Music therapy required by advanced trainings.** Participants were asked if they have ever participated in an advanced music therapy training program (Analytical Music
Therapy, Bonny Method of GIM, Vocal Psychotherapy) in order to evaluate which participants utilized music therapy as a result of training requirements. Of 177 responses, 41.81% (74 individuals) reported, “Yes.” The most common music therapy trainings reported by respondents included Bonny Method of GIM (31 individuals), Neurologic Music Therapy (15), NICU Music Therapy (11), Hospice and Palliative Care Music Therapy (5), and Nordoff-Robbins Music Therapy (4) (Figure 4).

Of the 74 individuals who participated in an advanced training, only 28 (37.84%) were required to utilize personal music therapy during their training. Twenty-five of 28 individuals (89.29%) reported that develop personal growth was a primary personal benefit of receiving music therapy (Figure 5). Other significant benefits included “work through personal issues” (21 individuals); “receive support” (16); and “work through professional issues” (13). Over half of the participants marked that their music therapy attendance was a requirement by a training and/or school. That being said, all 26 participants who were required to receive music therapy identified other benefits related to personal growth and competence. Due to a mistake by the researcher, participants
were not permitted to specify other personal benefits, but were able to contribute for professional benefits.

Figure 5. Personal benefits of music therapy as a part of an advanced training, n=28

The same 28 individuals were asked to identify professional benefits of receiving music therapy through advanced trainings (Figure 6). Over 50% of respondents believed that professional benefits were “increased self-awareness”; “increased empathy towards others”; “increased professional competence”; “increased understanding of music’s role in the therapeutic relationship”; and “increased insight of personal development.”

The four participants that chose “Other” were prompted to specify professional benefits they have experienced through personal music therapy required by an advanced training. Experiences included “increased competence in the psychology of music”; an “increased ability to be fully present and engaged with the client, the music, and self”; and one participant was significantly impacted throughout his/her Bonny Method of GIM experience. Those impacts included increased knowledge on: “the therapeutic relationship”; “altered states”; “the transformative power of music”; “being vulnerable in
music”; “importance of repeating meaningful songs in sessions”; and “working with non-verbal clients.” The last respondent did not specify his/her professional benefits.

![Figure 6](image)

*Figure 6.* Professional benefits of music therapy as a part of an advanced training, n=28

**Music therapy as personal therapy (excluding advanced training requirements).** All participants were asked if they were currently participating in music therapy as personal therapy. Of the 177 respondents, 26 (14.69%) individuals were currently utilizing music therapy services, leaving 151 (85.31%) individuals who did not currently use services. Of those 151, only 29 (19.2%) have used music therapy as personal therapy in the past. Seven individuals reported they have used music therapy as personal therapy, but later in the survey reported they have never. Due to this inconsistency, these seven individuals were not included in the number of music therapists who have engaged in music therapy. Those who have engaged in music therapy at some point in their lifetime were asked to identify reasons for music therapy
engagement. The most common reasons for music therapy engagement include “to explore personal issues,” “to receive support,” and “strengthen professional competencies” (Figure 7).

Nine individuals chose the answer “I have not participated in music therapy” and were perhaps misguided in the survey based on their previous answers; they are not counted in the 55 (19.2%) who have utilized music therapy in the past. Of the 14 respondents chose “Other,” three of the answers fell into the categories provided and were added accordingly. Of the remaining 11(17.19%), three individuals used music therapy in a medical setting including “pre-surgery,” “childbirth,” and to “treat orthopedic injury.” Another three utilized music therapy to empower their belief systems/spirituality; two to reduce stress; two to increase quality of life; and one to experience music therapy as the client.

![Figure 7. Reasons music therapists engage in music therapy, n=55](image)

*Figure 7. Reasons music therapists engage in music therapy, n=55*
Of the 55 music therapists who have engaged in music therapy as personal therapy (excluding required attendance due to advanced trainings), 21 music therapists have never participated in an advanced training. Fifteen music therapists have completed advanced trainings that did not mandate music therapy services, so they have sought out services separate from their certifications. Lastly, 19 music therapists have pursued music therapy as personal therapy in addition to their music therapy trainings that did require music therapy during the training period.

**Music Therapists Who Have Discontinued Services**

Participants who reported that they have utilized music therapy, whether as a requirement of an advanced training or not, were asked if they discontinued services (Figure 8). Twenty-six individuals who received music therapy as a part of an advanced training identified “lack of time,” “lack of financial resources,” and “lack of availability” as common reasons for terminating services. It is uncertain whether “not applicable” represents those who have not discontinued services or have not received personal music therapy. Two individuals skipped this question.

*Figure 8. Reasons for discontinued engagement of music therapy post-training, n=26*
Similarly, 59 music therapists who have discontinued music therapy as personal therapy were asked about reasons for termination (Figure 9). Fourteen individuals overlapped from Figure 6, as they received music therapy as a part of and excluding training requirements.

The most common answer being “I have not discontinued” with 18 responses followed by “Met goals” with 14. Of those who chose “Other” (6 individuals), “lack of music therapist in the area,” having “strong faith,” finding music therapy “unsatisfying and not helpful,” and “not applicable” were four of the answers. The other two responses reflect personal use of music to achieve stress reduction, but do not incorporate music therapy services elicited by another board-certified music therapist.

![Figure 9. Reasons for discontinued engagement of music therapy, n=59](image)

**Music Therapists’ Support Systems**

In addition to their engagement in music therapy services, participants were also asked about current professional support systems used for personal and professional development (Figure 10). Almost half (47.16%) of the currently participants utilize “peer
super supervision” followed by “supervision with another professional (not music therapist)” (22.73%), “supervision with a music therapist” (22.73%), “personal therapy (not with music therapist)” (24.43%), and “personal music therapy” (7.94%).

It is assumed that those who chose “not applicable” (18.75%) do not currently use professional support systems. Those who chose “Other” were prompted to specify support systems they are currently using. Of the 20 respondents, five individuals identified “support from music therapy professionals”; five, “spirituality/religion”; three, “family and friends”; one, “acupuncture”; one, “NMT fellowship process”; one, “group therapy”; one, “group music therapy”; one, “Jungian dream analysis group”; one, “interdisciplinary team meetings”; and one, “exercise.”

![Bar chart showing current utilization of professional support systems]

Figure 10. Current utilization of professional support systems

Participants were asked about their engagement with professional support systems throughout their career (Figure 11). Almost 50% of the participants have engaged in “peer supervision,” “supervision with a music therapist,” “supervision with another professional,” and “personal therapy (not music therapy). There was a low engagement
with “personal music therapy” (14.29%) and it is assumed that those who chose “not applicable” (8%) have not previously used professional support systems. Those who chose “other” included “energetic healing” (1), “meditation” (1), “yoga” (1), “mentor” (1), and the last did not specify.

Figure 1. Previous utilization of support systems; n=175

A comparison between current and previous utilization of professional support systems can be found on Figure 12.

Figure 12. Comparison of currently and previously utilized support systems; n=176
When asked about the last time personal therapy was sought, 79 of 175 (45.14%) respondents reported they have used personal therapy within the past year (Figure 13). Forty-six respondents (26.28%) engaged in personal therapy within the past month; 24 (13.71%) within 1-6 months; 9 (5.15%) 6-12 months ago; 65 (37.13%) over a year ago; 6 (3.45%) over 20 years ago; 23 (13.14%), never; and 2 (1.14%) “other.”

In regards to the two respondents who chose “other”, one reported on-going supervision throughout the year and the other reported using personal therapy 45 years ago. Eight other individuals originally chose “other.” Of those eight, six individuals reported using personal therapy over 20 years ago. The other two fell into the category “1-6 months ago” and were reallocated.

Figure 13. The last time music therapists sought out personal therapy, n = 175

Music Therapy Engagement Trends

This researcher was interested in exploring trends of music therapy engagement based on career experience. Nine individuals have been excluded from the upcoming data
based on misguided answers (e.g., those who have reported “yes” to engagement music therapy services then deny engagement during the explanation questions).

**Engagement and age group.** Music therapists in the 30-39 year old range utilized music therapy services than any other age range (Figure 14). Music therapists who are aged 20-29 are the most interested in pursuing music therapy as personal therapy, with almost half of the surveyed demographic (28 participants) electing that they are interested. The 20-29 range also displays the least engagement of any of the groups, capping at 16%, or nine individuals.

![Figure 14. Music therapy engagement by age range; n=168](image)

That being said, there were significant differences between age range and survey completion. Though participants 30-39 years old have utilized music therapy more than any other age group, only seven participants were apart of that category (Table 5).
Table 5

*Music Therapy Interest and Engagement by Age Range*

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Participants Utilized</th>
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<th>Participants Not Interested</th>
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<td>36</td>
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<td></td>
<td><strong>9</strong></td>
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</table>

The participants were divided into age groups and interest in music therapy as personal therapy (Figure 15). Of those interested, the 20-29 year-old age group (28 participants) identified “finances” (67.86%), “time” (67.86%); “not sure who to reach out to” (46.43%); “nervous about being the client” (45.71%); “not sure which approach to use” (28.57%); “dual relationships/no available music therapist” (28.57%); “other forms of therapy are sufficient” (7.14%) and “never considered” (3.57%) as reasons for their lack of engagement in music therapy, though interested. Of those in the 30-39 year-old age group (two participants), one identified “finances” as the primary reason for lack of engagement and the other “not sure who to reach out to.” Of the 40-49 year-old age group (9 participants), “time” (44.44%), “not sure who to reach out to” (44.44%); “dual relationships / no available music therapist” (33.33%); and “nervous about being the client” (33.33%); “finances” (22.22%); “not sure which approach” (22.22%) and “availability” (1.11%) were the top reasons. The 50-59 year-old age group (10 participants) noted that “time” (50%) and “finances” (40%) were top reasons for the lack of engagement, while “dual relationship/no available music therapist” (30%); “not sure who to reach out to” (30%) and “not sure which approach” (20%) were not as common.
Lastly, the 60 and over age group (nine participants) identified “not sure who to reach out to” (44.44%) and “time” (44.44%) as the most common reasons for lack of engagement in music therapy services followed by, “dual relationship/no available music therapist” (33.33%); “finances” (22.22%); “not sure which approach” (11.11%); “nervous about being the client” (11.11%); “never considered” (11.11%); and “other forms of therapy are sufficient” (11.11%).

Figure 15. Lack of engagement in music therapy by interested music therapy, by age

Notable reasons for not engaging in music therapy by uninterested music therapists differ from those who are interested (Figure 16). The 20-29 year-old age range (20 participants) display an assortment of reasons: “other forms of therapy are sufficient” (35%); “finances” (30%); “dual relationships/no available music therapist” (25%); “availability” (20%); “time” (20%); “overanalyze the music therapy/therapist” (10%); “music is strictly for pleasure” (5%); and “never considered services” (5%). Of the 30-39 age range (two participants), both chose “time” and one chose “other forms of therapy are enough” while the other chose both “never considered services” and “music is strictly for
pleasure.” The 40-49 age range (seven participants) chose “other forms of therapy are sufficient” (28.57%); “not interested” (28.57%); “finances” (14.29%); “time” (14.29%); “availability” (14.29%); “therapy not needed at this time” (14.29%); and “music is strictly for pleasure” (14.29%). The 50-59 year-old age range (14 participants) noted that “other forms of therapy are sufficient” (21.42%); “finances” (21.42%); “time” (21.42%); “dual relationships/no music therapist available” (14.28%); “not interested” (14.28%); “music is strictly for pleasure” (14.28%); “overanalyze the music therapy/therapist” (7.14%); and “therapy not needed at this time” (7.14%) as reasons for not attending music therapy. Lastly, the 60 and over age range (12 participants) noted that “other forms of therapy are sufficient” (41.67%); “time” (25%); “availability” (25%); “not interested” (16.67%); “therapy not needed at this time” (8.33%); “dual relationships/no available music therapist” (8.33%); and “finances” (8.33%) were reasons for not being interested in music therapy services.

Figure 14. Lack of engagement in music therapy by uninterested music therapy, by age
Engagement and education level. Participants’ engagement and interest in music therapy as personal therapy were explored by education level ranging from Bachelor’s degree holders to PhD (Figure 17). The Master’s and PhD categories include those who are enrolled in school and have completed the degree. Of those who have a Bachelor’s degree in music therapy (67 participants), 19 participants (33.03%) have engaged in music therapy as personal therapy; 26 (38.81%) are interested; and 22 (32.90%) are not interested in music therapy as personal therapy. Of the Master’s candidates and degree holders (83 participants), 30 (36.14%) have engaged in music therapy; 24 (31.33%) are interested; and 27 (32.53%) are uninterested. Lastly, of PhD candidates and degree holders (18 participants), six (33.3%) have engaged; five (27.77%) are interested; and seven (38.89%) are not interested.

![Figure 17](attachment:figure17.png)

*Figure 17. Music therapy engagement by education level, n=168 (9 skipped)*
Reasons for interest in music therapy (and lack thereof) were explored between individuals with varying degrees (Figure 18). Music therapists with Bachelor’s degrees, who are interested in music therapy as personal therapy found that “time” (65.38%); finances (53.84%); and “dual relationships/no available music therapist” (30.77%) as the top considerations for lack of engagement. Master’s candidates and degree holders who are interested in music therapy listed “not sure who to reach out to” (65.38%); “time” (53.85%); and “finances” (50%) as their top three concerns. Lastly, PhD candidates and degree holders listed “time” (60%) and “dual relationships/no available music therapist” (40%) as their top reasons.

![Figure 18. Lack of engagement in music therapy by interested music therapy, by degree](image-url)
Results from music therapists who are not interested in music therapy services are not as uniform as results from the interested music therapists (Figure 19). Bachelor’s degree holders noted that “other forms of therapy are sufficient” (31.81%); simply “not interested” (22.72%); and “time” (22.72%) as the three top reasons for lack of interest. Master’s degree candidates and graduates identified “do not need therapy at this time” (25.92%); “not interested” (25.92%); and “availability”; “time”; “finances”; and “dual relationship/no available music therapist” (all 18.52%) as their main reasons for not being interested in music therapy. PhD candidates and degree holders identified “dual relationship/no available music therapist” (28.57%) and “time” (28.57%) as their most common reason, followed by “overanalyze the music therapy/therapist” (14.28%); “not interested” (14.28%); and “do not need therapy at this time” (14.28%).

Figure 19. Lack of engagement in music therapy by interested music therapists, by degree
Recommendations Made by Music Therapists

Participants were asked if they recommend that music therapist receive therapy services including, but not limited to, music therapy. Of 158 music therapists, 123 (77.85%) recommend fellow music therapist utilize personal music therapy (Figure 20). Nineteen participants skipped this question and 35 (22.15%) would not recommend.

When asked if they believe music therapists should receive music therapy over other forms of therapy, 11 (6.71%) believe that it’s extremely important; 23 (14.02%), very important; 62 (37.8%) somewhat important; 53 (32.32%), not so important; and 15 (9.15%), not at all important (Figure 21). Fourteen individuals skipped this question.

Figure 20. Music therapists recommendations for music therapy as personal therapy, n=158
Figure 21. Importance of music therapists receiving music therapy over other forms

Participants were given the opportunity to explain their answers in regards to whether they believe music therapy is more important for music therapists to utilize than other forms of therapy. Many who chose “Not at all important,” “Not so important,” and “Somewhat important” believe that therapy highly depends on the individual and not all music therapists may benefit from music therapy services. On the other hand, a majority of the “Very important” and “Extremely important” valued the importance of music therapists experiencing music therapy. Common responses included “practicing what we preach,” “greater awareness of the therapeutic process,” “experiencing being the client,” and “a greater awareness of our needs in the moment.”

That being said a common theme that has been mentioned throughout the survey is the ethical considerations when seeking personal music therapy in a relatively small field. Many participants do not have access to a music therapist that would not breach professional boundaries, dual relationships, or potential job opportunities. Alternatives such as other creative arts therapies (e.g., art, dance/movement, drama) and verbal psychotherapy were suggested as alternatives to music therapy in these situations.
When asked if music therapists should receive any form of personal therapy, 157 of 165 (95.15%) reported that it is important for music therapists to receive any form of personal therapy (Figure 20). Fifty-seven individuals (34.55%) believe it is “extremely important” for music therapists to receive some sort of personal therapy. Forty-seven (28.48%) believe it is “very important,” 53 (32.12%) believe it’s “somewhat important,” and eight (4.85%) believe it is “not so important.” No participants thought it was “not at all important” and 13 participants skipped this question.

![Figure 20. How important it is for music therapists to receive any therapy, n=165](image)

Again, music therapists were offered the opportunity to explain their answers in regards to music therapists receiving any form of therapy. While a few individuals believed personal therapy was only necessary based on the individual, a vast majority strongly encouraged personal therapy usage among music therapists. Common themes such as “working through transference and countertransferences,” “avoiding burnout,”
“separating personal issues from our work,” and “to deepen personal insight” were brought up.

**Discussion**

Of the 177 sample size, each participant was a board-certified music therapist (MT-BC) working full-time, part-time, or per diem in the United States. The distribution of respondents by gender strongly reflect national tendencies with 90.4% of identified female participants; 8.47%, male; and 1.13%, non-binary. The AMTA calculated that 88.12% of its members are female; 10.58%, male; and 1.3%, transgendered/gender queer/non-conforming/other identifier (AMTA, 2017).

The age range differed from AMTA tendencies. Of the 178 participants, 33.9% were 20-29, 3.95% were 30-39; 15.25% were 40-49; 25.99% were 50-59, and 20.9% were 60 and over. Participants aged 30-49 made up only 19.1% of the study. The AMTA defines the most common age ranges to be individuals in their 20s and 30s. The AMTA Workforce Analysis Survey (2017) revealed that 39.9% of music therapists were 20-29; 26.3% were 30-39; 13.9% were 40-49; 10.8% were 50-59; and only 7.1% were 60 and over.

The ethnic/racial backgrounds of the participants closely resembled AMTA trends. Of this study’s participants, 90.4% were Caucasian/White; 1.13% were Black/African American; 3.39% were Hispanic; 1.69% were Asian/Pacific Islander; and 3.38% identified as Multiple Ethnicities/Other. The AMTA found that 89.3% of its members were Caucasian/White; 1.8% were Black/African American; 2.3% were Hispanic; 3.4% were Asian/Pacific Islander; and 2.9% identify as Multi-racial or Other.
**Discrepancies within Identified Theoretical Orientations**

It is apparent that not all music therapists understand music therapy approaches and theoretical orientations. Multiple participants identified as practicing “eclectic” music therapy, which raises ethical concerns and misguided representation of the field. Often music therapists are rooted in a theoretical orientation while being informed by principles of other paradigms. An example of this is the medical music psychotherapy model founded by music therapist, Dr. Joanne Loewy at Mount Sinai Beth Israel (Azoulay, 2009). Medical music psychotherapy is a “humanistic stance...combined with a holistic, mind-body understanding of patients’ needs, informed by psychodynamic, existential, and cognitive-behavioral principles” (Azoulay, 2009, p. 153). While music psychotherapy is rooted in a humanistic orientation, it is informed by principles of other models to fit the unpredictable nature of a hospital setting.

The phrase “eclectic music therapy” assumes a music therapist is settled in more than one framework, each of which define the client, therapist, and the therapeutic relationship through different lenses. With a plethora of theoretical orientations grounded in different perspectives of therapy and ways of thinking, the term “eclectic music therapy” perhaps signals a misunderstanding and/or lack of self-awareness of therapeutic beliefs.

**Integral practice.** Bruscia (2014) defines integral practice as “the therapist’s continual adjustment of his own way of thinking about and working with a client, to continually meet the emerging needs presented by the client as therapeutic priorities” (p. 261). Integral thinking moves form a one-way mindset to one that is encompassing of different philosophies to best meet clients’ needs. Often music therapy approaches and
theoretical orientations are taught within strict parameters without honoring the commonalities between them. Given the diverse clientele seen by music therapists, it is essential that music therapists are reflexive in the therapeutic process. This includes accepting and engaging in theoretical frameworks that challenge a one-way approach to treatment, while still honoring your belief systems.

**Music Therapy Engagement Compared to Recommendations**

Of 177 participants of this survey, only 55 (31.07%) are currently or have previously utilized music therapy as personal therapy, excluding mandatory music therapy as a requirement of an advanced music therapy training. While only 55 have utilized music therapy, 123 participants (77.85%) recommended that music therapists receive music therapy as personal therapy. While the engagement level is low, the recommendation for music therapists to receive music therapy is quite high. There seems to be a clear interest and need for music therapists to experience their own approach to therapy.

Though a handful of participants believe music therapy is not beneficial for everyone, 95.15% of participants recommended that music therapists receive some sort of therapy. This trend parallels recent studies regarding clinicians attending therapy and the benefits of working through personal and professional concerns, especially when working in a stressful and emotive field. A study conducted by Norcross (2005) found that more than 90% of therapists who have engaged in personal therapy reported beneficial experiences regarding personal and professional growth.
Lack of Engagement in Music Therapy

Notable reasons for lack of engagement in music therapy were “finances,” “time,” “not sure who to reach out to,” “nervous about being the client,” and “engagement in other forms is enough. Music therapy is a growing field and is gaining international attention in the healthcare realm. That being said, many music therapists are considered “out of network” and are not covered by health insurance in the United States. Those seeking music therapy as personal therapy may need to pay out of pocket. Individual music therapy session rates average at $66.82 an hour (AMTA, 2017), which can become a costly expenditure for many individuals.

While time may be a personal challenge that contributes to the lack of music therapy engagement, it may reflect the lack of accessibility to a music therapist. There simply may not be a sufficient number of music therapists who offer music therapy services in private settings conducive to individual music therapy sessions. Music therapists may be employed by agencies or facilities, but do not offer personal sessions. Additionally, about 64% of music therapists work 30 or more hours a week (AMTA, 2017), which could contribute to lack of personal availability for researching and engaging in music therapy services.

A handful of participants reported that they were nervous about being the client in a therapeutic space. The vagueness of this answer renders it difficult to pinpoint why participants are nervous. However, a recent study by Wilson, Weatherhead, and Davies (2015) found that clinical psychologists were shameful of attending therapy, mostly due to the fear of feeling inadequate and emotionally unstable or that they may be judged by their peers. Shame is a common occurrence that tends to involve feelings of being flawed
and is often a result of a societal stigmatization (Luoma & Platt, 2014). The stigmatization of mental health needs and therapy attendance very well may cause therapists to feel shameful, or nervous, about being clients in therapy, especially as it is their career to provide those services to others.

**Dual Relationships**

A common and important theme that was brought up by many individuals was the lack of knowing whom they may contact for music therapy services. This theme reflects the natural processes of researching and meeting a new therapist. However, 32 respondents mentioned the likelihood of dual relationships to arise when searching for a music therapist. This relatively small field encompasses a great range of theoretical orientations; it can be overwhelming to find a music therapist to fit a specific therapeutic want or need. Additionally, in areas with a concentrated workforce, it is difficult to find a music therapist that is not excluded from the prospective client’s professional network. Across the age range and education level in this survey, music therapists expressed worries about disclosing personal information to a potential colleague, supervisor, or employer. The sheer likelihood of receiving music therapy from a peer or potential employer has deterred numerous music therapists from pursuing music therapy as personal therapy.

**Engagement in Music Therapy**

Music therapists’ engagement in music therapy reflect themes characteristic to many studies regarding clinicians in therapy (Norcross, 2005; Orlinsky, Norcross, Rønnestad, & Wiseman, 2005; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). Those who have attended music therapy as personal therapy reported increased self-awareness,
increased empathy towards others, and overall increased personal and professional development. A study by Oteiza (2010) found that a majority of therapists reported that therapy was integral in their professional and personal development, which include self-awareness and increased empathy. It was apparent that those who have participated in music therapy as personal therapy advocate the importance of experiencing firsthand the benefits of being a client.

Limitations

One limitation of this study is the lack of an operational definition for “personal music therapy.” While certain questions within the survey hint at the definition, it was never explicitly outlined. Five of the 177 survey respondents noted a lack of clarity in the phrase “personal music therapy,” as reported so within the survey or as alluded to in their responses regarding the personal use of music therapy techniques for their overall wellbeing (e.g., stress reduction, breathing exercises).

Another limitation of the study was the format of the survey. Based on the answers given for certain questions, respondents were guided to relevant follow-up questions. Those who have never used music therapy as personal therapy received different questions than those who have used personal music therapy. While this method was effective for collecting necessary data, it made it difficult for the researcher to conveniently analyze trends within the data. A spreadsheet with meticulous coding of data was needed to ensure that mistakes were not made when reporting trends and information.

When music therapists were asked why they were not interested in music therapy as personal therapy, there was an option “not interested.” In hindsight, this answer option
should have been removed to encourage more detailed descriptions for lack of interest in music therapy. Similarly, music therapists who were asked to describe the personal benefits of required music therapy by advanced trainings should have had an “other” option to describe personal benefits that were not listed within the answer options.

Lastly, the lack of evenly distributed surveys amongst age group made it impossible for the researcher to make significant comparisons between age groups and music therapy engagement. Due to the randomization of the survey distribution, this could not have been anticipated.

Future Research

To further explore the engagement of music therapy as personal therapy among professional music therapists, more research is necessary. To the researcher’s knowledge, this study is the first of its kind and has provided a foundation for further exploration and research by other passionate and interested music therapists. It is imperative that a clear description of personal music therapy is available to future study participants to ensure there is no confusion.

Conclusion

The results of this survey suggest that few music therapists engage in music therapy as a form of personal therapy. Finances and dual relationships were important reasons for music therapists disengagement in music therapy services despite interest or lack thereof. Those who have participated in music therapy as personal therapy, whether through an advanced training or through personal means, have experienced benefits that have provided invaluable insight on their personal and professional development as a music therapist. These benefits include greater self-awareness, increased empathy
towards clients, a greater understanding of the therapeutic space in a music therapy context and overall professional competence.
References


Appendix A

Personal Music Therapy Questionnaire

1. Are you a current board certified music therapist (MT-BC)?
   - Yes
   - No
     → If no:
     Thank you for your time and interest in participating in this study. However, your response indicates that you do not meet the criteria necessary for this study.

2. Are you working full-time, part-time, or per diem in the United States?
   - Yes
   - No
     → If no:
     Thank you for your time and interest in participating in this study. However, your response indicates that you do not meet the criteria necessary for this study.

3. What is your identified gender?
   - Female
   - Male
   - Non-binary
   - Other (please specify) _____

4. What is your age?
   - 20-29
   - 30-39
   - 40-49
   - 50-59
   - 60 & Over

5. Which race/ethnicity best describes you (please choose only one).
   - African American/Black
   - Caucasian
   - Hispanic/Latino
   - Native American
   - Middle Eastern
   - Pacific Islander
   - Other (please specify) ______

6. What is your highest level of education?
   - Undergraduate/Bachelor’s
   - Graduate/Master’s Enrolled
7. Please describe your primary work setting (choose all that apply)
   • Children’s Day Care/Preschool
   • Children’s Hospital or Unit
   • Correctional Facility
   • Drug/Alcohol Program
   • Early Intervention Program
   • Forensic Facility
   • General Hospital
   • Geriatric Facility
   • Hospice/Bereavement Services
   • Inpatient Psychiatric Unit
   • Nursing Home/Assisted Living
   • Oncology
   • Outpatient Clinic
   • Physical Rehabilitation
   • School (K-12)
   • Self-employed/Private Practice
   • State Institution
   • University/Coller
   • Veterans Affairs
   • Wellness Program/Center
   • Other (please specify) _________

8. Please describe the age of your clientele (choose all that apply):
   • Infants
   • Children
   • Adolescents
   • Adults
   • Older Adults

9. In how many facilities do you currently work?
   • One
   • Two
   • Three
   • Four or more

10. What is the average number of hours you work?
    • Per Diem
    • Part-time up to 15 hours per week
    • Part-time 16 - 30 hours per week
    • Full-time
11. How many years of work experience do you have?
   • Less than 1
   • 1-4
   • 5-9
   • 10-14
   • 15-20
   • Over 20

12. Do you practice any of these approaches?
   • Cognitive-Behavioral MT
   • Analytical MT
   • Bonny Method of GIM
   • Nordoff-Robbins MT
   • Medical MT
   • Neurologic MT
   • Other (please specify)_________

13. What is your primary theoretical orientation?
   • Psychodynamic
   • Cognitive-Behavioral
   • Transpersonal
   • Humanistic
   • Ecological
   • Biomedical
   • Other (please specify)_________

14. Have you ever been enrolled in an advanced training program (e.g. Analytical MT, Bonny Method of GIM)?
   • Yes (please specify)_________
   • No

15. Please indicate if your advanced training required/requires personal music therapy?
   • Yes
   • No

16. If you have ever participated in music therapy as a part of an advanced training, what were/are some of the personal benefits you’ve experienced (check all that apply):
   • Address trauma
   • Work through personal issues
   • Work through professional issues
   • Receive support
   • Develop coping strategies
   • Develop personal growth
   • Required by school/training program
   • I have not participated in music therapy
• Other (please specify) ______________

17. If you have ever participated in music therapy as a part of an advanced training, what were/are some of the professional benefits you’ve experienced (check all that apply):
  • Increased self-awareness
  • Increased empathy toward clients
  • Increased professional competence
  • Increased musical competence
  • Increased understanding of music’s role in the therapeutic process
  • Increased insight on personal development
  • Not applicable
  • Other (please specify) ______________

18. If you have completed a music therapy training and no longer utilize personal music therapy, please indicate why:
  • Lack of time
  • Lack of finances
  • Lack of availability
  • Engagement in other forms of therapy is enough
  • Not interested
  • Not applicable
  • Other (please specify) ______________

19. Are you currently engaging in music therapy as personal therapy (excluding experiential learning, supervision, and advanced training)?
  • Yes
  • No

20. Have you ever engaged in music therapy as personal therapy (excluding experiential learning, supervision, and advanced training)?
  • Yes
  • No

21. Why do/have you participate(d) in personal music therapy (excluding experiential learning, supervision, and advanced training)?
  • To strengthen professional competencies
  • To explore personal issues
  • To work through trauma
  • To receive support
  • To experience other approaches to music therapy
  • I have not participated in personal music therapy
  • Other (please specify)______________
22. If you have participated in personal music therapy but discontinued, please indicate why:
   - Met goals
   - No longer needed music therapy
   - Lack of time
   - Lack of financial resources
   - Lack of availability
   - Moved to a new place
   - Participation in another form of therapy is enough
   - I have not discontinued
   - I have never participated in personal music therapy
   - Other (please specify) __________

23. Are you interested in using personal music therapy?
   - Yes
   - No

24. If you are interested in using personal music therapy but haven’t, is it due to:
   - Lack of music therapist in my area
   - Finances
   - Time
   - Not sure who to reach out to
   - Not sure which music therapy approach I would benefit from
   - Nervous about being the client
   - Other (please specify) __________

25. Why are you not interested in using personal music therapy?
   - Lack of time
   - Lack of finances
   - Lack of availability
   - Engagement in other forms of therapy is enough
   - Not interested
   - Other (please specify) __________

26. Please identify any professional support systems you are currently using for your own personal/professional development (check all that apply):
   - Peer supervision
   - Supervision with a music therapist
   - Supervision with another professional (not music therapist)
   - Personal music therapy
   - Personal therapy (not music therapy)
   - Not applicable
   - Other (please specify) __________
27. Please identify any professional support systems you have previously used for your own personal/professional development (check all that apply):

- Peer supervision
- Supervision with a music therapist
- Supervision with another professional (not music therapist)
- Personal music therapy
- Personal therapy (not music therapy)
- Not applicable
- Other (please specify)_________

28. When was the last time you sought any form of personal therapy?

- Within the past month
- 1-6 months ago
- 6-12 months ago
- Over a year ago
- Never
- Other (please specify)_______

29. Why do you seek personal therapy (check all that apply):

- Address trauma
- Work through personal issues
- Work through professional issues
- Receive support
- Develop coping strategies
- Develop personal growth
- Required by school/training program
- I do not seek personal therapy
- Other (please specify)_______

30. Do you recommend professional music therapists to utilize personal music therapy?

- Yes
- No
- Comments (why or why not?) _____________

31. How important is it for a music therapist to receive music therapy rather than other forms of personal therapy?

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

Comments: ______________________
32. How important is it for a music therapist to receive any form of personal therapy?
- Extremely important
- Very important
- Important
- Not important
- Not at all important

Comments: ________________________
Appendix B

Invitational Email and Informed Consent

Dear Music Therapist,

My name is Cara Wanamaker and I am a graduate student at the State University of New York at New Paltz. I am conducting a survey on the utilization of music therapy as personal therapy by music therapists as part of my Master’s program at SUNY New Paltz. This email is an invitation to participate in a brief and confidential online survey. You qualify to complete this survey if you are:

- a current board-certified music therapist (MT-BC)
- and working full-time, part-time, or per diem in the United States.

The purpose of this study is to investigate the use of personal music therapy among music therapists. Personal music therapy does not include supervision, experiential learning, or advanced music therapy trainings (e.g. Bonny Method of GIM, Analytical Music Therapy, etc). The results of this study are intended to provide a better understanding of current engagement in music therapy services by music therapists, as well as explore the reasons why music therapists do/do not seek out music therapy as personal therapy.

Your participation is voluntary. If you decide to participate, you will be asked to fill out an online survey through SurveyMonkey. The survey will take approximately 5-10 minutes to complete and will remain active for four weeks (closing on 4/6/19). Only the researcher will have access to the data, which will be stored on the researcher’s password-protected computer in a secure place. Your responses will remain anonymous and confidential.

By completing and submitting the survey, you consent to participate in this study. If you wish to participate, please click on the following link:

https://www.surveymonkey.com/r/TMWSK6K

If you have any questions or concerns about this study, please feel free to contact me at wanamakc1@hawkmail.newpaltz.edu or Dr. Heather Wagner, my research adviser, at wagnerh@newpaltz.edu. For questions about your rights as a research participant, you may contact the State University of New York at New Paltz Human Research Ethics Board at 845-257-3282.

Thank you,

Cara Wanamaker
Appendix C

Reminder Email

Dear Music Therapist,

On March 13, 2019, I sent an email inviting you to participate in my survey research study investigating the use of personal music therapy by music therapists. This is a reminder that the survey will remain open for two more weeks and close on April 9, 2019.

For those who have already participated in my survey, I greatly appreciate your time and your contribution! For those who haven’t, you are invited to participate in a brief and confidential online survey.

You qualify to complete this survey if you are:

• a current board-certified music therapist (MT-BC)
• and working full-time, part-time, or per diem in the United States.

The purpose of this study is to investigate the use of personal music therapy among music therapists. Personal music therapy does not include supervision, experiential learning, or advanced music therapy trainings (e.g. Bonny Method of GIM, Analytical Music Therapy, etc). The results of this study are intended to provide a better understanding of current engagement in music therapy services by music therapists, as well as explore the reasons why music therapists do/do not seek out music therapy as personal therapy.

Your participation is voluntary. If you decide to participate, you will be asked to fill out an online survey through SurveyMonkey. The survey will take approximately 5-10 minutes to complete and will remain active for four weeks (closing on 4/6/19). Only the researcher will have access to the data, which will be stored on the researcher’s password-protected computer in a secure place. Your responses will remain anonymous and confidential.

By completing and submitting the survey, you consent to participate in this study. If you wish to participate, please click on the following link: [https://www.surveymonkey.com/r/TMWSK6K](https://www.surveymonkey.com/r/TMWSK6K)

If you have any questions or concerns about this study, please feel free to contact me at wanamake1@hawkmail.newpaltz.edu or Dr. Heather Wagner, my research adviser, at wagnerh@newpaltz.edu. For questions about your rights as a research participant, you may contact the State University of New York at New Paltz Human Research Ethics Board at 845-257-3282.

Thank you, Cara Wanamaker