

Resilience Over Burnout:
A Self-Care Guide for Music Therapists Working with Clients Who Have Experienced Trauma

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Abstract

Self-care is crucial in preventing burnout (Lee & Miller, 2013) and an ethical responsibility for those in helping professions (Barnett & Cooper, 2009). Research has shown that music therapists experience an average range of burnout on the Maslach Burnout Inventory (Kim, 2012; Vega, 2010) due to work factors, social factors, individual factors, and a disconnection with music (Clementes-Cortes, 2013; Hesser, 2001). As music therapy is becoming a more widely accepted treatment for trauma, music therapists must be prepared with self-care tools (Borczonek, 2013), because compassion fatigue, secondary traumatic stress, and vicarious traumatization are consequences of the emotionally charged nature of trauma work (Newell & MacNeil, 2010). Although consequences of burnout for music therapists are multidimensional (Clementes-Cortes, 2013), burnout is not inevitable (Fowler, 2006). With self-care practices that promote self-awareness, self-regulation, and balance, burnout can be prevented (Baker, 2003). This project was developed to create a self-care guide for professional music therapists working with clients who have experienced trauma to increase resiliency through professional, personal, and creative self-care practices.

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Introduction

The therapist's most valuable instrument is the therapist's own self (Yalom, 2002). One of the greatest challenges therapists face is managing the intricate balance of caring for oneself while caring for others (Bien, 2006). As the importance of self-care gains momentum in therapeutic circles, it is recognized not only as a strategy to improve well-being, but as an ethical imperative, professional responsibility, and essential part of a professional's identity (Barnett & Cooper, 2009; Newell & MacNeil, 2010). Helping professionals who assist people with psychological, social, and physical needs are at risk for burnout (Freudenberger, 1974), including music therapists and trauma workers.

Burnout has been widely researched in various academic journals since the development of the Maslach Burnout Inventory in the 1980s (Skovholt & Trotter-Mathison, 2011). This research has helped determine the risk factors, warning signs, symptoms, and consequences of burnout for helping professionals. In addition, compassion fatigue, secondary traumatic stress, and vicarious traumatization are professional fatigue syndromes (Stebnicki, 2007) that have been identified with trauma work (Newell & MacNeil, 2010). Because these professional fatigue syndromes hold the potential to psychologically harm those working with clients who have endured trauma, professionals must take caution to care for themselves to protect their competence and quality of life (Hernández, Engstrom, & Gangsei, 2010).

Music therapists work with children, adolescents, and adults who are in treatment for abuse, developmental trauma, and catastrophic trauma (Borczone, 2013; Curtis, 2013; Hatcher, 2013; Rogers, 2013). In music therapy literature, research has shown that music therapists experience an average range of burnout on the Maslach Burnout Inventory (Kim, 2012; Vega, 2010) due to work factors, social factors, individual factors, and a disconnection with music

(Clementes-Cortes, 2013; Hesser, 2010). Clinification, the consequence of neglecting one's own creative process (Allen, 1992), is also a concern for a music therapist's competence and longevity (Iliya, 2014). Music therapists are encouraged to continually develop their music skills and personal relationship with music to avoid burnout and to maintain effectiveness as a clinician.

Although consequences of burnout for music therapists include job loss, career drift, fatigue, physical pain, hypertension, apathy, anxiety, hopelessness, irritability, substance abuse, and decreased patient care (Clementes-Cortes, 2013), burnout is not inevitable (Fowler, 2006). With self-care practices that promote self-awareness, self-regulation, and balance, burnout can be avoided (Baker, 2003). A multidimensional phenomenon that promotes resilience in the therapist's self and the therapeutic process, self-care is crucial in preventing burnout (Lee & Miller, 2013). Along with professional and personal self-care practices, music therapists working in trauma care may also benefit from the use of self-compassion to reduce empathetic distress (Neff, 2012), vicarious resilience to counteract vicarious traumatization (Hernández, Gangsei, & Engstrom, 2007), and self-exploration practices through music to address clinification (Allen 1992, Hesser, 2001).

Researchers recommended self-care programs that are ongoing and preventative (Barnett & Cooper, 2009), comprehensive (Lee & Miller, 2013), and individualized (Stebnicki, 2007) in order to sustain well-being and career longevity. Although many self-care suggestions have been made in the literature for music therapists and trauma workers, much of this information is scattered through various articles and not readily available. Music therapists working in trauma care do not yet have a practical and action-oriented tool to utilize in order to prevent burnout and practice the self-care necessary to increase resilience.

Definitions

In this project the following definitions will be used for these terms:

- Burnout: a state of physical, emotional, psychological, and spiritual exhaustion resulting from prolonged work with patients that are vulnerable or suffering (Pines & Aronson, 1989).
- Self-care: the implementation of skills and strategies to maintain the physical, psychological, emotional, social, spiritual, leisure, and professional needs of oneself (Lee & Miller, 2013; Newell & MacNeil, 2010).
- Resilience: “the ability to successfully adapt and cope despite threatening or challenging situations,” and “a pattern of competence and self-efficacy in the presence of extraordinarily difficult events” (Agaibi & Wilson, 2005, p. 198).
- Trauma: “stress events that present extraordinary challenges to coping and adaptation” (Agaibi & Wilson, 2005, p. 196).
- Vicarious traumatization: a consequence of trauma work that involves the cumulative stress that develops from empathetically working with clients who have endured trauma, which may affect a professional’s feelings, thoughts, memories, self-esteem, or sense of safety (Hernández et al., 2007).
- Vicarious resilience: a positive transformation of the therapist’s experiences when engaging with a client who has survived a traumatic event, including feelings of inspiration, growth, strength, and overcoming and coping with adversity (Hernández et al., 2007).
- Music therapy: “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 degree program” (American Music Therapy Association, 2014, para. 2).

Purpose Statement

The purpose of this project is to develop a self-care guide to increase professional and personal resiliency of professional music therapists working with clients who have experienced trauma. This guide will include educational components addressing burnout types, symptoms, risk factors, and consequences. Based on suggestions from the literature, self-care will be addressed in regard to professional, personal, and creative practices. This project will be converted into a downloadable e-book to support music therapy professionals in formulating and activating their own self-care plans and goals. In my nine years as a music therapist working with clients in mental health settings, I have realized both the consequences of burnout and the benefits of self-care. With this project, I hope to contribute to the longevity and well-being of other professionals and strengthen the quality of care towards ourselves and our clients.

Review of the Literature

Professional Burnout

In the 1970s, when Herbert Freudenberger was a practitioner treating drug abuse at a community agency in New York City, the term *burnout* was used to describe drug abusers who experienced a slow depletion of motivation and competence as a consequence of drug addiction (Skovholt & Trotter-Mathison, 2011). Freudenberger recognized similar trends in practitioners who worked with these clients, and was the first to use the term burnout to describe therapists who were no longer functioning effectively (Baker, 2003). Freudenberger (1974) described professional burnout as the physical, emotional, and mental exhaustion caused by the job demands of human service workers who help people with psychological, social, and physical needs.

In the 1980s, burnout not only became widely acknowledged in various occupations and academic journals, but also became measurable (Skovholt & Trotter-Mathison, 2011). Developed by Maslach and Jackson (1981), the Maslach Burnout Inventory (MBI) measures burnout symptoms of human service professionals using three subscales based on burnout research. The first subscale is emotional exhaustion, which refers to a depletion of emotional resources, reduced energy, tiredness, and feeling emotionally overextended (Cheek, Bradley, Parr, & Lan, 2003; Maslach & Jackson, 1981). Second is depersonalization, which includes negative, cynical, or detached attitudes towards clients (Newell & MacNeil, 2010). The third subscale is personal achievement, referring to a negative evaluation of one's work, dissatisfaction with one's accomplishments on the job, and a decline in feelings of competence and success (Cheek et al., 2003; Maslach & Jackson, 1981). With 22 survey items, the MBI measures and assesses burnout in individuals based on these three dimensions (Fowler, 2006).

Since the development of the MBI, the risk factors, warning signs, symptoms, and consequences of professional burnout have been widely researched. Risk factors contributing to burnout are categorized by individual, organizational, environmental, and stress factors (Baker, 2003; Maslach & Leiter, 1997; Newell & MacNeil, 2010). Individual risk factors include high caseloads, interpersonal tensions, maladaptive coping styles, emotional expectations, repressing emotions, difficulty with clients, and professional isolation (Barnett, Baker, Elman, & Schoener, 2007; Maslach & Leiter, 1997; Newell & MacNeil 2010). Organizational risk factors include bureaucratic constraints, inadequate supervision, low support, and lack of resources (Baker, 2003; Newell & MacNeil, 2010). Maslach and Leiter (1997) identified seven domains of the work environment that contribute to burnout: work overload, lack of control, insufficient reward, breakdown of community, unfairness, significant value conflicts, and an incongruence between the professional and their job.

Though these factors put a professional at risk for burnout and require awareness and prevention, burnout is not identified until warning signs and symptoms are present. Warning signs of burnout regarding work performance include frequent absenteeism, tardiness, fatigue, and low completion rate of job duties (Newell & MacNeil, 2010). Barnett et al. (2007) found that emotional warning signs for burnout in psychologists include feelings of frustration, anger, impatience, boredom, lack of focus, hoping clients will cancel, decreased motivation, and a decreased enjoyment of work. Symptoms of burnout include intrusive thoughts, difficulty sleeping, startle reactions, irritability, change in attitude towards clients, decreased social interests, nightmares, and depleted physical and mental energy (Baker, 2003; Newell & MacNeil, 2010). These behavioral, emotional, cognitive, and social indications may be dangerous if ignored.

When these symptoms, warning signs, and risk factors are not attended to, the consequences of burnout are multidimensional: professional, physical, behavioral, and emotional. Professional consequences can include job loss, professional impairment, and poor client care (Clementes-Cortes, 2013; Newell & MacNeil, 2010). The physical and behavioral consequences of burnout may include fatigue, hypertension, decreased immunity, pain, and substance abuse (Clementes-Cortes, 2013; Stebnicki, 2007). Emotional consequences can include apathy, anxiety, and hopelessness (Clementes-Cortes, 2013). Additionally, burnout is positively correlated with the experience of stress itself (Etzion, 1984). Chronic stress may lead to gastrointestinal problems, musculature problems, disrupted sleep, overeating or under eating, decreased immunity, anxiety, attention deficits, relationship difficulties, and performance impairment (Baker, 2003). Although stress does not necessarily mean impairment (Baker, 2003), the vulnerabilities caused by stress can be hazardous and require attention (Barnett & Cooper, 2009).

The consequences of burnout and stress may have further implications for therapists. Therapists experiencing stress and burnout may be vulnerable to clinical issues such as boundary violations, disinterest in clients, and a loss of objectivity (Barnett & Cooper, 2009; Clementes-Cortes, 2013). Additional consequences of burnout for therapists include depression, self-medicating with alcohol or other substances, and maladaptive coping strategies (Barnett & Cooper, 2009). Newell and MacNeil (2010) emphasize the vital importance for professionals to understand burnout consequences, warning signs, symptoms, and risk factors, for the health and well-being of everyone involved in the therapeutic relationship. When this professional relationship involves attending to trauma experienced by the client, even more considerations are necessary.

Burnout in Trauma Work

As research on professional burnout has evolved, specific types of burnout have been identified for professionals working with traumatized clients (Stebnicki, 2007). Trauma is defined as “stress events that present extraordinary challenges to coping and adaptation” (Agaibi & Wilson, 2005, p. 196), and trauma survivors are people who have experienced one or more events that have altered their sense of self, others, or the world (Briere, 2012). Caused by people, nature, or accident, traumatic experiences embody a wide range of occurrences including abuse, violence, neglect, loss, interruptions in attachment, or catastrophic events (Hernández et al., 2007; Rogers, 2013). The effects of the psychological harm of trauma can be devastating, long-lasting, and influence an individual’s physical and emotional survival (Borczone, 2013). The suffering caused by trauma is often what brings people into therapy, and for therapists, staying connected with a client who is suffering can be difficult (Siegel & Germer, 2012).

Compassion fatigue, secondary traumatic stress, and vicarious traumatization are professional fatigue syndromes (Stebnicki, 2007) and consequences of the emotionally taxing work with clients who have experienced trauma (Newell & MacNeil, 2010). Compassion fatigue is an emotional and physical reaction that is cumulative over time, and is experienced from the chronic use of empathy to support clients who are suffering (Newell & MacNeil, 2010; Skovholt & Trotter-Mathison, 2011). Secondary traumatic stress is a behavioral stress reaction to knowing about traumatic event experienced by a client and wanting to help, but feeling helpless (Figley, 1995; Newell & MacNeil, 2010). Vicarious traumatization is a cognitive stress reaction that results from empathic engagement with a person who has experienced trauma, which may cause a change or shift in the belief system of the professional (Newell & MacNeil, 2010). These

professional fatigue syndromes hold the potential to psychologically harm a professional working in trauma care (Hernández et al., 2010; Newell & MacNeil, 2010).

Compassion fatigue. The chronic use of empathy can put a helping professional at risk for burnout by activating a stress response in the body and reminding a clinician of his or her own wounds (Stebnicki, 2007). Empathy holds much value in a therapeutic relationship by allowing an internal sense of a client's world, and expressing an understanding of a client's experience (Briere, 2012; Rogers, 1961). However, compassion fatigue may occur when a clinician empathizes with a client's trauma and pain without attending to his or her own experience (Siegel & Germer, 2012).

Secondary traumatic stress. In order to effectively work with individuals who have endured trauma, professionals must be able to “experience the unbearable, think the unthinkable, and be prepared to experience the re-creation of scenarios of victimization, abandonment, betrayal, manipulation, and exploitation” (Rogers, 2013, p. 317). Because of this, secondary traumatic stress is a natural consequence of a therapeutic relationship in trauma work (Figley, 1995). When not properly addressed, the effects of secondary traumatic stress can lead to symptoms that parallel PTSD (Hernández et al., 2007) and may lead to burnout when the professional becomes overwhelmed, over-identifies with the client, or takes excessive responsibility for the client's life (Collins & Long, 2003). Professionals who become encumbered with traumatic material may also become ineffective, and create an unhealthy shift in the therapeutic relationship where the client becomes the helper. Also known as trauma-related stress, secondary traumatic stress may include indications such as insomnia, avoidance, nightmares, startle reactions, and irritability (Newell & MacNeil, 2010).

Vicarious traumatization. Hernández et al. (2007) described vicarious traumatization as a “unique and inevitable consequence of trauma work” (p. 231) that involves the cumulative stress that develops from empathetically working with traumatized clients, which may affect a professional’s feelings, thoughts, memories, self-esteem, or sense of safety. The negative impact of bearing witness to a client’s trauma may include feelings of anger, hopelessness, fear, and being overwhelmed and frustrated. This impact may depend on the length and intensity of the client’s traumatic stories, the professional’s own trauma history, and the professional’s ability to manage the inherent stress of trauma work (Hernández et al., 2010).

As seen in the descriptions of the professional fatigue syndromes, empathy may put a professional at risk for burnout (Klimecki, Ricard, & Singer, 2012). Research on the neurobiology of empathy supports the stressful nature of empathy on the brain (Singer, Seymour, O’Doherty, Kaube, Dolan, & Firth, 2004). Using functional magnetic resonance imaging (fMRI), neuroscientists measured the brain activity of pairs of people. In these pairs, one person experienced a painful stimulation and the other person observed the person receiving a painful stimulation. When comparing results from both conditions, overlapping activations in parts of the brain were found, specifically in the anterior insula and the anterior medial cingulate circuit. These regions of the brain are linked to the affective experience of pain, and these results suggest that empathizing with another person’s pain can activate a pain response in the brain. Further studies on empathy and stress have associated empathetic resonance with negative affect and a high burnout risk for helping professionals, especially those who work with people who are suffering (Klimecki et al., 2012). As professionals who often work empathetically with clients experiencing hardship, music therapists must be aware of their own risks for developing these professional fatigue syndromes and burnout.

Burnout in Music Therapy Professionals

Music therapists work with children, adolescents, and adults who are in treatment for abuse, developmental trauma, and catastrophic trauma (Borczone, 2013; Curtis, 2013; Hatcher, 2013; Rogers, 2013). The American Music Therapy Association (2014) defines music therapy 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 degree program” (para. 2). In this role, music therapists assess an individual’s emotional, physical, social, psychological, communicative, and cognitive goals and challenges, and design and facilitate therapeutic interventions to address these goals (American Music Therapy Association, 2014). Because burnout is prevalent among human service professionals who assist clients with psychological, social, and physical needs (Freudenberger, 1974), music therapists working with traumatized patients must consider the implications for burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization.

Music therapy research shows that professional music therapists fall in the average range of burnout on the Maslach Burnout Inventory (MBI) (Kim, 2012; Vega, 2010). Regarding the subscales of the MBI, Vega (2010) found an average range of emotional exhaustion, as well as a low range range of depersonalization and personal achievement. This means subjects reported an average level of feeling fatigued, but higher levels of feeling connected with clients and satisfaction with job-related accomplishments. Additionally, Kim’s (2012) results showed that age and income were significantly predictive variables of experiencing burnout on the personal achievement subscale, where older subjects with higher salaries experienced less burnout.

To make sense of the MBI subscale scores of music therapists, the results of Vega’s (2010) study were compared with the MBI norms of mental health workers. The occupational

subgroup of mental health workers includes psychologists, psychotherapists, counselors, psychiatrists, and mental health hospital staff. In regards to the emotional exhaustion subscale, music therapists experience a greater depletion of energy and emotional resources than the average mental health worker. Vega speculates that this may be due to level of education, as individuals with higher degrees experience less burnout. When comparing depersonalization subscale scores, music therapists are less negative, cynical, and detached from their clients than mental health workers. Finally, music therapists experience more confidence and feelings of success than mental health workers. These results show that the opportunity to work with clients through music may be emotionally tiring, but can also provide positive therapeutic relationships and outcomes to feel proud of.

Other variables contributing to burnout in music therapists can be categorized into work, individual and social factors (Clementes-Cortes, 2013). Work factors for music therapists were found to be “the most dominant variable contributing to burnout in the literature” (p. 167). These factors include insufficient pay, work overload, severity of clients’ problems, and poor client prognosis. Individual factors leading to burnout for music therapists included unrealistic expectations, idealism, altruism, age, years of work experience, lack of rewards, and limited feedback from supervisors. Although Clementes-Cortes (2013) found that older and more experienced music therapists experienced less burnout, Fowler (2006) found that years of experience were not associated with burnout for music therapists. Vega (2010) also examined personality as an individual factor and found that anxiety, sensitivity, and tension were predictive of burnout. Though these work and individual factors may vary by clinician, the potential influence of these factors is important to recognize.

Social factors are also a consideration for burnout regarding the unique challenges music therapists face (Clementes-Cortes, 2013). Because music therapists are a professional minority, feelings of being misunderstood and isolated are common and may lead to feeling a lack of support and control. The degree of contact between the therapist and client is also a consideration because “the intimacy of the musical space requires the therapist to feel emotions their clients feel and actively participate... [and] this intensity of contact with patients can lead to emotional exhaustion” (p. 170). Role ambiguity is another social factor and source of stress for music therapists who find themselves confused about their job obligations and duties, and are asked to perform tasks outside of their role as a music therapist. These social factors challenge music therapists to constantly advocate for their profession and position at work.

Further research focuses on the effect of job satisfaction on the career longevity of music therapists. Vega (2010) found that job satisfaction was closely linked to career longevity. Kim (2012) found that a higher degree of job satisfaction significantly predicted lower levels of burnout, even beyond the variables of age, income, and experience. Kim (2012) concluded that job satisfaction must be improved to decrease burnout, and that improving the collective self-esteem of the music therapy profession may prevent emotional symptoms of burnout, especially for those who are not satisfied with their job. Decuir and Vega (2010) found the most prevalent reasons why music therapists leave the field is because of a lack of support from administration and low salaries. However, the longevity of music therapists’ careers is gradually increasing.

Cultivating one’s own involvement in music is an important factor in the career of a music therapist (Decuir & Vega, 2010; Hesser, 2001). Investigating why music therapists persist in the field, Decuir and Vega (2010) surveyed 231 music therapists with over ten years of experience. Among these experienced professionals, participation in music activities outside of

work was reported to be important for job satisfaction and career longevity. Hesser (2001) also discussed the need for music therapists to keep their relationship with music alive and active because a disconnection with music may lead to burnout. Because a connection with music is a factor in career choice for music therapists, this disconnection may have serious consequences. In addition to participating in music activities outside of work, Hesser also recommended music therapists participate in their own self-exploration through music, and stated, “only to the extent that we can experience and understand this transformative power in our own lives can we offer it to others in our work” (p. 53). A music therapist’s effort in maintaining an active and positive relationship to music holds significant value in burnout prevention.

Allen (1992) introduced the term *clinification*, a consequence of a creative arts therapist neglecting his or her own creative process. Clinification is a phenomenon where professionals stop investing in their own art making and focus more on clinical skills, which creates a shift from being a creative arts therapist to a therapist who uses creative arts with clients (Iliya, 2014). A decline in one’s own art making process can cause a decline in a therapist’s ability to respond intuitively and empathetically, as well as a weakening in fluency with the materials and forms used. Clinification can lead to burnout, career drift, and a lack of research, and is intensified by ambivalence around clinical skills and isolation (Allen, 1992). Therefore, the survival and progression of creative arts therapies are dependent on the practitioner’s habitual engagement in personal creative practices (Iliya, 2014). Translated into the work of music therapists, the music that clinicians make when working with clients is not sufficient for a complete understanding of the therapeutic power of music (Hesser, 2001). Musical skills must be continually developed in order to avoid burnout and to maintain effectiveness as a clinician.

Burnout can be a serious condition, and it is important for music therapists to understand the warning signs, risk factors, and consequences of burnout, and seek help when necessary (Clementes-Cortes, 2013). Although individual, work, and environmental factors may put a music therapist at risk, burnout is not inevitable (Fowler, 2006). Along with an awareness of burnout risk factors and symptoms, maintaining self-care practices and strategies can help music therapists thrive.

Self-Care for Helping Professionals

Self-care is crucial in preventing burnout (Lee & Miller, 2013). Generally defined as engaging in behaviors that support health and well-being, self-care for helping professionals is the implementation of skills and strategies to maintain the physical, psychological, emotional, social, spiritual, leisure, and professional needs of oneself while attending to the needs of others (Lee & Miller, 2013; Newell & MacNeil, 2010). By doing so, professionals engage in healthy and self-respecting processes (Newell & MacNeil, 2010) that empower and enable a proactive and intentional ownership of health, well-being, and resilience (Lee & Miller, 2013). Self-care is a multidimensional phenomenon that considers both the personal and professional lives of the practitioner, and varies by individual preferences, beliefs, culture, and context of employment.

Caring for oneself not only protects an individual from the risk of burnout, but also protects the client and profession from harm caused by the failure to manage stress and work challenges (Barnett et al., 2007). Because burnout can lead to professional impairment and affect clinical competence, self-care is an ethical responsibility for professionals (Barnett et al., 2007; Richards, Campenni, & Muse-Burke, 2010). Standards of care and professional competence are found in professional ethical codes. The American Music Therapy Association's (2013) Code of Ethics section 1.5 states,

The [music therapist] is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems.

(para. 7)

The American Counseling Association (2014) Code of Ethics Section C states, counselors will “engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (p. 8). With this ethical imperative in mind, self-care should not be perceived as a luxury or indulgence, but rather an essential part of a professional identity (Barnett, Johnson, & Hilliard, 2006).

Professionals are recommended to engage in self-care programs that are ongoing and preventative (Barnett & Cooper, 2009), comprehensive (Lee & Miller, 2013), and individualized (Stebnicki, 2007). Baker (2003) also recommended self-awareness, self-regulation, and balance as objectives to consider for therapists’ self-care plans. Being self-aware of internal conflicts, physical experiences, psychological experiences, limitations, needs, and emotions allows therapists to responsibly observe one’s self as a person and professional. Self-regulation helps a therapist maintain a physiological and psychological equilibrium by proactively regulating mood and affect in order to reduce the risk of becoming overwhelmed and distressed. Lee and Miller (2013) provide a framework for self-care that implements strategies to manage symptoms and risks for burnout. These strategies are categorized by both professional and personal self-care practices.

Professional Self-Care. Purposefully engaging in practices that support one’s professional role promotes an effective and appropriate use of the self at work (Lee & Miller,

2013). Six professional self-care structures are identified: workload and time management, attention to professional role, attention to reactions at work, professional social support and advocacy, professional development, and the revitalization of energy. First is workload and time management, which involves mindfully managing, prioritizing, and organizing work tasks and time spent on tasks to maximize efficiency and balance. Included in this structure is taking breaks through the day and taking vacations. Second is attention to professional role, which means understanding the role and goals of one's job, and acknowledging limitations in one's scope of practice.

Attention to reactions at work is the third professional self-care structure, which is practiced through supervision, personal therapy, journaling, and debriefing with colleagues (Lee & Miller, 2013). Professional supervision as a support system is highly recommended and regarded in burnout prevention in the literature (Barnett & Cooper, 2009; Newell & MacNeil, 2010; Richards et al., 2010). Supervision is especially essential for therapists working with clients who have experienced trauma in order to avoid psychological harm, recognize vulnerabilities, attend to self-care issues, establish a support network, and process the painful emotions brought on by clients' trauma (Collins & Long, 2003; Hernández et al., 2010).

The fourth professional self-care structure is professional social support and self-advocacy, which involves building or belonging to a professional network or community, and advocating for changes such as a pay raise (Lee & Miller, 2013). Seeking constructive feedback, education, and guidance from peers and colleagues can help build a network of support and resources. Fifth is professional development. This structure includes becoming a member of a professional organization, attending conferences, reading current publications, and engaging in research. Lastly, the revitalization and generation of energy is a professional self-care practice of

sustaining hopefulness, energy, and inspiration around one's professional role for a sense of effectiveness and well-being. This includes creating a pleasant workspace, being reminded of clients' positive outcomes, and sharing meaningful experiences with colleagues. These six structures of professional self-care are essential in maintaining a positive and effective experience as a clinician.

Personal Self-Care. The second component of the framework for self-care is personal self-care (Lee & Miller, 2013). This is defined as “a process of purposeful engagement in practices that promote holistic health and well-being of the self” (p. 98). The five structures of support for personal self-care are physical, psychological and emotional, social, spiritual, and leisure. Physical self-care considerations include exercise, adequate sleep, a healthy diet, general body health, and prevention of illness. Sufficient exercise and sleep were repeatedly mentioned in the literature as important lifestyle habits to minimize the effects of burnout (Barnett & Cooper, 2009; Lee & Miller, 2013; Newell & MacNeil, 2010). Psychological and emotional self-care practices include engaging in stress management techniques, emotional regulation, recognizing one's strengths, seeking personal therapy, adopting positive coping strategies, and attending to emotional needs (Barnett & Cooper, 2009; Lee & Miller, 2013; Richards et al., 2010).

The social aspect of personal self-care includes sustaining meaningful supportive relationships, connecting with loved ones, participating in community events, and using a personal support system in times of need (Lee & Miller, 2013; Richards et al., 2010). Spiritual self-care considerations include meditation, prayer, reflection, spending time in nature, and faith-based practices (Lee & Miller, 2013). Spirituality is important in developing self-awareness, and meditation was found to increase awareness of thoughts, feelings, vulnerabilities, needs, and

patterns of relating to others when used by psychological therapists in training (Boellinghaus, Jones, & Hutton, 2013).

Lastly, leisure plays an important role in personal self-care (Lee & Miller, 2013). Leisure may involve activities such as sports, reading, time with pets, recreation, and pursuing creative endeavors. These five structures of personal self-care support a balanced lifestyle that honors an individual's interests and needs. Together, these structures of professional and personal self-care provide a framework for a comprehensive self-care plan.

Compassion and Self-Compassion

Compassion is a practice that bridges both professional and personal self-care to remedy the fatigue and burnout caused by empathic distress (Siegel & Germer, 2012). In research following Singer et al.'s (2004) study on the similarities of the brain's perception of pain and empathic resonance of pain, neuroscientists studied the brain function involved in states of empathy and compassion during meditation (Klimecki et al., 2013). First, magnetic resonance imaging scans were taken while subjects meditated on empathetic responses, or thought about and connected with the suffering of another person. These brain scans of empathetic responses showed brain activity similar to an affective experience of pain, and subjects reported feeling burnt out. However, when meditators were asked to focus on compassion, or warm feelings of acceptance for a suffering person, brain scans showed neuronal activity in areas associated with romantic love and reward (Kupfershmidt, 2013). These outcomes lead researchers to distinguish between empathy and compassion as two different inner states with different consequences for health and well-being (Klimecki et al., 2013). Though empathy may be necessary in therapeutic situations, when empathizing with a client's pain without a simultaneous attitude of compassion, burnout is likely to develop (Siegel & Germer, 2012).

In relation to self-care, researchers concluded that compassion for others is a skill that can be trained and cultivated through practice (Klimecki et al., 2013). Additionally, compassion for the self can also be learned practice, and is needed to avoid burnout (Neff & Germer, 2013). Neff (2012) presented the concept of *self-compassion*, or compassion directed inward, as a source of emotional strength and resilience that consists of three main elements. First is self-kindness, or internal dialogs that are caring rather than critical in order to offer acceptance, soothing, and support of oneself (Neff & Germer, 2013). Common humanity is the second element, which recognizes that challenges, failures, mistakes, and shortcomings are a part of a shared human experience. The third element of self-compassion is mindfulness, which refers to an awareness of thoughts and feelings with non-judgment and equanimity. The combination of these three elements of self-compassion acknowledges both positive and negative feelings, allowing them to exist together, with a receptive and nonresistant state of mind (Neff, 2012). Developed by Neff (2003), the Self-Compassion Scale measures an individual's experience of self-kindness, common humanity, and mindfulness, allowing for both self-examination and further quantifiable investigation.

Research on self-compassion has found that greater self-compassion is associated with positive feelings about one's work and making a difference in the world (Neff, 2012). Self-compassion is also correlated with less anxiety and depression, as well as increased motivation, emotional intelligence, and coping skills (Neff & Vonk, 2009; Neff, 2012). Because self-compassionate individuals are reported to have more compassion for themselves and others, they are less likely to experience distress when attending to the suffering of others (Neff, 2012).

This suggests that self-compassion is an important skill for helping professionals, and can not only protect against burnout, but may also create more effective therapeutic conditions for

survivors of trauma (Barnard & Curry, 2011; Klimecki et al., 2013). By reducing reactivity and supporting greater feelings of acceptance, compassion may allow a clinician to better remain present and approach a client's suffering without being personally activated. Furthermore, self-compassion can be increased through practices such as mindfulness, loving-kindness meditations, breathing techniques, and self-reflection exercises in order to evoke a more compassionate mindset and increase resilience (Siegel & Germer, 2012).

Resilience, Vicarious Resilience, and Self-Care

Resilience is “the ability to successfully adapt and cope despite threatening or challenging situations,” and “a pattern of competence and self-efficacy in the presence of extraordinarily difficult events” (Agaibi & Wilson, 2005, p. 198). Achieved in numerous ways, resilience is an ordinary phenomenon involving an individual's unique strengths (Mancini & Bonanno, 2012). Although most adults will be exposed to at least one potentially traumatic event in their lifetime, resilience is a common response to potential trauma (Bonanno, 2005), and traumatic experiences can sometimes lead to positive change and growth (Woodward & Joseph, 2003). Posttraumatic growth refers to the positive changes experienced as a result of the struggle of a traumatic event, which may include strengthened relationships, an increased awareness of personal strength, and a new perspective on life (Calhoun & Tedeschi, 1999). Although trauma literature is predominantly focused on the toxic effects of trauma work, resiliency and positive change in people exposed to trauma is worth paying attention to, and has applications for the therapist (Hernández et al., 2010).

Vicarious resilience is characterized by a positive transformation of the therapist's experiences when engaging with a client who has survived a traumatic event (Hernández et al., 2007). Positive effects of observing a client's resiliency include feelings of inspiration, growth,

strength, and overcoming and coping with adversity. The concept of vicarious resilience originates from qualitative research with psychotherapists working with individuals and families who suffered traumatic events in Bogota, Columbia (Hernández et al., 2007). Although all subjects reported experiences of vicarious traumatization, each described that witnessing their clients' capacity to heal and overcome adversity positively changed their attitudes and emotions. These positive transformations for the therapists included a cognitive shift in perceiving the severity of one's own problems, an increase in hope for the recovery of trauma survivors, increased tolerance for frustration, and an increased sense of effectiveness of their work.

Engstrom, Hernández, and Gangsei (2008) conducted similar research with mental health practitioners in the United States, and found congruent themes regarding vicarious resilience. In this study, subjects reported being positively affected by their clients' resilience, reframing their own negative experiences and problems, and reaffirming the value of their work with clients who experienced trauma. Results showed the most dominant theme was the positive alteration of one's own perspective on life, which additionally provided motivation to address personal and global issues. This motivation drawn from the clients' resilience served as a source of inspiration and self-care.

Unique self-care practices for professionals working with survivors of trauma are found in the application of vicarious resilience and its relationship to vicarious traumatization (Hernández, et al., 2007). By developing awareness of vicarious traumatization and resilience, these processes can be managed to improve self-care by decreasing vicarious traumatization and increasing vicarious resilience. Approaching vicarious traumatization and resilience as equally important processes can create important opportunities for professional and personal growth (Engstrom et al., 2008). Balancing the difficult and painful aspects of trauma work with hopeful

and growth-oriented aspects can provide professionals with a healthier lens to view themselves and their work (Hernández et al., 2010).

Hernández et al. (2007) suggest that purposefully cultivating vicarious resilience can strengthen a trauma worker's self-care abilities, and present six reasons for the importance of this cultivation. First is the use of vicarious resilience as a tool to counteract fatigue caused by vicarious traumatization. By doing so, a clinician can avoid becoming a "victim of those who have been victimized" (p. 239). Second is the ability of vicarious resilience to increase motivation and persistence while doing trauma work, which may help professionals continually find new meaning in their work. Third is the utilization of the concept of vicarious resilience in trainings and supervision, to make the concept part of one's professional vocabulary. When used as a tool and incorporated into one's conceptualization of trauma work, vicarious resilience can be incorporated into an effective self-care plan.

The importance of cultivating vicarious resilience is also seen in clinical work with clients who may be concerned about the toxic effect of their trauma (Hernández et al., 2007). Introducing the concept to clients can help facilitate their treatment by reducing their fear of burdening the therapist. Furthermore, because research has shown that vicarious learning extends to other contexts of the therapist's life, professionals may use their client's lessons of resilience during times of personal crisis. Finally, the awareness of vicarious resilience can enrich a professional's own conceptualization of their career. The process of a professional's reevaluation and introspection that stems from lessons of client resilience can help a professional better cope with personal challenges, and become less susceptible to burnout and job fatigue (Engstrom et al., 2008).

The reframing process that vicarious resilience provides contains cognitive, emotional, and behavioral elements (Engstrom et al., 2008). Most recent research has shown the positive changes that occur from witnessing a client overcome adversity includes reflecting on a human being's capacity to heal, reaffirming the value of therapy, regaining hope, and reassessing the dimensions on one's own problems (Hernández et al., 2010). Other positive changes include understanding and valuing the spiritual dimensions of healing, discovering the power of community healing, and increasing professional and public awareness of the multiple dimensions of trauma. The impact of vicarious resilience may be beneficial for all professionals working with clients who have been traumatized, and enrich their work and personal well-being.

Self-Care Practices for Music Therapists Working in Trauma Care

The use of vicarious resilience as self-care for music therapists is seen in a case study presented by Amir (2004), who used improvisational music therapy with a 32-year-old woman named Lisy who experienced sexual abuse in her childhood. In response to working with Lisy, Amir first expressed feelings of vicarious traumatization and subsequently provided an example of functional self-care:

I still remember moments when the pain was so big that I could hardly contain it. I would come out of some sessions completely exhausted. Sometimes I wasn't sure if she was going to make it. I had moments of doubt. At times I was so involved that I found myself going through the same emotions and feelings as Lisy. I was furious at her father, and also at her mother. I had to work hard and separate myself from her in order to help her. I remember that after my sessions with her I sat down at the piano and played. It helped me to release my emotions. I also wrote in my journal and reflected on the process that I was going through. (p. 103)

Amir (2004) then reflected on the vicarious resilience experienced from her work with Liszy:

Even though many years have passed since I worked with Liszy, I am still full of admiration for her. I admire her courage, her commitment to finding her real self and becoming a whole and complete human being. I am still affected by her authenticity. To be a witness to such transformation is a powerful experience, and I am so thankful for having had the chance to do it. Sharing Liszy's journey was a very meaningful experience for me as a therapist, but primarily as a human being. . . I learned a lot from Liszy. She showed me that even when the past is so dark, there is hope for the future. She showed me the powerful place music has in such a journey. (p. 102-103)

As music therapy is becoming a more widely accepted treatment for trauma, music therapists must be prepared with personal self-care tools (Borczon, 2013). Music therapy literature places an emphasis on the importance of professional support and professional development (American Music Therapy Association, 2013; Clementes-Cortes, 2013; Fowler, 2006). Attending conferences, networking, participating in continuing education, professional supervision, and maintaining a supportive professional network are self-care practices necessary for music therapists to reduce the stress of professional isolation (Clementes-Cortes, 2013; Fowler, 2006). Hesser (2010) recommended participating in a music therapy group with colleagues that meets regularly and allows exploratory music making for support and to increase self-awareness.

In literature pertaining specifically to the personal self-care practices of music therapy professionals, lifestyle practices of exercise, healthy eating habits, and meditation were also emphasized (Clementes-Cortes, 2013; Fowler, 2006). Two positive mental coping strategies, threat minimization and positive appraisal, were also found to be important for the career

longevity of music therapists (Fowler, 2006). Threat minimization refers to diverting attention away from a problem or situation instead of dwelling on it. Positive appraisal is the act of perceiving a stressful situation as manageable or beneficial, and focusing on the positive aspects of a situation rather than the negative.

Pursuing personal creative and music endeavors is also an essential self-care topic for professional music therapists (Decuir & Vega, 2010; Hesser, 2001). Suggested avenues of music participation outside of work include community bands, orchestras, choirs, and church groups (Decuir & Vega, 2010). Hesser (2010) suggests self-exploration practices through music such as a daily music journal, putting together a mix of favorite music, reflecting on childhood music, improvising dreams, improvising important life themes, or improvising about a problem. Continuing to practice the creative medium in which one works not only defends against clinification (Allen, 1992), but can also result in benefits such as transformation, wholeness, completion, spirituality, connection, and cleansing (Brown, 2008).

The use of music for self-care may also help music therapists increase self-awareness (Camilleri, 2001), one of the best defenses against burnout (Baker, 2003; Newell & MacNeil, 2010). Through musical expression, ideas and attitudes can be externalized and observed, enabling new perspectives and understanding (Camilleri, 2001). Self-awareness through music also adds depth and quality to therapeutic work, allowing for more genuine interactions. Likewise, as a music therapist uses music for growth and well-being, a positive model is provided for clients.

Problem Statement

Music therapy research shows that professional music therapists fall in the average range of burnout on the Maslach Burnout Inventory (Kim, 2012; Vega, 2010), and may experience

burnout due to isolation (Clementes-Cortes, 2013), clinification (Allen, 1992), and a disconnection from music (Hesser, 2001). As music therapy is becoming a more widely accepted treatment for trauma, music therapists must be prepared with tools to prevent burnout (Borczone, 2013), because compassion fatigue, secondary traumatic stress, and vicarious traumatization are potential consequences of trauma work (Newell & MacNeil, 2010). Self-care is crucial in preventing burnout (Lee & Miller, 2013) and a necessary part of an ethical professional role (Barnett et al., 2007). Suggestions for self-care practices for music therapists are widely proposed in the literature. However, this information is scattered, not readily available, and not specifically pertaining to trauma work. Therefore, the purpose of this project is to develop a practical and action-oriented guide that synthesizes current research and suggests professional, personal, and creative self-care practices to increase the resiliency of music therapists working with clients who have experienced trauma.

Development

Design

This clinical project is an e-book and self-care guide for professional music therapists working with clients who have experienced trauma. This e-book is divided into three main parts. Part one contains education on burnout and includes sections on: the history of burnout, risk factors for burnout, warning signs and symptoms of burnout, consequences of burnout, the professional fatigue syndromes, burnout in music therapy professionals, and clinification. Part two presents education on self-care and includes sections on: the importance of self-care, the six structures of professional self-care, resilience and vicarious resilience, empathy and compassion, the five structures of personal self-care, self-compassion, and self-care practices for music therapists working with clients who have been traumatized. Part three allows a self-care plan to be created with a self-assessment, self-care action brainstorm, formulation of self-care goals, and a self-care calendar. Throughout the e-book, ten self-reflection exercises are included to encourage awareness and processing of the educational components. Worksheets and exercises for professional, personal, and creative self-care practices are also included to guide the reader in creating an individualized self-care plan and schedule, along with suggestions for reevaluation for the continued practice of self-care.

Procedure

The first step in creating this e-book was to create an educational piece on burnout. This information came from the literature, starting with the broad implications of burnout for all helping professionals, and then focusing on the specific implications for trauma workers and music therapists working with clients who have experienced trauma. Next, an educational piece on self-care was created, which includes information from the literature and recommended

practices from current research. Attention was given to use of self-compassion to reduce empathetic distress (Neff, 2012), vicarious resilience to counteract vicarious traumatization (Hernández, Gangsei, & Engstrom, 2007), and self-exploration practices through music to address clinification (Allen 1992, Hesser, 2001).

Based on the educational components, ten self-reflection exercises were designed to help the reader process and relate to the information. The self-reflections include written exercises on defining your role as a music therapist, identifying a self-care team, identifying professional and personal self-care activities, identifying creative self-care activities, identifying obstacles to self-care, cultivating vicarious resilience, and visualizing an ideal lifestyle. Additional informational pieces were created to provide recommendations for setting boundaries, healthy lifestyle choices, self-exploration through music, self-compassion, self-kindness, and mindfulness.

Existing burnout assessments and inventories were reviewed in order to develop a self-reflective assessment for music therapists. A burnout self-assessment was created based on the risk factors, warning signs, and symptoms mentioned in the literature. To utilize the information collected in the self-assessment and self-reflections, a self-care action brainstorm worksheet was created to identify areas of improvement. To make this an action-oriented guide, a goals worksheet and calendar was created to allow the implementation of chosen self-care practices.

All of the worksheets, suggestions, and information in the e-book were grounded in the literature and based on existing strategies that have been researched and published for other helping professionals. After the content was created, the e-book was organized into a user-friendly guide intended for professional music therapists working with traumatized clients. This project was developed with the objective of later being converted into a PDF file to be downloaded as an e-book.

Evaluation

This project was evaluated by two professional music therapists with interests in self-care and experience in working with clients who have experienced trauma. The evaluators were asked to review this e-book for clarity, effectiveness, and quality. Feedback was collected via email, with specific questions pertaining to organization, practicality, quality of content, value to the music therapy profession, and presentation of information. Changes to the e-book were made based on the evaluators' feedback.

Resilience Over Burnout:

A Self-Care Guide for Music Therapists Working with Clients Who Have Experienced Trauma

By Ami Kunimura, MT-BC

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Introduction

The therapist's most valuable instrument is the therapist's own self (Yalom, 2002). One of the greatest challenges therapists face is managing the intricate balance of caring for oneself while caring for others (Bien, 2006). As the importance of self-care gains momentum in therapeutic circles, it is recognized not only as a strategy to improve well-being, but as an ethical imperative, professional responsibility, and essential part of a professional's identity (Barnett & Cooper, 2009; Newell & MacNeil, 2010). Professionals who assist people with psychological, social, and physical needs are at risk for burnout (Freudenberger, 1974), including music therapists and trauma workers.

I was only two years into my music therapy career when I began to feel it, and noticed that something was not quite right. It started with fatigue that became more perceptible each time I got into my car and took my name badge off at the end of the day. This slowly turned into a deep exhaustion that would hit hardest on Friday evenings. Eventually, my weekends were spent recovering from the workweek, trying to restore my energy levels to gather the strength to go back in on Monday. This was just the beginning of burnout for me.

At the time, I was working full-time on a trauma unit of an inpatient psychiatric hospital. Despite the growing burnout, I loved my job. I was a part of a strong team of mental health care workers treating clients coming into treatment for PTSD, trauma, personality disorders, eating disorders, sex addiction, dissociative identity disorder, and mood disorders. I learned that I naturally had a disposition that was well suited for this work, and enjoyed the analytical and in-depth approaches involved in the process. I also learned that music therapy holds a valuable role in trauma treatment as an instrument of change. Though strangely, the more effective I felt at my job, the less effective I felt about living my own life.

The physical exhaustion turned into emotional exhaustion as my ability to listen to my clients' traumatic experiences began to diminish. Hearing stories of rape, neglect, loss, pain, and abuse on a daily basis made my heart feel heavy. I found it difficult to hold the knowledge of such horrible events. Though I tried not to show it, I deeply resented my clients' perpetrators for tainting my perception of human nature and stifling my optimism. It made me feel discouraged, unmotivated, and sad.

The developing emotional exhaustion manifested as irritability, sensitivity, isolation, and anxiety. My relationship with music also began to change, as music became something associated more with work than with enjoyment. On top of this, I also felt frustrated with living paycheck-to-paycheck and working by the rules and regulations of a corporation. The stress began to show up in others ways: a twitch under my left eye, a bumpy rash on my hands, migraine headaches, and depression. I was tired, felt like a hypocrite in front of my clients, and could not shake the feeling that this was not the way life is supposed to be. The combination of an intense work environment, lack of administrative support, and feeling under-appreciated left me feeling empty. This state of being not only took away my vibrancy, but also my sense of identity.

The solution that sounded most appealing at the time was to get as far away from work for as long as I possibly could. I wanted and needed an extended amount of time off to rejuvenate, reevaluate, and get to know myself again. I knew I needed more than just a two-week vacation, so I did the opposite of what someone experiencing burnout should do: I worked more. After many months of working overtime, aggressively saving money, and careful planning, I quit my job and took a trip around the world. I started in Europe and ended at an ashram in India,

where I completed a yoga teacher training. I had no intention of becoming a yoga teacher, but I knew the program would give me the discipline and pursuit of self-care that I needed, and it did.

Though international travel can be a great life experience, quitting one's job and running off to the other side of the world is not a practical, sustainable, or realistic way to cope with burnout. I returned home ready to be a music therapist again, but knew I would have to find a new way to approach my work. By educating myself on burnout prevention and self-care, and through trial and error, I found my way to an improved state of balance. My experiences led me to pursue a master's degree in music therapy, where I had the opportunity to further study burnout and self-care and create this resource for other clinicians. With this guide, I hope to contribute to the longevity and well-being of other professionals and strengthen the quality of care towards ourselves and our clients.

The purpose of this e-book is to provide music therapists working in trauma care with information on burnout and self-care, as well as tools to increase professional and personal resilience. An abundance of self-care literature exists, and this guide will help synthesize current research and recommended self-care practices for music therapists and trauma workers.

To begin, here are the definitions we will use in this guide:

- **Burnout:** a state of physical, emotional, psychological, and spiritual exhaustion resulting from prolonged work with patients that are vulnerable or suffering (Pines & Aronson, 1998).
- **Self-care:** the implementation of skills and strategies to maintain the physical, psychological, emotional, social, spiritual, leisure, and professional needs of oneself (Lee & Miller, 2013; Newell & MacNeil, 2010).

- Resilience: “the ability to successfully adapt and cope despite threatening or challenging situations,” and “a pattern of competence and self-efficacy in the presence of extraordinarily difficult events” (Agaibi & Wilson, 2005, p. 198).
- Trauma: “stress events that present extraordinary challenges to coping and adaptation” (Agaibi & Wilson, 2005, p. 196).
- Music therapy: “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 degree program” (American Music Therapy Association, 2014, para. 2).

This guide is divided into three parts. In part one, education on burnout is provided to increase awareness of the risk factors, warning signs, symptoms, consequences, and types of burnout. We will also look at burnout research specific to trauma work and music therapy. Part two focuses on self-care. Professional, personal, and creative self-care practices from the literature are presented, as well as current research on vicarious resilience and self-compassion as solutions to burnout. Part three of this guide will help you formulate your own self-care plan and goals based on suggestions from the literature on professional, personal, and creative self-care practices.

One of the most important lessons I learned from my experiences with burnout was that a self-care mindset is necessary in order to make self-care a priority and lifestyle choice. One of the most powerful quotes from the literature that highlights this mindset comes from Barnett, Johnson, and Hilliard (2006): “Self-care is not an indulgence. It is an essential component of prevention of distress, burnout, and impairment. It should not be considered as something ‘extra’ or ‘nice to do if you have the time’ but as an essential part of our professional identities” (p.

263). For many of us, this attitude of self-care is something we need to learn. Ideally, we would learn this in our undergraduate education and internships as a proactive measure before the start of our careers or before the onset of burnout. However, wherever you are today, this guide will help you develop a self-care mindset and support your self-care practices to encourage your experience of resilience.

Part I: Education on Burnout

A Brief History of Burnout

In the 1970s, when Herbert Freudenberger was a practitioner treating drug abuse at a community agency in New York City, the term *burnout* was used to describe drug abusers who experienced a slow depletion of motivation and competence as a consequence of drug addiction (Skovholt & Trotter-Mathison, 2011). Freudenberger recognized similar trends in practitioners who worked with these clients, and was the first to use the term burnout to describe therapists who were no longer functioning effectively (Baker, 2003). Freudenberger (1974) described professional burnout as the physical, emotional, and mental exhaustion caused by the job demands of human service workers who help people with psychological, social, and physical needs.

In the 1980s, burnout not only became widely acknowledged in various occupations and academic journals, but also became measurable (Skovholt & Trotter-Mathison, 2011).

Developed by Maslach and Jackson (1981), the Maslach Burnout Inventory (MBI) measures burnout symptoms of human service professionals using three subscales:

1. Emotional exhaustion: a depletion of emotional resources, reduced energy, tiredness, and feeling emotionally overextended (Cheek, Bradley, Parr, & Lan, 2003; Maslach & Jackson, 1981).
2. Depersonalization: a negative, cynical, or detached attitudes towards clients (Newell & MacNeil, 2010).
3. Personal achievement: a negative evaluation of one's work, dissatisfaction with one's accomplishments on the job, and a decline in feelings of competence and success (Cheek et al., 2003; Maslach & Jackson, 1981).

Risk Factors, Warning Signs, and Symptoms of Burnout

Since the development of the MBI, the risk factors, warning signs and symptoms of professional burnout have been widely researched, and are presented in Table 1 and Table 2.

Table 1

Risk Factors for Professional Burnout

Individual Factors	Organizational Factors	Work Environment Factors
Use of empathy	Bureaucratic constraints	Work overload
High caseloads	Inadequate supervision	Lack of control
Interpersonal tensions	Low support	Insufficient reward
Maladaptive coping styles	Lack of resources	Breakdown of community
Emotional expectations		Unfairness
Repressing emotions		Significant value conflicts
Difficulty with clients		Job/Person incongruence
Professional isolation		
(Klimenki, Ricard, & Singer, 2013; Newell & MacNeil 2010; Maslach & Leiter, 1997; Barnett, Baker, Elman, & Shoener, 2007)	(Newell & MacNeil, 2010; Baker, 2003)	(Maslach and Leiter, 1997)

Table 2

Warning Signs and Symptoms of Professional Burnout

Warning Signs of Burnout	Symptoms of Burnout
Fatigue	Emotional exhaustion
Frequent absenteeism	Negative or cynical attitude toward work
Tardiness	Negative evaluation of work
Low completion rate of job duties	Feeling hopeless or helpless
Frustration	Intrusive thoughts
Anger	Difficulty sleeping
Impatience	Startle reactions
Boredom	Irritability
Lack of focus	Change in attitude towards clients
Hoping clients will cancel	Decreased social interests
Decreased motivation	Nightmares
Decreased enjoyment of work	Depleted physical and mental energy
(Barnett et al., 2007; Newell & MacNeil, 2010)	(Cheek et al., 2003; Baker, 2003; Newell & MacNeil, 2010)

The Consequences of Burnout

When these symptoms, warning signs, and risk factors are not attended to, the consequences of burnout are multidimensional: professional, physical, behavioral, and emotional. Professional consequences can include job loss, professional impairment, and poor client care (Clementes-Cortes, 2013; Newell & MacNeil, 2010). The physical and behavioral consequences of burnout can include fatigue, hypertension, decreased immunity, pain, and substance abuse (Clementes-Cortes, 2013; Stebnicki, 2007). Emotional consequences may include apathy, anxiety, and hopelessness (Clementes-Cortes, 2013). Additionally, burnout is positively correlated with the experience of stress itself (Etzion, 1984). Chronic stress may lead to gastrointestinal problems, musculature problems, disrupted sleep, overeating or under eating, decreased immunity, anxiety, attention deficits, relationship difficulties, and performance impairment (Baker, 2003). Although stress does not necessarily mean impairment (Baker, 2003), the vulnerabilities caused by stress can be hazardous (Barnett & Cooper, 2009).

The consequences of burnout may have further implications for therapists. Therapists experiencing stress and burnout may be vulnerable to boundary violations, depression, disinterest in clients, self-medicating with alcohol or other substances, maladaptive coping strategies, and a loss of objectivity (Barnett & Cooper, 2009; Clementes-Cortes, 2013). Newell and MacNeil (2010) emphasize the vital importance for professionals to understand burnout consequences, warning signs, symptoms, and risk factors, for the health and well-being of everyone involved in the therapeutic relationship. When this relationship involves a client's trauma, even more considerations are necessary.

Burnout in Trauma Work: The Professional Fatigue Syndromes

Trauma is defined as “stress events that present extraordinary challenges to coping and adaptation” (Agaibi & Wilson, 2005, p. 196), and trauma survivors are people who have experienced one or more events that have altered their sense of self, others, or the world (Briere, 2012). Caused by people, nature, or accident, traumatic experiences embody a wide range of occurrences including abuse, violence, neglect, loss, interruptions in attachment, or catastrophic events (Hernández, Gangsei, & Engstrom, 2007; Rogers, 2013). The effects of the psychological harm of trauma can be devastating, long-lasting, and influence an individual’s physical and emotional survival (Borczone, 2013). The suffering caused by trauma is often what brings people into therapy. For a therapist, staying connected with a client who is suffering can be difficult (Siegel & Germer, 2012).

Compassion fatigue, secondary traumatic stress, and vicarious traumatization are professional fatigue syndromes (Stebnicki, 2007) and consequences of the emotionally taxing work with clients who have experienced trauma (Newell & MacNeil, 2010). Compassion fatigue is an emotional and physical reaction that is cumulative over time, and is experienced from the chronic use of empathy to support clients who are suffering (Newell & MacNeil, 2010; Skovholt & Trotter-Mathison, 2011). Secondary traumatic stress is a behavioral stress reaction to knowing about a traumatic event experienced by a client and wanting to help the traumatized person (Figley, 1995; Newell & MacNeil, 2010). Vicarious traumatization is a cognitive stress reaction that results from empathic engagement with trauma survivors, which may cause a change or shift in the belief system of the professional (Newell & MacNeil, 2010). Though the lines that distinguish these professional fatigue syndromes are often blurry, each hold the potential to psychologically harm a professional working with traumatized clients (Hernández et al., 2010).

Professional Fatigue Syndromes

Compassion Fatigue

The chronic use of empathy for prolonged periods of time can put a helping professional at risk for burnout by activating a stress response in the body and reminding a clinician of his or her own wounds (Stebnicki, 2007). Empathy holds much value in a therapeutic relationship by allowing an internal sense of a client's world, and expressing an understanding of a client's experience (Briere, 2012; Rogers, 1961). However, compassion fatigue may occur when a clinician empathizes with a client's trauma and pain without attending to his or her own experience (Siegel & Germer, 2012).

Secondary Traumatic Stress

In order to effectively work with individuals who have endured trauma, professionals must be able to “experience the unbearable, think the unthinkable, and be prepared to experience the re-creation of scenarios of victimization, abandonment, betrayal, manipulation, and exploitation” (Rogers, 2013, p. 317). Because of this, secondary traumatic stress is a natural consequence of a therapeutic relationship in trauma work (Figley, 1995). When not properly addressed, the effects of secondary traumatic stress can lead to symptoms that parallel PTSD (Hernández et al., 2007) and may lead to burnout when the professional becomes overwhelmed, over-identifies with the client, or takes excessive responsibility for the client's life (Collins & Long, 2003). Professionals who become encumbered with traumatic material may also become ineffective, and create an unhealthy shift in the therapeutic relationship. Secondary traumatic stress may also include indications such as insomnia, avoidance, nightmares, startle reactions and irritability (Newell & MacNeil, 2010).

Vicarious Traumatization

Hernández et al. (2007) identified vicarious traumatization as a “unique and inevitable consequence of trauma work” (p. 231) that involves the cumulative stress that develops from empathetically working in trauma care. With vicarious traumatization, the professional's feelings, thoughts, memories, self-esteem, or sense of safety are affected. The negative impact of bearing witness to a client's trauma may include feelings of anger, hopelessness, fear, and being overwhelmed and frustrated. The impact may depend on the length and intensity of the client's traumatic stories, the professional's own trauma history, and the professional's ability to manage the inherent stress of trauma work (Hernández et al., 2010).

As seen in the descriptions of the professional fatigue syndromes, empathy may put a professional at risk for burnout (Klimecki, Ricard, & Singer, 2012). Research on the neurobiology of empathy supports the stressful nature of empathy on the brain (Singer, Seymour, O'Doherty, Kaube, Dolan, & Firth, 2004). Using functional magnetic resonance imaging (fMRI), neuroscientists measured the brain activity of pairs of people. In these pairs, one person experienced a painful stimulation and the other person observed the person receiving a painful stimulation. When comparing results from both conditions, overlapping activations in parts of the brain were found, specifically in the anterior insula and the anterior medial cingulate circuit. These regions of the brain are linked to the affective experience of pain, and these results suggest that empathizing with another person's pain can activate a pain response in the brain.

Further studies on empathy and stress have associated empathetic resonance with negative affect and a high burnout risk for helping professionals, especially those who work with people who are suffering (Klimecki et al., 2012). As professionals who often work empathetically with clients experiencing psychological, emotional, or physical pain, music therapists must be aware of their own risks for developing these professional fatigue syndromes and burnout.

Burnout in Music Therapy Professionals

Music therapy research shows that professional music therapists fall in the average range of burnout on the Maslach Burnout Inventory (MBI) (Kim, 2012; Vega, 2010). Regarding the subscales of the MBI, Vega (2010) found an average range of emotional exhaustion, as well as a low range on the subscales for depersonalization and personal achievement. This means subjects reported an average level of feeling fatigued, but higher levels of feeling connected with clients and satisfaction with job-related accomplishments. Kim's (2012) results also showed that age

and income were significantly predictive variables of experiencing burnout on the personal achievement subscale, where older subjects with higher salaries experienced less burnout.

To make sense of the MBI subscale scores of music therapists, the results of Vega's (2010) study were compared with the MBI norms of mental health workers. The occupational subgroup of mental health workers includes psychologists, psychotherapists, counselors, psychiatrists, and mental health hospital staff. In regards to the emotional exhaustion subscale, music therapists experience a greater depletion of energy and emotional resources than the average mental health worker. Vega speculates that this may be due to level of education, as individuals with higher degrees experience less burnout. When comparing depersonalization subscale scores, music therapists are less negative, cynical, and detached from their clients than mental health workers. Finally, when comparing scores with mental health workers, music therapists experience more confidence and feelings of success. These results show that the opportunity to work with clients through music may be emotionally tiring, but can also provide positive therapeutic relationships and outcomes to feel proud of.

Other variables contributing to burnout in music therapists can be categorized into work, individual and social factors (Clementes-Cortes, 2013). Work factors for music therapists were found to be "the most dominant variable contributing to burnout in the literature" (p. 167). These factors include insufficient pay, work overload, severity of clients' problems, and client prognosis. Individual factors leading to burnout for music therapists included unrealistic expectations, idealism, altruism, age, years of work experience, lack of rewards, and limited feedback from supervisors. Although Clemetes-Cortes (2013) found that older and more experienced music therapists experienced less burnout, Fowler (2006) found that years of experience were not associated with burnout for music therapists. Vega (2010) also examined

personality as an individual factor and found that anxiety, sensitivity, and tension were predictive of burnout. Though these individual and work factors may vary by clinician, the potential influence of these factors is important to recognize.

Social factors are also an essential consideration for burnout regarding the unique challenges music therapists face (Clementes-Cortes, 2013). Because music therapists are a professional minority, feelings of being misunderstood and isolated are common and may lead to feeling a lack of support and control. The degree of contact between the therapist and client is also a consideration because the degree of intimacy involved in sharing a musical space can lead to emotional exhaustion. Working with music as a part of the therapeutic relationship opens many doors. However, it may contribute to a lack of clarity about one's role at work. Role ambiguity is also a social factor and source of stress for music therapists who find themselves confused about their job obligations and duties, and are asked to perform tasks outside of their role as a music therapist. These social factors challenge music therapists to constantly advocate for their profession and position at work.

Further research focuses on the effect of job satisfaction on the career longevity of music therapists. Vega (2010) found that job satisfaction was closely linked to career longevity. Kim (2012) found that a higher degree of job satisfaction significantly predicted lower levels of burnout, even beyond the variables of age, income, and experience. Kim (2012) concluded that job satisfaction must be improved to decrease burnout, and that improving the collective self-esteem of the music therapy profession may prevent emotional symptoms of burnout, especially for those who are not satisfied with their job. Decuir and Vega (2010) found the most prevalent reasons why music therapists leave the field is because of a lack of support from administration and low salaries. However, the longevity of music therapists' careers is gradually increasing.

Cultivating one's own involvement in music is an important factor in the career of a music therapist (Decuir & Vega, 2010; Hesser, 2001). Investigating why music therapists persist in the field, Decuir and Vega (2010) surveyed 231 music therapists with over ten years of experience. Among experienced professionals, participation in music activities outside of work was reported to be important for job satisfaction and career longevity. Hesser (2010) also discussed the need for music therapists to keep their relationship with music alive and active because a disconnection with music may lead to burnout. Because a connection with music is a factor in career choice for music therapists, this disconnection may have serious consequences. A music therapist's effort in maintaining an active and positive relationship to music holds significant value in burnout prevention.

What is Clinification?

Introduced by Patricia Allen (1992), the term *clinification* comes from art therapy literature, and is a consequence of a creative arts therapist neglecting his or her own creative process. Clinification is a phenomenon where professionals stop investing in their own art making and focus more on clinical skills, which creates a shift from being a creative arts therapist to a therapist who uses creative arts with clients (Iliya, 2014). A decline in one's own art making process can cause a decline in a therapist's ability to respond intuitively and empathetically, as well as weakening the fluency in which the materials and forms are used. Clinification can lead to burnout and career drift, and is intensified by ambivalence around clinical skills and isolation (Allen, 1992). Therefore, the survival and progression of creative arts therapies are dependent on the practitioner's habitual engagement in personal creative practices (Iliya, 2014).

Translated into the work of music therapists, the music that clinicians make when working with clients is not sufficient for a complete understanding of the therapeutic power of music (Hesser, 2001). Music therapists must also personally experience the power of music, and musical skills must be continually developed in order to avoid burnout and to maintain effectiveness as a clinician. A music therapist's relationship to music is significant. It is important for clinicians to be aware of shifts in this relationship and nurture this relationship with love, attention, and effort.

Burnout can be a serious condition, and it is important for music therapists to understand the warning signs, risk factors, and consequences of burnout, and seek help when necessary (Clementes-Cortes, 2013). Although individual, work, and environmental factors may put a music therapist at risk, burnout is not inevitable (Fowler, 2006). Health, balance, and well-being are possible if we are willing to care for ourselves as we care for others. In the next section, we will look at how maintaining self-care practices and strategies can help music therapists thrive.

Part II: Education on Self-Care

The Importance of Self-Care

Self-care is crucial in preventing burnout and is generally defined as engaging in behaviors that support health and well-being (Lee & Miller, 2013). For helping professionals, self-care is the implementation of skills and strategies to maintain the physical, psychological, emotional, social, spiritual, leisure, and professional needs of oneself while attending to the needs of others (Lee & Miller, 2013; Newell & MacNeil, 2010). By doing so, professionals engage in healthy and self-respecting processes that empower and enable a proactive and intentional ownership of health, well-being, and resilience (Baker, 2003; Lee & Miller, 2013). Self-care is a multidimensional phenomenon that considers both the personal and professional lives of the practitioner, and varies by individual preferences, beliefs, culture, and context of employment (Lee & Miller, 2013).

Caring for oneself not only protects an individual from the risk of burnout, but also protects the client and profession from harm caused by the failure to manage stress and work challenges (Barnett et al., 2007). Because burnout can lead to professional impairment and affect clinical competence, self-care is an ethical responsibility for professionals (Richards, Campenni, & Muse-Burke, 2010; Barnett et al., 2007). The American Music Therapy Association's (2013) Code of Ethics section 1.5 states,

The [music therapist] is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems.
(para. 7)

With this ethical imperative in mind, self-care should not be perceived as a luxury or indulgence, but rather an essential part of a professional identity (Barnett et al., 2006).

Professionals are recommended to engage in self-care programs that are ongoing and preventative (Barnett & Cooper, 2009), comprehensive (Lee & Miller, 2013), and individualized (Stebnicki, 2007). Baker (2003) also recommended self-awareness, self-regulation, and balance as objectives to consider for therapists' self-care plans. Being self-aware of internal conflicts, physical experiences, psychological experiences, limitations, needs, and emotions allows therapists to responsibly observe one's self as a person and professional. Self-regulation helps a therapist maintain a physiological and psychological equilibrium by proactively regulating mood and affect in order to reduce the risk of becoming overwhelmed and distressed. Lee and Miller (2013) provide a framework for self-care that implements strategies to manage symptoms and risks for burnout. These strategies are categorized by both professional and personal self-care practices.

The Six Structures of Professional Self-Care

Purposefully engaging in practices that support one's professional role promotes an effective and appropriate use of the self at work (Lee & Miller, 2013). Here are the six structures of professional self-care:

1. **Workload and time management:** mindfully managing, prioritizing, and organizing work tasks and time spent on tasks to maximize efficiency and balance. Included in this structure are taking breaks through the day and taking vacations.
2. **Attention to professional role:** understanding the role and goals of one's job, and acknowledging limitations in one's scope of practice. This also involves setting boundaries.

Suggestions for Setting Boundaries

Boundaries are the relational lines between people that are not to be crossed and the proper contact to maintain in a relationship (Skovholt & Trotter Mathison, 2011). Well-established and clear boundaries with yourself and others can contribute to a professional's wellness, vitality, and ability to cope with difficult clients.

Examples of healthy boundaries to maintain with yourself:

- Accepting that you do not know all of the answers all of the time.
- Giving yourself permission to be imperfect.
- Being clear with yourself that it is not your job to save or fix anyone.
- Regulating the number of client contact hours per week to a manageable limit.

Examples of healthy boundaries to maintain with your clients:

- Saying “no” and setting limits when necessary. Inability to say no can lead to being overextended and burned out.
- Separating your clients' emotions from your own.
- Allowing your self-esteem to be independent from your clients' behavior or progress.

3. Attention to reactions at work: practiced through supervision, personal therapy, journaling, and debriefing with colleagues. Clinical supervision as a support system is highly recommended and regarded in burnout prevention in the literature (Barnett & Cooper, 2009; Newell & MacNeil, 2010; Richards et al., 2010). Therapists working in trauma must care for her or himself through supervision (Borczone, 2013; Hernández et al., 2010), of which the goals may include:

- Building awareness of one's self.
- Increasing confidence in clinical skills and knowledge.
- Increasing faith in the therapeutic process.
- Addressing the potential impact of trauma work.
- Becoming aware of vulnerabilities.
- Attending to self-care issues.

4. Social support and self-advocacy: building or belonging to a professional network or community, and advocating for changes such as a pay raise. Seeking constructive feedback, education, and guidance from peers and colleagues can help build a network of support and resources.
5. Professional development: includes becoming a member of a professional organization, attending conferences, reading current publications, and/or engaging in research.
6. Revitalization and generation of energy: sustaining hopefulness, energy, and inspiration around one's professional role for a sense of effectiveness and well-being. This includes creating a pleasant workspace, being reminded of clients' positive outcomes, and sharing meaningful experiences with colleagues.

Based on these six structures of professional self-care, let's take a look at three things: your role as a music therapist, your support network, and your current professional self-care efforts and activities. Please print the next two pages and complete reflections 1, 2, and 3.

Reflection #1: My Role as a Music Therapist

Why did I choose to become a music therapist?	Why did I choose my current job?
What are the goals of my job?	What are the roles and tasks involved in my current job?

Reflection #2: My Professional Self-Care Team

Identify the people who provide essential support in your professional life

Clinical Supervisor:

<p style="text-align: center;">Music Therapy Colleagues: (Other music therapists you can turn to for support, reassurance, and understanding)</p>	<p style="text-align: center;">Coworkers: (People at work you trust and respect to turn to for support when needed or debrief with)</p>
<p style="text-align: center;">Professional Organizations: (Organizations or associations you belong to)</p>	<p style="text-align: center;">Professional Communities: (Local community networks, online communities, support groups, or peer supervision groups)</p>

Reflection #3: My Professional Self-Care Efforts and Activities

List the professional self-care activities you participate in

<p>Workload and time management: (Managing, prioritizing, and organizing work tasks; maintaining a balanced and efficient schedule)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Attention to professional role: (Understanding your scope of practice, setting boundaries with yourself and clients)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>Attending to reactions at work: (Supervision, therapy, journaling, or debriefing with colleagues)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Professional and self-advocacy efforts: (Advocating for yourself and your profession, serving on committees or leadership positions)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>Professional development: (Attending conferences, reading publications, engaging in research, continuing education)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Revitalization of energy and inspiration: (Creating a pleasant and organized workspace, scheduling vacations, taking breaks)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Resilience and Vicarious Resilience

Resilience is “the ability to successfully adapt and cope despite threatening or challenging situations,” and “a pattern of competence and self-efficacy in the presence of extraordinarily difficult events” (Agaibi & Wilson, 2005, p. 198). Achieved in numerous ways, resilience is an ordinary phenomenon involving an individual’s unique strengths (Mancini & Bonanno, 2012). Although most adults will be exposed to at least one potentially traumatic event in their lifetime, resilience is a common response to potential trauma (Bonanno, 2005), and traumatic experiences can sometimes lead to positive change and growth (Woodward & Joseph, 2003). Posttraumatic growth refers to the positive changes experienced as a result of the struggle of a traumatic event, which may include strengthened relationships, an increased awareness of personal strength, and a new perspective on life (Calhoun & Tedeschi, 1999). Although trauma literature is predominantly focused on the toxic effects of trauma work, resiliency and positive change in people exposed to trauma is worth paying attention to, and has applications for the therapist (Hernández et al., 2010).

Vicarious resilience is characterized by a positive transformation of the therapist’s experiences when engaging with a client who has survived a traumatic event (Hernández et al., 2007). Positive effects of observing a client’s resiliency include feelings of inspiration, growth, strength, and overcoming and coping with adversity. The concept of vicarious resilience originates from qualitative research with psychotherapists working with individuals and families who suffered traumatic events in Bogota, Columbia (Hernández et al., 2007). Although all subjects reported experiences of vicarious traumatization, each described that witnessing their clients’ capacity to heal and overcome adversity positively changed their attitudes and emotions. These positive transformations for the therapists included a cognitive shift in perceiving the

severity on one's own problems, an increase in hope for the recovery of trauma survivors, increased tolerance for frustration, and an increased sense of effectiveness of their work.

Researchers conducted a similar study with mental health providers in the United States, and found congruent themes regarding vicarious resilience (Engstrom, Hernández, & Gangsei, 2008). In this study, subjects also reported being positively affected by their clients' resilience. Results showed the most dominant theme was the positive alteration of one's own perspective on life, which additionally provided motivation to address personal and global issues. This motivation drawn from the clients' resilience helped practitioners reaffirm the value of their work, served as a catalyst in reframing personal problems and negative experiences, and provided a source of inspiration and self-care.

By developing an awareness of vicarious traumatization and resilience, these processes can be managed to improve self-care by decreasing vicarious traumatization and increasing vicarious resilience (Hernández, et al., 2007). Approaching vicarious traumatization and resilience as equally important processes can create important opportunities for professional and personal growth (Engstrom et al., 2008). Balancing the difficult and painful aspects of trauma work with hopeful and growth-oriented aspects can provide professionals with a healthier lens through which to view themselves and their work (Hernández et al., 2010).

Hernández et al. (2007) present six reasons why the purposeful cultivation of vicarious resilience is important in trauma work as a self-care practice. First is the use of vicarious resilience as a tool to counteract fatigue caused by vicarious traumatization, and to avoid becoming a "victim of those who have been victimized" (p. 239). Second is the ability of vicarious resilience to increase motivation and persistence while doing trauma work, which may help professionals continually find new meaning in their work. Third is utilizing the concept of

vicarious resilience in trainings, supervision, and self-care plans, to encourage and guide trauma workers to care for themselves.

The importance of cultivating vicarious resilience is also seen in clinical work with clients who may be concerned about the toxic effect of their trauma (Hernández et al., 2007). Introducing the concept can help facilitate the clinical work by reducing clients' fear of burdening the therapist. Furthermore, because research has shown that vicarious learning extends to other contexts of the therapist's life, professionals may use what they learn from clients about resilience in their own lives in times of crisis. Finally, the awareness of vicarious resilience can enrich a professional's own conceptualization of their career. The process of a professional's reevaluation and introspection that stems from lessons of client resilience can help a professional better cope with personal challenges, and become less susceptible to burnout and job fatigue (Engstrom et al., 2008).

The reframing process that vicarious resilience provides has cognitive, emotional, and behavioral elements (Engstrom et al., 2008). The positive changes that occur from witnessing a client overcome adversity include recognizing human beings' capacity to heal, reaffirming the value of therapy, regaining hope, and reassessing the dimensions of one's own problems (Hernández et al., 2010). Other positive changes include understanding and valuing the spiritual dimensions of healing, discovering the power of community healing, and increasing professional and public awareness of the multiple dimensions of trauma. The impact of vicarious resilience may be beneficial for all professionals working with clients who have been traumatized, and enrich professionals' work and personal well-being.

The use of vicarious resilience as self-care for music therapists is seen in a case study presented by Amir (2004), who used improvisational music therapy with a 32-year-old woman

named Lisy. A survivor of childhood sexual abuse, Lisy's music therapy treatment focused on exposing, dealing with, and healing her trauma. In response to working with Lisy, Amir first expressed feelings of vicarious traumatization and subsequently provided an example of functional self-care:

I still remember moments when the pain was so big that I could hardly contain it. I would come out of some sessions completely exhausted. Sometimes I wasn't sure if she was going to make it. I had moments of doubt. At times I was so involved that I found myself going through the same emotions and feelings as Lisy. I was furious at her father, and also at her mother. I had to work hard and separate myself from her in order to help her. I remember that after my sessions with her I sat down at the piano and played. It helped me to release my emotions. I also wrote in my journal and reflected on the process that I was going through. (p. 103)

Amir (2004) then reflected on vicarious resilience experienced from her work with Lisy:

Even though many years have passed since I worked with Lisy, I am still full of admiration for her. I admire her courage, her commitment to finding her real self and becoming a whole and complete human being. I am still affected by her authenticity. To be a witness to such transformation is a powerful experience, and I am so thankful for having had the chance to do it. Sharing Lisy's journey was a very meaningful experience for me as a therapist, but primarily as a human being. . . I learned a lot from Lisy. She showed me that even when the past is so dark, there is hope for the future. She showed me the powerful place music has in such a journey. (p. 102-103)

As a professional self-care practice to counteract vicarious traumatization, we can cultivate vicarious resilience by discussing clients' strengths and stories of resilience with coworkers, journaling about clients' ability to survive traumatic events, writing down positive outcomes in treatment, and acknowledging client breakthroughs. Now it is your turn to nurture vicarious resilience by taking time to focus on your clients' stories of resilience. Print out the next page and start your vicarious resilience list. Keep this as an ongoing list.

Balancing Empathy and Compassion

Compassion is a practice that bridges both professional and personal self-care to remedy the fatigue and burnout caused by empathic distress (Siegel & Germer, 2012). In research following Singer et al.'s (2004) study on the similarities of the brain's perception of pain and empathic resonance of pain, neuroscientists studied the brain function involved in states of empathy and compassion during meditation (Klimecki et al., 2013). First, magnetic resonance imaging scans were taken while subjects meditated on empathetic responses, or thought about and connected with the suffering of another person. These brain scans of empathetic responses showed brain activity similar to an affective experience of pain, and subjects reported feeling burnt out. However, when asked to focus on compassion, or warm feelings of acceptance for a suffering person, brain scans showed neuronal activity in areas associated with romantic love and reward (Kupfershmidt, 2013).

These outcomes lead researchers to distinguish empathy and compassion as two different inner states with different consequences for health and well-being (Klimecki et al., 2013). Though empathy may be necessary in therapeutic interactions, when empathizing with a client's pain without a simultaneous attitude of compassion, burnout is likely to develop (Siegel & Germer, 2012). Researchers concluded that compassion for others and ourselves is a skill that can be trained and cultivated through practice (Klimecki et al., 2013). Germer (2012) suggests two exercises for building compassion: breathing compassion in and out, and phrases of equanimity.

Exercises for Building Compassion

1. Breathing Compassion In and Out

Germer (2012) suggests this exercise during times of stress, emotional discomfort, or when feeling the fatigue that comes with empathy. This may be done in a quiet moment alone or even during a session with a client:

- Sit comfortably, close your eyes, and focus on your breathing.
- Identify any physical feelings of tension, stressful emotions, or feelings of suffering in your awareness.
- Being aware of the stress, take a deep breath in, drawing compassion into your body. Give yourself compassion as you inhale deeply.
- Exhale and send compassion to the suffering person or to the world in general.
- Continue breathing compassion in and out. Open your eyes when ready.

2. Phrases of Equanimity

These phrases may be repeated to ourselves for mental calmness and to build compassion for both the client and clinician (Germer, 2012)

- *Everyone is on his or her own journey.*
- *I am not the cause of my patients' suffering, nor is it entirely within my power to make it go away, no matter how much I wish I could.*
- *Although this moment is difficult to bear, it remains a privilege to help.*

The Five Structures of Personal Self-Care

Personal self-care involves the things we do to purposefully engage in practices that promote holistic health and well-being for ourselves, and includes five structures (Lee & Miller, 2013):

1. **Physical:** includes exercise, adequate sleep, a healthy diet, general body health, and prevention of illness. Sufficient exercise and sleep were repeatedly mentioned in the literature as important lifestyle habits to minimizing the effects of burnout (Barnett & Cooper, 2009; Lee & Miller, 2013; Newell & MacNeil, 2010).

Health and Lifestyle Recommendations

Diet: The USDA (2010) recommends healthy eating habits which includes:

- Limiting intake of added sugar, saturated fat, and sodium.
- Focusing on consuming nutrient-dense foods.
- Increasing intake of fruit, vegetables, and whole grains.
- Planning your meals ahead to make better food choices.
- Staying hydrated with water and/or unsweetened beverages.
- Preparing your own food rather than eating out.

Exercise: The American Heart Association (2015) recommends that adults get 30 minutes of moderate intensity aerobic activity five days a week.

Sleep: The National Sleep Foundation (2015) recommends that young adults and adults get seven to nine hours of sleep per night. As an essential component of health, the following sleep hygiene habits are recommended (Skovholt & Trotter-Mathison, 2011):

- Go to bed at the same time each night.
- Develop a nightly routine to relax your body and mind and prepare for sleep.
- Reserve your bedroom for sleep and intimacy only- no TV, work, or electronic devices in bed.
- Make sleep a top priority.

Unplug: Disconnect from phone or internet and schedule a digital detox to connect with yourself and loved ones (Huffington, 2014).

2. Psychological and emotional: engaging in stress management techniques, emotional regulation, recognizing one's strengths, seeking personal therapy, adopting positive coping strategies, and attending to emotional needs (Barnett & Cooper, 2009; Lee & Miller, 2013; Richards et al, 2010).
3. Social: sustaining meaningful supportive relationships, connecting with loved ones, participating in community events, and using a personal support system in times of need (Lee & Miller, 2013; Richards et al., 2010).
4. Spiritual: includes meditation, prayer, reflection, spending time in nature, and faith-based practices (Lee & Miller, 2013). Spirituality is important in developing self-

awareness. Meditation was found to increase awareness of thoughts, feelings, vulnerabilities, needs, and patterns of relating to others when used by psychological therapists in training (Boellinghaus, Jones, & Hutton, 2013).

5. Leisure: enjoyable activities such as sports, reading, time with pets, recreation, and pursuing creative endeavors (Lee & Miller, 2013).

Based on these structures of personal self-care, let's take a look at your support network, and your personal self-care efforts and activities. Please print and complete reflections 4 and 5.

Reflection #5: My Personal Self-Care Team Identify the people whose support is essential in your personal life	
Family Support	Friends Support
Therapist/Coach/Mentors (People who provide professional services and individualized time with you to focus on your growth, challenges, and goals.)	Community Support: (Community groups, support groups, online communities)

Reflection #6: My Personal Self-Care Efforts and Activities
List your current personal self-care efforts and participation

Physical

(Exercise, adequate sleep, a healthy diet, general body health, and prevention of illness.)

Psychological & Emotional

(Engaging in stress management techniques, emotional regulation, recognizing one's strengths, seeking personal therapy, adopting positive coping strategies, and attending to emotional needs.)

Social

(Sustaining meaningful supportive relationships, connecting with loved ones, participating in community events, and using a personal support system in times of need.)

Spiritual

(Mediation, prayer, reflection, spending time in nature, and faith-based practices.)

Leisure

(Enjoyable activities such as sports, reading, time with pets, recreation, and pursuing creative endeavors.)

Self-Compassion

Compassion for the self is a key part of self-care (Klimecki et al., 2013). Kristin Neff (2012) presented the concept of *self-compassion*, or compassion directed inward, as a source of emotional strength and resilience that consists of three main elements. First is self-kindness, or internal dialogues that are caring rather than critical, in order to offer acceptance, soothing, and support of oneself (Neff & Germer, 2013). Common humanity is the second element, which recognizes that challenges, failures, mistakes, and shortcomings are a part of the shared human experience. The third element of self-compassion is mindfulness, which refers to an awareness of thoughts and feelings with non-judgment and equanimity. The combination of these three elements of self-compassion acknowledges the existence of both positive and negative feelings with a receptive and nonresistant state of mind (Neff, 2012).

Research on self-compassion has found that greater self-compassion is associated with positive feelings about one's work and making a difference in the world (Neff, 2012). Self-compassion is also correlated with less anxiety and depression, and increased motivation, emotional intelligence, and coping skills (Neff, 2012; Neff & Vonk, 2009). Because self-compassionate individuals are reported to have more compassion for themselves and others, they are less likely to experience distress when attending to the suffering of others.

This suggests that self-compassion is an important skill for helping professionals, and can not only protect against burnout, but also create more effective therapeutic conditions for survivors of trauma (Barnard & Curry, 2011; Klimecki et al., 2013). By reducing reactivity and supporting greater feelings of acceptance, compassion may allow a clinician to better remain present and approach a client's suffering without being personally activated. Self-compassion can be increased through self-reflective exercises and practices such as mindfulness and loving-

kindness meditations in order to evoke a more compassionate mindset and increase resilience (Siegel & Germer, 2012).

Exercises for Self-Compassion and Self-Kindness

The following practices are recommended to soothe and nurture ourselves and approach ourselves with warmth and understanding rather than self-criticism.

- Self-Compassionate Letter (Neff, 2012): Describe a problem that makes you feel bad about yourself and identify the emotions that come up as you write. Then, think of an imaginary friend who is unconditionally accepting of you and understands the limits of human nature. Write a letter to yourself from the perspective of this imaginary friend. What would this friend say about your problem? How would your friend remind you that you are human? What suggestions would they make? Allow yourself to be soothed and comforted.
- Self-Compassionate Phrases (Germer, 2012): Take a deep breath, put your hands over your heart, and repeat the following phrases:
 - This is a moment of suffering.*
 - Suffering is a part of life.*
 - May I be kind to myself.*
 - May I give myself the compassion I need.*

Mindfulness Exercises

Germer (2012) suggests four mindfulness practices to increase awareness of the present moment and gently be present with your experience of the moment:

- Formal Mindfulness Meditation: setting aside a set period of time to be mindful of what you are thinking, feeling, and sensing. Germer recommends 30-minutes of formal mindfulness meditation per day, which is the amount of time that has been shown to increase well-being. However, he stated that 20-minutes per day may also be sufficient.
- Informal Mindfulness Meditation: taking a brief mindful moment in the midst of being busy. In the short moment of mindful awareness, you stop what you are doing, take a few moments to observe yourself in the moment, and then return to what you were doing.
- Conscious Breathing: Taking a deep breath in, focusing on your breath, and being aware that you are breathing.
- Mindful Walking: Walking slowly and deliberately while keeping your mind focused on the physical sensations of walking and maintaining an attitude of kindness and gratitude.

Loving-Kindness Meditation

Boellinghaus, Jones, and Hutton (2013) studied psychological therapists in training who participated in guided loving-kindness exercises and found that the meditation helped participants become more aware of their thoughts, feelings, and patterns of relating to others.

Loving-kindness meditation involves the repetition of the phrases:

May I be safe.
May I be happy.
May I be healthy.
May I live with ease.

These phrases may also be extended to another person or to the world:

May you be safe.
May you be happy.
May you be healthy.
May you live with ease.

May we all be safe.
May we all be happy.
May we all be healthy.
May we all live with ease.

Repeat these phrases while in a comfortable position and in a meditative state and focus on extending compassion to yourself and others.

A self-compassion scale developed by Rae, Pommier, Neff, and Van Gucht (2011) is available on the next page. This scale can help you get a general idea of your relationship to self-compassion. Use this scale as a tool for reflection to help you gauge where you stand with the elements of self-compassion.

Self-Care Practices for Music Therapists Working in Trauma Care

As music therapy is becoming a more widely accepted treatment for trauma, music therapists must be prepared with personal self-care tools (Borczone, 2013). Music therapy literature places an emphasis on the importance of professional support and professional development (American Music Therapy Association, 2013; Clementes-Cortes, 2013; Fowler, 2006). Attending conferences, networking, participating in continuing education, professional supervision, and maintaining a supportive professional network are self-care practices necessary for music therapists to reduce the stress of professional isolation (Clementes-Cortes, 2013; Fowler, 2006).

In literature pertaining specifically to the personal self-care practices of music therapy professionals, lifestyle practices of exercise, healthy eating habits, and meditation were also emphasized (Clementes-Cortes, 2013; Fowler, 2006). Two positive mental coping strategies, threat minimization and positive appraisal, were also found to be important for the career longevity of music therapists (Fowler, 2006). Threat minimization refers to diverting attention away from a problem or situation instead of dwelling on it. Positive appraisal is the act of perceiving a stressful situation as manageable or beneficial, and focusing on the positive aspects of a situation rather than the negative.

Pursuing creative and music endeavors outside of work is also an essential self-care topic for professional music therapists (Decuir & Vega, 2010; Hesser, 2001). Suggested opportunities of music participation outside of work include community bands, orchestras, choirs, and church groups (Decuir & Vega, 2010). Experiencing both the fun of music making and the continued development of musical skills can help music therapists honor their relationship to music as a musician. Continuing to practice the creative medium in which one works not only defends

against clinification (Allen, 1992), but can also result in benefits such as transformation, wholeness, completion, spirituality, connection, and cleansing (Brown, 2008).

In addition to participating in music activities outside of work, Hesser (2001) also recommended music therapists participate in their own self-exploration through music and stated, “only to the extent that we can experience and understand this transformative power in our own lives can we offer it to others in our work” (p. 53). Hesser suggests utilizing self-exploration practices through music and participating in music therapy experiences.

Avenues of Exploration Through Music for Music Therapists

1. Self-exploration through music

Maintaining an active relationship with music can help avoid a disconnection with music and clinification (Hesser, 2001). Self-exploration practices through music contribute to this active relationship, while also building a deeper awareness and understanding of the client’s process in music therapy. Examples of self-exploration practices include:

- Write or record your story of how you came to be a music therapist.
- Explore your music history: reflect on music experiences and memories from your childhood or adolescence.
- Reflect on the role music played in your family, school, and community during your childhood and make or listen to music from this time.
- Reflect on the role music plays in your current life.
- Create a playlist of your favorite music and reflect on the meaning by journaling or drawing. Share this playlist with a friend or colleague.
- Select a piece of music that is meaningful to you and listen to it and/or play it live. Reflect on its meaning through imagery, art, or journal writing.
- Record a daily music journal.
- Improvise your dreams, feelings, themes in your life, or challenges. Record your improvisations and listen back. Then, draw or write about your experience.

2. Music therapy and music therapy supervision

Hesser (2001) also recommends the active participation in music therapy with an experienced professional, music therapy supervision, and music therapy experiences with colleagues. Suggestions to deepen your relationship with music therapy and gain insights include:

- Participating in a music therapy group with peers/colleagues that meets regularly and allows for exploratory music making.
- Seeking individual therapy with a music therapist or creative arts therapist.
- Using music in clinical supervision.
- Joining a peer supervision group for music therapists.

The use of music for self-care may help music therapists increase self-awareness (Camilleri, 2001), one of the best defenses against burnout (Baker, 2003; Newell & MacNeil, 2010). Through musical expression, ideas and attitudes can be externalized and observed, enabling new perspectives and understanding (Camilleri, 2001). Self-awareness through music also adds depth and quality to therapeutic work, allowing for more genuine interactions. As a music therapist uses music for growth and well-being, a positive model is provided for clients.

In the next two reflections, you will be identifying your creative self-care team and your creative self-care involvement. Print the next page and identify your sources of inspiration and your own musical and creative interests in reflections 7 and 8.

Reflection #7: My Creative Self-Care Team Identify the people whose support is essential in your personal life	
People to make music with:	People to experience and share music with:
People who inspire me: (Musicians, bands, artists, writers, etc.)	Favorite albums and songs

Reflection #8: My Creative Self-Care Efforts and Activities	
My music making (The instruments you play, songwriting, composition, music recreation, etc.)	Community music involvement (Community bands, orchestras, choirs, and church groups, etc.)
Music practices for self-exploration	Other creative endeavors and involvement

Before we move on to the next section of creating a self-care plan, remember: “self-care is not an indulgence. It is an essential component of prevention of distress, burnout, and impairment. It should not be considered as something ‘extra’ or ‘nice to do if you have the time’ but as an essential part of our professional identities” (Barnett et al., 2006, p. 263). With this mindset, along with the reflections you have completed in this section, let’s start the creation of a personalized self-care plan. Make sure you have the following reflections and exercises completed before moving on:

- Reflection #1: My Role as a Music Therapist
- Reflection #2: My Professional Self-Care Team
- Reflection #3: My Professional Self-Care Efforts and Activities
- Reflection #4: Vicarious Resilience List
- Reflection #5: My Personal Self-Care Team
- Reflection #6: My Personal Self-Care Effort and Activities
- Reflection #7: My Creative Self-Care Team
- Reflection #8: My Creative Self-Care Efforts and Activities
- Self-Compassion Scale

Part III: Creating a Self-Care Plan

This section will help you create a personalized self-care plan based on your reflections, preferences, and goals. Researchers recommend self-care programs that are ongoing (Barnett & Cooper, 2009), preventative, comprehensive (Lee & Miller, 2013), and individualized (Stebnicki, 2007) in order to sustain well-being and career longevity. Remember that self-care is a multidimensional phenomenon that considers both the personal and professional lives of the practitioner, and varies by individual preferences, beliefs, culture, and work setting (Lee & Miller, 2013). Therefore, this guide will not present a one-size-fits-all self-care plan, but rather an opportunity for you to create a plan that is right for you.

Your personalized self-care plan will center around three objectives as recommended by Baker (2003):

1. **Self-awareness:** Being self-aware of internal conflicts, physical experiences, psychological experiences, limitations, needs, and emotions allows a therapist to responsibly observe one's self as a person and professional. The ability to observe our own physical and psychological experience, as well as receive feedback from others, can help us develop healthy behaviors, habits, and coping skills.
2. **Self-regulation:** Managing and maintaining a physiological and psychological equilibrium can help proactively regulate mood and affect in order to reduce the risk of becoming overwhelmed and distressed. Our ability to self-regulate increases when we are self-aware.
3. **Balance:** Striving for a healthy balance between the mind, body, and spirit, as well as balance between yourself, others, and your community. Balance helps us prioritize and aim for realistic outcomes.

The exercises on the following pages will help you build self-awareness, encourage self-regulation, and find balance in three domain areas of self-care: professional, personal, and creative self-care practices. You will identify areas for improvement and self-care goals for each domain, and then create a plan of action. Before getting into these domains, we are going to start with a self-assessment.

The self-assessment on the next page will help you gauge your experiences and relationship to the risk factors, warning signs, and symptoms of burnout. This self-assessment is not a scale to tell you how much burn out you are experiencing. Rather, it is a tool to build awareness and provide information on your self-care progress by allowing you to compare data over time. You are encouraged to share your responses with a therapist or supervisor to work through any concerns that may arise.

To complete the self-assessment, print it out and write today's date in the first column on the right. On a scale of one to five, rate the degree to which you relate to each factor. This will be your starting point. For future re-assessments, use the additional columns and cover your previous responses while reassessing. Ongoing periodic reassessments can help you compare your scores over time and build awareness of your relationship to the risk factors involved in burnout.

Burnout Factors Self-Assessment

On a scale of 1-5 rate the degree to which you relate to the following factors

0- Not applicable 1-Not at all 2-Somewhat 3-Moderately 4-Very much 5-Extremely

Factors Relating to Burnout	Date:	Date:	Date:	Date:
A. Work Factors				
High caseload/ Work overload	_____	_____	_____	_____
Difficulty with clients	_____	_____	_____	_____
Bureaucratic constraints	_____	_____	_____	_____
Lack of supervision	_____	_____	_____	_____
Lack of support	_____	_____	_____	_____
Lack of resources	_____	_____	_____	_____
Feeling like you are not a good fit for your job	_____	_____	_____	_____
Increased absenteeism/tardiness	_____	_____	_____	_____
Low completion rate of job duties	_____	_____	_____	_____
Hoping clients will cancel	_____	_____	_____	_____
Decreased enjoyment of work	_____	_____	_____	_____
Negative or cynical attitude toward work	_____	_____	_____	_____
Interpersonal tensions with coworkers	_____	_____	_____	_____
Insufficient pay/Insufficient reward	_____	_____	_____	_____
Professional isolation	_____	_____	_____	_____
Difficulty coping with clients' prognosis	_____	_____	_____	_____
Role ambiguity (Unsure about your work role)	_____	_____	_____	_____
TOTAL:				
B. Physical and Emotional Factors				
Fatigue	_____	_____	_____	_____
Apathy	_____	_____	_____	_____
Frustration/Anger	_____	_____	_____	_____
Impatience/Boredom/ Lack of focus	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Repressing emotions	_____	_____	_____	_____
Lack of sleep	_____	_____	_____	_____
Emotional exhaustion	_____	_____	_____	_____
Physical exhaustion	_____	_____	_____	_____
Mental exhaustion	_____	_____	_____	_____
Feeling hopeless or helpless	_____	_____	_____	_____
Difficulty sleeping/Nightmares	_____	_____	_____	_____
Pain/Illness	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
TOTAL:				
C. Personal Factors				
Decreased social interests/increased isolation	_____	_____	_____	_____
Decreased motivation	_____	_____	_____	_____
Maladaptive coping styles	_____	_____	_____	_____
Interpersonal tensions	_____	_____	_____	_____
Idealism/Altruism	_____	_____	_____	_____
Feeling misunderstood	_____	_____	_____	_____
Feeling a lack of control	_____	_____	_____	_____
Decreased enjoyment of music	_____	_____	_____	_____
TOTAL:				

Self-Care Action Brainstorm

Use your responses on the reflection sheets and self-assessment to complete this page and start brainstorming what will be needed in your self-care plan.

My Role as a Music Therapist	
What questions were difficult to answer? What questions do I need more clarity with?	Action I can take to gain clarity or find the answers to these questions:

My Self-Care Team		
	Who do I need to add to my team? What relationships do I need to nurture?	Actions I can take to utilize or build my professional support system:
Professional		
Personal		
Creative		

My Self-Care Efforts and Activities		
	Of the activities I listed, which do I need to work on or cultivate more of?	What efforts/activities do I need to add to my self-care practice?
Professional		
Personal		
Creative		

Prioritize your self-care goals according to your current needs and choose three goals per category to focus on this month. Try your best to make your goals specific and measurable or time-limited if possible (ex. Meditate for 20-minutes 5 days per week).

Create Your Self-Care Goals	
Professional Self-Care	
Personal Self-Care	
Creative Self-Care	

Using your goals as a guide, create your self-care plan for the next month on the calendar on the next page. Schedule your activities at specific times and days. For goals that you are not able to schedule, make a note on the bottom of the calendar. Also, pick a day during the last week to create a self-care plan for the following month.

Self-Care Calendar and Schedule

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
<p>Other goals and areas of focus:</p> <p style="text-align: center;">Date to create next month's self-care plan: _____</p>						

Obstacles, Accountability, and Reevaluation

Now that you have your self-care plan in place for the next month, let's talk about the actual implementation of your plan in regards to self-care obstacles, accountability, and the need for reevaluation. Common obstacles to self-care are a busy schedule, the expenses involved in self-care activities, and the energy required to follow through on a plan. Additionally, therapists often face challenges such as a lack of support, difficulty saying no to requests, imbalanced personal relationships, perfectionism, and unresolved personal issues (Skovholt & Trotter-Matthison, 2011). Feelings of selfishness and guilt may also be a factor in creating resistance or avoidance of self-care practices.

Many of these obstacles are hard to face and overcome on your own. Call in your self-care team for support and to help you gain insight into the underlying meaning behind the obstacles that challenge you. Use your self-care team to also help you stay accountable to your goals and plan. It may be beneficial to have a peer or colleague as an accountability partner who is also working on his or her own self-care plan. Supervisors, mentors, and coaches can also help hold you responsible for your self-care plan and serve as and regular sources of encouragement. Share your self-reflections, goals, and self-care calendar with them. The self-care calendar you created is also an accountability tool. Keep it visible and check off activities as you go through your month to give yourself a sense of accomplishment.

As you start to implement your self-care plan, consider this to be a lifelong pursuit, and aim for progress, not perfection. Both patience and persistence is required in prioritizing self-care, and delicate balance exists in pushing yourself to commit to a self-care mindset but without being too hard on yourself. Self-compassion can help you stay connected to your self-care practices and help you be kind to yourself in the process.

Remember that self-care programs need to be ongoing (Barnett & Cooper, 2009), preventative, comprehensive (Lee & Miller, 2013), and individualized (Stebnicki, 2007) in order to sustain well-being and career longevity. To keep your self-care practice ongoing, create a new self-care calendar each month. The exercises, self-reflections, and self-assessment should be reevaluated three months, six months, and one year from now. A chart on the next page will help you create your reevaluation schedule. Like an employee evaluation, take time to assess your successes and areas for improvement, and what self-care practices work for you and what does not. Allow your self-care plan to evolve with your life and honor your own preferences, strengths, and needs.

On the next page, use the self-reflection to identify your obstacles to self-care and ways to overcome these obstacles. In addition to support from your self-care team, another way to problem solve your obstacles is to imagine that a friend or client came to you for help regarding this challenge to one of their personal goals. What guidance would you give them? Also on the next page you will identify your supports for accountability. Lastly, we will end with creating a vision of your ideal lifestyle, and where you want your self-care plan and goals to ultimately take you.

Reevaluation Schedule	
3 months from now:	To be completed at each reevaluation: <ul style="list-style-type: none"> • Self-assessment • Self-reflections #1-10 • Self-care action brainstorm • Self-care goals and calendar
6 months from now:	
1 year from now:	

Reflection #9: Obstacles and Accountability	
My obstacles to self-care:	Ways to overcome these obstacles
People who can help keep me accountable for my self-care goals:	How they can help support me and hold me accountable for my goals:

Conclusion

Take a deep breath in through your nose. Fill your lungs with air. Now, slowly exhale through your mouth. Self-care can be as simple as this, and as vitally important as the act of breathing. A common metaphor for self-care is the airline safety measure of putting on your own oxygen mask before assisting someone else with theirs. The act of putting on an oxygen mask is a great symbol for self-care. However, it is important to remember that self-care is also the oxygen itself.

Through my career as a music therapist working with clients in mental health settings, I have experienced both the consequences of burnout and the benefits of self-care. I have learned that self-care is a process that requires both patience and perseverance, but never perfection. The practices of professional, personal, and creative self-care will look different for each of us. However, all of our efforts in caring for ourselves will contribute to the strength and growth of the music therapy profession as a whole. Honor your own process, and remember to call upon your self-care team, your intuition, your willpower, and the grace within you. Thank you for taking the time to value your self-care, and thank you for doing the work that you do.

Suggested Resources

Books:

Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York, NY: Guilford Press.

Huffington, A. (2014). *Thrive*. New York, NY: Random House.

Yalom, I. (2002). *The gift of therapy*. New York, NY: HarperCollins Publishers.

Websites:

<http://self-compassion.org> – Dr. Kristin Neff's website featuring free guided meditations and self-compassion exercises. The long form of the Self-Compassion scale is also available here.

<http://www.compassion-training.org> – A free e-book featuring the research of Tania Singer on compassion and empathy.

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Reflection

The creation of this thesis project taught me about the depths of self-care, the positive aspects of trauma work, and details of my own writing process. Though I held a passion for self-care for many years, I did not understand it the way I do now. Through the writing and researching process, I found myself becoming more deeply connected to the ethical imperative of self-care and truly realizing its importance for our clinical work and for the music therapy profession as a whole. I feel much more well-versed in speaking about self-care, and more sensitive to the experience of professional burnout.

The literature on trauma helped me see a different side of my work with clients who have experienced trauma. Learning about vicarious resilience, posttraumatic growth, and the opportunities to practice compassion with those who are suffering, has helped me see that trauma work is not always about being in the dark depths of pain, but recognizing both the light and the dark in the process. I also found that learning the difference between empathy and compassion helped me understand and take more ownership of my responses to my clients, and be more compassionate with myself.

This thesis project also showed me aspects of my writing process that come with such an involved venture. I found it was important to allow myself large amounts of time when sitting down to work on this project, as research and writing almost always took longer than expected. Additionally, I have learned that I cannot force my brain to do something it does not want to do, and to pay attention to my mind when it signals me to take a break and stop. It was sometimes a challenge to not get burnt out on burnout, however, I was grateful the content of this project always served as a reminder on how to honor my process and creativity.

This project was evaluated by Nicole Edwards, M.A., MT-BC, and Anne Parker, M.A., MT-BC, MHSA, FAMI for clarity, effectiveness, and quality. I also wanted to make sure the project itself could stand strongly on its own apart from the thesis. The feedback from both evaluators was invaluable and greatly contributed to the final product. Nicole suggested many changes in language and grammar to increase clarity of the content, and helped me reformat the charts and tables to communicate the information more effectively. Anne suggested an emphasis on regularly updating self-care plans and goals, and adding direction on how to implement the plan. Additionally, Anne recommended that I add a discussion of obstacles to self-care before the conclusion in order to strengthen the existing content. Their evaluations helped reinforce the value of allowing my work to be evaluated even though I felt vulnerable in the process.

The main thing I would do differently next time would be to relax into the process and not be so hard on myself. I often got frustrated when words did not come out the way I wanted it to, I got distracted, or simply had a hard time writing. Although I enjoy writing I cannot always expect it to be easy. I also would have organized my resources better from the very beginning. I did not know I would end up with so many resources. Although I did find an efficient way to organize my resources, it would have been easier if I started the process earlier.

Before publishing this e-book, I would like to change its aesthetic quality and readability. The information in the e-book may be easier to digest when the presentation does not look and read so much like a document. I would like to be more creative with the charts, fonts, colors, and graphics. Adding inspirational quotes on self-care could also contribute to the overall warmth and help support the information presented. I plan on publishing this e-book on my website, and I hope it will reach those who can benefit from it.

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