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Personal Therapy for Undergraduate Music Therapy Students: A Survey of AMTA Program Coordinators

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Abstract

The primary purpose of this study was to gather information in order to understand how various modalities of personal therapy are employed in undergraduate music therapy curricula in the United States. Undergraduate degree program coordinators were asked about three therapy modalities, in particular: verbal therapy, music therapy, and expressive arts therapy (excluding music therapy). More specifically, this survey study aimed to answer the following questions: 1) What percentage of undergraduate music therapy training program coordinators *require* personal verbal, music, and/or expressive arts therapy in their curricula and what percentage *encourage* it? 2) What reasons are offered for the coordinators' decisions to *require/not require* and *encourage/not encourage* personal therapy? 3) Among those that require therapy, who provides such therapy and in what format (group/individual) is it typically offered?

It was predicted that less than a quarter of the respondents would indicate that personal therapy of any modality was required in their undergraduate curricula, but that a larger percentage would indicate that it was encouraged. Both hypotheses were supported, with just over 14% of the respondents indicating that they require some form of personal therapy and 32% indicating that they encourage it, with 73% of this latter subgroup encouraging verbal therapy and 46% encouraging music therapy. It was further predicted that, when therapy was required or encouraged, it was most often provided by an individual who was associated with the college/university, and that therapy was usually provided in a group format. Respondent comments related to these two questions revealed considerable confusion between experiential exercises and personal therapy, leading to dubious validity of numerical data.

Narrative responses illuminated four salient issues regarding personal therapy for undergraduate music therapy students, as follows: 1) the legal and ethical feasibility of making personal therapy a requirement of music therapy curricula; 2) the cost and availability of qualified professionals to provide personal therapy; 3) the benefits of personal therapy as an integral facet of undergraduate music therapy training and education; and, 4) the appropriateness of personal therapy at the undergraduate level of training.

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> *In terms of the old adage, "Physician heal thyself!" I am saying not only that a music therapist should heal himself but also that he should take his own medicine. Any music therapist who has not, can not, or will not experience music therapy as a client needs to change professions (Bruscia, 1998, p. 116).*

No matter if the reader agrees or disagrees with Bruscia's quote, one fact is clear: The decision of whether or not to engage as a client in personal therapy of any type is a choice that every music therapist makes at some point along the trajectory of her or his career. This decision may occur during initial training or afterward, once the individual has taken on the mantle of professional clinician.

The American Music Therapy Association (AMTA) does not require therapy of any kind as a curricular feature of its approved training programs. Rather, the decision of whether to mandate personal therapy for students seems to be left to the individual program coordinators. Because it does not mandate therapy, the AMTA does not keep statistics on how many program coordinators require or encourage their students to seek such services (personal communication, J. Creagan, July 22, 2009). This lack of data results in an incomplete picture of the nature of the training of music therapists in this country. This situation, coupled with the researchers' long-standing interest in the topic, served as the impetus for the conceptualization of the present survey study. The overarching purpose was to contribute to the knowledge base about the use of personal therapy in undergraduate music therapy training in this country. More specifically, the researchers aimed to answer the following questions: 1) What percentage of undergraduate music therapy training program coordinators *require* personal verbal,

music, and/or expressive arts therapy in their curricula and what percentage *encourage* it? 2) What reasons are offered for the coordinators' decisions to *require/not require* and *encourage/not encourage* these modalities of personal therapy? 3) Among coordinators who require therapy, who provides such therapy and in what format (group/individual) is it typically offered?

Based on the authors' extensive contact and conversation with other educators throughout the past several years, it was predicted that less than a quarter of the respondents would indicate that personal therapy of any modality was required in their undergraduate curricula, but that a substantially larger percentage would indicate that it was encouraged. It was further conjectured that, when therapy was required or encouraged, it was provided by an individual who was associated with the college/university, and that therapy was most often provided in a group format.

Review of Literature

Personal Therapy for Psychotherapists in Training

Beginning with Freud, there has been a long train of psychoanalysts to recommend that personal analysis should be a fundamental component of psychoanalytic training (Macaskill, 1999). However, the issue of mandated psychotherapy in training – not only as it relates to psychoanalysis but also to more contemporary approaches to psychotherapy – has been and remains highly controversial (Daw & Joseph, 2007), with some practitioners rallying vehemently in support of required therapy, some arguing against it, and some indicating that personal therapy is necessary only when a trainee is experiencing psychological difficulties (Atkinson, 2006; Kelley et al., 1978; Truax & Carkhuff, 1967). Nonetheless, requisite personal psychotherapy for students in counselor

training programs in this country appears to be on the rise and is the most commonly utilized remediation strategy for identified trainee deficiencies (Forrest, Elman, Gizara, & Vache-Haase, 1999). (While the present authors recognize a distinction between "counseling", "psychotherapy", and "therapy", these terms are used interchangeably in much of the related literature and, hence, in this report.)

Arguments in support of required psychotherapy point to benefits related to increasing professional efficacy (i.e., becoming a better therapist) and the role of personal therapy as a psychological buoy for the trainee, whose work is viewed as requiring optimal mental health. The first type of benefits – those related to increasing a therapist's overall effectiveness – have been discussed extensively in the literature (Macaskill, 1999) and include enhancing sensitivity and empathy for the client, increasing self awareness and thus reducing "blind spots" and/or allowing for the appropriate handling of countertransference, increasing mastery of techniques via observation of a skilled therapist, and increasing conviction about therapeutic models, approaches, or techniques used. Personal, psychological benefits have been reported as elevated self-esteem, increased self-awareness, symptom reduction, and improved emotional and mental functioning, among others (Gold & Hilsenroth, 2009; Macaskill & Macaskill, 1992; Norcross, Strausser-Kirtland & Missar, 1988; Pope & Tabachnik, 1994). In spite of longstanding and ongoing research in this area, the specific effects (both negative and positive) of mandated personal therapy for counselors in training have yet to be confirmed.

Personal Psychotherapy for Music Therapists in Training

As for other therapists, the value of personal psychotherapy for music therapists has been advanced by noted scholars as a way to improve therapy skills, increase awareness about feelings and attitudes that impact one's work (including negative countertransference), and nurture oneself (Bradt, 1997; Bruscia, 1998; Goldberg, 1989; Loewy, 2003). Student participation in therapy during undergraduate and/or graduate levels of music therapy training has also been promoted in this country and abroad (Bonde, 2007; Chong, 2006; Hesser, 1985; McGuire, 2006; Munro, 1985; Pedersen, 2002; Prefontaine, 1997; Tims, 1989). Unfortunately, scant literature exists about any kind of personal therapy in the training of music therapists and, for that matter, in the training of expressive arts therapists.

As early as 1985, Munro stated her opinion that personal therapy for students is essential. She voiced her belief that competence as a music therapist is a cumulative process involving the assimilation of experience, knowledge, observation, and insight. She worried aloud that "In many instances training programs for music therapists simply follow traditional patterns of education and leave the development of the therapist to chance, supposedly a natural outcome of accumulated facts" (pp. 75-76).

Tims (1989) echoes Munro's observations and opinion, noting that music therapy training programs in this country evolved from a traditional music education model which, quite obviously, did not include mechanisms for student self-exploration. Tims advocates for personal therapy as one facet of both undergraduate and graduate music therapy curricula as a way to enhance clinical competence, prevent burn-out, and stay in touch with the "power of music." He mentions Priestley's model of Intertherapy and

claims that group psychotherapy experiences patterned after this model can move a student to heightened awareness of self and others and, quite possibly, to an elevated professional status – from activity director to music therapist.

Although not without debate, in some countries, such as Denmark and the United Kingdom, personal music therapy is mandated in the music therapy curricula (Bonde, 2007; Odell-Miller & Sandford, 2009). Bonde (2007) writes:

> In the psychodynamic tradition, self-experience (training analysis) is considered the basis of psychotherapeutic training. In the same way we consider the student's experiences as a "student client" in music therapy (individually as well as in groups) a necessary foundation for his/her development as a "student therapist." The mandatory therapy training/self-experience was controversial from the very beginning. It is very different from traditional university learning models (and unique even in the Danish system), and the inclusion of this training in the program is still controversial from an international perspective.

Again, little is known about the extent to which psychotherapy is included as a required or encouraged component of music therapy training programs *in this country*, nor about the nature and corollaries of its incorporation. Over twenty years ago, Tims (1989) hypothesized that only a handful of programs in the United States offered therapy for students, unlike in Europe where music psychotherapy at that time was viewed as an essential component of training.

One issue that thwarts a comprehensive understanding of the scope and nature of personal psychotherapy in music therapy training is the fact that the lines between therapy and other forms of so-called “experiential” or “hands-on” learning are, at times, blurry. In an effort to delineate the relationship between personal therapy and other experiential methods and techniques, a brief review of literature related to experiential instruction follows.

Experiential Instruction for Music Therapists in Training

"Experiential learning" is a broad term that refers to any type of learning that occurs through direct and immediate encounters with a phenomenon, which stands in contrast to learning that happens through traditional means, such as thinking, reading, or observing – or what typically may be called "didactic" means. Experiential learning can occur through interactions with the events of everyday life as well as through structured experiential education, such as that arranged and sponsored by academic institutions (Brookfield, 1983). It is common for experiential and didactic methods to be used in tandem; for instance, music therapy students may learn how to play the guitar, piano, etc. by reading about how to play, observing others play, and encountering the instrument directly in hands-on fashion.

In music therapy, the broad term "experiential instruction" has been used to reference a host of distinct methods and techniques, all of which attempt to promote learning through direct encounters with the material to be learned. Examples include but are not limited to the following: 1) musical skill rehearsal in the classroom; 2) role-playing (Stige, 2001; Tims, 1989); 3) supervised practica and internships (Tims, 1989; Wheeler, 2002); 4) peer support groups (Milgram-Luterman, 2000) and peer group supervision (personal communication, J. Hiller, February 28, 2010; Summer, 2001); and 5) experiential music therapy groups (Hesser, 1985; Stephens, 2001). The last of these, the experiential music therapy group, bears an especially close resemblance to personal therapy but is not synonymous in the opinion of the present authors. The distinctions will be addressed below.

Based on data from interviews with music therapy faculty at one mid-Atlantic music therapy training program, Murphy (2007) purports that there are three primary purposes, or goals, of experiential learning toward the education of the music therapy student. The first, *Developing an Understanding of Concepts and Techniques,* refers to the connection of cognitive or so-called "didactic" instruction (lectures and readings) with emotional experience and the application of learning in clinical contexts. The second, *Developing Personal Awareness,* includes increased awareness of self and the development of empathy. The third goal, *Developing an Understanding of the Human Condition,* relates to gaining insight, through direct experience, into the spectrum of human emotions, such as loneliness and pain.

Murphy (2007) was the first to categorize experiential initiatives into a continuum of four *types* of experiences, based on faculty interviews. *Demonstrations* are experiences in which the professor leads an experience linked to a concept and one or two students participate. For example, the teacher might facilitate a song discussion to illustrate psychotherapeutic concepts of identification and projection. The second type, *laboratory experiences*, occurs when students practice the role of therapist or client with direct supervision. For instance, a student may rehearse the procedural steps of Music Assisted Relaxation in the classroom with peers and with guidance from an instructor. In *experiential exercises*, students practice or explore the self outside of the classroom setting. As an illustration, students may be asked to compose a simple song or instrumental piece based on an emotional referent (e.g., sadness, anger, etc.), record the composition, and reflect upon what they hear in their own creation. The final type is *group models*, in which students authentically participate in peer-led music therapy

groups in which the professor serves to connect participants' experiences to material presented in the classroom. An example of this is when students gather two times per week to improvise according to a given model, verbally process the group dynamics that emerge, and link these dynamics to theories about group development.

Murphy's final category – group models – might neatly house the so-called "experiential music therapy group" mentioned above, providing the group is peer-facilitated (personal communication, K. Murphy, February 27, 2010). In an experiential music therapy group, the methods of performing, improvising, composing, and music listening are used to build clinical knowledge and skill, develop professional identity, share music in community, and meet novel and ongoing challenges of the profession (Stephens, 2001). It might be tempting also to place personal music therapy in this last category. However, there are at least two salient distinctions to be made. First, not all personal music therapy for students is group-based (Scheiby, 1998), and second, although the trainees participate in both group model experiences and personal therapy as themselves (rather than in a fabricated role), and the "issues/content of the group come from the students' own lives" (Murphy, 2007, p. 38), the personal therapy group is not peer-led, nor is leadership rotated.

For purposes of the present study, the authors defined personal music therapy as *a systematic process of intervention wherein a credentialed music therapist helps a client to access, work through, and resolve personal/interpersonal issues primarily through music interventions.* With this definition in mind, it should be easy to discern how personal therapy differs from each of the previously mentioned experiential initiatives:

1. Musical skill rehearsal is not the focus of personal therapy, although musical skills may be employed and practiced in the context of such therapy.

2. Role-playing and other clinical simulations are different from personal therapy in that students participate authentically in the latter, rather than in a prescribed role.

3. In practica and internships, the students act as therapists rather than as clients.

4. Peer support groups and peer supervision, as these titles imply, involve shared responsibility between individuals of equal standing, which means that there is not a designated therapist who directs the process in a consistent manner.

5. The boundary between personal therapy and experiential music therapy groups has been articulated previously.

Method

Participants

The researchers gained university institutional review board approval to circulate an online survey designed to answer the research questions. A list of electronic mail addresses for AMTA-approved undergraduate program coordinators was acquired from AMTA. All 61 members of this distribution list were recipients of the survey and none was returned as undeliverable. Consent was implied by each recipient's return of the survey.

Measurement Tool

The 22-question survey was designed on Survey Monkey® by the researchers. The survey draft was piloted by a colleague with survey research experience and publications to his credit; this individual provided suggestions for improving the

construct and content validity of the tool. In the final survey, questions were a blend of multiple-choice and open-ended formats. As noted above, three types of therapy – verbal therapy, music therapy, and expressive arts therapy (excluding music therapy) – were the focus of the survey questions. An operational definition for each modality was provided, as follows: 1) "*Verbal Therapy* is a systematic process of intervention wherein a credentialed therapist helps a client to access, work through, and resolve personal/interpersonal issues primarily through verbal discourse. Verbal therapy may occur individually or in a group setting."; 2) "*Music Therapy* is a systematic process of intervention wherein a credentialed music therapist helps a client to access, work through, and resolve personal/interpersonal issues primarily through music interventions. Music therapy may occur individually or in a group setting."; and 3) "*Expressive Arts Therapy* is a systematic process of intervention wherein the expressive arts, excluding music, (e.g., visual and literary arts, dance/movement, drama) are used by a credentialed therapist to help a client access, work through, and resolve personal/interpersonal issues. Expressive arts therapy may occur individually or in a group setting."

Procedure

All coordinators were sent an electronic mail message with information about the protection of human subjects, a brief description of the research project, and a hyperlink to the survey. One week after the targeted participants received the initial message and survey link, they received a follow-up message via electronic mail indicating that they had one more week in which to complete the survey. All data went directly to the Survey Monkey® site. Complete anonymity was preserved; the researchers did not know which

recipients had completed the survey, nor were the researchers able to link respondents with specific responses.

Analysis

Data from the multiple-choice questions on the survey were tallied by Survey Monkey® and converted into percentages. Narrative responses to the open-ended questions were also collected and reported by Survey Monkey®. The content of these responses were categorized by the researchers. Categorization of data for the open-ended questions consisted of a 4-step process:

1. The researchers read all responses to the first open-ended question to get a general sense of the content. Irrelevant and unclear information was culled from the complete data set.

2. Responses to the first question were read a second time and discrete meaning units were identified. Individual statements often contained multiple meaning units.

3. Meaning units were grouped into preliminary categories, which were given acronyms (e.g., RES – Restrictions of University; CUR – Curricular Issues, etc.). A complete list of data category acronyms and their meanings appears in Table 1.

4. Narrative data from each subsequent question was treated in the same manner, with preliminary categories altered and new categories created in order to fully account for all identified meaning units of all questions.

Insert Table 1 about here.

Results

Of the 61 surveys distributed, 42 were completed and returned, for a 70% return rate. One survey recipient indicated in the first question that she or he was not currently a program coordinator/director and thus was exited immediately from the survey, leaving a total of 41 surveys eligible for analysis. It is important to note that not all respondents answered all questions.

Insert Table 2 about here.

Respondents hailed from all regions in which there are undergraduate music therapy programs. Table 2 shows the distribution of the respondents according to region. These respondents reported that they hold a number of different professional credentials and designations. These are shown in Table 3. Those who selected "Other" identified Licensed Creative Arts Therapist (LCAT), Addictions Counselor Certified (ACC), Licensed Mental Health Counselor (LMHC), and Nordoff-Robbins Music Therapist (NRMT). Educational degrees and specialized training that respondents identified for this question are not included in this report since they are not recognized professional credentials.

Insert Table 3 about here.

Respondents were asked to provide information regarding the requirement of personal therapy in various modalities for the students in their programs, including verbal

therapy, music therapy, and expressive arts therapy (excluding music therapy). The frequency with which personal therapy is required, or is encouraged, of music therapy students as a part of their curriculum is shown in Table 4. Predictions about the percentage of coordinators requiring and encouraging therapy were supported, with 14% requiring and 32% encouraging therapy. Respondents also were asked who provides the therapy services that are required and in what format students receive that therapy. These data are shown in Tables 5 and 6, respectively.

Insert Tables 4, 5 and 6 about here.

Throughout the survey, respondents were given opportunities to provide unrestricted, explanatory comments. Within the therapy modality sections of the questionnaire, some participants explained why they do or do not require or encourage various forms of therapy. At the conclusion of the study, respondents could make any other related comments that they wished. The comments provided by study participants about why they do or do not require or encourage personal therapy for their students are presented in paraphrased, categorized form in Table 7.

Insert Table 7 about here.

Some respondents made comments in this area that were not directly relevant to why they do or do not require or encourage therapy for their students; these comments were

removed and added to the section reserved for general comments. Paraphrased, categorized general comments are provided in Table 8.

Insert Table 8 about here.

All open-ended comments made by respondents were also qualitatively analyzed to further ascertain what topics or issues are most important to the discussion about the use of personal therapy in music therapy training. Twelve categories of comments were identified in this analysis; these are presented in Table 9. Comments that did not clearly fit in the established categories or that did not relate specifically to verbal, music, or expressive arts therapies were considered "Miscellaneous" (MIS). In order to avoid redundancy, specific results of this qualitative analysis have been included in the Discussion section, and have been marked with the corresponding acronym when relevant.

Insert Table 9 about here.

Discussion

Personal Therapy Required

In total, six respondents indicated that some form of personal therapy is required for their undergraduate students, lending support to the first hypothesis. Four of these six require only music therapy, while the others require verbal and music therapy, and music and expressive arts therapy, respectively. The one coordinator who indicated that verbal

therapy is a curricular requirement stated, “We study Bruscia’s verbal processing techniques.” This may mean that because verbal techniques are studied in class, students are required to experience verbal therapy as clients. It might also mean, however, that this individual misinterpreted the definition of verbal therapy, referring instead to experiential exercises required in the classroom rather than to personal verbal therapy. Considerable confusion about the difference between experiential learning and personal therapy seemed evident in this and other participants’ responses throughout the study. As indicated by the numbers and percentages reflected in Table 9, confusion was especially evident in comments related to music therapy. Other comments that implied uncertainty about what constitutes experiential education and what constitutes personal therapy included statements about the importance of role-playing and class demonstration in order to learn about the therapy process. This finding may be related to the fact that, while verbal, music, and expressive arts therapies were seemingly clearly defined in the survey, specific distinctions between personal therapy and experiential instruction were not delineated for the recipients.

Three of the six respondents indicated that they, or other music therapy faculty, provide the required therapy services, including the one respondent who mandates verbal therapy. Again, this suggests the confusion noted above, since providing required therapy services to students would raise important ethical questions regarding dual relationships between faculty and students. The other three indicated that students receive music therapy and expressive arts therapy services from music and expressive arts therapists who are affiliated with their universities. This seems more appropriate and logical; one

might expect a university to provide some means for meeting the requirements of its degree program.

When asked to indicate why personal therapy is required in their programs, the six respondents answered in ways that indicated both clarity and confusion about the difference between experiential education and personal therapy. All respondents, however, indicated that development of the student's self-awareness is a primary objective. It is important to question whether the classroom and other academic experiences mentioned (EDU) (e.g., practica) are sufficient vehicles for increasing student self-awareness, when the primary purpose of these experiences is to acquire clinical knowledge and skills, with personal development in areas such as greater self-awareness appearing as a secondary gain in some, but not all, cases. One could argue that music therapy clinical practice, even at an entry level, requires greater than average self-awareness. Self-consciousness enables the practitioner to address and resolve quickly and effectively any personal issues that may negatively impact therapy. This allows for the highest possible quality of services for clients and enables the therapist to prevent burn-out and other difficulties. Experiential education alone may not address the development of self-awareness to the extent required to manage these types of issues.

Personal Therapy Not Required

A number of respondents indicated that they are not allowed by their universities to require personal therapy of their music therapy students (RES). In fact, this prohibition was the most frequent explanation given by respondents for not requiring personal therapy. Statements that represent this category include the following: "As faculty we are not allowed to require personal therapy for students", "I don't think we can require this in

an educational program", and "We are told by administration that it is a violation of their rights to require this…" Perhaps these comments point to legal concerns; however, the notion that requiring personal therapy is a violation of a student's legal rights – presumably the right to refuse treatment – could be challenged on at least three counts. First, requirements of degree programs are made public through the bulletins of universities. One could make the case that students exercise their rights by choosing to enroll in a particular degree program and, in so doing, agree to complete the published requirements. From this perspective, mandated personal therapy would be no different than mandated auditions, practica, final exams, etc. Certainly, once accepted into a program, all students have the right to discontinue participation in that program for any reason. Second, as noted above, some educational institutions require personal therapy for psychotherapists in training, albeit typically at the graduate level. Finally, colleges and universities have long had provisions for mandated disciplinary counseling for disruptive students (Kiracofe & Wells, 2007). Together, these facts suggest that a precedent has been established for mandated personal therapy in higher education. However, the means by which students are allowed and/or expected to meet such requirements could raise significant ethical questions that yet may not have been fully addressed.

Comments related to prohibitions by institutions could also suggest that program directors have not made a compelling enough case to university administration for the educational benefits of student participation in personal therapy. It is unclear whether those who responded in this way disagree or are in accordance with the restrictions imposed by their universities. Some respondents imply that they do see educational value

in the students' involvement in therapy because they encourage their students to participate even when they do not require it.

Ethical concerns (ETH) about how required personal therapy could be provided for students were also expressed by a number of respondents. One wrote, "[It is] unethical for [an] educator to serve as a therapist." Without a doubt, the instructor/advisor-student relationship is a contractual relationship that requires careful maintenance of roles and boundaries, and a conscious awareness of ethical behavior on the part of the instructor or advisor is imperative. For this reason, music therapy faculty and advisors must not assume the role of therapist for their students; thus, availability of appropriate providers is a factor that must be considered if psychotherapy is to be required of students.

When asked why they *do not require* personal therapy, some of the coordinators wrote instead about the situations in which they *encourage* therapy – responses more directly related to a subsequent question. (These responses are discussed both here and below.) For instance, many respondents indicated that their universities have low- or no-cost therapy and counseling services available to students who need this type of support (CAM). Quite a few respondents indicated that they encourage this route when it becomes apparent that certain students have personal issues that are interfering with their academic progress (ISS). This could be interpreted to mean that personal therapy is warranted only when a student has a specific "life" problem or psychopathology. This argument is advanced in some of the counselor training literature, as noted above. In this scenario, the focus of personal therapy likely would be the student's presenting problem(s) and identified treatment issues; thus, the student's growth and development as

a music therapist would not be guaranteed. Moreover, university mental health and counseling services typically provide verbal therapy exclusively. Does the fact that respondents refer emotionally compromised students to a campus counseling center suggest their preference for verbal therapy over music or other expressive arts therapies? Or do these responses have more to do with lack of availability of services apart from conventional counseling? The latter seems a more plausible explanation.

In fact, availability of therapy services (STF) and cost (FIN) were cited as practical difficulties associated with requiring personal therapy, which aligns with findings of research in other healthcare professions such as counseling and psychiatry (Haak & Kaye, 2009; Holzman, 1995; Wampler & Strupp, 1976). Statements included "No easy access to therapists for no cost…[additional cost] makes adding this prohibitive" and "I cannot offer suggestions where this can be done at minimal expense with a good role model/therapist, so I choose not to even officially bring it up." Availability of services seemed to be a particular problem in terms of requiring music therapy and other expressive arts therapies, as suggested by the following comments: "Other than myself, there is no one who is a practicing therapist and music therapist in this area", "The only credentialed music therapists who might conduct this are also associated with [the students'] academic or clinical practica programs, which would inhibit free and honest participation", and "There are no expressive arts therapists in this town or nearby communities."

While these functional concerns were expressed by music therapy program directors, they may also be real concerns of university administrators. Perhaps universities do not "allow" personal therapy requirements because of the costs associated

with them: No requirements can be placed on students outside of what is stipulated in the curriculum, and if personal therapy were to be a curricular requirement, the university would be obligated to ensure that such services were readily available to the students, and at reasonable and customary costs. Not only might the necessary personnel be unavailable for these services, but the university also might not have the funds available to pay that personnel. In many cases, the payment of therapists as associate or adjunct faculty might not be commensurate with the income generated by the tuition paid for those credits. And yet, as Wampler and Strupp (1976) point out for training in clinical psychology, one must consider the "potentially greater cost to the profession and public if personal therapy for students in training is not provided" (pp. 196-197).

Another practical concern of respondents was the inclusion of additional requirements to an already heavy curriculum (CUR): "The undergraduate curriculum in music therapy is already overloaded with requirements; adding additional hours seems prohibitive." Although the National Association of Schools of Music (NASM, 2009) identifies a baccalaureate degree as a program of a minimum of 120 semester credit hours and four years in length, it also requires that the total amount of time for completion be "reasonable." Yet some music therapy curricula push far past NASM's expectations – with as many as 145 credit hours – and many courses in these curricula demand more time and effort than the awarded credits would suggest. The addition of personal therapy credit hours to an already jam-packed music therapy curriculum is a real concern that warrants future consideration.

Many respondents expressed personal views and philosophies (OPI) about a psychotherapy mandate. For example, one stated, "While we recognize that personal

awareness and growth is crucial to developing student clinicians, we do not feel that participation in personal therapy is required for this growth." Related justifications for not requiring therapy included "Students experience music therapy in classroom settings" and "Students are required to participate in role-play situations but not personal therapy", insinuating either the aforementioned confusion about the distinction between experiential exercises and personal therapy or the perception that personal therapy would not provide students with any type of insight or experience that could not be imparted through classroom and pre-clinical courses. A return to the psychotherapy research lends some support to this notion. Macaskill (1999) writes, "Personal therapy, however, is not the only way to get this experience, and many training programmes use sessions of peer counseling and role play as alternatives" (pp. 148-149). She cites multiple studies from the 1960's and 1970's with findings that empathy, genuineness, and warmth can, in fact, be taught through individual and group "exercises" (Carkhuff, 1972; Truax & Carkhuff, 1967; Truax & Mitchell, 1971; Strupp & Hadley, 1979).

One participant commented on learning about "in-depth" therapy techniques: "We feel that undergraduate students will not (and should not) be providing in-depth therapy after graduation…" According to the recently adopted *AMTA Advanced Competencies* (AMTA, 2009), an advanced clinician is expected to "develop self awareness and insight through personal experiences in music therapy, other creative arts therapies, verbal therapy, and/or personal growth work" (7.1) and to "identify, confront, and work through personal issues" (7.2). Although adopted as hallmarks of advanced practice, one might contend that the personal development and insight described above is relevant to interns and entry-level clinicians who work in certain psychiatric and/or medical settings. In

these settings, often there is a heavy emphasis on intra- and inter-personal communication and social-emotional awareness, development, and support, and countertransference may emerge as a particularly significant feature of the therapeutic process (e.g., with clients who are terminally ill or who have experienced psychological trauma). On the other hand, it could be argued that, under the provisions of the *Advanced Competencies*, interns and entry-level clinicians simply are not prepared for this type of work. If one were to adopt the latter position, the AMTA roster of approved internships would need to be carefully scrutinized and changes made to reflect a clearer delineation between entry-level and advanced training and practice. Naturally, this type of scrutiny would necessarily apply to pre-clinical courses within undergraduate programs as well.

One might question whether the differences in opinions between those respondents who do not require or encourage personal therapy and those who do are based on the extent to which each has experienced personal therapy as a client herself or himself. Does one's own experience in personal therapy provide an understanding of its benefits that is not shared by those who have not experienced it? Holzman (1995) found that graduate clinical psychology students who had engaged in personal psychotherapy were more likely than students who had never engaged to perceive therapy as beneficial in dealing with issues related to transference and, in general, as a significant factor in professional clinical practice. Without such an encounter with therapy, is there a lack of understanding about the differential benefits of experiencing one's own personal therapy process and, say, participating in experiential exercises such as role-playing in the classroom?

Personal Therapy Encouraged

Of the respondents who offered comments about why they encourage personal therapy within their music therapy curricula, about a third indicated that they encourage at least one modality of therapy, with nearly three-quarters of these encouraging verbal therapy, about half encouraging music therapy, and just under a quarter encouraging expressive arts therapy. Reasons given for encouraging personal therapy are examined below.

Twelve individuals indicated that they only encourage personal therapy for those students who are experiencing personal difficulties (ISS). For example, one respondent wrote, "We do not encourage the students unless a situation exists which indicates that the student has needs that are interfering with their success in the curriculum or in life." Another wrote, "Many personal issues about being a therapist, participating in the role-playing in classes, doing the music work in their classes often create overwhelming stresses, which prevent them from completing their coursework. I then suggest that therapy might be very helpful." This implies that these respondents view personal therapy as being advantageous for identifiable personal problems only and not as an experience that has more general personal or educational benefits, as was noted also in the previous section of this report. Five other coordinators indicated that they encourage therapy because it assists students in working through personal problems. It is difficult to ascertain from their comments if they encourage some or all of their students to engage in personal therapy.

One respondent noted that she or he encourages (rather than requires) therapy due to the fact that research has suggested that therapy is ineffective for those who are forced to participate. Perhaps assuming student willingness, 12 respondents indicated that they

encourage their students' participation in therapy because they believe that it will increase the students' insight into the therapeutic process (THR). Representative comments include these: "Experience as a therapy client is one of the best ways of learning how to be and how NOT to be a therapist" and "Develop an understanding of the process from the inside." The respondents who made comments such as these seem to be of the opinion that the experience of personal therapy does have benefits for the willing student beyond simply addressing identifiable personal problems. Additionally, other respondents wrote that they encourage personal therapy because it is integral to the students' personal and professional development (PER), and because it increases an understanding of the client's point of view (CLI). Representative statements include "I absolutely encourage students to seek [personal] therapy for many reasons - but most importantly, I believe that experiencing therapy can help one be a better therapist", "I recommend every student in the program seek music & imagery sessions to gain the emotional strength, or emotional skills, necessary to become a therapist", and "…it is one of the best ways to develop the student therapist's self and to learn about therapy."

Here, as previously stated, there is a clear division in opinions about the need for and benefit of personal therapy as part of an undergraduate music therapy student's training. Does this division illustrate differences in the clinical orientations of the educators? Or might it be indicative of differences in educators' experiences (or lack thereof) of personal therapy in their own training? Or again, does this division indicate disagreement about what is appropriate in music therapy education at the undergraduate level and subsequently what is appropriate music therapy practice for those entering the field? These questions warrant further, in-depth investigation.

Personal Therapy Not Encouraged

Reasons offered for not encouraging students to participate in personal therapy reflect the same issues as those for not requiring personal therapy, such as cost and availability (the most frequently cited reasons), lack of room in the curriculum, and privacy concerns (two respondents). It is important to note that some respondents encourage verbal and music therapy but not expressive arts therapy, while others encourage only verbal therapy. As above, some respondents indicated that personal therapy is only encouraged if students have personal problems that are in some way interfering with their training. As would be expected, those coordinators who do not encourage their students to participate in any form of psychotherapy were also those who do not require it.

General Comments

General comments (Table 8) made by respondents at the conclusion of the questionnaire largely reiterated the opinions and concerns that they had expressed in response to specific questions, as explicated above. Two comments warrant some additional attention, however. These comments are "I believe that most students would benefit from therapy and some very much NEED therapy. There is no system in place to weed out the students who should be removed from the MT program....This is a huge problem for the profession and ultimately the clients....", and, "… how do you deal with students who are obviously emotionally unstable? I encourage therapy, but cannot require it. I have informally met with students to share my concerns, and to state [I] think they should consider another major." These statements raise a critical question: Would music therapy students' participation in personal therapy help to "weed out" those students who

have personal issues that might make music therapy – or perhaps any helping profession – a poor career choice? It seems as though some coordinators have had the experience of dealing with a student who, though she or he excels academically and/or musically, is not suited to the profession because of personality or mental health issues. If there is no mechanism for removing such a student, the educator may feel trapped between over-stepping academic advising boundaries and protecting future music therapy clients from someone who is not capable of providing appropriate, ethical treatment. While this question is well beyond the scope of this particular study, it is ripe for future examination.

Conclusion

The responses to this survey illuminate several salient issues regarding personal therapy for undergraduate music therapy students. These are as follows: 1) the legal and ethical feasibility of making psychotherapy a requirement of music therapy curricula; 2) the cost and availability of qualified professionals to provide personal therapy; 3) the perceived benefits of personal therapy as an integral facet of undergraduate music therapy training and education; and, 4) the appropriateness of personal therapy at the undergraduate level of training.

There is considerable uncertainty among respondents about the legality of requiring personal therapy as part of an educational curriculum. Public and private universities may differ on what types of requirements might be placed upon students and on the process required for making such curricular additions. Further investigation into legal statutes dictating curricular requirements, as well as examination of the differences between different types of universities, needs to occur in order to fully understand what

opportunities exist related to personal therapy for undergraduate music therapy students. This type of investigation may also reveal ethical questions that need to be addressed.

Cost and availability of therapy services for students is an issue that cannot easily be resolved. Many educators face a lack of availability of qualified music therapists for supervision of community-based training, with some educators offering several hours per week of no-cost therapy services in order to provide their students with supervised practica. Although most universities offer counseling services to their student bodies, the availability of music and expressive arts therapists for university students will increase only as these positions are added to facilities within surrounding communities. Even then, the availability of a therapist does not ensure that this individual's area and level of practice will be appropriate for the provision of personal therapy to students. Moreover, increased educational costs for personal therapy may be prohibitive for many students. Only a curricular requirement for personal therapy would allow students to use financial aid to pay for such services, which again raises a plethora of legal and ethical issues.

There is notable disagreement among respondents about the necessity of personal therapy in the training and education of undergraduate music therapists. Those who do not agree that psychotherapy should be a component of training believe that experiential learning in the classroom (e.g., role-playing) is sufficient for gaining requisite skills, that self-awareness and development can be supported through other types of experiences, and that basic music therapy skills should be the focus of training. Those who do agree that personal therapy is necessary are of the opinion that therapy can increase empathy and understanding of the client and can help students develop self-awareness, therapeutic skills, and insight into the therapy process. It is unclear at this point whether these

positions are based on personal opinion, clinical orientation of the educator, or some other factor. Further research into pedagogical methods and best practice in the training of therapists may be helpful. Comparison between the educational practices in music therapy, expressive arts therapy, and other helping professions may also be valuable.

Perhaps the most compelling question is that of the appropriateness of personal therapy for undergraduate music therapy students. Here, too, there is disagreement, which leads to more questions. Are there "basic" music therapy skills that can be learned and practiced that do not involve personal development or intra- and inter-personal awareness? If there are, does this mean that there are ways of using music to help others that do not have a simultaneous impact upon the therapist? It is disturbing to these authors to consider that a music therapy educator might believe (and teach from) the position that music is something that is "done" to the client rather than something that influences and is influenced by both therapist and client. In his book, *Emotional Processes in Music Therapy*, Pelliterri (2009) states that

> …the therapist is a significant force within the psychological field. The therapist's intrapersonal and interpersonal elements will influence the client. The therapist's theoretical orientation is a set of beliefs (cognitive structures) that will influence how the therapist intervenes to shape the [therapeutic] field. Countertransference and unconscious bias act as forces in the field and can disrupt a client's progress. If a new therapist has anxieties about "performing" or being correct or if the therapist has negative associations towards the client, then these emotions will be forces in the field that can adversely affect the client and the process. The importance of self-awareness cannot be understated. The extent that the therapist is aware of his or her intrapersonal elements determines the degree of control over those unconscious forces that might detract from the therapeutic process (p. 18).

The question of the appropriateness of personal therapy at the undergraduate level of training begs the reassessment of the *Professional Competencies* (AMTA, 2008) and of undergraduate music therapy curricula and internship programs intended for

undergraduate and equivalency students. As previously stated, if it is inappropriate for undergraduate students to participate in personal therapy to assist with self-awareness, then it would also be inappropriate to allow those same students to enter internships in certain clinical settings in which a high level of awareness is requisite to ethical and effective practice. It becomes fair to ask, then, if the typical undergraduate student is ready to engage in an "in-depth" therapy process that leads to this kind of self-development. If a clearer distinction needs to be made between what is appropriate for undergraduate training and what is appropriate at the graduate level, then a reassessment of educator qualifications might also need to be made. What constitutes "instructor readiness" to teach courses imparting clinical skills that require personal insight and development? Are educational degree and number of years of clinical experience adequate benchmarks of this readiness?

While the results of this survey provide helpful information about the current status of personal therapy in undergraduate training in music therapy, more important questions obviously have surfaced. The profession would be served by further investigation of ethical and legal guidelines and ramifications of mandated personal therapy, cost and availability of personnel, specific benefits of therapy as a required or an encouraged component of undergraduate curricula, and the developmental readiness of both undergraduate students and educators for this potentially advantageous curricular addition.

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