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Components Related to Occupational Stress or Burnout Among Music Therapists Working in Hospice/Palliative Care Arenas

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COMPONENTS RELATED TO OCCUPATIONAL STRESS OR BURNOUT
AMONG MUSIC THERAPISTS WORKING IN
HOSPICE/PALLIATIVE CARE ARENAS

by

Dorothy Virginia Pienta

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Music
School of Music

Western Michigan University
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Dorothy Virginia Pienta

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AMONG MUSIC THERAPISTS WORKING IN
HOSPICE/PALLIATIVE CARE ARENAS

Dorothy Virginia Pienta, M.M.

Western Michigan University, 1999

Music therapists who work in hospice/palliative care settings are susceptible to burnout as well as others who work in health care settings. In this descriptive-correlation study, the components of occupational stress or burnout among music therapists working in hospice/palliative care settings were studied. A mail survey was sent to 300 music therapists who worked in hospice/palliative care settings and were members of the American Music Therapy Association. Of the 181 surveys that were returned, 106 were acceptable for use in this study. Their responses to the Maslach Burnout Inventory, Work Environment Scale, as well as information from the demographic data form revealed moderate to low levels of burnout in the three subgroups of Emotional Exhaustion, Depersonalization, and Personal Accomplishments. Some respondents reported experiencing stress and work environment concerns while others found personal stress release from the music therapy interventions provided for their patients. Comments from a number of respondents indicated that the music may have acted as a buffer to burnout along with the use of facility support programs, and support from family as helpful coping measures.

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CHAPTER I

INTRODUCTION

Professionals in various settings of healthcare encounter stressful situations on a daily basis. They are challenged with a high volume and frequency of problems. They confront issues such as drugs, alcohol, violence, injury, terminal illness, loss, and death. There may be lack of peer or social support and/or poor supervisory interactions. Along with high technologic care comes ethical dilemmas in decision making and caregiving. In addition, inadequate staffing and scheduling, work overload, and conflicts with other staff members, administrators, and physicians can add to the number of stressors that individuals encounter at their work. The cumulative effects of a stressful work environment can overwhelm the defenses of health care workers and may cause them to psychologically withdraw and burnout (Ogus, 1990; Oehler, Davidson, Starr, & Lee 1991).

Because health care workers are, by nature, compassionate people in the helping professions, they are likely to focus on their patients needs first and their own last (Cassity, 1991). However, symptoms such as exhaustion and loss of energy, irritability, impatience, cynicism, detachment, and depression begin to occur. Overtime, the professional caregiver may experience progressive loss of enthusiasm, and empathy, become stagnant and frustrated, apathetic, becoming burned out, and in

need of intervention (Biller & Rice, 1990; Martin & Julian, 1987; Stubbs & Brophy, 1985; Turnipseed, 1987; Wolfelt, 1989; Wolfelt, 1990).

Although health care providers in any setting may experience the aforementioned challenges, the demand for those working in hospice or palliative care facilities may be even greater. (Maslach & Jackson 1986).

Hospice Care

The term hospice and palliative care are frequently used interchangeably in various countries. In Canada, the term hospice translates in French to “poor house”. Consequently, the more commonly used term there is palliative care (Vachon, 1987). To palliate is to “lessen the pain or severity of without actually curing, to alleviate or ease” (Webster’s New World dictionary 1991). The word *hospice* has a linguistic origin from the Latin word *hospes* meaning both host and guest. It has the same root as the words *hostel*, *hospitality*, and *hospital*. The first hospices, which were way stations founded in the Medieval times, cared for dying pilgrims on their journeys to the Holy Land. Dame Cicely Saunders was the founder of the modern hospice movement and created St. Christopher’s in London in 1967. Here, she integrated the spiritual care along with modern medical techniques for managing symptoms, pain relief, and grief support to both the patient and families (Beresford, 1993).

Death is a universal fact of life and, whether or not it is accompanied by disease, dying is a normal process. Hospice, as an option in the medical care system, exists not to postpone death but, with special skills and therapies, to help the patient

and family live as fully as possible. Hospice is a program of care for patients with terminal illness that is directed towards upholding the quality of life through the relief of physical and psychological suffering. Terminal illness may be difficult to define and to diagnose. In order to be eligible for reimbursable hospice services, Medicare and Medicaid require physician certification that, if the disease takes its course, the expected length of survival is less than 6 months (Schonwetter, 1996).

According to hospice philosophy, death is not denied, but life is affirmed and lived until death comes. Everyone is entitled to participate in this part of life to prepare for death that is as personally satisfactory as possible. Patients and their families are encouraged to participate in the decisions effecting the manner in which patients are to live out the final moments of their lives. Patients are helped to preserve mental alertness to fully live and experience the support of family and a caring community. Hospice can provide appropriate quality care through less expensive alternatives of acute care hospitals.

Goals of hospice are to help the patient and family live as fully as possible, to provide comprehensive services to patients and their families, and to arrange counseling during the period of bereavement (Northwest Ohio Hospice Association, 1979). Due to advances in knowledge base with research and education, credibility has been furthered. As standards in health care have been established, hospice and palliative care have been able to integrate into the American health care system. As a result the prospect of dying well beyond symptom management has become possible. The focus is on helping people to attain a sense of completion in the social and

interpersonal dimensions, develop or deepen their sense of worthiness, and find their unique meaning of life (Byock, 1997).

Palliative Care

Hospice incorporates the constructs of palliative care, however palliative care is not necessarily hospice care. Palliative care is applicable earlier in the course of the illness and is not time limited like that of hospice care, where patients have a prognosis of six month or less to live. Palliative care can occur throughout the length of terminal illness; it provides total, active, holistic care, controlling pain and other symptoms, as well as psychological, spiritual, and social support for both the patients and their families. Because the body, mind, and the spirit are viewed as inseparable, a disruption of one area disturbs the harmony and peace that exists in health and wellness (McIntier, 1997). Similar to the goals in hospice care, the goal in palliative care is to achieve the best possible quality of life and enhance harmony and peace for patients and their families.

The palliative care trajectory includes three phases. In the active phase, the goals are to fight and control the disease, in the hopes of prolonging survival with tolerable side effects. In the symptomatic phase the goals are to control the disease, to provide comfort, hope, and optimal quality of life in the remaining time. The goals in the supportive phase are to provide comfort without attempting to control the disease and to accept impending death. While palliative care affirms that death is a natural

process and occurs throughout the trajectory of the terminal illness and near death, it neither hastens nor postpones death (Brant, 1998).

Problems Affecting Healthcare Providers in Hospice/palliative Care Settings

All health care workers may encounter many stressors in their personal lives as well in the work environment. They may experience a death with a family member or friend, be preparing for marriage or going through a divorce, dealing with the birth of a child, having child care problems, have a change in residence, or experience a personal serious illness or of a family member. Many health care providers (especially women) are challenged by the interface of work and home-related stressors. The home workload responsibility may disproportionately fall on the health care workers at home as a wife and mother as well as a health care professional at the workplace (Hobfoll & Freedy, 1993).

Burnout is characterized by emotional or physical exhaustion, detachment, depression, physical complaints, disorientation, confusion, omnipotence and indispensability, depersonalization, and lack of personal accomplishment (Wolfelt, 1990; Stubbs & Brophy, 1985, Maslach & Jackson, 1981). Burnout occurs with prolonged energy exhaustion or excessive exposure to stressors resulting in the diminished ability to adapt to stress (Dick, 1992). Typically burnout results in negative reactions to others or withdrawing from interactions and decreased job productivity.

Those who provide services for the dying open themselves to care for not only the patient but to care for the families as well. Although the time spent with the patients and families is short, it can be very intense and demanding in emotional investment from the caregiver. Many times professional caregivers are immersed in the psychological and emotional conflicts with the family members of the patients. There is uncertainty in knowing when the patient will die, if the death will be peaceful, and if one can help resolve any conflicts. As stated in the book of Ecclesiastes, "There is a time for everything, a season for every activity under heaven: a time to be born and a time to die..." (Ecclesiastes 3:2). The only certainty is that the patient will die (Ray, Nichols, & Perrit, 1987).

Grief, the internal reaction to loss, is usually the first emotion felt when patients die. Not only are family members stricken with grief, but professional caregivers may also be affected by the loss. In hospice/palliative care arenas, since some patients die within days or hours of admission, the professional caregiver often cannot complete the task of grieving for one patient before another death occurs, layering one grief experience on top of another (Bigelow & Hollinger, 1996; Biller & Rice, 1990). Multiple deaths are frequent because the median length of stay for a patient on most hospice programs is less than three weeks (Finn, 1993). Many times the caregiver does not have time to say good-bye or experience closure by attending the funeral. As soon as the bed is empty, it is filled by yet another dying person.

Purpose of the Study

The purpose of this study was to obtain demographic information from music therapists belonging to the American Music Therapy Association (AMTA) who were presently working in hospice/palliative care to determine if there was a relationship between the scores of Maslach Burnout Inventory (MBI), the Work Environment Scale (WES) and the respondents age, sex, number of hours per week, and number of years worked.

Research Questions

1. What is the degree of burnout of music therapists as measured by the MBI?
2. Is there a relationship between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of hours per week at hospice/palliative care programs?
3. Is there a relationship between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of hours per week at hospice/palliative care programs?
4. Is there a relationship between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of hours per week at hospice/palliative care programs?
5. Is there a relationship between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of years worked at hospice/palliative care programs?

6. Is there a relationship between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of years worked at hospice/palliative care programs?
7. Is there a relationship between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of years worked at hospice/palliative care programs?
8. Is there a relationship between the scores on the Maslach subtest (Emotional Exhaustion) and age of music therapists working in hospice/palliative care programs?
9. Is there a relationship between the scores on the Maslach subtest (Depersonalization) and age of music therapists working in hospice/palliative care programs?
10. Is there a relationship between the scores on the Maslach subtest (Personal Accomplishment) and age of music therapists working in hospice/palliative care programs?
11. Is there a relationship between the scores on the Maslach subtests (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) and the Work Environment Scale?

Definition of Terms

Hospice Care

Conceptual: A health care system of interdisciplinary services provided to clients and their families during the final stage of life (National Hospice Organization, 1995).

Operational: A prognosis of less than six months to live.

Palliative Care

Conceptual: Total care of a patient whose disease does not respond to curative treatment.

Operational: A prognosis of life being limited but without definite time limitation.

Occupational Stress/burnout

Conceptual: The frequency and/or intensity of work related stressors in the areas of emotional exhaustion, reduced personal accomplishment, and depersonalization (Maslach & Jackson, 1981)

Operational: The scores from the Maslach Burnout Inventory.

Work environment

Conceptual: The workplace setting where people spend most of their time on

the job affecting individual and family functioning (Moos, 1994).

Operational: The scores on the Work Environment Scale

Assumptions

The following assumptions for the basis of this study were:

1. The participants were honest in their responses.
2. The tests were reliable and valid.

Delimitations

There were several limitations to this study:

1. This was a convenient sample.
2. There is caution in generalizing the results.
3. The mailing list was limited to AMTA music therapists working in hospice/palliative care.

Significance of the Study

Music therapy in hospice and palliative care meets many needs of the patients.

The music becomes the medium that promotes and establishes a therapeutic relationship providing a close and intimate connection with patient and the patient's family. Music addresses the physical, psychological, social, and spiritual issues of human existence and enters the intimate space of the dying process. Music promotes muscular relaxation, relieves anxiety, alters perception of pain, alters mood and

lessens depression, provides non-verbal means of expression, is a socially acceptable means of self-expression, decreases isolation, acts as a diversion activity, and provides an avenue for expressing spiritual issues. (Munro & Mount, 1978; West, 1995).

Music therapists use creative arts in their therapeutic encounters. Clear and distinct mental abilities, professional performance, and innovation with creativity are crucial to the profession of music therapy. Because the patient's condition may change from one day to another in the hospice/palliative care arena, the music therapist must be flexible, innovative, and adaptable to daily variations and declines in the patient's condition. The burnout syndrome with physical and emotional exhaustion can be significant and lead to a decrease in professional performance, diminished mental abilities, and stifled creativity and innovation.

Facilities offering music therapy resources typically have only one music therapist on staff as opposed to a number of nurses or other health care providers. Consequently, many music therapists do not have the same peer support as other health care professionals. Furthermore, many music therapists work on contract or in a private practice and are not part of the interdisciplinary team at all. They may become removed from the social support system of an organization. Often health care professionals do not realize the full scope of music therapy and the important role it plays in the treatment and inner healing of patients and family members. Music therapists may feel that their interventions are not understood or valued.

This study may reveal components related to burnout of music therapists. If appropriate methods can be implemented to recognize the symptoms of burnout, measures can be taken to provide coworker support and coping strategies before one approaches emotional exhaustion, depersonalization, and lack of personal accomplishment. Training programs may be initiated to help music therapists work with people who are experiencing life-threatening illnesses that are beyond the basic music therapy education.

Summary

Hospice and palliative care arenas have similar constructs of philosophy and holistic care. Both of them encompass interpersonal connections with patients and their families dealing with grief and death. Working in arenas that confront terminal illness and death can lead to physical and emotional exhaustion symptoms of burnout. Other factors that may be encountered are role ambiguity, lack of peer or supervisory support, and the interface of personal stressors and job related stressors.

CHAPTER II

REVIEW OF LITERATURE

Burnout

Characteristics

Burnout is the end result of a process that is characterized by disillusionment usually found in people who are highly motivated and highly involved. In order to be “burned out” one had to first be “on fire”. One has to be highly motivated, committed, have high goals for oneself, and high expectations from others. People who work in social services are highly motivated to do something good for and with others (Pines, 1993).

Burnout can occur and emerge in any occupation and is not restricted to health professionals. It is a condition that is a result of emotional strain. In blue collar occupations, especially those who work with machines, burnout is associated with emotional estrangement as an effect of long lasting, low control, high monotonous types of work, few personal contacts, and low social support. Among professionals and health care workers, emotional demands, interplay and connections from other people result in physical and emotional exhaustion (Winnubst, 1993). Work relations, social support, type of feedback, level of autonomy, amount of challenge, and effectiveness of the organization are correlated with the level of burnout.

Maslach and Jackson (1981) view the initial state of burnout as having increased feelings of emotional exhaustion, depersonalization, and having reduced personal accomplishment among individuals who do people work. Over a period of time, individuals may experience emotional overload, over-extension, and become overwhelmed by requests from others. The inability to satisfy one's own emotional demands is what can eventually lead to burnout. No matter how hard one works, one feels that he or she cannot make a significant impact in a negative and non-supportive environment. Chernis (1993) argues that stressors such as excessive workloads, lack of administrative support, and bureaucratic restraints, give workers the message that what they do is insignificant. The inability to attain a sense of competence and self-efficacy is a major source of burnout in professionals. Conversely, a work environment that provides positive qualities such as autonomy, resources, support, and minimizes negative features can enable people to attain their goals and expectations. Not all work environments are all supportive or all stressful, but a combination of each. Balance of the two, perception of stress, and the amount and kind of support by the individual are factors that contribute to the likelihood of burnout occurring (Pines, 1993).

Many individuals who become depressed, fatigued, alienated, or experience job stress do not necessarily experience burnout. Individuals with these symptoms can recover quickly. For example, people who exercise strenuously can feel physically exhausted but have a positive experience of physical fatigue and feel like they have achieved success. With burnout there is physical exhaustion different from the normal

physical tiredness. One usually does not recover quickly from the physical fatigue of burnout. It is the result of a gradual process of disillusionment in the pursuit to have a sense of significance and competency at work. Furthermore and specifically, burnout occurs with people who work in emotionally demanding work settings, over long periods of time, and who frequently work with people. The causes and cures of burnout focus on stressors in the work environment. Professionals with high expectations and goals believe they are doing something meaningful, important, and making a significant contribution in their work. They view the care they are providing as impacting their patients' lives and striving to make a difference. Professionals, who gain credit for their patients' improvement, report a high sense of efficacy, and sense of significance in their work. Susceptibility to burnout occurs when professionals believe they have failed (Pines, 1993).

Conceptual Models

There are several conceptual models describing the development and existence of burnout. In an existential model of burnout, Pines (1993) posits that a supportive environment (which includes the presence of positive features, the absence of negative features, and the achievement of goals and expectations), can lead to success and existential significance. Conversely, a stressful environment (that includes the presence of negative features, absence of positive features, or where goals and expectations are not achieved), can lead to failure and burnout. Stress can

occur in many situations such as illness, disasters, unemployment, and various work situations.

Hallsten (1993) views burnout as a process of emotional exhaustion and depletion of resources. Symptoms are similar to depression with lowered energy and chronic fatigue. Burnout is one route to depression when the “self-definitional role is threatened or disrupted” (p. 99), and there is no alternative role available according to Hallsten. Several factors contribute to burning out. A person with a certain degree of vulnerability may have low self-image and self-esteem, lack of potential role for self-definition, and lack of social support. Long term goals of improving organizational routines, helping clients, and solving problems may go unfulfilled leading to frustration and ultimately passivity, pessimism, detachment, and negative views of self and others. Shared values and goals in various forms of social support along with personal and organizational competencies are essential for the vulnerable person to have positive self-image. An incongruent organizational environment is likely to result in professional burnout. Hallsten believes that burnout is not only influenced by individual factors but shaped by societal changes and the gap between organizational means and resources to meaningful ends such as seen in many human service organizations. Distressing and taxing effects for vulnerable professionals are goal displacement, role ambiguity, and inconsistent feedback.

Hobfall and Freedy (1993) asserts the conservation of resources (COR) theory where individuals strive to achieve and preserve things they value. When resources, defined as objects (clothing, tangible items), conditions (marriage, employment),

personal characteristics (skills, hardiness), and energies (knowledge, money, endurance) are threatened or lost, or when individuals invest in resources and do not reap the anticipated benefit of those resources, stress occurs. This is magnified even farther when an individual experiences physical or psychological overload.

Individuals will strive to protect themselves from resource loss and invest in resources to prevent loss. Other elements basic to stress are transitions and change (such as in job relocation and role ambiguity) where individuals invest resources with no guarantee of rewards. Intervention consists of strengthening resources, eliminating vulnerability to resource loss and finding the causative factors that relate to the loss cycles rather than allaying the symptoms with one-shot workshops or alleviating stress through relaxation and biofeedback. The COR theory asserts that interventions should focus on building and enhancing resources, interrupting loss chains, and activating gain spirals.

Research Evidence

Those who develop personal relationships in their work setting (such as health care providers and clients, managers and employees, or teachers and students) seem to be susceptible to burnout. For example, professional burnout on creativity and innovation were tested by Noworol, Zarczynski, Fafrowicz, and Marek (1993). Eighty male managers, ages 27-46 who worked in private or state owned companies, were given the Consequences Anticipation Test and the Test of Divergence Thinking (to measure creative thinking), the Strzalecki's Style of Creative Behavior Questionnaire

(to assess remaining dimensions of creativity), the Kirton Adaptation-Innovation Inventory (to classify innovation of the managers), and the Maslach Burnout Inventory (to measure the three aspects of burnout). The results indicated that individuals experiencing burnout had decreased creativity and used an adaptive style of problem solving, while the individuals who did not experience burnout were more creative and had innovative ways of problem solving. However, personality traits such as dependence, being vulnerable to social pressures and authority, cautious, sensitive and self-doubting can be developed by burnout. Conversely, individuals with those personality traits can also be more vulnerable to burnout. Further studies may clarify the viability of this understanding.

Greenglass, Fiksenbaum, and Burke (1994) examined the determinants of burnout testing a convenient sample of 179 women and 182 men working as teachers or principals of a school system. The study, done over a two year period compared measures of work setting stressors using several different measures. Analysis indicated that those participants with low support had increased burnout scores from stress, while those with high support had less burnout. Burnout levels were also related to perceived work stress in teachers. However, those teachers who had ongoing supportive networks had less burnout levels with stressors in the environment. The researchers' results suggest that social support acts as a buffer inoculating participants against harmful effects of work stress.

In a descriptive-correlation study, Dick (1986) investigated the relationship of burnout among faculty in collegiate nursing programs to academic demands and

workload. Three hundred seventy four nursing faculty from National League for Nursing accredited schools were surveyed using the Maslach Burnout Inventory, Likert's Profile of Organizational characteristics, Behavior Contingent Approval scale, and the Survey of Collegial Communication. The data support that burnout does occur in nurse faculty but less than those working directly with clients in other human service workers. Collegiate support and management styles and behaviors as well as continuous contact in intense interpersonal relationships were factors and predictors in nurse faculty burnout. In this study, workload was found to be unrelated to burnout.

In a longitudinal study, Fong (1993) examined the causal relationships between social support, role overload, and burnout in nursing educators. Responses to The Work Environment scale, Mueller's Role Overload scale, and the Maslach Burnout Inventory were correlated with demographic information (age, marital status, academic rank, years in nursing, hours worked in a typical week, tenure status, and educational attainment). One hundred forty participants completed the questionnaires the first time and 84 the second time two years later. The results supported earlier findings that respondents reporting many hours of work, high job demands, extreme work pressure, and high job ineptitude were more likely to experience emotional exhaustion. Chairperson and peer support were significantly and negatively correlated with all aspects of burnout. Job demands were the most significant predictors of emotional exhaustion followed by lack of peer support for depersonalization, and lack of tenure for feelings of decreased sense of accomplishment. Job demands best

predicted emotional exhaustion although the study revealed that both job demands and lack of support were related to burnout in the two-year period.

Although burnout has been studied with various occupations particularly within the last 20 years, there has been a rising amount of attention towards burnout in the human service professions. There is further and abundant research related to occupational stress or burnout with various health care workers such as physicians (Martin & Julian, 1987), clergy (Vachon, 1987), hospice (Levy & Gordon, 1987; Robbins, 1991), bereavement caregivers (Wolfelt, 1990), occupational therapists (Bennett, 1991); counselors, (Wolfelt, 1990); and nurses (Cooper & Mitchell, 1990; Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995; Kent, Wills, Faulkner, Parry, Whipp, & Coleman, 1994; Levy & Gordon, 1987; Stubbs & Brophy, 1985; Turnipseed, 1987, and Wolfelt, 1988), and music therapists (Oppenheim, 1989).

Corrigan, Holmes, and Luchins (1995) studied burnout, collegial support, prolonged anxiety, physical health and job attitude of 47 clinical staff member's (nurses, mental health technicians, mental health specialists, social workers, activity therapists, psychiatrists, psychologists, and administrators) at a state psychiatric hospital. The subjects completed the Maslach Burnout Inventory, Modified Social Support Questionnaire, State Trait Anxiety Inventory, Health History Questionnaire, Barriers to the Implementation of Behavior Therapy, and the Needs Assessment Inventory. Data analysis indicated a significant overall burnout score in emotional exhaustion and depersonalization. There was significant correlation between Emotional Exhaustion and Depersonalization with anxiety (.60) and those with

prolonged anxiety had frequent illnesses (.42). Those who received peer social support and perceived influential administrators as helpful experienced less burnout. The study indicated that burnout was associated with anxiety, physical health, and negative job attitudes across the job groups. The findings led researchers to question whether those who were sickly would burnout more frequently or whether that negative work attitudes could expose the workers to burnout. Because of the small sample size, a cause and effect relationship could not be clearly defined.

Determinants of burnout in geriatric nursing were identified in a study by Duquette, Kerouac, Sandhu, Ducharme, and Saulnier (1995). A random sample of 1990 (1545 participated) was drawn from a register of geriatric nurses. The self administered questionnaires included the Nursing Stress Scale, the Hardiness Scale, the Work Relationship Index, and the Indices of Coping Responses. All instruments were considered to be reliable and valid. The results supported previous research findings in that frequent and repetitive stressful events may lead to increased strain. Geriatric work stressors appear to be determinants of burnout, and hardiness is a predominant predictor of burnout. The results further suggest that geriatric nurses who have hardy personality traits are able to reduce strain and avoid burnout when faced with work stress-generating events. The amount of work support from superiors and peers were also determinants of burnout.

Kent, Wills, Faulkner, Parry, Whip, and Coleman (1994) examined the relationship between hospital oncology staff's (medical, nursing, university, receptionists, catering and domestic) perceived success and failure in helping patients

on levels of personal stress and distress. One hundred twenty-five staff were randomly selected to respond to a three part questionnaire. Forty-eight questionnaires (38 females, 10 males) were returned and used. The first part of the questionnaire consisted of a description of two situations where they were able and not able to help a patient or family member with a difficult situation. The second and third part consisted of the Maslach Burnout Inventory and the Hospital Anxiety and Depression scale. Twenty-five of the staff mentioned that they considered leaving their current position due to emotional reactions and organizational problems. Some, however, reported personal satisfaction and fulfillment. Those who stated examples of not being able to help a patient scored higher on the frequency ($p < 0.01$) and intensity ($p < 0.05$) of Emotional Exhaustion and higher frequency ($p < 0.01$) on Depersonalization and Personal Accomplishment. Even though staff who cited unfavorable incidents more emotionally demanding with more emotional withdrawal, they also reported high levels of Personal Accomplishment. The results indicated that staff members who perceive themselves as being unable to help patients experience greater stress than those staff members who do not.

In a study by Oehler, Davidson, Starr, and Lee (1991), 49 registered nurses and licensed practical nurses working 30 hours or more in the neonatal intensive care unit were surveyed. The Maslach Burnout Inventory was used to measure three aspects of burnout: emotional exhaustion, depersonalization, and personal satisfaction. In addition, the State-Trait Anxiety Inventory assessed the present level of state and trait anxiety, the Nursing Stress Scale was used to measure potentially

stressful nursing situations, and social support was measured by House and Wells.

The measures were valid and reliable. The results indicated moderate ranges of burnout on emotional exhaustion and depersonalization and high range of personal accomplishment. Those with less job experience had a higher degree of burnout.

Those with head nurse support had an increased sense of personal accomplishment while less support revealed lower scores. Higher job stress scores and higher anxiety scores were associated with the higher subscale scores. The results of this study were consistent with other studies in nursing care areas.

In a similar study (Duxbury, Armstrong, Drew & Henly, 1984), a random sample of 283 nurses employed in level-III neonatal intensive care units in the United States were surveyed to determine if there was a relationship between staff nurse perceptions of head nurse structure and leadership style and staff nurse satisfaction and burnout. The Minnesota Satisfaction Questionnaire, the Tedium Scale and the Leadership Opinion Questionnaire were the instruments used in the study. The results indicated that elevated levels of burnout scores were found in staff nurses whose head nurses had leadership styles of high structure and low consideration. Even though leadership style may influence staff burnout, there are other environmental, administrative, and personal events that can contribute to burnout in staff nurses.

Ray, Nichols and Perritt (1987) reviewed existing literature relating to job stress and burnout in caregivers working with individuals with terminal illness. Many sources of stressors in the hospice setting were identified, such as sense of loss when patient dies, being involved with terminally ill patients exclusively, dealing with

emotional concerns of the families, conflict with physicians, inadequate time to grieve, and high workload and 24/hour call. In addition, the personality traits and coping abilities had an impact on the perception of job stress and burnout. Certain individuals had internal resources to cope thus reducing emotional distress, while others had outside support systems that helped them maintain positive work attitudes. Other factors affecting stress included various characteristics of the institutions, the type of care provided, and the differences in hospice programs (free standing, mixed with traditional care, and home care). Those nurses who provided care in inpatient units were less stressed than those who cared for depressed patients and had to deal with poor patient and family relationships in the home. The authors concluded that differences in the individual (coping abilities, support, and conflicts), and in the institution (management style, organizational structure, and degree of flexibility) can affect the level of job stress and burnout in hospice settings.

As a subset and part of a larger study of 581 caregivers, Vachon (1987) interviewed 60 hospice caregivers in order to learn the sources of stress they experienced working with the critically ill, dying, and bereaved. The data gathered were from 26 individual semi-structured interviews; 11 group interviews with 51 caregivers; and 23 less formal discussions. All respondents were asked to comment on their personal stressors, symptoms of stress, and personal and environmental coping mechanisms to deal with stressors. The data were coded and analyzed using the Glaser and Strauss (1967) content analysis yielding a total of 8,912 anecdotes with 1657 related to hospice. The response rate of stressors reported by caregivers

were 8.78 per interview. When compared to the large group, that number was less than the average number for emergency room, obstetrics, ICU, and chronic care staff, but more than those reported in oncology, or pediatrics. The greatest source of stressors reported in hospice were from work environment (48%), occupational role (29%, patient/family (17%) and illness (7%). When compared to the large group, emergency room staff members were the only persons reporting more environmental stressors than hospice (53%). Communication problems within the system or community, gaining credibility to receive referrals, role ambiguity and role conflict, and team and administration communication problems were the greatest occupational stressors. Other issues included feelings of depression, grief, and guilt due not only to the loss of the patients but to feelings of inadequate role performance or loss of support from colleagues. High expectations of oneself may be unrealistic causing feelings of helplessness and insecurity (Vachon).

From an official membership list provided by the National Association for Music Therapy, Oppenheim (1987) randomly surveyed 500 Registered Music Therapists in order to correlate demographic data with the degree of burnout as measured by the Maslach Burnout Inventory. Surveys completed by 239 respondents were acceptable for the data analysis. The demographic data revealed a mean age of 30.17 years, with 87.13% females and 12.86% males. The number of hours worked varied from 50 or more hours per week to less than 20 hours per week. The average number of years that music therapists worked in their positions was 4.03 years. The common work areas were psychiatry (33.9%) and facilities for mental retardation

number of years that music therapists worked in their positions was 4.03 years. The common work areas were psychiatry (33.9%) and facilities for mental retardation (25.5%). The results revealed a low degree of burnout in Depersonalization and moderate degrees of burnout in Emotional Exhaustion and Personal Accomplishment. The results may have been confounded due to limited experience and the low number of years that music therapists have worked in the field.

There are studies to support the relationship between work environment and burnout in various settings (Constable & Russell, 1986; Cronin-Stubbs & Rooks, 1985; Duxbury, Armstrong, Drew, & Henly, 1984; Fong, 1993; Oehler, Starr, & Lee, 1991, and Ogus, 1990;) but there are no studies found demonstrating the relationship between work environment and music therapists working in hospice or palliative care settings.

Summary

Burnout can occur in most health care settings where there is an interplay and connection with other people. The literature suggests that burnout is influenced by many individual as well as societal factors. The degree of burnout can be affected by leadership styles of supervisors, the amount of direct contact with clients, collegiate support, stress, job demands, and hardiness. Those with poor health status had a tendency to burnout quicker and those who experienced burnout may have less creative behavior.

CHAPTER III

METHOD

Subjects

A list of 300 men and women music therapists was compiled from the membership of the AMTA. Only those who indicated that they worked in hospice/palliative care were considered as subjects. The survey consisted of a demographic form, the Maslach Burnout Inventory (Maslach and Jackson, 1986) and the Work Environment Scale (Moos, 1994). Following the initial mailing, total of 115 surveys were returned within a four week period. Those who did not respond were sent a reminder several weeks after the first mailing. A total of 181 surveys were collected for data analysis and 106 were acceptable for use in the survey.

Instruments

Maslach Burnout Inventory

Burnout was conceptualized as the frequency of work related stressors in the areas of emotional exhaustion, reduced personal accomplishments, and depersonalization and operationalized by the use of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). The Maslach Burnout Inventory, a self-report

measure was designed to measure three aspects of the burnout syndrome, emotional exhaustion, depersonalization, and a lack of personal accomplishment.

The Emotional Exhaustion subscale consists of 9 items that measure “feelings of being emotionally over extended and exhausted by one’s work” (Maslach, 1986, p. 2). Specific questions asked respondents to rate their feelings of being used up, tired, and stressed. The Depersonalization subscale has 5 items that measure an “unfeeling and impersonal response toward recipients of one’s care” (p. 2) including perceptions of callousness, and becoming hardened emotionally. The 8- item Personal Accomplishment subscale, relatively independent of burnout, assesses feelings of “competence and successful achievement in one’s work” (p. 2). It measures perceptions of working well with others and having an influence on others. The MBI is meant to measure the burnout syndrome with professionals who work with recipients in some manner.

Burnout is measured from low to high rather than present or absent. High degrees of burnout are determined by high scores on the Emotional Exhaustion and Depersonalization subscales and low scores on the Personal Accomplishment subscale. Moderate levels of burnout are reflected by moderate scores on each of the three subscales. Low burnout is measured by low scores on Emotional Exhaustion and Depersonalization, and high scores on Personal Accomplishments. Scores are considered high if in the upper third of the normative distribution, moderate if in middle third, and low if lower third (Turnipseed, 1987, p.107-108). Table 1 demonstrates the range of experienced burnout in the MBI subscales of the overall

sample of occupational subgroups of teaching K-12, post-secondary education, social services, medicine, mental health, and other occupations who work with people.

Table 1
Range of Experienced Burnout

MBI	Low	Average	High
Subscales	(lower third)	(middle third)	(upper third)
Overall Sample			
Emotional Exhaustion	≤ 16	17-27	≥ 27
Depersonalization	≤ 6	7-12	≥ 13
Personal Accomplishments	≥ 39	38-32	≤ 31

The reliability coefficients for Emotional Exhaustion is .90, Depersonalization is .71, and Personal Accomplishment .71. The MBI has been used by researchers to measure burnout in various populations and work areas such as nurses in hospitals, nursing homes, education, oncology, psychiatric setting (Constable, & Russell, 1986; Corrigan, Holmes & Luchins, 1995; Dick, 1986; Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995; Fong, 1993; Hare, Pratt, & Andrews, 1988; Oehler, Davidson, Starr, & Lee 1991, and Orgas, 1990), music therapists (Oppenheim, 1987), and teachers (Greenglass, Fiksenbaum, & Burke, 1994).

Work Environment Scale

Social climate was operationalized by the Work Environment Scale (WES) (Moos, 1994). The WES, one of 10 Social Climate Scales has 10-nine item subscales that assess three underlying sets of dimensions: relationship, personal growth, and system maintenance and change dimensions. The first subscale, relationship dimensions, was used in this study. The relationship dimensions measures how people help one another in the work setting, how involved they are, and how they spontaneously express their feelings. The scale also taps into cohesion such as how employees are friendly and support one another. It also measures the extent to which management is supportive of employees and employees supportive of one another. Moos posits that “positive relationships foster commitment and motivation, making the setting more stable” (p. 13). Cohesion makes confronting demanding and stressful environments easier to handle.

The statements on the scale focus on areas of involvement, coworker cohesion, and supervisor support. The respondents decide if statements in each respective are (e.g. “The work is really challenging”, “People go out of their way to help a new employee feel comfortable”, “Supervisors tend to talk down to employees”) were true, mostly true, false, or mostly false to their environments and answer accordingly. Scores range from 0-9 in each area and can be converted to standard scores. High scores suggest an employee’s concern and commitment to job, friendliness and support to one another, and the extent to which the management is supportive to employees and encourages mutual employee support.

Reliability coefficients range from .73 to .86. The WES has been used in studies of nursing staff and educators (Constable, & Russell, 1986; Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995; Fong, 1993; Hare, Pratt, & Andrews, 1987). Because only part of the WES was used in this study, special permission to modify and reproduce the scale was granted from the publisher (See Appendix A).

Demographic Questionnaire

The sociodemographic variables were gathered on a questionnaire developed by the researcher (See Appendix B). The instrument gathered information regarding respondents' age ranges, gender, marital status, number of children, level of completed education, and professional credentials. Respondents were also asked to provide current employment, length of time in position, hospice, palliative care, agency or private contractual, hours per week, part time (20 hours) or full time (40 or more hours), the number of years and months worked in their designated area, as well as the caseload of patients and visits per week. In addition, the respondents were asked to indicate any supervisory responsibilities, (the number of students, interns, others, and the hours spent per week with supervision) as well as the presence of a clearly defined job description. The participants were also requested to indicate the availability of support groups, memorial services, stress reduction, and problem solving programs at their respective facilities and whether they used these services.

Finally, the participants were asked to indicate the degree of support and help provided by their families (child care and household chores, support from their

spouse or significant other as well as by their co-workers and family members of their clients) and significant life experiences (negative or undesirable personal life event changes in the past year such as death, divorce, birth, marriage, serious illness, residence change, change of administrator, change of job, and job loss). Additional space was provided for comments.

Procedure

The purpose of the present study was to investigate the components related to occupational stress or burnout among music therapists working in hospice/palliative care arenas using a descriptive correlation design. Surveys were mailed to 300 music therapists from a list belonging to the American Music Therapy Association who had indicated that they worked in hospice/palliative care settings. Other demographic data such as age, sex, marital status, educational level, length of employment and caseload, job description and responsibilities, support systems, and stressful life events were also considered. Those who did not indicate that they worked in hospice or palliative care on the data form were not used in the study. The frequency of visits to each patient was assessed on a weekly basis. For those respondents that gave a range of numbers, an average was used.

The initial mailing of 300 surveys resulted in 115 surveys being returned. A second mailing was sent four weeks later to remind those who did not respond in the initial mailing. Of the 300 surveys mailed, a total of 181 were returned (60%) and 106 of that number (60%) were actively working in hospice or palliative care arenas and

were used in the study.

Consent and Approval

The study was approved by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University for investigation involving human subjects with data collection that is anonymous and normal educational practice (See Appendix C). The informed consent (See Appendix D) contained the following: introduction to the research activities, statement of the research purpose, reason for selecting music therapists in hospice/palliative care, explanation, description of risks, benefits, assurance of anonymity and confidentiality, the offer to answer questions, a non coercive disclaimer, and the option to withdraw. The return of the completed survey indicated the respondent's consent to participate in the study. To ensure confidentiality, all information was coded and the results of the study were reported as group data.

Data Collection and Analysis

Hypothesis 1: There will be no difference in the MBI scores of music therapists as compared to other groups of workers.

Hypothesis 2: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of hours per week at hospice/palliative care programs.

Hypothesis 3: There will be no correlation between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of hours per week at hospice/palliative care programs.

Hypothesis 4: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of hours per week at hospice/palliative care programs.

Hypothesis 5: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of years worked at hospice/palliative care programs.

Hypothesis 6: There will be no correlation between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of years worked at hospice/palliative care programs.

Hypothesis 7: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of years worked at hospice/palliative care programs.

Hypothesis 8: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) and age of music therapists working in hospice/palliative care programs.

Hypothesis 9: There will be no correlation between the scores on the Maslach subtest (Depersonalization) and age of music therapists working in hospice/palliative care programs.

Hypothesis 10: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) and age of music therapists working in hospice/palliative care programs.

Hypothesis 11: There will be no correlation between the scores on the Maslach subtests (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) and the Work Environment Scale.

This was a descriptive correlation study. Data were analyzed on a MacIntosh G3 computer using the Excel 98 software program. The quantitative data were analyzed using parametric and non-parametric methods as appropriate. Mean, median, mode, percentile, ranges, and standard deviation were tabulated from the demographic data. The descriptive data were reported as comments. The scores from the MBI and the WES were tabulated using correlation statistics and categorized according to strength of correlation. The following guidelines (See Table 2) were used to determine the strength of correlation for this study (Munro & Page, 1993, p.181). The hypotheses were accepted if in the “low” or “little if” any categories and rejected in the “moderate”, “high”, or “very high” categories.

More music therapists are working in hospice/palliative care arenas as well as in other clinical areas where they have close contact with individuals. Many of them work with an interdisciplinary team in a clinical area while others work alone in private practice. An awareness of the components that affect burnout in the clinical area would be helpful to both the music therapist and the staff of the facility. Support from peers and supervisors, stress reduction and problem solving programs could be

implemented to prevent or minimize the effects of job and home related stresses before the effects become detrimental to the individuals productivity and creativity.

Table 2
Correlation Categories Including + and – r s

r	Descriptor
0.00 – 0.25	little if any
0.26 – 0.49	low
0.50 – 0.69	moderate
0.70 – 0.89	high
0.90 – 1.00	very high

Implications for Music Therapists

More music therapists are working in hospice/palliative care arenas as well as in other clinical areas where they have close contact with individuals. Many of them work with an interdisciplinary team in a clinical area while others work alone in private practice. An awareness of the components that affect burnout in the clinical area would be helpful to both the music therapist and the staff of the facility. Support from peers and supervisors, stress reduction and problem solving programs could be

implemented to prevent or minimize the effects of job and home related stresses before the effects become detrimental to the individuals productivity and creativity.

Summary

This descriptive correlation study was to investigate the components related to occupational stress or burnout among music therapists working in hospice/palliative care arenas. The MBI, the WES and a sociodemographic form were used to survey the subjects. Data were analyzed by parametric and non-parametric methods. The descriptive data were reported as comments. Implications for music therapists working in hospice/palliative care were summarized.

CHAPTER IV

RESULTS

Sample

The sample for this study consisted of a convenience sample of music therapists who work in hospice/palliative care and were members of the American Music Therapy Association. Of the 300 surveys mailed, 181 were returned (60%) and 106 of those respondents (60%) actively worked in hospice or palliative care arenas and were usable for data analysis.

Demographics

Age was divided into category ranges of category 1 (20-30 years), category 2 (31-40 years), category 3 (41-50 years), category 4, (51-60 years), and category 5, (over 60 years). The mean and median age were in category 2, (31-40 years old), and the mode was in category 1, (20-30 years old). Out of 106 subjects, 32 (31%) were in category 1, thirty-one (30%) were in category 2, twenty-eight (26.4%) were in category 3, nine (8%) were in category 4, and only five (4.6%) were in category 5 (See Table 3).

Fifty-three (50%) of the 106 subjects were married, 37 (30.5%) were single, 3 (2.8%) were divorced, and 5 (4.6%) were cohabiting (See Table 4). Eight subjects did

Table 3
Age of Respondents

Years	n	%
20-30	32	31
31-40	31	30
41-50	28	26.4
51-60	9	8
>60	5	4.6

Table 4
Marital Status of Respondents

	n	%
Married	53	50
Single	37	30.5
Divorced	2	2.8
Widowed	0	
Cohabiting	5	4.6

not respond to the question. Sixteen subjects reported having families with one child, twenty-three had 2 children, five had 3 children, and three had 4 children. Two subjects stated they had no children, and 57 subjects did not respond to the question. One hundred one (94.5%) of the subjects were female and five (4.6%) were male. More than half (56%) of the subjects, had a bachelor degree while 41% were masters prepared. Only 3 were doctoral prepared. One subject did not answer the information (See Table 5).

Table 5
Educational Level of Respondents

	n	%
Bachelor	59	56
Master	43	41
Doctoral	3	1

The number of years that the respondents had worked in hospice/palliative care ranged from 6 months to 20.8 years. The average number of years subjects worked in hospice/palliative care was 4.89 and the mode was 4. The range of hours worked per week was from 2 hours to 55 hours. The average amount of hours was 33.43, the median 40 hours, and the mode 40 hours. Forty-two subjects reported they

worked in hospice care, 63 reported palliative care, 23 reported both hospice/palliative care, 11 said they worked in contractual hospice care, and 21 said they worked in contractual palliative care (See Table 6 and 7).

Table 6
Employment Setting of Respondents

	Facility			Contract	
	Hospice	Palliative	Hospice/Palliative	Hospice	Palliative
Subjects	42	63	23	11	21

Table 7
Years and Hours Worked in Setting

	X	Range
Years	4.89	1/2-20.8
Hours/week	33.43	2-55

The caseload of patients per week varied from 1.5 patients a week to 200 patients per week. The mean was 28.4 the median 15 and mode 10. The subjects

reported that they saw each of the patients from as little as one time 15 minutes a week to five times a week not specifying amount of time (See Table 8).

Table 8
Caseload of Patients and Number of Visits Provided per Week

Caseload		
	Number of Patients	Visits per Patient Per Week
Range	1.5-200	1-5
Mean	28.4	2.5
Median	15	1
Mode	10	1

Many of the respondents reported they had supervisory responsibilities as well. Nineteen subjects reported they supervised between 1-40 students spending from 2-40 (mean of 7.63) hours per week. Seventeen subjects reported they spent a range of 2-30 (mean 10.25) hours per week supervising 1-6 interns (See Table 9). The subjects also stated that they also supervised up to 60 volunteers, other music therapists, activity assistants, volunteer musicians, bereavement staff, activity department, recreational assistants, other staff members, peer training, acted as craft room supervisor, and taught at a university.

Only one subject did not respond to the question of having a clearly defined job description. Seventy-six subjects (72%) reported they did have a clearly defined job description while 29 (27%) said they did not. Several music therapists stated that

Table 9
Supervisory Responsibilities per Week

Supervisory Responsibilities				
	Students	Hours	Interns	Hours
Range	1-40	2-40	1-6	16
Mean	4.47	7.63	1.7	10.25
Median	2	6	1	10
Mode	1	6	1	10

they created their own job contract and description. Some reported that they had considerable flexibility in their job description. Others reported that they have been asked to do their own or had the freedom to create one. On the other hand, others respondents reported they had to feel their way along without a job description. Others reported that the facility did not believe in a job description.

The survey asked the subjects if their facility offered support services.

Forty -nine respondents said that their facility offered employee support groups but only 28 used them. Sixty four said that their facility offered memorial services and

Table 10

Programs Offered by Facilities and Use by Respondents

Offered by Facility		Used by Respondents
Employee Support	49	28
Memorial Services	64	44
Stress Reduction Programs	35	23
Problem Solving Programs	21	13

forty-four of them had attended at least one of the services. Out of 35 subjects that said their facility offered stress reduction programs, 23 utilized the services. Twenty-one facilities offered problem solving programs with 13 subjects utilizing the services (See Table 10). Others responded in the comment section that they found stress release from the music experiences with their patients and had team retreats on a regular basis for support and team building. Some had problem solving based on 1:1 supervision or case review and had close network of support (friends, relatives) outside work. Others experienced stress release through prayer with staff and patients, good continuing education programs, massage, Guided Imagery and Music (GIM) outside of work. Other music therapists reported they had to pay extra for the services where others said that there were no programs offered.

The demographic survey also asked about home-related stressors and whether the respondent's family was supportive. Out of 33 subjects who had children, 28 said they had help with childcare. From the 81 subjects who responded to having household chores, 68 said they had help from the family. Eighty-three of the 87 subjects were positively supported by a spouse or significant other. Eighty-three of the 91 subjects were supported by others in their family, eighty-four of 93 were supported by co-workers, and ninety-five of the 98 music therapists were supported by family members of clients (See Table 11).

Table 11
Support Systems

Home Related Support	Yes	%	No
Childcare	28	85%	5
Household Chores	68	84%	13
Spouse	83	95%	4
Family	83	91%	8
Work Related Support	Yes	%	No
Co-Workers	84	90%	9
Clients Family	95	97%	3

The last part of the demographic survey asked the music therapists if there had been any stressful life events that occurred within the last year. Out of the 106 responses there were 22 deaths, 14 births, 1 divorce, 7 marriages, 14 serious illnesses, 25 residence changes, 28 change in administrators at worksite, 16 changes of job, and 18 other responses (See Table 12). Other individual responses consisted of comments such as poor administration creating stress, agency job site changes and population changes on daily basis with difficulty to be relaxed and grounded, corporation merger with position cuts, reducing money for patient care, low morale, and high frustration, change of administrators and supervisors in short period of time, downsizing of jobs, increased paper work, administrators negative and non-supportive towards music therapy program, on the road too much, non-supportive environment, co-workers and employees work against each other, coordinating a new program, and low paying job. Some stated that they were coordinating a program at a new facility, had added responsibilities without proper training, or needed to be in the music therapy role and not activity services. Other music therapists said that patient deaths were numerous and stressful, especially those concerning children. Others commented on personal aspects of stressful events such as the end of a long relationship, financial stress and family illness, more help needed at home, family does not understand music therapy, divorce and remarriage, reverse parenting role and limited time to see spouse, continuing education, and child custody and court problems.

Hypotheses

Hypothesis 1: There will be no difference in the MBI scores of music therapists as compared to other groups of workers. The hypothesis was rejected. Mean, median, and standard deviation were calculated using the Excel 98 software. The sample of music therapists was compared to an overall sample of occupational subgroups consisting of K-12 teachers ($n=4163$), post-secondary education ($n=635$), social services ($n=1538$), medicine ($n=1104$), mental health ($n=730$) and other ($n=2897$) (Maslach & Jackson, 1986, p.9).

The overall mean for Emotional Exhaustion for the sample of music therapists was 20.82, well within the average range of burnout 17 to 27. The standard deviation was 10.36 and the median was 20.5. The mean for Depersonalization was 4.41, falling within the low range of burnout. The standard deviation was 4.68, and the median 3. The mean for Personal Accomplishment was 40.24, also in the low range of burnout, with a standard deviation of 7.17, and median of 42 (See Table 13).

Hypothesis 2: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of hours per week at hospice/palliative care programs. The hypothesis was accepted, however the results were approaching “moderate” correlation ($r = 0.475$).

Hypothesis 3: There will be no correlation between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of hours per week at hospice/palliative care programs. This hypothesis was accepted. Depersonalization ($r = 0.275$) was in the “low” range of the correlation category.

Table 12

Number of Respondents Reporting Stressful Life Events Within the Past Year

Stressful Event	n
Deaths	22
Births	14
Divorce	1
Marriage	7
Serious Illness	14
Residence Change	25
Change in Administrators	28
Change of Job	16
Other	18

Hypothesis 4: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of hours per week at hospice/palliative care programs. The hypothesis was accepted. Personal Accomplishment and number of hours per week correlated at the “little if any” range ($r = -0.071$)

Because Emotional Exhaustion was closest to approaching “moderate” correlation, the data was further analyzed in groups of hours per week. The first group

Table 13

Mean Scores for the MBI Standardized Group and Music Therapists Sample

MBI Subscales	Low (lower third)	Average (middle third)	High (upper third)	Music Therapists
Overall Sample				
Emotional Exhaustion	≤ 16	17-27	≥ 27	20.82
Depersonalization	≤ 6	7-12	≥ 13	4.41
Personal Accomplishments	≥ 39	38-32	≤ 31	40.24

was ≤ 20 hours per week where the correlation between Emotional Exhaustion and hours resulted in $r = -0.131$ ("little if any") correlation. The second group was < 20 to ≤ 40 where Emotional Exhaustion correlated with hours at $r = 0.483$ ("low" but approaching "moderate"), and the last group of hours (> 40) correlated with Emotional Exhaustion resulted in $r = 0.119$ ("little if any") (See Table 14).

Hypothesis 5: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) of music therapists and the number of years worked at hospice/palliative care programs. The hypothesis was accepted. The results for Emotional Exhaustion was $r = -0.025$ ("little if any" correlation).

Hypothesis 6: There will be no correlation between the scores on the Maslach subtest (Depersonalization) of music therapists and the number of years worked at

hospice/palliative care programs. The hypothesis was accepted. The results for Depersonalization $r = -0.14$ (“little if any” correlation).

Hypothesis 7: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) of music therapists and the number of years worked at hospice/palliative care programs. The hypothesis was accepted. Personal

Table 14
Correlation of Hours per Week and Maslach Burnout Inventory

Hours correlated with	<i>r</i>
MBI scores	0.436
Emotional Exhaustion	0.475
Depersonalization	0.275
Personal Accomplishment	-0.071
Emotional Exhaustion and ≤ 20 hours per week	-0.131
Emotional Exhaustion and >20 to ≤ 40 hours per week	0.483
Emotional Exhaustion and >40 hours per week	0.119

Accomplishments correlated with number of years at $r = 0.098$ (“little if any” correlation) (See Table 15).

Data was further analyzed in the three categories of years worked to determine if there was any relationship between years worked and the MBI subgroups. The first

group consisted of subjects that had worked in hospice/palliative care programs for less than 5 years. The result for Emotional Exhaustion was $r = -0.036$ (“little if any”). Depersonalization measured $r = 0.075$ and Personal Accomplishments $r = 0.021$. Both demonstrated “little if any” correlation. The second group consisted of subjects that

Table 15

Correlation of Number of Years Worked and Maslach Burnout Inventory

Years and MBI Scores	r
Total Scores	-0.031
Emotional Exhaustion	-0.025
Depersonalization	-0.139
Personal Accomplishment	0.098

worked from 5 years to less than 10 years. There was “little if any” correlation for this group in Emotional Exhaustion ($r = -0.123$), Depersonalization ($r = -0.057$), or Personal Accomplishment ($r = 0.123$). The last group of subjects had worked ten years or more. “Little if any” correlation existed with this group in Emotional Exhaustion ($r = 0.000$), and Depersonalization ($r = -0.162$). However, Personal Accomplishments ($r = 0.445$) was approaching moderate correlation.

Hypothesis 8: There will be no correlation between the scores on the Maslach subtest (Emotional Exhaustion) and age of music therapists working in

hospice/palliative care programs. The hypothesis was accepted. The correlation for Emotional Exhaustion and age was $r = -0.157$ (“little if any” correlation).

Hypothesis 9: There will be no correlation between the scores on the Maslach subtest (Depersonalization) and age of music therapists working in hospice/palliative care programs. The hypothesis was accepted. There was “little if any” correlation ($r = -0.155$) between Depersonalization and age.

Hypothesis 10: There will be no correlation between the scores on the Maslach subtest (Personal Accomplishment) and age of music therapists working in hospice/palliative care programs. The hypothesis was accepted. Personal Accomplishments and age correlated at $r = 0.182$ (“little if any” correlation).

There was “little if any” correlation between any of the subgroups and age of music therapists working in hospice/palliative care settings (See Table 16).

Hypothesis 11: There will be no correlation between the scores on the Maslach subtests (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) and the Work Environment Scale. The hypothesis was accepted. The correlation of the MBI and WES total scores resulted in a negative, approaching moderate relationship ($r = -0.432$). Further analysis of the scores of the WES and each of the three subgroups measured moderate negative relationship ($r = -0.515$) for Emotional Exhaustion, approaching moderate ($r = -0.487$) for Depersonalization, and positive low ($r = 0.289$) for Personal Accomplishments (See Table 17).

The mean and standard deviation of the WES subgroups (Involvement, Co-worker Cohesion, and Supervisor Support of the respondents were closely related to

Table 16

Correlation of Age and Maslach Burnout Inventory

Age	$r =$
MBI Total Scores	-0.059
Emotional Exhaustion	-0.157
Depersonalization	-0.155
Personal Accomplishments	0.182

Table 17

Correlation of Work Environment Scale Scores and Maslach Burnout Inventory

WES	$r =$
MBI Total Scores	-0.432
Emotional Exhaustion	-0.515
Depersonalization	-0.487
Personal Accomplishments	0.289

the normative values (mean and standard deviation) of health care work groups (See Table 18).

The mean of the standard scores of the WES subgroups were in the upper range of the normative values of the health care groups (See Table 19).

Table 18

Means and Standard Deviation for Health Care Work Groups and Music Therapists Working in Hospice/Palliative Care Settings

Subscale	Health Care Work Groups (N= 4,879 employees)		Music Therapists (N= 106)	
	Mean	SD	Mean	SD
Involvement	5.43	2.26	6.32	2.78
Co-worker Cohesion	5.24	1.99	5.60	2.29
Supervisor Support	4.82	2.21	5.38	2.45

Table 19

Ranges of Standard Scale Scores and Means of Music Therapists in WES Subgroups

	Standard Scores	Music Therapists
Involvement	24 - 65	52.75
Coworker Cohesion	22 - 68	50.44
Supervisor Support	26 - 67	51.0

High scores suggest employees concern and commitment to job, friendliness and support to one another, and the extent to which the management is supportive to employees and encourages mutual employee support.

CHAPTER V

DISCUSSION

Findings

The results of the MBI indicated average to low burnout among music therapists working in hospice/palliative care programs. The mean scores on Emotional Exhaustion were in the average range where the mean scores for Depersonalization and Personal Accomplishments were in the low burnout range when compared to the occupations represented in the normative group samples. This study's findings support similar findings in the prior research by Oppenheim (1987) who surveyed 239 music therapists working in various music therapy settings. Oppenheim's survey revealed a low degree of burnout in Depersonalization and moderate degrees of burnout in Emotional Exhaustion and Personal Accomplishment. The mean years for working in music therapy settings (4.03) in the Oppenheim study were similar to the present study (4.89). The majority of music therapists responding in both the Oppenheim (87.3%) and the present study (94.5%) were female.

Low degrees of burnout in Personal Accomplishment and Depersonalization and moderate degree of burnout in Emotional Exhaustion in this study could imply that music therapists in hospice/palliative care settings may be finding meaning in their work and feeling like they are satisfied with their accomplishments on the job. Pines (1993) maintains that highly motivated professionals need to accomplish high

goals and expectations and make a significant contribution to their work. Those who do not succeed may be susceptible to burnout.

In the present study, the amount of hours worked in the hospice/palliative setting may have been an indicator of burnout. The relationship of hours worked in a week when correlated with the total scores of the MBI were approaching “moderate” correlation ($r = 0.436$). Further analysis of hours to each of the subgroups of the MBI (See Table 12) demonstrated a “moderate” relationship as well ($r = 0.475$) in Emotional Exhaustion, “low” correlation ($r = 0.275$) in Depersonalization, and a negative “little if any” correlation in Personal Accomplishment ($r = -0.07$). There was also a higher relationship between Emotional Exhaustion ($r = 0.483$) and those working 20-40 hours per week than those working less ($r = -0.131$ or more ($r = 0.119$)). While the correlation is modest, it does support earlier research. For example, in a two-year study by Fong (1993), higher numbers of hours of work was one of the predictors of burnout in nursing educators. Even though the overall burnout in hospice caregivers was relatively low, Ray, Nichols and Perritt (1987) discovered that the larger number of hours worked, full time status, and longer tenure contributed to higher incidence of burnout. The amount of time spent with patients may also account for the lower burnout in music therapists as compared to other direct health care workers. The respondents reported that they visited a patient 1 to 5 times a week, some spending as little as 15 minutes to a half-hour with each. Others reported that they worked with groups and had little individual contact with patients. Nurses and

other direct care health care workers are typically in a facility where they see a patient several times a day providing intimate health care in an intense environment where there may be multiple deaths occurring (Bigelow & Hollinger, 1996; Biller & Rice, 1990).

Another contributing factor to the moderate to low burnout may have been additional supervisory job responsibilities of the respondents. Approximately 20% of the respondents reported that they supervised up to 40 students, interns, up to 60 volunteers, and other staff members in the hospice/palliative care setting with a range of 20- 40 hours per week.

In general, the number of years worked was not a factor in overall burnout in this study. However, when the subgroups of the MBI were further analyzed with the three categories of years worked, Personal Accomplishment correlated at $r= 0.123$ for music therapists working 5-10 years, and $r= 0.445$ for music therapists working more than 10 years. Although the latter approaches “moderate” correlation, it is important to note the size of that particular age group was smaller than the younger age groups. Nevertheless, this finding may indicate that the longer individuals work in a setting the happier they are with their work with clients and with their accomplishments on the job. Braswell, Decuir, and Jacobs (1989) surveyed 1344 music therapists to measure job satisfaction. The study found that length of service for music therapists was a factor in job satisfaction and experiencing a pleasurable emotional state in their work. Other factors related to job satisfaction in that study were challenge, autonomy, staff relationships, professional respect, and job security.

Age did not seem to be a factor in burnout when correlated with the MBI. The results indicated “little if any” correlation with Emotional Exhaustion, and Depersonalization or Personal Accomplishment.

The WES and the MBI total scores correlated in negative relationship as well as the subgroups of Emotional Exhaustion and Depersonalization. Personal Accomplishments and the WES indicated a low relationship. The mean scores of the WES were slightly higher than the normative mean scores of the Health Care Work Groups indicating average to above average involvement in their work, co-worker support, and management support. The majority of the subjects also reported having a clearly defined job description or some flexibility in creating their own. Hobfall and Freedy (1993) maintain that role ambiguity leads to a loss of control and inability to carry out clear-cut goals, leading to ambiguous work situations and frustration. Lack of job description may have been a contributing factor to burnout in some of the music therapists. However, the overall moderate to low burnout in the Emotional Exhaustion and Depersonalization subgroup of the MBI may indicate that the subjects tend to feel like they have a positive work environment and are experiencing personal accomplishment in their profession.

From the responses on the demographic data form, there was a high percentage (84%-97%) of support from family members and families of clients. In addition, most of the respondents who had employee support programs also made use of them. This may have been a buffer to burnout and provided social support and a

sense of balance in their lives. Studies with teachers (Greenglass, Fiksenbaum, & Burke 1994) and nurse faculty (Dick 1986) revealed higher levels of burnout with low social support, and less burnout with high support. On the other hand, there were various stressful life events within the past year for many respondents such as death, residence change, illnesses, and change in administrators that may also have contributed to the moderate to low burnout. Some respondents included critical comments focusing on poor administration, low morale, job downsizing, low paying job, non-supportive environment, and personal stressors.

Implications to Practice

Although this study indicates that burnout is relatively low in two of three subsets of the Maslach Burnout Inventory, music therapists need to be aware of the signs and symptoms of burnout, the methods of coping and problem solving, and conscious of management strategies at the personal (self-care) level and at the administrative level of their facility to reduce burnout. Creativity is essential to the field of music therapy. Burnout, as reported by Norowal, Zarczynski, Fafrowicz, and Marek (1993), can have an effect on creativity and innovation and may impact the outcomes of patient care provided by music therapists.

The results of this study suggest that there is moderate to low burnout among music therapists working in hospice/palliative care arenas. As music therapists provide relaxation and imagery sessions for their patients, they too may experience psychological well-being and comfort along with their patients. Perhaps music

therapists working in hospice/palliative care settings are reaping the positive benefits of music therapy as well as are their patients.

Implications for Further Research

This research provided some discoveries but also evoked questions for further research. Are music therapists in hospice/palliative care settings more satisfied with their jobs than other health care providers? Even though music therapists work with serious illness, dying patients, and ultimately face the death of their patients, do they achieve more personal satisfaction from the type of work they provide? If the components of burnout are similar to those of other health care providers, then what part does the music play? Is the music along with the techniques used by music therapist (relaxation, expression through singing, instrument playing, etc) acting as buffers against the negative effects of job stress and burnout? Are these outcomes also having an effect on Emotional Exhaustion, Depersonalization, and Personal Accomplishments of the MBI scores of the music therapists. As many of the respondents reported on the demographic data form, they found stress release from the music experiences with their patients as well as participating in the prayers of staff and patients. Do music therapists working in other settings experience similar burnout scores? Further research may provide explanations to these inquiries.

Summary

There may be many components that contribute to burnout in music therapists

working in hospice/palliative care settings. Respondents noted many elements such as number of hours, workload, social support, home- related, personal, and work stressors, availability and use of support programs, supervisory responsibilities, and work environment that may affect burnout.

From this study, music therapists in the hospice/palliative care setting experience moderate to low burnout. Conversely, research indicates that those working other helping professions experience greater levels of burnout. The difference may be in a balance that occurs, a buffer that music therapists derive from rendering the music therapy itself. Music therapists may be benefiting along with providing music therapy interventions for their patients. Perhaps further research in this area will provide clarity and support for this supposition.

Appendix A

Permission Agreement for Modification of WES

Dottie Pienta RN, RMT-BC
Harmony in Health
Music Therapy Center
Lambertville, MI 48144

**PERMISSION AGREEMENT FOR MODIFICATION
& REPRODUCTION**

Agreement Issued: August 20, 1998
Customer Number: 246490
Product Code: 5211
Permission Number: 11751

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"The test user, in selecting or interpreting a test, should know the purposes of the testing and the probable consequences. The user should know the procedures necessary to facilitate effectiveness and to reduce bias in test use. Although the test developer and publisher should provide information on the strengths and weaknesses of the test, the ultimate responsibility for appropriate test use lies with the test user. The user should become knowledgeable about the test and its appropriate use and also communicate this information, as appropriate, to others.

6.1 Test users should evaluate the available written documentation on the validity and reliability of tests for the specific use intended.

6.3 When a test is to be used for a purpose for which it has not been validated, or for which there is no supported claim for validity, the user is responsible for providing evidence of validity.

6.5 Test users should be alert to probable unintended consequences of test use and should attempt to avoid actions that have unintended negative consequences."

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- (i) Dottie Pienta RN, RMT-BC agrees that the WES as modified under this Agreement is a derivative work of the WES and hereby automatically assigns all right, title, and interest in any such derivative work created under this Permission

Agreement in perpetuity to Consulting Psychologists Press (CPP) or as directed by CPP, immediately upon completion and without further consideration.

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I AGREE TO THE ABOVE CONDITIONS.

By Chris Buslop
Authorized Representative

By Dottie Pienta RN RMT-BC
Dottie Pienta RN, RMT-BC

Date September 28, 1998

Date Sept 10, 1998

Appendix B
Demographic Data Form

Age: ☐ 20-30, ☐ 31-40, ☐ 41-50, ☐ 51-60, ☐ over 60☐ Male, ☐ Female, ☐ Married, ☐ Single, ☐ Divorced, ☐ Widowed, ☐ Partnering/Cohabiting

No. of children: _____ Ages: _____

Level of education completed: _____ Professional Credentials: _____

Are you currently employed? ☐ Yes, ☐ No. How long in current position _____ ☐ Agency,☐ Private contractual, ☐ Part time, Hours per week _____ ☐ Full time, Hours per week _____Do you work in: ☐ Hospice, No. of years _____ months _____☐ Palliative (Terminal) care, No. of years _____ months _____

Case load: No. of patients visited per week _____ How often do you see each patient? _____

Supervisory responsibilities: ☐ Yes, ☐ No

No. of Students _____ Hours per week spent _____

No. of Interns _____ Hours per week spent _____

Others _____

Do you have a clearly defined job description? ☐ Yes, ☐ No

Comments _____

Does your facility offer:

☐ Employee support groupsDo you generally use them? ☐ yes, ☐ no☐ Memorial servicesDo you generally use them? ☐ yes, ☐ no☐ Stress reduction programsDo you generally use them? ☐ yes, ☐ no☐ Problem solving programsDo you generally use them? ☐ yes, ☐ no☐ Other, Explain _____Does your family help you with home-related stressors? Child care: ☐ yes, ☐ no, ☐ N/AHousehold chores: ☐ yes, ☐ no, ☐ N/A Others? _____

If no, what could be better _____

Do you feel supported in your work by your spouse or significant other? ☐ yes, ☐ noBy others in your family? ☐ yes, ☐ no. By your co-workers? ☐ yes, ☐ no.By the family members of your clients? ☐ yes, ☐ no.

Have there been any stressful life events that occurred in your life within the last year? Please check if yes.

☐ Death, ☐ Birth, ☐ Divorce, ☐ Marriage, ☐ Job loss, ☐ Serious illness, ☐ Residence change,☐ Change in administrators at worksite, ☐ Change of job. ☐ Other (explain) _____

Additional Comments (Please use back if necessary) _____

Thank you!! Please return this form with surveys in envelop provided.

Appendix C
Protocol Clearance From the Human Subjects
Institutional Review Board



WESTERN MICHIGAN UNIVERSITY

Date: 3 November 1998

To: Brian Wilson, Principal Investigator
Dorothy Pienta, Student Investigator for thesis

From: Sylvia Culp, Chair *Sylvia Culp*

Re: HSIRB Project Number 98-09-14

This letter will serve as confirmation that your research project entitled "Components Related to Occupational Stress or Burnout Among Music Therapists Working in Hospice/Palliative Care Arenas" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 3 November 1999

Appendix D
Informed Consent

College of Fine Arts
School of Music
Music Therapy Clinic



70

Kalamazoo, Michigan 49008-3831
WESTERN MICHIGAN UNIVERSITY
H. S. I. R. B.
Approved for use for one year from this date:

WESTERN MICHIGAN UNIVERSITY

NOV 03 1998

x *Stephen L. G.*
HSIRB Chair

Dear Fellow Music Therapist,

You are invited to participate in a research project "Components Related to Occupational Stress or Burnout Among Music Therapists Working in Hospice/Palliative Care Arenas" designed to measure occupational stress and work environment. This project is being conducted by Brian Wilson, MT-BC and Dottie Pienta, RN, MT-BC from Western Michigan University, School of Music. This research is part of the thesis requirements for Dottie Pienta.

This survey is comprised of demographic questions and two questionnaires. The first contains 22 items and the second contains 27 items on the Likert scale, and will take approximately 20 - 30 minutes to complete. So your replies will be completely anonymous, please do not put your name anywhere on the form. Returning the surveys indicates your consent to use the answers you supply. If you choose to not participate in this survey, you may either return the blank survey or you may discard it and discontinue participation in the research at any time without prejudice, penalty, or risk of any loss of service you would otherwise have. Surveys will be kept in a locked file cabinet in my office and will be destroyed after the data have been transferred to a computer data file. The information will then remain locked in the office of Brian Wilson.

This consent document has been approved for use for one year by the Human Subjects Institutional review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in the research if the corner does not have a stamped date and signature.

Please take a few minutes to complete and return the questionnaire on or before January 12, 1999, in the stamped envelope provided. If you have any questions or problems during the course of the study, you may contact Brian Wilson at 616- 387-4667 or Dottie Pienta at 734- 854-3002, the Human Subjects Institutional Review Board at 616- 387-8293 or the Vice President for Research at 616- 387-8298.

Your participation will provide current information regarding issues influencing burnout and stress among music therapists in the hospice/ palliative care arena.

Thank you very much,

Dottie Pienta RN, MT-BC
Brian Wilson MM, MT-BC

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