A Phenomenological Examination of Imposter Phenomenon in Music Therapy Students

By

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Abstract

The current study investigated the prevalence, or lack thereof, of imposter phenomenon in music therapy students. Imposter phenomenon (IP) is an internal experience that describes feelings of fraudulence an individual may encounter, regardless of their achievements. A sample of music therapy students ($n = 7$) at a large, Midwestern AMTA-approved university were recruited to participate in one-time focus groups. An interpretive phenomenological analysis was performed on the transcripts, resulting in the development of three recurrent themes of discussion regarding IP: (a) uncertainty in transitions, (b) challenges of the music therapy profession, and (c) awareness and impact of IP constructs and patterns. These findings provide insight into the prevalence of IP in this population, and inform professors, supervisors, and other key stakeholders about the needs may of developing music therapy students. In addition, these findings aid in further solidifying and modifying the guiding theoretical framework of this study.

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Chapter 1: Introduction

Imposter Phenomenon

Imposter phenomenon (IP) is a personality construct that attempts to explain an internal experience of feeling intellectually fraudulent that was identified by researchers Pauline R. Clance and Suzanne Imes (1978). Since this initial identification, IP has become the topic of many subsequent research articles, books, newspaper and magazine articles, podcasts, and TED Talks. Individuals who exhibit symptoms of IP often feel like frauds in their field of study or work, and believe that any of their achievements are falsely gained. "Imposters" attribute their achievements to external factors such as luck or being in the right place at the right time, instead of internal factors such as intelligence, consistent work ethic, or organizational abilities. Individuals with IP are in a constant state of feeling unworthy and believe that they are fooling everyone into thinking they are more competent than they are. In addition, individuals with IP tend to set personal standards of achievement that are difficult to attain (Clance & Imes, 1978). While the precise prevalence of IP in society is difficult to ascertain, it is suggested that up to 70% of people have encountered its symptoms at some point in their lives (Warrell, 2014).

Imposter phenomenon was first identified in professional women who were highly successful, or "high-achieving;" these women held varying levels of college degrees and were respected individuals in their vocational field, held Ph.D.'s, or were considered to be academically achieving college students (Clance & Imes, 1978). Since this initial claim, imposter phenomenon's presence has been further examined and identified in many other populations considered to be high-achieving, including high school and college level students (Caselman, Self, & Self, 2006; Clance & Imes, 1978; Cromwell, Brown, Sanchez-Huceles, & Adair, 1990; Gibson-Beverley & Schwartz, 2008; King & Cooley, 1995; Lane, 2015; Peteet, Montgomery, &

Weekes, 2015), higher education faculty (Clark, Vardeman, & Barba, 2014; Hutchins, 2015; Topping & Kimmel, 1985), and helping professionals, including clinical nurse specialists, medical, dental, nursing, and pharmacy students, and family medicine residents (Arena & Page, 1992; Christensen et al., 2016; Henning, Ey, & Shaw, 1998; Oriel, Plane, & Mundt, 2004). Many IP studies have examined its prevalence amongst academics. The academic environment is likely to foster the emergence of imposter phenomenon (Kets de Vries, 2005; Zorn, 2005;) as these individuals deal with the stress and expectations associated with a higher education-related workload.

Treatment for those afflicted by IP includes a variety of different techniques, none of which have been tested for clinical efficacy. These include Gestalt exercises (Clance & Imes, 1978), cognitive restructuring (Clance & O'Toole, 1988; Langford & Clance, 1993; Matthews & Clance, 1985), group therapy (Clance & O'Toole, 1988; Matthews & Clance, 1985), feminist-oriented group therapy (Clance, Dingman, Reviere, & Stober, 1995), journaling (Clance & Imes, 1978; Clance & O'Toole, 1988; Warrell, 2014), and expressive and relaxation exercises (Heinrich, 1997).

Influence of Imposter Phenomenon

Researchers of imposter phenomenon have examined and identified psychological constructs that are present in individuals exhibiting its symptoms. The seminal research of IP suggests clinical symptoms that include anxiety, low self-confidence, feelings of depression, and frustration related to unattainable goal achievement (Clance & Imes, 1978). The subsequent IP literature has since corroborated these negative constructs and further identified others. These additional constructs include introversion, low self-esteem, helpless reactions, feelings of unworthiness, shame, neuroticism, guilt about success, detachment, emotional exhaustion,

shame, perfectionism, and fear of failure (Bernard et al., 2002; Clance & Imes, 1978; Clance & O'Toole, 1988; Cusack, Hughes, & Nuhu, 2013; Harvey, 1981; Holmes, Kertay, Adamson, Holland, & Clance, 1993; Hutchins, 2015; Langford & Clance, 1993; Ross, Stewart, Mugge, & Fultz, 2001; Topping, 1983). Based on these constructs and the populations in which imposter phenomenon resides, IP is a potentially problematic mindset that negatively impacts the overall well-being of those who suffer from its effects.

The negative influences of IP may also affect job performance and satisfaction (Hutchins, 2015). Individuals exhibiting symptoms of IP are prone to setting unachievable goals that result in failure, and may engage in thoughts related to low self-esteem and harsh self-criticism. In a vocational environment, these factors are likely to cause poor working conditions and subsequent burnout (Kets de Vries, 2005). In addition, due to anxiety and self-doubt, these individuals may not be achieving that which they are capable. When imposter feelings are intense, these individuals are more likely to turn down opportunities of advancement in their line of work, thereby undermining their potential to achieve and demonstrate success (Clance & O'Toole, 1988).

Imposter phenomenon may be a prevalent influence in the population of music therapy students. While research has identified the presence of IP in collegiate students and helping professionals, no study has yet examined its influence amongst students in the helping profession of music therapy. The current research study presents a theoretical framework which suggests that IP's formation in music therapy students is based on four main components: the prevalence of specific family dynamics (Clance & Imes, 1978), a transitional stage of life (Arnett, 2000; Lane, 2015;), and a population that includes high-achieving individuals (Clance & Imes, 1978) and is comprised of a high ratio of females (Clance & Imes, 1978). As the population under

study is residing in a transitional stage of life, may be considered "high-achieving" due to their being a helping profession, and is comprised of a female-dominated profession (American Music Therapy Association, 2012), it is hypothesized that individuals within this population may exhibit symptoms of IP.

Since the development of IP includes an array of psychological constructs that may negatively influence an individual, the guiding theoretical framework of this study suggests that the therapist effectiveness of music therapy students with IP may suffer. In order to be an effective therapist, one must possess a specific set of intrapersonal skills (Ott, 2016). However, a common feature of IP is lack of awareness of having developed imposter tendencies (Clance et al., 1995). This lack of self-awareness, which also affects the intrapersonal component of self-regulatory abilities, may negatively influence the effectiveness of the therapist (Ott, 2016). Job performance, satisfaction, and overall well-being can also suffer (Hutchins, 2015) and potentially influence future job burnout (Kets de Vries, 2005).

The influence of the constructs of IP and their subsequent impact on individuals, as well as the pervasiveness of IP in academic and high-achieving populations, serve as the basis for the present research study. This study seeks to explore the prevalence of imposter phenomenon in a phenomenological focus group, or groups, of collegiate music therapy students. The methodology will incorporate a design of interpretive phenomenological analysis (IPA) to explore if and how music therapy students experience imposter phenomenon. Music therapy students from an American Music Therapy Association (AMTA)-approved program at a large Midwestern university will be recruited, and subjects will partake in a one-time focus group. The number of focus groups will be dependent on the sample size recruited from the population

under study. The data collected from the focus group(s) will attempt to answer the following research questions:

1. What experiences have music therapy students had with imposter phenomenon? (e.g., effect on self-awareness, effect on therapist effectiveness)

2. What contexts/situations may have influenced their experiences with imposter phenomenon? (e.g., family dynamics, transitional stage of life, high-achieving characteristics, female-dominated profession)

The information gathered from the focus group(s) will be transcribed and inductively coded by the researcher. The themes identified from the transcriptions will serve to answer the research questions, as well as help to further develop the theoretical framework regarding the prevalence of IP in this distinct population.

Chapter 2: Review of Literature

The current study will attempt to create an understanding of and describe any imposter phenomenon (IP) experiences of music therapy students through an interpretive phenomenological analysis of data collected from focus groups. In order to corroborate the theoretical framework for IP in music therapy students, as well as answer the corresponding research questions, an understanding of the relevant literature is essential. The following will include an overview of the research regarding the manner in which IP may be measured, the populations who may be impacted, concurrent theoretical testing, and the proposed treatment methods that have developed over time. In addition, an examination of the education of student music therapists and a theoretical framework regarding therapist effectiveness will provide support for the proposed theoretical framework. An overview of phenomenology, including the types of phenomenological approaches, the techniques used to collect phenomenological data, analysis of phenomenological data, a description of interpretive phenomenology, and the relevant focus group literature, will provide a rationale for the methodological approaches that will be utilized for the current study

Imposter Phenomenon

Clance and Imes (1978) first identified IP when studying a sample of "high achieving women" (p. 241) who had earned Ph.D's, were respected professionals in their field of study, or were academically high-achieving students. Initially, Clance and Imes (1978) believed that IP was more likely to occur in women than in men because women have an internalized sense of incompetence as a societal stereotype. This seminal article identified many clinical symptoms of IP that included anxiety, low self-esteem, depression, and feelings of constant frustration. The authors also believed that family dynamics played a dominant force in the development of this

phenomenon. For instance, when growing up, a woman was either labeled as the "social" sibling who was constantly trying to prove she was intellectually accomplished, or she was defined as the "bright" child who believed that she was not able to live up to her family's standards no matter how hard she worked (Clance & Imes, 1978). As IP was further examined in research studies, many sought to create a tool to demonstrate its validity as a behavioral construct.

Measurements of IP. Since the identification of imposter phenomenon in 1978, several instruments of measurement have been created. These instruments were generated to provide procedures through which IP may be validated and assessed as a distinct construct. Though these tools have undergone explicit statistical examination to determine their appropriateness for research application, there does not appear to be a consensus as to which is the most valid and reliable. Validity assists in describing whether a tool of measurement adequately measures the construct for which it was designed (e.g., imposter phenomenon). Reliability determines whether a tool of measurement produces consistent results (Johnson & Christensen, 2014). The instruments developed for measuring IP have undergone examination for both reliability and validity. These instruments include the Harvey Imposter Phenomenon Scale (Harvey, 1981), the Perceived Fraudulence Scale (Kolligian & Sternberg, 1991) and the Clance Imposter Phenomenon Scale (Clance, 1985).

The Harvey Imposter Phenomenon Scale (HIPS, 1981) is a 14-item instrument in which participants answer how accurately statements apply to them using a 7-point Likert-type scale (Harvey, 1981). The psychometric properties of this scale have been examined in several studies and have produced varying alpha scores (i.e., strength of internal reliability)**.** Due to this variance, the appropriateness of this tool for measuring IP is uncertain. Edwards, Zeichner, Lawler, and Kowalski (1987) completed a factor analysis of the HIPS results of 104 post-

graduate students to explore the factor structure of the HIPS in addition to validating IP as a construct. The alpha score found for the full HIPS was equal to .341. However, the alpha scores for the three factors (imposter, unworthiness, and inadequacy) that contributed to 54.7% of the total variance, with eigenvalues > 1, produced alphas of .807, .706, and .650, respectively. Edwards et al. (1987) concluded that these results were tentatively promising in providing data regarding the validity of the HIPS. Hellman and Caselman (2004) disagree with this assessment. While their findings among a sample of 136 adolescents indicated an adequate internal consistency (alpha = .70), concerns were expressed due to content homogeneity for at least three items on the scale. Hellman and Caselman (2004) concluded that a great deal of caution should be exercised concerning the use of the HIPS.

Kolligian and Sternberg (1991) used the Perceived Fraudulence Scale (PFS) when examining perceived fraudulence and its corresponding personality traits in young adults. The authors chose to use the term "perceived fraudulence" instead of imposter phenomenon because they believed the term more precisely captured the overall meaning of the experience. This 51-item instrument prompts respondents to answer statements while utilizing a 7-point Likert-scale format. Kolligian and Sternberg (1991) compared the HIPS to the PFS, determining that while the two scales were highly correlated with one another (r = .83), the PFS had a significantly higher internal consistency (alpha = .95 as compared to .64).

The Clance Imposter Phenomenon Scale (CIPS, 1985) is a self-administered instrument that consists of 20 items that utilize a 5-point Likert-type scale for responses. The scale was created in response to the HIPS (Harvey, 1981). Not only does the CIPS assess dimensions of IP, but it also assumes to incorporate constructs not addressed in the HIPS such as fear of evaluation, feeling less capable than peers, and fear of inability to repeat success. In addition, the

wording of the CIPS is intended to minimize any possible effects of social desirability when answering the questions (Holmes et al., 1993). The reliability and validity of this instrument as an appropriate measure for IP has been studied extensively. When the CIPS was administered to a large sample of engineering college students (N = 1271), results concluded an internal consistency reliability of .92 (French, Ullrich-French, Follman, 2008). Chae, Piedmont, Estadt, and Wicks (1995) administered the test to a sample of 654 Korean men and women. Not only was the overall scale reliability significant (alpha = .84), but the results also indicated that IP does represent a valid construct when translated into another language, such as Korean. A translation of the CIPS into a German-language version further indicated significant results, as the alpha levels for two samples of study yielded .87, and .89 (Brauer & Wolf, 2016).

A comparison of the CIPS and the HIPS provided suggestions of cutoff scores for both tests and demonstrated that both had high internal consistency for a sample of 62 participants. The CIPS obtained a coefficient alpha of .96 while the HIPS obtained a coefficient alpha of .91. However, based on the results of an ANCOVA performed for between-group differences, results indicated that the CIPS might be the more sensitive and reliable instrument (Holmes et al., 1993).

Chrisman, Pieper, Clance, Holland, and Glickauf-Hughes (1995) compared the CIPS to the PFS. While the PFS had already been tested concurrently with the HIPS (Kolligian & Sternberg, 1991), these researchers believed the CIPS to be a more sensitive and reliable measurement with which to compare the PFS. After administering the two tests to groups of undergraduate students, the results indicated a high reliability for both tests. The PFS produced an alpha score equal to .94, while the CIPS produced an alpha score equal to .92. In addition, both measurements were significantly correlated with one another (r = .78, p ≤ .01). Chrisman et al. (1995) concluded that

while both scales were equally appropriate due to their internal-consistency reliability, they believed the CIPS to be more clinically appropriate due to its shorter length.

Overall, measurements of IP in individuals include the HIPS (Harvey, 1981), the PFS (Kolligian & Sternberg, 1991), and the CIPS (Clance, 1985). These instruments were created to better identify individuals who have IP characteristics, as well as determine the appropriateness of IP as a distinct construct. While the use of the HIPS has indicated validity, use of it as a reliable measurement is questionable due to a weak internal consistency of .64 (Kolligian & Sternberg, 1991). While the PFS and CIPS contain strong internal consistency alphas of .94 and .92 respectively (Chrisman et al., 1995), it is suggested that the CIPS is the more appropriate tool, due to specific wording meant to minimize effects of social desirability and being shorter in length (Chrisman et al., 1995; Holmes et al., 1993). The development of these different IP measurements has not only been vital in further supporting the validity of IP as a construct, but it has also provided a crucial means for testing the prevalence of IP in specific populations.

IP populations. The study of IP has not only incorporated the development of different tools of measurement, but has also peaked curiosity regarding the different populations in which it is most likely to reside. Notably, such populations include students of various educational levels including high school and colleges students (Caselman et al., 2006; Clance & Imes, 1978; Cromwell et al., 1990; Gibson-Beverly & Schwartz, 2008; King & Cooley, 1995; Lane, 2015; Peteet et al., 2015;), higher education faculty (Clark et al., 2014; Hutchins, 2015; Topping & Kimmel, 1985), and individuals within the helping professions (Arena & Page, 1992; Christensen et al., 2016; Henning et al., 1998; Oriel et al., 2004;)

Adolescence is a transformative period of development and insight during which a great deal of self-awareness and introspection must occur. As the transition from adolescence to

adulthood takes place, the formation of one's identity provides a crucial hallmark of change. It is believed that this change may bring out characteristics of imposter phenomenon (Lane, 2015). Cromwell et al. (1990) provided the first study to examine IP in an adolescent population. By assessing a sample of high school honors English students using the HIPS (Harvey, 1981), the Irrational Beliefs Test (Jones, 1968), and the Adjective Check List (Gough & Heilbrun, 1980), results indicated that not only is IP present in this population, but conclusions could also be drawn as to the personality profile of these IP individuals. Such personality constructs include being easily distracted, anxious, self-rejecting, dispirited, and inadequate interpersonal relationships.

Similar studies further corroborated the conclusions of Cromwell et al. (1990). Caselman et al. (2006) asked high school juniors and seniors to complete various questionnaires, of which included the HIPS. Results purported that IP exists in this population at a similar rate as adult populations. In addition, the support of close friends was concluded to be the most common way in which both male and female students avoided feelings of IP. Lane (2015) implemented a descriptive examination of "emerging adults" (p. 114) by providing one of the first qualitative analyses of imposter phenomenon. These "emerging adults," a new theoretical development group (Arnett, 2001), were between the ages of 18-25 and were either not enrolled in any sort of educational program, or were within one year of graduating from a program. Lane (2015) believed this age group to be at-risk for IP symptoms due to the transition from adolescent to professional adult life, and the indications that this transition can produce many symptoms of IP, including low self-efficacy. Coded results identified patterns of IP constructs, including perceived fraudulence, discrediting evidence of competence, and self-doubt.

College students are a population frequently studied for imposter phenomenon. A reasonable explanation for this may be due to the fact that IP was first identified in high-achieving women in different levels of collegiate study. Clance and Imes (1978) first noted the existence of imposter phenomenon after studying the behaviors of women in psychotherapy, interactional groups, and college classes. These women had earned Ph.D.'s, were respected professionals in their fields of specialty, or students who had been recognized for the high academic achievements. Clance and Imes believed the foundations for IP's development in this population of college-level students could be explained by family origins and social expectations.

Since Clance and Imes' seminal article (1978), IP's pervasiveness in other collegiate populations has been studied. King and Cooley (1995) used the Achievement Orientation Subscale (Moos & Moos, 1986), as well as the CIPS, to determine the role of family achievement orientation with IP among college students. Family achievement orientation is described as the act of a child's family conveying the importance of effortless intelligence and success (King & Cooley, 1995). Results indicated a direct relationship to higher IP scores and the amount of family emphasis placed on achievement while growing up. In addition, greater IP scores were associated with females than males, and for those with higher grade point averages.

Little research has been implemented that examines the prevalence of IP in ethnic minority students. A sample of Black and Hispanic undergraduate students were surveyed on measures of first-generation status (i.e., whether they were the first in their families to attend a collegiate institution), racial/ethnic identity, IP (using the CIPS), and psychological well-being (Peteet et al., 2015). Results determined that low psychological well-being and low ethnic identity were the best overall predictors of IP for this population.

A study of IP in female graduate students was implemented to examine possible predictors related to attachment theory and factors of entitlement (Gibson-Beverly & Schwartz, 2008). While the prevalence of IP amongst specific genders is unclear, a sample of female graduate students was utilized for this study due to the scarcity of literature on this specific population. Participants were asked to complete the CIPS, Entitlement Attitudes Scale, and Experiences in Close Relationships Scales-Revised. Results suggested positive correlations between anxious attachment, narcissistic expectations/self-promotion entitlement and IP, and negative correlations between self-reliance/self-assurance entitlement and IP.

Another population that has been examined for IP's prevalence includes university faculty members, as they may be considered a representative sample of high-achievers. In order to establish the integrity of IP as an individual construct, in addition to understanding the role of IP in higher education faculty, Topping and Kimmel (1985) administered the Harvey IP scale, along with seven other instruments to a sample of 285 university faculty members. These additional instruments included a Demographic Sheet, Self-Esteem Scale (Rosenberg, 1965), Self-Monitoring Scale (Snyder. 1972), and Attribution for Success Measures (Harvey, 1981). Results indicated that measures of faculty rank, self-esteem, and attributing of success to effort were negatively related to IP, and measures of self-monitoring behavior were positively related to IP. These findings were further corroborated in the study of Hutchins (2015), who provided a descriptive analysis of higher education faculty experiences. Hutchins (2015) also found a relationship with faculty rank and IP, based on results of administering the CIPS, as the sample of untenured faculty in this study suffered from higher levels of IP symptoms than tenured faculty. In addition, emotional exhaustion, a component of professional burnout, had a positive relationship to IP.

In accordance with studies examining university faculty, factors of age and career influencing the emergence of IP is seen among college and research librarians (Clark et al., 2014). A sample of 352 university librarians completed the Harvey IP scale. Reported results indicated that as the age of participants increased, the score for IP decreased. Additionally, librarians who were in their first three years of their career reported higher IP scores than their more experienced colleagues, and tenure-track librarians with three or less years of experience had higher IP scores than their non-tenure counterparts.

A helping profession is a vocation in which the sole purpose is to provide help to people (Canadian Oxford Dictionary, n.d.). Such professions can include counseling, nursing, doctors, creative arts therapy (e.g., art, music, play), social work, speech pathology, physical therapy, and occupational therapy (Himelein, 1999). The influence of imposter phenomenon as it relates to helping professionals has been extensively examined, and includes insight into the clinical nurse specialists (Arena & Page, 1992), medical, dental, nursing and pharmacy students (Christensen et al. 2016; Henning et al., 1998), and family medicine residents (Oriel et al., 2004).

Arena and Page (1992) provided one of the first examinations of imposter phenomenon in a helping profession. This descriptive study examined the multi-faceted roles of clinical nurse specialists (CNS) as contributing factors to feelings of IP, in addition to constantly addressing issues in patient care that arise outside of one's immediate bank of knowledge. Arena and Page argue that because CNS professionals engage in five different sub-roles of specialty (i.e., educator, consultant, researcher, clinician, and manager), feelings of low self-esteem and poor role implementation are likely. In addition, it is suggested that the longer a CNS professional resides in their career, the less likely they are to continue having imposter-related symptoms.

When examining medical, dental, nursing, and pharmacy students for perfectionism, imposter phenomenon, and psychological distress, multiple regression analyses suggested that IP was the overall best predictor of psychological distress (Henning et al., 1998). Measurement tools included the Brief Symptom Inventory, Multidimensional Perfectionism Scale, and Clance Imposter Phenomenon Scale. Using a cutoff score of 62 on the CIPS (Holmes et al. 1993), the study resulted in 30.2% of the sample as being in the clinical range for IP, with women earning higher scores than their male counterparts. Christensen et al. (2016) examined the extent of IP's presence in final year undergraduate nursing students, as the authors suggest the final year can lead to feelings of low self-esteem and anxiety related to transitioning from student to nurse. Using the Clance Imposter Phenomenon Scale, 45.1% of students tested as having moderate IP, 33.4% as having frequent IP, and 8.3% as experiencing intense IP.

The existence of IP in helping professions is further corroborated in the study of Oriel et al. (2004) who sought to determine its prevalence in family medicine residents. The survey instruments included the Clance Imposter Phenomenon Scale, State Anxiety Scale (Spielberger, 1983), Trait Anxiety Scale (Spielberger, 1983), and Rosenberg Self-esteem Scale (1989). Symptoms of IP correlated with depressive symptoms ($r^2 = .45$), Trait Anxiety ($r^2 = .65$), and low self-esteem ($r^2 = .63$). In addition, IP scores did not correlate directly with longevity in the field, contradicting suggestions made in Arena and Page (1992) and Clark et al. (2014).

Since its identification in 1978, the prevalence of the imposter phenomenon has been examined in many different populations. Much of this research focuses predominately on student populations, particularly high school students, undergraduate students, and graduate students (Caselman et al., 2006; Cromwell et al., 1990; Clance & Imes, 1978; Gibson-Beverly & Schwartz, 2008; King & Cooley, 1995; Lane, 2015; Peteet et al., 2015). Other researchers have

sought to identify IP in higher education faculty members (Hutchins, 2015; Topping & Kimmel, 1985) as well as college and research librarians (Clark et al., 2014). In addition, there is an emergence of studies regarding imposter symptoms in helping professions, mainly nurses in transitional roles and clinical nurse specialists (Arena & Page, 1992; Christensen et al., 2016; Henning et al., 1998; Himelein, 1999; Oriel et al., 2004). As the intricacies of IP's presence in specific populations becomes further understood, studies have also emerged which combine the testing of IP measurements and populations with other behavioral theories.

Theories tested concurrently with IP. The study of imposter phenomenon has prompted researchers to explore the different psychological constructs that IP individuals encompass. Not only does this allow a more in-depth understanding of the prevalence of this phenomenon, but it also allows for the suggestion of potential treatment methods. In order to further create an understanding of IP, researchers have tested its prevalence concurrently with other psychological theories related to personality. These include the NEO Personality Inventory (Costa & McCrae, 1992), the social interdependence theory of achievement (Johnson & Johnson, 1989), and achievement goal theory (Midgley et al., 1998; Nicholls, 1984).

The NEO Personality Inventory, or the "Big Five Personality Factors," is a measure of personality traits based on the Five-Factor Model (FFM). The five different dimensions of measurement include: Neuroticism (N) vs. Emotional Stability, Extraversion (E), Openness to Experience (O) or Intellect, Agreeableness (A) vs. Antagonism, and Conscientiousness (C) or Will to Achieve. By assessing traits using this personality measurement, a clinician may better understand a patient, establish therapeutic rapport, formulate an appropriate diagnosis, and anticipate and select an optimal course of treatment (Costa & McCrae, 1992).

Bernard et al., (2002) utilized the NEO-Personality Inventory-Revised (Costa & McCrae, 1992), the Clance Imposter Phenomenon Scale (Clance, 1985), and the Perceived Fraudulence Scale (Kolligian & Sternberg, 1991) to relate IP to the FFM in a sample of 190 college students. Results indicated high IP scores were positively related to the "Neuroticism" dimension, and negatively related to the "Conscientiousness" dimension, particularly, self-discipline (Bernard et al., 2002, p. 329-330).

Ross et al. (2001) investigated the relationship of IP to achievement dispositions and the FFM. The researchers built their framework of achievement dispositions based on Johnson and Johnson's (1989) social interdependence theory of achievement, which characterizes interpersonal achievement in terms of "competition and cooperation" (Ross et al., 2001, p. 1348). Individuals with cooperative tendencies exhibit more social acceptance, as well as a greater dynamic view of themselves and others, while those with competitive tendencies have less social development and socialization abilities. From this theoretical framework, the authors determined the need to use measurements including the Debilitating Anxiety Scale (Alpert & Haber, 1960), Hypercompetitive Attitude Scale (Ryckman, Hammer, Kaczor, & Gold, 1990), Personal Development Competition Scale (Ryckman, Hammer, Kaczor, & Gold, 1996), Cooperative Strategy Subscale (Simmons, Wehner, Tucker, & King, 1988), and the Self-Handicapping Scale (Rhodewalt, 1990), in addition to the HIPS and the FFM. As with Bernard et al.'s (2002) study, results suggested a positive relationship between IP and Neuroticism.

Achievement goal theory examines the specific goals that people create and their effects on different situations regarding achievement. Individuals in achievement contexts either focus on demonstrating competence or avoid demonstrating incompetence (Nicholls, 1984). Competence is defined differently for these individuals, subsequently impacting the goals that

they choose to adopt for these situations. Such goals include ability-approach, where individuals are motivated to outperform others, and ability-avoid, where individuals attempt to avoid failure (Midgley et al., 1998). Kumar and Jagacinksi (2006) studied the relationship between the imposter phenomenon and achievement goal theory using the Clance Imposter Phenomenon Scale, task, ability-approach, and ability-avoid scales, Dweck's (1999) measures of confidence in intelligence and theory of intelligence, and a test anxiety scale. The results suggested that any individual who exhibits high levels of IP and attempts to avoid failure (i.e., exhibits ability-avoid goals) is more likely to have anxiety related to testing and a lack of confidence in their abilities to succeed.

Many studies of IP implement a methodology that not only tests for the occurrence of IP in a specific population set, but also concurrently tests for the validity of implementing another theoretical framework. Such studies have incorporated the NEO Personality Inventory (Costa & McCrae, 1992), the social interdependence theory of achievement (Johnson & Johnson, 1989), and achievement goal theory (Midgley et al., 1998; Nicholls, 1984). The use of these additional measurements or frameworks allows researchers to further corroborate their findings of IP as a distinct construct, and further enhances knowledge of the supposed psychological outcomes of individuals with IP symptoms and potential treatment modalities.

Proposed treatment methods. Treatment for imposter phenomenon is a varied and untested component of imposter phenomenon. Many researchers include treatment suggestions as a facet of the discussion portion of their studies, instead of examining the efficacy of proposed treatment methods as the main focus of the study. Suggested treatment for imposter phenomenon includes cognitive behavioral strategies (Clance & O'Toole, 1988; Langford & Clance, 1993; Matthews & Clance, 1985), Gestalt techniques (Clance & Imes, 1978), rational-emotive therapy

(Matthews & Clance, 1985), group therapy (Clance & O'Toole, 1988; Matthews & Clance, 1985), feminist-oriented group therapy (Clance et al., 1995), journaling (Clance & Imes, 1978; Clance & O'Toole, 1988; Warrell, 2014) and expressive and relaxation exercises (Heinrich, 1997).

Many treatment methods for imposter phenomenon have centered around or been influenced by various psychotherapeutic techniques. Cognitive behavioral approaches, specifically those developed by Beck (1976), are suggested due to the proclivity for imposters to discount feedback when given, compare their abilities and successes with other individuals, and constantly live with feelings of self-doubt. Cognitive restructuring through this approach, in addition to asking concrete questions and developing client knowledge and awareness, can provide the client with the insight needed to alter these negative thinking patterns. It is important for the therapist to help the client identify patterns of negative thoughts and recognize cognitive distortions of which they may not be aware (Clance & O'Toole, 1988; Langford & Clance, 1993; Matthews & Clance, 1985).

In addition to cognitive behavioral techniques, Gestalt exercises are another recommended course of treatment. Clance and Imes (1978) suggest that individuals experiencing symptoms of IP work through a role-playing exercise in which they recall all the people they believe they have fooled. Once they develop this list, the individual must pretend to tell those people that they have been "conned," then verbally imagine how those people might respond to them. This can allow individual suffers of IP to gain a unique perspective regarding the pervasiveness of their symptoms. The authors also suggest that the IP sufferer record instances in which they receive positive feedback, and what they did to discount that feedback. By highlighting and being made aware of these instances, the imposter may not only be aware of a

pattern of discounting praises, but they may also experiment by practicing to react in an opposite manner.

In order to address the fear of failure construct of IP, therapy work may also focus on rational emotive interventions (Matthews & Clance, 1985). Rational-emotive therapy (RET) is a method of psychotherapy that addresses the belief system that triggers specific emotional thoughts and feelings that are attached to the outcome of a significant event. In other words, RET asserts that when a significant event occurs, the belief system that creates the effectual emotional response needs to be identified. By examining this belief system, one can work towards attaching different emotional responses to a significant occurrence (Ellis, 1989). RET can assist with the fear of failure construct by identifying the individual's belief system that causes them to feel like a failure (Matthews & Clance, 1985).

Group therapy for imposter phenomenon is one of the more consistently suggested techniques for effectively treating this construct. Researchers suggest that by allowing IP sufferers to share their thoughts, feelings, and experiences in a group-based setting, they may begin to feel less isolated in their experiences (Matthews & Clance, 1985). Groups can be particularly helpful in providing perspective as IP clients begin to realize that others share similar thoughts. This can be beneficial in starting the process in realizing the unreasonableness of the imposter viewpoint (Clance & O'Toole, 1988). As IP's roots lie historically in the experiences of high-achieving females, suggestions have been made as to the efficacy of feminist-oriented women's groups. Clance et al. (1995) outline three stages of a women's imposter group. In the first stage, participants explore their individual symptoms of IP as a way of recognizing and claiming the problem. Next, the group works to become a cohesive, supportive unit as they

recognize IP behaviors in themselves and their group members. Finally, the members continue their support as each works towards completing non-imposter related tasks.

Journaling the thoughts, feelings, and behaviors regarding IP may act as an assistive component to the psychotherapeutic techniques discussed. For instance, a component of Gestalt techniques asked clients to keep a record of positive feedback they receive, then identify how they reacted to that feedback and discuss how they rejected or discounted the comments (Clance & Imes, 1978; Clance & O'Toole, 1988). Another strategy asked clients to keep a running list of accomplishments. Such journaling strategies help develop insight so individuals can develop a complete self-awareness as to their actual capabilities (Warrell, 2014).

Heinrich (1997) developed an entire workshop curriculum dedicated to assisting nurses who are going through educational or workplace transitions and developing imposter symptoms. Entitled, "Heroes Are Impostors No More!" Heinrich's technique incorporates a combination of small group exercises, expressive interventions such as writing and drawing, and relaxation techniques. The six total exercises were grounded in the feminist writings of Kathleen Noble (1990), who, upon examining the male hero motif, encouraged women to create their own hero mythology. The six exercises include examining the individual's life story, naming the "adventure," identifying allies as well as "dragons" (e.g. challenges, obstacles), and focusing on the future by answering the question, "What is the next step on the path of your heroic journey?"

In summary, a variety of treatment methods have been suggested intermittently throughout the imposter phenomenon literature. Included are psychotherapeutic techniques such as cognitive behavioral strategies (Clance & O'Toole, 1988; Langford & Clance, 1993; Matthews & Clance, 1985), Gestalt practices (Clance & Imes, 1978), rational-emotive therapy (Matthews & Clance, 1985), group therapy (Clance & O'Toole, 1988; Matthews & Clance,

1985), and feminist-oriented group therapy (Clance et al., 1995). Other suggestions include journaling (Clance & Imes, 1978; Clance & O'Toole, 1988; Warrell, 2014) and expressive and relaxation exercises (Heinrich, 1997). These treatment methods have all been developed and implemented as a means of making an individual mindful of their imposter tendencies (Clance & Imes, 1978) and decreasing the various psychological symptoms of this phenomenon, including depression, anxiety, low self-esteem, introversion, and lack of self-confidence (Bernard et al., 2002; Chae et al., 1995; Clance & Imes, 1978; Clance & O'Toole, 1988; Cusack et al., 2013; Kolligian & Sternberg, 1991; Kumar & Jagacinski, 2006; Topping & Kimmel, 1985). While these strategies are suggested intermittently throughout the expanse of IP literature, it is notable that there are no studies that examine their efficacy as a proper treatment for IP.

Student Music Therapists

Student music therapists are a population which have yet to be examined for the prevalence of IP. This specific group of individuals includes of a unique combination of college level students and helping professionals, which are two populations who have been identified as comprising of individuals with high levels of IP symptoms (Arena & Page, 1992; Christensen et al., 2016; Gibson-Beverley & Schwartz, 2008; Henning et al., 1998; King & Cooley, 1995; Oriel et al., 2004; Peteet et al., 2015). In accordance, it may be possible that music therapy students also comprise of individuals with high levels of IP symptoms. One such reason for this may be due to the multi-faceted educational components of becoming a music therapist.

Education of student music therapists. The education of music therapy students is unique and rigorous due to its combination of musical and therapeutic elements. It is recommended that anyone interested in being a music therapist exude, or learn to exude, qualities of patience, empathy, openness to new ideas, flexibility, creativity, and understanding of oneself,

while also holding a background in music and a passion for helping others (AMTA, 2016). The overall music therapy curriculum for a bachelor's degree is comprised of five different areas of study, which were organized in accordance with the National Association for Schools of Music (NASM). Musical foundations account for 45% of the coursework and include music theory, composition and arranging, music history, applied lessons, ensemble performances, conducting, and lessons for piano, guitar, and voice. Clinical foundations for therapy account for 15% of the educational curriculum, and comprise of principles of therapy, the therapeutic relationship, human development, and exceptionality and psychopathology. Music therapy courses account for 15% of the curriculum and include, but are not limited to, foundations and principles, psychology of music, influence of music on behavior, and music therapy methods and techniques. General education and elective classes account for the remaining 25% of the course load for music therapy students. In addition to this multifaceted curriculum student music therapists are required to obtain up to 1200 clinical training hours through fieldwork experiences and internship (AMTA, 2016). After music therapy students have successfully completed these requirements, they may sit for their board-certification examination. This examination is required for the ethical practice of music therapy and certification must be maintained throughout the music therapist's entire career (CBMT, 2016).

Student music therapists must complete a multi-faceted curriculum that is comprised of five different areas of educational competency. Students are required to be both musicians and a therapists, and are challenged with the role of becoming competent in implementing therapeutic services based on a combination of these two professional fields. Based on the educational endeavors of student music therapists, in addition to being comprised of both a student and helping professional population, imposter phenomenon may reside within these individuals.

While there are many IP studies examining its prevalence in collegiate student populations (Gibson-Beverley & Schwartz, 2008; King & Cooley, 1995; Peteet et al., 2015;), as well as helping populations (Arena & Page, 1992; Christensen et al., 2016; Henning et al., 1998; Oriel et al., 2004), there are no studies that examine imposter phenomenon in a student music therapist population.

Therapist Effectiveness

People seek therapeutic services to receive some sort of help. By seeking out therapeutic assistance, individuals generally assume that the professional they are working with is educated, trustworthy, and possesses the ability to effect growth and change in behaviors. The effect of therapists on client outcomes is widely studied throughout the literature. It is suggested that to be an effective therapist, one must possess a set of internal qualities that include flexibility, perceptiveness, and achievement of consistent outcomes with reliable improvements in the clients (Kottler & Carlson, 2014; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011). Effective therapists must also exude qualities of empathy (Elliot, Bohart, Watson, & Greenberg, 2011) and work towards developing a strong and appropriate therapeutic alliance (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008). Effectiveness as a therapist may be determined not only on the therapist's personal qualities, but also on patient outcomes (Baldwin & Imel, 2013).

Therapist effectiveness is the most important factor in eliciting change in clients, even holding more importance than theory-based interventions (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Wampold & Brown, 2005). It has been noted that the therapeutic orientation of a therapist is not necessarily a deciding factor in determining the outcome of

treatment (Baldwin & Imel, 2013). In fact, eight percent of change observed in clients may be attributed to the effectiveness of the therapist (Kim, Wampold, & Bolt, 2006).

Ott (2016) attempts to identify the key qualities of an effective therapist by developing a theoretical framework that depicts the interplay between intrapersonal and interpersonal qualities. By explicitly outlining this interaction, conclusions are drawn for future clinical training and practice needs, and a description for the manner in which therapists interact with their clients.

According to Ott's (2016) theoretical framework, intrapersonal traits are those that lie implicitly within an individual and include self-awareness, ability to self-regulate, and selflessness (Brookins, 1984; Camirelli, 2001; Kraus et al., 2011; Vega, 2010). Self-awareness is described as the clear understanding that an individual has regarding his or her own personal strengths, weaknesses, emotions, and reactions (Merriam-Webster, n.d.). A therapist must have a high sense of self-awareness to develop not only great confidence in their clinical efficacy, but also understand their professional strengths and weaknesses (Ott, 2016). A component of self-awareness is the self-other distinction, a characteristic that allows a therapist to be aware of the emotions of the client, their own emotional response, and understand the distinction between the two (Coutinho, Silva, & Decety, 2014; de Waal, 2009).

The next component of therapist intrapersonal traits, self-regulation, includes both immediate and long-term strategies that support the maintenance of emotional homeostasis. By being aware of, and working to regulate one's emotions, an individual can be more sensitive and deliberate with client interactions, respond to daily stressors in a rational manner, and prevent against therapist burnout (Vega, 2010). Self-awareness and self-regulation work together to

streamline the coping processes of the therapist, which in turn allow the therapist to put more focus on the needs of the client.

The third component of intrapersonal traits offers suggestions regarding the selflessness of the therapist. Ott (2016) provides an explanation for this in the form of a functional, bell-curved spectrum, entitled the *Zone of Optimal Selflessness*. If a therapist is experiencing too little selflessness, their emotional homeostasis falls out of balance, which in turn decreases their effectiveness. If a therapist is experiencing too much selflessness, they may struggle with relating too much with their clients, which will impact the self-other distinction. This can cause stress and anxiety, therefore decreasing therapist effectiveness (de Waal, 2009; Kraus et al., 2011; Ott, 2016; Vega, 2010).

Interpersonal qualities are traits that individuals use to interact with the world around them. Within Ott's (2016) theoretical framework, interpersonal qualities of an effective therapist are comprised of three levels of empathy: emotional, cognitive, and empathetic concern. Emotional empathy is the instinctual, involuntary desire that humans have for fostering social connections and relationships. Contained within this level is the physiological reaction of mirror neurons. When an individual observes someone expressing an emotion, or emoting, mirror neurons will fire and allow the observing individual to literally feel the emotions of the other (Ott, 2016). Mirror neurons are advantageous in creating a sense of shared experiences between two people (Coutinho et al., 2014).

Cognitive empathy brings the subconscious feelings of emotional empathy to the forefront of one's consciousness. Herein lies another instance of the self-other distinction, as cognitive empathy requires one to be cognitively aware of another individual's emotions and the effect the other individual's emotions has on them. This is important in therapist effectiveness, as

it allows the therapist to validate the emotional responses of a client, while also creating a

necessary emotional separation (de Waal, 2009).

Empathetic concern requires an individual to not only utilize their emotional and

cognitive empathy skills, but also to fall within the *Zone of Optimal Selflessness* so that they may

view the situation rationally and appropriately adapt helping styles. It is through empathetic

concern that a therapist may feel their client's emotions and needs, cognitively understand their

client's emotions and needs, and provide a logical and appropriate helping style to best work

towards treatment of their client (Ott, 2016).

Based on Ott's (2016) theoretical framework, imposter phenomenon has a direct impact

on the intrapersonal aspects that affect therapist effectiveness, particularly the self-awareness and

self-regulation components. High self-awareness allows a therapist to have confidence in their

skills and abilities, in addition to understanding their clinical strengths and weaknesses. Self-

regulation allows a therapist to manage their emotions in the moment and long-term, which in-

turn assists in improving their overall well-being. However, individuals who suffer from

symptoms of IP generally exude characteristics which include low self-esteem (Ross &

Krukowski, 2003) and self-confidence (Clance & Imes, 1978), anxiety (Bernard et al., 2002;

Clance & Imes, 1978), self-handicapping (Ross et al., 2001) and self-monitoring tendencies

(Kolligian & Sternberg, 1991), low perceived competence (Bernard et al., 2002), frustration

(Clance & Imes, 1978), and fear of failure (Clance & O'Toole, 1988; Kumar & Jagacinski, 2006;

Ross et al., 2001). These symptoms of IP have a direct effect on self-awareness and self-

regulation, as individuals who experience IP are generally unaware of the development of these

symptoms due to not internalizing their accomplishments (Clance & Imes, 1978), and they

struggle with keeping these symptoms under control, as indicated by the fact they often overwork themselves into emotional exhaustion (Hutchins, 2015).

Therapist effectiveness in music therapy students. The effectiveness of a therapist is an important component to building a therapeutic alliance and eliciting goal-directed outcomes in patients (Baldwin & Imel, 2013; Dinger et al., 2008). Ott's (2016) theoretical framework provides an explicit description of the intrapersonal and interpersonal qualities that a therapist should work towards, being aware of and refining, as part of their clinical foundations. For music therapists and music therapy students, such qualities are not explicitly addressed in the curriculum requirements set forth by the American Music Therapy Association.

According to AMTA (2016), an individual who wants to practice music therapy should possess such personal qualities including a desire to empower others, empathy, creativity, and an understanding of oneself. Additionally, music therapists are required to adhere to specified Standards of Practice (AMTA, 2013), a Code of Ethics (AMTA, 2014), and Professional Competencies (AMTA, 2013). The Professional Competencies of a music therapist outlines the requirements for Clinical Foundations, which include: Therapeutic Applications, Therapeutic Principles, and The Therapeutic Relationship. While these competencies describe necessary qualities of a professional music therapist (e.g., "Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship," and "Establish and maintain interpersonal relationships with clients and team members that are appropriate and conducive to therapy"), there is not an explicit outline of the qualities of an effective therapist.

IP Impact on Therapist Effectiveness

Imposter phenomenon presents a range of constructs that impact an individual's quality of life. Such constructs include depression, low self-esteem, anxiety, introversion, and fear of

failure (Clance & Imes, 1978; Clance & O'Toole, 1988; Kumar & Jagacinski, 2006; Ross & Krukowski, 2003). If an individual is experiencing symptoms of IP, they do not internalize or enjoy their successes, they set unattainable goals which they fail to meet, they have a skewed definition of intelligence, and they constantly compare their abilities to those of others. These factors negatively impact an individual's overall well-being, a defining trait among therapists that significantly relates to the outcome of clients (Beutler et al., 2004).

If music therapy students are identified as experiencing symptoms related to imposter phenomenon, it may be directly assumed that their therapeutic effectiveness, a skill that they are in the process of learning and refining, is at risk. Music therapy students must go through a rigorous training program that includes academic elements of both being a musician and a therapist. In accordance with the National Association of Music Schools (NASM), the coursework of a music therapy student includes nine musical foundations courses, at least four courses dedicated to clinical foundations, and at least eight courses dedicated to music therapy practices and techniques (AMTA, 2016). With this rigorous combination of courses, in addition to these students being in a transitional stage of life (Lane, 2015), it may be assumed that imposter phenomenon is present among music therapy students, thereby impacting their current and future therapeutic effectiveness

Theoretical framework of IP development in music therapy students. Based on a review of the literature, a working theoretical framework for imposter phenomenon has emerged (Figure 1). This framework attempts to describe the general development of IP, if and how IP relates to music therapy students, and the manner in which IP negatively impacts therapist effectiveness of those who develop it. This framework serves not only to organize and synthesize information regarding IP, but it also provides a foundation from which to explore the existence

of IP in music therapy students through a phenomenological focus group(s). The discussion

prompts for the focus group(s) will be derived directly from this framework, and the information

gleaned from the discussions will serve to both corroborate and further inform different and new

aspects of the framework.
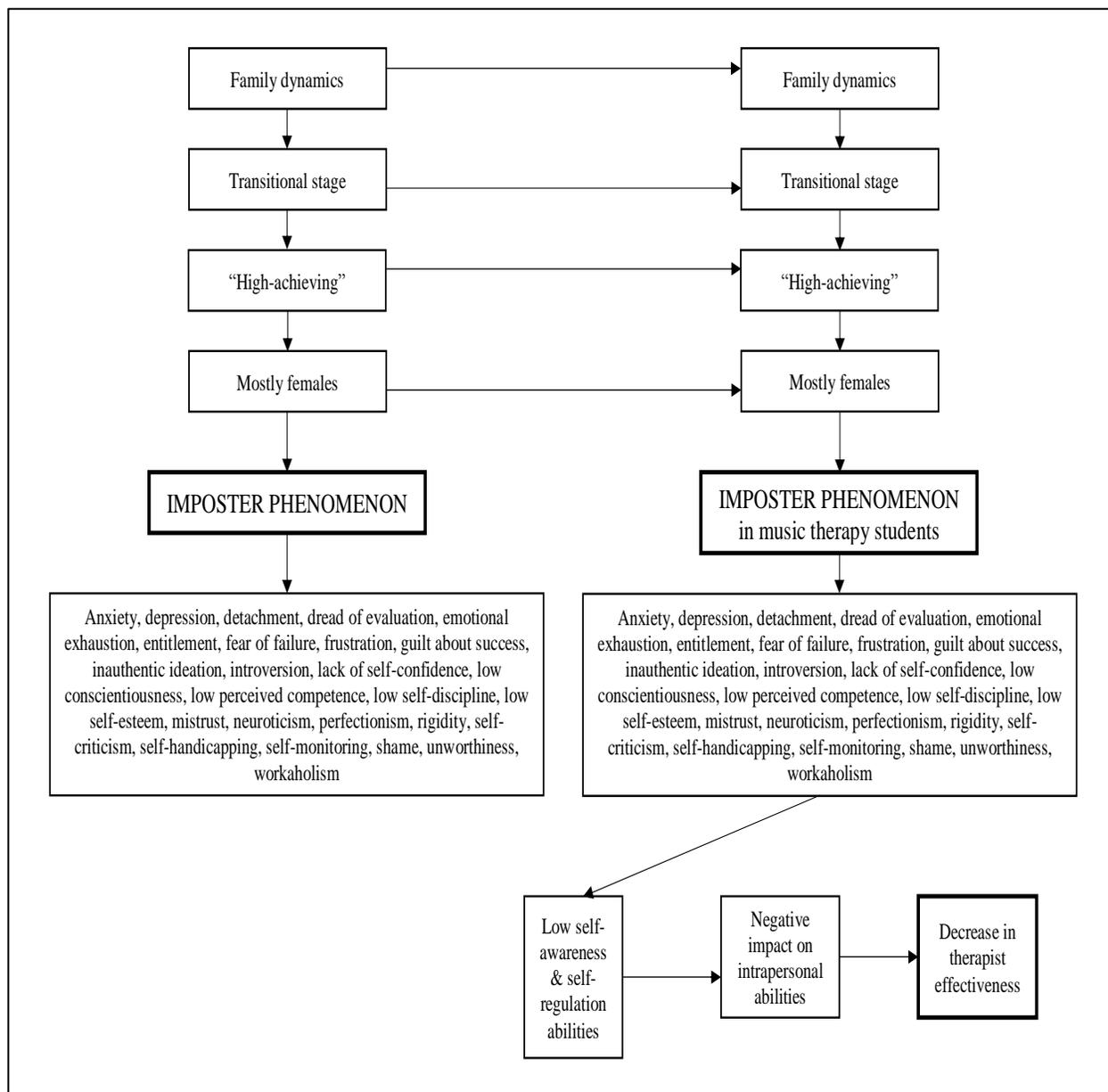
Figure 1: Theoretical Framework of IP Development in Music Therapy Students

The development of imposter phenomenon is comprised of four main components: family dynamics (Clance & Imes, 1978), a transitional stage of life (Arnett, 2000; Lane, 2015), high achieving individuals (Clance & Imes, 1978), and a profession comprised of mostly females (Clance & Imes, 1978). An individual may develop IP due to one of two different family dynamics: either s/he is labeled as the "bright" child of the family, or as the "sensitive" one while another child is labeled as "bright." Those individuals who are labeled as "bright" are told throughout their upbringing that they are smart, talented, and can do anything to which they put their minds. It is insisted that their accomplishments come naturally to them and that they do not have to work hard to be successful. However, this child has experiences in which they have difficulties with some achievements, and that in order to succeed, they have to work and study hard. Due to these struggles and an inability to achieve with ease, this child feels inadequate and concludes s/he is an intellectual imposter. In contrast, the child who is labeled as "sensitive" may work hard to prove themselves to their family by working hard to succeed and achieve academic honors. However, this hard work is overshadowed by the other "bright" sibling in such a way that the "sensitive" child begins to doubt their intellect. They attribute their successes to luck and personal charm, thus allowing the imposter phenomenon to emerge (Clance & Imes, 1978, p. 242-243).

IP may also develop in individuals who are currently residing in a transitional stage of life. The college years can be a time of transition and change for individuals. During this time, individuals are challenged academically, facing different social situations, dealing with personal growth and change, and even adjusting to new residence. This specific age group, ranging around 18 to 25 years of age, is classified as emerging adulthood (Arnett, 2001). As a theory of development, this group resides in a transitional stage of life (Lane, 2015), during which

individuals do not identify independently as either adolescents or adults. Emerging adults are still in the process of forming their identities. While the process of identity formation normally resides in adolescence, it has also been suggested that the developmental stage of adolescence is prolonged in industrialized societies, which corroborates the notion of an emerging adulthood for individuals aging around 18 to 25 years of age (Erikson, 1950, 1968). During this transitional period, as transitions are developing for college roles and/or professional roles, and roles are not clearly defined, tension may occur (Murphy, Bluestein, Bohlig, & Platt, 2010). This tension can bring about feelings of low self-efficacy and turmoil, both of which are directly related to symptoms of imposter phenomenon (Polach, 2004).

Individuals who are considered "high-achieving" serve as the foundation for many IP studies. "High-achieving" samples include students of high school and college level educations (Cromwell et al., 1990; Gibson-Beverly & Schwartz, 2008; King & Cooley, 1995; Peteet et al., 2015), collegiate faculty members (Clark et al., 2014; Hutchins, 2015; Topping & Kimmel, 1985), and helping professionals (Arena & Page, 1992; Christensen et al., 2016; Henning et al., 1998; Oriel et al., 2004). While "high-achieving" has no formal definition, various studies have attempted to set certain parameters on their samples. A grade point average (GPA) of 3.0 has been used to provide a cut-off for study participation involving students (Holmes et al., 1993; Peteet et al., 2015). Other studies of IP in students have not included a GPA cut-off. Instead, these scores were collected in order to examine any correlations between IP and GPA (King & Cooley, 1995; Gibson-Beverly & Schwartz, 2008). For the purposes of the following study, "high-achieving" individuals will be defined as those who are students, collegiate faculty members, and/or are involved in the helping professions. GPA will serve as an informational tool, rather than a cut-off for participation.

Another important aspect regarding the development of IP is gender. The initial examination of IP developed due to its apparent occurrence among women who were considered highly successful in their field of work (Clance & Imes, 1978). In addition to family dynamics, assertions were made for the role of societal stereotypes of women as a decisive factor in the development of IP. Many proceeding studies have attempted to further corroborate this claim, with mixed results. While there is evidence to imply a lack of gender differences for individuals with IP (Bernard et al., 2002; Caselman, et al., 2006; Clark et al., 2014), there is also evidence to support Clance and Imes's (1978) seminal research findings of IP's presence amongst women (Cusack et al., 2013; King & Cooley, 1995; Kumar & Jagacinski, 2006; Li, Hughes, & Thu, 2014; McGregor, Gee, & Posey, 2008).

Once IP develops in an individual, due to a combination of family dynamics, being in a transitional stage of life, belonging to a high-achieving population, and the possible attribute of gender roles, the resulting psychological effects are abundant and varied. The following table provides a comprehensive overview of the negative effects of IP, as well as the research articles from which they are derived. The citations are incorporated to indicate the pervasiveness of each construct within the research literature of IP.

Table 1

Psychological Constructs Related to the Development of IP

Construct	Citations
Anxiety	Bernard, Dollinger, & Ramaniah, 2002; Clance & Imes, 1978; Clance & O'Toole, 1988; Cusack, Hughes, & Nuhu, 2013; Kolligian & Sternberg, 1991; Kumar & Jagacinski, 2006; Topping & Kimmel, 1985
Depression	Bernard, Dollinger, & Ramaniah, 2002; Clance & Imes, 1978; Kolligian & Sternberg, 1991
Detachment	Ross & Krukowski, 2003

Dread of evaluation	Clance & O'Toole, 1988
Emotional exhaustion	Hutchins, 2015
Entitlement	Ross & Krukowski, 2003
Fear of failure	Clance & O'Toole, 1988; Kumar & Jagacinski, 2006; Ross, Stewart, Mugge, & Fultz, 2001
Frustration	Clance & Imes, 1978
Guilt about success	Clance & O'Toole, 1988
Inauthentic ideation	Kolligian & Sternberg, 1991
Introversion	Chae, Piedmont, Estadt, & Wicks, 1995; Clance & O'Toole, 1988; Langford & Clance, 1993
Lack of self-confidence	Clance & Imes, 1978
Low conscientiousness	Bernard, Dollinger, & Ramaniah, 2002; Chae, Piedmont, Estadt, & Wicks, 1995
Low perceived competence	Bernard, Dollinger, & Ramaniah, 2002
Low self-discipline	Bernard, Dollinger, & Ramaniah, 2002
Low self-esteem	Ross & Krukowski, 2003
Mistrust	Ross & Krukowski, 2003
Neuroticism	Bernard, Dollinger, & Ramaniah, 2002; Chae, Piedmont, Estadt, & Wicks, 1995; Ross, Stewart, Mugge, & Fultz, 2001
Perfectionism	Cusack, Hughes, & Nuhu, 2013
Rigidity	Clance & O'Toole, 1988
Self-criticism	Kolligian & Sternberg, 1991
Self-handicapping	Ross, Stewart, Mugge, & Fultz, 2001
Self-monitoring	Kolligian & Sternberg, 1991
Shame	Langford & Clance, 1993
Unworthiness	Langford & Clance, 1993
Workaholism	Ross & Krukowski, 2003

Based on these constructs, it may be generalized that the occurrence of IP in an individual can have an array of negative consequences. As per the theoretical framework, the occurrence of these constructs may negatively influence an individual's self-awareness and self-regulation. According to Ott (2016), self-awareness and self-regulation are core intrapersonal components which must be present to ensure the effectiveness of a therapist. While self-awareness allows a therapist to be constantly mindful of their skills and abilities (Merriam-Webster, n.d.) thus ensuring confidence and awareness of client reactions (Kraus et al., 2011), self-regulation

encourages a therapist to properly manage their present and long-term emotions, thus assuring a positive overall sense of well-being (Ott, 2016). However, the presence of IP and its many psychological constructs may negatively influence the adequate development of therapist self-awareness and self-regulation, thereby inhibiting overall therapist effectiveness in music therapy students.

Phenomenology

To reduce the potential impact of IP on music therapist effectiveness, it must first be determined if the phenomenon exists in music therapy students. The following research study will implement a phenomenological method of design. A phenomenon is a thing which appears, or which is perceived or observed (Oxford English Dictionary, n.d.), and is not bounded by space or time (Ravitch & Carl, 2016). Phenomenological research seeks to learn about and describe the commonality of a group of individual's lived experiences regarding a certain phenomenon (Creswell, 2013; Ravitch & Carl, 2016; Starks & Trinidad, 2007). Phenomenology is both a qualitative methodology and a philosophical principle.

The founding principle of phenomenology can be traced back to the writings of German mathematician Edmund Husserl, who argued for the importance of knowing and being aware of one's own subjective experience of a phenomenon (Smith, Flowers, & Larkin, 2009). By doing so, a better understanding of the phenomenon could present itself. Accordingly, Stewart and Mickunas (1990) outlined four philosophical perspectives on phenomenology: (a) phenomenology implementation is meant to provide a return to the traditional roots of Greek philosophy, whereas there is less emphasis on empirical science and more emphasis on the search for wisdom; (b) phenomenology is meant to be implemented free of presuppositions, until a clear and certain explanation emerges, also called the practice of "epoche;" (c) phenomenology

is based on the perspective of the intentionality of consciousness, or the notion that the reality of an object, or phenomenon, is explicitly linked to one's own subjective perspective of it; and (d) this reality may only be perceived based on an individual's subjective experience (Creswell, 2014, p. 77-78).

Phenomenological research aims to collect data from groups of individuals through one or more interview meetings. These interviews are analyzed to determine the subjective lived experiences of these individuals, and to explain the objective and universal qualities they share as a group. In addition, these interviews comprise of open-ended questions that derive from inquiries regarding the phenomenon in study (Cosgrove & McHugh, 2008; Smith et al., 2009).

Traditionally, phenomenological research places emphasis on "bracketing," in which the researcher must describe their own personal experiences with the phenomenon to distance themselves from the analysis of the data. "Bracketing," or phenomenological reduction, allows the researcher to set aside their everyday assumptions and biases so that they may focus explicitly on the phenomenon as it is experienced by the sample participants (Bradbury-Jones, Sambrook, & Irvine, 2009; Cosgrove & McHugh, 2008; Creswell, 2013; Ravitch & Carl, 2016). This practice, however, is not always implemented, as there are arguments that it is impossible for a researcher to fully bracket oneself out of their work (Bradbury-Jones et al., 2009).

Types of phenomenological approaches. The argument for or against the practice of phenomenological reduction depends on the type of phenomenological research being implemented. Descriptive, or transcendental, phenomenology reflects back to this method's original philosophical aims of searching for wisdom and remaining free of presuppositions (Moustakas, 1994). Descriptive phenomenology allows the lived experiences of the participants to shine through, with no interpretation by the researcher. Textual (i.e., what is experienced) and

structural (i.e., how the phenomenon is experienced) descriptions are implemented as a means of conveying the essence of the phenomenon (Moustakas, 1994).

Interpretive, or hermeneutic, phenomenological approach (IPA) places less emphasis on what is explicitly stated by participants, and focuses more on understanding and interpreting what is reported (van Manen, 1990). This method supposes that it is difficult, if not impossible, for a researcher to fully remove their biases and presuppositions when collecting and analyzing data (Creswell, 2013; Smith et al., 2009). It asserts that to be interpretive is to be human, and that understanding is a reciprocal activity (Bradbury-Jones et al., 2009). In order to truly understand the experiences of research participants, the researcher must interpret what is reported.

Collection of phenomenological data. Traditional phenomenological research relies on collecting individual interviews from research participants (Creswell, 2013; Smith et al. 2009; Starks & Trinidad, 2007). These accounts can provide explicit understandings of how people experience a specific phenomenon due to easy management, allowing for rapport development between interviewer and interviewee, and providing participants the space and time to think through responses (Smith et al., 2009). Participants may be interviewed one time or on multiple occasions, and sample sizes may range from one to 25 subjects (Creswell, 2013; Stark & Trinidad, 2007). Data collection may also derive from other individual means including journals, observations, poetry, music, and questionnaires (Creswell, 2013; Smith et al., 2009; Starks & Trinidad, 2007).

More recently, phenomenological research has incorporated focus groups as a means of collecting data regarding participant's lived experiences. These focus groups may provide a more complex and interactional viewpoint of the experiential nature of a phenomenon (Palmer, Larkin, de Visser, & Fadden, 2010) due to the verbal exchanges between participants. In addition, these

exchanges can elicit and enrich the discussion content, as well as bring to light viewpoints which may not have occurred with one-on-one interviews. This method of data collection can also allow for the compilation of larger data samples within smaller data collection events (Smith et al., 2009). However, phenomenological researchers advise to approach these focus groups with caution, as this method directly contrasts with Husserl's original approach of objectively describing lived experiences of a phenomenon through the compilation of individual accounts.

Analysis of phenomenological data. Overall, phenomenological data analysis is general, non-specific, non-linear, and follows the basics of qualitative research analysis (Creswell, 2014; Crist & Tanner, 2003). There is no specifically prescribed method for examining this data, though many researchers have outlined and shared their own personal means for interpreting phenomenological studies (Colaizzi, 1978; Giorgi, 1985; Moustakas, 1994; Smith et al., 2009; van Kaam, 1966). Phillips-Pula, Strunk, and Pickler (2011) examined the analysis methods of different researchers in an attempt to describe and organize the similarities and differences in how phenomenological data may be interpreted.

In general, phenomenological data analysis is contrived following a basic qualitative model. Creswell (2014, p. 197-200) offers six steps to approaching qualitative data:

1. Prepare the data for analysis by organizing, transcribing, and scanning materials.

2. Read through all the data so that a general sense of the information may be formed. Begin to write notes in the margins regarding initial thoughts and ideas.

3. Code the data.

4. Generate themes, or categories, using the codes collected. Attempt to identify thematic patterns across the different cases of data, or create a theoretical model.

5. Organize the findings in a qualitative narrative. This organization can also incorporate the use of visual models.

6. Interpret the results.

    Smith et al. (2009) draw upon elements of qualitative data analysis to provide a process for phenomenology. Based on the theoretical perspective of IPA, the authors outline a six-step procedure that is meant to provide a flexible, heuristic framework from which to complete phenomenological data analysis (Smith et al., 2009, p. 82-107). The outline is based on the collection of data through individual, recorded interviews.

1. Begin by reading the data several times to familiarize oneself with the transcript. One of the readings should occur concurrently with the audio recording. In addition, the researcher should write down any powerful recollections or initial observations in a notebook before reading.

2. Read through the transcript and note anything of interest in the margins. There are no rules as to what is noted. Comments may be descriptive, linguistic, and/or conceptual. A hard copy of the data is suggested, with wide margins for notes.

3. Go through the previous notes and map out patterns and interrelationships. Write emergent themes (i.e., codes) in another separate margin.

4. Review through the emergent themes and search for connections and patterns. Come up with a way in which they may be organized. Organizational techniques include: abstraction, subsumption, polarization, contextualization, numeration, and function. Consider creating a graphic representation of the themes.

5. Repeat steps 1-4 for the next case (i.e., interview transcript). Treat each individual case in its own right and allow new themes to emerge, if necessary.

6. Look for overarching patterns across cases, and reconfigure/relabel themes as necessary. Create a table which represents these thematic connections, and include quotes from transcripts for corroboration.

Interpretive phenomenology in studies of healthcare and music therapy. IPA has been widely incorporated throughout healthcare and music therapy-related research literature. These studies attempt to examine a specific phenomenon in their field by utilizing individual interviews, focus groups, or a combination of the two. This approach allows for the discovery of specific themes so that the phenomenon under study may be better understood. Suggestions regarding treatment approaches, client experiences, and professional well-being are included based on the derived themes. Additionally, these studies implement purposive sampling techniques which allow a homogenous sample of participants who can provide rich and detailed descriptions of the phenomenon under study.

The following tables provides graphic representations of examples of healthcare (Table 2) and music therapy (Table 3) research studies that implement IPA as the guiding methodological approach. The tables present the explicit phenomenon examined, the sampling techniques utilized, the data collection methods, and the themes derived from analysis of the data.

Table 1

IPA in Healthcare Studies

Researchers, Publication Year	Phenomenon Examined	Sampling Technique	Data Collection Method	Themes Derived
Coyne, Rands, Gurung, Kellett, 2016	Nursing graduates transitional experience from	Purposive sampling	Focus groups, open-ended	1. Unsure of expectations 2. Understanding responsibilities 3. Facing challenges of new role

	university to facility			
Hosseini, Davidson, Khoshknab, & Nasrabadi, 2015	Spiritual care experiences in a cardiac rehabilitation team	Purposive sampling, snowball method	Focus groups (discussion structure not specified) and individual interviews, semi-structured	1. Helping patients maintain sense of being 2. Providing care with religious/spiritual focus 3. Providing rehabilitation with a holistic approach 4. Acknowledging spirituality as a neglected aspect of rehabilitation
Lamb & Cogan, 2016	Stress in mental health workers	Not specified	Focus groups	1. Perceived lack of control 2. Ways of building resilience 3. Dual impact of values 4. Effect of environment

Table 2

IPA in Music Therapy Studies

Researchers, Publication Year	Phenomenon Examined	Sampling Technique	Data Collection Method	Themes Derived
Ghetti, 2011	Dual-certified music therapists/child life specialists	Purposive sampling	Individual interviews, semi-structured	1. Theoretical framing for child-life training 2. Influence of previous music therapy training on current clinical practice 3. Outcomes of child life training and certification 4. Nature of role 5. Music therapy-specific roles 6. Child life-specific roles 7. Shared roles 8. Role conflict 9. Advanced competency areas in pediatric medical music therapy
Gilboa,	"Musical	Purposive	Focus group	Focus group themes:

Zilberberg, & Lavi, 2011	personality" of the piano, as discussed by music therapists	sampling (Homogeneous sampling)	(discussion structure not specified) & open-ended questionnaire	1. The piano is about intimacy/authenticity 2. The piano is a container 3. The piano provides expression 4. The piano is intimidating 5. The piano is related to self-criticism 6. The piano is related to confidence and non-confidence Questionnaire themes: 1. The piano enables an intimate relationship 2. The piano provides a reflection of myself 3. The piano provides a sense of security 4. The piano enables expression 5. The piano encourages range and depth 6. The piano enables intimidation and self-criticism 7. The piano encourages feelings of ambivalence
Lindenfelser, Grocke, & McFerran, 2008	Music therapy experiences of bereaved parents with terminally ill children	Purposive sampling (criterion case)	Individual interviews, semi-structured	1. Music therapy was valued due to altering perception of situation in midst of adversity 2. Music therapy provided remembrance 3. Music therapy experience was multifaceted for parents and children 4. Music therapy enhanced both communication and emotional expression 5. Parents shared perceptions and recommendations for music therapy service

				improvement
Masko, 2016	Chaplain and music therapist-identified ethics issues regarding spiritual care in end-of-life	Purposive sampling	Individual interviews, semi-structured	1. Scope of practice 2. Cultural competence 3. Maintaining personal boundaries 4. Spiritual care training
Pothoulaki, MacDonald, & Flowers, 2012	Psychological processes of music therapy patients receiving improvisational music therapy	Convenience sampling	Individual interviews, semi-structured	1. Playing the instruments 2. Group interaction/dynamics 3. Self-confidence 4. Relaxation 5. Stress relief 6. Importance of the group 7. Positive feelings related to the musical experience 8. Strong bond related to similar illnesses 9. Communication through music

Focus Groups

Focus groups are a qualitative method of data collection that allow the researcher to develop insight about a specific topic based on the social interactions between participants. This method can provide a platform for experiences, attitudes, and opinions to surface that may not have been apparent in individual interviews. This can provide insight into the complexities of behaviors and motivations surrounding a topic as participants share and comment in relation to each other's thoughts and responses. Focus groups also allow for the procurement of large, concentrated amounts of data in a short span of time (Morgan, 1997; Ravitch & Carl, 2016).

While focus groups are a unique and effective means to collect data, there are potential weaknesses associated with implementing this method. Although this method allows for large sums of data to be collected, the setting is considered to be less naturalistic, as the participants

are led through a discussion based on questions and prompts provided by the researcher. In addition, it is important to consider the manner in which certain individuals may react in a group setting. Participants may conform to what others are saying despite having a differing viewpoint. Conversely, members may polarize the conversation and present a sharply contrasting viewpoint, which can lead other members to feel uncomfortable and unwilling to share their experiences. (Morgan, 1997).

For the purposes of the current study, the transcripts derived from the focus groups will be inductively coded. While the guiding theoretical framework for the development of IP in music therapy students might prompt a deductive analysis, an inductive approach will be utilized to allow other recurrent themes to emerge. These themes will work to support, and alter as needed, the guiding theoretical framework of this study, as the discussion prompts will be developed from the framework. Additionally, the implementation of focus groups with potential IP individuals may serve a secondary, and therapeutic, purpose, as a group setting can help individuals feel less isolated and alone in regards to their IP-related symptoms (Matthews & Clance, 1985).

The following study will examine the potential prevalence of imposter phenomenon in a sample of music therapy students at a large Midwestern university. Data will be collected through the implementation of one-time focus group(s), and will be coded and analyzed in accordance with interpretive phenomenological practices. An understanding of IP, its measurements, the populations in which it resides, concurrently tested theories, and proposed treatment methods is essential for accurate methodological implementation, as well as a comprehension of the education of music therapy students, the literature regarding therapist effectiveness, and an understanding of interpretive phenomenology and focus groups. A

theoretical framework for the development of IP in music therapy students (Figure 1) has been

developed based on the purpose of the study and the relevant literature. The following research

questions have been derived from this framework, and will be incorporated in to the discussion

prompts for the focus group(s):

1. What experiences have music therapy students had with imposter phenomenon?

   (e.g., effect on self-awareness, effect on therapist effectiveness)

2. What contexts/situations may have influenced their experiences with imposter

   phenomenon? (e.g., family dynamics, transitional stage of life, high-achieving

   characteristics, female-dominated profession)

Chapter 3: Methods

Theoretical Framework

The methodology for this study incorporated an interpretive phenomenological approach (IPA). IPA derives from the practice of phenomenological research, which seeks to provide an objective description of how individuals experience a phenomenon. IPA deviates from this original foundation in such a manner that the data are both objectively examined and subjectively interpreted by the researcher. Studies that implement IPA as a framework reside under the notion that it is impossible for the researcher to fully extricate, or bracket, oneself when analyzing phenomenological data. In addition, the researcher must include an explanation of any preconceptions and biases they may have regarding the phenomenon, and explicitly discuss how these may influence the research (Ghetti, 2011).

Traditional phenomenological research consists of multiple individual interviews to create an objective portrayal of a phenomenon. However, Bradbury-Jones et al., (2009) question the importance of one-on-one interviews, and suggest that focus group implementation can be just as useful, if not more so, in collecting thorough and dense data. These authors believe the social interaction that occurs between focus group subjects may be beneficial in enriching the data set, as those involved may hear each other's ideas and be reminded of their own thoughts on the subject matter. The following study collected data using one or more focus groups.

Focus Groups

Focus groups allow for social interactions to occur based on a specific topic determined by the researcher and the research questions. These interactions, guided by discussion prompts, provided the data by which to examine the experiences of imposter phenomenon in collegiate music therapy students. In addition, these interactions may have been somewhat therapeutic in

nature, as subjects were able to interact with other individuals who act, feel, and think in a similar manner. These social connections are an important component in proposed treatment methods for IP (Clance et al., 1995).

The level of focus group moderator involvement may vary, depending on the research approach of the study. Less structured groups are implemented when the research design is of an exploratory nature. This allows the subjects to discuss what is of interest to them and minimizes moderator involvement. However, focus groups with less structure regarding discussion topics are difficult to analyze and compare from group to group. Focus groups with more structure and moderator involvement are advantageous when there is a strong and preexisting agenda for the research topic. These groups are easier to analyze and compare, and allow the discussion to focus only on the topic at hand, as opposed to extraneous issues. However, these more structured groups are likely to produce limited data sets (Morgan, 1997).

The current study collected data based on a semi-structured approach to group discussions. The discussion topics (Appendix A) were explicitly outlined, with suggestions for prompting questions. The topics were derived from the Clance Imposter Phenomenon Survey (CIPS; Clance, 1985) and the guiding theoretical framework of this study (Figure 1).

Figure 1- Theoretical Framework for the Development of IP in Music Therapy Students
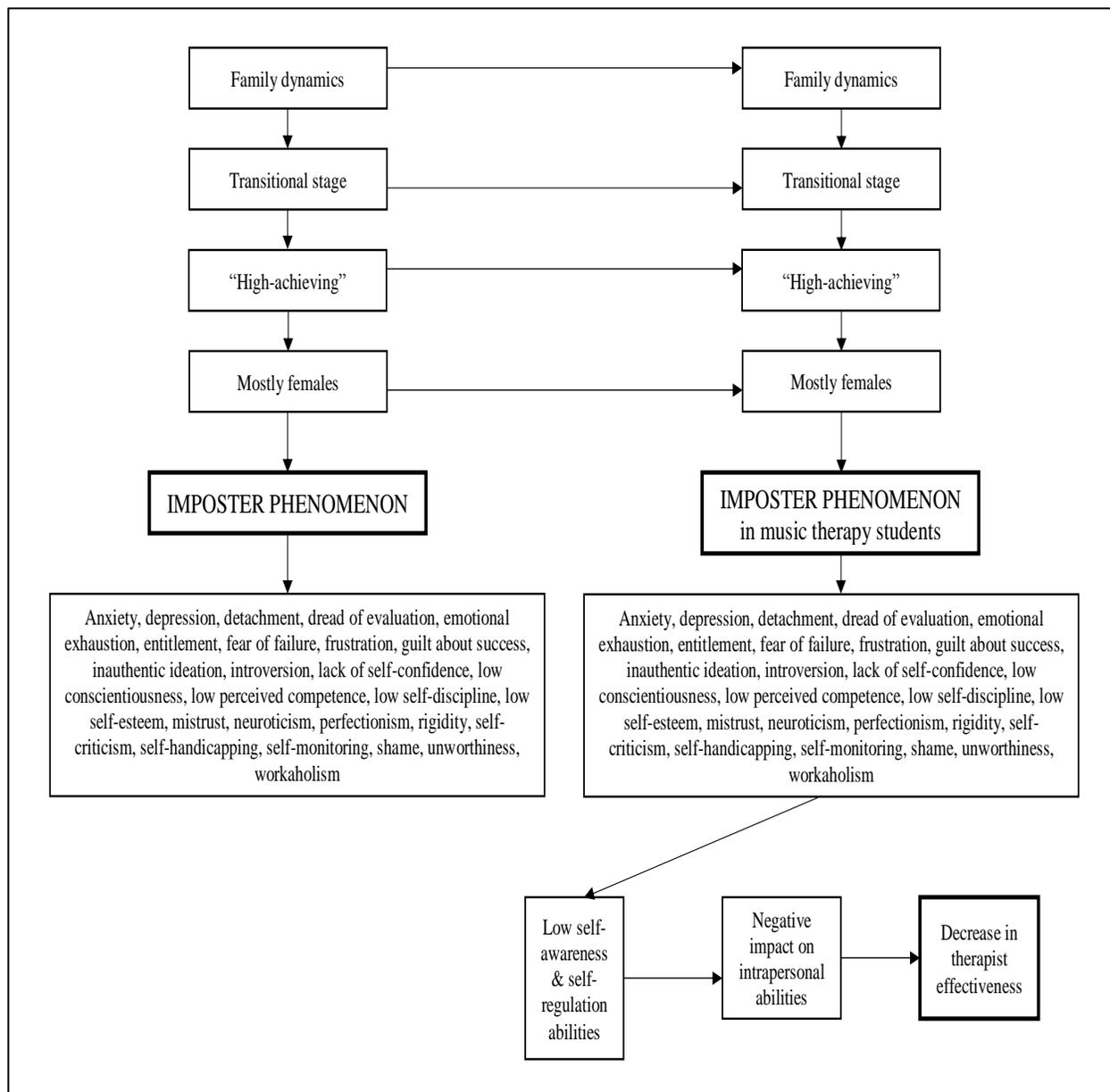
However, the prompts were not meant to enforce a rigid structure to the focus groups, but instead acted as a guide to assist with grounding the discussion when needed. The subjects were told that they are the "experts" on the subject topic, and the interviewer deviated between moderating the group and acting as an active listener (Smith et al., 2009).

Subjects

This study utilized purposive sampling in order to gather an appropriate and homogenous group of subjects. This qualitative method of participant selection allows for the gathering of rich and insightful information in accordance with the research questions (Ghetti, 2011; Hedden & Eason, 2015). Subjects were recruited from music therapy undergraduate and graduate students enrolled at a large, American Music Therapy Association (AMTA) approved Midwestern university. Recruitment procedures included the use of emails and flyers that were directed towards this student population (Appendices G and H). The emails and flyers were created in accordance with guidelines of compliance outlined by the Office of Human Research Protection (OHRP) at the university. Emails were distributed to music therapy students through the University department and flyers were displayed on department and building bulletin boards near classrooms and offices. The number of students who chose to participate determined the number of focus groups. Focus groups were initially meant to be comprised of a minimum of four and a maximum of seven students. A minimum number of four students ensured that subjects would have enough peers to listen to and share ideas with, while a maximum number of seven allowed the researcher to facilitate and manage a group discussion that maximized subject contributions. Due to unexpected circumstances, the minimum number of focus group participants was decreased to three. Once subjects signed informed consent to participate in this study, they were asked to provide an individual schedule so that a 60-90 minute time frame could be scheduled for the focus groups to meet. Subjects who gave consent to participate were sent an email with follow-up information on the date, time and location of the focus group meeting. A reminder email was sent the day of the focus group meeting to the individual subjects in the focus group.

Informed Consent

All subjects who agreed to participate in a focus group were asked to sign the Informed Consent Statement (Appendix B). This statement included an overview of the focus group procedures and discussed the potential risks and benefits of participation. In addition, a statement of Participant Confidentiality was included in the Informed Consent Statement. This additional statement required subjects to agree to refrain from the sharing of any personal information discussed during the focus group. A signature on the Informed Consent Statement, as well as an initial for the Participant Confidentiality statement, was required for participation in the research study. These signatures were obtained via a one-on-one meeting between each individual subject and the researcher.

While the advantages of focus groups include collecting a large amount of data in a short period of time, as well as allowing the subjects to share and validate ideas for one another, an overarching ethical dilemma of this method of data collection is subject confidentiality. Subjects of focus groups may sign informed consent and confidentiality statements, but it is impossible to truly assure anonymity, as there are no sanctions against disclosure of subject involvement and experiences (Tolich, 2009). This potential for harm was explicitly stated as part of the "Risks" section of the Informed Consent Statement (Appendix B) for this research study.

Subjects were informed of other potential risks incurred from participating in this study. Participation in the focus group required discussion of experiences and stories of a personal nature. For some individuals, these admissions may have brought about discomfort and/or an emotional response. During the focus group meetings, the researcher returned a copy of each subject's completed CIPS that was placed in a sealed envelope with the faculty advisor's signature on the seal and secured with tape. The researcher told subjects the relationship of their

score to few, moderate, frequent, or severe characteristics of imposter phenomenon without asking for the subject's score. An additional potential risk, although not expected, may have be any noticed or suspected adverse responses (e.g. refusal or shift in level of participation, crying, yelling or leaving in the middle of the focus group) by a subject during the focus group. The researcher reminded subjects about the university counseling services at the end of the focus group. Any adverse response during the focus group experience were to be reported to the faculty advisor by the researcher or researcher assistant. The faculty advisor was to follow up in person and/or email within 24 hours of the focus group with the subject. This was to ensure the safety of the subject and recommend the subject seek university counseling services. Subjects were informed of university counseling services and provided a handout containing contact information for this service at the introduction information to the focus group (See Appendix I). Any adverse responses were to be reported to the IRB. No such measures were needed upon completion of the focus groups.

The potential benefits were thought to outweigh the potential risks. One benefit was that participation in the focus group would bring awareness to certain thoughts, ideals, and personality patterns related to IP. The dynamics and interrelated discussion of the focus group might have provided a supportive environment for those students with IP tendencies. Identification of personal characteristics of IP that can be minimized may have improved a subject's personal and professional development as a music therapist. For individuals who may not have exhibited symptoms of IP, this group possibly provided an informational experience regarding this psychological phenomenon. In addition, participation in this study informed the prevalence, if any, of IP tendencies in a small purposive sample of music therapy students. Outcomes of this study provided information that can be used to understand how to better

support student development and ultimately improve therapeutic effectiveness in clinical training programs.

Data Collection

To ensure the anonymity of subject identifiable information from the researcher, a list of individual identification numbers were generated through the Pretty Random application®. This list of numbers was generated by the researcher after closing enrollment for the study. The faculty advisor was provided with the list of randomized numbers, and created an Excel spreadsheet with a list of subject's names and corresponding identification numbers. This Excel file was password protected and stored on the faculty advisor's university office computer separate from the focus group audio recordings, transcriptions, and demographic information. The researcher or research assistant did not have access to the spreadsheet of subject names and individual identifications numbers. Once the study was complete, the faculty advisor destroyed this document linking study subjects with their unique individual identification number. The faculty advisor also created a separate password protected spreadsheet that included subject identification numbers, demographic information, and CIPS scores. This spreadsheet was stored on the faculty advisors university office computer until it was needed for data analysis, at which time it was printed off and given to the researcher.

Since more than seven subjects were initially enrolled in this study, more than one focus group was formed by the faculty advisor. Subjects were originally to be placed into focus groups by the advisor based on the subjects' CIPS score of few, moderate, frequent, or severe. This was planned in order to minimize any discomfort of discussing IP in the presence of other subjects with vastly different experiences. The faculty advisor also attempted to avoid placing subjects together in focus groups with known pre-existing bias towards other participating subjects. Due

to concerns expressed by the graduate level subjects, considerations were also made regarding the placement supervisors in groups with their current students The researcher and research assistant did not have access to the demographic spreadsheet prior to data analysis so as to avoid researcher bias during the focus group.

Prior to the focus group meeting, subjects were asked to fill-out a Demographic Questionnaire (Appendix C) and complete the CIPS (Appendix E). The researcher instructed the subjects to complete the CIPS specifically regarding their experiences as a music therapy student. These were completed and collected at the same time as the Informed Consent Statement and Participant Confidentiality signatures. Completed questionnaires and CIPS's were given to the faculty advisor, and each set was assigned an individual identification number. These numbers were based on the randomized list provided to the faculty advisor by the researcher. Hard copies of completed forms were in a locked file cabinet in the faculty advisor's private, locked office at the university, separate from the focus groups audio recordings, transcriptions, and data analysis documents. The completed Demographic Questionnaires and CIPS's were given to the researcher upon completion of the focus groups to aid with data analysis. All data records will be retained for up to five years post publication in a peer-reviewed journal in order to verify data should any questions arise during and post-publication. Hard copies will be shredded through the secure University system and the electronic files will be disposed of according to University policy.

Data for this study was collected through two focus groups, in addition to a Demographic Questionnaire handout (Appendix C) and the completion of the CIPS (Appendix E). The focus groups were audio recorded on a Zoom Q2HD Handy Video Recorder®, and the entirety of the discussions were transcribed, coded, and analyzed by the researcher. In addition, an

undergraduate or graduate student research assistant assisted as a scribe during the focus groups. The transcriptions were completed by the researcher using Microsoft Word and were password-protected. Only the researcher and the faculty advisor had access to the Word document passwords. Both the audio recordings and the completed transcriptions were stored on an encrypted external flash drive, stored in a locked file cabinet in the faculty advisor's university designated research room. Upon completion of the data analysis, the data was moved to a locked file cabinet in the faculty advisor's private university office.

Procedures

As there were enough subjects to create more than one focus group (i.e., more than three), the focus group assignments were dependent on the CIPS scores and any known biases between subjects. As each subject completed the CIPS, during the Informed Consent meeting, they were asked to place it in a mailing envelope that they sealed and signed so that the researcher would remain blind to the scores. This was to ensure that the researcher did not facilitate the groups with unintentional bias based on the subject's CIPS scores. Once all CIPS were collected from the subjects, the researcher gave the envelopes to the faculty advisor, who added up the scores and included these numbers on the Excel spreadsheet containing each subject's individual identification number and demographic information. The researcher was informed of the group assignments, but was not made aware of the CIPS score make-up of each group. Once focus groups were assigned, the researcher began the process of contacting the subjects to determine availability.

The focus groups were asked to meet in a room designated for research located on the campus of a large Midwestern university, for both the convenience of the subjects and to protect the integrity of the meeting. The room consisted of a table and chairs, a Zoom Q2HD Handy

Video Recorder®, and a poster board depicting the constructs of IP. Notepads, pens, bottles of water, and pizza were also provided. A packet containing the focus group handouts was provided to each subject. The contents of the packets included a copy of the Imposter Phenomenon handout (Appendix D) and an informational handout for the university's counseling services (Appendix I). Once subjects were seated, they were provided with copies of their signed Informed Consent Statements (Appendix B) and their completed and scored CIPS in a sealed, taped, and signed envelope.

The researcher conducted the focus groups in accordance with the following interview schedule:

1. Turn on the Zoom Q2HD Handy Video Recorder®.

2. Read through Focus Group Script (Appendix J)

3. Begin the semi-structured discussion (Appendix A).

4. Prior to ending the focus group, whether due to time constraints or exhausting all discussion topics, each subject was asked if they would like to share a final summary statement (Morgan, 1997).

5. Read through concluding section of Focus Group Script (Appendix J).

6. Turn off the Sony Voice Recorder.

7. Let subjects know meaning of CIPS scores, if interested.

8. Follow-up with individual subjects, as necessary (i.e., those who appear to have had an emotional reaction to the discussion).

Data Analysis

The researcher, using a password protected Microsoft Word document, transcribed each focus group's audio recording. The subject's names were not used in the transcriptions.

After the focus group interviews were transcribed, each was individually analyzed for themes related to the research questions and the theoretical framework for IP in music therapy students. Appendix F shows the worksheet template by which all the transcript data was analyzed. The following analytical steps were derived from those outlined by Smith et al. (2009) and utilized by the researcher:

1. Hard copies of the transcriptions were printed and read through several times. At least one of the readings happened concurrently with the audio recording.

2. Once familiarized with the data, the researcher read through and noted anything of interest in the left-hand margin. This included descriptive, linguistic, and/or conceptual thoughts and findings.

3. The notes indicated in the previous step were analyzed for patterns and interrelationships. Emergent themes were notated in another margin.

4. Emergent themes from the previous step were analyzed for patterns and connections. A graphic representation of these themes was created.

5. Steps 1-4 were repeated for the next focus group transcript. Each transcript was treated in its own unique right, and new themes could emerge, as necessary.

6. Once all transcriptions were analyzed, the researcher looked for overarching themes and patterns. A table was created to represent thematic connections, and included quotes from the transcripts to provide corroboration.

Researcher Biases

An essential component to IPA suggests the researcher identify any personal biases they may have regarding the research topic. While descriptive phenomenological research recommends "bracketing" one's personal biases so that the data may be only objectively described (Bradbury-Jones et al., 2009; Cosgrove & McHugh, 2008; Creswell, 2013; Ravitch & Carl, 2016), IPA asserts that it is impossible for the researcher to fully "bracket" oneself from the data (Bradbury-Jones et al., 2009; Smith et al., 2009). Instead the researcher must work in a cyclical manner in which they identify their preconceptions prior to collecting data, work to move away from these preconceptions during the data collection, then revisit their perspectives when analyzing and interpreting the data (Smith, 2007).

The researcher of the present study was a female, third year post-internship graduate equivalency student with board certification in music therapy. The topic of imposter phenomenon was chosen for this study based on a personal curiosity regarding the subject of IP, and in acknowledgment of the researcher's own possible IP symptoms. The idea of examining imposter phenomenon derived from a previous research study in which the researcher worked with other peers to examine the elements of therapist effectiveness and the idea of an "authentic self" in music therapy students and practitioners. The focus group subjects were peers of the researcher, as they attended the same large, Midwestern university as the researcher. Thus, the researcher was blind to the subjects' individual demographic information and CIPS scores. The discussion prompts for this study were derived from an extensive review of the literature, as well as the theoretical framework developed by the researcher. The researcher was mindful that this theoretical framework was fluid and subject to change, depending on the outcomes of the focus group data analyses.

Chapter 4: Results

Focus Group Demographics

Eight music therapy students contacted the researcher with interest in participating in the study. Potential subjects individually met with the researcher prior to the focus group meetings to review the informed consent. All eight students agreed to participate and signed the informed consent. Following the informed consent signing, the subjects completed the demographic questionnaire and the Clance Imposter Phenomenon Scale (CIPS). Focus groups were designed to be four to seven people per group. Since there were eight subjects, two focus groups were formed. Due to unexpected circumstances, one subject was unable to attend the focus group meeting on their assigned day, bringing the subject total to seven. All seven subjects were female music therapy students at a large, AMTA-approved Midwestern university. The average age of the sample was 23 and the average GPA was 3.8 (one subject did not provide a GPA estimate). Four subjects were undergraduate students and three subjects were graduate level students, two of which were board-certified music therapists. One focus group was comprised of three undergraduate students, while the other was comprised of one undergraduate student and three graduate students. Subjects identified their ethnicity as White (*n*=6) and Asian/Pacific Islander (n=1). The following table depicts the age, gender, year in school, GPA estimate, and the Clance Imposter Phenomenon Scale (CIPS) score of each subject. The demographic information regarding ethnicity was not included to protect the identifiable information of the one subject who selected Asian/Pacific Islander.

Table 4

Focus Group Demographic Information

Subject Number	Age	Gender	Year in School	GPA Estimate	CIPS Score
Subject 1	25	Female	Graduate-Masters	4	52
Subject 2	26	Female	Graduate-Masters	3.75	75
Subject 3	22	Female	Undergraduate	3.75	75
Subject 4	20	Female	Undergraduate	3.97	77
Subject 5	22	Female	Undergraduate		55
Subject 6	19	Female	Undergraduate	3.4	65
Subject 7	26	Female	Graduate-Masters	4	77

CIPS Results

The results of CIPS scale were derived from a score based on the accumulation of 20 Likert-type survey items. Each item is comprised of five answer choice options ranging from 1 "not at all true" to 5 "very true." The total score indicates whether an individual exudes few, moderate, frequent, or severe imposter characteristics. From the current study, two subjects scored as having moderate imposter tendencies (i.e., a score between 41-60), and five subjects scored as having frequent imposter tendencies (i.e., a score between 61-80). The average CIPS score of all subjects was 69.8 (i.e., frequent imposter tendencies).

The following table depicts the specific CIPS answer choices for each subject and the average score for each item on the CIPS. Items 10 (i.e., "It's hard for me to accept compliments or praise about my intelligence or accomplishments") and 18 (i.e., "I often worry about not succeeding with a project or examination, even though others around me have considerable confidence that I will do well") had high averages for all subjects (4.0 and 4.1, respectively). However, item 17 (i.e., "I often compare my ability to those around me and think they may be more intelligent than I am") had the highest average score of 4.7. The lowest averages were for

items 9 (i.e., "Sometimes I feel or believe that my success in my life or in my job has been the result of some kind of error.") and 15 (i.e., "When I've succeeded at something and received recognition for my accomplishments, I have doubts that I can keep repeating that success").

Table 5

Clance Imposter Phenomenon Scale Answer Choices
(Clance, 1985)

Subject Number	1) I have often succeeded on a test or task even though I was afraid that I would not do well before I undertook the task	2) I can give the impression that I'm more competent than I really am	3) I avoid evaluations if possible and have a dread of others evaluating me	4) When people praise me for something I've accomplished, I'm afraid I won't be able to live up to their expectations of me in the future	5) I sometimes think I obtained my present position or gained my present success because I happened to be in the right place at the right time or knew the right people	6) I'm afraid people important to me may find out that I'm not as capable as they think I am	7) I tend to remember the incidents in which I have not done my best more than those times I have done my best	8) I rarely do a project or task as well as I'd like to do it	9) Sometimes I feel or believe that my success in my life or in my job has been the result of some kind of error	10) It's hard for me to accept compliments or praise about my intelligence or accomplishments
Subject 1	3	2	2	3	1	4	3	2	1	3
Subject 2	4	3	3	4	4	3	4	3	3	4
Subject 3	3	3	3	4	3	4	4	4	2	5
Subject 4	4	5	2	4	5	3	4	3	3	4
Subject 5	4	3	1	2	2	3	4	3	1	3
Subject 6	4	3	5	2	2	4	2	3	1	5
Subject 7	5	3	5	5	4	5	3	3	2	4
Average Scores	3.86	3.14	3	3.43	3	3.71	3.43	3	1.86	4

Table 5 (Continued)

Clance Imposter Phenomenon Scale Answer Choices
(Clance, 1985)

11) At times, I feel my success has been due to some kind of luck

12) I'm disappointed at times in my present accomplishments and think I should have accomplished much more

13) Sometimes I'm afraid others will discover how much knowledge or ability I really lack

14) I'm often afraid that I may fail at a new assignment or undertaking even though I generally do well at what I attempt

15) When I've succeeded at something and received recognition for my accomplishments, I have doubts that I can keep repeating that success

16) If I receive a great deal of praise and recognition for something I've accomplished, I tend to discount the

17) I often compare my ability to those around me and think they may be more intelligent than I am

18) I often worry about not succeeding with a project or examination, even though others around me have considerable confidence

19) If I'm going to receive a promotion or gain recognition of some kind, I hesitate to tell others until it is an accomplished fact

20) I feel bad and discouraged if I'm not "the best" or at least "very special" in situations that involve achievement

Subject Number	11)	12)	13)	14)	15)	16)	17)	18)	19)	20)
Subject 1	3	3	2	3	2	2	4	3	5	3
Subject 2	4	3	4	4	4	2	5	5	4	5
Subject 3	3	5	4	4	3	3	5	5	4	4
Subject 4	5	4	2	3	4	3	5	4	5	5
Subject 5	3	2	3	3	2	3	4	3	4	2
Subject 6	3	3	4	3	2	4	5	4	3	3
Subject 7	2	4	4	4	3	4	5	5	2	5
Average Scores	3	3.43	3.29	3.43	2.86	3	4.71	4.14	3.86	3.86

Focus Group Transcript Analysis

The focus groups took place on two different weekday evenings in accordance with each subject's individual schedule. The first group's discussion lasted one hour and six minutes, while the second group's discussion was one hour and 36 minutes in length. The audio data for both focus groups was transcribed by the researcher of this study. When the transcriptions were complete, the researcher began the following analytical procedures:

1. Hard copies of the transcriptions were printed and read through several times. At least one of the readings happened concurrently with the audio recording.

2. Once familiarized with the data, the researcher read through and noted anything of interest in the left-hand margin. This included descriptive, linguistic, and/or conceptual thoughts and findings.

3. The notes indicated in the previous step were analyzed for patterns and interrelationships. Emergent themes were notated in another margin.

4. Emergent themes from the previous step were analyzed for patterns and connections. A graphic representation of these themes was created.

5. Steps 1-4 were repeated for the next focus group transcript. Each transcript was treated in its own unique right, and new themes could emerge, as necessary.

6. Once all transcriptions were analyzed, the researcher looked for overarching themes and patterns. A table was created to represent thematic connections, and included quotes from the transcripts to provide corroboration.

Three themes emerged from the transcripts of the focus groups, each explaining the prevalence of imposter phenomenon in music therapy students. The themes include (a) uncertainty in transitions, (b) challenges of the music therapy profession, (c) and awareness and

impact of IP constructs and patterns. The follow table depicts these three themes and their

corresponding subthemes.

Table 6

Focus Group Themes and Subthemes

Themes	Subthemes

Uncertainty in transitions	1. Undergraduate students
	    a. Transition into college
	    b. Transition into clinical practicum
	    c. Transition into internship
	2. Graduate students
	    a. Transition back to school
	    b. Transition out of graduate school

Challenges of the music therapy profession	1. Ambiguity 2. Misconceptions 3. Advocacy
Awareness and impact of IP constructs and patterns	1. Self 2. Peers 3. Therapist effectiveness

As the discussion prompts were created based on both the guiding theoretical framework (Figure

1) and the research questions of this study, there are themes that directly relate to both of them.

In addition, due to the semi-structured nature of the focus group proceedings, new themes

unrelated to either the theoretical framework or the research questions were identified. The

following will provide the focus group results as related to the research questions. In addition,

the results of the three identified phenomenological themes will be explored and corroborated

through excerpts from the focus group transcripts. The terms "constructs" and "symptoms" of IP

will be utilized interchangeably throughout the examination of results and subsequent discussion.

"Constructs" was initially utilized by the researcher of the study to describe specific experiences

of IP; however, during the focus group discussions, subjects preferred to use the term

"symptoms" to describe their imposter characteristics.

The current study sought to answer the following research questions:

1. What experiences have music therapy students had with imposter phenomenon? (e.g., effect on self-awareness, effect on therapist effectiveness)

2. What contexts/situations may have influenced their experiences with imposter phenomenon? (e.g., family dynamics, transitional stage of life, high-achieving characteristics, female-dominated profession)

Experiences. For each focus group, the subjects were provided a list of constructs, or symptoms, which were written on a poster board and hung on a wall in the room where the focus groups took place. The subjects were asked to identify and elaborate on the presence, or lack thereof, of these constructs of imposter phenomenon in music therapy students. The constructs are adverse in nature and were included in the discussion to encourage discussion and awareness of imposter tendencies and patterns. Not only did subjects provide insight regarding the prevalence of many imposter symptoms in music therapy students during this specific portion of the discussion, but they also elaborated on different symptoms and experiences throughout the entirety of the focus group meeting. According to the subjects, music therapy students have the following experiences, or symptoms, related to imposter phenomenon: anxiety, fear of failure, fear of judgment, dread of evaluation, unsureness, unworthiness, constant comparisons, low self-esteem, low self-efficacy, and perfectionism. These constructs were experienced in educational and professional contexts and situations.

Contexts/situations. The focus group subjects were asked to describe specific contexts and/or situations during which they have experienced symptoms of imposter phenomenon. As per the theoretical framework and corresponding discussion prompts, the subjects were asked about family dynamics, transitional life stages, being considered high-achieving, and residing in

a predominately female profession. While there was not a consensus between groups on the applicability of family dynamics and gender roles for creating imposter feelings in music therapy students, both groups talked extensively regarding the impact of educational and professional transitions. Though not explicitly discussed, patterns relating to qualities of high-achieving were also identified throughout the transcripts.

Uncertainty in transitions. All subjects in the study reported transitional struggles related to their educational classification. The undergraduate student subjects reported imposter symptoms concerning the transitions of beginning college, starting music therapy clinical practicum work, and preparing for clinical music therapy internship. The graduate student subjects reported personal struggles and imposter feelings related to returning to school and/or transitioning out of graduate school.

Undergraduate students. These subjects reported feelings of unsureness and unpreparedness when beginning their degrees in music therapy. Subjects indicated concerns related to not specifically knowing what they wanted to do with their lives or having to take on new responsibilities of being an adult:

> *"I'm just starting this whole college thing and figuring out what I wanna do with my life…"*
>
> *"I'm in a transition with going away to college and figuring out my medical stuff on my own, without my parents there. So that's hard."*

In addition, feelings of self-doubt, lack of success, unworthiness, and lack of belonging were included when talking about clinical practicum:

> *"I was having a lot of self-doubt because I wasn't doing very well in my practicum, and [I] wasn't feeling very successful."*
>
> *"Right now, with practicum, [I have] some of these symptoms, the unworthiness… or feeling like I don't really belong…I'm not a music therapist yet."*

Feeling of unpreparedness, anxiety, and procrastination tendencies were reported for the transition of students into their clinical music therapy internships:

> *"I put off looking for internships again [be]cause I just felt like I wasn't ready."*

> *"For me right now, [be]cause I'm still in the student phase, and I don't really have to get to that professional phase until next year, I'm putting off [looking for internship] as long as possible."*

> *"I mean, I know what the interns do…. But yeah, I definitely have anxiety related to that transition."*

Graduate students. The discussions with graduate student subjects included remarks regarding feelings of self-doubt and low self-efficacy, fear of failure, and worry about educational and clinical preparedness regarding returning to and leaving graduate school:

> *"…coming back to grad school's kind of like, whoa! …realizing how little of the broader philosophies I have been taught…feeling like my knowledge is smaller in those areas than I originally thought."*

> *"I don't know if I'll ever feel…like I've learned enough."*

> *"I feel like I'm not ready for…going to the real world, so I'm just…anxious in graduate school."*

Challenges of the music therapy profession. A recurrent theme among both focus groups was the unsureness and anxiety related to being in a newer profession that is currently experiencing its own internal transitions. The subjects reported imposter symptoms (i.e., constructs) due to ambiguity and misconceptions of the music therapy profession, as well as the professional responsibility to constantly advocate for the profession.

Ambiguity. Subjects agreed that the identity of the music therapy profession was currently an ambiguous one. One student remarked:

> *"It's a really new field…when I came to [the] program, the biggest reason I feel like an imposter, it's because I feel like it's so ambiguous."*

Another student corroborated this comment by adding:

"As soon as there's ambiguity, there's increase in anxiety [and] unsureness."

Misconceptions. A component of this ambiguity appeared to be the result of misconceptions from other peers and/or professionals. The experience of one subject, which was agreed upon by the other subjects of the focus group, was that other non-music therapy peers had:

> *"...that preconceived notion that [music] therapists are just these girls learning their pop songs."*

Advocacy. In addition to agreeing on the ambiguity and misconceptions of the profession of music therapy, the focus group subjects reported the importance of advocacy and the subsequent struggles related to this recurrent professional responsibility. One subject commented:

> *"I feel like an imposter, and I'm in a setting where I see new clients every single week...you're advocating for the profession all the time [be]cause you're explaining who you are, what you're gonna do. And a lot of the times, people are hesitant...And so I feel like I don't really belong...[it] makes it harder for me to advocate."*

Another subject agreed, remarking:

> *"I think as a student, it's hard to advocate because you're not a professional yet..."*

One subject highlighted the impact of having to advocate for a new profession:

> *"... [we have these] high work expectations, we talk about trying to grow and change the profession, that's a big weight on our shoulders."*

Awareness and impact of IP constructs and patterns. The focus group subjects reported having an awareness of the hard work they were putting into their studies and professional skills, the extent of their own imposter tendencies after taking the CIPS, imposter tendencies amongst their peers, and how imposter symptoms during music therapy sessions may inhibit therapist effectiveness. Subjects also described patterns of constantly comparing their

abilities to and fearing judgment from their peers. These components are grouped under the subthemes of "Self," "Peers," and "Therapist effectiveness."

        Self. A tenant of imposter phenomenon (IP) includes discounting successes, achievements, and competence (Clance, 1985). However, the music therapy students included in the focus groups appeared to be fully aware of the hard work they were putting into their studies and clinical work. In addition, related CIPS item 9 (i.e., "Sometimes I feel or believe that my success in my life or in my job has been the result of some kind of error.") and 15 (i.e., "When I've succeeded at something and received recognition for my accomplishments, I have doubts that I can keep repeating that success") received the lowest average scores. Focus group subjects commented:

> *"I know I've worked hard to obtain what I have…"*

> *"I've worked really hard, and harder…compared to some."*

In addition, a subject made note when talking about item 9 on the CIPS:

> *"'Sometimes I feel or believe that my success in life [and] in my job has been the result of error…' I don't really [agree with] that."*

Further discussion of the CIPS allowed subjects to express awareness regarding the extent of applicability of the items on the scale. One such comment included:

> *"I feel like I don't think about these things when I'm doing them. So taking a step back and [realizing] I do…this."*

Some subjects suggested their CIPS score would represent different scores at different times in their lives:

> *"My thoughts were like, oh, this is how I feel at this point in time, but next week it could be different, [or] next year could be different."*

> *"I was filling it out and I was thinking…maybe it's a cycle."*

Throughout the focus group discussions, subjects reported a pattern of constantly comparing their skills and abilities to those around them and fearing judgment from others. The average score for CIPS item 17, "I often compare my ability to those around me and think they may be more intelligent than I am," received the highest average score of 4.7. The comparing of oneself to others is a critical component of imposter phenomenon (Clance, 1985), and the fear of judgment from peers and colleagues is synonymous with the dread of evaluation construct of IP. For instance, an undergraduate subject noted:

> "I almost feel like I'm not supposed to be here…all of the other upperclassman around me are…doing these great things, and I'm like, 'Should I be a music therapist?'"

Another subject remarked:

> "[I] compare myself to others and feel where I fit in… [I think], 'Oh man, they're so much better than me,' that is more of what I'm feeling most of the time. So, I think that's often the kind of basis for that fear of judgment."

While most of these comments centered around constant comparisons to peers, the topic of where the music therapy profession sits amongst other professions was brought up. One subject made connections between professional comparisons and the current debate of master's level entry:

> "[Master's level entry] could have something to do with this imposter syndrome of, 'we're not good enough, we're gonna be completely judged by other medical professionals."

Peers. In order to develop an understanding of the prevalence of IP in other music therapy students, the focus group subjects were asked if they ever observed imposter constructs in their peers. All subjects agreed that they had observed specific constructs. While these subjective observations do not directly suggest that all music therapy students from this

university experience imposter phenomenon, it is important to note the possibility of its prevalence. One subject's thoughts on the matter included:

> *"I think in general, I would say that imposter phenomenon…just by observing peers, I feel like it's definitely present and especially the peers that I've been with since the beginning of the program. I've really seen a lot of these symptoms in people, just by sharing in class…I feel like a lot of other people would relate to all of this stuff."*

Therapist effectiveness. A component of the current study's theoretical framework makes assertions about imposter phenomenon's influence on therapist effectiveness. When asked their thoughts on the topic, the focus group subjects believed IP symptoms had an impact on the effectiveness of a music therapist. One subject remarked on the impact it had on their own self-efficacy:

> *"I find that if I don't believe my session plan is good…then I don't think that it will go well, and some of the times it doesn't [be]cause I think that."*

Another subject suggested a fear of failure may influence the effectiveness of a music therapy student:

> *"I would say if you're sitting in a session, and you're all of a sudden feeling like, 'Oh, this is not going well, oh that's not right…' [you] get stuck up in your head [and] that's when your effectiveness goes down…. like the fear of failure."*

Two focus group discussions comprising of current music therapy students allowed for an insightful understanding of the prevalence of imposter phenomenon in this population. The three common themes derived from both groups (i.e., educational transitions, transition of the music therapy profession, and awareness and prevalence of IP constructs and patterns) provide a thorough description of the presence of IP in this population. These results not only suggest the presence of IP in music therapy students, but they also help inform revisions to the theoretical framework of the development of IP in music therapy students.

Chapter 5- Discussion

Based on the results of the focus groups and the themes derived from the corresponding discussions, it is apparent that imposter phenomenon (IP) is indeed prevalent in music therapy students. The following will explore the applicability of the three overarching themes to the research questions, present a revision of the theoretical framework, identify future implications based on the study, and highlight limitations and delimitations of the study.

Research Questions

In addition to examining the prevalence, or lack thereof, of imposter phenomenon in music therapy students, the study sought to answer the following research questions:

1. What experiences have music therapy students had with imposter phenomenon? (e.g., effect on self-awareness, effect on therapist effectiveness)

2. What contexts/situations may have influenced their experiences with imposter phenomenon? (e.g., family dynamics, transitional stage of life, high-achieving characteristics, female-dominated profession)

Synthesis of research questions. According to the focus group discussion results, student music therapist's experiences with imposter phenomenon include: anxiety, fear of failure, fear of judgment, dread of evaluation, unsureness, unworthiness, constant comparisons, low self-esteem, low self-efficacy, and perfectionism. The contexts and/or situations in which these experiences occur include educational and professional transitions. As the results of the focus groups provided overlapping findings in relation to the two research questions, the following will provide a synthesis to support understanding and provide clarity. The three themes, and corresponding subthemes, derived from the focus group transcripts provide a thorough synthesis of the research questions. These themes include: educational transitions,

transition of the music therapy profession, and awareness and prevalence of IP constructs and patterns.

   Educational transitions. Based on the focus group discussions, music therapy students may be in education-related transitional situations which bring about imposter experiences. Such transitions include the transitioning into college, clinical practicum, internship, graduate school, and graduation. Feelings of self-doubt, unsureness, anxiety, and fear of failure were the most commonly reported imposter experiences. Undergraduate music therapy students remarked on transitions related to beginning college, clinical practicum, and/or internship. While all experiences were not necessarily adverse, subjects did relate to some adverse imposter experiences at one point during their schooling. This is not surprising, as the coursework of a music therapy student may be considered challenging, as it is comprised of a unique and evolving combination of music and therapy courses (AMTA, 2016). Additionally, graduate music therapy students experienced imposter symptoms due to the return to school, as well as the eventual graduation from school. These subjects felt unsureness about coming back to school, as this transition meant they must work to combine their professional and student identities. Others felt self-doubt about eventually leaving graduate school, as they did not feel they had learned enough in their schooling to go out and be professional music therapists.

   The applicability of these transitional findings to the population of music therapy students is corroborated by the literature on emerging adulthood by Arnett (2000). Emerging adulthood is defined as a transitional life stage that includes individuals who are between the ages of 18-25 and do not identify as adolescents or adults. Emerging adults may include undergraduate and graduate students (Arnett, 2000). Lane (2015) provided an inspection of imposter experiences for

this identified population and suggested that emerging adults were likely to exhibit imposter

tendencies related to self-doubt and perceived fraudulence (i.e., unsureness).

   Transition of the music therapy profession. Another finding of the current research

study suggests that music therapy students experience imposter symptoms due to the evolving,

transitional nature of the field of music therapy. Subjects cited the definition of the profession as

seemingly ambiguous, as it is still in its infancy stage of growth. This ambiguity may also effect

the advocacy portion of belonging to the field of music therapy, as students feel they are

constantly having to advocate for the profession. Subjects did not complain about having to

advocate, but stated they often felt like imposters, or felt extremely anxious, due to the heavy

responsibility of advocating for such an evolving profession.

   While the idea of music as therapy has been around for centuries, the process of founding

a professional organization in America did not begin until 1950 (AMTA, 2016), indicating that

music therapy may be considered younger as compared to other helping professions. Despite this

youthfulness, music therapy is constantly evolving and adapting. In 2006, there were 4,859

qualified music therapists working in the United States (AMTA, 2006). In just ten years, that

number increased by almost 50%, as 7,256 qualified music therapists were working in the United

States (AMTA, 2016). Though such changes in the profession are exciting and necessary to keep

pace with today's society, the music therapy students of the study believe it to be nerve-

wracking. Advocating is a professional component that is not only reinforced throughout the

music therapy curricula, but it is also a component of professional certification. Under section IV

in the "Board Certification Domains," a document which outlines the requirements for an

individual to receive music therapy board certification, it states that a professional responsibility

of a music therapist requires them to, "[s]erve as a representative, spokesperson, ambassador, or advocate for the profession of music therapy" (CBMT, 2015, p. 4).

Awareness and prevalence of IP constructs and patterns. Throughout the focus group discussions, subjects noted an awareness of constructs related to imposter phenomenon in both themselves and their peers. The most commonly cited constructs in music therapy students included anxiety, fear of failure, fear of judgment, dread of evaluation, unworthiness, unsureness, low self-esteem, low self-efficacy, self-doubt, and perfectionism. While these constructs were cited frequently throughout focus group discussions, the subjects were all in agreeance that they did not feel them constantly, but sporadically. One subject noted that their imposter feelings were like a roller coaster, going up and down, depending on what was going on in their education and studies. Another remarked that while the constructs of IP are negative, occasional IP symptom experiences might help music therapy students to learn and grow as clinicians. This idea bears similarities to Vygotsky's zone of proximal development (1978), an educational theory that informs the level of difficulty that is required for optimal learning to take place.

Constant experiences with the constructs of low self-efficacy and fear of failure were noted to be possible detriments to the clinical effectiveness of music therapy students. A component of being an effective therapist requires having an ability to be self-aware and to self-regulate when needed (Ott, 2016). However, subjects noted not being aware of their imposter tendencies until talking about them in the focus group setting. Many noted that IP symptoms, including low self-efficacy, had influenced their abilities to conduct past music therapy sessions. Such comments bear similarities to self-fulfilling prophecies, to which individuals will not perform well because they do not believe they will perform well (Oxford English Dictionary, n.d.). These prophetic behaviors, as well as IP symptoms, were also noted in the peers of focus

group subjects. The presence of IP constructs as being influential on therapist effectiveness is important to note and be made aware of, especially as it relates to the professional ethics of a music therapist. Section 1.5, under "Professional Competencies and Responsibilities" in the American Music Therapy Association Code of Ethics states:

> The MT is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems (AMTA, 2014).

Specific behavioral patterns related to IP include constantly comparing oneself to those around them and having a fear of judgment from others (Clance, 1978). After taking the Clance Imposter Phenomenon Scale (CIPS), subjects noted that they were suddenly aware of patterns, such as constantly comparing their abilities to those around them and fearing judgment from their peers. The pattern of music therapy students constantly comparing themselves to others is corroborated in the results of the subjects' CIPS scores. Item 17 of the CIPS states, "I often compare my ability to those around me and think that they may be more intelligent than I am." Analysis showed that two subjects scored this item as 4 (i.e., "often"), and the remaining five subjects score this item as 5 (i.e., "very true). Out of all 20 items on the CIPS, item 17 was scored the highest, with an average score of 4.7.

Revision of the Theoretical Framework

The guiding theoretical framework of this study was created to display how imposter phenomenon might develop in music therapy students. The theoretical framework suggested that IP would develop due to being in a transitional stage of life, belonging to a female-dominated profession, having certain family dynamics, and being part of a high-achieving population. As a result, individuals could experience constructs of IP including anxiety, depression, fear of failure,

and unworthiness. It was proposed that these constructs would negatively impact an individual's intrapersonal abilities and cause low self-awareness and low self-regulation, thereby causing low therapist effectiveness. The results of the focus group discussions brought about modifications to the theoretical framework (Figure 2). The following will describe the new framework. This framework is introduced as an emerging model which is subject to future changes.
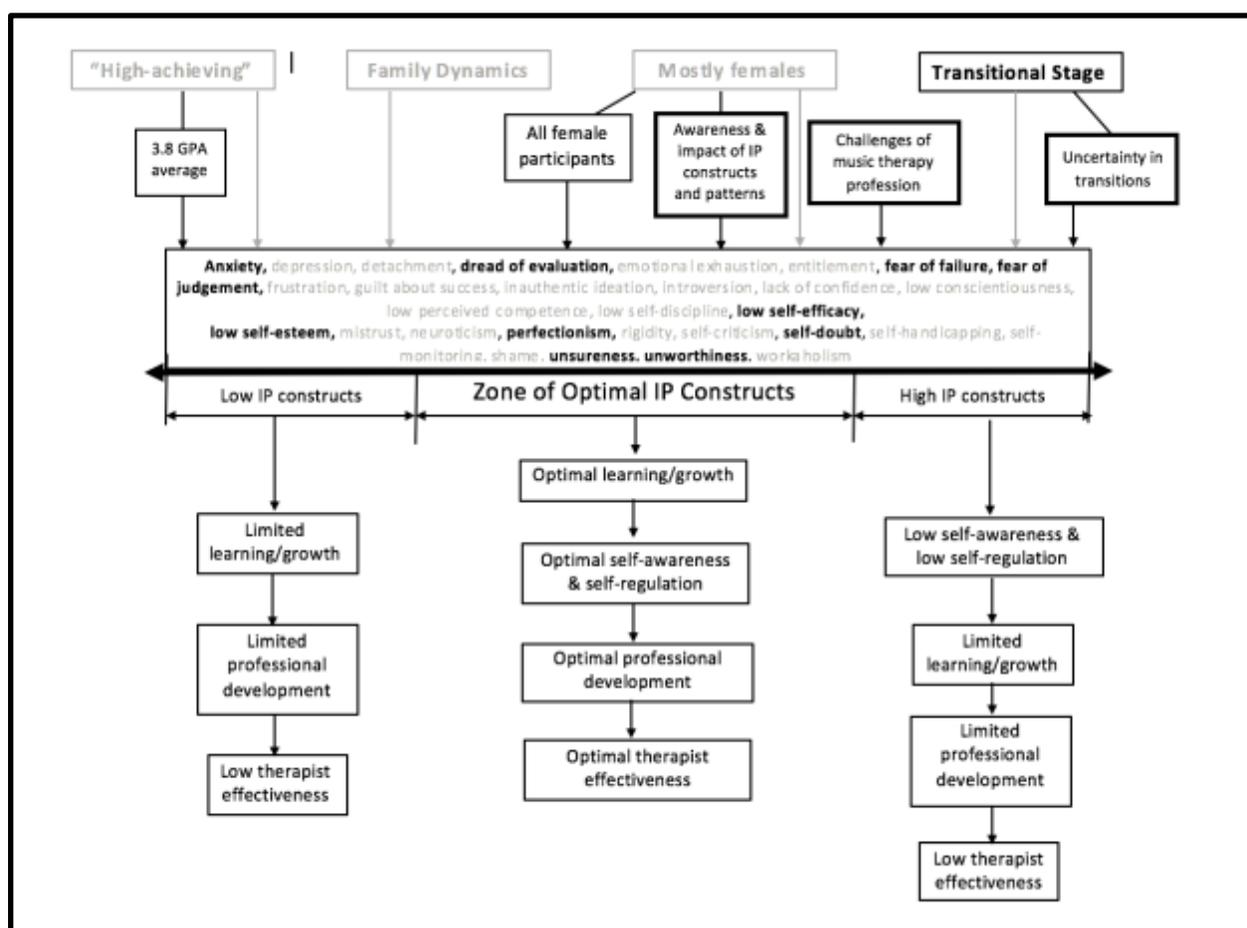

Figure 2: Emerging Conceptual Framework of IP Development in Music Therapy Students

This emerging conceptual framework incorporates both the elements from the guiding theoretical framework of the study, as well as the themes and results derived from the focus group meetings of music therapy students. It may be read and understood as three large events,

beginning at the top and working down to the bottom. These three events include: causes of IP, IP symptoms, and effects of IP symptoms. The cluster of boxes at the top (i.e., "Family Dynamics," "Uncertainty in transitions"), depict the elements which may contribute to the development, or cause, of IP symptoms. The symptoms of IP reside on a sliding scale, dependent on the severity with which they are experienced. The boxes below this scale indicate the possible effects of these IP symptoms on therapist effectiveness. These effects differ depending on the severity of the symptoms. All components with a grey coloring depict those which are derived from the original theoretical framework. These elements are included to describe the emergence of IP, as based on the initial review of the literature; however, as there was not a consensus between focus groups regarding these items, they are incorporated with grey coloring in an attempt to suggest areas of future research for corroboration.

Causes of IP. The boxes at the top of the conceptual framework depict a combination of elements from the original theoretical framework and the results of the data collection for this study. As IP's influence regarding family dynamics (Clance & Imes, 1978), high-achieving (Clance & Imes, 1978), and a mostly female population (Clance & Imes, 1978) were not corroborated in the focus groups, they are colored grey. However, there are connecting boxes for high-achieving and mostly females, including "3.8 GPA average" and "All female participants." This information was gathered from the demographic questionnaires and provides support for the role of high-achieving characteristics and gender as possibly contributing to the development of IP symptoms. The three themes derived from the focus group transcripts (i.e., uncertainty in transitions, challenges of the music therapy profession, and awareness and impact of IP constructs and patterns) are also included as contributing factors to IP symptoms, and are delineated with bolded outlines.

IP symptoms. The box of IP symptoms includes all those which were derived from the literature in the original theoretical framework. Those symptoms that are bolded are those which were discussed during the focus group meetings. An important facet of this new framework is the sliding scale component, which works to describe the severity, and corresponding effects, of IP symptoms in an individual. The horizontal arrows are included to indicate that the severity of IP constructs lies on a three-part continuum: low IP constructs, the Zone of Optimal IP Constructs, and high IP constructs.

Effects of IP symptoms. According to the focus group discussions, while IP constructs are prevalent in music therapy students, they are not always present. The occurrence of these constructs is subjective and dependent on what is going on in the student's life, both personally and educationally. In addition, the occurrence of these constructs is not necessarily negative, as it could provide opportunities for professional learning and growth. A modification to the original framework includes likening the IP constructs found in music therapy students to a sliding scale. If the student is constantly exhibiting low IP constructs (i.e., positioned on left side of the scale), they are not self-aware or growing professionally, and are inhibiting their therapeutic effectiveness. If the student is constantly exhibiting high IP constructs (i.e., positioned on the right side of the scale), they are low on their self-awareness and self-regulatory abilities and are inhibiting their learning, professional development, and ultimately their therapeutic effectiveness. This area of high IP constructs is directly informed from Ott's (2016) framework of therapist effectiveness, which includes the need for proper self-regulation and self-awanress.

If the student's level of constructs resides in the middle of the scale, they are in the "Zone of Optimal IP Constructs," which bears similarities to Vygotsky's (1978) zone of proximal development. It is here that a student music therapist can learn to be their most effective

therapeutic self, as they are exhibiting a useful balance between too few and too severe imposter constructs, and are also aware of the imposter constructs and patterns that they exhibit. As with Vygotsky's zone of proximal development, this "zone" allows for the most effective learning to take place, thereby allowing for the development of effective therapeutic skills.

Current Implications of the Findings

The findings of the following study indicate that there is indeed a prevalence of imposter symptoms, or constructs, in music therapy students. While a healthy presence of these constructs can help in developing therapeutic effectiveness, an unhealthy presence can be detrimental to the mental health of music therapy students and can inhibit therapist effectiveness. A lack of awareness of IP symptoms and their effects of therapeutic skills may be seen as a violation of professional ethics (AMTA, 2014).

Several subjects commented on having developed an awareness of IP symptoms and patterns that they had not noticed before. Simply developing an awareness of imposter phenomenon has been suggested as a strategy towards alleviating its symptoms (Clance & Imes, 1978). Using a group format to discuss feelings of imposter phenomenon has also been advised as a way of allowing individuals to feel supported and less isolated in their experiences (Matthews & Clance, 1985).

By simply developing an understanding and awareness of imposter phenomenon in music therapy programs, the effects of its symptoms may be alleviated. Professors and supervisors should be aware of IP constructs, and be mindful of the impact it may have on students and their professional development and ultimately their therapeutic effectiveness with clients. In addition, students who are made aware of possibly having symptoms and patterns of IP should seek supervision and/or support from their peers (Clance & O'Toole, 1988; Matthews & Clance,

1985). Reflective journaling can also be an effective strategy in developing an awareness of the impact of IP (Clance & Imes, 1978; Clance & O'Toole, 1988; Warrell, 2014). In extreme situations, personal therapy services should be sought to provide appropriate psychotherapeutic support (Clance & Imes, 1978; Clance & O'Toole, 1988; Langford & Clance, 1993; Matthews & Clance, 1985)

Limitations

The statistical profile of music therapy students across the country is currently unknown. However, when compared to the statistical profile of professional music therapists who are members of the American Music Therapy Association (AMTA), the sample utilized for the study was not a representative one. According to the 2016 AMTA Member Survey and Workforce Analysis, 10.54% of the music therapy profession includes male practitioners, with 0.87% identifying as "Transgender," "Gender Queer/Gender Nonconforming," and "Different Identifier" (p. 9). The sample of the current study included subjects who all identified as female.

While the statistical profile of music therapy students across the country is not currently known, AMTA reports that the total number of student members within the organization, both undergraduate and graduate, is around 1,554, or 39.3% of total membership (2016, p. 6). The sample size for the current study was comprised of seven subjects, which accounts for about 0.45% of reported student membership. This small sample size renders the generalizability of the results weak. Further phenomenological studies of music therapy student's experiences with imposter phenomenon are needed in order to corroborate the results of this study.

Additionally, while focus group assignments were supposed to be made according to CIPS scores, unanticipated circumstances made this difficult. Three of the subjects who participated were graduate students, two of whom were current clinical supervisors in the music

therapy department at the university where the focus groups took place. Each supervisor expressed concern to the researcher regarding being placed in a group with any students they may be currently supervising, or might possibly supervise in the future. After consulting with these students and with the faculty advisor of the current study, the researcher chose to make the concerns of these students the initial priority for group assignments before considering individual CIPS scores. In the end, the focus group assignments were decided solely on undergraduate and graduate classifications. One group was comprised of three undergraduate students while the other was comprised of three graduate students and one senior level undergraduate student, who was not under the direct supervision of the graduate student participants.

Delimitations

The current study utilized an interpretive means of phenomenological analysis, instead of descriptive analysis. Descriptive phenomenological analysis asserts that in order to fully understand a phenomenon, the researcher must "bracket" themselves, or set aside their own assumptions and biases, so as to let the lived experiences of the sample participants be objectively observed. (Bradbury-Jones, Sambrook, & Irvine, 2009; Cosgrove & McHugh, 2008; Creswell, 2013; Ravitch & Carl, 2016). Interpretive phenomenological analysis (IPA) was utilized for this study to allow for the researcher to interpret the sample data, as needed. IPA suggests that it is impossible to fully "bracket" oneself from data analysis, and instead, the researcher should focus on understanding and interpreting what is reported (Creswell, 2013; Smith et al., 2009; van Manen, 1990).

Traditional phenomenological data collection relies on individual interviews of research participants (Creswell, 2013; Smith et al. 2009; Starks & Trinidad, 2007). Advantages of individual interviews include rapport development between interviewer and interviewee, as well

as creation of a space in which the interviewee has time to think through their responses (Smith et al., 2009). Recent phenomenological research has begun to incorporate focus groups to better understand a phenomenon. Focus groups are advantageous in that they allow for large amounts of data to be collected at one time (Smith et al., 2009). In addition, verbal exchanges between participants can enrich discussion content by bringing to light viewpoints which may not have occurred during individual interviews. The current study chose to collect data through the means of one-time focus groups in order to collect rich accounts of imposter phenomenon in one meeting, and to encourage subject to engage in rich discussions with one another.

Implications for Future Research

The results of the current study indicate an extensive prevalence of imposter constructs in music therapy students. However, these results are confined to the students currently enrolled in a large, Midwestern AMTA-approved university. Future research should seek to describe the prevalence, or lack thereof, of imposter phenomenon in other music therapy university programs. Such findings could further elaborate on the constructs of IP in music therapy students, provide revisions to the theoretical framework, and bring about an understanding of how to support music therapy students and their future clients.

The focus group discussions did not provide a consensus for patterns relating to family dynamics or gender roles as contributing to the development of imposter phenomenon in music therapy students. While each focus group provided unique insights into each of these topics, the tenants of interpretive phenomenological analysis do not suggest including results without a consensus between groups. A future study which allows for the formation of more than two focus groups would be helpful in further understanding how these two components might contribute to IP symptoms in music therapy students.

Conclusion

The following study sought to examine the prevalence, or lack thereof, of imposter phenomenon (IP) in music therapy students at a large Midwestern AMTA-approved university. While previous studies have identified the presence of IP in similar populations (Arena & Page, 1992; Christensen et al. 2016; Clance & Imes, 1978; Gibson-Beverley & Schwartz, 2008; Henning et al., 1998; King & Cooley, 1995; Lane, 2015; Oriel et al., 2004; Peteet et al., 2015), there are no studies that have utilized a sample of music therapy students. Based on a phenomenological analysis of two, one-time focus group meetings, the results of the current study suggest that music therapy students experience symptoms related to imposter phenomenon in a variety of different contexts and situations. These include educational transitions, profession-related transitions, and through comparisons to and fear of judgment from peers.

Imposter phenomenon is an experience which is likely to affect high-achieving individuals, including college-level students. While the presence of IP symptoms is by no means a detriment to music therapy students, an awareness of its patterns is vital in developing clinical wisdom and therapeutic effectiveness. If IP symptoms are experienced frequently, or not at all, the level of therapeutic effectiveness of a clinician is at risk. If IP symptoms are experienced in such a way that there is a balance between high and low frequencies, then an individual is likely to reside in the "Zone of Optimal IP Constructs." It is here that a student music therapist is going to develop optimal learning, awareness, and growth as a clinician, thereby allowing for the delivery of effective and ethical music therapy services.

References

Alpert, R. & Haber, R. (1960). Anxiety in academic achievement situations. *Journal of Abnormal and Social Psychology, 37*, 207-224. doi: 10.1037/h0045464

AMTA (2016). *A career in music therapy*. Retrieved from http://www.musictherapy.org/careers/employment/

AMTA (2016). *History of music therapy.* Retrieved from http://www.musictherapy.org/about/history/

AMTA (2014). *American music therapy association code of ethics*. Retrieved from http://www.musictherapy.org/about/ethics/

AMTA (2013). *American music therapy association professional competencies.* Retrieved from http://www.musictherapy.org/about/competencies/

AMTA (2013). *American music therapy association standards of clinical practice*. Retrieved from http://www.musictherapy.org/about/standards/

AMTA (2012). *AMTA member survey & workforce analysis*. Retrieved from http://www.musictherapy.org/assets/1/7/12WorkforceAnalysis.pdf

AMTA (2006). *A descriptive statistical profile of the 2006 AMTA membership*. Retrieved from http://www.musictherapy.org/assets/1/7/statprofile06.pdf

Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*(7), 755-768. doi/10.1002/jclp.20583/abstract

Arena, D. M. & Page, N. E. (1992). The imposter phenomenon in the clinical nurse specialist role. *Journal of Nursing Scholarship, 24*(2), 121-126.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55*(5), 469-480. doi: 10.1037//003-066X.55.5.469

Arnett, J. J. (2001). Conceptions of the transition to adulthood: Perspectives from adolescence through midlife. *Journal of Adult Development, 8*(2), 133-143. doi: 10.1023/A:1026450103225

Baldwin, S. A. & Imel, Z. E. (2013). Therapist effects: Findings and methods. In A. E. Bergin & M. J. Lambert (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change*, (pp. 258-297). Hoboken, NJ: John Wiley & Sons, Inc.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Bernard, N. S., Dollinger, S. J., & Ramaniah, N. V. (2002). Applying the big five personality factors to the impostor phenomenon. *Journal of Personality Assessment, 78*(2), 321-333. doi: 10.1207/S15327752JPA7802_07

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 227-306). New York, NY: Wiley & Sons.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2009). The phenomenological focus group: An oxymoron? *Journal of Advanced Nursing, 65*(3), 663-671. doi/10.1111/j.1365-2648.2008.04922.x

Brauer, K. & Wolf, A. (2016). Validation of the German-language Clance impostor phenomenon scale. *Personality and Individual Differences, 102*, 153-158. doi: 10.1016/j.paid.2016.06.071

Brookins, L. M. (1984). The music therapy clinical intern: Performance skills, academic knowledge, personal qualities, and interpersonal skills necessary for a student seeking clinical training. *Journal of Music Therapy, 21*(4), 193-201.

Caelli, K. (2001). Engaging with phenomenology: Is it more of a challenge than it needs to be? *Qualitative Health Research, 11*(2), 273-281. doi: 10.1177/104973201129118993

Camirelli, V. (2001). Therapist self-awareness: An essential tool in music therapy. *Arts in Psychotherapy, 28*(1), 79-85. doi: 10.1016/S0197-4556(00)00069-1

Caselman, T. D., Self, P. A., & Self, A. L. (2006). Adolescent attributes contributing to the imposter phenomenon. *Journal of Adolescence, 29*(3), 395-405. doi: 10.1016/j.adolescence.2005.07.003

CBMT (2016). *About CBMT*. Retrieved from http://www.cbmt.org/about-cbmt/

CBMT (2015). *Board certification domains*. Retrieved from file:///Users/julia11190/Downloads/CBMT_Board_Certification_Domains_2015%20(3).pdf

Chae, J. H., Piedmont, R. L., Estadt, B. K., & Wicks, R. J. (1995). Personological evaluation of Clance's impostor phenomenon scale in a Korean sample. *Journal of Personality Assessment, 65*(3), 468-485. doi: 10.1207/s15327752jpa6503_7

Chrisman, S. M., Pieper, W. A., Clance. P. R., Holland, C. L., & Glickauf-Hughes, C. (1995). Validation of the Clance impostor phenomenon scale. *Journal of Personality of Assessment, 65*(3), 456-467. doi: 10.1207/s15327752jpa6503_7

Christensen, M., Aubeeluck, A., Fergusson, D., Craft, J., Knight, J. Wirihana, L., & Stupple, E. (2016). Do student nurses experience imposter phenomenon? An international comparison of final year undergraduate nursing students readiness for registration. *Journal of Advanced Nursing, 72*(11), 2784-2793. doi: 10.1111/jan.13034

Clance, P. R. (1985). *The impostor phenomenon: Overcoming the fear that haunts your success*. Atlanta, GA: Peachtree Publishers.

Clance, P. R., Dingman, D., Reviere, S. L., & Stober, D. R. (1995). Impostor phenomenon in an interpersonal/social context: Origins and treatment. *Women & Therapy, 16*(4), 79-96. doi: 10.1300/J015v16n04_07

Clance, P. R. & Imes, S. A. (1978). The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. *Psychotherapy: Theory, Research & Practice, 15*(3), 241-247. doi: 10.1037/h0086006

Clance, P. R. & O'Toole, M. A. (1988). The imposter phenomenon: An internal barrier to empowerment and achievement. *Women and Therapy, 6*, 51-64. Retrieved from http://paulineroseclance.com/impostor_phenomenon.html

Clark, M., Vardeman, K., & Barba, S. (2014). Perceived inadequacy: A study of the imposter phenomenon among college and research librarians. *College & Research Libraries, 75*(3), 225-271. doi: 10.5860/crl12-423

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Vaile & M. Kind (Eds.), *Existential phenomenological alternatives for psychology* (pp. 48-71). New York: Oxford University Press.

Cosgrove, L. & McHugh, M. C. (2008). A post-Newtonian, postmodern approach to science: New methods in social action research. In S. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 73-86). NY: Guilford.

Costa, P. T. & McCrae, R. R. (1992). Normal personality assessment in clinical practice: The NEO personality inventory. *Psychological Assessment, 4*(1), 5-13. doi: 10.1037/1040-3590.4.1.5

Coutinho, J. F., Silva, P. O., & Decety, J. (2014). Neurosciences, empathy, and healthy

interpersonal relationships: Recent findings and implications for counseling psychology.

Journal of Counseling Psychology, 61(4), 541-548. doi: 10.1037/cou0000021

Coyne, E., Rands, H., Gurung, S., & Kellett, U. (2016). I-Kiribati nursing graduates experience

of transition from university residential aged care facilities in Australia. *Nurse Education*

Today, 36, 463-467. doi: 10.1016/j.nedt.2015.10.020

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five*

approaches. (3rd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods*

approaches. (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Crist, J. D. & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive

phenomenology. *Nursing Research, 52*(3), 202-205. Retrieved from

http://ovidsp.tx.ovid.com.www2.lib.ku.edu/

Cromwell, B., Brown, N., Sanchez-Huceles, J., & Adair, F. L. (1990). The impostor

phenomenon and personality characteristics of high school honor students. *Journal of Social*

Behavior and Personality, 5(6), 563-573.

Cusack, C. E., Hughes, J. L., & Nuhu, N. (2013). Connecting gender and mental health to

imposter phenomenon feelings. *Psi Chi Journal of Psychological Research 18*(2), 74-81.

Retrieved from

http://web.a.ebscohost.com.www2.lib.ku.edu/ehost/pdfviewer/pdfviewer?sid=3d0b0921-

3733-4e46-99fb-d3b96dd92449%40sessionmgr4010&vid=3&hid=4209

De Waal, F. (2009). *The age of empathy: Nature's lessons for a kinder society*. New York, NY:

Three Rivers Press.

Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology, 64*(3), 344-354. doi: 10.1002/jclp.20443

Dweck, C. (1999). *Self-theories: Their role in motivation, personality, and development.* Philadelphia, PA: Psychology Press.

Edwards, P. W., Zeichner, A., Lawler, N., & Kowalski, R. (1987). A validation study of the Harvey impostor phenomenon scale. *Psychotherapy, 24*(2), 256-259. doi: 10.1037/h0085712

Elliot, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*(1), 43-49. doi: 10.1037/a0022187

Ellis, A. (1989). Rational-emotive therapy. In R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (197-238). Itasca, IL: F. E. Peacock Publishers, Inc.

Erikson, E. H., (1950). *Childhood and society*. New York: Norton.

Erickson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

French, B. F., Ullrich-French, S. C., & Follman, D. (2008). The psychometric properties of the Clance impostor scale. *Personality and Individual Differences, 44*(5), 1270-1278. doi: 10.1016/j.paid.2007.11.023

Ghetti, C. M. (2011). Clinical practice of dual-certified music therapists/child life specialists: A phenomenological study. *Journal of Music Therapy, 48*(3), 317-345. doi: 10.1093/jmt/48.3.317

Gibson-Beverly, G. & Schwartz, J. P. (2008). Attachment, entitlement, and the impostor phenomenon in female graduate students. *Journal of College Counseling, 11*(2), 119-132. doi: 10.1002/j.2161-1882.2008.tb00029.x

Giorgi, E. (Ed.). (1985). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.

Gilboa, A., Zilberberg, D., & Lavi, D. (2011). What's a piano? Music therapists portray the "musical personality" of the piano. *Music Therapy Perspectives, 29*(2), 138-148. doi: 10.1093/mtp/29.2.138

Gough, H. G. & Heilbrun, A. B. (1980). *The adjective checklist manual.* Palo Alto, CA: Consulting Psychologists Press.

Harvey, J. C. (1981). *The impostor phenomenon and achievement: A failure to internalize success* (Doctoral dissertation). Retrieved from http://search.proquest.com.www2.lib.ku.edu/docview/303035505

Hedden, D. G. & Eason, B. J. (2015). Qualitative research. In C. Johnson (Ed.), *Untitled manuscript* (pp. 71-101). University of Kansas.

Heinrich, K. T. (1997). Transforming impostors into heroes: Metaphors for innovative nursing education. *Nurse Educator, 22*(3), 45-50. Retrieved from http://ovidsp.tx.ovid.com.www2.lib.ku.edu/sp-3.23.1b/ovidweb.cgi?

Hellman, C. M. & Caselman, T. D. (2004). A psychometric evaluation of the Harvey imposter phenomenon scale. *Journal of Personality Assessment, 83*(2), 161-166. doi: 10.1207/s15327752jpa8302_10

Helping profession. (n.d.). Retrieved December 27, 2016, from http://www.oxfordreference.com.www2.lib.ku.edu/view/10.1093/acref/9780195418163.001 .0001/m_en_ca0031619?rskey=mFxrOY&result=1

Henning, K., Ey, S., & Shaw, D. (1998). Perfectionism, the impostor phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students. *Medical Education, 32*(5), 456-464. doi: 10.1046/j.1365-2923.1998.00234.x

Himelein, M. J. (1999). *A student's guide to careers in the helping professions*. Retrieved from http://citadel.sjfc.edu/faculty/tspitzer/helpingprof99.htm

Holmes, S. W., Kertay, L., Adamson, L. B., Holland, C. L., & Clance, P. R. (1993). Measuring the impostor phenomenon: A comparison of Clance's IP scale and Harvey's IP scale. *Journal of Personality Assessment, 60*(1), 48-59. doi: 10.1207/s1537752jpa6001_3

Hosseini, M., Davidson, P. M., Khoshknab, M. F., & Nasrabadi, A. N. (2015). Experience of spiritual care in cardiac rehabilitation: An interpretative phenomenological analysis. *Journal of Pastoral Care and Counseling, 69*(2), 68-76. doi: 10.1177/1542305015586347

Hutchins, H. M. (2015). Outing the imposter: A study exploring imposter phenomenon among higher education faculty. *New Horizons in Adult Education & Human Resource Development, 27*(2), 3-12. doi: 10.1002/nha3.20098

Johnson, R. B. & Christensen, L. (2014). *Educational research: Quantitative, qualitative, and mixed methods approaches* (5th ed.). Thousand Oaks, CA: SAGE Publication, Inc.

Johnson, D. W. & Johnson, R. T. (1989). *Cooperation and competition: Theory and research*. Edna, MN: Interaction Book Company.

Jones, R. G. (1968). *A factored measured of Ellis' irrational belief systems with personality and maladjustment correlated*. Wichita, KS: Test Systems.

Kets de Vries, M. F. R. (2005). The dangers of feeling like a fake. *Harvard Business Review, 83*(9), 108-116. Retrieved from https://hbr.org/2005/09/the-dangers-of-feeling-like-a-fake

Kim, D.-M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research, 16*(2), 161-172. doi: 10.1080/10503300500264911

King, J. E. & Cooley, E. L. (1995). Achievement orientation and the impostor phenomenon among college students. *Contemporary Educational Psychology, 20*(3), 304-312. doi: 10.1006/ceps.1995.1019

Kolligian, J. & Sternberg, R. J. (1991). Perceived fraudulence in young adults: Is there an "Impostor Syndrome?" *Journal of Personality Assessment, 56*(2), 308-326. Retrieved from http://web.b.ebscohost.com.www2.lib.ku.edu/ehost/detail/

Kottler, J. A. & Carlson, J. (2014). *On being a master therapist: Practicing what you preach*. Hoboken, NJ: John Wiley & Sons Inc.

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*(3), 267-276. doi: 10.1080/10503307.2011.563249

Kumar, S. & Jagacinski, C. M. (2006). Imposters have goals too: The imposter phenomenon and its relationship to achievement goal theory. *Personality and Individual Differences, 40*(1), 147-157. doi: 10.1016/j.paid.2005.05.014

Lamb, D. & Cogan, N. (2016). Coping with work-related stressors and building resilience in mental health workers: A comparative focus group study using interpretative phenomenological analysis. *Journal of Occupational and Organizational Psychology, 89*(3), 474-492. doi: 10.1111/joop.12136/full

Lane, J. A. (2015). The imposter phenomenon among emerging adults transitioning into professional life: Developing a grounded theory. *Adultspan Journal, 14*(2), 114-128. doi: 10.1002/adsp.12009/abstract

Langford, J. & Clance, P. R. (1993). The imposter phenomenon: Recent research findings regarding dynamics, personality and family patterns and their implication for treatment. *Psychotherapy: Theory, Research, Practice, Training, 30*(3), 495-501. doi: 10.1037/0033-3204.30.3.495

Lindenfelser, K. J., Grocke, D., & McFerran, K. (2008). Bereaved parents' experiences of music therapy with their terminally ill child. *Journal of Music Therapy, 45*(3), 330-348. doi: 10.1093/jmt/45.3.330

Li, S., Hughes, J. L., & Thu, S. M. (2014). The links between parenting styles and imposter phenomenon. *Psi Chi Journal of Psychological Research, 19*(2), 50-57. doi: 10.1016/j.paid.2005.10.005

Masko, M. K. (2016). Music therapy and spiritual care in end-of-life: A qualitative inquiry into ethics and training issues identified by chaplains and music therapists. *Journal of Music Therapy, 53*(4), 1-27. doi: 10.1093/jmt/thw009

Matthews, G. & Clance, P. R. (1985). Treatment of the impostor phenomenon in psychotherapy clients. *Psychotherapy in Private Practice, 3*(1), 71-81.

McGregor, L. N., Gee, D. E., & Posey, K. E. (2008). I feel like a fraud and it depresses me: The relation between the imposter phenomenon and depression. *Social Behavior and Personality, 36*(1), 43-48. Retrieved from http://web.a.ebscohost.com.www2.lib.ku.edu/ehost/pdfviewer/pdfviewer?sid=e3eaf731

Midgley, C. Kaplan, A. Middleton, M., Maehr, M. L., Urdan, T., Anderman, L. H., Anderman, E., & Roeser, R. (1998). The development and validation of scales assessing students' achievement goal orientations. *Contemporary Educational Psychology, 23*(2), 113-131. doi: 10.1006/ceps.1998.0965

Moos, R. H. & Moos, B. S. (1986). *Family environment scale manual* (2nd ed.). Palo Alto, CA: Consulting Psychologists Press.

Morgan, D. L. (1997). *Focus groups as qualitative research*. Newbury Park, CA: SAGE Publications, Inc.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE Publications, Inc.

Murphy, K. A., Blustein, D. L., Bohlig, A. J., & Platt, M. G. (2010). The college-to-career transition: An exploration of emerging adulthood. *Journal of Counseling & Development, 88*(2), 174-181. doi: 10.1002/j.1556-6678.2010.tb00006.x

Nicholls, J. G. (1984). Achievement motivation: Conceptions of ability, subjective experience, task choice, and performance. *Psychological Review, 91*(3), 328-346. doi: 10.1037/0033-295X.91.3.328

Noble, K. D. (1990). The female hero: A quest for healing and wholeness. *Women and Therapy, 9*(4), 3-18.

Oriel, K., Plane, M. B., & Mundt, M. (2004). Family medicine residents and the impostor phenomenon. *Family Medicine, 36*(4), 248-252.

Ott, A. (2016). *What separates the good from the great? Identifying key qualities of effective therapists.* (Unpublished manuscript).

Palmer, M., Larkin, M., de Visser, R., & Fadden, G. (2010). Developing an interpretative phenomenological approach to focus group data. *Qualitative Research in Psychology, 7*(2), 99-121. doi: 10.1080/14780880802513194

Peteet, B. J., Montgomery, L., & Weekes, J. C. (2015). Predictors of imposter phenomenon among talented ethnic minority undergraduate students. *The Journal of Negro Education, 84*(2), 175-186. doi: 10.7709/jnegroeducation.84.2.0175

Phillips-Pula, L., Strunk, J. & Pickler, R. H. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatric Health Care, 25*(1), 67-71. doi: 10.1016/j.pedhc.2010.09.004

Polach, J. L. (2004). Understanding the experience of college graduates during their first year of employment. *Human Resource Development Quarterly, 15*(1), 5-23. doi: 10.1002/hrdq.1084

Pothoulaki, M., MacDonald, R., & Flowers, P. (2012). An interpretative phenomenological analysis of an improvisational music therapy program for cancer patients. *Journal of Music Therapy, 49*(1), 45-67. doi: 10.1093/jmt/49.1.45

Ravitch, S. M. & Carl, N. M. (2016). *Qualitative research*. Thousand Oaks, CA: SAGE Publications, Inc.

Rhodewalt, F. (1990). Self-handicappers: Individual differences in the preference for anticipatory self-protective acts In R. Higgins, C. R. Snyder, & S. Berglas, *Self-handicapping the paradox that isn't* (pp. 69-106). New York: Plenum Press.

Ryckman, R., Hammer, M., Kaczor, M., & Gold, J. (1990). Construction of a hypercompetitive attitude scale. *Journal of Personality Assessment, 55*, 630-639. doi: 10.1080/00223891.1990.9674097

Ryckman, R., Hammer, M., Kaczor, M., & Gold, J. (1996). Construction of a personal

    development competitive attitude scale. *Journal of Personality Assessment, 66*, 374-385.

    doi: 10.1207/s15327752jpa6602_15

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton

    University Press.

Rosenberg, M. (1989). *Society and the adolescent self-image* (Rev. ed.). Middletown, CT:

    Wesleyan University Press.

Ross, S. R. & Krukowski, R. A. (2003). The imposter phenomenon and maladaptive personality:

    Type and trait characteristics. *Personality and Individual Differences, 34*(3), 477-484. doi:

    10.1016/S0191-8869(02)00067-3

Ross, S. R., Stewart, J., Mugge, M., & Fultz, B. (2001). The imposter phenomenon, achievement

    disposition, and the five factor model. *Personality and Individual Differences, 31*(8), 1347-

    1355. doi: 10.1016/S0191-8869(00)00228-2

Self-awareness. (n.d.). Retrieved December 6, 2016, from www.merriam-

    webster.com/dictionary/self-awareness

Self-fulfilling. (n.d.). Retrieved April 11, 2017, from

    http://www.oed.com.www2.lib.ku.edu/view/Entry/175256?redirectedFrom=self-

    fulfilling+prophecy#eid23803090

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice.

    International Journal of Qualitative Studies in Health and Well-being, 2(1), 3-11. doi:

    10.1080/17482620601016120

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis:

    Theory, method and research*. London: SAGE Publications LTD.

Snyder, M. (1972). *Individual differences and the self-control of expressive behavior*. (Doctoral dissertation). Retrieved from

http://search.proquest.com.www2.lib.ku.edu/docview/302669772

Spielberger, C. D. *State-trait anxiety inventory for adults*. Palo Alto, CA: Mind Garden Publishers.

Starks, H. & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. doi: 10.1177/1049732307307031

Stewart, D. & Mickunas, A. (1990). *Exploring phenomenology: A guide to the field and its literature*. Athens, OH: University Press.

Tolich, M. (2009). The principle of caveat emptor: Confidentiality and informed consent as endemic ethical dilemmas in focus group research. *Bioethical Inquiry, 6*(1), 99-108. doi: 10.1007/s11673-008-9124-3

Topping, M. E. (1983). *The impostor phenomenon: A study of its construct and incidence in university faculty members*. (Doctoral Dissertation). Retrieved from

http://search.proquest.com.www2.lib.ku.edu/docview/303193165/

Topping, M. E. & Kimmel, E. B. (1985). The impostor phenomenon: Feeling phony. *Academic Psychology Bulletin, 7*, 213-226.

Van Kaam, A. (1966). *Existential foundations of psychology.* Pittsburgh, PA: Duquesne University Press.

Van Manen, M. (1990). *Researching lived experience*. New York: State University of New York Press.

Vega, V. P. (2010). Personality, longevity, and burnout in professional music therapists. *Journal of Music Therapy, 47*(2), 155-179. doi: 10.1093/jmt/47.2.155

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes.* Cambridge: Harvard University Press.

Wampold, B. E. & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Counseling and Clinical Psychology, 73*(5), 914-923. doi: 10.1037/0022-006X.73.5.914

Warrell, M. (2014). Afraid of being 'found out?" How to overcome impostor syndrome. *Forbes Magazine*. Retrieved from http://www.forbes.com/sites/margiewarrell/2014/04/03/impostor-syndrome/#1edbe2e7eb9d

Zorn, D. (2005). Academic culture feeds the imposter phenomenon. *Academic Leader, 21*(8), 1-8. Retrieved from http://web.a.ebscohost.com.www2.lib.ku.edu/ehost/detail/detail?vid=2&sid=e92a44a1

Appendix A

Focus Group Script and Discussion Prompts

Focus Group Script

Introduction

        Hello and welcome to the focus group. Thank you all for being here and for taking the time out of your schedules to participate in a discussion about imposter phenomenon, a topic on which I will elaborate later in our discussion. Before we begin, everyone present should have read through and signed an informed consent statement, and completed a demographic questionnaire and CIPS; is there anyone who has not completed these handouts?

        If you look in your packet, you will see a copy of the informed consent statement, which I will briefly review. (READ THROUGH PROCEDURES, RISKS, BENEFITS, CONFIDENTIALITY STATEMENT, CANCELLING).

        In addition, you have been provided a handout regarding the Counseling and Psychological Services program at the University of Kansas. As stated in the Informed Consent Statement, today's discussion holds the risk of creating discomfort and/or an emotional response. Upon completion of the focus group, consult these services if needed.

        In order for the focus group to be productive, we need to discuss some basic ground rules. First, let's try to have one person speak at a time - this allows everyone's thoughts and ideas to be stated, and will help maintain the clarity of the audio recording. Next, let's try to refrain from side conversations, as we want to be respectful of the thoughts and opinions of our peers. Also, if a disagreement happens between two or more peers, that is ok, even encouraged. Thoughtful disagreements allow us to learn from one another and develop another viewpoint on a topic. If a disagreement occurs, let's focus on speaking to each other with respect and kindness.

        As we begin, I want to iterate everyone's role in this focus group. While I have a solid understanding of the tenants of imposter phenomenon, I believe you all to be the "experts" regarding its prevalence, or lack thereof, in music therapy students. Please feel free to share all ideas you may have, as these thoughts will provide important insight regarding the aims of this research study.

        Ok, let's begin our discussion.

        (Begin discussion prompts) …

Conclusion

        As we wrap up our conversation, I would like to give each of you the opportunity to make a final summary statement, if you wish to do so. This can include concluding thoughts, suggestions, ideas, topics you forgot to expand upon earlier…

(Allow subjects to provide statements.)

        That concludes our focus group. Thank you all again for taking the time to discuss this unique topic. In our first meeting you completed a survey indicating characteristics of imposter phenomenon. If you would like to have a copy of your survey and know the meaning of your CIPS scores, I can provide that information. Please keep in mind that Counseling and Psychological Services program at the University are available should you feel the need to seek support. Remember, all topics discussed in this meeting are confidential and are not to leave this

room. Discussion of topics outside of this meeting will be a direct violation of your Confidentiality Statement. Thank you very much for listening to and respecting the privacy of your peers, and thank you for taking the time out of your busy schedules to have a meaningful discussion.

(Should the subjects request their CIPS surveys, the researcher will return a copy of their survey that has been placed in a sealed envelope with the faculty advisor's signature on the seal and secured with tape. The researcher will privately tell subject the relationship of their score to low, moderate, or high characteristics of imposter phenomenon. If the subject expresses any adverse response to their CIPS score, they will again be reminded of the availability of university counseling services and this occurrence will be reported to the faculty advisor for follow up. Any adverse responses will also be reported to the IRB.)

Discussion Prompts

1. Please look in your packet and find the document with the title, "Imposter Phenomenon Handout." (Researcher will read through the basic tenants of the handout and highlight that this is going to be the main point of discussion for the group).
    a. What are your thoughts about IP?
    b. Have you heard of IP before?
    c. Does this sound like something that may apply to you? If so, in what way(s)?
    d. Does this sound like something that may apply to you as a student?
        i. If so, in what way(s)?
    e. Does this sound like something that may apply to your peers?
        i. If so, in what way(s)?
2. The presence of IP in an individual has been shown to produce many different psychological constructs, or symptoms. On the wall is a list of these constructs.
    a. During your time as a music therapy student, you may have experienced one or more of these constructs/symptoms?
        i. Is there a construct anyone would like to talk about?
        ii. Would anyone like to describe a specific instance of experiencing this construct during your time as a music therapy student? (Remind subjects that they do not have to share if they do not feel comfortable).
3. At this point, everyone should have completed the CIPS. You may find your completed CIPS in your packet.
    a. What are your thoughts about it?
    b. Do you think this scale applies to you? Why or why not?
    c. What was it like to take the CIPS?
        i. Does everyone agree? Anyone have a different experience?
        ii. Which question(s) do you think best describe(s) you? Why?
        iii. Which question(s) did you feel most directly related to you as a music therapy student? Why?
4. The research indicates that there may be family dynamics which influence the development of IP. This can include a child who is considered the "bright" one of the family. For this child, success comes easily to them, and this idea is reinforced throughout their lives. When they do finally encounter failure, they believe the success

they previously had was luck. In contrast, a child may not be considered the "bright" one of their family, so they work hard for their successes. While they do accomplish, these are not often acknowledged by the family, so they feel like they do not deserve the achievements they gain.

    a. Can you relate to either of these situations?
        i. If so, how so? Can you describe a specific example?
    b. Are there any other ways you feel that your upbringing may have contributed to/hindered the development of IP?

5. Individuals with IP may also be experiencing a transition in their lives. This transition may be job-related, personal, or school-related (i.e., transition from high school to college, college to a job, a job to graduate school…) This transition can bring with it uncertainty, stress, tension, and personal imbalance, which may contribute to feelings of IP.

    a. Would you describe yourself as being in a transitional stage of life?
        i. If so, in what ways?
        ii. If so, what does "transition" look like for you?
        iii. If so, in what ways is that influencing you personally?
        iv. If so, in what ways is that influencing you professionally?

6. The origins of IP began with an investigation of "high-achieving" women. Subsequent research of IP has provided mixed results as to whether or not women experience more IP than men. As the profession of music therapy is inherently female-based, part of the guiding framework for this study is asserting that music therapy students are likely to have symptoms of IP due to gender.

    a. Why might female music therapy students feel like "imposters?"
    b. Why might male music therapy students feel like "imposters?"
    c. Do you believe IP is inherent in music therapy students?
        i. If so, what are your thoughts regarding IP in women vs. men?
        ii. If not, why?

7. A component of this research study seeks to understand if and how IP might influence therapist effectiveness.

    a. How would you describe therapist effectiveness?
    b. Do you think therapeutic effectiveness might be influenced by IP?
        i. If so, how so?
        ii. If not, why not?
    c. For those who believe they may experience one or more symptoms relating to IP, do you think it may have influenced, or is currently influencing, your effectiveness as a therapist?
        i. If so, how so?
        ii. If no, why not?

Appendix B

Informed Consent

Informed Consent Statement

A Phenomenological Examination of Imposter Phenomenon in Music Therapy Students

INTRODUCTION

The Department of Music Education and Music Therapy at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or the University of Kansas.

PURPOSE OF THE STUDY

The purpose of the following study is to examine and gain a general understanding of the prevalence, or lack thereof, of imposter phenomenon (IP) in music therapy students.

PROCEDURES

You will be asked to complete a survey of imposter phenomenon tendencies (i.e., CIPS) and participate in a focus group along with other music therapy peers. The group size will range from four to seven subjects. The focus group will be conducted on campus in Murphy Hall, room 578. The focus group will meet for a duration lasting between 60-90 minutes. During the focus group meeting, you will be asked to:
1. Review the basic elements of IP
2. Discuss and share your individual experiences, or lack thereof, regarding IP

The focus group will be run by the researcher of this study, who will provide the discussion prompts in accordance with the focus group schedule. A research assistant will also be in attendance, and will be taking notes for the researcher.

Participation in the focus group requires knowledge and consent to be audiotaped. If at any moment you wish to cease participation, you may do so, and the audiotape will be paused. The audiotaped recording will be transcribed following the conclusion of the focus group. Transcriptions will be completed by the researcher. The researcher, research assistant, and faculty supervisor will have access to the recordings and subsequent transcriptions, which will be stored on an encrypted external flash drive. The flash drive will be stored in a locked file cabinet, to which the researcher, research assistant, and faculty supervisor have access. The faculty advisor will be the only one with access to your CIPS score and will form the focus groups should more than seven students consent to participate. Upon request, CIPS will be returned to you following the focus group discussion and you will be provided with information about the scoring of this survey.

RISKS

Participation in the focus group requires discussion of experiences and stories of a personal nature. For some individuals, these admissions may bring about discomfort and/or an emotional response. If such events occur, the participant may consider consulting the University of Kansas Counseling and Psychological Services for follow-up support. Although not expected, any noticed or suspected adverse responses (e.g. refusal or shift in level of participation, crying, yelling or leaving in the middle of the focus group) by a subject during the focus group will be reported to the faculty advisor by the researcher or researcher assistant. The faculty advisor will follow up in person and/or email within 24 hours of the focus group with the subject to ensure safety of the subject and a recommendation to seek university counseling services will be made. Any adverse responses will also be reported to the IRB.

Should the subjects request their CIPS surveys, the researcher will return a copy of their survey that has been placed in a sealed envelope with the faculty advisor's signature on the seal and secured with tape. The researcher will tell subjects the relationship of their score to low, moderate, or high characteristics of imposter phenomenon without asking for the subject's score. If the subject expresses any adverse response to their CIPS score, they will again be reminded of the availability of university counseling services and this occurrence will be reported to the faculty advisor for follow up with the subject to ensure safety of the subject. Any adverse responses will also be reported to the IRB.

Additionally, participation in focus groups brings about the risk of disclosing information in the presence of other subjects. While all subjects are asked to sign a statement of confidentiality, disclosure of information outside of the focus groups is impossible to restrict, particularly as there are no formal sanctions towards preventing this.

BENEFITS

Participation in the focus group may bring awareness to certain thoughts, ideals, and personality patterns related to IP. The dynamics and interrelated discussion of the focus group may also provide a supportive environment for those who may have IP tendencies. For individuals who may not exhibit symptoms of IP, this group may provide an informational experience regarding this psychological phenomenon.

On a personal level, participating in this study may help you identify characteristics of IP that can be minimized to improve your personal and professional development as a music therapist. In addition, your participation in this study will inform the prevalence, if any, of IP tendencies in a small convenience sample of music therapy students, which may provide information that can be used to understand how to better support student development and ultimately improve therapeutic effectiveness in clinical training programs.

PARTICIPANT CONFIDENTIALITY

Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researchers will use a participant identification number rather than your name. Your identifiable information will not be shared unless (a) it is required by law or university policy, or (b) you give written permission.

Permission granted on this date to use and disclose your information remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

_____ **Participation in this study asks that subjects share personal experiences and thoughts related to IP experiences. These admissions have the potential to bring about a variety of emotional topics and responses. By initialing this statement, you are hereby agreeing to refrain from discussing or sharing any topics or content that are discussed or shared by you or other subjects of this focus group. Consenting to this statement is required to participate in the study.**

INSTITUTIONAL DISCLAIMER STATEMENT

In the event of injury, the Kansas Tort Claims Act provides for compensation if it can be demonstrated that the injury was caused by the negligent or wrongful act or omission of a state employee acting within the scope of his/her employment.

REFUSAL TO SIGN CONSENT AND AUTHORIZATION

You are not required to sign this Consent and Authorization form and you may refuse to do so without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. However, if you refuse to sign, you cannot participate in this study.

CANCELLING THIS CONSENT AND AUTHORIZATION

You may withdraw your consent to participate in this study at any time. You also have the right to cancel your permission to use and disclose further information collected about you, in writing, at any time, by sending your written request to: *juliadsims@gmail.com*

If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

QUESTIONS ABOUT PARTICIPATION

Questions about procedures should be directed to the researchers listed at the end of this consent form.

PARTICIPANT CERTIFICATION:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email irb@ku.edu.

I agree to take part in this study as a research participant. By my signature I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

_____   _____
    Type/Print Participant's Name   Date

_____
            Participant's Signature

Researcher Contact Information

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Appendix C

Demographic Questionnaire

4. <u>Current Year in School</u>:

1. <u>Age</u>: _____

___ *Undergraduate*

2. <u>Please Identify Your Gender</u>:

____ How many semesters?

_____

___ *Masters*

3. <u>Ethnicity</u>:

____ How many semesters?

___ White

___ Hispanic/Latino   ___ *Doctorate*

___ Black/African American

___ Native American/American

Indian   ____ How many semesters?

___ Asian/Pacific Islander

___ Other   5. <u>GPA Estimate</u>: _____

   Specify: _____

Appendix D

Imposter Phenomenon Handout

<u>Imposter Phenomenon</u>

Imposter phenomenon (IP) is an internal experience that impacts an individual's inability to accept any achievements as something they have rightfully gained. An individual with IP may work hard towards a goal (e.g., a job promotion, a passing grade on a test, acceptance into college), but will fail to believe that their hard work helped in fulfilling that goal. This individual will attribute their success to "luck" or "being in the right place at the right time" or as a mistake.

Appendix E

Data Analysis Worksheet

Emergent Themes (Step 3)	Original Transcript (Step 1) Date of Focus Group: _____	Exploratory Comments (Step 2)

Appendix F

Recruitment Flyer

A Phenomenological Examination of
Imposter Phenomenon in Music Therapy Students

DO YOU EVER FEEL LIKE AN IMPOSTER?

Music Therapy Students

Purpose
This research study seeks to examine the prevalence (or lack thereof) of imposter phenomenon in collegiate music therapy students

Who
-All music therapy students at the University of Kansas. This includes:
- -1st year   -4th year
- -2nd year   -5+ years
- -3rd year

-Graduate equivalency (pre- & post-internship)
-Masters
-Ph.D.'s
-*Must be 18 years of age or older*

Symptoms
-Anxiety   -Depression
-Low Self Esteem   -Perfectionism
-Fear of Failure   -Workaholism

Participation
-One-time focus group meeting
-Between 60-90 minutes
-Minimal risk involved with participating

CONTACT:
Julia Sims, MT-BC
juliadsims@gmail.com
Dr. Hanson-Abromeit
dhansonabromeit@ku.edu

Appendix G

Recruitment Email

Research Study: *A Phenomenological Examination of Imposter Phenomenon in Music Therapy Students*

You are invited to participate in a focus group discussion regarding the prevalence, or lack thereof, of imposter phenomenon in music therapy students. In order to be included in the study, you must be a current music therapy student enrolled at the University of Kansas. Both undergraduate and graduate music therapy students may enroll in the study.

Participation includes two components:
1. A one-on-one meeting with the researcher, lasting 20-25 minutes. During this meeting, you will learn more about the research study and informed consent. If you choose to sign the Informed Consent Statement, you will be asked to complete the Demographic Questionnaire, a 20-item Clance Imposter Phenomenon Scale test, and provide your availability for the focus group.
2. Participation in a one-time focus group, lasting 60-90 minutes. The focus group meeting will take place in Murphy Hall, room 578. Accommodations will be made as necessary in accordance with each participant's availability.

If you are interested in participating, please contact Julia Sims at juliadsims@gmail.com or 817-584-1694, or Dr. Hanson-Abromeit at dhansonabromeit@ku.edu.

Sincerely,
Julia Sims, MT-BC

Appendix H

University of Kansas Counseling and Psychological Services Handout

Mission Statement

The mission of Counseling and Psychological Services is to aid in the emotional and psychological development of students in the university environment for the purpose of enhancing performance; assist in the evaluation of student academic progress for the purpose of improving student and faculty functioning and; contribute to the professional education of graduate students in mental health and counseling professions.

Goals

Assist students in improving decision-making; identifying and using resources; and achieving academic, social and personal success.

Why CAPS?

Students who visit CAPS have a variety of interests and concerns. Many students seek help for psychological, interpersonal, family problems and other issues related to succeeding at the university. Individual and group session are available.

CAPS staff are also available for consultation to students who may have concerns about another student or friend, or about a particular situation. CAPS staff members are also available to consult with faculty and staff regarding such issues.

Appendix I

Table of Transcript Themes, Subthemes, and Corroborating Quotes

Uncertainty in education transitions • Transition into college • Transition into practicum • Transition into internship	• "I'm just starting this whole college thing and figuring out what I wanna do with my life." • "I'm in a transition with going away to college and figuring out my medical stuff on my own. Without my parents there. So that's hard." • "…I put off looking for internships again cause I just felt like I wasn't ready." • …my junior year…I was having a lot of self-doubt because I wasn't doing very well in my practicum, and it wasn't feeling very successful." • …right now with practicum, some of these symptoms, the unworthiness one, or feeling like I don't really belong…I'm not a music therapist yet…"
• Transition back to school • Transition out of graduate school	• "…coming back to grad school's kind of like, whoa! …realizing how little of the broader philosophies I have been taught…feeling like my knowledge is smaller in those areas…Definitely testing me at the beginning." *(Regarding returning to school)* • "I don't know if I'll ever feel…like I've learned enough." *(Regarding leaving graduate school)* • "I feel like I'm not ready for…going to the real world, so I'm just...anxious in graduate school." (#2, p. 7)
Challenges of the music therapy profession • Ambiguity of music therapy profession • Struggles related to professional advocacy and responsibilities	• <u>Ambiguity</u> • "…it's a really new field…when I just came to [the] program, the biggest reason I feel like an imposter…it's because I feel like it's so ambiguous…" (#2, p. 38) • "As soon as there's ambiguity, there's increase in anxiety, unsuredness…" (#2, p. 38) • "…that preconceived notion that therapists are just…these girls learning their pop songs." (#2, p. 8). • <u>Advocacy</u> • "I feel like an imposter, and I'm in a setting where I see new clients every single week…you're advocating for the profession all the time cause you're explaining…who you are, what you're gonna do. And a lot of times people are hesitant…And so I feel like I don't really belong...makes it harder for me to advocate…" (#1, p. 19) • "I think as a student, it's hard to advocate because you're not a professional yet…" (#1, p. 20) • "…the high work expectations, we talk about trying to

	grow and change the profession, that's a big weight on our shoulders." (#2, p. 10)
Awareness and impact of IP constructs and patterns • Awareness of putting in a great deal of work for achievements	• "…'sometimes I feel or believe that my success in life in my job has been a results of error of like, luck…'I don't really feel like that…" (#2, p. 17) • "…I know I've worked hard to obtain what I have, it's more…are other people's opinions just incorrect…" (#2, p. 17) • "It's like, if nobody says anything, I feel like I did the worst job in the world. And I wish that I didn't depend on validation, external validation." (#2, p. 23)
• Awareness of personal extent of imposter tendencies after taking CIPS	• "…I was filling it out, and I thought, well, I don't know, I guess, I was filling it out and I was thinking, 'I mean, I'm kind of this way, but not really…' like maybe its…a cycle." (#2, p.17) • "My thoughts were like, oh this is how I feel at this point in time, but next week it could be different, next year could be different…" (#2, p. 15)
• Awareness of imposter tendencies in peers	• "I think in general, I would say that imposter phenomenon…just by observing peers, I feel like it is definitely present and especially the peers that I've been with since the beginning of the program. I've really seen a lot of these symptoms in people, just by sharing in class…I feel like a lot of other peers would relate to all of this stuff." (#1, p. 28)
• Awareness of emotions during sessions that may inhibit therapist effectiveness • • Constant comparison of skills to other peers • Fear of judgment from others	• "I find that if I don't believe my session plan is good…then I don't think that it will go well, and some of the times it doesn't cause I think that…" (#2, p. 35) • I feel like as a[n] [undergraduate], I almost feel like I'm not supposed to be here, like, all of the other upperclassman around me are like, doing these great things, and I'm like…"Should I be a music therapist?" (#1, p. 2) • "…we don't want to be like those people that left [the program]." (#2, p. 9) • "…debate about Master's level entry…that could have something to do with this…imposter syndrome of, '…we're not good enough, we're gonna be completely judged by other medical professionals'" (#2, p. 33)

	• "[I] compare myself to others and feel where I fit in…'oh man, they're so much better than me,' that is more of what I'm feeling most of the time. So, I think that's often the kind of basis for that fear of judgment." (#2, p. 8)