

## Kenny Music Performance Anxiety Inventory: Seven or eleven categories of response? Some empirical evidence

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**Abstract:** The objective of this work was to propose an adaptation of the Kenny Music Performance Anxiety Inventory (KMPAI) scale for the assessment of musical performance anxiety that offers better psychometric indices (such as reliability and sensitivity) than the original scale, and that is more in line with our cognitive/cultural context. The instrument has been presented to 134 musicians in two forms: (a) the original questionnaire (with 7 response options) and (b) another with an extended response scale (with 11 anchor points). The results suggest that the adapted form (KMPAI-ERE) improves its psychometric and discriminative properties compared to the original form, and is proposed as valid for the assessment of performance anxiety. It was concluded that this form of the questionnaire can be proposed as an alternative to the original form in future research, as it allows for more precise responses in its scope.

**Keywords.** Musicians; musical performance anxiety; assessment; K-MPAI.

*Estudio del cuestionario de ansiedad escénica de Kenny:  
 ¿Siete u once categorías de respuesta? Algunas evidencias empíricas*

**Resumen:** El objetivo del presente trabajo ha sido proponer una adaptación de la escala KMPAI para la evaluación de la ansiedad escénica musical que ofrezca mejores índices psicométricos (como la fiabilidad y sensibilidad) que la escala original, y que resulte más acorde a nuestro contexto cognitivo/cultural. El instrumento se ha presentado a 134 músicos en dos formas: a) la original del cuestionario (con 7 opciones de respuesta) y b) otra con una escala de respuesta extendida (con 11 puntos de anclaje). Los resultados sugieren que la forma adaptada (KMPAI-ERE) mejora sus propiedades psicométricas y discriminativas respecto de la forma original, y se postula como válida para la evaluación de la ansiedad escénica musical. Se concluye que esta forma del cuestionario puede ser propuesta en futuras investigaciones como alternativa a la forma original al permitir respuestas más precisas en su amplitud.

**Palabras clave:** Músicos; ansiedad escénica musical; evaluación; cuestionario K-MPAI.

### Introduction

Musical performance anxiety (MPA) is a complex phenomenon that combines biological, psychological and

environmental factors (Kenny et al., 2004). It is, therefore, a multifaceted experience, experienced in a problematic way by many musicians, which can not only hinder the enjoyment of musical activity but even discourage them from pursuing a professional career (Cina, 2021).

On the other hand, MPA is common to students entering formal music schools (Fehm y Schmidt, 2006; Lupiáñez et al., 2022; Osborne y Kenny, 2005; Zarza-Alzugaray et al., 2018) and has been identified at different stages of their education, both in the early

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years (Boucher y Ryan, 2011; Kenny y Osborne, 2006; Urruzola y Bernaras, 2020) and in higher education (Zarza-Alzugaray et al., 2016). There is also evidence of the presence of MPA in professional and amateur musicians (Casanova et al., 2018; Herrera y Campoy, 2020; Wilson y Roland, 2002) having a negative impact on or impairing musical performance (Herrera, Manjón y Quiles, 2015) especially when performing as a soloist as opposed to in a group (Papageorgi et al., 2013). It affects musicians throughout their lives and can be experienced at any of the formative stages. The quality of the interpretation may not necessarily be affected (Kenny, 2011).

Recent research shows that the prevalence of MPA ranges from 16.5% to 60% and with variations of increasing intensity in terms of the presence and manifestation of symptoms (Fernholz et al., 2019). Furthermore, according to some studies, the estimated drop-out rate in specialized music education fields due to this reason is around 20% (Dalia, 2004).

Different strategies have been proposed to help prevent and/or cope with this specific anxiety (Burin y Osório, 2017; Fernholz et al., 2019; McGrath et al., 2016; Sinico y Winter, 2013). The research shows us that the cognitive behavioural approach presents clear scientific and empirical evidence of its usefulness, addressing musicians cognitive, behavioural and emotional symptoms in their treatment strategies (Kenny, 2004; Kenny, 2005; Ortiz-Brugués, 2011). The recent proposal presented by Moral-Bofill (Moral-Bofill et al., 2022; Moral-Bofill et al., 2020) is noteworthy; it proposes a program for coping with performance anxiety based on the development of self-regulation skills of flow state.

A key challenge for the generalization of these proposals lies in the possibility of assessing their impact. That is, having measurement tools that can be used to verify the effect of these actions and strategies. In this context, one of the most widely used instruments is the *Kenny Music Performance Anxiety Inventory-KMPAI* (Kenny, 2011). The original version of the questionnaire by Kenny et al. (2004) had a sample of thirty-two elite choir singers, who were invited to participate voluntarily, and which also explored the interrelationships of state and trait anxiety, occupational stress and perfectionism with MPA. This first version of the KMPAI consisted of 26 items whose responses were expressed on a 7-point Likert-type scale. The internal reliability of the questionnaire obtained from Cronbach's Alpha was .92. In the inspections of the correlations between the items, three problematic items were detected and eliminated, allowing the instrument to obtain a final Cronbach's Alpha of .94. The total correlation of the items ranged from .347 to .89.

Several versions of this instrument have been presented, some expanding the number of items (Kenny, 2009b) and others making adaptations for adolescent musicians (Osborne, y Kenny, 2005). In Spain, the original 26-item version of the KMPAI was translated and adapted to the Spanish population by Zarza-Alzugaray in 2014 and subsequently revised in 2015 (Zarza-Alzugaray, 2014; Zarza-Alzugaray et al., 2015). This version obtained a Cronbach's Alpha of 0.86, providing good psychometric properties and making it valid for measuring MPA. The 40-item version of the KMPAI (Kenny, 2009b) was also adapted to the Spanish population by Rodríguez (2015), obtaining a reliability scale with a Cronbach's Alpha of .91.

The instrument proposed by these authors has been widely accepted and its use has become very popular among Spanish speakers, however, from our point of view, it is worth reviewing it to try to get better psychometric indices, as well as a true adaptation to our social and cultural environment. For example, this scale uses a Likert-format response range with 7 anchor points, each labelled on an ordinal scale ranging from *strongly disagree* to *strongly agree*. However, reports have been submitted showing that larger scale ranges seem to improve the sensitivity and accuracy of the measurements (Batista-Foguet et al., 2009; Cummins, 1997; Hooker y Siegler, 1993; Lozano et al., 2008; Watkins et al., 1998). Furthermore, other studies question the use of central categories in this type of scale (Andrich et al., 1997; Baeza et al., 2001; Dubois y Burns, 1975; Tort y Romà, 1999; Tort et al., 1999). Finally, it should be noted that in our cultural environment it is common and widespread to use scales from 0 to 10 when evaluating or assessing almost any object or event (Bisquerra y Pérez-Escoda, 2015).

The main objective of this study was to examine two forms of presentation of the KMPAI. To do so, the KMPAI questionnaire will be compared, according to the version adapted and validated in Spain by Zarza-Alzugaray (2014), with a form of this instrument in which, while maintaining the items originally proposed, the response alternatives are offered on a Likert scale with a range of 0 to 10. 2. A complementary objective was to determine the preference indicated by participants for either of the forms of presentation of the KMPAI scale.

The objectives were operationalized in the following hypotheses: (1) The adapted form of the KMPAI-ERS (Extended Response Scale) questionnaire will offer better reliability and internal consistency indices than the original form (KMPAI-FO). (2) The items from both types of the questionnaire will be grouped in a similar way according to the three original factors proposed by Zarza-Alzugaray (2014). The items of both forms of the

questionnaire will be grouped, with similar weights, into the three original factors proposed by Zarza-Alzugaray (2014). (3) The sensitivity/specificity of the adapted form of the questionnaire (KMPAI-ERS) will give better values than the original form (KMPAI-FO). And (4) the percentage of participants showing a preference for the adapted form of the questionnaire (KMPAI-ERS) will be significantly higher than those indicating a preference for the original form (KMPAI-FO).

## Method

### Participants

134 musicians participated in the study, of whom 54% were women, 45% were men, and there were two cases of subjects who chose not to report this personal characteristic. The mean age was 31.41 years ( $SD = 14.60$ ). The starting age for musical training ranged from 3 to 59 years ( $M = 10.47$ ;  $SD = 8.45$ ). In terms of their dedication to music, the hours of practice with the instrument ranged from 1 to 42 hours per week ( $M = 10.9$ ;  $SD = 8.26$ ). Subjects reported having participated in an average of 13 auditions or concerts in the last year (with a minimum of 0 and a maximum of 136).

Regarding musical training at the time of this study, it was found that 31% of the sample were undertaking professional music studies, and 29% were undertaking higher studies, with 40% of the sample being graduates (with different postgraduate degrees). Overall, the participants represented the majority of symphonic instruments which are, in turn, studied in conservatories (piano, flute, clarinet, percussion, trombone, cello, trumpet, bassoon, French horn, saxophone, tuba, euphonium, guitar, double bass, violin, viola, oboe, organ, electric guitar, vocal singing), with 40.8% being pianists.

### Instruments

A form containing various sociodemographic and musical level questions was used, as well as the KMPAI questionnaire in two forms: (a) Original Form (KMPAI-FO) with 7 anchor points, labelled as: *Totally Disagree*, *Strongly Disagree*, *Somewhat Disagree*, *Indifferent*, *Somewhat Agree*, *Strongly Agree* and *Totally Agree* (Zarza-Alzugaray, 2014). This is a 26-item self-report scale that assesses the degree of musical performance anxiety. The items are grouped into three factors (negative cognitions, helplessness and family context) and high scores on each factor indicate high scores due to the corresponding vulnerability factor and vice versa. Normal values are in a range of 0-67 points divided by quartiles: Quartile 1, 0-39 points; Quartile 2, 40-55;

Quartile 3, from 56-67; and Quartile, from 68 onwards. The total score is obtained from the sum of the items. Subjects who score in quartile 4 are considered to have AEM. As previously indicated, the Zarza-Alzugaray version obtained a Cronbach's  $\alpha$  of 0.86, therefore being an instrument with good psychometric properties. And (b) Extended Response Scale Form (KMPAI-ERS), with response range from 0 to 10 (11 anchor points). In addition, at the end of the questionnaire there was a question regarding the preference for either type of response according to each of the two forms of the KMPAI questionnaire.

The form was programmed to adapt the wording of the questions to the self-reported gender. Thus, questions were asked with feminine wording for those who said they were female, while for those who said they were male (or who chose not to answer this question) questions were asked with masculine wording. The questions were organized in such a way that it was "mandatory" to answer them all (Google marks this requirement with a red asterisk at the end of each question). In this way, the participants answered all the questions in the survey and there were no cases where there was no response to any of the questions posed by the tool. This instrument is presented in Appendix 1.

### Procedure

The sample was obtained through snowball sampling, through social networking and UNED communication tools, as well as various conservatories and music schools in Spain. All interested individuals were offered the possibility to participate in this research by completing a survey that was submitted online. The form was published through the *Google Forms* tool, which included the KMPAI questionnaire in two forms: (a) original form (Zarza-Alzugaray, 2014) and (b) extended response scale form. Recipients were informed that participation consisted of filling in a Google form, and included a text on compliance with bioethical standards. At the beginning of the questionnaire, participants were asked for their informed consent. Minors who participated in the study (up to 15 years old) were asked for explicit permission from their parents or legal guardians. In addition, parents or legal guardians must be present during the answer to the first two questions.

### Statistical analysis

Statistical analyses were carried out using SPSS version 27.0 (IBM Corp., 2020). For the descriptive study of both KMPAI forms, the values of central tendency

and dispersion (mean and standard deviation) were calculated. Reliability was calculated for both forms of the questionnaire using the Cronbach's Alpha statistic. In addition, Pearson's correlation coefficient was calculated for the overall scores of both questionnaires. To determine the dimensionality or factorial structure of the original and adapted forms of the questionnaire, both factorial analyses were carried out using the principal components method with varimax rotation, forcing the solution to three factors, in accordance with the procedure followed for the adaptation of this questionnaire to Spanish carried out by Zarza-Alzugaray et al. (2016). The sensitivity and specificity indices of the two instruments (KMPAI-FO and KMPAI-ERS) were calculated and compared, taking as criteria those subjects in the sample who had received medical or psychological treatment, or had had to resort to taking medication to cope with the difficulties generated by musical activity, and those who had not received any type of medical treatment and/or psychological intervention and had not taken any type of drug or substance to cope with the demands of musical activity. The calculation of these indices was carried out following the procedure described by Vizcaíno-Salazar (2017). Finally, the percentages of participants who said they preferred either form of presentation of the KMPAI were calculated and compared descriptively.

## Results

The mean values and standard deviations obtained for both forms of the questionnaire were 67.81 (SD = 26.67) for the original form (KMPAI-FO) and 110.30 (47.16) for the adapted form (KMPAI-ERS). Regarding the reliability of the questionnaires, the Cronbach's Alpha statistic for the original form was 0.91, and for the adapted form (KMPAI-ERS), 0.92. Correlation between both forms of the questionnaire (KMPAI-FO and KMPAI-ERS) was .97 ( $p \leq .001$ ).

Based on the factor analysis, the explained variance was 49.21% for KMPAI-FO and 54.65% for KMPAI-ERS. No differences were found in factor configurations, although the rotated solutions showed some variations in the ordering of the factors due to their weights.

Table 1 shows the rotated component matrices for both forms of the instrument used.

Table 2 shows the mean values and standard deviations obtained by the sample as a whole, as well as by those who had or had not gone to a psychologist and those who had or had not used medication. The data collected in the table show the relationship between the mean values obtained in both forms of the KMPAI (overall sample and the subgroups of whether they

resorted to psychological professionals or whether or not they used medication).

To estimate the diagnostic ability of both forms of the questionnaire (KMPAI-FO and KMPAI-ERS) with respect to subjects who, scoring positively or negatively (according to the KMPAI scale parameters), have or do not have MPA, sensitivity and specificity indices were calculated. Table 3 presents the results obtained for the calculation of sensitivity and specificity for both forms of the questionnaire, according to the procedure described in Vizcaíno-Salazar (2017).

The results of our study show greater sensitivity when the amplitude was increased with 11 anchor points (KMPAI-ERS) compared to the 7 anchor points of the KMPAI-FO form. Specifically, when we used the use or non-use of healthcare professionals as a criterion, the sensitivity of the form with an extended response scale was 0.82 compared to 0.68 for the original form. When the criteria was the use or non-use of medication, the KMPAI-FO form showed a sensitivity of 0.666 compared to 0.571 for the original form.

Finally, regarding the subjective preference for the presentation of the two forms of the KMPAI, the original form (Likert scale with 7 anchor points, labelled nominally) and the adapted form (anchor range of 11 points, 0 to 10), we found that 62.7% of the sample (84 subjects out of 134) preferred the response form with a scale of 0 to 10, compared to 37.3% (50 subjects) who opted for the response form with sentences. Table 4 shows the frequencies and percentages of participants who preferred the original KMPAI response form (with sentences) and the adapted form (numerical scale).

## Discussion

The primary objective of this study was to evaluate the psychometric properties of the two forms of presentation of the KMPAI scale in order to maximize the validity of the data obtained with them, that is, the estimation of the degree of MPA present in the musicians being assessed.

Results confirm in general our predictions. Reliability (Cronbach's alpha) was higher for the adapted KMPAI-ERS than for the original KMPAI-FO. On the other hand, the correlation between both forms of the questionnaire is very high ( $r = .97$ ), suggesting the construct validity of the adapted form. These results are consistent with findings of different authors who have found a positive correlation between the response range on a scale and its reliability, so that increasing the number of options on the scale also increases its reliability (Bisquerra y Pérez-Escoda, 2015; Carrillo, 2022). Furthermore, the mean values obtained in both forms of the KMPAI indicate a

Table 1. Rotated component matrices for both forms of the instrument used

Original form KMPAI-FO			Adapted form KMPAI- ERS				
Item	Component*			Item	Component**		
	1	2	3		1	2	3
22	.829			22	.831		
14	.774			10	.757		
12	.759			18	.753		
20	.752			20	.745		
10	.725			12	.743		
18	.720			13	.722		
25	.657			17	.699		
15	.655			14	.694		
17	.655			25	.692		
13	.639			15	.651		
7	.499			7	.610		
5	.373			5	.456		
23		.763		23		.842	
11		.752		6		.837	
6		.743		11		.801	
1		.683		1		.797	
4		.613		16		.724	
16		.610		4		.672	
3		.433		3		.572	
19			.771	19			.824
9			.759	9			.805
24			.741	24			.794
21			.407	21			.493
2				2			
8				8			
26	.372		.369	26	.394		.392

Note: Extraction method: principal component analysis. Rotation method: Varimax with Kaiser normalization. \* Rotation has converged in 5 iterations. \*\* Rotation has converged in 6 iterations

Table 2. Mean (and SD) scores obtained by participants in each of the KMPAI forms according to whether or not they required professional care and whether or not they used medication

	Total sample (N=134)	Psychologist* (N=50)	Medication** (N=42)	No psychologist (N=84)	No medication (N=92)
KMPAI	67.81	83.26	72.50	58.61	65.67
Original form	(26.67)	(22.82)	(27.33)	(24.56)	(26.24)
KMPAI	110.30	132.52	116.33	90.70	101.72
Adapted form	(47.16)	(39.72)	(45.43)	(44.40)	(47.46)

Note: \* Participants who reported having required professional care in relation to performance anxiety

\*\* Participants who reported using medication in relation to performance anxiety

Table 3. Sensitivity and specificity values of the KMPAI in both forms, KMPAI-FO and KMPAI- ERS, according to whether or not healthcare professionals were used, and according to whether or not medication was used

		KMPAI-FO	KMPAI-ERS
Healthcare professionals	Sensitivity	.680	.820
	Specificity	.788	.726
Medication	Sensitivity	.571	.666
	Specificity	.615	.304

Table 4. Frequency and percentage of individuals who preferred the original KMPAI response form (with sentences) and the adapted KMPAI response form (numerical scale)

		Frequency	Percentage	Valid percentage	Cumulative percentage
Valid	The response form with sentences	50	37.3	37.3	37.3
	The response form with a scale of 0 to 10	84	62.7	62.7	100.0
	Total	134	100.0	100.0	

positive relationship in the scores of the subjects, both in the overall sample and in the subgroups, according to whether or not they went to psychological professionals or whether or not they used medication. These results allow us to infer the usefulness of quartile scores in determining the degree of MPA.

Concerning results based on factor analysis, the variance explained in the case of KMPAI-ERS was higher than in the case of KMPAI-FO. This result allows us to think that from a mathematical point of view the variance explained indicates the orthogonality of the factors, hence it is preferable to use the adapted form (KMPAI-ERS), rather than the original form (KMAI-FO). On the other hand, in relation to the original questionnaire, the assignment of the items to the factors coincides with the proposal made by Zarza-Alzugaray (2014). Furthermore, the same problems have been found, in terms of their relative weights, in the same items described in the validation work carried out by Zarza-Alzugaray (2015). That is, it confirms our hypothesis that the items from both modalities of the questionnaire will be grouped in a similar way according to the three original factors proposed by Zarza-Alzugaray (2014). This indicates the similarities and equivalences in the structure of the items for both questionnaires, and that the proposed adapted form (KMPAI-ERE) works in the same way.

In addition to the above argument on the analysis of the psychometric differences of the two KMPAI forms, it is worth pointing out some of the problems encountered with 7-point anchor scales, such as the one presented by the KMPAI-FO form used in this study. On the one hand, the verbal labels in the scale's response options imply a transition from continuous variables to categorical

nominals (Cummins, 1997). In this sense, psychometric theory assumes that Likert scales are interval or ratio scales, with a certain equidistance between the response options, but as Bisquerra and Pérez-Escoda (2015) point out, this principle is invalidated when the anchor points are labelled. Furthermore, evidence from various studies indicates that the psychological distances between different labelled alternatives are not equal (Kennedy, Riquier y Sharp, 1996; Matas, 2018). In the KMPAI-ERS form, 0 is real and absolute and the difference between values 4-5 is the same as between values 7-8 or between 1-2, which eliminates this problem of equidistance of the categories.

On the other hand, in the 5- or 7-point scales, a certain controversy has become evident with the intermediate category *Indifferent* (which is supposed to represent a central position with respect to the rest of the categories along a continuum), as a person may be inclined towards the central values, but not identify with that denomination (Hernández et al., 2001; Bisquerra y Pérez-Escoda, 2015). Finally, there are studies that show people's tendency to ignore or reject extreme values in response to a Likert-type scale (Cañadas-Osinsky y Sánchez-Bruno, 1998), as participants can often find exceptions to extreme responses.

Regarding to the analysis of sensitivity and specificity, it should be remembered that these parameters are widely used in the field of public health and epidemiology and their predictive values are of great relevance as they allow screening to correctly identify, in the general population, those with a specific disorder (Gómez y Pérez, 2007). That is, to diagnose accurately and early, and to identify those who have a problem or disorder

as opposed to those who do not (Carrillo, 2022). The sensitivity/specificity of instruments built with Likert-type scales are particularly important parameters in the field of health sciences, although as described by Bisquerra and Pérez-Escoda (2015), they have been practically ignored in Psychology.

In this regard, when considering the KMPAI questionnaire as an instrument for assessing the presence and degree of MPA in the population of musicians and music students, the instrument has to fulfill a number of requirements that show its usefulness (Gómez y Pérez, 2007). That is, if it is considered to be good as a diagnostic test, it should yield *normal* (lower) values in subjects who do not have the problem, and *abnormal* (higher) values in subjects who do have behavioral and emotional alterations in the evaluated area, in our case, musical performance anxiety. The scores regarding the sensitivity and specificity indices show better sensitivity values in the KMPAI-ERE form than in the KMPAI-FO form. Regarding specificity, the results show better specificity values in the KMPAI-FO form. This data leads us to consider the KMPAI-ERS form as more suitable in terms of its ability to predict the presence of the disorder if the test result is positive.

Specificity is conceptualized as the probability of detecting true negatives, that is, the probability that an individual who does not have a disorder is correctly identified as such (negative test). In our case, the results show better specificity values in the KMPAI-FO form both when using the criteria of whether or not healthcare professionals were used (0.788 vs. 0.726) and when taking into account the criteria of whether or not medication was used (0.615 vs. 0.304). This seems to indicate that the original form is better at detecting those without MPA.

It can be noted that, for our purpose, specificity is not as relevant as sensitivity. This statement is based on the studies of Gómez and Pérez (2007) for whom a more sensitive test is preferable when: a) we want to screen the population of musicians (students, teachers or performers) in order to capture the maximum number of cases with the disorder; b) we do not want to miss out on the cases with the highest MPA because of their academic/professional/personal impact or their seriousness; c) facing treatable disorders such as MPA; or d) false positives (scoring high on the KMPAI when not having MPA) do not cause psychological trauma for the individual.

With regard to our complementary objective focused on finding out the participants' preference for one or other of the forms presented (KMPAI-FO and KMPAI-ERE), the data also confirms what was expected in the study's

approach and suggests that a considerable percentage of the sample seems to understand, comprehend or interpret responses better when offered a 0-10 point scale.

In short, the results suggest that proposing a scale with a response range of 0 to 10 (11 anchor points) produces improvements in the reliability and internal consistency of the scale, and is preferable in mathematical terms. Furthermore, it increases the instrument's sensitivity and eliminates some of the problems presented by the 7-point anchor scale, such as the equidistance of the naming of categories and the stability of meaning of the linguistic quantifiers (Cañadas-Osinsky y Sánchez-Bruno, 1998).

It should be noted that this study offers a tool with sufficient psychometric guarantees to assess MPA in musicians, which may have both clinical and educational implications, as it is an instrument that, due to its greater sensitivity, facilitates more accurate detection of musicians with MPA. We consider that one of the limitations of the study may be the failure of simple random sampling. The use of this sampling procedure would allow obtaining a sample with greater guarantees of rigor. Finally, given its superior psychometric properties, it is suggested that the adapted form of the KMPAI questionnaire, which we have called KMPAI-ERS in this study and which offers 11-item scale responses, should be used for future research on MPA. Furthermore, this form of the questionnaire was endorsed by almost three quarters of the participants.

### Conflicts of interest

The authors have no conflicts of interest to disclose.

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**Appendix 1.**  
**Questions making up the form completed by participants**

In addition to the following questions, participants were also asked to complete the two KMPAI forms described in the corresponding section of this report.

1. My age is
2. Write down the age at which you started studying at the conservatory or music school
3. What instrument do you play?
4. Currently, how many years have you been playing your musical instrument?
5. How many hours per week do you dedicate to music?
6. How many hours per week do you spend practicing your musical instrument at home?
7. How many auditions or concerts did you participate in during the last year?
8. What is your current level of music education?
9. What musical genre do you usually play? (Classical – Jazz – Flamenco – Pop/rock – Other)
10. Your city of residence is:
11. Throughout your life, have there been any situations in which, because of nerves, you have had to withdraw or not show up for an audition or public performance? (Never – Once or twice – 3 to 6 times – More than 7 times – Other)
12. Throughout your life, have there been any situations in which you didn't have enough courage to audition or perform in public? (Never – Once or twice – 3 to 6 times – More than 7 times – Other)
13. Throughout your life, have there been times when you felt like giving up music completely? (Never – Once or twice – 3 to 6 times – More than 7 times – Other)
14. Have you ever had to seek professional help (doctors, psychologists...) to solve the difficulties caused by your musical activity? (Never – Once or twice – 3 to 6 times – More than 7 times – Other)
15. Have you had to use the help of drugs (Sumial, tranquilizers...) to cope with the difficulties caused by your musical activity? (Never – Once or twice – 3 to 6 times – More than 7 times – Other).