A Phenomenological Study on Music Therapists Treating Trauma Patients

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Dedications

This thesis is dedicated to everyone who has helped me to grow. Thank you very much for all your support.

For T,
Thank you very much for allowing me to question and to become curious of trauma.

My Family,
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Abstract

A Phenomenological Study on Music Therapists Treating Trauma Patients
Dominique J. Lee, MM
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The purpose of this study was to gain understanding and knowledge of the lived-experience of music therapists treating trauma patients. Within the music therapy field, the trauma therapy has been gaining interest over the years. There have been many books and articles written about the trauma patient population itself and the music therapy interventions. However, the problem to be addressed is that currently there is a lack of study focused on the music therapists’ experience of treating trauma patients in relation to such topic as Vicarious Traumatization (VT), Compassion Fatigue (CF), and Burn Out. There is evidence from the Secondary Traumatic Stress Syndrome (STS) how conducting trauma therapy may result in VT, CF, and Burn Out for the therapists. However, within the music therapy field this is a subject that was not explored and studied much. The research was conducted within the phenomenological framework with added musical improvisation of “Self-Portrait” as an artistic inquiry component. The subjects who conduct trauma therapy were recruited and they were interviewed using the open-ended interview guide. The musical data was analyzed based on a Structural Model for Music Analysis (SMMA) developed by Erdonmez Grocke (1999) and the verbal data was analyzed based on Modification of the Stevick-Collaizzi-Keen Method of Analysis of Phenomenological Data (Moustakas, 1994). The results show how challenging it is for the therapist to be present and working with trauma patients and what it feels like to hear the trauma materials of the patients. There was only one case reported of having experienced VT, CF, and Burn Out as a result of working with trauma patients. It is important to note
the findings from the musical data and the verbal data are congruent and concurrent
which supports and strengthens the research results.
Chapter 1: Introduction

The purpose of this research was to study the music therapists’ experience of treating the Post Traumatic Stress Syndrome (PTSD) diagnosed patients. Traditionally, particular and varied patient populations or related treatments were the center of the music therapy research focus. However, with the recent events of 9/11, the hurricane Katrina, Gulf, Afghanistan and Iraq War much of our attention has been brought to the areas of Trauma therapy. Thus, there is a greater need to study the potential impact VT has on the therapist in treating their patients with PTSD as well as their own association with music, since music is the main vehicle for therapy for music therapists. The result from such a study will be beneficial to furthering our understanding and awareness of an area of current concern to the music therapy profession: “Caring for the Caregiver” (Lowey, 2002), but also the knowledge regarding this special patient population as well.

For the purpose of this research, the music therapists who have been treating and are currently treating the PTSD diagnosed patients were to be interviewed in person using an open-ended, semi-structured interview method. As the study evolved, the researcher quickly realized that patients often revealed not one, but multiple traumas in their past, and that not all incidents of trauma necessarily developed into PTSD. In addition, their diagnosis often revealed yet another Axis I diagnosis that took precedence over the PTSD diagnosis. Since PTSD is a subcategory of Trauma, the researcher interviewed music therapists working with trauma patients (See Appendix B: Consent Form). As part of this study, the music therapists’ working relationship
with trauma patients was explored through musical improvisation called, “Self-Portrait; Myself as music therapist working with trauma patient,” therefore music improvisation was recorded and analyzed as a part of this study. This artistic inquiry component was added in order to add yet another dimension to the verbal interview data. Since music therapists use music as their primary medium in their work, it seemed appropriate and an interesting way to research the lived experience of the music therapist through musical improvisation as well.

Music therapy in America began after World War I and World War II when community musicians went to Veterans hospitals around the country to play for the thousands of veterans suffering both physical and emotional trauma from wars. Therefore, the history of music therapy in America is intrinsically linked with the trauma therapy. As society witnesses the increase in the PTSD diagnosed patients resulting from natural as well as man made disasters such as war, there is an increasing need for the music therapists to be prepared to understand not only this special patient population, but also the occupational hazard of treating this specific population such as Vicarious Traumatization, Compassion Fatigue, Secondary Traumatic Stress, and Burn Out. This study proposes to understand what and how treating this special group of patients affects the music therapists on both physical and emotional level.

As evidenced by researches conducted by Pearlman & Saakvitne (1995b), Trippany et al. (2004), and Canfield (2005), one of the occupational hazards of trauma therapy is VT. As a result, the therapists could experience many profound
changes that globally affect their functioning ability, both cognitively and emotionally.

This researcher proposes to bring focus on the essence of trauma therapy from the music therapist’s point of view, which includes the perils of trauma therapy namely, VT that can profoundly change therapists (Pearlman & Saakvitne, 1995b) and leave them with potentially permanent impact (Pearlman & Saakvitne, 1995b; Trippany et al., 2004; Canfield, 2005). In the broadest sense, the result from this study would add more in-depth knowledge that can aid the music therapists’ understanding of this particular patient population that includes specific treatment techniques. More narrowly, this study can be used as a career related educational resource for those who wish to enter into the practice of trauma therapy. Canfield (2005) noted that rarely do therapists enter the field of trauma therapy with a full understanding of the implications of their choice. By understanding VT and related occupational hazards associated with this clinical work, this study hopes to bring attention to the importance of prevention and management of VT.

The research in the field of VT is a relatively new one, which started to attract attention in 1995. Starting from the study conducted by Pearlman & Saakvitne in 1995, there has been a steady growth of research in the VT field. A phenomenological study of the mental health workers treating PTSD patients recovering from the sexual assault & rape (Steed & Rowning, 1998), Secondary Traumatic Stress and Vicarious Trauma: A Validation Study (Jenkins and Baird, 2002), Compassion Fatigue and Psychological Distress Among Social Workers: A Validation Study (Boscarino, J., Figley, C.R., & Adams, R., 2004) have been carried out in the past. Recent studies tend to be more literature-based such as Vicarious Traumatization: implications for

In the field of music therapy, the “Caring for the Caregiver” (Loewy, 2001), Dr. Loewy was the first author to address the music therapists’ experience of treating and helping the 9/11 rescue workers. The effect of music therapy sessions on compassion fatigue and team building of professional hospice caregivers was carried out by Hilliard in 2006. Most recently, Christine Wineberg (2007) has completed a literature-based study on mass trauma and its effect on music therapists in 2007. There are many books written on the trauma therapy with case studies that focus on the music therapy techniques and patients. However, there were none that studied the music therapist’s lived experience of treating trauma patients.

The empirical studies in this field have largely focused on the incidence and symptoms of VT among crisis workers and therapists; the validation of instruments measuring VT; correlations between VT and other salient therapist variables; correlation between secondary traumatic stress and salient therapist with STS and VT (Canfield, 2005). Since the term VT has been coined by Pearlman and Saakvitne in 1995, few studies used qualitative methods and these were done with small samples. The idea that resiliency is a protective factor against VT was addressed in a
qualitative study conducted by Bennett-Baker in 1999. Pierce (2000) conducted a qualitative study to explore how therapists describe their experiences of coping with the impact of treating individuals who experienced severe trauma. Ilife & Steed (2000) explored the impact of working with domestic violence survivors or perpetrators on clinicians who treat a high number of such clients in a qualitative study. The study found out that most participants of the study experienced visual imagery with what they had heard and reported the permanence of the visual memory of hearing such violent incidences. So far the topic of resiliency, domestic violence, and professional development of trauma therapists has been explored.

The future studies that explore the gender differences in coping mechanisms, attachment style, treating patients who experienced man made trauma vs. natural disasters have been suggested. Within the music therapy research, the focus on the music therapists’ experience of treating the PTSD patients have not been explored and this study attempts to study this phenomenon.

The research evidence for VT is inconsistent and has a number of discrepancies according to Sabine-Farell & Turpin (2003), whereas the studies conducted by Schauben & Frazier (1995), and Pearlman & MacIan (1995) have been used as sources of evidence for VT in trauma therapists. Canfield (2005) is focused on making the distinction between the VT, CF, and STS. However, for the purpose of this study, VT, CF, and STS will be treated as synonymous.

“What is the lived experience of the music therapists treating their PTSD patients? The past researches on the Compassion Fatigue (CF), Vicarious Traumatisation (VT), Secondary Traumatic Stress (STS) points to the fact that professionals treating the
trauma patients may experience similar fear, pain, and suffering feeling of their clients that are the impact of VT (Figley, 1995; Jenkins & Baird, 2002; Newlson-Gardell & Harris, 2003; Schauben & Frazier, 1995). Moustakas (1994, p.99) suggests the following as a possible guidance for the research objectives and these questions will be used in this particular research as objectives;

No.1 What are the possible structural meanings of this experience?

No.2 What are the underlying themes and contexts that are conditioned in this experience?

No.3 What are the universal structures that precipitate feelings and thoughts about the experience?

The limitation of the study is the small sample size due to the inclusion criteria;

1. Music therapists should at least have been practicing in the field of trauma therapy for the past two years

Achieving the evenly balanced sex ratio of the subjects that the study hopes to recruit might not be possible.

As evidenced by the study conducted by Bennett-Baker (1999), the results from the proposed study will confirm that VT is a normal and frequent reaction to doing trauma therapy and this will change the therapist both as a person and as a therapist. With this result, one hopes to find better understanding of the trauma therapy and its occupational hazard for music therapists and find ways to prevent and manage VT.

**Chapter 2: Literature Review**
2.1 Trauma

The history of trauma starts with the study of hysteria. The French neurologist, Jean-Martin Charcot was the pioneer in this field, as well as Pierre Janet, and Freud. By the mid 1890s, it became apparent to Janet and Freud that hysteria was a result of psychological trauma. Not only they came to the same conclusion regarding the cause of hysteria, but also found that understanding the psychological trauma and by putting the traumatic memories into words could alleviate hysterical symptoms (Herman, 1992).

During and after the First World War, the exposure to trauma was to be seen in the soldiers and it acquired a name, “Shell Shock” (Herman, 1992). This was further studied by an American Psychiatrist, Abram Kardiner in 1922, when he came back from Vienna being analyzed by Freud. Kardiner has been the greatest influence of our time in defining trauma and posttraumatic stress (Loewy, 2002). Kardiner’s work has not been recognized until some 40 years later when his work has been integrated into the diagnostic literature in 1980 (Loewy, 1992). With the advent of the Second World War once again brought many interests in combat neurosis. So, it is with the knowledge gleaned from the studies of combat neurosis and veterans that led the body of existing literature about traumatic disorders (Herman, 1992).

Many key ideas regarding both psychoanalysis and trauma theory started in France in the late nineteenth century and the fields of psychoanalysis and trauma then diverged, became parallel, and are now reconverging (Pearlman, 1995). The trauma theories now have developed into emphasizing cognitive, behavioural, and biological perspectives (Pearlman, 1995).
Traumatic events involve threats to life or bodily integrity, or a close personal encounter with violence and death (Herman, 1992), thus the traumatic events include sexual assault, domestic violence, accident, natural disaster, events of terror, and war.

2.2 The Effects of Trauma

Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning (Herman, 1992). The traumatic experience leaves one with profound changes in physiological arousal, emotion, cognition, and memory. Dissociation, somatization, and affect dysregulation were highly interrelated among the participants who were exposed to traumatic experiences (van der Kolk, et al., 1996).

Understanding trauma and its effects from the Constructivist Self Development Theory (CSDT) allowed Pearlman to study that the individual who experiences trauma showed considerable disruptions and disturbances in the following areas; frame reference, capacity to modulate affect and maintain benevolent inner connection with self and others, ability to meet his/her psychological needs in mature ways, central psychological needs, which are reflected in disrupted cognitive schemas, and memory system, including sensory experience (Pearlman, 1995).

Herman writes that while the trauma specific intrusive thoughts, nightmares, and fears of safety fades over time, the numbing and constrictive symptoms come to predominate after a while (1992).

2.3 PTSD
The Posttraumatic Stress Disorder was included in the DSM-III in 1980. It has the following diagnostic criteria in DSM-IV;

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder;

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed. (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content. (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur. (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (5) physiological reactivity on exposure to internal or external
cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and **numbing** of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma (2) efforts to avoid activities, places, or people that arouse recollections of the trauma (3) inability to recall an important aspect of the trauma (4) markedly diminished interest or participation in significant activities (5) feeling of detachment or estrangement from others (6) restricted range of **affect** (e.g., unable to have loving feelings) (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent **symptoms** of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep (2) **irritability** or outbursts of anger (3) difficulty concentrating (4) **hypervigilance** (5) exaggerated **startle response**

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify if:

**Acute:** if duration of symptoms is less than 3 months  **Chronic:** if duration of symptoms is 3 months or more

Specify if:

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

### 2.4 Recent Psychological Theories of PTSD

According to Brewin & Holmes (2003), earlier theories of PTSD include the stress response theory, theory of shattered assumptions, conditioning theory, information processing theories, anxious apprehension model.

One of the most recent theories is emotional processing theory that has greater power to explain the many different aspects of PTSD using the exposure treatment and its effectiveness has been tested showing this method as a highly effective one (Foa et al., 1991, 1999).

Dual representational theory proposed by Brewin et al. (1996) stipulates that we have two different systems of memory working together in parallel and one takes over in different times. Those two memory systems are verbally accessible memory (VAM) and situationally accessible memory (SAM). VAM is usually accessible orally or written narrative and SAM manifests take the form of flashbacks. Therefore, the treatment of PTSD is looked at as managing both systems of memory involving the resolution of the negative beliefs and their accompanying emotions, and the one involving the flashbacks. The limitation of theory is such that this focuses mainly on memory, emotion, and appraisal, and other important PTSD features such as the
increased conditionability or emotional numbing are not addressed much (Brewin & Holmes, 2003).

The paradoxical nature of the people’s anxiety for the future, despite the fact that the trauma lies in their past was explored and studied by Ehlers & Clark (2000). They proposed that pathological responses to trauma arise when individuals process the traumatic information in a way that produces a current external as well as internal threat and this involves negative appraisal. This model is called, “Cognitive Model of PTSD.”

2.5 Trauma and Music Therapy

Hannah Arendt wrote in her book, “The Life of the Mind” the following;

“The crucial verses occur when Odysseus has come to the court of the Phaeacians and, at the king’s order, is entertained by the bard, who sings some story of Odysseus’ own life, his quarrel with Achilles: Odysseus, listening, covers his face and weeps, though he has never wept before, and certainly not when what he is now hearing actually happened. Only when he hears the story does he become fully aware of its meaning. And Homer himself says: The bard sings for men and gods what the Muse, Mnemosyne, who watches over Remembrance, has put into his mind. The Muse gave him good and bad: she deprived him of eyesight and gave him sweet song.” (1978, p. 132)

The above really speaks to what the music therapist does in the context of trauma therapy. By providing a chance for the trauma survivor to listen to their own terrifying journey of trauma pieced together supported by appropriate, expressive, and
affective component of music, the trauma survivors can finally release the amorphous and helpless feeling of terror, and gain perspective, understanding, and meaning of that event for oneself. Although today’s music therapy students may or may not specifically receive additional education on trauma and trauma patient population, with the recent event of 9/11, Columbine, Colorado and Virginia Tech shootings, Sierra-Leon, Iraq, and Afghanistan wars, and natural disasters such as Katrina and Rita calls for the music therapy educators to pay special attention in educating the future generation of music therapists on this important topic.

Johnson, Lahad, & Gray (2009) mentioned the unique contribution that the creative arts therapies may have in the areas of imaginal exposure, cognitive restructuring, and cognitive interventions for the adult trauma patients and cites the studies (Blake & Bishop, 1994; Schulberg, 1997) that used the guided imagery and music technique successfully.

Sullivan (2007) researched the contributions of women’s military bands during the Second World War and she shares some historians’ view that this contribution of music played in the military hospitals might have been the impetus for the music therapy profession in the US.

Roberts (2006) explains how the music therapy has fostered a change in the sexually abused children that she was treating. Through the music making, her patient, Sally changed from being disturbed, easily retraumatized and dissociative to a child who can learn to assimilate new experiences and express herself in an appropriate way.
Vocal psychotherapist, Diane Austin found specific music therapy techniques such as toning, vocal improvisation, and vocal holding to be effective with the trauma population (2001). She defines vocal psychotherapy as a depth music psychotherapy with an emphasis on the voice; speaking, sounding and singing. Within an analytical orientation, it uses the voice for improvisation and song writing in order to promote intrapsychic and interpersonal change (Austin, 2001).

Improvisational music therapy is also shown to be effective in dealing with sexually abused patients (Amir, 2004). Music improvisations act as musical acts that can bring out hidden, unconscious material and make it conscious and available to the client and by utilizing the analytical-music techniques, the trauma of the past can be unearthed, processed and dealt with.

“Sexually abused patient and music therapy using the Bonny Method of Guided Imagery and Music” was studied by Beck (2005). The progressive muscle relaxation, Quiet Music (Bonny, 2002), Emotional Expression I (Bonny, 2002), Positive Affect (Bonny, 2002), Emotional Expression II (Bonny cited in Grocke, 2002), and Transition (Bonny, 2002) were used for the six sessions for this particular patient, S. The music listening and imagery experience allowed the damaged, and angry part of patient S to emerge and released. Through the music, S was able to find himself (Beck, 2005).

“Caring for the Caregiver: The Use of Music and Music Therapy in Grief and Trauma” (Loewy & Hara, 2002) addressed many of the techniques in music therapy that were used in working with children, adults, caregivers, and families affected by the attacks of September 11, 2001. Lowey (2002) was the first to addressed the
concept of caring for the caregiver within the music therapy field, which is closely related to the study of STS, VT, CF, and Burn Out.

The music therapy techniques that were used in trauma therapy are varied as shown above. The key would be to find the treatment method that works for each patient. As the nature of trauma is varied and holds personalized meaning for each patient, the treatment option also should be varied and tailored to suite the individual patient’s needs.

2.6 Overview of Secondary Traumatic Stress (STS)

The phenomenon called secondary traumatic stress (STS) is considered a reaction in a person who has empathically listened to the traumatic things that have happened to other people and it is suggested that the empathy that the workers used to build relationships with the trauma survivors is the main conduit for the stress suffered by the social workers (Nelson-Gardell & Harris, 2003). It is considered natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other (Figley, 1995). STS may result in compassion fatigue, vicarious traumatisation, and covictimization (Figley, 1995; MaCann & Pearlman, 1990). The fact that two or more terms are used synonymously to describe this phenomenon means that not all researchers agree on what to call this phenomenon or how to define it (Hesse, 2002). Workers who suffer from STS may experience increased fatigue or illness, emotional numbing, social withdrawal, reduced productivity, and feelings of hopelessness and despair (Saakvitne, K., Gamble, S., Pearlman, L., & Lev, B., 2000). However, further research studies have been conducted to uncover the distinctions between all the above terms. The
comparison between the STS and Burn Out has been made and the key factor that differentiates them was suggested in the cause of the symptoms. STS results from direct result of hearing emotionally shocking material from clients, whereas burnout can occur as a result of working with any client population and it is more related to the organizational environment (Iliffe & Steed, 2000).

Nelson-Gardell & Harris (2003) researched the relationship between the childhood abuse history and the secondary traumatic stress amongst the child welfare workers. Seven variables such as emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, age of the worker, and years of experience were used as possible predictors for STS in child welfare workers. They found that the combination of childhood experiences of abuse and neglect in a child welfare worker increases the risk for STS and especially, emotional abuse or neglect in a child welfare worker’s personal history places them at most. The research also found out that neither the experience nor the age was significantly correlated with a risk of STS. Older participants had lower STS risk scores than younger participants and it was suggested that the older participants could be less intensely exposed to the primary trauma survivors and it was deemed that the older participants are better able to cope with knowledge from life experience and coping skills.

STS shares many of the same symptoms as posttraumatic stress disorder, including sleep disturbances, anger, fear, suppression of emotions, nightmares, flashbacks, irritability, anxiety, alienation, feelings of insanity, loss of control, and even suicidal thoughts (Hodgkinson & Shepherd, 1994). Thus, it is noted how the symptoms of STS can seriously affect the therapist and leave an impact on therapeutic relationships
and even cause harm to patients. The serious consequences of STS in therapists can disrupt their ability to remain empathic towards patients that poses a problem in carrying out the trauma therapy (Hesse, 2002).

2.7 Vicarious Traumatization

According to Pearlman and Saakvitne (1995), the therapist’s ways of experiencing the self, others, and the world is transformed by the long-term empathic engagement with traumatized patients. Some researchers believe that the symptoms of the STS can result from a single exposure to a traumatic experience (Conrad & Perry, 2000) whereas VT results from a cumulative exposure (Pearlman & MacIlan, 1995). VT is defined as a process of change resulting from empathic engagement with trauma survivors, and anyone who is engaged with trauma survivors in an empathic way is vulnerable to VT (Pearlman, 1999).

Essentially, there are five different areas in a therapist that are affected by VT defined as Pearlman (1995) as follows;

Frame of Reference is a framework of beliefs through which the individual interprets experience; includes:

- World View
- Identity
- Spirituality

Self Capabilities are abilities that enable the individual to maintain a sense of self as consistent and coherent across time and situations; intrapersonal; includes abilities to:

- Tolerate strong affect
• Maintain positive sense of self
• Maintain inner sense of connection with others.

_Ego Resources_ are abilities that enable the individual to meet psychological needs and to relate to others; includes two types:

• Resources important to the therapy process; intelligence, willpower and initiative, awareness of psychological needs and abilities to be introspective, to strive for personal growth, and to take perspective.

• Resources important to protect oneself from future harm; Abilities to foresee consequences, to establish mature relations with others, to establish boundaries, and to make self-protective judgments.

_Psychological Needs and Related Cognitive Schemas_ (in relation to self and others)

• Safety; The need to feel secure and reasonably invulnerable to harm by oneself or others.

• Trust; The need to have confidence in one’s own perceptions and judgment and to depend on others.

• Esteem; The need to feel valued by oneself and others, and to value others.

• Intimacy; The need to feel connected to oneself and to others.

• Control; The need to feel able to manage one’s feelings and behaviours as well as to manage others in interpersonal situations.

_Memory System_
• Verbal
• Affect
• Imagery
• Somatic
• Interpersonal

Not only may VT disrupt an individual’s spirituality as they can experience despair, confusion, and helplessness (Pearlman & Saakvitne, 1995b), it is noted that the therapist may start to question the meaning and purpose of life when hearing the trauma materials from their patients (Canfield, 2005).

The contributing factors to VT are empathy and the individual’s perception and meaning in one’s identity, worldview, spirituality, style, ability to recognise and meet one’s needs, personal history and current personal and professional circumstances (Pearlman & Saakvitne, 1995b).

Schauben & Fanzier (1995) found that among the female counsellors working with sexual violence survivors, the counsellors who had the highest caseload reported more symptoms of PTSD, more disrupted beliefs and self-reported VT.

In a study of eighteen counsellors treating either domestic violence survivor or perpetrator reported a loss of confidence, having a visual imagery, nausea, need to distance themselves from the trauma material and feeling of isolation and powerlessness in addition to experiencing the change in cognitive schema (Illiffe & Steed, 2000).

It is important to note that those who were new to the trauma therapy field experienced more disruptions in self-trust, self-intimacy, and self-esteem as well as
higher overall symptoms of VT (Pearlman & MacIan, 1995) which calls for the much needed special trauma therapy education for the music therapy students, before they enter the job market and start working with trauma patient population.

In addition, therapists who have personal trauma history showed most disturbances in general and trauma specific measures (Pearlman & MacIan, 1995) which means that for those therapists who have personal trauma history need to exercise the preventive measure for VT and be aware of the higher possibility in experiencing VT than others who do not have personal trauma history in their past.

It has shown that the factors such as level of training, clinical setting, whether the therapists have addressed the effects of their own personal trauma work in their own personal therapy can affect how much the therapists experience the disruptions in their cognitive schemas (Pearlman & Maclan, 1995).

STS and VT differ conceptually in their relative emphasis on emotional/social versus cognitive symptomatology, and differ empirically (Jenkins & Baird, 2002) and the future studies on the etiological process of STS and VT development have been suggested.

2.8 Compassion Fatigue

Compassion Fatigue (CF) is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient (Figley, 1995). Figley who first focused on this area defines CF as a function of bearing witness to the suffering of others and considers a natural response or reaction to working with individuals or groups of people who are in crisis. CF can develop as a
result of the helping professionals’ exposure to hearing clients’ traumatic material in combination with the professional’s sense of empathy for the client (Jacobson, 2006). In comparison to the burn out and countertransference, CF is related to the sense of helplessness and also there is a greater sense of isolation from supporters. It has a faster onset and recovery of symptoms compared to the burn out (Figley, 2006).

CF can be characterised as decreased level of concern and empathy for client that encompasses cognitive, emotional, physical, spiritual, work-related, interpersonal, and behavioural reactions, physical and emotional exhaustion, decreased positive feelings for the patients, increased levels of job dissatisfaction, and feelings of hopelessness related to the job that can affect other areas of professional’s life (Figley, 1995).

The basic premise of this model is based upon how the therapist works with their empathy and emotional energy in effectively working with the suffering in general and in terms of maintaining an effectively therapeutic alliance, and delivering effective services including an empathic response (Figley, 1995; Figley, 2002a). Since the CF theory relies on the concept of empathy, the therapist who increases their level of empathy is considered at a greater risk for experiencing the negative reactions to offering crisis intervention services (Jacobson, 2006). There are variables that contribute to the causes of CF and those are empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, life disruption (Figley, 2002). Jacobson (2006) conducted an quantitative study of the impact of the CF, Compassion Satisfaction, and burnout on the Employee Assistance (EA)
professionals and found out that despite the overall sample reporting low to moderate risk for the CF and burnout and moderate to high potential for compassion satisfaction, EA professionals who utilized more negative coping skills scored higher on risk for CF, higher on risk for burnout, and lower on potential for compassion satisfaction.

According to the Compassion Stress and Fatigue Model (Figley, 1995), the exposure to the client in combination of empathic ability and empathic concern creates an empathic response in the therapist. This empathic response is then met with either the disengagement or the satisfaction. The residual compassion stress coupled with prolonged exposure and traumatic memories then results in compassion fatigue with degree of life disruptions. Figley (2002) defines the above important terms as follows;

*Empathic Ability* is the aptitude of the psychotherapist for noticing the pain of others and it is this ability that is the keystone both to helping others and being vulnerable to the costs of caring.

*Empathic Concern* is the motivation to respond to people in need.

*Exposure to the Client* is experiencing the emotional energy of the suffering of clients through direct exposure.

*Empathic Response* is the extent to which the psychotherapist makes an effort to reduce the suffering of the sufferer through empathic understanding.

*Compassion Stress* is the residue of emotional energy from the empathic response to the client and is the on-going demand for action to relieve the suffering of a client.
Sense of Achievement is one factor that lowers or prevents compassion stress and is the extent to which the psychotherapist is satisfied with his or her efforts to help the client.

Disengagement is the other factor that lowers or prevents compassion stress. It is the extent to which the psychotherapist can distance himself or herself from the ongoing misery of the client between sessions in which services are being delivered.

Prolonged Exposure is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time.

Traumatic Recollections are memories that trigger the symptoms of PTSD and associated reactions, such as depression and anxiety.

Life Disruption is the unexpected changes in schedule, routine, and managing life responsibilities that demand attention (e.g., illness, changes in life style, social status, or professional or personal responsibilities).

The associations between CF, secondary trauma, and burnout were studied recently and it was shown that the researchers were able to explicitly test the claim that secondary trauma is different from burnout by using two different scales (Boscarino, Figley, & Adams, 2006). This study brought to attention that secondary trauma, burnout, and more generally, CF as unique features of the workplace environment and not merely different designations for negative life events, personal trauma, lack of social support, or low mastery.

The effect of music therapy sessions on CF and team building of professional hospice caregivers was researched by Hillard (2006). Two experimental music therapy groups comprising of seventeen professional hospice workers participated in
this study. Experimental group 1 used a music therapy approach that is more open, free form without structure in making live music with toning and chanting as well as instrumental improvisations and experimental group 2 used more structured formats of music therapy approach with guided meditation with live music, lyric analyses, and music and movement. The result showed the significant improvement in team building in both groups but no significant difference with regard to CF.

2.9. Burnout

Burnout differs from STS (Secondary Traumatic Stress) in that it is defined as “a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations (Pines & Aronson, 1988). According to Hesse (2002), burnout is often seen as an organizational problem, not an individual problem. Whereas STS can result from the continual exposure of the traumatic materials from the trauma survivors, burnout can result from any patient population and there is a bigger component of organizational environment that is involved in its causes (Iliffe & Steed, 2000). Perry (2003) states that burnout differs from STS in that it produces the emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment and it is a condition that begins gradually and gets progressively worse. In contrast to slow progressing burnout, STS can result rapidly with little warning and can cause helplessness and confusion (Figley, 1995).

Within the music therapy context, the occupational burnout has been investigated by Fowler (2006) in a research that investigated the relations between professional well-being and various factors such as age, level of education, income, attitudes regarding the workplace, attitudes towards work measured by the Maslach Burnout
Inventory (Maslach & Jackson, 1986a), and measures of stress and stress management as measured by the Stress Profile (Nowack, 1999a). The findings showed that the greatest professional longevity is linked with higher ratings on items regarding cognitive coping strategies and greater perception of personal achievement.

Constant change and adaptation to the point of apathy, over policing, unrealistic workloads with low pay, compromising ideals, lack of respect, continuous crisis intervention, ‘going by the book’ leadership attitudes, limited opportunities for sharing and contributing to decision making, and excessive control of emotional expression have been identified as number of factors that contribute towards burnout in the music therapist (Bitcon, 1981).

The relations between personality characteristics, work environment, and the professional well being of music therapists with the burnout has been studied by Fowler (2006) and she describes the five stages of burnout by Greenberg (2002) as follows;

- **Honeymoon**; high job satisfaction
- **Fuel Shortage**; fatigue sets in and have trouble sleeping
- **Chronic symptoms**; decreased energy level leading to exhaustion, susceptibility to disease, and psychological effects that can include anger and depression
- **Crisis**; therapist can develop illness that may result in a loss of work and problems with personal relationships.
- **Hitting the wall**; Symptoms of this stage can contribute to life-threatening illnesses such as heart disease or cancer.
2.10. Coping and Prevention of STS

Schauben & Franzier (1995) found that the therapists exercise active coping strategy such as making a plan of action in order to address the issues relating from conducting trauma therapy such as VT, CF, and Burn Out. However, the very first is to recognize and accept that secondary or VT is a normal part of doing trauma work (Pearlman & Saakvitne, 1995).

Herman (1992) said, “Just as no survivor can recover alone, no therapist can work with trauma alone” which brings importance of seeking social support in doing trauma therapy (Schauben & Franzier, 1995; Saakvitne, 2002, and Hesse, 2002). The same kind of coping strategies such as exercising, meditating, cognitive restructuring, and participating in leisure activities that the therapist recommend their patients can be used for the therapists themselves (Schauben & Franzier, 1995).

In coping with stress to prevent burnout, Folwer (2006) relays Bitcon’s advice such as keeping in touch with other professionals through professional conference or support groups, partaking in enjoyable extracurricular activities, eliminating unneeded stress such as extra paper work, developing and documenting goals in order to see personal progress, budgeting time to prioritize the important parts of life such as family and friends, continuing education, involvement with the facility’s decision making and policy making in order to reinforce what is liked, and having a sense of humour.

The recognition of the risks and effects of STS is of vital importance within work place and it is suggested that the prevention and management of STS must be shared by the work place and the workers (Nelson-Gardell & Harris, 2003).
The need for further research in STS is called for (Hesse, 2002). Gaining more knowledge of how STS specifically affects the therapist and understanding variables such as different types of trauma, race, age, gender, and sexual orientation or disability will allow the therapists to be prepared to address these issues. Education and Training is suggested as another preventive measure for STS (Hesse, 2002; Trippany, Kress, & Wilcoxon, 2004).

Sharing experiences of trauma therapy with other professionals offers social support and normalization of VT experiences, therefore the peer supervision can serve as important resources for trauma therapists (Catherall, 1995; Conrad & Perry, 2000 & Hesse, 2002).

Self-awareness and self-care is suggested for the therapists who work with trauma patients. In addition, respect for your limits, needs, and experience, be informed about the risks of psychotherapy, yourself, and your work, and connected to all of yourself, to others and community is recommended (Saakvitne, 2002).

As a preventive measure, limiting the exposure to traumatized patients (Hesse, 2002), and better management of the therapist’s caseload (Trippany, Kress, & Wilcoxon, 2004) is suggested in the literature.

It has been found that therapist with a “larger sense of meaning and connection” (Pearlman & Saakvitne, 1995) are less likely to experience VT, therefore the finding and strengthening the meaning in spirituality is advised through the activities such as meditation, yoga, journal writing, engagement with art and beauty (poetry and Nature) (Pearlman, 1999).
Chapter 3: Methodology

3.1. Overview

This research is intended to explore the lived experience of the therapists working with trauma patients. From the moment the therapist is assigned a patient, building up the therapeutic alliance, uncovering the nature of trauma, and working through the trauma materials with the patient focusing on the therapist’s journey of trauma therapy is the very essence of what this research is trying to capture. This research is not only explores different theoretical frame works of working with trauma patients, but also it is very much interested in what happens to the therapists while they are in contact with the traumatic materials of their patients. The phenomenological research method focuses on the subjective experience of the individual in understanding the meaning of a phenomenon or experience (Mertens, 2005). Therefore, in searching for the experience and meaning, a phenomenological research method has been chosen. The researcher wishes to study the following in this study using the phenomenological method;

No.1 What are the possible structural meanings of this experience?

No.2 What are the underlying themes and contexts that account for this experience?

No.3 What are the universal structures that precipitate feelings and thoughts about the experience?
3.2. Design

This phenomenological research will be carried out with an open-ended interview as well as two musical improvisations incorporating the artistic inquiry method. Since music therapists mainly work with their patients using music as their main medium, this study also wishes to study the experience of music therapists treating trauma patients through musical improvisation. Arts-based inquiry is a research method in which arts play a primary role in any or all of the steps of the research method. Art forms such as poetry, music, visual art, drama, and dance are essential to the research process itself and central in formulating the research question, generating data, analyzing data, and presenting the research results (Austin & Forinash, 2005). We were hoping to have at least one male and three female participants for this study. The overall interview including the two musical improvisations would be at least one hour to two hours long. And for the purpose of this research, the entire interview including one improvisation was audio taped.

3.3. Location of Study

Interviews were conducted at Drexel University’s Center City Campus in Philadelphia, PA, NCB #4417.

3.4. Participants

This study hoped to find four subjects; three female and one male. They need to be a practicing and board certified music therapists working with trauma patients.

3.5. Recruitment and Initial Contact

The subjects for this study were recruited by the purposeful sampling method, which means that the subjects was recruited through the word of mouth and be asked
to take part in this study. The list of possible subjects was generated from the American Music Therapy Association (AMTA) Member Sourcebook by the patient population, and the principal investigator and co-investigator approached the recruitment of the subjects via electronic mail (Appendix A).

Once the subjects have been selected, in order to protect the privacy of the subjects, any identifiable marker was erased and replaced with a code for the subjects. In addition, the consent form was sent to the subjects and explained in detail in person prior to the interview.

3.5.1. Participant Inclusion Criteria

The inclusion criteria were;

• Music therapist who is board certified;
• Music therapist must have been in practice for the past two years;
• Music therapist must have been treating the PTSD patients at least for the past two years and still seeing PTSD diagnosed patients;

Healthy adults (25 and older) male or female of any age, race religious, ethnic, cultural, or socioeconomical background are to be recruited to participate in this study (Appendix B).

3.6. Investigational Methods and Procedures

An in-depth phenomenological interview was conducted in order to study the music therapists’ experience of treating trauma patients. The subjects were asked questions in regards to their experience. However, the interviewer did not generate questions, but asked for more descriptive details in order to understand the subjects’ answers more fully.
3.6.1. Epoche

The first step in the phenomenological research is called, Epoche. In Greek, this means to stay away from or abstain. In phenomenology research, it is used to stay away from everyday habits of knowing things, people, and events, thereby acquiring “purified” consciousness. Through this process, the researcher set aside prejudgements, biases, and preconceived ideas about things (Moustakas, 1994).

This step is used to allow whatever is there in us in our consciousness to disclose itself so that we may see with new eyes in a naïve and completely open manner (Moustakas, 1994). Before the research began the researcher journaled about her prejudices and biases regarding this research and recorded possible musical improvisations on this as well.

The researcher found that she had to pay extra attention to the way she asked the questions during the interview process. She had to keep reminding herself not to ask leading questions and be mindful of the choice of words that she was using or going to use with the subjects. However, the researcher was able to listen to the musical improvisations with open attitude that needed no vigilance.

3.6.2. Data Collection

It took approximately two and a half weeks to interview all three subjects. Each interview lasted approximately one hour. During the interview, the subjects describe as much as they could about their experience of working with trauma patients. The subjects met with the researchers at Drexel University, Center Campus, New College Building #4417 and the interviews were audio taped. The purpose of this audio taping was to transcribe the interview and to gather data for the data analysis that will be
used for this research. In addition to the musical improvisation and the interview, a
demographic data collection form was given to the subjects in order to gather further
information regarding their background (Appendix C).

3.6.3. Musical Improvisation and Open-Ended Responsive Interview

Originally, two musical improvisations were included in this study; one at the very
beginning and the other at the end of the interview. In order to understand the
subject’s relationship to music, the first one was titled, “Self-Portrait; Myself as
music therapist treating trauma patients” and the other one was titled, “Self-Portrait.”
The later self-portrait improvisation was included just in case the first improvisation
would bring up unpleasant or anxiety provoking responses that they may have had
while working with trauma patients. The second improvisation was titled as such in
order for the subjects to view themselves as a whole person and not by their
professional role only. By doing so, the researcher was hoping that the subjects would
tap into their ego strength in order to reduce the level of anxiety that they may have
experienced while performing the first improvisation. The subjects were provided
with familiar music therapy instruments such as piano, guitar, and drums. The
instruction for the five-minute musical improvisation was given in the following
manner;

“For the next five minutes, you will be engaged in a musical
improvisation titled, ‘Self-Portrait; Myself as a music therapist
working with Trauma Patient(s).’ Please feel free to use the
instruments that are in front of you. Also, feel free to reflect upon the
overall experience of working with this particular patient population.
In addition, you may also choose to reflect upon your experience with particular patient should you wish to do so.”

When the subject was performing the musical improvisation, the researcher listened carefully and noted the elements of music as well as the features that stood out while listening to the improvisation such as overall impressions and possible symbolic/metaphoric meaning in the musical expressions that would be related to the subject’s experience of working with trauma patients. After the subject completed the improvisation, he/she was asked to join the researcher at the table in order to proceed to the verbal interview part of the data gathering process of the research.

“Can you describe your music therapy experience with two different populations, what is it like for you as a music therapist with these people? The subjects’ response lead to other research questions such as “What’s that like?” and “Can you tell me more about that?” until it seems that the topic that the subject chose was fully described. Then the researcher asked, “Can you compare what it is like now compare to when you first started as a music therapist?”

“How do you start your therapy sessions with your patients?”

“What kind of music therapy interventions do you use and how do you go about making decisions as to what interventions to use?”

“What is it like for you when you are off work, do you think much about your clients?” Again, all answers followed up with the question, “Can you say more about that?” or “Is there anything more to say about that?”

In addition, following questions were asked:
• What dimensions, incidents and people intimately connected with the experience stand out for you?
• How did the experience affect you?
• What changes do you associate with the experience?
• How did the experience affect significant others in your life?
• What feelings were generated by the experience?
• What thoughts stood out for you?
• What bodily changes or states were you aware of at the time?
• Have you shared all that is significant with reference to the experience?

The above questions, as in the phenomenological tradition, served as follow-up questions in response to the subject’s word (Appendix D). The researcher did not generate questions that are not directly a response to what the subject has introduced.

3.6.4. Validation Process

The interview was transcribed and the transcript was sent to each and all of the research subjects for validation process. It gave the subjects an opportunity to clarify their responses and then the transcript was ready for the data analysis.

3.7. Data Analysis

The improvisations were analysed using the “Structural Model for Music Analysis (SMMA)” (Grocke, 1999). Grocke developed this model, in order to seek information about the structure of the music in a music programme immediately prior to a ‘pivotal moment’ in therapeutic process using Guide Imagery and Music (GIM). Musical expression is a complex combination of all musical elements and in order to be able to talk about musical expression that further speaks to the mood, symbolic,
and the associational meaning derived from those musical expressions, the researcher thought that it is important to be able to analyse the music using a comprehensive instrument that consists of twelve categories of musical elements. As a professional musician with more than twenty years of performing experience and with a master’s degree in performance from a top ranked music conservatory plus a master's degree education in music therapy, the researcher found SMMA to be the music analysis model that is appropriate to use for this study.

In addition, the music improvisation timeline analysis was included in lieu of the transcribed music manuscript of the improvisation in order to further supplement and highlight the descriptive musical analysis.

Three inter-raters (see Appendix E) performed a music improvisation analysis on all three improvisations in order to increase the validity (Appendix E). They were given only one piece of information in performing the analysis and that was the title of the music improvisation. Music improvisation analysis involves making a lot of interpretations based on the musical elements. The inter-raters were employed in order to observe how much agreement exists between the raters as well as the researcher. This added measure of having the inter-raters increased the reliability of the data found by the researcher.

The data analysis followed the steps from the Modification of the Stevick-Colaissi-Keen Method of Analysis of Phenomenological Data (Moustakas, 1994);

1. Using a phenomenological approach, obtain a full description of your own experience of the phenomenon.

2. From the verbatim transcript of your experience complete the following steps;
a. Consider each statement with respect to significance for description of the experience.

b. Record all relevant statements.

c. List each nonrepetitive, nonoverlapping statement. These are the invariant horizons or meaning units of the experience.

d. Relate and cluster the invariant units into themes.

e. Synthesize the invariant meaning units and themes into a description of the textures of the experience. Include verbatim examples.

f. Reflect your own textural description. Through imaginative variation, construct a description of the structures of your experience.

g. Construct a textural-structural description of the meanings and essences of your experience.

3. From the verbatim transcript of the experience of each of the other co-researchers, complete the above steps, a through g.

4. From the individual textural-structural descriptions of all co-researchers’ experiences, construct a composite textural-structural description of the meanings and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experience representing the group as a whole.

The data analysis in a phenomenological study has three different processes, which are bracketing, horizontalization, and imaginative variation (Moustakas, 1994). The bracketing refers to the data being taken apart and essential structure being analysed. The fact that every form of data is considered with equal importance and
the statements from the interview will be brought together into clusters of meanings, and these clusters will be collected together into a textural description of the experience of treating PTSD patients. The bracketing and horizontalization refers to phenomenological reduction.

The imaginative variation allows the researcher to look at the possible meaning of data through the utilization of imagination, varying the frame of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, in order to arrive at the structural description of an experience (Moustakas, 1994).

The last step of the phenomenological research is intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon as a whole (Moustakas, 1994).

### 3.8. Operational Definitions

**Compassion fatigue** – the burnout and stress-related symptoms experiences by caregivers and other helping professionals in reaction to working with traumatized people over an extended period of time. (Figley as cited by APA, 2007)

**Empathy** - *n.* understanding a person from his or her frame of reference rather than one’s own, so that one vicariously experiences the person’s feelings, perceptions and thoughts. (APA, 2007)

**Posttraumatic disorders** – emotional or other disturbances whose symptoms appear after a patient has endured a traumatic experience. Common posttraumatic disorders include posttraumatic stress disorder, acute stress disorder, the dissociative disorders, and some types of phobias and anxiety disorders. (APA, 2007)
**Posttraumatic Stress Disorder (PTSD)** in DSM-IV-TR, a disorder that results when an individual live through or witnesses an event in which he or she believes that there is a threat to life or physical integrity and safety and experiences fear, terror or helplessness. The symptoms are characterized by (a) re-experiencing the trauma in painful recollections, flashbacks or recurrent dreams or nightmares; (b) diminished responsiveness (emotional anesthesia or numbing), with feelings of detachment and estrangement from others; and (c) chronic physiological arousal, leading to such symptoms as exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, guilt about surviving when others did not, and avoidance of activities that call the traumatic event to mind. Subtypes are Chronic Posttraumatic Stress Disorder and Delayed Posttraumatic Stress Disorder. (APA, 2007)

**Trauma n.** 1. an event in which a person witnesses or experiences a threat to his or her own life or physical safety or that of others and experiences fear, terror, or helplessness. The event may also cause dissociation, confusion and loss of a sense of safety. Traumatic events challenge and individual’s view of the world as a just, safe and predictable place. Traumas that are caused by human behavior (e.g. rape, assault, toxic accidents) commonly have more psychological impact than those caused by nature, (i.e., earthquakes.) 2. A physical injury. Such traumas include head injuries, such as blows to the head; brain injuries, such as hemorrhages and cerebrovascular accidents; and injuries to other parts of the body, such as burns or amputations. (APA, 2007)

**Secondary Traumatic Stress (STS)** the natural, consequent behaviors and emotions
resulting from knowledge about a traumatizing event experienced by a significant other (Figley, 1999). It is the stress resulting from helping or wanting to help a traumatized or suffering person. Other terms are used throughout the literature in discussing STS. They are compassion fatigue (Figley, 1995), vicarious traumatization (McCann & Pearlman, 1990). For this study, the terms “secondary traumatic stress” will be synonymous with all of the above mentioned terms.

**Vicarious Traumatization (VT)** the impact on a therapist of repeated emotionally intimate contact with trauma survivors. More than countertransference, VT affects the therapist across clients and situations. It results in a change in the therapist’s own world view and sense of justness and safety of the world. Therapist isolation and over involvement in trauma work can increase the risk of vicarious traumatization. (APA, 2007)
Chapter 4: Results and Discussion

“Ah Bartleby! Ah humanity!”

Melville (1986, p.46)

The results section is organized in such a way that the musical analysis on the improvisation will be followed by the interview analysis. Within the musical improvisation analysis, the SMMA (Structural Model for Music Analysis), music timeline analysis, and a detailed music analysis by the researcher will appear in that order.

In the interview analysis, the textural data analysis will be followed by the structural data analysis for all the subjects. All the descriptive data in the textural data analysis is from the subjects. Those are the very words used by the subjects. However, the researcher performed all the structural data analysis using imaginative variation. Some words or sentences are bolded in order to highlight the meaningful units that the researcher found from the verbal interview data.

4.1. Subject #1—Sarah

Musical Analysis on the Improvisation

Thoughts that came to the researcher while the improvisation was being performed;

- Profound Sadness; Depth of Sorrow
- Sonorous Wide Range of Register; Fuller & Bigger Scale
- Left Hand Arpeggiated Accompaniment; Waves of Ocean; Ebbs and Flows
- Recurring melody reminded the researcher of the persistent recurring aspect of the trauma
• Sense of hope and beauty in the trauma work for this subject expressed in this improvisation
• Highly Structured almost “Composition-Like” improvisation

Musical Analysis based on A Structural Model for Music Analysis (SMMA) (Erdonmez Grocke 1999)

1. Style and Form

1.1. Period of composition

March 24, 2009.

1.2. Form

Roughly A B

1.3. Structure

Predominantly simple

2. Texture

2.1 Consistently thick/thin or variable

Mostly throughout the improvisation

2.2 Monophonic; homophonic; polyphonic

Polyphonic

3. Time

3.1. Meter

4/4

3.2 Complexity and variability in meter

4/4 throughout the improvisation
3.3 Silences; rests; pauses

Not much silence and pauses

4. Rhythmic features

4.1 Underlying pulse of the work-consistent/inconsistent

Very consistent…every pulse stressed

4.2 Important rhythmic motifs

Running 8th notes in the left hand accompaniment and also series of 8th notes on the right hand-Busy left hand movements.

4.3 Repetition in rhythmic motifs

Running 8th notes in the left hand accompaniment

4.4 Variability in rhythm-predictable/unpredictable

Very predictable

4.5 Syncopation; not often present.

5. Tempo

5.1 Fast; slow; moderato; allegro, etc


5.2 Alterations in tempi; change of meter; use of accelerandi and ritardandi; No change in meter.

6. Tonal features

6.1 Key in which the work is written

The improvisation begins in a minor and ends in C major.

6.2 Key structure; diatonic; modal

Mostly Diatonic.
6.3 Major/minor alternations
Not much alternations.

6.4 Chromaticism
Not much chromaticism.

6.5 Modulation Points;

7. Melody

7.1 The main themes in the selection (1st theme, 2nd theme with development or variations)

7.2 Significant melodic fragments
Ascending melodic line with descending step wise melodic fragments

7.3 The structure of the melody; propinquity; step-wise progressions; large intervallic leaps
One big intervallic leap at the beginning of the melody followed by the stepwise descending motion in melody

7.4 Significant intervals (e.g., fall of an octave in a melody). Intervals conventional or unconventional
6th and 7th ascending leaps

7.5 Shape-rounded, ascending, descending
Over arching phrase shape

7.6 Length of phrases; symmetrical, short, long
8 bar phrasing

7.7 Pitch range of instruments
Very wide range of the piano was used for this improvisation.

8. Embellishments, ornamentation and articulation

8.1 Embellishments to the melodic line

Often the beginning of the melody was embellished with the appoggiaturas.

8.2 Trills; appoggiaturas

Melodies had a lot of appoggiaturas.

8.3 Accentuation; marcato; accents; detached bowing

Every beat was accentuated. It gave a plodding feeling to the phrases at times.

8.4 Pizzicato/Legato

N/A

8.5 Use of mute

N/A

9. Harmony

9.1 Predominantly consonant, or dissonant

Consonant

9.2 Consonance/dissonance alternation within the selection

Dissonance was used as a passing tone between the consonant notes.

9.3 Significant harmonic progressions

9.4 Rich harmonies

The use of the wide register of the piano as well as the broken down arppeggiated left hand accompaniment was rich in harmonies.
9.5  Predictable harmonies (e.g., I; IV; progression)

9.6  Unpredictable harmonies

   Not really present.

9.7  Cadence points-perfect; imperfect; interrupted

10. Timbre and quality of instrumentation

10.1 Solo Instrument; instrumental; vocal

   Piano-sounded rich due to the use of wide range in terms of register.

10.2 Accompaniment to solo instrument/voice; orchestral; choral; other instrument

   Left hand accompanied the right hand melodies on the piano.

10.3 Small Group-e.g. quartet, combinations of instruments

   N/A

10.4 Instrument groups used in orchestration (strings, woodwinds, brass, percussion, harp) creating timbral colour

   N/A

10.5 Interplay between instruments and instrument groups

   N/A

10.6 Layering effects (adding and reducing instrument parts)

11. Volume

11.1 Predominantly loud or soft-alternations between/gradation between
It varied within the improvisation. However, it started off with medium loudness and it peaked in the middle of the improvisation and came down towards the end.

11.2 Special effects of volume; pianissimo; fortissimo; Sforzandi

There was no extreme volume.

12. Intensity

12.1 Tension/release

In terms of tension and release, there were regular harmonic resolutions that facilitated this. However, it was also achieved by accents on every beat in the peak of the improvisation and the accent-ridden chords disappeared after the peak thereby releasing the tension.

12.2 Crescendi, building to peak, and resolution

There was one big build up towards the peak in the middle of the piece.

12.3 Tension in harmony, texture, etc., and resolution

12.4 Delayed resolution or absent resolution

12.5 Ambiguity resolved or unresolved

13. Mood

13.1 Predominant mood, as depicted by melody, harmony and predominant instrument
The predominant mood of this improvisation was of questioning suggested by the ascending 6\textsuperscript{th} or 7\textsuperscript{th} interval and accented by ploddingly coming down step wise line within the phrases.

13.2 Feelings and emotions represented.

One of great sadness, but also hopefulness.

14. Symbolic/associational

14.1 Culturally specific associations-e.g. Vaughan Williams’ English idioms

Western classical music influenced improvisation. It has a definite structure on multiple levels, and although this was an improvisation, this felt more like a composition while listening to it.

14.2 Metaphoric associations

The arpeggiated left hand accompaniment really made one think of waves of ocean, and water. The rich polyphonic texture really brought out the deep sonority of the piano and accentuated the depth of the sadness that the music therapist felt while working with trauma patients.

The ascending melodic line with major 6\textsuperscript{th} or major 7\textsuperscript{th} leap made one feel like one was questioning something and the answer that came with the step wise descending line with heavy accents on every beat left an impression of the hard, complex, and slowness of the work that may be associated with this particular therapist’s experience of working with trauma patients.
The subject’s main melody repeated many times which reminded the researcher of the nature of recurring traumatic memories.

15. Performance

15.1 Quality of performance (including the technique of the performers)

This subject performed confidently throughout the improvisation. The subject utilized all the register that was on the piano and throughout the performance the volume never really dropped too soft until the piece reached the end.

15.2 Stylistic interpretation-artistic merit

There was an element of beauty through this performance and that is entirely the merit of the music therapist.

15.3 Articulation of feeling and emotion

The music therapist expressed the feeling of great sadness by choosing to play in a minor key, but also the hopefulness of working with trauma patients through bringing in some major chords and a great sense of balance and structure that combined gave the overall sense of beauty in this improvisation.

Music Improvisation Timeline Analysis

0’00” Section A in a minor or C major. Reaching upwards; major 6th and then step wise movement in the right hand melody. Left hand accompaniment has the arpeggiated chord, which creates the feeling of a lot of movement.
0’43-1’12” Rumbling movements created in the left hand. Falling step wise motive feels like waves…
1’40” Waiting…
2’20” Section B; Finally arrived at something, or the question has been answered and it sounds more brighter. [ABC]
3’10” Triplet against Duple; creates the rhythmic tension.
3’15”-4’00” Something new has emerged. Higher register in the right hand.
4’00”-4’45” Middle register melody in the right hand.
4’46”-4’55” Brightness, unexpected momentary joy/happiness from the chord progression.
4’56” Coda
5’18” Ends in C major-very bright sounding key. Bright and Hopeful.

It is structured for an improvisation and it had a lot of the symbolic movements of the water in the left hand accompaniment part. It had a predictable meter, which was one of the constant elements of music that was present throughout the improvisation. There were clearly established melodies in the right hand and the left hand was there to support them. It had a great flow and although the music had much sorrow and sadness to begin with, there were brief moments of joyfulness and happiness sprinkled on rare occasions, which definitely had an orienting experience from the listener. The first section seemed unsettling due to the ambiguous tonality of it and the major 6th leap motif in the right hand melody sounded like a question. It took quite a while for that questioning feeling to be answered with a response until we reach 2’20.”
Improvisation Analysis

Sarah has worked with the natural disaster trauma patients and she also worked with veterans with trauma at the very beginning of her career as a music therapist. She has fourteen years of clinical experience as a music therapist. Throughout the interview, she mentioned how important it was for her and the music to be the **secure and constant source of container** for her patients and this thought was expressed in her improvisation that was **highly structured** [For example, from the excerpt 0’00”-2’20”]. Her improvisation had a “composition-like, already made up” quality rather than an extemporaneous one that is typical of the improvisations. Her improvisation is highly structured with clear delineation of different parts supported by the secure regular predictable tempo, highly diatonic harmony, medium volume, and medium intensity, which give the listener the feeling of regularity and stability without any unexpected surprises. This regularity and stability was the very thing that was missing in trauma patients when Sarah saw them. And this establishment of secure and holding musical environment became one of the important goals for Sarah in working with trauma patients.

In addition, Sarah played her improvisation with medium volume and intensity pretty much throughout the improvisation and this supports the feeling of **consistency** that she wanted to provide for patients and this was mentioned in her interview.

“Realizing that you know part of being a therapist is being there consistently no matter how you get treated. And if they don’t want your services, you cannot pack up and say, “Ok” then that is it.

Nobody came to the group on Monday, I am not going for the rest of
the week. You have to go back. Because sometimes it is that

consistency that is the only thing that helps some one realise that they can trust you.”

Her desire to provide a safe and consistent musical holding environment for her trauma patients is reflected in her improvisation through the usage of combined effect of the above mentioned musical elements.

According to Sarah, her adult trauma patients would often seem very hesitant and not ready to engage in music therapy. However, she often saw adult trauma patients just wandering into her office and pick at the guitar and start up a conversation with her. She said,

“…you know, making music and having conversation with me amidst of all the chaos of the office…probably matched their inner sense of chaos vs. going into a quiet room.”

Despite the highly structural elements, there is a section in Sarah’s improvisation where there are dense, wide, block chords played by both hands alternating with arpeggiated left hand 8th notes against the right hand contrary motion melody [4’00”-4’30”]. This creates a very complex texture. Heavy accents are placed on each beats as well as in different hands on different beats, thereby throwing off the longer melodic line and chopping it down to smaller units. The regular flowing feeling of stability is replaced by the feeling of being thrown off and pounded down by great weight. It does resemble the chaotic environment of the place where she was working and it also correctly reflects the inner sense of chaos that was felt by her patients.
She also mentioned that she felt strong and energized when she was working with her trauma patients and this can be heard in her usage of medium volume and intensity. The fact that her sound on the piano did not seem feeble or fragile may support her feeling that she was not feeling very tired despite long shifts at the command center and extra hours of work during the time when she worked with the hurricane trauma patients.

**Textural Description of Treating Trauma Patients**

No.1 Engagement

Pre-Connection

It was important for me to have allowed the patients to broach the subject of trauma themselves. I believed in giving them choices and control to come to the therapy and until then, I patiently waited. Being open and suspending my own judgment was an important step in meeting and being present with my trauma patients. The establishment of the therapeutic relationship and connection happened in the most spontaneous and unpredictable ways and circumstances. For example, many of the patients just wandered into my makeshift office at the command center and started playing the instruments, while I was working on other duties such as completing paper work and that are how most individual sessions occurred. Initially, there was some resistance to partake in the therapy by the adults. Also, being prepared to take the rejections from the patients allowed me to be there for them constantly.

During
I felt strangely energized during the two intense months of working with the natural disaster trauma patients. I understood the nature of the brief time limit that I had and the limitations that came from the setting. I felt personally and professionally rewarded when seeing the patients taking the music therapy opportunity that was offered to the patients and reconnecting with others to experience what it is like to be in a community being in a supportive environment and enjoy expressing and reconnecting with the inner sense of self again in music. For people who lost loved one and things, I just wanted to be there for them in any way that I could by wearing many different hats aside from being a music therapist and be part of the constancy that they desperately lacked.

There was a heightened sense of intensity and urgency that people responded to and I was amazed at how we could accomplish a lot of things in such short time. Normally, I can be notoriously disorganized and relaxed, but during this time I have been called, “Compulsive.” I think it was due to the urgency of the demand that I responded to. There was a need to be compulsive and that organized. Being prepared and thinking about many things in great detail kind of helped me to feel not afraid to make a mistake. It was very freeing.

Post-Therapy

There was a healthy dis-engagement that came with dissociation for me. When asked what I did after working with these patients, I could not recall any significant or mundane details of my life during this period. I felt relieved to go back to my normal life and I look forward to putting 100% of my focus to my long-term patients.

No.2 Music Therapy Interventions
I used a lot of familiar songs to establish the sense of trust and belonging with the patients. I was particularly surprised by the willingness of the patients to sing the songs about water, rain, and flood.

Song writing was another method that I used with my patient. The song format gave a lot of structure as well as creative outlet for the emotions to be expressed.

I cannot stress the importance of the structured activities and I did not use the less structured music therapy method such as music improvisation and Guided Imagery of Music.

No.3 Music Therapist Self-Care

The importance of the clinical supervision and peer supervision cannot be emphasized enough. Cultivating relaxing self-care activities just for oneself is another important thing for me. Having good boundaries and having the strict on and off work hours that I observed turned out to be one great self-care that I practiced.

No.4 Advice to the future music therapists who will be working with trauma patients

The education is the key. The understanding of the nature of trauma and catching up with the latest research on trauma and putting that into practice is an important part of trauma therapy. Along side with education, the clinical supervision was suggested as a very integral part of working with trauma patients.

Structural Descriptions of Treating Trauma Patients

Treating the trauma patients gave Sarah an opportunity to suspend judgements and allowed her to patiently wait for them to exercise their choice to have music therapy with Sarah. For people who have lost everything to a natural disaster, it was an important aspect of conducting music therapy for Sarah to have given them the means
to exercise their own agency. Those two months at the resource center was intense, but also energizing due to the special circumstances of dealing with the aftermath of a natural disaster. The time was a precious element as well as resources and because of this, one was driven by immediate priorities and efficiency. One wanted to be of help in any way one could. In addition, Sarah stated that this also brought out a leadership quality in her to take on many different roles in addition to being a therapist.

Due to the exigent as well as extemporaneous circumstances and timeline, the priorities of the treatment had to be given to the establishment of structure and security in music, thereby meeting the patients’ need for safety and normality. By establishing a sense of stability and constancy, the groups and individuals started to come together in music therapy. Establishing the therapeutic alliance with the patients were hard initially due to the high level of anxiety produced by what they experienced and the chaos of the setting itself. Everything was a makeshift and there were no set rules to go by at the very beginning. However, slowly the order was re-introduced and the patients took advantage of what was offered. Watching that process unfolds was incredibly rewarding as a therapist for Sarah. The groups were open to not only the patients, but also the people in the community such as policemen and other volunteers and when everybody came together, there was a real sense of community.

Sarah did not report any of the symptoms of VT, CF, or Burn Out during or after this work and this may be due to the short duration of time that she worked with the natural disaster trauma patients. The importance of the advance training and education in treating trauma patients and clinical supervision that she received may have contributed to this effect.
4.2. Subject #2-Rachel

Musical Analysis on the improvisation

Thoughts that came to the researcher while the improvisation was being performed;

• Strangeness
• Isolation
• Unknown
• Frozen
• Silences
• Fear
• Haunted
• Suspension of Time
• Fragility
• Beauty

Musical Analysis based on A Structural Model for Music Analysis (SMMA)
(Erdonmez Grocke 1999)

1. Style and Form

1.1. Period of composition

April 5, 2009.

1.2. Form

Difficult to say…The entire four minute improvisation sounds like one long piece.

1.3. Structure

Nothing is structured. Nothing is predictable.
2. Texture

2.1. Consistently thick/thin or variable

Very thin and never thick.

2.2. Monophonic; homophonic; polyphonic

It alternates between monophonic and homophonic mainly. However, there are polyphonic moments.

3. Time

3.1. Meter

There is no sense of meter. Although it feels like the main beat is equal to-quarter note equal to 60 on a metronome.

3.2 Complexity and variability in meter

There is no sense of time in this piece. It sounds as if the time is suspended and frozen.

3.3 Silences; rests; pauses

There are lots of silences in this improvisation. It feels like silence dominates this piece than the actual notes.

4. Rhythmic features

4.1. Underlying pulse of the work-consistent/inconsistent

The underlying pulse of the improvisation is consistent. However, it does not group itself to any discernable meter. Therefore, it gives a feeling of suspense…unknown.

4.2 Important rhythmic motifs
Long held notes and chords that feels like a “Pause” than any rhythmic motifs. There is some rhythmic motif that resembles triplets.

4.3 Repetition in rhythmic motifs

It is very difficult to speak of repetition in rhythmic motifs in this improvisation. However, if there is one, there is a triplet rhythmic motif.

4.4 Variability in rhythm-predictable/unpredictable

Unpredictable

4.5 Syncopation

No real syncopation present.

5. Tempo

5.1 Fast; slow; moderato; allegro, etc.

Slow. It feels like we are out of time.

5.2 Alterations in tempi; change of meter; use of accelerandi and ritardandi

It does not feel like the tempo undergoes any alterations.

6. Tonal features

6.1 Key in which the work is written

Atonal.

6.2 Key structure; diatonic; modal.

Atonal.

6.3 Major/minor alternations
N/A

6.4 Chromaticism
N/A

6.5 Modulation Points
N/A

7. Melody

7.1 The main themes in the selection (1\textsuperscript{st} theme, 2\textsuperscript{nd} theme with development or variations)
No discernable themes present.

7.2 Significant melodic fragments
Clusters of notes.

7.3 The structure of the melody; propinquity; step-wise progressions; large intervallic leaps
It seems like the melody is derived from atonal clusters of notes.

7.4 Significant intervals (e.g., fall of an octave in a melody). Intervals conventional or unconventional
Minor 2\textsuperscript{nd} Suspensions.

7.5 Shape-rounded, ascending, descending
Very fragmented.

7.6 Length of phrases; symmetrical, short, long
Short.

7.7 Pitch range of instruments
The wide range of the piano was utilized for this improvisation.
8. Embellishments, ornamentation and articulation

8.1 Embellishments to the melodic line

No embellishments.

8.2 Trills; appoggiaturas

No trills or appoggiaturas.

8.3 Accentuation; marcato; accents; detached bowing

N/A

8.4 Pizzicato/Legato

N/A

8.5 Use of mute

N/A

9. Harmony

9.1 Predominantly consonant, or dissonant

Dissonant

9.2 Consonance/dissonance alternation within the selection

Dissonance through out the improvisation with some consonance mixed in.

9.3 Significant harmonic progressions

No significant harmonic progressions.

9.4 Rich harmonies

It is not harmonically rich, but sparse. The notes in the chords are either too close or too wide apart.

9.5 Predictable harmonies (e.g., I; IV; V progression)
There is no predictable harmony in this improvisation.

9.6 Unpredictable harmonies

This improvisation is filled with unpredictable harmonies.

9.7 Cadence points-perfect; imperfect; interrupted

No real feeling of cadence is present in this improvisation. Everything feels unresolved and left hanging.

10. Timbre and quality of instrumentation

10.1 Solo Instrument; instrumental; vocal

Piano

10.2 Accompaniment to solo instrument/voice; orchestral; choral; other instrument

It is difficult to distinguish the melodic line from the accompaniment.

10.3 Small Group-e.g. quartet, combinations of instruments

N/A

10.4 Instrument groups used in orchestration (strings, woodwinds, brass, percussion, harp) creating timbral colour

N/A

10.5 Interplay between instruments and instrument groups

N/A

10.6 Layering effects (adding and reducing instrument parts)

N/A

11. Volume
11.1 Predominantly loud or soft-alternations between/gradation between
Predominantly soft through out the improvisation.

11.2 Special effects of volume; pianissimo; fortissimo; Sforzandi
Soft…

12. Intensity

12.1 Tension/release
Tension is present throughout the improvisation and the release is not really present always. The release is actually rare.

12.2 Crescendi, building to peak, and resolution
There is no real build up towards the peak and there is no real resolution.

12.3 Tension in harmony, texture, etc., and resolution
There are numer of minor 2nd suspensions present throughout the improvisation.

12.4 Delayed resolution or absent resolution
Absent resolution

12.5 Ambiguity resolved or unresolved
Ambiguity unresolved.

13. Mood

13.1 Predominant mood, as depicted by melody, harmony and predominant instrument
The use of few notes that are spread far and wide mixed with lot of silences produced a very delicate, but yet frozen mood. The image of
frozen rain drops that are literally hanging in the mid air came to the researcher while listening to this improvisation.

13.2 Feelings and emotions represented.

There is a feeling of ambiguity, ambivalence, sadness, and loneliness. However, there is also this feeling of incredible fragility that is of rare beauty.

14. Symbolic/associational

14.1 Culturally specific associations—e.g. Vaughan Williams’ English idioms

Not having any tonal center presents a feeling of unknown and evokes the feeling of not being connected to any culture, but of isolation.

14.2 Metaphoric associations

The use of silence strikes me as the most important part of this improvisation. The single notes as well as the clusters of notes resonating for the unknown duration of time speaks to the feeling of not being connected, not being communicated, not knowing what to expect from these notes put together. There seems to be a lack of flow signified by the lack of any discernable meter. Therefore, it also seems to express the frozenness.

15. Performance

15.1 Quality of performance (including the technique of the performers)
There is this quality of reflectiveness in the manner that was performed by this subject.

15.2  Stylistic interpretation-artistic merit

Despite the atonality and not having any discernable meter, there was this magical quality about this performance. There was a beauty in the resonance of just one note followed by longer silence. The fact that each note or each cluster was allowed to ring without feeling the need to get to the next note gave a strange beautiful quality to the whole improvisation.

15.3  Articulation of feeling and emotion

What was expressed was performed with clear intention and was well articulated.

Music Improvisation Timeline Analysis

0'58” Unknown Territory
1’20” Togetherness-Awkward
1’43” Attempt to meet/communcate
1’59” Being Alone? Just one note or is it unison?
2'06” Self-Expression
2’29” Together-Accord
2’42” Together Travelling
2'52” Uncertainty
3’11” Uncertainty
3’20” Some Understanding
3’40” Moving towards…

The minor 2nd interval is the closest interval on the piano. This interval sounded symbolic of the relationship that this particular therapist has with her patients. It sounds as if the therapist is the main note and the patient is staying very much closer to the therapist. In order to understand any kind of harmonic relationship between notes, one has to decide which key the music is in and according to this tonality, one analyses the intervallic relationship within that key. However, this improvisation is not in any key and that is very symbolic of the relationship between the therapist and the patient. We do not know how to look at or understand these intervals. We have lost the reference point. Thus, this gives the listener a feeling of uncertainty and since the two notes often appear as minor 2nds, it sounds like the therapist and the patient is not separated enough. It sounds as if the therapist and the patient is fused or enmeshed together.

Improvisation Analysis

Rachel works at an institution for the mentally impaired patients. Most of the patients have no or very little language abilities and she relies heavily on the musical improvisation and countertransference songs when working with her patients. She has twenty-two years of clinical experience of working as a music therapist and she uses object relations/relationally based approach in her work.

Right from the beginning, there is a hollowness and emptiness that comes in due to the sparse, limited usage of notes and ranges of the piano; therefore there is a lot of
empty musical space. This creates a feeling of loneliness. The tonality is ambiguous and it is because the improvisation is not centered in any key. It is atonal. This coincides with the feeling of Rachel being in the constant state of uncertainty and ambiguity.

“What I most feel when I am working with them is the constant state of uncertainty…where do we go next? Most of my patients do not use speech to communicate, so largely I have to rely on paying extremely close attention, which um…when you are working with people who have trauma…who have been traumatized…I think I tend to be hyper vigilant. So there is this sense of becoming very hyper vigilant in my work.”

That musical empty space is called, “Silence.” And according to Rachel, there are different qualities of silence. Silence has many hidden meanings.

“There is a lot of silence in the work that I do…One of the things that I talked about a lot is how the silences with different people feel different. There is a different quality with each person.”

When silence occurs, the musical or even the physical space gets uncluttered and more exposed and therefore, you are able to really focus and attend to that silence which corresponds to Rachel’s experience of hyper vigilance in working with trauma patients.

The most frequently occurring interval in this improvisation is a minor 2\textsuperscript{nd} and augmented ones, which signify the relationship between Rachel and her patients. Minor 2\textsuperscript{nd} is the technically the closest interval that you can have on the piano and
since this improvisation is atonal-lacking any tonal center- it is difficult to analyse and to understand which is the main note, meaning harmonically more established and which is not. Therefore, when you have two notes, which are closely put together in an atonal context, the relationship between them is difficult to understand from any vantage point. You have no referential point to understand it, but to note that these two notes are extremely close and fused.

“It was a very very enmeshed kind of a relationship.”

Throughout the improvisation many of the times the voices move in a homophonic manner which means that it travels within the same direction in same rhythm and so forth. This also is symbolic of the enmeshed kind of relationship that Rachel experiences with her trauma patients.

The augmented interval is an interval that is stretched and it feels that whenever you hear this interval, you hear Rachel trying her best to reach out and try to connect with her patients. In addition, it feels that she is stretching herself out of the music therapist role and become an advocate and a voice for her voiceless patients.

“I hate that people have been traumatized. Um, I really do. I find myself a lot of the times wanting to be a crusader…”

The establishment of the therapeutic relationship is further challenged by the limited language usage with her patients and this is expressed in music harmonically. The intervals do not really resolve in any ways and as a result it feels that one is constantly striving to meet and find the patient.

“This person I was working with yesterday…I have actually worked with him since 1998, I think. I work with a lot of my clients for a long
time. **It takes a long time with a lot of the guys to build up rapport of any sort...**

However, there is a brief moment where the voices move independently in a polyphonic contrary motion [2’24”-2’45”]. During that time, it feels that one has finally found the other and they are travelling together.

Despite the lack of fixed tonal center, abundance of silences, and discordant and unresolved cadences, this improvisation has incredible elements of beauty in it.

**“It is really profound work and there is a beauty in it”**

Beauty comes in the form of concordant harmony and resolution [0’30”-0’40”, & 2’05”-2’18”].

**Textural Description of Treating Trauma Patients**

No.1 Engagement

Pre-Connection

There is a considerable difficulty in establishing the therapeutic alliance with the patients that she sees due to their limited language skills. Therefore, much of the therapy process and progress is depended on my ability to read the emotional as well as behavioural cues from my patients. For this reason, I feel ambivalent, anxious, and uncertain most of the time. I become hyper-vigilant being attentive to my patient’s physical movements as well as behaviours in search of the signs in order to gain understanding of them and foster communication with them. Since majority of my patients have limited language ability, I use countertransference as a tool to gather information about my patients.

During
I communicate to my patients through **music improvisations**. I would try to play the feelings and the questions all in the music. Music is the main medium for the communication in my sessions. And I would rely on the behavioural signs from the patients and pay particular attention to their use of space in order to gain further understanding of them.

**I also use a lot of countertransferencial songs with my patients.** I pay really close attentions to the songs that suddenly pop into my mind. When I play such songs as “Behind Blue Eyes” with this one particular patient, I know that I’ve gotten somewhere because there is this shift that occurs within that moment during the session. There is a physical shift in the session.

Often I experienced **blurred boundary issues** with some of my patients and I have a **difficult time separating myself from certain patients**. The empathy for the patients who lack voices to stand up for themselves and communicating their wishes by becoming an advocate for them activates the rescuer in myself. **I literally become the voice for them** by speaking up for them against other professionals at times.

When working with institutionalized patients with trauma, I realise that there are a **lot of abandonment issues** with them. Many family members stop coming to see the patients after a certain period of time. Sometimes **a patient would parentify me** and convey the message of “You do it” and “You take care of me” to me. A patient has a hard time leaving the sessions with me.

**I think institutions are morally and ethically wrong.**
I have experienced some of the symptoms of vicarious traumatisation, 
compassion fatigue, and burnout in the past and I had to take a break from work in 
the past. In general, I am a hopeful person, but I have gotten to be a lot more cynical 
about the world. I often feel like they’ve gotten shafted. In the past, when some one 
told me specific stories about a patient’s trauma, I had certain visual images that 
lingered in my memory. With one particular patient in particular, there was a lot of 
STS working with him. **I feel traumatized on behalf of my clients.**

**It is so very easy to get overly involved** in my work to the point where I think it 
was less than useful for me and for my patients. There are specific clients who I have 
this wanting to rescue quality… towards.

The institutional setting teaches compliance to patients on all levels and I really try 
my best to give them an opportunity to exercise their own agency and express 
their wishes in my sessions with them. “**It is good that my patients can say, ‘No’ 
and have it respected.”**

The difficulties in maintaining the therapeutic alliance as well as continuing the 
therapy process exists during this stage and you need to be attentive. You need to be 
present in the moment and pay attention to the music, to the songs that are in your 
head, to the patient reactions, etc., etc.,

There are many rejections from the patients and moving through the therapy 
impasse is a hard process. However, when able to find a way to move beyond 
impasse I know that I have reached another stage/level of therapeutic alliance with 
the patients.
As much as this is a difficult work, I truly love the work that I do. There is nothing more profound than sitting with some one who is in a lot of pain.

It means I did something and it was worth this person’s while that I was there…that this was something important for this person.

Post-Therapy

Some terminations are extremely hard for me. It is heartbreaking for me.

Throughout the different stages of the therapy process, the feelings of anxiety, doubting, and ambivalence existed.

No.2 Music Therapy Interventions

Music improvisation is used majority of the time and singing familiar songs as well as countertransferencial songs have been used with my trauma patients.

Mo.3 Music Therapist’s Self-Care;

I found the clinical supervision and my own personal therapy work to be very helpful in meeting the challenges that came up while seeing the trauma patients.

Clinical supervision saved my life as a music therapist because I was truly burning out in the field.

One needs to take self-care time away from work and have separate music work aside from your music therapy work. I am a singer and a songwriter and this saved me over the years.

Nowadays, I blog about my work…I used to do a lot of journaling about my work.

No.4 Advice to the future music therapists who will be working with trauma patients;
Please find a clinical supervisor whom you can work with and continue with your own personal therapy. It is important to understand one’s own issues that could be activated while working with patients and seek expert opinion when you do not know and when you feel stuck.

A sense of humour is very much appreciated and you would like to bring humour to your patients as well.

You need to have some space for your own music as well. I think it is important to have space to find ways to separate yourself from your work.

**Structural Descriptions of Treating Trauma Patients**

For Rachel, working with trauma patients has its meaning in being present with suffering patients and helping them to cope with their everyday life. Being there with them and giving them opportunity to take an active stance in making choices and expressing their feelings are the things that Rachel values in her work with trauma patients in an institutional setting.

Working with patients who have limited language skills forced Rachel to pay extra attention and focus to her patient’s usage of space and behaviour. In addition, it has allowed Rachel to really tune into her cognitive, emotional, and physical self while being attentive to her patients in order to find ways to communicate with them and gather information from them. With the limited language usage and the institutionalized setting, she has experienced herself extending her role from being just a music therapist to their advocate and a crusader.

Although working with trauma patients present many challenges to Rachel, she loves her work and finds profound beauty in it. She has experienced VT, CF, and
Burn Out and understands how to prevent them from happening again by the virtue of having experienced them and overcoming them.

4.3. Subject #3-Timothy

Music Analysis on Improvisation

Thoughts that came to the researcher while the improvisation was being performed:

- Reaching Out
- Where are you?
- Air/Foggy air
- Unknown
- Being Alone & also a sense of community

Musical Analysis based on A Structural Model for Music Analysis (SMMA)

(Erdonmez Grocke 1999)

1. Style and Form

1.1. Period of composition

April 9, 2009.

1.2. Form

Section A and Section B with Coda at the end.

1.3. Structure: predominantly simple

2. Texture

2.1 Consistently thick/thin or variable

The texture pretty much stays thin most of the time.

2.2 Monophonic; homophonic; polyphonic

Homophonic throughout.
3. Time

3.1. Meter

Roughly 4/4 with steady quarter note equals approx. 60.

3.2. Complexity and variability in meter: 4/4 throughout the improvisation.

3.3. Silences; rests; pauses—not much silence and pauses

The main melodic motif a starts with an off beat. There are few places of silence.

4. Rhythmic features

4.1. Underlying pulse of the work-consistent/inconsistent;

Very consistent…every pulse stressed

4.2. Important rhythmic motifs

Melodic motif a starts off with an off beat.

4.3. Repetition in rhythmic motifs;

Running 8\textsuperscript{th} notes in the left hand accompaniment

4.4. Variability in rhythm-predictable/unpredictable;

Very predictable.

4.5. Syncopation; Not present.

5. Tempo

5.1. Fast; slow; moderato; allegro, etc.


5.2. Alterations in tempi; change of meter; use of accelerandi and ritardandi; No change in meter.
6. Tonal features

6.1 Key in which the work is written;

It is ambiguous. F Lydian Mode with occasional C#. It also sounds like C major.

6.2 Key structure; diatonic; modal;

Mostly modal.

6.3 Major/minor alternations;

It pretty much stays in one center.

6.4 Chromaticism; not much chromaticism.

Not really chromatic.

6.5 Modulation Points;

7. Melody

7.1 The main themes in the selection;

1st melodic motif a [0’00”-0’24”] with variations, and 2nd melodic motif b [1’28”-1’30”] with variations.

7.2 Significant melodic fragments

Melodic motif a [0’00”-0’24”] and melodic motif b [1’28”-1’30”].

7.3 The structure of the melody; propinquity; step-wise progressions;

Melodic motif a stays pretty much within third and fifth leap ranges of the tonic F mixed in with step wise motion.

7.4 Significant intervals (e.g., fall of an octave in a melody). Intervals conventional or unconventional
Perfect 4\textsuperscript{th} leap up and Major 6\textsuperscript{th} leap up in the right hand melody and step wise octave melodic motif b in the left hand.

7.5 Shape-rounded, ascending, descending
Balanced between rounded, ascending and descending.

7.6 Length of phrases; symmetrical, short, long
It starts with the standard two bar melodic motif and then it grows.

7.7 Pitch range of instruments;
Very wide range of the piano was used for this improvisation.

8. Embellishments, ornamentation and articulation

8.1 Embellishments to the melodic line
Passing tone in between the main chordal notes.

8.2 Trills; appoggiaturas
None.

8.3 Accentuation; marcato; accents; detached bowing
Heavy Accents [2’26”-2’40”, & 3’19”-3’33”]

8.4 Pizzicato/Legato
Legato.

8.5 Use of mute
None.

9. Harmony

9.1 Predominantly consonant, or dissonant
Mostly consonant.

9.2 Consonance/dissonance alternation within the selection
Mostly consonant.

9.3 Significant harmonic progressions

9.4 Rich harmonies

From 2’13”-2’38”.

9.5 Predictable harmonies (e.g., I; IV; V progression)

F pendal tone

9.6 Unpredictable harmonies

9.7 Cadence points-perfect; imperfect; interrupted

Imperfect Cadence but ends on F.

10. Timbre and quality of instrumentation

10.1 Solo Instrument; instrumental; vocal;

Piano.

10.2 Accompaniment to solo instrument/voice; orchestral; choral; other instrument;

Piano Left Hand Accompaniment.

10.3 Small Group-e.g. quartet, combinations of instruments

N/A.

10.4 Instrument groups used in orchestration (strings, woodwinds, brass, percussion, harp) creating timbral colour

N/A.

10.5 Interplay between instruments and instrument groups

Right Hand and Left Hand of the Piano.

10.6 Layering effects (adding and reducing instrument parts)
N/A.

11. Volume

11.1 Predominantly loud or soft-alternations between/gradation between;
    Medium Loudness with occasional Forte.

11.2 Special effects of volume; pianissimo; fortissimo; Sforzandi
    Some Sforzandi used.

12. Intensity

12.1 Tension/release
    Tension and release is built in within small melodic units.
    [0’00”-0’24”].

12.2 Crescendi, building to peak, and resolution
    Not present.

12.3 Tension in harmony, texture, etc., and resolution
    The piece resolves in F at the end.

12.4 Delayed resolution or absent resolution
    Section A [0’00”-2’10”] feels like it was based on one chord of F.

12.5 Ambiguity resolved or unresolved
    Not really.

13. Mood

13.1 Predominant mood, as depicted by melody, harmony and
    predominant instrument
    Uncertainty, unknown, and also questioning played by piano.

13.2 Feelings and emotions represented.
Uneasiness and Fear. Feelings of ambiguity.

14. Symbolic/associational

14.1 Culturally specific associations-e.g. Vaughan Williams’ English idioms

The Modal and minor harmonic ambiguity that belongs to the western harmony.

14.2 Metaphoric associations;

The F Lydian mode belongs to the old harmonic system before the diatonic harmonic system was established. Therefore, it gives a feeling of something old and even primordial. Because it does not move tonally very much, it also gives a feeling of reflectiveness or not flowing.

15. Performance

15.1 Quality of performance (including the technique of the performers)

Very sensitive and reflective.

15.2 Stylistic interpretation-artistic merit;

Throughout the improvisation, the performance had an expressive quality about it. It conveyed carefulness.

15.3 Articulation of feeling and emotion;

The performance conveyed the feelings of uncertainty [0’32’’]. This was expressed by the left hand octave tremolo. The feeling of fear [1’30’’] was expressed by the left hand octave pedal. The feeling of being connected [2’11’’] was expressed by the right hand reaching for
the high register. The feeling of warmth [3’00”-3’19”] was expressed by the fuller texture and harmony. The ambiguity was expressed by the overall tonality being somewhat between F Lydian and d minor.

Music Improvisation Timeline Analysis

0’00”-0’24” Melody a

0’32” Left Hand Uncertainty—E-G-E-G alternating rumble tremolo…uneasiness

0’43” Right Hand—Melodic motif a’ (CFCAGF) Looking out for something?

Wondering…

0’51” Melodic motif a answered by a variation of motif A, A’ (CFCED-AGEGE)

1’00” Head Shaking (A-G-E), dis-belief?

1’30” Pedal “E” – Low register interruption.

1’42” D-E-E Left Hand Low; something is trying to surface? Come up?

2’11” Higher Register- Right hand melody … Came Up? Reached?

2’14”-Texture Change, more movement, more harmony, more block chords.

2’22” Contact-Some Communication-Connection

2’26”-2’40” Heavy Accents

2’50” Fragments of Melodic motif a

2’59” E pedal again… alternating E-E-F ascending

3’00” Feeling of warmth and movement… some flow; working together…

3’21” Not feeling warm---less flow

3’24” Something struck… interrupted… weighed down?

3’37” Octave F-G-G Left Hand, echo?
4’10” Coda; Question being asked again and being answered.

Overall feeling; ambiguous and ambivalent

Timothy is a male music therapist with six years of clinical experience who approaches his patients with Humanistic framework. At present, he works at an inpatient psychiatric facility.

The improvisation starts off with a melody a [0’00”-0’24”] in a key that is ambiguous. It sounds like F Lydian or with occasional appearances of C#. The very first melodic a sounds very much like a simple folk melody that is inviting. It also has a contemplative quality about it due to the slow tempo. Usually, the folk melody is sung by the village folks and this melody gives the feeling of a small village, a community setting. It is symbolic that Timothy works with his trauma patients in a group music therapy setting and how this improvisation unfolded with a folk song like melody. The melody unfolds in a meandering manner that outlines the tonic triad of F Lydian mode. More than anything the meandering feeling was given by the way this music therapist performed it as well as the ambiguous tonality of the piece. F Lydian mode has the exactly same notes that of the C major scale and just the fact that the piece started with F pedal in the left hand and C on the right hand already made it difficult for the listeners to decide which key we are in. We are unsure of the tonality of this improvisation. We are unsure of where we are going and what to expect.

“Sometimes it is difficult to be in the moment…sometimes it is difficult to be in one place…does this go somewhere?”
When the octave tremolo appears for the first time [0’32”], we feel some anxiety. Just as we feel our stomach unsettling, the oscillating octaves in the left hand signals that there might be something that is coming near or being unearthed that signifies the anticipation of the trauma patient’s self disclosure.

A much more concrete octave motif appears in the left hand that sounds ominous [1’39”-1’41”]. If this ominous motif sounded rather soft earlier, this time it is played with deliberateness and clear diction as if to show that the patient has made his/her trauma self-disclosure.

When the melody returns in a higher register [0’43”-0’55”, & 1’46”-2’11] one feels that the music therapist is looking further and checking in with everybody trying to reach everyone. Something unsettling has come up and the music therapist is trying to check in with everybody because the group is about everybody. I am just trying to tap into where people are…to support them and to provide a setting and context.

After this, there is a much more textural change in the music resulting in more movement and block chords enter, and this sounds like the music therapist and the patients are working together in music in synch [2’11”-2’38”].

During the segment from 2’26”-2’34,” it sounds like the patient is talking about his/her trauma with feeling and this was emphasized with the heavy accents on the chords and there is a small echo right after this [2’34”-2’37”] and this echo sounds like the music therapist listening and reflecting what the patient has just said.

“If you can really be that and be willing to listen to hard stuff…you are providing something that is really rare.”
After one patient’s self-disclosure, the texture becomes much more richer and in harmony also and this sounds like the rest of the group members supporting the trauma patient [3’00”-3’18”]. With more harmony and change of texture, it feels warmer. There is a sense of community and support here.

The biggest and heaviest musical expression occurs from 3’19” to 4’10” and that also sounded like another patient’s trauma self-disclosure which ended in silence. The coda is from 4’10” till the end and the opening melody comes back. It feels that the searching and questioning has ended and the question has been answered. The ambiguous and ambivalent feeling is somewhat resolved with the final note of F. The improvisation comes to an end on F in unison rather than a full chord.

“When the session is over, there are times where I feel solemnness…”

Ending on the note of F in unison without any other added harmony embodies the meaning of solemnness; not cheerful or smiling, serious, and characterized by deep sincerity.

Textural Description of Treating Trauma Patients

No.1 Engagement

Pre-Connection

I mostly run music therapy groups in an in-patient psychiatric facility and for me, I am never really guaranteed to see anybody again. Therefore, accepting the limitation is important. “Ultimately knowing that not everything is going to be wrapped up and solved in any kind of way, while someone is in the hospital…”
From my experience, if you try to create a safe environment, the patients will take the opportunity to express themselves and even feel safe enough to disclose trauma history.

During

When patient discloses about their trauma history in a group session, I am in disbelief and in a shock, because it is not an easy thing to do in a group. And it also makes me question that act of self-disclosure when I see incongruent responses or if that had a too matter of fact tone of voice in delivery. There was a female patient who disclosed her traumatic past and although I believed her story, it sounded like she was using her trauma story to gain attention from others.

Immediately after they disclosed about their trauma history, the comparison to my own life happens. I try to imagine what living through that must have been like for this patient and how that experience might colour their outlook on the world and the effect that has on their sense of trust and security. When the trauma involves betrayal from parent esp. when it involves younger children, it is particularly hard for me to hear that.

I usually try my best to be open and suspend my own judgment and that applies to being ready to change plans and working with the flow of things. Sometimes this can be the source of conflict for me. There was a patient with trauma history one day and I decided to allow this patient to explore his trauma related issues. I was feeling kind of torn… I felt like I was going on instincts just to allow the clients to explore some of these things…
When I know that there are trauma patients in my group, **the balancing the need of the trauma patient and the rest of the group gets hard.** My attention gets really kind of preoccupied with that thing and it gets really hard to balance the group. I had to realise that there could be a real problem doing that and while still maintaining the right kind of sensitivity and presence for an individual who has had trauma, but...I also need to remind myself not to neglect the rest of the group. **The group is about everybody.**

Usually my patients pick songs that they would like to sing during the session. **I believe in giving patients the opportunity** to exercise their free will and I think it empowers them. I also use musical improvisations and **it is a profound experience** when people really go for and tap into something. **I usually feel proud of them and impressed** that they used this opportunity to explore like that. When it is happening, **it is riveting to listen to** somebody using music in that way and to really take in what it sounds like and what it means. I also have **feelings of anxiety about using musical improvisations and have thoughts like “Is this going to fly?”**

**Sometimes songs are such strong triggers** [for self-disclosure]. Song may act as one of the powerful factors for an individual patient in making the decision to share their trauma history with the rest of the group members.

**Post-Therapy**

Due to the in-patient group setting, I do not expect to see the same patients twice and therefore, termination is built in within one session.

**The things that stick with me are what they say and trauma stories bother me sometimes.** There was a time when I was very sensitive about traumatic things that I
was hearing and I wondered about that more. I felt so fortunate and lucky in some ways and I had the feeling of being haunted by the cruelty that they had gone through. It used to be more about “Trauma” itself, but now my thoughts stay with what and how I could better serve my trauma patients. I feel less prone to feeling that nowadays. I find myself really dwelling on what can I provide to this person or what should I do with the group?

After the session is over, I feel solemn…I have the respect for other group members who took supporting roles during the session. It is a real accomplishment for everybody there. We have allowed ourselves in this direction and to be with uncomfortable feelings. I also feel in awe about being able to create musical experience that will be helpful. I probably do not spend enough time reminding myself that it is pretty profound and I think I walk away feeling incredible.

Sometimes I walk away with a lot of doubt and criticism of myself and not sure any of this is helping at all or doing more harm. But I also think it is healthy to have these doubts. Sometimes there is also a moral and ethical dilemma that I feel in regards to whether I created a situation that was exposing my patients to trauma memories and details about this trauma in a situation where they were not going to be able to contain it if they need to.

No.2 Music Therapy Interventions

I like to use music improvisation to explore or create something for patients themselves like a resource. Often the patients will bring in the words also. I also do drumming with the patients, song communication with themes, and sing songs of wide varieties and genres such as R&B, Hip-Pop, and Spirituals.
No.3 Music Therapist Self-Care

I have a very supportive spouse and she understands what I go through with my work. I think I have a healthy way in dealing with my patients’ trauma stuff. I do not think I am plagued by it and I feel like I can handle it. **I have a healthy way of putting things in perspectives for myself** so that I can continue to work and I feel good about that.

No.4 Advice to Future Music Therapists

The important thing that helped me is a clinical supervision. I also think it is important to know that you can’t expect yourself to be there to provide the answers for any of that or to provide solutions. But if you are willing to listen to other people in whatever context, you can do that in music or without you are providing something that is incredibly valuable because these are the people in particular who don’t have any reason to trust anybody else. **If you can really be there and be willing to listen to hard stuff, you are providing something that is really rare.** If you can provide opportunities for them to talk about it then that is an important thing for them and **that is a part of healing process itself.**

**Be mindful of the language usage** because you are creating and presenting ways for your patients to start to talk about their trauma. And also **be mindful of the just having opportunities that where patients can explore things if they want to.**

**Structural Descriptions of Treating Trauma Patients**

Working at the in-patient psychiatric center in a group setting presents Timothy with many different challenges. The likelihood of seeing the same patients twice for Timothy is slim, therefore he focuses on working towards creating and providing the
safest environment possible and balancing out the need of the trauma patient and the rest of the group members. With this limitation, Timothy essentially works through song communication, drumming, and improvisation music therapy interventions for his patients to explore or create something for themselves. He finds meaning in being able to bear witness to the trauma patients’ struggle as well as attempts to really tap into music and to explore their issues. He used words such as “Profound,” “Proud,” “Riveting,” “Impressed,” and “In-Awe,” to describe his feelings when witnessing trauma patient’s attempt at healing through music.

4.4. Composite Textural Description of Treating Trauma Patients

Treating the trauma patients is a difficult, but profoundly rewarding experience that comes with its own challenges. Depending on the clinical setting, the challenges differ. However most of the time, the therapist encounters the difficulty in establishing the therapeutic relationship with trauma patients at the beginning of their relationship. Forming this therapeutic alliance with the trauma patient often tests the limit of the therapist in multiple ways; patience to stay engaged with open attitude, suspending the therapist’s own judgment, fighting with the urge to rescue and provide solutions for the patients, being prepared to be rejected, and maintaining a consistent presence with empathy.

Staying open and waiting patiently until they establish a connection with the trauma patient takes a lot of effort on the therapists’ part. However, they are able to stay being present because many times the therapists are in shock and disbelief of what their patients had to endure and this deeply affects the therapist’s own sense of
moral, justice, and ethics and as a consequence, this brings out the humanitarian in them.

Niggling doubt and anxiety arise over the therapist’s own ability to create the safe environment and whether any of the interventions were helpful to the patients or ended up doing more harm.

The therapist focuses on providing the safe environment for the patients to experience and regain the sense of trust with others that they have lost through the traumatic events of the past. More over, providing the opportunity for the trauma patients to feel safe enough to start their process of integrating the fragmented memories of the traumatic event is considered one of the most important part of conducting trauma therapy.

Singing familiar songs is a popular music therapy intervention with trauma patient population. Allowing the patients to select the songs has been considered an important aspect of the therapy that provides an opportunity for the patients to exercise their will and regain their sense of control that they have lost.

The clinical supervision came up as one of the most important aspect of self-care practice. In addition, continuation of music therapist’s own therapy is considered important in being able to function as a therapist for their trauma patients.

Despite the difficulties and challenges, music therapists find meaning in being able to be with another person who had a deeply disturbing experience in silence as well as in sound. Being a faithful witness to their patient’s recalling of the traumatic experience and being able to offer the opportunity for the patients to explore and express the feelings in regards to their traumatic event leaves them with profound
feelings. Witnessing and listening to the trauma patient taking that very opportunity to process their trauma through music and working towards healing by taking that initial step gives the tremendous feeling of happiness to the music therapists.

4.5. Composite Structural Description of Treating Trauma Patients

One of the difficulties of conducting group music therapy is balancing the need of the trauma patient and that of the rest of the group members. This reveals interesting personal characteristics of trauma therapists. Trauma patients by definition are the ones who have experienced the event that involve actual or threatened death or serious injury, or other threat to one’s physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person. There exists a level of power structure between the trauma patient, the victim and the perpetrator. Perpetrator violates the universal human rights of the powerless victim. Music Therapist’s concern in regards to balancing the needs of everyone in the group not just the trauma patient suggests that they are deeply committed to the value of fairness and justice. This sense of fairness and justice comes from looking and treating everyone as being equal. In fact, the Universal Declaration of Human Rights (UDHR) highlight the values that all three music therapists expressed in their interview in regards to working with trauma patients;

“Article 1.

All human beings are born free and equal in dignity and rights.

They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 3.
Everyone has the right to life, liberty and security of person.

Article 5.

No one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.”

The fact that all three music therapists felt very strongly of the suffering and misfortunes of their patients tells us that they are all humanitarians in spirit. In order to reach beyond being sympathetic by showing pity and concern, music therapists utilize their creativity and poetic imagination in order to tap into the patients’ stories filled with gruesome details with images, and physical symptoms of suffering from trauma and try to find an entry point for their empathy to be activated. During this process, it is inevitable that the therapists live through the patient and their trauma materials as a way of getting to know the inner experiences of the trauma patient.

Music therapists who work with trauma patients tap into this process of transforming sympathy to empathy by utilizing all their senses and by being present. That is why they all stressed the importance of listening. They are not only listening just for words, but also taking in the manifestations of patient’s emotional as well as physical expressions in order to have a deeper understanding of trauma patient’s experience.

Treating trauma patients elicits higher than normal level of anxiety and self-doubt in therapists due to their awareness of trauma and conscientious effort not to expose or re-expose their trauma patients from further harm. There is a higher than usual responsibility in being aware of every intervention that they use when working trauma patients. The ethical principle of “Non Malfeasance” in particular is highlighted and given extra emphasis. Thus, the presence of anxiety and doubt during
the course of working with trauma patient for the music therapist can be understood as a necessary and inherent part of conducting trauma therapy.

Music therapists intuitively understand the importance of the social support and how that plays into their patient’s recovery and healing from traumatic events. Just as their patients need support from them, music therapists themselves need extra support in dealing with the issues that arise from working with trauma patients. The constant level of anxiety and doubt need to be processed in order for the music therapists to be at their proper functioning level and due to this need, the clinical supervision is a necessary part of music therapist’s self care regime. While talking about the trauma patient cases with the clinical supervisor, music therapists gain extra vantage point as well as an opportunity to clarify an issue that has been plaguing them.

Singing familiar songs have been a popular intervention used with trauma patients in a group setting and also for the individual trauma patients. When patients request certain familiar songs, they know exactly what they will be hearing from the songs they requested. In an attempt to establish the sense of security and safety, the music therapists try to give much control to their patients in choosing the songs, and choosing the instruments and honouring their patients’ choice during the course of treatment. Allowing the patient to choose and honouring their choice is a symbolic act of paying respect to basic human dignity that the trauma patients have lost through their trauma. Through this repeated restorative interaction that shows respect, music therapists are engaging their trauma patients in trust building and helping them to regain the self-esteem.

4.6. Textural-Structural Synthesis
Treating trauma patients stirs a lot of questions in regards to the music therapist’s own sense of justice, moral, and responsibility. Such values get re-evaluated and the humanitarian in them gets activated and this enables the therapists to stay on the course being engaged with their trauma patients throughout the challenging therapeutic relationship. The long waiting period until the relationship is forged is beset with anxiety and ambivalence for the therapist and this continues on till the end. However, despite challenges, in an effort to better understand and to help the patient who has gone through un-imaginable harrowing events and survived, music therapists are more than willing to be their patient guide and a witness on the road to healing. This willingness to be present in another persons suffering really shed light on the characteristics of these music therapists as people who are deeply committed to the human rights cause. Therapists pay extra attention to every aspect of conducting trauma therapy with conscientiousness in an adherence to the ethical code “None Malfeasance” because trauma patients have already been exposed to great harm. This ethical concern continues on till the termination. The anxiety and self-doubt that the therapists experienced stem from having this ethical question when treating trauma patients.

Establishment of safety and security is one of the biggest goals in trauma therapy and music therapists work very hard to provide this experience for their trauma patient. They facilitate this through listening and by giving options for the patients to exercise their own choice and respecting that choice. Allowing the patients to be in control and to have their choice respected is a way to re-experiencing and restoring human dignity that they lost through trauma.
Clinical supervision is necessary in conducting trauma therapy for music therapists for good reasons. In order to deal with the impasse and issues of conducting trauma therapy, it is necessary for the music therapists to seek extra help from external source. By doing so, music therapists gained extra viewpoint and shared the emotional burden of carrying all that anxiety and ambivalence alone and as a result, music therapists were able to function properly and be there for their patients instead of experiencing VT, CF, and Burnout.

Music therapists try to see hope and provide an opportunity for the trauma patients to feel hopeful again. Watching the patient take chances and opportunities to express themselves and be brave enough to disclose the past trauma history to another which signals the beginning of a self willed healing process for the trauma patient touches music therapists and from this, they derive the biggest meaning in what they do and who they are as a person. They see and experience beauty in this process. They see beauty in their work in the midst of waiting, living with the feelings of anxiety and ambivalence, and in the active listening with deep empathy stemming from the respect for life and living, social responsibility, and a keen sense of justice.

4.7. Discussion

This research was focused on the overall experience of what it is like to treat trauma patients for music therapists. Three music therapists working at different settings allowed them to have three distinct experiences. The long-term individual therapy in comparison to the short-term group therapy proved to have different goals and structure adding complexities that the music therapists had to understand and take
consideration into their clinical experience. Despite the distinct experiences, they all expressed the core universal aspects of treating trauma patients.

4.7.1. Verbal Data and Musical Data

The phenomenological research method using the interview relies heavily on the data derived from the verbal interview. Therefore, when designing this study, the researcher expected much of the data to be surfacing from the rich language based verbal interview. However, while the researcher was doing the data analysis for the musical improvisation as well as the verbal part for each subjects, the researcher started to notice that the essence of the lived experience of the music therapist treating trauma patients expressed in the musical improvisation and the verbal interview had intricate connections. Not only the musical data and verbal interview data found to be congruent and correspondent, it looked like they were intrinsically linked which strengthened the research findings from both sources. Initially, the verbal interview data was considered to be the primary source and the musical data from the improvisation was to be considered as a secondary source of data due to the fact that it was only going to be five minutes long for each subject whereas the verbal interview was designed for 55 minutes. However, during the data analysis, it became apparent that the musical data really encapsulated the essence of this phenomenological study and the verbal data provided much more detailed and contextual information regarding the essential lived experience of the music therapist treating trauma patients. The emotional reactions of the music therapists treating trauma patients are well expressed in the music improvisation and that can be felt immediately upon listening.
It is also interesting to note that the findings from musical improvisation analysis performed by all the inter-raters concur in picking up the emotional aspects of the music therapists working with trauma patients (Appendix E).

4.7.2. Limitations

The study only had three music therapists and the higher number of subjects would have increased the validity of the research findings.

In total, two female music therapists and one male music therapist participated in this study and having music therapists of each gender in equal numbers would have also increased the validity of the research finding as well as making an interesting discovery of how gender might affect the music therapists’ experience of treating trauma patients.

The total time designed for the study was one time, 55 minutes of verbal interview and the study would have benefited from having another hour of interview in order to delve deep into some of the areas of interest as well as in order to clarity whatever was expressed previously.

4.7.3. Future Directions

Since trauma therapy within music therapy field is a growing area, there are many interesting topics that could be studied and explored. The future study could focus on music therapists working with patients who had one type of trauma such as sexual assault or rape victims and find out the detailed and descriptive experience of conducting therapy with that patient population only.

In order to study further, a survey could be conducted to get more responses about the themes that emerged from this study.
Knowing how difficult it is to establish the therapeutic alliance with trauma patients in general, the future research could focus on the phenomenon of establishing the therapeutic relationship. Exploring the awareness and quality of that connection from the music therapist’s point of view as well as from the patient’s view would make an interesting study.

The relationship between the trauma patients’ verbal as well as musical feedback and the music therapists’ level of stress and burn out possibility over a prolonged period of time might be another interesting area to study, since one subject who works with trauma patients with limited language abilities reported the presence of constant anxiety, ambivalence, and hyper-vigilance in an effort to be attentive to the patient’s behavioural expressions throughout the course of conducting trauma therapy that may put a strain on the therapist’s ability to be fully present and function without impairment. The findings from this study would be helpful for the future music therapists to be aware of the consequences of burnout and work satisfaction level that could significantly affect the therapist’s ability to function at their best.

The experience of treating trauma patients even with the secondary traumatic stress syndrome as a secondary focus of this study might have been too broad of an area to study well with one interview and a small sample. In the future, one could envision studies focusing on one stage of therapy or just focusing on VT, CF, or Burn Out in greater depth and detail.
Chapter 5: Summary and Conclusions

The research found that conducting trauma therapy is indeed a very challenging endeavor. From establishing the therapeutic relationship till the termination, music therapists are faced with a certain level of anxiety and doubt in regards to what they are doing is supportive enough. They have to be mindful of not re-traumatizing their patients and that takes extra care and caution. The result showed that the music therapists work towards establishing the sense of security and safety for their trauma patients and this runs through the entire course of treatment as one of the foremost important aspects of conducting trauma therapy.

Singing familiar songs reported as one of the universal and popular method in allowing the patients to feel safe and song writing as well as musical improvisation was used as an source of accessing and expressing the emotions of the trauma patients in aiding them to have an opportunity to integrate the fragmented memories of trauma. All the subjects emphasized allowing the patients to exercise their will and time to express their inner thoughts. Having the decision making power of one’s own, having a range of options from which you can make choices, ability to exercise assertiveness in collective decision making, and self-initiated growth process were stressed by all the music therapists as important in their work with trauma patients. By doing so, the therapists are bringing back the sense of control and empowerment to the patients who experienced the loss of control and powerlessness.
Time and time again, all three music therapists emphasized allowing the patients to initiate the healing process by being present with them as a constant source of support exercising good listening skills.

In some cases, the materials from working with trauma patients affected the therapists’ sense of security, justice, and led to have doubts about the way things are in the world. The trauma materials lingered on after the work hours and as one therapist commented it could make you a little more cynical. In terms of VT, CF, and Burn Out, only one of the therapists has experienced a few of the symptoms of VT, and Burnout as a result of prolonged exposure to working with trauma patients with limited language usage.

Clinical supervision, and the need for further education in terms of understanding trauma were stressed as important aspect of self-care for the music therapists working with trauma patients. In addition, they also mentioned their own therapy aside from their work to be one of the important aspects of maintaining mental health and being able to function as a music therapist for their trauma patients.

It was interesting that this research also shed light on the music therapist’s personal characteristics. All three music therapists expressed a deep desire to be present with the trauma patient on their journey towards recovery and healing and the fact that they all found incredible meaning in that conveyed their deep commitment towards justice and human rights issues. Without such commitment to those values, it would be hard for any therapists to endure the challenges that come with trauma therapy.
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Appendix A: Research Cover Letter

Dear :

My name is Dominique Lee and I am a second year graduate student in the Hahnemann Creative Arts in Therapy program at Drexel University, located in Philadelphia, PA. Currently, I am working on my master’s thesis research study that explores the music therapists’ experience of treating PTSD patients. For the purpose of this study, I am recruiting volunteers from the music therapy community who may be interested in being involved with this research.

The study announcement that describes the purposes of this study and the requirement for participation are as follows;
This research wishes to address the music therapists’ experience of treating the Post Traumatic Stress Syndrome (PTSD) diagnosed patients with the focus on understanding the music therapists’ experience of doing trauma therapy. Traditionally, particular and varied patient populations or the related treatments were the centre of the music therapy research focus. However, with the recent events of 9/11, the hurricane Katrina, Gulf, Afghanistan and Iraq War brought much of our attention to the areas of Trauma therapy. Thus, there is a greater need to study the impact of providing trauma therapy that has on music therapists and their own association with music, since music is the main vehicle for therapy for music therapists. The result from such study will be beneficial to furthering our understanding and awareness in the area of “Caring for the Caregiver” (Lowey, 2002), but also the knowledge regarding this special patient population as well.

For this study, the music therapists that qualify the below inclusion criteria will be selected;

   a. Music therapist who is board certified;
   b. Music therapist must have been in practice for the past two years;
   c. Music therapist must have been treating the PTSD patients at least for the past two years and still seeing PTSD diagnosed patients;

Healthy adults (25 and older) male or female of any age, race religious, ethnic, cultural, or socioeconomical background are to be recruited to participate in this study.
If you are interested in being part of this research study and meet the inclusion requirements, please contact me at (215) 762 6927 or send me an e-mail to Dominique_j_lee@yahoo.com.

Thank you for your time.

Sincerely,

Dominique J. Lee

Appendix B: Consent Form

DREXEL UNIVERSITY
CONSENT TO TAKE PART IN A RESEARCH STUDY

1. PARTICIPANT’S NAME: ____________________________________________________________

2. TITLE OF RESEARCH: A Phenomenological Study of Music Therapists Treating the Post Traumatic Stress Disorder patients.

3. INVESTIGATOR’S NAME: Paul Nolan, M.C.A.T., MT-BC, LPC, Principal Investigator; Dominique Lee, Co-Investigator

4. RESEARCH ENTITY: Drexel University

5. CONSENTING FOR THE RESEARCH STUDY: This is a long and an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family members, attorney or any one else you would like before you sign it. Do not sign it unless you are comfortable in participating in this study.
6. **PURPOSE OF RESEARCH:** You are being asked to participate in a research study. The purpose of this study is to begin developing an understanding of the subjective experience of music therapists treating PTSD patients. This research study is being conducted in partial fulfilment of a master’s degree in music therapy.

You are being asked to participate in this study because you meet the inclusion criteria,

- Between the ages of 25-75.
- A board certified music therapist (MT-BC).
- Currently in professional practice for a minimum of 2 years.
- Must have been treating the PTSD patients at least for the past two years and still seeing PTSD diagnosed patients.

Music Therapists who have previous history of the PTSD will not be asked to participate in this study.

Approximately 4 persons will be recruited for this study. You may withdraw from the study at any point.

7. **PROCEDURES AND DURATION:** You understand that the following things will be done.

- You will participate in one interview that will include two musical improvisations with the researcher supporting you and you will be asked questions regarding your subjective experience of treating PTSD patients. This may involve talking about feelings of a physical, emotional and intellectual nature as well as other thoughts, sensations and responses.
- The interview will last approximately 1 hour and will take place in New College Building, 245 N 15th Street, Room #4417. The interview will be audio taped for further study and evaluation by the researchers.
- The purpose of the study will be explained to you at the beginning of the interview, and the researcher will go over the consent form with you. Only then, you will be asked to make the first musical improvisation with the researcher using the familiar music therapy instruments such as piano, guitar, and drums. This musical improvisation will be titled, “Self-Portrait.”
- After the first improvisation, you will be asked to describe your subjective experience of treating the PTSD patients. A second musical improvisation will follow the verbal interview once the researcher feels that the subject has fully explored and described their experience of treating the PTSD patients. The second musical improvisation will be titled, “Music Therapist treating the PTSD patients.” After the 2nd musical improvisation, the main interview part of this research will officially be over.
• After completion of the interview, the audiotape will be turned off and the researcher will debrief you. The debriefing is a one-time, semi-structured conversation about your experience with the study. You will be given an opportunity at this time to express questions and/or concerns as a result of your participation in the study.

8. **RISKS AND DISCOMFORTS/CONSTRAINTS:** Although there are no known risks or discomforts reported when speaking about your clinical work or playing music, you may experience a small degree of anxiety as in any interview situation, or while playing a musical improvisation duet.

   If at any point you are uncomfortable with the music or the interview, you may choose to discontinue your participation in this study. You will also be offered the telephone number of the principle investigator, Paul Nolan, who is a Licensed Professional Counselor, as well as the number of Drexel University’s Student Counseling Center.

9. **UNFORESEEN RISKS:** Participation in this study may involve unforeseen risks. If unforeseen risks should occur, the Office of Regulatory Research Compliance will be notified.

10. **BENEFITS:** There may be no direct benefits from participating in this study.

11. **ALTERNATIVE PROCEDURES:** The alternative is not to participate in this study.

12. **REASONS FOR REMOVAL FROM STUDY:** You may be required to stop the study before the end for any of the following reasons:
   a) If all or part of the study is discontinued for any reason by the investigator, or university authorities.
   b) If you are a student, and participation in the study is adversely affecting your academic performance.
   c) If you fail to adhere to requirements for participation established by the researcher.

13. **VOLUNTARY PARTICIPATION:** Participation in this study is voluntary, and you can refuse to be in the study or stop at any time. There will be no negative consequences if you decide not to participate or to stop.

14. **RESPONSIBILITY FOR COST:** Participation in this study will be of no cost to you.

15. **IN CASE OF INJURY:** If you have any questions or believe you have been injured in any way by being in this research study, you should contact Paul Nolan at telephone number (215) 762-6927. However, neither the investigator nor Drexel University will make payment for injury, illness, or other loss resulting from your being in this research project. If you are injured by this
research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If you are injured or have an adverse reaction, you should also contact the Office of Regulatory Research Compliance at 215-255-7857.

16. CONFIDENTIALITY: In any publication of presentation of research results, your identity will be kept confidential, but there is a possibility that records which identify you may be inspected by authorized individuals, representatives of the institutional review boards (IRBs), or employees conducting peer review activities. You consent to such inspections and to the copying of excerpts of your records, if required by any of these representatives.

The audio tapes will be stored in a locked cabinet in the principle investigator’s office for approximately one year; Audio recordings will be transcribed by the researcher and at the completion of this study the tapes will be destroyed by the Co-Investigator in the presence of the Principal Investigator. The transcriptions will be kept by the Co-Investigator in a secure place in a locked cabinet at Drexel University until completion of the study at which time they will be shredded with the Principal Investigator as witness.

17. OTHER CONSIDERATIONS: If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems please contact the Institution’s Office of Regulatory Research Compliance by telephoning 215-255-7857.

18. CONSENT:

- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all my questions answered.
- I have carefully read this consent form, have initialed each page, and have received a signed copy.
- I give consent voluntarily.

_______________________________________  _________________________
Subject                                      Date

_______________________________________  _________________________
Investigator                                 Date
Individuals authorized to obtain consent:

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<th>Title</th>
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<tr>
<td>Dominique Lee</td>
<td>Co-investigator</td>
<td>215-762-6927</td>
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Appendix C: Demographic Data Collection Form

Subject Identification #

No.1 Gender

No.2 Age

No.3 Credentials

No.4 Graduate music therapy program attended

No.5 Years of professional music therapy clinical experience

No.6 Other
Appendix D: Interview Questions

No.1 What dimensions, incidents and people intimately connected with the experience stand out for you?
No.2 How did the experience affect you? What changes do you associate with the experience?
No.3 How did the experience affect significant others in your life?
No.4 What feelings were generated by the experience?
No.5 What thoughts stood out for you?
No.6 What bodily changes or states were you aware of at the time?
No.7 Have you shared all that is significant with reference to the experience?
Appendix E: Inter-Raters’ Music Improvisation Analysis

Inter-Rater #1

Age: 57 year old

Professional Standing: Professional Music Therapist

Orientation: Analytically Oriented

Main Instrument: Cello, Piano and Voice

No.1 Subject #1 Improvisation Analysis

- Sadness, Tears, Depression, Loneliness

- Circle- Repetition

- Hopelessness
• Aesthetic Beauty—working with trauma patient

• Present

• Grounding Feeling

• Change-Major, Hope, Surviving Trauma, Relief

• Positive Energy

• Meaningfulness in working with Trauma itself

• There is a flow in the music

• Constancy—providing constancy

• Change in it!! Reflecting the change

• Tonal-clear structure, definite relationship between all the components of the frame work.

• No singing??!Is this person not using the verbal part in the therapy?

• Not? Too direct to use vocal /verbal/expression/communication

• Perhaps it is hard to speak about trauma…

• Deep…no words for unspeakable

• Sounded like a person was using the feminine part of oneself while improvising this piece
• The choice of instrument being piano—pre-structural instrument where all the tones are arranged in sequence.

• This may indicate that this therapist feels that the piano has a clear structure where it can provide a good holding container for the trauma patients.

• One could picture the therapist sitting next to the patients—closeness in physical proximity…

• Tempo-Overall it was not fast…slow to medium paced which could indicate this therapist’s pacing of the work with the trauma patients. Pacing is important when working with trauma patients. This sounded like a conscious choice.

• Spirituality—This therapist may connect with spirituality in working with the trauma patients. Elements about death and rebirth. One could hear the meaningfulness of how spirituality could help in working with trauma patients in this improv.

• This therapist might have often felt sad and also might have often felt relieved in feeling the positive sense of being hopeful as well.

• Dynamic—neither loud nor soft, in the middle.

• Intensity—held it in medium, medium intensity of the world

• Consistency

• All register of the piano was used-wide register
• Clear beginning and clear ending; it is important in working with the trauma patients

• The therapist is working with “Here and Now” orientation as well as “Past” trauma of the patients. Working on both levels.

• Thematic Development—there was a recurring theme present that came back several times. This theme may represent “Trauma.”

• Accompaniment—Left Hand; arpeggiated—wavy…

• Hesitation at the beginning of the improvisation and then it moved towards hopefulness.

No.2 Subject #2 Improvisation Analysis

• Feeling of being stuck

• Physical Heaviness

• Constant Searching

• Tension

• Fragmentation

• Very Slow Tempo; As a therapist, she works very slowly with patients. There is a lot of waiting in terms of making decisions, waiting for patients, and waiting for the materials to come up. Therapist receives very little materials from the patients.
• Disconnection; Disconnection with patients; Disconnection within the patients themselves; Disconnection expressed in terms of big distances between the registers; Disconnection expressed as atonality with no direction.

• Fragility in patients; Therapist’s perceives the patients as fragile beings. It is like walking on thin ice or walking on eggshells. It gives a very ungrounded feeling. The patients are ungrounded. There is less structure in their life or in their psyche.

• There is a searching quality in her work.

• Feeling of being lost or loosing connection with the patients; Person feels often lost with the patient.

• Simplicity; There is a simplicity in the material which suggests that the patients that this therapist sees is internally at a very young child developmental level.

• Work; Sitting with unknown most of the time. Sitting with a situation where there is no direction.

• Depression

• Sadness

No.3 Subject #3 Improvisation Analysis

• Darkness and Hopelessness

• Frustration
• Very Slow Tempo in terms of the work process. Slow Work Process.

• Emptiness and Meaninglessness

• Loneliness

• A lot of Waiting

• Directionless

• Endless Empathy with Trauma Victim

• Empathy is a big part of music therapy technique

• Frozen Tears

• Few Rare Places of Relief and Solution

• Dissonant Work

• Developmentally, the music suggests adult patients. Adult thinking and playing.

• Thoughtfulness in the work. It comes from a thinking place.

• Periods of stuckness. Very little movements.

• Heavy Place/Setting in terms of environment

• Sad

• A lot of Caring

• Hard Work
• Torn in Difference Directions Constantly: No Tonal Center.

• Bits and Pieces: Fragmented: Hard to Integrate: Parallels the trauma therapy work

• Cautious

**Inter-Rater #2**

Age: 26 years old

Professional Standing: Music Therapy Grad Student

Main Instrument: Voice

No. 1 Subject #1 Improvisation Analysis

• Minor Mode; Going through

• Freely ascending and descending melody; Musical

• Pulse and rubato taken and present; 4/4 tempo moderate

• Within a key (i-IV-i-IV) possible-diatonic

• Definite Key and harmonic structure

• ½ way some major like sounds come in and more consonant---Hope

• Containing and holding trauma not still maintaining themselves

• Space in Music-Appropriate

• Tonally-wide range
• Some modulation (step wise and half step)

• A B A’ Form?

No.2 Subject #2 Improvisation Analysis

• Low dynamic

• Lots of space, dissonance and minor sounds

• Free rhythm-arythmic “Uncertain?” “Delicate” Aware in regards to patient’s needs

• Wide range tonally

• “Careful placement” of chords not definite structure

• Free but appeared to have some tonal center/home tone—centered

• Ending unexpectedly –not definite harmonic ending

• “Reflection of not always getting to end/closure with patient?”

No.3 Subject #3 Improvisation Analysis

• Wide range tonally-overall all tones were used…from bass to upper treble

• Thematic idea in treble

• Very supportive and grounding bass; maybe the therapist sees him/herself as that bass and treble is the patient??

• Modal-major sounding but switched to somewhat minor sounding mode
• Rather a rhythmic

• Form; A B A’ C’ A’ D A’ maybe?

• A section include treble idea “sol do sol mi re do” definite sense of self application in tx

• Free in tonality but definitely centered in key idea

• Pretty generous dynamic-didn’t get excessively loud or too too soft

• Started ended softly

• Unison sol me re do

• Bass and treble parallel motion ending

**Inter-Rater #3**

Age: 55 year old

Professional Standing: Professional Music Therapist

Orientation: Psychodynamics Orientation

Main Instrument: Percussion

No.1 Subject #1 Improvisation Analysis

• Tonal Expression Delayed cadences

• Suspensions 2-1 Over arching phrasings

• Vulnerable first section—reflecting the patient?
• Arpeggiated Left hand within tonality

• Grounded (Heavier Beats)

• Modulation-brighter-hopeful Stronger, brief positive sound

• Return to opening-developes differently –stronger—empathy??

• Brief return and resolution

No.2 Subject #2 Improvisation Analysis

• Stark, isolated, tonality???? Yes/No

• Space Introspective

• Exploration/searching/questioning??/ Avoidance of resolution??

• Resoluteness to atonality

• No melody—“No Voice”

No.3 Subject #3 Improvisation Analysis

• Home tone

• Wondering in treble

• Settles in tonality

• Occasionally moves to other bass notes

• Empty??? Wide internal followed by repetitive searching

• Fills in the chord-brighter??? Affect change…lyrical
• Brief hints at meter. Then rubato

• Close to original home tone-safety?

• Resolution at the end.