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Music Therapists' Self-Care: Examining the Effectiveness of Educational Preparation for Clinical Practice

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MUSIC THERAPISTS' SELF-CARE: EXAMINING THE EFFECTIVENESS OF EDUCATIONAL PREPARATION FOR CLINICAL PRACTICE

A DISSERTATION

(submitted by)

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In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

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ABSTRACT

The purpose of this study was to explore the effectiveness of undergraduate academic and clinical training programs for music therapy in addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempted to identify which self-care strategies are being used by practicing music therapy clinicians and how a practice of self-care impacts their work with distressed and/or traumatized individuals.

An electronic survey sent to all board-certified music therapists (MT-BCs) (N = 6369) generated a demographic profile of music therapy practitioners who identified their clientele as distressed and/or traumatized. The survey doubled as a means to identify a sample population for participation in face-to-face interviews. These interviews disclosed the clinicians' perception of the effectiveness of their educational programs in preparing them to work with trauma-informed populations. An arts-based response further provided qualitative information corroborating the interviews. An open-ended survey questionnaire sent to academic directors of AMTA approved program directors (N = 79), investigated whether curricula related to self-care was included.

The results revealed that 63.83% of MT-BCs (bachelor, masters, and doctorate levels) identified their clientele as distressed and/or traumatized. Specifically, 45.03% were bachelor-level clinicians. Results of the survey questionnaire to academic program directors (n = 16; 20.25% responding) indicated that 50% did not include a dedicated unit on self-care in their curricula. Interviews with clinicians exposed that 37.5% graduated from either graduate or undergraduate programs where the topic of self-care was not

addressed. A thematic analysis of interview data and mandala arts-based responses, generated five primary and secondary themes; the analysis further identified indicators of vicarious traumatization related to the work experience. A plethora of self-care strategies and practices were communicated throughout the interview and creative response.

The results of the survey suggest that more emphasis related to self-care in music therapy academic and clinical training programs would serve to provide graduates with increased knowledge and resources regarding self-care, thereby enabling clinicians to mitigate or circumvent the potential professional risks associated with treating a distressed and/or traumatized clientele.

Key Words: *music therapy, education, self-care, trauma, creative arts, self-care strategies, clinical preparation*

CHAPTER 1

Introduction

Reports of mass shootings, acts of terrorism, domestic violence, and natural disasters continue to infiltrate daily news broadcasts and personal conversations almost daily. The effects of these traumatic events may be potentially devastating, both for those who are directly impacted, and for those who witness and experience the trauma of others. Counselors, social workers, therapists, and other professional caregivers who are exposed to the stories of distressed and traumatized individuals may experience similar effects as a result of tending to the needs of their clients.

Clinical work with individuals who are distressed or traumatized may be very exacting for the professional caregiver, in ways that are emotionally, psychologically, physically, relationally, or spiritually demanding and difficult (Bell, 2003; Boscarino, Adams, & Figley, 2010; Dombo & Gray, 2013; Figley, 1995; Hafkenscheid, 2005). While such affective reactions may be "a natural by-product of the work" and "should be expected, normalized, and anticipated," (Dombo & Gray, 2013, p. 90), there may be preventative measures which may lessen and/or circumvent the potential debilitating impact these conditions have on the caregiver.

Psychotherapeutic work requires that the therapists be fully present and authentically engaged throughout the presentation of the client's material (Kenny, 2006). Providing treatment for distressed or traumatized individuals can be a difficult process for the client and the therapist; great care must be taken to protect the integrity of the self for both individuals (Hafkenscheid, 2005; Hoyt, 2001; Kantrowitz, 1997). Paavilainen,

Lepisto, and Flinck (2014) also claimed that "researchers and therapists … run the risk of becoming too involved with their subjects and clients [and] must be ever vigilant of their own emotional involvement and how they are affected by the [client's] experiences that are disclosed during treatment" (p. 51). In recent years, educational and advanced training programs for professionals who will work with traumatized individuals have emphasized the importance of clinicians being mindful of their own needs in order to protect against the effects of compassion fatigue, secondary traumatic stress, vicarious traumatization, or burnout (Courtois, 2002; Cunningham, 2004).

A look back at the 1960s reminds us that this was a period of protest and reform, much of which played out in the social reforms of the 1970s. The personal energy and time that it required to navigate through this turbulent and anti-establishment period of history, distracted individuals from focusing on many of their own needs. In the 1980s people (specifically in the United States) gradually began to reflect more on their own needs, financial security, personal freedoms, and community-awareness (Sirota, 2011). It was during the 1980s that the word *self-care* became popularized. While the commercial markets targeted products to promote healthful-living, the field of psychology was investigating the concepts of intentionality, an increased awareness of the present moment, mindfulness, and more authentic ways of living *(*Pagnini & Phillips, 2015).

Definitions

Terminology of secondary traumatic stress, vicarious traumatization, compassion fatigue and burnout, frequently described in the literature, is "often [used] erroneously [and] interchangeably" (Newell & MacNeil, 2010, p. 60). In reality, each of these words

is describing a unique condition. Compassion fatigue and burnout tend to be association more with prolonged work with clients who are distressed, suffering, or traumatized (Pines & Aronson, 1989). Stebnicki (2000) asserted that empathy fatigue, or the chronic use of empathy, is the dominant factor in placing professionals at risk for burnout. According to Figley (1995), secondary traumatic stress is a natural consequence of a shared therapeutic relationship in trauma work, and that in order to be effective as clinicians, it is reasonable to speculate that professional caregivers would be required to "experience the unbearable, think the unthinkable, and … experience the re-creation of scenarios of victimization, abandonment, betrayal, manipulation, and exploitation" (Rogers, 2013, p. 317). Vicarious traumatization is potentially more damaging to an individual's core self, "marked largely by cognitive changes in meanings, beliefs, schemas, and adaptation" (Baum, Rahav, & Sharon, 2014, p.112). Some authors have gone so far as to suggest that vicarious traumatization "may challenge the caregiver's basic faith, heighten a sense of personal vulnerability, and create distrust and cynicism about the human condition" (Herman, 1992, p. 141). When an individual's core self is challenged, and fundamental values and beliefs shaken, their sense of hope, optimism, and trust in the overall goodness of humankind may be forever altered. Furthermore, the defense mechanisms and coping strategies an individual once used to navigate through such emotional and devastating loss may be irrevocably compromised. Research supports the argument that professionals who work with victims/survivors of trauma and other vulnerable populations are at higher risk of experiencing vicarious traumatization

(Baum et al., 2014; Craig & Sprang, 2010; Newell & MacNeil, 2010; Sabin-Farrell & Turpin, 2003).

If indeed vicarious traumatization impacts the clinician's life on an unconscious level, then the need to bring this to conscious awareness and provide resources and strategies for mitigating its effects becomes a necessity. This is also an opinion shared by others, who suggested that increased self-awareness in health-care professionals is necessary in order to identify the impact of vicarious traumatization in their personal and professional lives (Campbell, 2013; Figley, 1995; Hafkenscheid, 2005; Miller, 1998). Moulden and Firestone (2007) wrote, "More systematic analyses of the relationship between the contributors and consequences of VT (vicarious traumatization) as well as mediators and moderators of this relationship are required" (p. 78).

Rationale of the Study

In a pilot study, Hearns (2015) investigated the phenomenon of vicarious traumatization on professional caregivers and what impact it might have had in their lives which contributed to a decision to abandon work with traumatized individuals and choose a different clinical population or a different vocation altogether. The four participants in this pilot study (social workers, an expressive arts/music therapist, and a burn unit nurse) had worked with traumatized individuals for a minimum of five years and had subsequently resigned from such work prior to the study.

The results revealed that indicators of vicarious traumatization were present throughout the interviews and may have been contributing factors leading to the development of vicarious traumatization, ultimately influencing participants to abandon

their work with traumatized individuals. The primary themes consistent with such indicators included boundary issues, avoidance/denial strategies, perceived professional incompetence, and significant change in personal life.

The results further underscored the importance of understanding such factors in order to develop preventative strategies to mitigate the effects and impact of vicarious traumatization. Though none of the participants in the pilot study reported using strategies of self-care during the time they were working with traumatized individuals, all four participants have since implemented a routine practice of self-care in their personal lives.

Respecting that not all clinicians will work exclusively with distressed and/or traumatized individuals, "the likelihood of encountering clients with trauma-related issues is still high" (Sommer, 2008, p. 61). Pearlman and Saakvitne (1995a) reported that trauma therapists and clinicians have articulated general guidelines for self-care that include professional, organizational, and personal strategies. Research has also shown that instructors in social work programs have advocated for education about vicarious traumatization and developing personal self-care strategies (Bussey, 2008; Courtois, 1998; Cunningham, 2004; Dane, 2002).

The American Music Therapy Association's (AMTA) *Professional Competencies* (2013), articulated the educational competencies that must be addressed in the curricula for a bachelor's degree in music therapy. Respecting personal growth and development, the standards state, "A music therapist at the Professional Level of Practice … has the ability to… demonstrate critical self-awareness of strengths and weaknesses" (Section

17.8). Furthermore, AMTA's *Standards for Education and Clinical Training* (2014), identify the responsible that academic and clinical training programs have on ensuring student acquisition of each professional competency.

> The academic institution shall take primary responsibility for the education and clinical training of its students at the professional level. This involves: offering the necessary academic courses to achieve required competency objectives, organizing and overseeing the student's clinical training, integrating the student's academic and clinical learning experiences according to developmental sequences, and evaluating student competence at various stages of the program. (Section 3.1.3)

Statement of the Problem

My own experience as a music therapy educator for the past 13 years has made me aware of the consequences many of my young students' experience when working with a distressed or traumatized individual for the first time. The experience is often difficult for them to process as they have never experienced the feelings that are evoked within them. Unfortunately, they tend to feel that there was "something wrong" with the way they interacted with the client, or that somehow they were responsible for "making it better." These undergraduate students may then think they do not have "what it takes" to be a music therapist. On the other side of the educational experience is the post-academic, pre-professional music therapy intern, who now (while working fulltime in a clinical setting for a minimum of six months) is experiencing the full weight and demands that may be placed on a professional caregiver. Out of fear and self-doubt they

may leave the field before they actually begin working in it. Over the past ten years, I have been surprised in the attrition rate that I have seen, not only within the undergraduate program, but with graduates who leave the field within the first five years of practice. According to the American Music Therapy *Member Survey and Workforce Analysis* (2014c), 88.8% of music therapists are female. Some of the attrition may be explained due personal circumstances and changes in life (marriage, children, etc.) particularly for women clinicians. Nevertheless, witnessing this attrition over the years has prompted me to examine my pedagogy and curriculum to ensure that the presentation and discussion of material regarding the potential hazards of clinical work, is sufficient for their needs.

Conversations with my colleagues at regional, national, and international conferences has made me realize that many of us were not prepared for the later trauma work we found ourselves engaged in doing. The development of personal self-care strategies was frequently an afterthought rather than a preparation *before* beginning our professional careers. I also became aware during these conversations, that there were differences in understanding of our responsibility to inform students and prepare them for trauma-informed work. Though we were working with competency-based curriculums reflective of the educational standards required by our professional association, there were large discrepancies in how we interpreted some of the competencies.

Purpose of the Study

The purpose of this study was to explore the ways that undergraduate academic and clinical training programs in music therapy are addressing the subject of personal

growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempted to identify how the practice of self-care is viewed by music therapists who work with distressed and/or traumatized individuals, which self-care strategies are being most frequently employed, and how a practice of self-care affects their work and their personal lives.

Research Questions

The research questions for the qualitative study are: (1) Do undergraduate academic and clinical training programs in music therapy adequately prepare students to work with distressed and/or traumatized individuals by educating them about vicarious traumatization and other potential hazards of professional work? (2) Are undergraduate music therapy students given instruction related to the development of self-care strategies to modulate or mitigate the potential hazards of professional work?

Anticipated Contributions

It is anticipated that the study will benefit the field of expressive arts therapies, and specifically the music therapy profession, by alerting educators of a possible disparity between the need for clinicians who exhibit self-awareness and practice self-care strategies, and the current educational curriculum that supports this development. This may also have a direct impact on the retention rate of professionals who provide therapeutic treatment for distressed and/or traumatized individuals. Furthermore, as the AMTA continues to explore a move to master level entry for the profession, the results of this study may contribute to this decision-making process.

Incorporation of Socio-cultural Perspective

A purposeful selection of participating music therapy clinicians will focus on providing diversity of culture and background thus bringing multiple perspectives of practice and theoretical orientation into the research. Given that self-care may mean different things to different people, it is hoped that this diversity will provide a multifaceted perspective to the use of self-care practices among music therapists.

Research Approach

With the approval of the Institutional Review Board at Lesley University, this study surveyed board-certified music therapists in order to a compile a descriptive illustration of their educational levels, experience, and current practice. Music therapy academic program directors were surveyed to investigate the effectiveness of academic and clinical trainings in preparing music therapists for clinical work with distressed and/or traumatized individuals. Through personal face-to-face interviews, eight currently practicing music therapists were queried in an attempt to identify their understanding of what it means to demonstrate critical self-awareness and how that concept related to their professional work and personal practice of self-care strategies. The study utilized a semi-structured interview schedule to further examine the participants' current clinical experience with distressed or traumatized individuals and to gain an understanding of ways in which these clinicians practice self-care. Each interview was conducted in-person with the participant either at the facility where they were employed, a public location, or in their home. The interviews lasted between 60-90 minutes and were followed by the participant's engagement in an arts-based response, reflecting their

interview experience. The interviews were recorded, transcribed verbatim, and reviewed by the participants for accuracy. An interpretative analysis of the arts-based response was provided by a licensed professional counselor and expert clinician in this area.

A thematic analysis and codification of the data was conducted to identify the emergent primary and secondary themes. Transcripts were read and re-read repeatedly, to synthesize the thematic material. Throughout the research process, the researcher consulted with colleagues to determine agreement on evolving thematic material.

Limitations

Limitations of the study were imposed by the low response rates on surveys sent to credential board-certified music therapists (16.06%) and educators of AMTA approved music therapy programs. Even though the survey sent to academic program directors was accessible for four months, with the allowable periodic reminder messages sent, the rate of response remained at its initial rate of 20.25%. The researcher, also an academic program director for an approved AMTA program, acknowledges her personal bias in regards to the effectiveness of academic and clinical training programs to prepare students for work with trauma-informed populations. A heightened awareness and conscientious effort was taken throughout the research process to minimize any potential effects of such bias.

Assumptions

I assumed participants who self-identified as working with distressed and/or traumatized individuals had experienced symptomology associated with vicarious traumatization. Further, I assumed that participants understood the concept of self-care

and employed ongoing practices of the same. I assumed that I did not influence the participants to respond to the semi-structure interview questions in a manner that would be in favor of my assumptions, personal beliefs or values. Finally, I assumed the methodology of investigation was appropriate to examine and illustrate the subsequent results of my study.

CHAPTER 2

Literature Review

Traumatic stressors do not only consist of direct, personal exposure to catastrophic events, but may also include indirect exposure to events by witnessing or learning about personal trauma experienced by others. This chapter introduces the basic tenets of factors leading to vicarious traumatization, and a review of the literature related to the effects of impact trauma on professional caregivers. It also reviews research on self-care, developing self-care strategies, and the role of educational training programs in preparing future clinicians to work with trauma-informed populations.

Clinical Work with Trauma Populations

It has been suggested that providing psychotherapy, or other therapeutic interventions, to individuals who have in some way been traumatized may be psychologically, socially, emotionally, or spiritually difficult for the professional caregiver (Bell, 2003; Boscarino et al., 2010; Dombo & Gray, 2013; Figley, 1995; Hafkenscheid, 2005; Shah, Garland, & Katz, 2007). Such difficulty has often been recognized as "a natural by-product of the work" and "should be expected, normalized, and anticipated" (Dombo & Gray, 2013, p. 90). While perhaps traumatic exposure may be viewed as a professional hazard of psychotherapeutic work, therapists who work with victims of trauma nevertheless need to be compassionate and empathetic in order to understand the client's subjective experience (Rogers, 1961; Walsh, 2009). Figley (2002) wrote that the "very act of being compassionate and empathetic extracts a cost" (p. 1434).

Several studies have acknowledged these conditions as being not only unavoidable, but also part of the reality and process of trauma therapy (Adams,

Boscarino, & Figley; 2006; Austin, 2002; Bober & Regehr, 2006; Hesse, 2002; Stamm, 1999). In a study by Thompson, Amatea and Thompson (2014), mental health counselors (N = 213) responded to a national survey that explored factors that may predict burnout and compassion fatigue, such as years of experience, gender, personal resources for well-being, coping strategies, and perception of work environment. The results indicated that personal attitude and mindfulness, use of coping strategies, perceived working conditions and job satisfaction accounted for 66.9% of the factors contributing to professional burnout. Specifically, results indicated that an individual's perception of their working environment and working conditions significantly predicted burnout (t = -12.009, p < .001). In a similar study conducted by Lent and Schwartz (2012), the researchers investigated possible correlations between burnout and personality factors, demographics, and work environment. Responses from mental health outpatient counselors who were also members of the American Counseling Association (N = 360) showed the relationship between work setting and burnout to be significant. "A conservative Pillai's Trace = 12, F (6, 656) = 7.24, p < .001… showed that work settings accounted for 6.2% of the variance in reported burnout" (pp. 362-363). While these studies both demonstrate that environmental factors (in other words, the settings wherein therapy is facilitated) are a predictor of burnout, neither serves to identify factors or stressors within the settings that may directly contribute to burnout, nor do they identify the number of counselors who have left their practice in consequence of such factors.

As a shared relationship, psychotherapeutic work may strain the therapist's abilities to remain authentically engaged and empathetic throughout the presentation of

the client's material (Kenny, 2006). Saakvitne (2002) categorized psychotherapeutic work with clients who have experienced traumatic events "as a process of *risking connection.*… in which both [client] and therapist must risk deep emotional connection, both intrapsychically [*sic*], within themselves, and interpersonally, with one another" (p. 445). When Rogers (1961) described the need for a therapist to be genuine, authentic, and empathetic and accepting towards the client, he was also placing the therapist in a vulnerable position. Reasonably, in being able to nonjudgmentally and subjectively view the client's world from his or her perspective, the experience of counseling is destined to have an effect on the therapist. Saatvitne (2002) emphasized the hierarchy of "multiple levels of traumatization" and indicated that "our personal vulnerability not only is a backdrop for our clinical work, but also is an acknowledged fact in many therapeutic relationships" (p. 444).

Kenny (2006) referred to expressive arts therapists as "*Technicians of the Sacred"* (p. v). In psychotherapeutic work, and specifically within the expressive arts, therapists *hold the space* for clients to make effective altering changes in their lives, and in so doing they are often witnesses to moments of great personal insight or catharsis. It is in being privy to transformative change that "witnessing" takes on a sacred nature. In a study by Moulden and Firestone (2007), therapists were asked to listen to recorded audio and visual graphic descriptions of traumatic events reported by clients and suggest possible therapeutic interventions for both the victims and perpetrators, and also to witness the client's reenactments or recollections, all the while being empathetically engaged with the client. The researchers concluded that therapists' behaviors were changed as a result

of being in this role. The study asserted that trauma work may have a significant impact and effect on the therapist, and that the extent to which one is aware and cognizant of this effect may serve to mitigate its impact and preserve the emotional and psychological well-being of the therapist, thus circumventing compassion fatigue and professional burnout.

Trauma therapy is a difficult process for the client and the therapist; great care must be taken to protect the integrity of the self for both individuals (Hafkenscheid, 2005; Hoyt, 2001; Kantrowitz, 1997). Paavilainen et al. (2014) also claimed that "researchers and therapists … run the risk of becoming too involved with their subjects and clients [and] must be ever vigilant of their own emotional involvement and how they are affected by the [client's] experiences that are disclosed during treatment" (p. 51). In recent years, educational and advanced training programs for professionals who will work with these "dark aspects of human nature" (Miller, 1998, p. 145) have emphasized the importance of clinicians being mindful of their own needs in order to protect against the effects of compassion fatigue, secondary traumatic stress, vicarious traumatization, or burnout (Courtois, 2002; Cunningham, 2004).

Definitions

The literature has presented an ambiguous use of terminology to describe the phenomena that practitioners often experience when working with distressed or traumatized individuals (Bride, 2004; Craig & Sprang, 2010). The conditions of secondary traumatic stress, vicarious traumatization, compassion fatigue and burnout are dissimilar from one another but "are often erroneously used interchangeably in the

literature" (Newell & MacNeil, 2010, p. 60). In general, secondary traumatic stress, vicarious traumatization, and compassion fatigue tend to be more specifically related to work with trauma populations while burnout is a more widespread phenomenon occurring in a variety of clinical and non-clinical occupations (Baird & Kracen, 2006; Deighton, Gurris, & Traue, 2007; Rothschild & Rand, 2006). Theory and research, however, continue to identify specific symptomatology and observable effects relative to each (Adams, Figley, & Boscarino, 2008; Baird & Kracen, 2006; Harr & Moore, 2011). Building a collective approach to understanding these terms, Knight (2013) has introduced an umbrella term, *indirect trauma*. For purposes herein, endeavoring to identify the similarities and differences between these concepts, along with adding clarity to the ensuing discussion, each concept will be reviewed respectively and expanded upon.

Secondary traumatic stress. *Secondary traumatic stress* (STS), or secondary traumatization, refers to the "effects of *experiencing* [italics added] the traumatization of others … for whom you feel responsible" (Saakvitne, 2002, p. 444). Figley (1995) defined secondary traumatization as "the natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or client] and the stress resulting from helping or want to help a traumatized or suffering person [or client]" (p. 7). The symptoms of secondary traumatization frequently resemble the symptoms of post-traumatic stress disorder (PTSD), such as intrusive thoughts, difficulty concentrating, avoidance of clients and client situations, hypervigilance, fatigue, chronic irritability, or insomnia (Banyard, Williams, & Siegel, 2001; Bride, 2007; Dutton & Rubenstein, 1995; Figley, 1995; Leverich & Post, 2006;

Newell & MacNeil, 2010; Rothschild, 2000). Clinicians experiencing symptoms of secondary traumatic stress have been known to show a preoccupation with thoughts about their clients' experiences beyond the work setting, even to the point of re-experiencing their clients' trauma in their own personal experiences, dreams, and waking thoughts (Knight, 1997; Knight, 2013; Meldrum, King, & Spooner, 2002). The prominent features of STS emphasize changes in overt behavioral patterns that parallel PTSD symptomatology presented in primary victim(s) of trauma, rather than the covert changes in an individual's cognition (Newell & MacNeil, 2010).

Vicarious traumatization. *Vicarious traumatization* is identified in the literature as a phenomenon which "results from exposure to clients' material, empathetic engagement with clients and a sense of responsibility for them and culminates in not only cognitive, but also affective and relational changes" (Deighton, et al., 2007, p. 64) for the therapist. Vicarious traumatization is "a process of [cognitive] change resulting from [chronic] empathic [*sic*] engagement with trauma survivors" (Pearlman, 1999, p. 52). It is often equated to secondary traumatization or secondary traumatic stress (Bell, 2003), but is potentially more damaging to an individual's core self, "marked largely by cognitive changes in meanings, beliefs, schemas, and adaptation" (Baum et al., 2014, p.112). Baird and Kracen (2006) wrote that vicarious traumatization "is associated with disruptions to schema in five areas… safety, trust, esteem, intimacy and control" (p. 182). Similarly, Herman (1992) suggested that vicarious traumatization "may challenge the caregiver's basic faith, heighten a sense of personal vulnerability, and create distrust and cynicism about the human condition" (p. 141). Saakvitne (2002) defined vicarious

traumatization as the negative transformation of an individual's "inner self [experience] as a result of [their] empathic [*sic*] engagement with [and sense of responsibility for] traumatized clients in the context of a helping relationship" (p. 444, 446). The Constructivist Self Development Theory (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a) formed the basis for this phenomenon, and asserted that vicarious traumatization "affects the same general aspects of self that are affected by traumatic life events" (Saakvitne, 2002, p. 447). When an individual's core self is challenged, and fundamental values and beliefs shaken, their sense of hope, optimism, and trust in the overall goodness of humankind may be negatively impacted (Birck, 2001; Byrne, Lerias, & Sullivan, 2006; Cunningham, 2003; Knight, 2013). Personal beliefs once held sacred may be forever changed, and an individual's defense mechanisms to navigate through emotional and personal loss may be compromised. It is not uncommon for clinicians who witness the traumatic experiences of others to experience such distortions in thinking or risk coming to view the world, and others, as unpredictable and untrustworthy.

Compassion fatigue. Often, those who experience secondary traumatic stress or vicarious traumatization are at a greater risk for *compassion fatigue* as well as other issues that may affect their personal lives and relationships. The term compassion fatigue (CF) has existed in the literature for over 30 years (Bourassa & Clements, 2010; Figley, 1995). Compassion fatigue is "based on the construct of a syndrome resulting from empathizing with people who are experiencing pain and suffering" (Deighton et al, 2007, p. 64). Newell and MacNeil (2010) wrote that "the experience of compassion fatigue tends to occur cumulatively over time; whereas vicarious trauma and secondary traumatic

stress have more immediate onset" (p. 61). Compassion fatigue is frequently synonymous with secondary traumatic stress (STS) and may have similar symptomology with post-traumatic stress disorder (PTSD), but may also be experienced in any clinical setting and is not restricted to practitioners working primarily with distressed and/or traumatized individuals (Collins & Long, 2003; Stamm, 1999; Stebnicki, 2000; Tehrani, 2010). In the case of mental health professionals working with either traumatized individuals or those with a mental illness, clinicians may experience compassion fatigue even without experiencing secondary traumatic stress. In a comprehensive definition of the term, compassion fatigue "involves a loss of ability to empathize with clients" (Knight, 2013, p. 228).

Burnout. *Burnout* is defined in the literature as a more permanent state of fatigue characterized by a feeling of emotional exhaustion, frustration, disheartenment, and an inability to realize and achieve a sense of accomplishment from one's work (Cherniss, 1980; Conrad & Kellar-Guenther, 2006; Figley, 1995; Greenberg, 2002; Stamm, 1999; Trippany, Kress, & Wilcoxon, 2004). Such feelings may foster a disconnection from other people, one's professional work, and possibly one's self (Barford & Whetton, 2010; Maslach, 1982; Maslach & Leiter, 1997; Saakvitne, 2002). The effects of burnout may be problematic not only in terms of rendering effective treatment, but also may compromise the therapeutic relationship. Numerous authors have referred to the negative costs of caring as burnout and compassion fatigue (Figley, 1995, 2002; Maslach, 1982; Maslach, & Leiter, 1997; Sexton, 1999; Sprang, Clark, & Whitt-Woosley, 2007; Thompson et al., 2014). For therapists and other professional caregivers working

specifically with traumatized individuals, “these negative costs are associated with secondary traumatization, vicarious trauma, and secondary traumatic stress” (Linley & Joseph, 2007, p. 385).

Craig and Sprang (2010) conducted a quantitative study designed to investigate the use of evidence-based practices to circumvent the negative outcomes of compassion fatigue and burnout among therapists and other professionals working in highly stressful, trauma-laden environments. A survey was sent to 2000 social workers and clinical psychologists who self-identified in the registry of their professional organization as having experience with trauma treatment. The randomly selected sample used for data analysis (N = 532), consisted of 34% males and 65% females, with a mean age of 53.2 years. Two separate measurement tools were used: (1) Professional Quality of Life III (Stamm, 2005), a 30-item inventory designed to measure burnout, compassion fatigue, and compassion satisfaction; (2) Trauma Practices Questionnaire (Craig & Sprang, 2009; Sprang & Craig, 2007), a 19-item inventory to measure evidence-based and non-evidenced-based practices. Independent *t*-tests for gender, education, licensure, and specialized training, were used as the dependent variables for burnout, compassion fatigue, and compassion satisfaction. An analysis of variance (ANOVA) was conducted using compassion satisfaction, compassion fatigue, and burnout as dependent variables and the type of employment organization related to the caregiver as an independent variable. Results showed that the only variable related to a significant difference in levels of impact for therapists was specialized training. Among participants, 12% experienced burnout, and 6% experienced compassion fatigue, although there was no

analysis to indicate the number of clinicians who subsequently made a career change. While the conclusion by Craig and Sprang (2010) suggested that witnessing another's trauma may negatively impact the professional's sense of self and psychological well-being, caregivers must also be mindful of the positive effects of trauma work for the therapist (Bonanno, 2004; Connor, Davidson, & Lee, 2003; Grady & Cantor, 2012; Hernandez, Engstrom, & Gangsei, 2010; Linley & Joseph, 2004; Linley & Joseph, 2007).

Whether describing the phenomena as vicarious traumatization, secondary traumatic stress, compassion fatigue or burnout, theorists and researchers appear to concur that a transformational change often results from therapists' empathetic engagement with survivors of traumatic experiences (Pearlman & Saakvitne, 1995b). As previously noted, the literature frequently uses these terms interchangeably, suggesting a significant overlap between them. Nevertheless, each has unique, detailed processes and expressions (Baum et al., 2014; Sabin-Farrell & Turpin, 2003). Craig and Sprang (2010) argued that these similar, yet slightly differing, definitions suggested a lack of clarity in terminology. These authors also supported the argument that professionals who work with victims/survivors of trauma are at higher risk of experiencing vicarious traumatization or secondary traumatic stress.

For the purposes of this paper the term vicarious traumatization will be used to describe the effect(s) continued exposure to a client's experience(s) might have on the therapist. While the literature suggests that both positive and negative effects of vicarious traumatization have been observed (Dombo & Gray, 2013; Hunter, 2012; Kenny, 2006; Linley & Joseph, 2007; Tedeschi & Calhoun, 2004; Thompson, 2014), a

greater percentage of studies have investigated the negative effects. The present study attempts to identify therapists' level of awareness of such phenomenon, and to investigate the role that education may have in preparing clinicians to work with distress and/or traumatized individuals and in mitigating the effects of vicarious traumatization. The investigation will also examine self-care strategies utilized by music therapy clinicians to circumvent such effects.

Effects of Vicarious Traumatization

The effects of vicarious trauma may manifest in several ways, such as feelings of confusion, difficulty participating in intimate relationships, unmet dependency needs, identity formation and self-esteem regulation (Austin, 2002; Smith, Kleijn & Hutschemaekers, 2007). Other behavioral changes might include intrusive thoughts, hypervigilance, and some forms of avoidance behaviors (Chouliara, Hutchison, & Karatzias, 2009; Moulden & Firestone, 2007). Vicarious trauma may even have an effect on integrity of the self and the integrity of the personality (Saakvitne, 2002). Several theories have suggested that the psyche has the capacity to attack and persecute itself, thus causing part of the psyche to recede from consciousness (Herman, 1992; Jung, 1965). This paper supports and furthers the discussion regarding the need to examine how the therapist's personality, and his or her unconscious feelings and inner state, can affect the client and the therapeutic relationship.

The phenomenon of vicarious traumatization may contribute not only to professional burnout, but also to compromised relationships, cynicism and mistrust, and other types of personal loss. Figure 2.1 lists various indicators of vicarious trauma that

are frequency noted in individuals who suffer from its effects. If indeed vicarious traumatization impacts the clinician's life on an unconscious level, then the need to bring awareness of this phenomenon to conscious awareness becomes a necessity. This is also an opinion shared by others, who suggested that increased self-awareness in health-care professionals is necessary in order to identify the impact of vicarious trauma in their personal and professional lives (Campbell, 2013; Figley, 1995; Hafkenscheid, 2005; Miller, 1998). Moulden and Firestone (2007) wrote, "More systematic analyses of the relationship between the contributors and consequences of VT (vicarious traumatization) as well as mediators and moderators of this relationship are required" (p. 78).

Indicators of Vicarious Traumatization

Emotional	Behavioral	Physical	Spiritual	Cognitive
Prolonged sadness and grief	Avoidance	Migraines	Changed relationship with meaning and hope	Difficulty focusing
Irritability	Boundary violations	Exhaustion	Loss of hopefulness	Intrusive imagery
Discouraged	Sense of incompetence	Heartburn	Lack of sense of purpose	Negativity
Tuning out	Insomnia	Ulcers	Changes in sense of self	Changes in cognitive schema
Depression	Hyper vigilant	Anxiety	Changes in fundamental beliefs	Distrustful
Personal vulnerability	Interpersonal relationship problems	Fatigue	Basic faith and values challenged	Transformation of inner self

Figure 2.1. Indicators of vicarious traumatization

Recognizing Stressors of Vicarious Traumatization

Clements-Cortez (2002) investigated the occupational stressors of hospice music therapists. The researcher interviewed practicing clinicians to "identify factors and

stressors they experience[d]… that may lead to burnout and compassion fatigue… [and to] identify coping strategies" (p. 34). Murphy (2013) asserted that this need is a necessity for clinicians rather than merely an option. Identifying stressors and coping strategies was also the focus of Rothschild's (2002) case study of a client who presented with "distinct signs of traumatic stress arousal" (p. 26). In this study, the clinician helped the client to identify vicarious trauma and develop effective coping strategies.

Smith et al. (2007) conducted a mixed-methods study with 26 therapists who were asked to share their experiences in working with both traumatized and non-traumatized clients in individual settings. After the participants described a self-identified difficult situation with a client, they were asked to describe in greater detail what had taken place, how they felt, what initially triggered their reaction, what they did, how they tried to cope, and what the results were. The interviews were transcribed and analyzed using a grounded theory protocol. This resulted in 20 categories of therapist reactions, such as shock, helplessness, disgust, irritation, and intrusive images (for example, nightmares, dreams). The categories informed the creation of a reactions-checklist that was subsequently used to score each participant's complete interview. This process allowed for a quantification of data that enabled the researchers to conduct a multiple correspondence analysis of therapist reactions. Personal therapeutic style was also examined to determine which reaction tendencies were more associated with a particular orientation. It was found that therapists with more experience reported greater incidences of shock, intrusive imagery, anxiety, and fatigue from the powerful and intense feelings that overwhelmed them.

Self-Care

It is well-documented that caring for the needs of others is exacting and makes demands on an individual's emotional, social, psychological, physical, and spiritual well-being. Over 100 years ago psychoanalysts were writing about the need for self-care: "No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed" (Freud, 1905, p. 184). Not only is the need to care for oneself a healthy and necessary practice, but for the helping professional it is an ethical responsibility (Barnett, Johnson, & Hilliard, 2006; Carter & Barnett, 2014; Dileo, 2000; Hernandez, et al., 2010; Newell & Nelson-Gardell, 2014). Newell and MacNeil (2010) broadly defined self-care as "the implementation of skills and strategies to maintain the … needs of oneself while attending to the needs of others" (p. 62). Carter and Barnett (2014) wrote, "Self-care is the ongoing practice of self-awareness and self-regulation for the purpose of balancing psychological, physical, and spiritual needs of the individual" (p. xiii).

The impact that working with distressed and/or traumatized individuals, and the propensity that exists leading to burnout, secondary traumatic stress, compassion fatigue and/or vicarious traumatization, are not phenomena that can be eliminated. Rather, the caregiver must become increasingly aware of their personal reactions and what their work is "bringing up" for them. Knight (2013) wrote that "practitioners and students [must first] 'own' their thoughts and feelings… Giving voice to these reactions begins to normalize and validate them and takes some of the onus off of the individual" (p. 231). Professional caregivers must turn their attention towards cultivating a culture of self-care

both for personal and professional needs (Capri, Kruger, & Tomlinson, 2013; Carter & Barnett, 2014; Sansbury, Graves, & Scott, 2015). In a study by Campenni, Muse-Burke, and Richards (2010), researchers found significant positive correlations between self-awareness and mindfulness, and self-care frequency and overall well-being. These findings suggested that increased participation in self-care activities fostered an increase in self-awareness and mindfulness, and vice versa. These components (self-awareness, mindfulness, and self-care practices) are essential in creating a culture of self-care.

In developing this culture and mindfulness of self-care, students and practitioners of helping professions need to discover the strategies that complement their way of being in the world. The strategies used by one individual do not necessarily provide the same benefits for someone else. Self-care strategies are not a "one size fits all" commodity (Bober & Regehr, 2006; Collins & Long, 2003; Danieli, 1998; Knight, 2013; Moore, Perry, Bledsoe, & Robinson, 2011). Saakvitne (2002) suggested the following: "To balance the cost of bearing witness, we need opportunities that allow us to turn away, to escape from harsh reality into fantasy, imagination, art, music, creativity, and sheer foolishness" (p. 448). An intentional exploration and immersion in these, and other self-care strategies, will foster an increased awareness of personal needs, limitations, physical and psychological experiences, the development of healthy boundaries, emotional reactions to environment factors, and relationships (Amir, 2004; Baker, 2003; Camilleri, 2001; Fowler, 2006; Klimecki, Ricard & Singer, 2013; Norman, 2009).

Effective Coping Strategies

The literature supports the need for trauma therapists to develop appropriate coping strategies and self-care practices in order to avoid turning to a variety of other defense strategies that will ultimately affect the therapist's ability to focus on the client's needs and potentially cause the therapist to become more vulnerable (Hafkenscheid, 2005; Kiesler, 2001). Silverman (2014) surveyed music therapists (N = 295; n = 38) to determine what practices they engaged in when feeling stressed; 63.16% indicated they used a coping skill, 34.21% recommended a vacation, and 23.68% said they sought personal therapy. Coping strategies may be focused on specific tasks such as striving for a balance between one's personal and professional life, frequently reflecting on the therapeutic relationship, maintaining a manageable caseload, and increasing awareness of the impact vicarious trauma may have in one's life, both professionally and personally (Baker, 2012; Smith et al., 2007).

Campbell (2013) suggested that the mental health system needed to undergo a level of social change by training supervisors to recognize how stress develops into fatigue and burnout, and how it is subsequently manifested in a decrease in therapists' job satisfaction. Campbell further proposed that giving increased attention to caseworkers, providing administrative support, and identifying resources to improve job satisfaction will minimize early retirement by professionals who are suffering from burnout. Clements-Cortez (2006), reported that it is beneficial to address not only the more typical stressors such as ongoing loss, differing palliative care philosophies, and issues of countertransference, but also stressors resulting from workplace environments,

relationships with treatment team members, and the difficult tasks that therapists are often confronted with when required to represent themselves in multiple roles. Other studies have also identified that networking within a supportive environment and the conscientious practice of self-care is necessary and beneficial (Austin, 2002; Figley, 2002; O'Callaghan, McDermott, Hudson, & Zalcberg, 2013; Saakvitne, 2002; Smith et al., 2007).

Treatment for secondary traumatic stress disorder, vicarious traumatization, and other related phenomena, are often explored through various self-care activities in the areas of physical, psychological, spiritual, and support systems (Figley, 1995). Positive health behaviors (O'Halloran & O'Halloran, 2001), affirming means of self-expression (Hesse, 2002), and philanthropic activities (Csiernik & Adams, 2002), are noted in the literature as being effective strategies for mitigating the potential harmful effects associated with burnout, compassion fatigue, secondary trauma and vicarious traumatization. The creative arts have also been recognized as a means of self-care and pathway to wholeness (Jung, 1973; Murrant, 2000). Jung (1963) believed that if people allowed "a mood or problem to become personified or given the cloak of an image, [they] cannot only begin to view [the issue] more clearly, more creatively, but also experience the emotions that are blocked behind it" (p. 46). In his own personal work, and work with his clients, Jung (1973) incorporated a practice of sketching circular drawings, using a circular art form known as the *mandala*, a Sanskrit term loosely defined to mean 'circle.' Fincher (1991) and Bush (1992) also endorsed the use of the mandala to evoke images capable of bringing repressed material to conscious awareness.

Hahna and Borling (2004) suggested that the use of music imagery could be a viable, multi-level treatment approach in addressing vicarious trauma. The technique of music imagery is based on the belief that our bodies respond to what we envisage. Too often, however, the individual is unaware of the work of their imagination, and consequently unaware of the responses the body is having to experiences and situational events, such as witnessing trauma, either personally or vicariously. Bonny and Savary (1990) wrote that the effects of trauma, whether experienced personally or vicariously, are part of the unconscious. Music imagery, being one technique that can be utilized to evoke imagery, may bring unconscious matter to the present, allowing an individual to process through barriers that may exist in achieving optimal psychological health. In a study with bereaved caregivers (O'Callaghan et al., 2013), the researchers used music imagery experiences as a means of self-care and found such experiences to provide an effective means for relieving stress, tension build-up, and fatigue.

A number of music therapy interventions have been investigated to determine their effectiveness in treating professional clinicians who experience secondary traumatic stress. Hilliard (2006) reported a significant difference between pre- and post-scores on a Team Building Questionnaire with nurses, social workers and hospice chaplains *(N* = 17) who participated in active and receptive music experiences, including chanting, guided meditation to music, lyric analysis, and movement to music. This study, though relatively small in sample size for a quantitative study, and provided qualitative narrative data to support the positive effects of music therapy to empower caregivers and help them

increase their coping skills, thereby enhancing client care, by helping professionals deal with job-related stressors.

The vocal holding technique, pioneered by Austin (2002), may be a viable treatment option for allowing the expression of emotions that have been too threatening for the individual to embody. Being able to express deep emotions that have been repressed is thought to be both liberating and empowering. Herman (1992) hypothesized that trauma therapists often repress their own emotions in order to remain attentive to the client. If the emotional effects resulting from the experiences therapists have when working with traumatized individuals can negatively impact both client and therapist, research should aim to increase therapists' ability to deal with these effects. Exploring and finding means for expressing such emotions, rather than attempting to keep them at bay may negate barriers and obstacles inhibiting effective therapeutic work.

Role of Education in Developing Self-Care Strategies

The research is scant in identifying what role education has in mitigating the effects of vicarious traumatization and suggests that education focused on preparing students to understand and become aware of the effects of vicarious traumatization is limited (Bussey, 2008; Chapman, Oppenheim, Shibusawa & Jackson, 2003; Cunningham, 2004; Dziegielewski, Turnage, & Roest-Marti, 2004; Knight, 2010; Leiter & Maslach, 2005; Lerias & Byrne, 2003; Moore et al., 2011; Newell & MacNeil, 2010; Phipps & Byrne, 2003; Pines & Aronson, 1988; Rothschild & Rand, 2006). Addressing the affective aspects of clinical practice must not only be done during clinical supervision

with students, but also as a part of classroom instruction. Knight (2013) asserts the following:

> As the instructor presents the various manifestations of indirect trauma [secondary traumatic stress, vicarious traumatization, compassion fatigue, and burnout] as well as discusses the need for students to develop self-care strategies, she or he legitimizes and normalizes this phenomenon. This, in turn, encourages the student to be proactive in looking for signs of indirect trauma in themselves and taking appropriate steps to minimize its impact. (p. 237)

Authors agree that pre-professional caregivers need to be educated and informed regarding the affective aspects of working with clinical populations, and not solely populations related to trauma work (Bussey, 2008; Courtois, 2002; Dane, 2002; Dileo, 2000; Harr & Moore, 2011; Power & Bogo, 2002; Walker, 2004). Studies show that clinicians with limited clinical experience working with traumatized and/or distressed individuals are more vulnerable to the effects of compassion fatigue, secondary trauma and vicarious traumatization (Lerias & Byrne, 2003; Shackelford, 2006).

Undergraduate music therapy education. Baccalaureate and equivalency programs in music therapy offered at institutions accredited by the National Association of Schools of Music (NASM) are eligible to apply for program approval by the American Music Therapy Association (AMTA). Program approval by AMTA ensures that such programs are in compliance with AMTA Standards for Education and Clinical Training (2014b) and/or Code of Ethics (2014a).

In AMTA's Standards for Education and Clinical Training (2014b), it states that "the bachelor's degree in music therapy (and equivalency programs) shall be designed to impart professional competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles, as specified in the *AMTA Professional Competencies*" (Section 3.1.1). A closer look at the AMTA Professional Competencies identifies only one competency for undergraduate curricula (listed under the section *Music Therapy Foundations and Principles)* that may address the affective aspects of clinical practice, depending on how it is interpreted. Section 17.8 of this document states, "Demonstrate critical self-awareness of strengths and weaknesses" (AMTA, 2013). In reference to graduate curricula, the AMTA Advanced Competencies are more succinct in addressing the need of self-care, as seen in the figure below.

AMTA Advanced Competencies (AMTA, 2015)

Personal Development and Professional Role

8.1 Utilize self-awareness and insight to deepen the client's process in therapy.
8.2 Identify and address one's personal issues.
8.4 Use personal reflection
(e.g., journaling, artistic involvement, meditation, other spiritual pursuits).
8.5 Recognize limitations in competence and seek consultation.
8.6 Practice strategies for self-care.

Figure 2.2. AMTA Advanced Competencies

It may be postulated that an individual's ability to be critically aware of their strengths and weakness is concomitant to their ability to "own" their thoughts and feelings. Knight (2013) identified the first step in addressing phenomena such as vicarious traumatization as being the practitioner's ability to articulate whatever thoughts, feelings, and emotions they may have associated with their work. This purposeful act will begin to empower students and professionals with the knowledge and resources needed to manage and mitigate the potentially harmful effects of their work.

Furthermore, the AMTA Code of Ethics (2014a), to which any AMTA approved education and clinical training program must adhere, states the following:

> The MT is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems. (Section 1.5)

This section of the AMTA Code of Ethics may provide some guidance and direction as to the how the professional competency, previously referred to for undergraduate curricula, might be interpreted. The professional's ability to be critically aware of their strengths and weaknesses may be demonstrated by their level of self-awareness respecting any personal limitations, problems, and values that may possibly interfere with his/her professional work (Silverman, 2014).

Evolution of Research Questions

Nearly a decade ago, I participated in a research project designed to investigate the effectiveness of using the creative arts in working with women survivors of domestic violence. According to my written reflections on the experience, "This was also my initial work with women victims of domestic violence, and I found myself flooded with emotion – shock, surprise, anger, disbelief, fear, horror, hurt, immeasurable loss – emotions that manifested in ways I had never before experienced" (Hearns, 2009, p. 113). The experience of participating in this research marked a transformation in consciousness for me; the work "impact[ed] my own views and influence[d] the perceptions I had held of my reality" (p. 114). This transformative change has proven irreversible. Herman (1992) would describe this type of shift in consciousness as being an unanticipated consequence of being involved in such highly emotionally charged work. I have queried myself as to what level of awareness I had at the time, and presently have, as to how this work has impacted my life. Even today, I doubt that I have a full conscious awareness of such. I think that I have buried some of my own voices deep inside, and I speculate that other professionals who do "emotionally charged work" have done the same. In a way, it's a coping mechanism—a means of professional survival, in order to be able to work with my next client who is dealing with the same issues.

While the role of the witness or secondary debriefer (those who provide professional assistance to victims of domestic violence and other traumas) is characterized as one of summarizing, containing, and making psychological sense of what has occurred (Talbot, Dutton, & Dunn, 1995), the potential for the occurrence of

vicarious traumatization should not be overlooked or minimized. Research has indicated that more investigation needs to be focused on understanding the relationship that exists between the factors that contribute to vicarious traumatization and the resources and strategies available to mitigate its effects (Moulden & Firestone, 2007).

The current global social climate would suggest that the need for trauma therapists is ever increasing. In order to maximize retention of effective practitioners, and increase the longevity of new professionals entering the field, research is needed to increase understanding of the impact trauma work has on therapists, clinicians, caseworkers and counselors who bear witness to stories of trauma. Future investigations may include such questions as: (1) Are changes in cognitive schemas a result of witnessing trauma vicariously? (2) To what degree are professional caregivers aware of the phenomenon of vicarious traumatization? (3) Are therapists and clinicians able to identify and address their own needs in order to remain effective in their work? (4) Are certain practices more effective for developing personal coping skills to manage the potential impact of vicarious traumatization?

The present study will investigate the following primary research questions: (1) In what ways do undergraduate academic and clinical training programs in music therapy address the subject of personal growth as it relates to the development of critical self-awareness? (2) Are undergraduate music therapy students given instruction related to the development of self-care strategies as a means of modulating or mitigating the effects of secondary trauma and/or vicarious traumatization that may result from working with distressed and/or traumatized individuals? Secondary questions will include the

following: (1) How is a practice of self-care viewed by professional music therapists who work with distressed and/or traumatized individuals? (2) What self-care strategies are being employed by music therapists? (3) How does a practice of self-care affect the music therapists' personal and professional life?

CHAPTER 3

Methodology

In this methodology chapter I will describe the research design, sample selection, research instruments and methods, data collection, and analysis of the data. The chapter begins with a review of the purpose of the study, research questions, then presents the research protocol, limitations, and institutional review board approval and confidentiality.

Purpose of the Study

The purpose of this study was to explore the effectiveness of undergraduate academic and clinical training programs in music therapy in addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempted to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care impacts their work with distressed and/or traumatized individuals.

Research Questions

With the primary responsibility being given to educators at institutions with AMTA approved music therapy programs for the education and clinical training of its students at the professional level, the researcher was interested in determining to what level educators were preparing undergraduate students to work with distressed or traumatized individuals, insomuch that students were being educated as to the potential risks involved with trauma work. The primary research questions included: (1) In what ways do undergraduate academic and clinical training programs in music therapy address the subject of personal growth as it relates to the development of critical self-awareness?

(2) Are undergraduate music therapy students given instruction related to the development of self-care strategies to modulate or mitigate the effects of secondary trauma and/or vicarious traumatization that may result from working with distressed and/or traumatized individuals? Secondary questions included: (1) How is a practice of self-care viewed by professional music therapists who work with distressed and/or traumatized individuals? (2) What self-care strategies are being employed by music therapists? (3) How does a practice of self-care affect the music therapists' personal and professional life?

Research Design

This qualitative study explored the experiences of music therapy clinicians who self-identified as working with distressed and/or traumatized individuals. Surveys were sent to board-certified music therapists and music therapy academic program directors for the purpose of collecting demographic information, interpretations to existing education competencies, and generating a sample pool for selecting participants for personal interviews. Face-to-face semi-structured interviews were conducted with selecting music therapy clinicians who identified their clientele as being distressed and/or traumatized. The researcher desired to identify the degree to which pre-professional academic and clinical training programs had prepared the music therapists (participants) for working with trauma populations. Furthermore, the researcher was interested in identifying the self-care strategies employed by the participants. To honor the participants' experience within the interview itself, and to provide a moment of self-care thereafter, participants were invited to provide an arts-based response by creating a drawn mandala. After the

participant had completed creating the mandala, the researcher conducted a brief verbal processing of this arts-based response with each participant. The interviews were audio-recorded and later transcribed verbatim and sent to the participant for member-checking. A digital image of the participant's mandala and a copy of the transcription of the mandala processing were sent by the researcher to a professional MARI Practitioner for interpretation and corroboration. This approach was assumed by the researcher to be the most effective for framing the study within a humanistic orientation.

Additionally, the study invited program directors of approved AMTA music therapy academic and clinical training programs via a survey to provide their interpretation of an undergraduate educational competency that targets the student's ability to demonstrate critical self-awareness of strengths and weaknesses. The survey also invited the program directors to state whether or not a unit on self-care was included in their curricula, and where such modules are placed.

Participant Groups

Three participant groups comprised this study: (1) individuals holding the credential of Music Therapist-Board Certified (MT-BC) issued by the Certification Board for Music Therapists; (2) eight selected practicing MT-BCs who graduated from approved AMTA academic and clinical training programs and who self-identified as currently working with distressed and/or traumatized individuals; and (3) program directors (faculty) of approved AMTA academic and clinical training programs.

Board-certified music therapists. A list of e-mail addresses for all board-certified music therapists (MT-BC) was obtained from the Certification Board for Music

Therapists (CBMT) following approval of this study by the Executive Director of CBMT. All individuals holding the MT-BC credential (N = 6369) received an e-mail (see Appendices A and B) inviting their participation in an online survey/questionnaire. The e-mail also served a dual purpose for obtaining the participants' informed consent.

The purpose of the online survey/questionnaire (see Appendix C) sent to board-certified music therapists was two-fold: (1) to obtain general demographic information of the population including age, gender, ethnicity, education, years of practice, and clinical populations served; and (2) to identify currently practicing clinicians that met a specific criteria and would be willing to participate further in the study via a face-to-face interview.

Interviewed participants. A purposive sampling procedure was utilized to select a sampling of clinicians for an in-person interview. From the initial survey sent to all MT-BCs, 1023 completed responses were gathered. This indicated a 16.06% response rate. From these respondents (n = 1023), 364 (35.5%) individuals indicated their willingness to participate further in the study. A total of 292 (28.5%) of these respondents met the following specific criteria for participation: (1) educational degree in music therapy had been obtained from an approved AMTA academic and clinical training program; and (2) minimum one year of clinical experience working with distressed or traumatized individuals. The researcher intentionally identified potential music therapists to interview who were residing and practicing in different geographical locations within each of AMTA's seven regions, and represented different gender, ethnicity, education and clinical experience, thus providing variety and diversity for the sample. At length, 10

clinicians (n = 10) were identified and sent an invitation letter (see Appendix D) via e-mail to participate in the interview process. The invitation letter explained the purpose of the study, its possible value to the training and education of music therapists, and outlined the participation requirements. The final number of clinicians selected for the in-person interview was eight. To further honor the experience of each MT-BC, and to demonstrate my personal investment in the study, I chose to conduct the interviews face-to-face by traveling to either to their place of employment, residence, or another location which they preferred. (Note: Hereafter, the eight clinicians who were interviewed for this study will be referred to as *participants*.)

Academic program directors. Music therapy academic program directors were identified by the American Music Therapy Association (AMTA). E-mail addresses for each director were provided following approval of this study from AMTA's Executive Director. The academic program director of each AMTA approved program received an e-mail (see Appendices E and F) inviting their participation in a three-question online survey/questionnaire (see Appendix G). The e-mail also served a dual purpose for obtaining the participants' informed consent.

Research Protocol for Interviews

Interviewed participants in this study (n = 8) were board-certified music therapists who had graduated from an AMTA approved academic/clinical training program and had a minimum of one year of clinical experience working with distressed and/or traumatized individuals. Participants represented diversity within age, education, experience, gender and ethnicity, and respectively resided within each of the seven geographical regions of

AMTA, excepting that two participants were from the same region. Over e-mail communication with the selected participants, a date, time, and location to meet was established. As previously stated, each semi-structured interview was conducted in-person. Five of the eight participants were interviewed at their place of employment, two were interviewed in their personal place of residence (home), and one participant was interviewed in a public facility (library).

Each interview was framed within a 10-question interview schedule (see Appendix H) and took between 60-90 minutes. The interviews were recorded using an iPad application, "Voice Recorder," and later transcribed verbatim. Electronic copies of the transcripts were sent to participants for member-checking. All edits and revisions contributed by participants were honored and included in the final transcriptions used for data analysis.

At the conclusion of each interview, participants were invited to provide an arts-based response to the interview experience for the purpose of containing thoughts and feelings that had arisen for them during the interview. Consent to use and or display the participants' art (see Appendix I) was obtained prior to providing this response.

The arts-based response was in the form of a drawn mandala. To create the mandala, participants were given an 11 ½" x 14" sheet of drawing paper and a box of 36 oil pastels. Initially, no pre-drawn circle was on the drawing paper, as is generally the protocol when individuals are asked to draw a mandala. There was no intentionality in omitting the pre-drawn circle, but rather an oversight on the part of the researcher. When

this was realized (following the second interview), the researcher proceeded to give each participant a sheet of drawing paper that contained a pre-drawn circle.

When participants completed the mandala drawing they were invited to share their personal interpretation with the researcher. This dialogue, which usually lasted 5-10 minutes, was also recorded, transcribed verbatim, and sent to the participant for member-checking. As with the semi-structured interview transcript, all edits and revisions contributed by participants were honored and included in the final transcription.

Data Analysis

Survey analysis. A descriptive analysis of the MT-BC survey responses (n = 1023; 16.06%) was conducted to provide a profile of board-certified music therapists. Gender, ethnicity, age, years of practice, education, and populations served were included in the descriptive analyses and presented within the results section of this paper.

Survey responses provided by music therapy educators (n=16; 20.26%), were analyzed for descriptive statistics; written responses were tabled and are included within Chapter 4, Results.

Transcript analysis. Transcripts were initially read by each respective participant for accuracy prior to beginning the analyses. After receiving approval from the participants of the final transcript draft, a thematic analysis was conducted on participants' responses to questions within the semi-structure interview guide (Bruscia, 2005; Delamont, 1996; Reissman, 1993). Emergent themes, patterns, categories and concepts were documented using a coding method described as Analytic Memo Writing

(Saldaña, 2016). From these memos, which essentially served as the researcher's journal, thematic material was coded, grouped into categories and subcategories, and primary and secondary themes were identified. This method of analysis was applied with both the interview transcripts and the transcripts of the verbal processing with the participants' arts-based response.

Arts-based response analysis. Participants' drawn mandalas were similarly coded for thematic material and analyzed using the MARI method of mandala analysis. The researcher employed the assistance and mentorship of an experienced MARI practitioner and certified MARI instructor to provide an analysis of each participant's mandala.

Institutional Review Board Approval and Assurance of Confidentiality

The researcher received Institutional Review Board (IRB) approval from Lesley University on February 16, 2016 (IRB Number 16-08). Participants in this study signed a participation consent form (see Appendices B, D, and F) for the online surveys (see Appendices C and G), interviews (Appendix D) and use and/or display of art (see Appendix I). These informed consents assured participants that all personal identifying details would be kept confidential by the researcher, data would be coded with pseudonyms, and that the participants' identity would not be revealed by the researcher. It also indicated that all audio files, written transcripts, and creative art products would be kept confidential, securely stored, and destroyed after 10 years.

CHAPTER 4

Results

Data for this study were collected through four means, and thus comprised the four major components of this study. This chapter presents the results for the following:

1. Results of survey sent to all individuals currently holding the credential of Music Therapist-Board Certified (MT-BC) issued by the Certification Board for Music Therapists (CBMT).
2. Findings of participants' semi-structured interviews identifying primary themes and secondary themes.
3. Illustrations and analyses of participants' arts-based responses to the interview experience.
4. Results of survey sent to program directors of approved AMTA academic and clinical training programs.

Survey Results of Board Certified-Music Therapists

A survey (see Appendix C) was initially sent to 6,369 board certified music therapists (MT-BCs) credentialed by the Certification Board for Music Therapists (CBMT). Tables 1 thru 3 present the demographics of the survey population, $N = 1023$. Age, gender, ethnicity, education, years of experience, and populations served are identified for the total population. Table 4 shows the level of education attained by therapists throughout the geographic membership regions of AMTA, and Figure 4.1 illustrates the educational levels within the sample population for music therapists working with distressed and/or traumatized individuals. The data revealed that 87.78% of board-certified music therapists are female. This percentage is slightly lower that

AMTA's membership profile of 2014, which was reported at 88%. Individuals of European descent comprised the largest ethnic group with 90.52% identified as White Caucasian. The number of music therapists with a bachelor's degree was relatively equal to the number of therapists with a master's degree—47.80% and 46.52%, respectively—with only a 1.28% difference. The number of MT-BCs at the doctorate level is substantially less, only 5.87%.

The average age of the population is 38.63 years with 11.45 years of experience. This is somewhat representative of the traditional college student who, after obtaining an undergraduate degree, continues on to obtain a masters' degree by age 25, or works as a clinician for 2-3 years and then returns to school to obtain a graduate degree (USU *Graduating Students Survey 2014-15*). Results indicated that 17.04% of the participants had obtained additional specialized or advanced trainings in areas such as neurologic music therapy, hospice music therapy, guided imagery and music, and vocal psychotherapy. The percentage of individuals with advanced trainings was fairly consistent with the number of individuals holding bachelor and master-level degrees, suggesting that acquiring these trainings was equally appealing to both bachelor and master-level therapists. Within the total population, 90.52% reported maintaining a current practice.

Results show that 47.80% of the responding music therapists are at the bachelor-level of entry; 46.52% have earned a master's degree; 5.87% are doctorate level. Among all survey respondents, 63.83% reported that they worked with distressed and/or traumatized clientele, or in trauma-related populations; 45.03% of this group were

bachelor-level clinicians. The number of music therapists who selected 'Crisis and Trauma' as the category defining their clinical population, was 157 or 15.35% (see Table 3). Nevertheless, the percentage of clinicians who reported working with distressed and/or traumatized individuals was 63.83% (see Table 1). This suggests the probability that clinicians working in other populations, such as mental health, hospice, and forensics, also identify their clientele as being distressed and/or traumatized.

Survey results additionally show that the largest concentration of bachelor-level music therapists (60.81%) who worked with distressed and/or traumatized individuals, were living within the geographic area of the Western Region of AMTA. At the time of this study, the least number of graduate programs in music therapy (5%) were located in the Western Region (AMTA, 2014c). Conversely, survey results indicate that the smallest concentration of bachelor-level music therapists (31.13%), resided in the Mid-Atlantic Region, where the greatest number of AMTA-approved graduate programs (38%) were located.

Tables 1 thru 5 present demographics of the population surveyed including educational levels and clinical populations served. Tables 6 thru 12 separate the data into AMTA regions and report educational levels, years of practice, and average age of MT-BC survey respondents that identified their clientele as distressed and/or traumatized. This was done to facilitate a comparison of the survey data with the responses from the survey sent to AMTA program directors. However, the latter provided insufficient data to complete such an analysis.

Table 1. *Board-Certified Music Therapists' Demographic Data*

Variable	*n*	%
Gender		
Male	121	11.83
Female	898	87.78
Other*	4	0.39
Ethnicity		
American Indian	1	0.10
Asian	32	3.14
Black or African-American	20	1.96
Hispanic or Latino	27	2.64
White	926	90.52
Other	15	1.47
Education		
Bachelors	487	47.80
Male	56	40.29
Female	428	40.76
Other	3	60.00
Masters	475	46.52
Male	61	43.88
Female	413	39.33
Other	1	20.00
Doctorate	59	5.87
Male	5	3.60
Female	54	5.14
Other	0	0.00
Currently practicing	926	90.52
Completed specialized training[+]	174	17.04
Clientele identified as distressed or traumatized	653	63.83

Variable	*n*
Average Years of Experience of Population	11.45
Average Age of Population in Years	38.63

Note. N = 1023

* transgendered male; non-binary

[+] Specialized trainings predominantly included NMT, GIM, NICU, HMTP and AVPT

Table 2. *Board-Certified Music Therapists within AMTA Regions: Demographic Data*

Region	*n*	%	Average Age	Average Years of Experience
Great Lakes Region	232	23.36	39.07	12.28
Male	29	25.00		
Female	203	23.23		
Other	0	0.00		
New England Region	52	5.23	36.84	10.24
Male	7	6.03		
Female	43	4.93		
Other	1	33.33		
Mid-Atlantic Region	231	23.26	38.81	11.90
Male	29	25.00		
Female	202	23.11		
Other	0	0.00		
Midwestern Region	142	14.30	38.90	11.77
Male	13	11.21		
Female	128	14.65		
Other	1	33.33		
Southeastern Region	135	13.60	36.94	10.50
Male	18	15.52		
Female	117	13.39		
Other	0	0.00		
Southwestern Region	75	7.55	40.95	13.62
Male	7	6.03		
Female	68	7.78		
Other	0	0.00		
Western Region	127	12.79	39.41	9.55
Male	13	10.27		
Female	113	88.98		
Other	1	0.79		

Note: n = 993; Demographics for survey respondents separated into membership geographical regions of the American Music Therapy Association (AMTA)

Table 3. *Clinical Populations Served by Board-Certified Music Therapists*

Population	*n*	%
Autism Spectrum Disorder	491	49.35
Alzheimer's / Dementia	404	39.49
Correctional & Forensic	47	4.72
Crisis & Trauma	157	15.35
Medical / Surgical	170	17.09
Mental Health	418	42.01
Developmentally Disabled	474	47.64
Pain Management	143	14.37
Special Education	297	29.85
Early Childhood	299	30.05
Military	49	4.92
Hospice	267	26.83
Neurologic	202	20.30
Neonatal / Pediatric	83	8.34
Wellness	152	14.86
Other[+]	128	12.86

Note: $N = 1023$; Five most frequently reported 'Other' populations were: acute psychiatric, bereavement, eating disorders, learning disabilities, and multiple disabilities. MT-BC is the credential designating board-certified music therapist

Table 4. *Education Levels of MT-BCs within AMTA Regions*

Region	n	%
Great Lakes Region	232	
Bachelor	133	57.32
Masters	90	38.79
Doctorate	9	3.88
New England Region	52	
Bachelor	18	34.62
Masters	29	55.77
Doctorate	5	9.62
Mid-Atlantic Region	229	
Bachelor	79	34.50
Masters	137	59.83
Doctorate	13	5.68
Midwestern Region	142	
Bachelor	71	50.00
Masters	61	42.96
Doctorate	10	7.04
Southeastern Region	134	
Bachelor	50	37.31
Masters	72	53.73
Doctorate	12	8.96
Southwestern Region	75	
Bachelor	33	44.00
Masters	40	53.33
Doctorate	2	2.67
Western Region	127	
Bachelor	86	67.72
Masters	34	26.77
Doctorate	7	5.51
Non-identified Region	15	
Bachelor	8	53.33
Masters	6	40.00
Doctorate	1	6.67
All Reporting Areas	1006	
Bachelor	478	47.51
Masters	469	46.62
Doctorate	59	5.86

Note: n = 1006; MT-BC is the credential for board-certified music therapists; AMTA is the professional membership organization for music therapists, the American Music Therapy Association

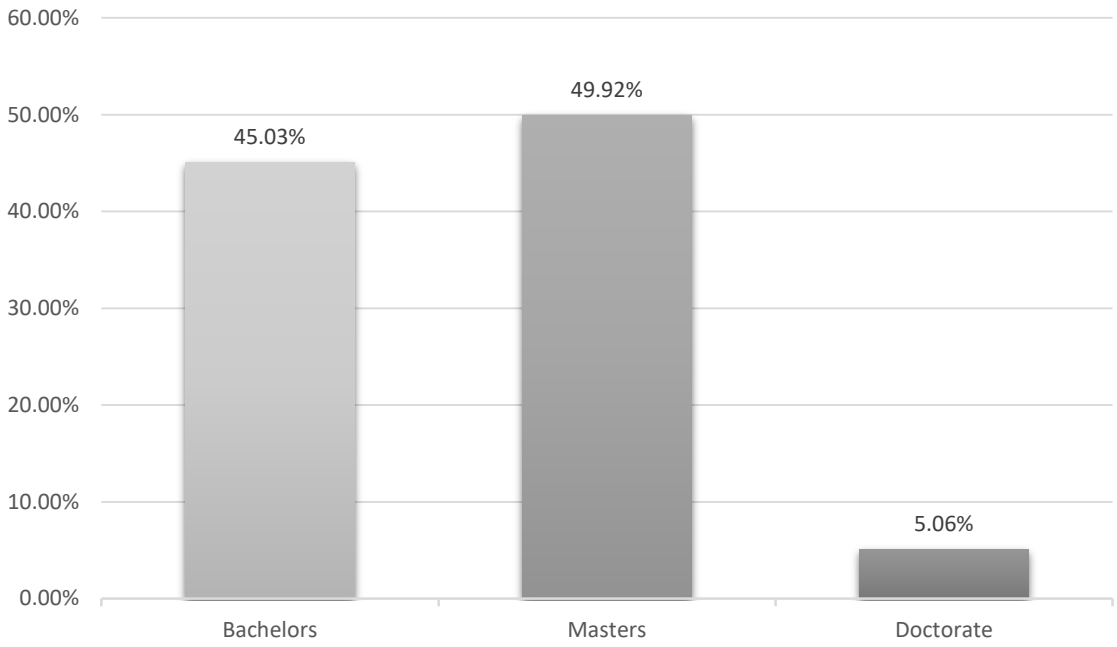

Figure 4.1. Educational Levels of MT-BCs within Sample Population Currently Working with Clientele Identified as Distressed and/or Traumatized; *n* = 593

Membership within the American Music Therapy Association (AMTA) is divided into seven geographical regions: Great Lakes Region, Mid-Atlantic Region, Midwestern Region, New England Region, Southeastern Region, Southwestern Region, and the Western Region. The following tables provide a more detailed examination of the demographics within each region. Table 5 shows the educational levels of the MT-BC survey respondents who identified their clientele as being distressed and/or traumatized. Tables 6 thru 12 show the levels of education for music therapists in each respective regions, percentage of reporting MT-BCs currently practicing, and the number of MT-BCs who identified their clientele as distressed or traumatized. Subsequently, Figures 4.2 thru 4.8 provide a graphic illustration depicting the percentages of distressed and/or traumatized clients served by music therapists with bachelor, master, and doctorate levels

of education. These figures illustrate that 44.91% of distressed and/or traumatized clients are served by bachelor-level clinicians, ranging from 31.13% in the Mid-Atlantic Region to 60.81% in the Western Region. Master-level clinicians serve 49.69% of this population, and doctorate-level clinicians serve 5.4%.

Table 5. *Education Levels of MT-BCs within AMTA Regions Identifying Clientele as Distressed and/or Traumatized*

Region	n	%
Great Lakes Region	146	
Bachelor	80	54.79
Masters	59	40.41
Doctorate	7	4.79
New England Region	31	
Bachelor	12	38.71
Masters	15	48.39
Doctorate	4	12.90
Mid-Atlantic Region	151	
Bachelor	47	31.13
Masters	95	62.91
Doctorate	9	5.96
Midwestern Region	79	
Bachelor	39	49.37
Masters	34	43.04
Doctorate	6	7.59
Southeastern Region	69	
Bachelor	26	37.68
Masters	41	59.42
Doctorate	2	2.90
Southwestern Region	43	
Bachelor	18	41.86
Masters	24	55.81
Doctorate	1	2.33
Western Region	74	
Bachelor	45	60.81
Masters	28	37.84
Doctorate	1	1.35

Note: n = 593; MT-BC is the credential for board-certified music therapists; AMTA is the professional membership organization for music therapists, the American Music Therapy Association

Table 6. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Great Lakes Region*

Degree	n	%
Bachelor	133	57.33
Currently practicing	129	96.99
Distressed / Traumatized clientele	80	62.02
Average years of practice	9.62	---
Average age (in years)	35.49	---
Masters	90	38.79
Currently practicing	81	90.00
Distressed / Traumatized clientele	59	72.84
Average years of practice	13.81	---
Average age (in years)	41.05	---
Doctorate	9	3.88
Currently practicing	8	88.89
Distressed / Traumatized clientele	7	87.50
Average years of practice	24.29	---
Average age (in years)	52.14	---

Note: n = 232

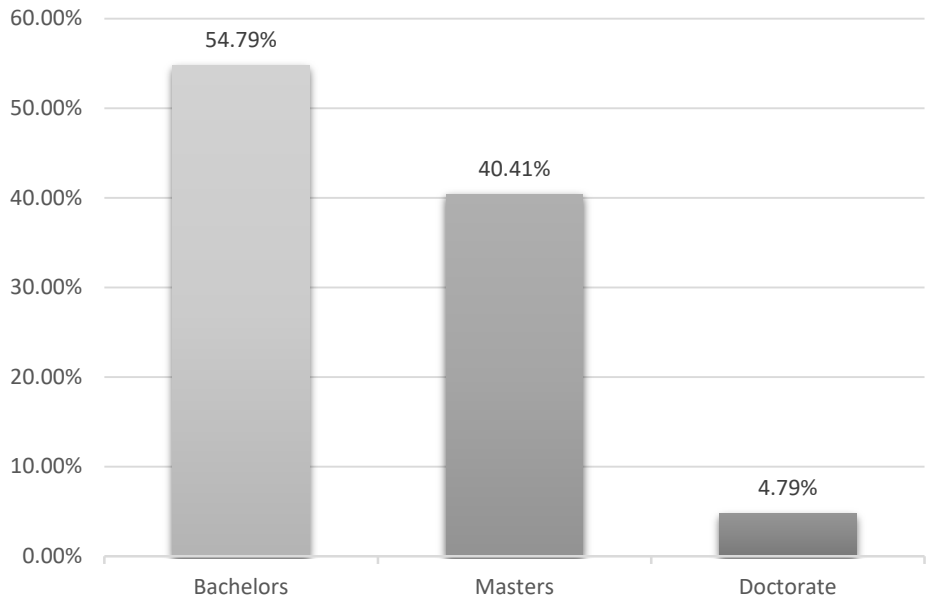

Figure 4.2. Clients' Music Therapist Education Level in the Great Lakes Region

Table 7. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Mid-Atlantic Region*

Degree	n	%
Bachelor	79	34.50
Currently practicing	75	94.94
Distressed / Traumatized clientele	47	62.67
Average years of practice	9.81	---
Average age (in years)	34.49	---
Masters	137	59.83
Currently practicing	130	94.89
Distressed / Traumatized clientele	95	73.08
Average years of practice	11.89	---
Average age (in years)	39.32	---
Doctorate	13	5.68
Currently practicing	11	84.62
Distressed / Traumatized clientele	9	81.82
Average years of practice	27.11	---
Average age (in years)	57.56	---

Note: n = 229

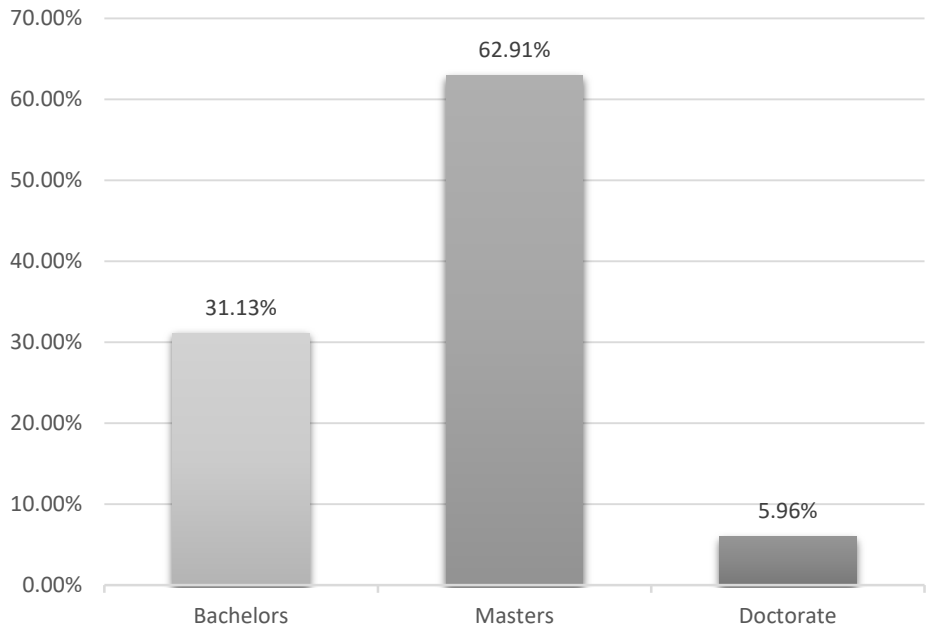

Figure 4.3. Clients' Music Therapist Education Level in the Mid-Atlantic Region

Table 8. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Midwestern Region*

Degree	n	%
Bachelor	71	50.00
Currently practicing	67	94.37
Distressed / Traumatized clientele	39	58.21
Average years of practice	10.41	---
Average age (in years)	37.87	---
Masters	61	42.96
Currently practicing	56	91.80
Distressed / Traumatized clientele	34	60.71
Average years of practice	12.77	---
Average age (in years)	40.76	---
Doctorate	10	7.04
Currently practicing	7	70.00
Distressed / Traumatized clientele	6	85.71
Average years of practice	15	---
Average age (in years)	42	---

Note: n = 142

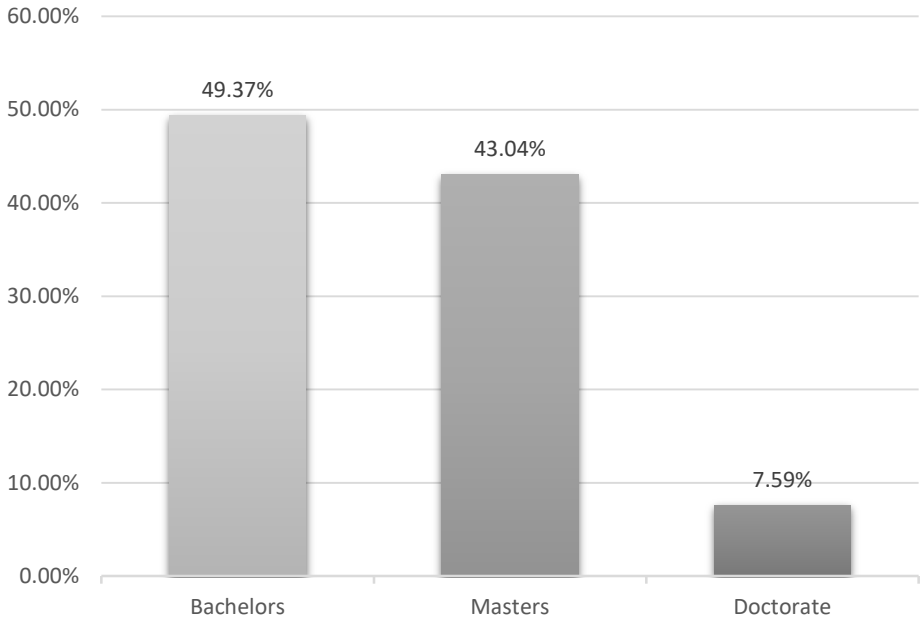

Figure 4.4. Clients' Music Therapist Education Level in the Midwestern Region

Table 9. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the New England Region*

Degree	n	%
Bachelor	18	34.62
Currently practicing	14	77.78
Distressed / Traumatized clientele	12	85.71
Average years of practice	6.25	---
Average age (in years)	30.67	---
Masters	29	55.77
Currently practicing	25	86.21
Distressed / Traumatized clientele	15	60.00
Average years of practice	9.6	---
Average age (in years)	37.33	---
Doctorate	5	9.62
Currently practicing	5	100.00
Distressed / Traumatized clientele	4	80.00
Average years of practice	22.6	---
Average age (in years)	49.4	---

Note: $n = 52$

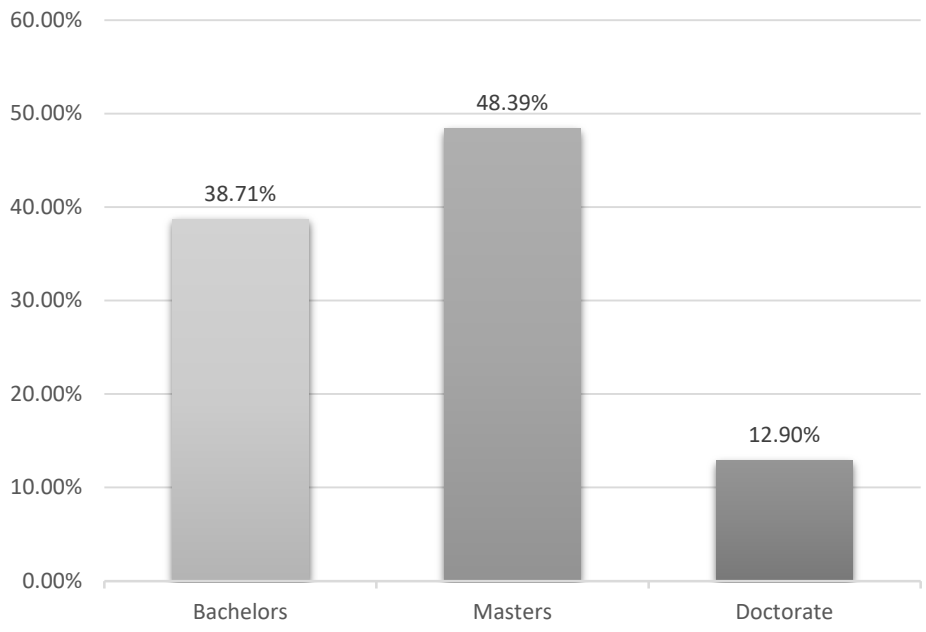

Figure 4.5. Clients' Music Therapist Education Level in the New England Region

Table 10. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Southeastern Region*

Degree	n	%
Bachelor	50	37.31
Currently practicing	47	94.00
Distressed / Traumatized clientele	26	55.32
Average years of practice	8.05	---
Average age (in years)	32.12	---
Masters	72	53.73
Currently practicing	63	87.50
Distressed / Traumatized clientele	41	65.08
Average years of practice	10.73	---
Average age (in years)	36.66	---
Doctorate	12	8.96
Currently practicing	4	33.33
Distressed / Traumatized clientele	2	50.00
Average years of practice	21.5	---
Average age (in years)	47.5	---

Note: n =134

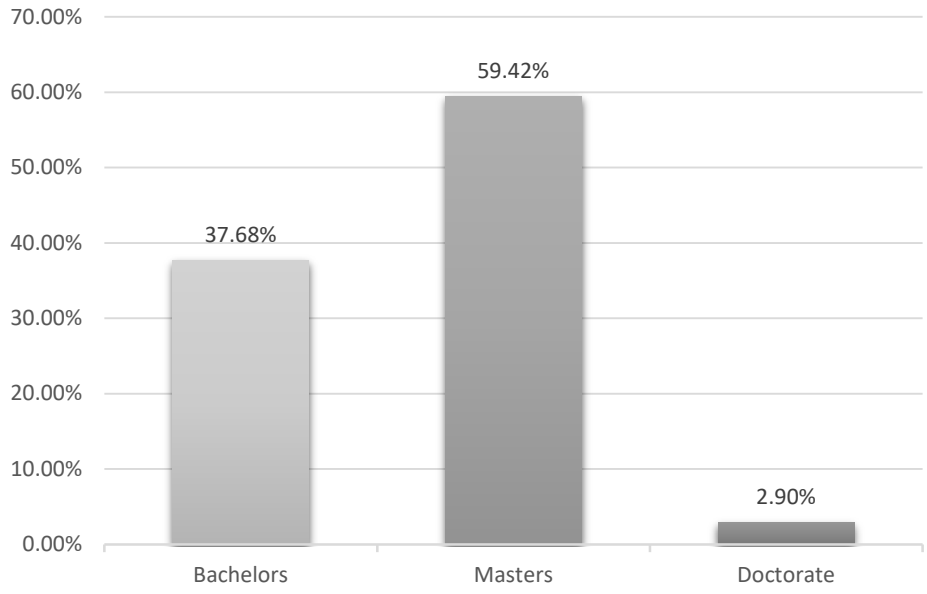

Figure 4.6. Clients' Music Therapist Education Level in the Southeastern Region

Table 11. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Southwestern Region*

Degree	n	%
Bachelor	33	44.00
Currently practicing	33	100.00
Distressed / Traumatized clientele	18	54.55
Average years of practice	8.33	---
Average age (in years)	37	---
Masters	40	53.33
Currently practicing	34	85.00
Distressed / Traumatized clientele	24	70.59
Average years of practice	18.13	---
Average age (in years)	45.87	---
Doctorate	2	2.67
Currently practicing	1	50.00
Distressed / Traumatized clientele	1	100.00
Average years of practice	30	---
Average age (in years)	56	---

Note: n = 75

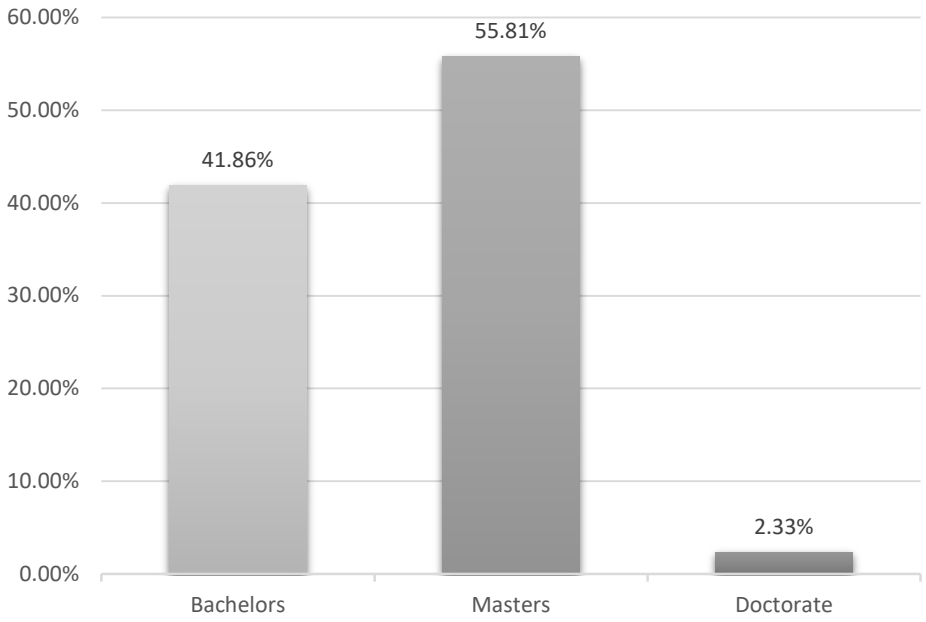

Figure 4.7. Clients' Music Therapist Education Level in the Southwestern Region

Table 12. *Education Levels of MT-BCs Currently Practicing with Distressed or Traumatized Individuals in the Western Region*

Degree	n	%
Bachelor	86	67.72
Currently practicing	72	83.72
Distressed / Traumatized clientele	45	62.50
Average years of practice	8.45	---
Average age (in years)	36.62	---
Masters	34	26.77
Currently practicing	33	97.06
Distressed / Traumatized clientele	28	84.85
Average years of practice	10.80	---
Average age (in years)	44.48	---
Doctorate	7	5.51
Currently practicing	2	28.57
Distressed / Traumatized clientele	1	50.00
Average years of practice	40	---
Average age (in years)	63	---

Note: n = 127

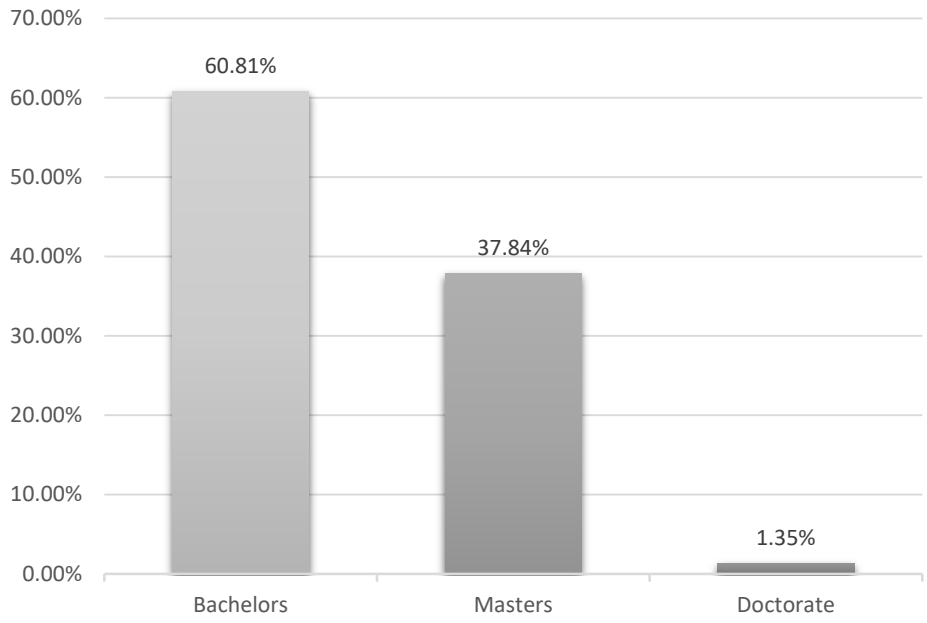

Figure 4.8. Clients' Music Therapist Education Level in the Western Region

Demographics of Interviewed Participants

A total of eight music therapy clinicians were selected to participate in semi-structured interviews. Table 13 illustrates the diversity of the sample in terms of gender, ethnicity, age, years of experience, level of education and the clientele served. Each participant resided and practiced in a different geographical region of AMTA, excepting two clinicians who were from the Southeastern Region.

Table 13**.** *Interviewed Participants' Demographics*

Participant	Gender	Ethnicity	Age[+]	Years of[*] clinical experience	Education	Clinical Population
Araceli	Female	Asian	36	10	Masters	PTSD; personality disorders; substance abuse; severe trauma
Chandra	Female	White	24	1	Bachelors	Hospice and Bereavement
Jakobe	Male	White	35	5	Masters	Adolescents diagnosed with PTSD and/or abandonment issues; women survivors of domestic violence
Maude	Female	Hispanic	31	7	Masters	Child abuse
Mariano	Male	White	32	3	Masters	Oncology
Rowena	Female	White	39	16	Doctorate	Elder abuse; at-risk adolescents; sheltered homeless people; domestic violence; families in crisis
Tulsi	Female	White	35	10	Bachelors	Hospice
Windsor	Female	African-American	66	30	Doctorate	Women survivors of domestic abuse; mother-child attachment issues

Note: n = 8; Average age of participants, M = 37.25 years; range = 24-66; mode/median = 35; average years of clinical experience, M = 10.25 years

Participant Responses to Questions within Semi-Structured Interview

The participants who were interviewed shared their personal stories regarding their educational and clinical training experiences, and how such experiences did or did not prepare them for the clinical populations they currently serve. These clinicians all reported that self-care was an important piece of their professional and personal lives. Nevertheless, the results indicate that when these same clinicians were undergraduates or graduates studying music therapy, only 75% were given resources and strategies for self-care.

Within the semi-structure interviews, three questions were prioritized for obtaining participant response:

- Did your music therapy training program provide education respecting self-care?
- How was self-care addressed in your academic program? Your clinical training?
- Do you feel your educational experience enabled you to develop a level of critical self-awareness as cited in the AMTA Professional Competency 17.8: "Demonstrate critical self-awareness of strengths and weaknesses."

Tables 14, 15, 16 and 17 include textual examples to the above questions obtained during the interview process. The results show that participants were equally divided as to whether they had completed a training program where self-care was emphasized or one in which self-care was not emphasized (see Tables 14 and 15). Five of the eight participants received academic and clinical training in music therapy when enrolled in graduate programs. Only one participant identified their undergraduate program as having included instruction regarding self-care and self-care strategies. Table 16

provides examples of how self-care was addressed in the participants' curricula; Table 17 contains examples of how participants interpreted an AMTA professional competency for undergraduate programs that addressed a student's ability to develop a critical awareness of their own strengths and weaknesses.

Table 14. *Affirmative Responses to Question Regarding Education Respecting Self-care in Participants' Music Therapy Academic and Clinical Training Program*

Participant	Textual Example	Program
Chandra	"Yeah, it was. So I feel lucky."	Graduate
Mariano	"They always talked about how you should make sure that you separate your work, and your personal life… always try to maintain appropriate ethics."	Graduate
Rowena	"In my master's program I think it was ingrained into us from day one!"	Graduate
Tulsi	"I think it's something that I always heard… *Take care of yourself* *and make sure you're … drawing mandalas* *and writing in your journal* *and go on walks…"*	Undergraduate

Note: n = 4; 50% of participants interviewed indicated their undergraduate or graduate program included a dedicated unit on self-care

Table 15. *Negative Responses to Question Regarding Education Respecting Self-care in Participants' Music Therapy Academic and Clinical Training Program*

Participant	Textual Example	Program
Jakobe	"I don't think I was aware of self-care at the time I was in school."	Graduate
Maude	"I don't really recall anything specific other than, you know, in our intro[ductory] class"	Undergraduate and Graduate
Araceli	"No it wasn't, or actually, at least not that I can remember. I think I would have remembered, at least remembered the word *self-care*." "And also my internship … we never talked about what self-care actually is. I don't think I heard that word."	Undergraduate
Windsor	"Oh they didn't! Some embellishments, maybe, and some reminders, but mostly [they] really didn't."	Graduate

Note: n = 4; 50% of participants interviewed indicated their undergraduate or graduate program did not specifically address self-care

Table 16. *Description of Self-care Education in Participants' Academic and Clinical Training Programs*

Participant	Textual Example	Program
Rowena	"There were some courses that definitely honed in, helped me to refine and define what self-care meant."	Graduate
Tulsi	"I was given techniques in school… and [instructor] made me draw mandalas all the time."	Undergraduate
Maude	"I think there was a little bit more emphasis on self-care because we were all working on our theses, which is very stressful!"	Masters
Chandra	"We had to create a self-care menu, and there were categories like spiritual self-care, physical self-care, relational or social self-care… but then we could add our own."	Masters

Table 17. *Participant Interpretation of AMTA Professional Competency 17.8*

Participant	Textual Example
Araceli	"It is so necessary to know who you are in a therapeutic interaction. That way you can separate yourself from your clients."
Chandra	"*Do your own work*! It's doing my personal work because I don't know ways to understand my own… or to have awareness around my strengths and weaknesses, other than personal therapy… [creating] my own music." or being in relationship with people."

continued

Table 17 continued

Participant	Textual Example
Jakobe	"Understanding where my own thoughts and feelings may prevent me from having a clear mind focus on the clients."
Maude	"I think the initial interpretation would be your clinical strengths and weaknesses, or your musical strengths and weaknesses…" "… now as a clinician, and being in the field for a couple of years, I think it's identifying not only my clinical or musical skills, but personal things as well… recognizing my own personality, strengths and weaknesses, and what family circumstances might be coming into play."
Mariano	"Identifying your strengths, and identifying your weaknesses, allows you to put things in place… learning about who you are and how you can grow."
Rowena	"I think that I interpret it [the educational competency] as kind of a layered approach to it [self-care/self-awareness]."
Windsor	"Well, I tell you that the thought that I had as I was going through the program… I had to ask the director and some of the faculty the question, *Don't you require your students to be in therapy?"* "So when I hear *critical self-awareness,* see that's what I think of. You really do have to understand your own transference, countertransference issues, and how you respond, and how you work with violence, and hearing stories of violence, how does that impact you?"

Note: The responses in this table reflect the participants' interpretation of the AMTA Professional Competency 17.8: "Demonstrate a critical self-awareness of strengths and weaknesses."

Thematic Material

Face-to-face interviews were transcribed verbatim and given to each respective participant for member-checking prior before beginning a thorough analysis of the data using the coding method described in the previous chapter. In the process of interviewing, the dialogue generated additional thematic material. After identifying, categorizing, and collapsing the evolving themes, a listing of primary and secondary themes emerged according to the frequency with which they were found in the transcripts. The primary themes were referenced by all or a large majority of participants, whereas secondary themes were referenced in less than 33% of the transcriptions. The identified themes are reported in Table 18. In order to create an authentic portrait of the responses given and experienced by each participant, relative to the emergent themes within the semi-structured interviews, the researcher used a method of presentation Richardson (2000) described as *poetic representation*, or writing the transcription in lyrical prose. It is believed by the researcher that this method allows the participant's unique and individual voice to be heard. Tables 19-24 include textual examples for the emergent themes identified in the analysis.

Table 18. *Identified Thematic Material in Interviews with MT-BCs*

Primary Themes	Secondary Themes
Importance of self-care in professional practice	Boundaries
Pre-professional preparation	Supervision
Clinical work with distressed and/or traumatized clients	Personal therapy
Work ethics in personal and professional life	Self-awareness
Creative expression as a means of self-care	Support systems

Importance of self-care in professional practice. All music therapy clinicians interviewed asserted that self-care is essential for a practicing clinician, and that without maintaining a conscientious practice of self-care their effectiveness as a therapist would be significantly compromised. Nevertheless, when specifically asked whether or not their undergraduate academic training program provided education respecting self-care only 50% of those interviewed reported that self-care topics had been addressed in their academic training programs (see Tables 14 and 15). Table 19 below presents textual examples from the interviews that illustrate the importance these clinicians place on maintaining a regular practice of self-care.

Table 19. *Primary Theme: Importance of Self-Care in Professional Practice*

Participant	Textual Example
Chandra	"There's no way to do the work well, or sustainably, without a commitment to self-care."
Jakobe	"She [supervisor] said, *'Well, if we're not taking care of ourselves* *we can't take care of others.'* And I remember in that moment, just recognizing that she has that appreciation and understanding that we need to take care of ourselves in order to treat others."
Maude	"This is important if this is something that you really want to do long term."

continued

Table 19 continued

Participant	Textual Example
Jakobe	"It [the practice of self-care] impacts me because I know I'm feeling more confident. I want to say it keeps me going…"
Mariano	"I think that being able to take care of yourself as a therapist is one of the most important things you can do."
Rowena	"I feel very strongly that self-care is directly related to how I've been able to stay inspired in the field."
Rowena	"Our guiding principle here is 'self as instrument.' And that is completely all about self-care. So you are the instrument, and in order to be a flexible, dynamic, well-oiled instrument, then you got to be able to know what helps you stay that way, what helps you stay healthy."
Tulsi	"In the beginning… things were different because it was new and interesting. But now I have a family to take care of too. If I'm not okay, then my family is not okay."

Pre-professional preparation. Another recurring theme emphasized by 75% of those interviewed focused on the necessity of personal and professional preparation for working with the distressed and/or traumatized individual. Without an awareness of the

effect and impact that an individual's work may have on their personal and professional well-being, the emotional and psychological cost may be prohibitive. Rather than developing into effective long-term clinicians, such individuals may fall victim to burnout, fatigue, secondary traumatization, and leave the profession early in their careers. Recognizing that the factors which contribute to trauma in our societies and communities are not likely to be eradicated any time soon, professional caregivers must be sensitive to the fact that there is a high probability that they will work with a client who has experienced some level of distress or trauma in their life. Research has shown that work with distressed and/or traumatized individuals will have an effect on the clinician. Taking preventative measures to lessen this impact has also been shown to be effective. Selected examples below, taken from the interviews, illustrate this theme.

Table 20. *Primary Theme: Pre-Professional Preparation*

Participant	Textual Example to Theme
Araceli	"Most music therapists work in trauma in some capacity [and] should at least come from some kind of trauma-informed approach, because trauma is everywhere."
Tulsi	"My work is very extensive and varied. I never know what I'm about to walk into, and it's always different."
Araceli	"We all deal with loss and grief and hardship… and working with our clients when they're in these just really tough places…, it's hard not to take that on."

continued

Table 20 continued

Participant	Textual Example to Theme
Araceli	"We become like angels in these spaces, but like we're not angels, we're humans, and we need to learn how to be able to be human and allow ourselves to be able to take care of ourselves." "I didn't quite have a full understanding of what I was doing. Not really understanding how working with [my clients] was affecting me."
Windsor	"You know some things very well, but then with each new population… some of the [previous] challenges return; you have to be really aware of… Okay, what is this raising?"

Clinical work with distressed and/or traumatized clientele. Carl Rogers (1961), in *On Becoming a Person*, implied that excellent clinical work requires a genuine, empathetic, and authentic presence of the therapist, and that such attributes are necessary factors in achieving an unconditional positive regard for the client. To be fully present, to listen, to validate the experience of someone else, requires much of the therapist. Similar to recognizing the need to prepare for such work, it is important to acknowledge that trauma work is difficult work. Even in cases where the client presents more as a distressed individual, rather than one who has been traumatized by a specific event or set of circumstances, the work remains demanding and exacting. Hypervigilance on the part of the therapist may not necessarily be a negative stance, but rather a self-protecting

boundary. All eight (100%) of the participants interviewed in this study identified their clientele as being distressed or traumatized. It was noted that oftentimes these therapists challenged their own preparation and questioned whether or not they were suited for the work they were doing. There were often feelings of helplessness, professional incompetence, inadequacy, not knowing if what they were doing was even making a difference in the other person's life. But acknowledging these concerns was in-and-of-itself strengthening. Recognizing that their work was difficult, that this type of work comes with perceivable challenges, and unexpected ones, was personally empowering knowledge. Some participants expressed that if they did not feel the heaviness, in some sense, of their work with traumatized and distressed individuals, perhaps the humanness within the therapeutic relationship was compromised. Other participants reflected on the philosophy that in order to give so much to others, they need to be able to come from a place on inner security with the knowledge that their own needs are being or will be met. Perhaps a prerequisite of vital importance in clinical practice in the ability of the clinician to acknowledge that their work is difficult and does exact a cost.

Table 21. *Primary Theme: Clinical Work with Distressed and/or Traumatized Clients*

Participant	Textual Example to Theme
Araceli	"Sometimes it can be so difficult when really challenging stuff comes up."
Tulsi	"It takes a lot of energy, especially when it's really scary where that person actually is."

continued

Table 21 continued

Participant	Textual Example to Theme
Chandra	**“**I have lots of different kinds of … emotionally challenging sessions. … there’s a dark quality, to things that are unsettling and like an unknown.”
Maude	“The intensity of what we were seeing, definitely took a toll on me.”
Mariano	“When you sit and listen to people’s problems all day it’s hard to be able to just go home and just be happy.”
Chandra	“Eventually I have to walk away from it, you know, finish the session and try to make some meaning out of it for myself to be able to continue with my day… that feels draining sometimes.”
Mariano	“It takes a lot of emotional drain out of you.”
Tulsi	“They were in need and I was the one that was sitting there. It was my job. It was my work. I needed to help him.”
Araceli	“I don’t think there’s a way for us to not be affected by our work… we should be.”

Work ethics in personal and professional life. A recurring theme referenced by 50% of those interviewed emphasized society's view of professional productivity. These participants suggested that society, at large or within the individual family unit, often views the individual who is not always working as someone who has too much free time on their hands, and a more-or-less unproductive person. That time spent not working is time lost; and in order to get ahead in the professional arena one needs to be constantly engaged in their work. While certain communities and organizations may be more forthcoming in requiring this standard of their members and employees, it may be true that this is an underscored expectation. This expectation may have factored into why some participants felt guilty if they were not constantly at work in some sense of the word. Examples taken from the interviews illustrating this point are shown in Table 22.

Table 22. *Primary Theme: Work Ethics*

Participant	Textual Example to Theme
Maude	"I think also just this whole, like the Western society of like, *work, work, work, work…* We need to give people that permission to… you can take care of yourself, you need to take care of yourself."
Windsor	"The work is never going to end. Nobody's ever going to appreciate this, they don't need to, they shouldn't. Why should I do this?"
Araceli	"They [employers at hospital/administration] kept us so busy that it was just too much."

continued

Table 22 continued

Participant	Textual Example to Theme
Jakobe	"I come from a family where everyone's called a workaholic… Even in my internship I was notorious for, *'I'm going to work as hard as I can.'* That sort of thing."
Maude	"Our supervisors would very clearly and point blank say, *'If you can't handle it, we will find somebody who can.* *So put on your big girl panties and truck along.* *Get the hours we need.* *Make the numbers!'* It was all about the numbers."
Windsor	"I was probably a workaholic in my university days especially…"
Araceli	"I felt like self-care always took away from something… like I would feel guilty if I wasn't working."

Self-care strategies and practices. In addition to exploring what emphasis had been placed on self-care in pre-professional undergraduate and graduate coursework, another major focus of this study was to investigate what the music therapists interviewed were currently doing in order to care for themselves and mitigate the effects that working with distressed or traumatized clients may have in their personal and professional lives. The literature asserts that a positive correlational exists between engaging in purposeful acts of self-care and the development of a multilevel personal and professional hierarchy of needs. While the list was relatively extensive for the eight participants, there were six

self-care practices and strategies that were repeatedly identified. The first of these, using the arts and one's own modality for creative expression, was referenced so frequently that it was identified as one of the five primary themes within this study. Table 23 provides textual examples from the interviews that supported this theme.

Table 23. *Primary Theme: Creative Expression as an Intentional Act of Self-Care*

Participant	Textual Example to Theme
Araceli	"I do believe that it [our own music-making] needs to be an essential part of our self-care practice."
Chandra	"…make your own music… and [place] emphasis on musical self-care… go into one's own relationship with music, to go into my own relationship with music, and discover what I have for myself in that relationship."
Rowena	"I think self-care in directly related to our identity and how we hold our craft. Because if you don't go deep in your craft you're not going to discover the things you need to discover about yourself."
Windsor	"[I] immerse myself in creative activities that are not music. [This is not only self-care, but I am] tuning into what it is I am learning about myself."
	"The ability to create means that you create something meaningful out of shapelessness, giving it shape and form… and that is [a] pretty powerful voice."

The remaining five self-care practices and strategies constitute what the researcher identified as secondary themes and include (1) maintaining healthy boundaries, (2) seeking supervision, (3) entering personal therapy, (4) increasing self-awareness and (5) establishing and maintaining strong support systems. Textual examples are given in Table 24.

Table 24**.** *Secondary Themes Related to Self-care Strategies and Practices*

Theme	Textual Example
Maintain boundaries	
Rowena	"I think boundaries comes up a lot for me when I'm thinking of self-care, … to attempt to stay as authentic and present with this person, and align and attune so that I can really send the message of, *I'm with you, I see you, I hear you."*
Seek supervision	
Araceli	"A psychologist working on the unit … invited me to a supervision group. *I wasn't even sure what supervision was at the time.* So I went… I was the only music therapist… I saw what group supervision actually looked like. I also saw that they [other therapists] would talk about themselves, and there was a big focus on their own process, about what they were going through." "I attended this supervision group every week and slowly started to open up and uncover what my role was and how it fit into everything else and also how I was reacting to my clients and realizing how they were reacting to me."

continued

Table 24 continued

Theme	Textual Example
Rowena	"Sometimes we would not be able to talk, but being able to be together and not talk, and then just sit with that. [Other times] being able to just flush out and then be in peer supervision and also in supervision."
Engage in personal therapy	
Araceli	"Eventually I got into therapy… that was life changing."
Jakobe	"Counseling helped me to feel like I have addressed issues that have come up in my life."
Increase self-awareness	
Rowena	"Self-awareness [is] linked very closely to self-care. So if you're in good shape mentally, emotionally, physically, spiritually, then you were aware [of how] to manage your transferences and countertransferences… to really be present and authentic with the client."
Establish support systems	
Tulsi	"Back when I was in school, I was surrounded by people who do what I do."
Rowena	"I would say the biggest self-care was, I just built a social system for myself."
Windsor	"*Oh yeah, I can move through that. I can hear it.* And then I know that I need to go talk with someone about the images, … something that I am going to hold on to."

Note: Secondary themes were referred to in all interviews, though less frequently than the primary themes.

Indicators of Vicarious Traumatization

Throughout the interviews, symptoms were of vicarious traumatization were noted: personal vulnerability, depression, boundary violations, loss of hopefulness, insomnia, difficulty concentration, relational problems, fatigue, changes to the personal belief system, and others. To effectively mitigate the potential effects of vicarious traumatization, professional caregivers need to be able to recognize the symptoms associated with it in order to circumvent the potential impact such conditions may have in their personal and professional lives. Table 25 shows examples of these symptoms expressed by the participants.

Table 25. *Indicators of Vicarious Traumatization*

Participant	Textual Example	Indicator
Araceli	"At the end of the week I would be so exhausted… there was nothing left in me to socialize."	Fatigue
	"I didn't want to talk to anybody. I loved my job, [but] I felt like it was draining this life force out of me."	Avoidance
Tulsi	"Just thinking about it now, it's like… see? It's even happening now!"	Invasive Thoughts
Maude	"I just felt icky… and I don't really know another way to say that other than it hurt the…. I didn't want to be intimate with my husband because I felt icky…."	Interpersonal Relationship Problems

continued

Table 25 continued

Participant	Textual Example	Indicator
Maude	"Just feeling icky, or dirty, or… never really realizing and saying, *I really am being traumatized by this!* *This really is impacting my life!"*	Boundary Violations
Araceli	"I started to realize that listening to my clients' stories … started to affect me and my moods, and how I saw the world."	Changes in Perception…
Maude	"I don't think I really understood the toll that secondary trauma takes on you."	Personal Vulnerability
Rowena	"There's nothing worse than not wanting to go into another session or another team meeting."	Avoidance
	"It's so incongruent with how I identify and I know how other colleagues identify."	Compromised Self-Identify
Araceli	"I felt like working on the trauma unit started making my worldview a lot smaller, when the world started to become this scary place, where bad things and these horrible, horrible things, happened."	Distrust
Maude	"But I also realized the toll that it can quickly take in your life without even really realizing how much it's affecting you and the things you're internalizing."	Changes in Inner Self
	"I was hypersensitive to sounds. something would make a sound and I would like jump out of my skin, like just really over reacting."	Hypersensitive

continued

Table 25 continued

Participant	Textual Example	Indicator
Maude	"I was having nightmares, and then also having like somatic symptoms, so like having headaches, having stomach problems, when previously I was quite healthy."	Physical Symptoms
Tulsi	"If it [work] didn't [take a toll on me] then I [would] think … there would be something that wasn't connecting."	Incompetent
Maude	"It affected my relationship with my husband… So yeah, it definitely impacted us, impacted the family…"	Compromised Relationships
	"I feared having kids because I thought, *Well, one in four kids are abused.* *Why do I want to bring somebody into that?"*	Core Values Altered
Araceli	"I remember just having all these work dreams … like my brain was trying to just help me let go… but I just felt so attached to it [work] and like still hearing like the clients' stories in my mind and carrying that with me."	Intrusive Thoughts
Windsor	"You really have to have an ongoing critical awareness of how things affect you and what your issues are… and how they come to bear in relationships."	Vulnerability
Chandra	"When I think about working with folks who … can't tell me what would be helpful, it's challenging because there's this feeling … of helplessness."	Feelings of Helplessness

continued

Table 25 continued

Participant	Textual Example	Indicator
Maude	"So yeah, it [the work] was definitely… it impacted my world view for sure. Pretty much everyone was a perpetrator.**"**	Loss of Hopefulness
Araceli	"I thought… I was a terrible music therapist that day. And it wasn't just that feeling of insecurity and being incompetent, but just being with the client in that space. I was so shaken… *I can't do this anymore.* I was so tempted to not even go in the next day."	Perceived Professional Incompetence
	"I remember just feeling burned out and just feeling confused, like a little bit lost… and sometimes feeling like something was wrong with me. Either I'm doing this wrong or there was that scary thought of … *Maybe I can't be a music therapist.* *Maybe I can't handle this.* *Maybe it's too much."*	Confusion and Self-doubt

Note: Indicators/symptoms of vicarious trauma were noted within the interviews. It is important to clarify that these clinicians were recalling past events and experiences. For some, such events and experiences are what prompted their need for self-care.

Arts-based Responses

An arts-based response by each participant was created following their respective interview. Participants were given a sheet of 11" x 14" drawing paper with a large circle drawn on it, a box on 36 multi-colored oil pastels, and invited to draw an image that

summarized the interview experience for them. [Note: The first two participants did not receive a paper with a drawn circle on it due to an oversight on the part of the researcher.] Following the drawing, participants engaged in a brief verbal discussion of their drawn mandala (image) with the researcher. As with the semi-structured interviews, this dialogue was audio-recorded, transcribed, and returned to the participant for member-checking. The researcher further employed the services of two MARI (Mandala Assessment Research Instrument) practitioners to corroborate a professional interpretation of the participants' mandalas. These individuals received both the participants' mandalas and a copy of the transcript created during the mandala processing. Erin Johnson, LPC, FAMI, a MARI practitioner and instructor with over 30 years of clinical experience, provided an extensive and thorough analysis of each mandala (see Appendix J). Although both practitioners received transcripts of the participants' description of their mandala, Johnson chose to provide the analysis independent of the verbal processing in order to minimize the possible influence of suggestive comments made by the participants.

The personal stories shared by these clinicians were corroborated by the art-based responses provided. Images and symbols related to boundary issues, vulnerability, distrust, conflict, power vs powerlessness, anxiety, anger, and self-criticism were among the indicators of vicarious traumatization noted in all drawn mandalas. It may be that the current practices of self-care engaged in by these clinicians is a mitigating factor that circumvents the negative effects that may result from work with distressed and/or traumatized individuals.

Participants' drawn mandalas were analyzed utilizing the MARI protocol and coded for thematic material (see Tables 26-41).

Table 26. *Identified Thematic Material in Participant Mandalas*

Primary Themes	Secondary Themes
Boundaries / Protection	Education
Difficulty of clinical work	Guides / Mentors
Creative expression as a means of self-care	Personal healing
Essential need for balance in life tasks	Self-awareness
Work ethics in personal and professional life	Support systems

MARI analyses and thematic content of participants' mandalas. In the following sections, each participant's mandala is shown, followed by a synthesis of the MARI analyses and identified thematic material.

Rowena. Rowena was one of the two participant's given a blank sheet of drawing paper without a circle drawn on it (an oversight by the researcher). However, she immediately drew a circle for herself exclaiming, "there has to be a circle!" In providing a general description of her mandala, Rowena stated that she "love[d] the colors. They are so beautiful and soft and restful." In addition, she identified a fundamental tone (G) and an energy emanating from the mandala that she experienced as being felt in her solar plexus and said that it resembled a "light sensation." The energy originating from this area was an important realization for Rowena in that it was "easily accessible [to her]," more so than if the energy was "just located in [her] heart."

Figure 4.9. Rowena's mandala: "Protect the Personhood"

Table 27. *MARI Analysis of Rowena's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Possible Meaning
MARI Stage 4, 5, 6	"Quadrant of Becoming" – suggesting new beginnings, establishing identity; dealing with one's needs; engaging with a focus
Split circle in interior	Dealing with issues around power/powerlessness; suggestive of some type of struggle
Heavily drawn black rim	Need for boundaries; Protective layer between the Self inside the circle and the outer world; provides a sense of containment
Peach color around inner split circle	Provides self-protection Vulnerability

continued

Table 27 continued

MARI Stage/Image/Symbol/Color	Possible Meaning
Pink and yellow combination of inner, borderless circle	Stress caused *by* the 'struggle' (pink) vs having energy *for* the struggle (yellow)
Inner circle	New awareness of oneself
	Awareness of the importance of connections, both with one's body and with others
	Need to nurture self
Title: *"Protect the Personhood"*	How to connect with others and not lose own sense of personhood/self

Note: Interpretative analyses given by MARI practitioners

Thematic material in Rowena's mandala was both unique and consistent with the primary and secondary themes identified across participant interviews (see Table 28).

Table 28. *Identified Thematic Material in Rowena's Drawn Mandala*

Theme	Textual Example
Self-care	"Self-care is about protecting the light, protecting your personhood … accepting the complexity about what it takes to protect your light."
Work ethics	"… lots of work hours and competitivism [*sic*] around the length of the hours or feelings of anxiety if you're not doing the same hours as a colleague, and what does that say?"

continued

Table 28 continued

Theme	Textual Example
Boundaries / Protection	"[The personhood/the light] is what we're protecting… not from a defensive lens, but from a compassionate lens, from a relational lens."
Self-awareness	"**…** protecting the personhood is also having an awareness of how you impact the other…"

Windsor. Windsor was the second of two participants not to be given drawing paper with a pre-drawn circle (researcher oversight). Consequently, she proceeded to create her mandala more like a drawing. She indicated that she "didn't know what [she] was going to draw" but had an image of a "progression of growth… in knowledge and wisdom… [and the] picture of life becoming more fragrant and joyous along the way."

Figure 4.10. Windsor's mandala: "Seeding the Path" or "Growth"

Table 29. *MARI Analysis of Windsor's Drawn Mandala)*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 2	Bliss, imagination, creativity, potential
MARI Stage 9	Relationship with self and community
Lightly drawn	Tentative and uncertain
	Lightness and playfulness
Flowers, grass, trees blooming	New beginnings
Unrooted trees	Sense of being ungrounded
	Personal sense of grounding associated with others' influence and support
Stick figures	Interpersonal connections; self and others
Purple	Spirituality/divinity, dependency, sense or specialness or entitlement, mourning, woundedness

continued

Table 29 continued

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
Blue	Intuition, love, passivity, wisdom
Orange	Ambition, power, energy, assertion
Title: *"Seeding the Path" or "Growth"*	Giving back; moving forward

Note: Interpretative analyses given by MARI practitioners

As though she were providing a chronology of her life, Windsor referenced difficult issues "for a black family [during] the 40s and 50s and 60s…," acknowledged the guidance and gifts she had received from mentors throughout her life, and expressed that she now felt she had arrived at a time in her life where her "mission … [was] to give away everything [she knew] to as many people as [she could]." Textual examples of identified themes in Windsor's mandala are shown in Table 30.

Table 30. *Identified Thematic Material in Windsor's Drawn Mandala*

Theme	Textual Example
Protection / Boundary	"The protective guidance of the Creator [is] represented in nature and [in the] strength and rootedness of a tree, [and] the gentle grace and mercy of these beautiful blossoms as well."
Balance / Ebb and Flow	"They [mentors] have transferred so much to me and … I've risen to start another path."
Creative Expression	"I can't tell you how meaningful music was in my early years… it saved [me] when there were so many other things that were giving me other negative messages."

Tulsi. Tulsi described the process of creating her mandala by acknowledging that she "put it [the colors] on thick, too!" Her explanation for this was that she "really want[ed] to be heard! I want that color to be there!" Perhaps for Tulsi, the broad intense colors were symbolic of a voice may have felt silenced at times. The arts-based response may have provided her with a space of safe containment in which to sound her inner landscape without sensing any type of restraint in doing so. Tulsi's mandala is shown in Figure 4.11; Table 31 provides a synthesis of the MARI analyses.

Figure 4.11. Tulsi's mandala: "Just Keep Swimming"

Table 31. *MARI Analysis of Tulsi's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 6	Stage of struggle, conflict, tension of the opposites
Orange and blue in close proximity	Passive/aggressive conflict
Waves	Break up the strong line between the two halves and suggest a more cooperative nature between the parts
Orange color in upper half	Represents what is more conscious; orange may represent power, assertion, and/or energy to deal with the struggle; orange color in upper half appears more "sun-like"
Blue color in lower half	Represents what is more unconscious; blue may indicate a passivity to bring meaning to the struggle rather than energy; blue color in lower half is fluid and "ocean-like"
Spiral	Characteristic of when energy for the journey is activated, and one is/is not trusting the process; energy may move either inward or outward
Fish	Possible representation of the self
Rope-like cord	Tethered in a positive way, or movement of self is in some way limited or restricted; perhaps a need to find the self, but not quite sure how to do so
Brown color of fish	Possible self-esteem issues or racial identity
Title: *"Just Keep Swimming"*	Perseverance through the struggle

Note: Interpretative analyses given by MARI practitioners

Thematic material in Tulsi's mandala included balance, perpetual motion, the expectation of change, creative expression, and a sense of self-care provided within the mandala-making process. Textual examples of thematic material are presented in Table 32.

Table 32. *Identified Thematic Material in Tulsi's Drawn Mandala*

Theme	Textual Example
Balance	"If you let everything go into the ocean then you're left with nothing. So you have to wait for the tide to come back and you have to get something from the tide too."
Perpetual motion	"There's motion here too. It's never the same. There's no one wave that's ever, ever the same."
Change	"Just like live music as opposed to recorded music. It's never the same."
Creative Expression / Mandala	"This was fun! This was like my own therapy session. It's nice to be heard."

Araceli. The colors in Araceli's mandala "reminded [her] of home" and brought a feeling of happiness to her. She indicated that she felt a sense "of wholeness and completeness and it [mandala] made [her] feel really good and proud of [herself]." Araceli explained that "the pink is the feminine, the green is the continuation of growth, and the yellows bring in brightness and the hope." Araceli's mandala is shown in Figure 4.12; Table 33 provides a synthesis of the MARI analyses.

Figure 4.12. Araceli's mandala: "Being and Growing"

Table 33. *MARI Analysis of Araceli's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 8	Suggested by the image of the three leaves that may represent the Self Stage 8 suggests coming into full autonomy, identity, career issues
MARI Stage 5	Suggested by intentional outlining of the circle, and three bands of color in the inner circle
Significance of the number 3	Three leaves; three colors of leaves; three bands of color in the circle; three dots; three outer walls May represent the need for mind, body, and spirit to work together in creating wholeness

continued

Table 33 continued

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
Significance of the number 3	May represent stages of professional career: burnout, healing, self-discover
Reinforced outer boundary	Establishing strong boundaries for self-protection; dealing with issues around power/powerlessness
Outer gray boundary	Defending against pain and/or guilt; feeling stuck, or feeling numb
Dark blue boundary	Difficulty accessing own intuition; tendency to engage in criticism of self or others
Inside color bands/ Stage 5	Engaging with a focus
Colors at Stage 5	
Green (top)	Trying to heal; trying to defend oneself
Pink (middle)	Vulnerability, anxiety, weak defenses
Yellow (bottom)	Attempting to bring awareness to the need to set boundaries; feeling trapped; low energy
Three leaves (or flames) / Stage 8	Possible representation of the Self
Colors at Stage 8	
Blue (middle leaf)	Intuition, wisdom, flow, trust
Purple (left-side leaf)	Spirituality, mourning, or entitlement
Yellow (right-side leaf)	Self-identifying as an intellectual, rational person
Flames	The symbol of a flame may also represent higher guidance, an eternal flame, and a sense of rebirth
Title*: "Being and Growing"*	Who one is (or was) and is becoming; the process of growing from being burned out as a professional music therapist, to healing, to discovering

Araceli interpreted her mandala as representing three distinct periods of her life: (1) the beginning of her professional career, which included a period of burnout; (2) the healing process that came about as a result of travel, education, and establishing her own private practice; and (3) the place where she is now, a place where she can "feel like [she is] able to be a thriving music therapist." Identified thematic material included topics of self-care, difficulty of clinical work, and the impact of personal work ethics. Textual examples of these themes are presented in Table 34.

Table 34. *Identified Thematic Material in Araceli's Drawn Mandala*

Theme	Textual Example
Self-care	"Hopefully we can start to educate music therapists [about self-care] in the very early stages, especially in education."
	"I am just so glad I made it here and to a point where self-care is both natural [and] a very conscious choice for me."
Difficulty of clinical work	"Sometimes it [clinical work] can be draining, but it's not inhibiting my experience of life anymore and I love that I was able to get here."
Work ethics	"I am a person who does work really hard, regardless of what anyone is going to tell me, I am going to keep pushing myself."

Jakobe. Jakobe began his mandala by allowing himself to be very free and expressive with whatever came to mind. His intention was not to "be self-critical and

over analysis," but rather to allow "the circle to guide where [he] was going." Jakobe's mandala is shown in Figure 4.13; Table 35 provides a synthesis of the MARI analyses.

Figure 4.13. Jakobe's mandala: "Flow"

Table 35. *MARI Analysis of Jakobe's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 2	Stage 2 may suggest things being diffuse, without a clear sense of ego boundaries, lacking in form, regeneration or regression, multiple forms of growth (positive and negative) Stage 2 may also represent bliss, imagination, creativity, potential

continued

Table 35 continued

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
Curved lines	Fluidity
Red streak of color	Issues of anger or resentment; woundedness
Abstract quality	Suggesting that the more important aspect of this mandala was the person's experience in drawing/creating it
Open (white) spaces	Allow for freedom of movement in and out without disrupting existing movement, thus creating a natural sense of balance
Half-circles outside the circle	Provide balance to inside images; or representative of outside forces at work within the individual's life
Title: "*Flow*"	Depicting a "natural flowing movement"

Note: Interpretative analyses given by MARI practitioners

Thematic material identified in Jakobe's mandala included balance, movement, unrestricted freedom, and the lack of boundaries. Textual examples of these themes are presented in Table 36.

Table 36. *Identified Thematic Material in Jakobe's Drawn Mandala*

Theme	Textual Example
Balance / Movement / Freedom	"[The] open space … allows that freedom for space to exit, but keeps the flow going. A lot of things are allowed to come on the outside as well, and so I feel like it's really balanced and actually I'm feeling the movement too."
Boundaries	"I went out of bounds because I don't need boundaries."

Mariano. Mariano purposefully chose the images in his mandala to represent his self-care strategies, and rather than placing himself in the image, Mariano "wanted the self-care to be a reflection of [him]… like [him] looking in a mirror." Mariano's mandala is shown in Figure 4.14; Table 37 provides a synthesis of the MARI analyses.

Figure 4.14. Mariano's mandala: "A Center of Importance Reflects on Life"

Table 37. *MARI Analysis of Mariano's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
Stage 5	Engaging with a focus; setting boundaries for self-protection; dealing with issues of power/powerlessness
Multiple lines on rim of circle	Emphasis on boundaries
Dark green lines	Suggest a need to heal self or others by ritualistic means (religious rituals)
Dark blue lines	Relate to self-criticism, difficulty accessing intuition
Loose circle inside	Emphasis on boundaries
Light blue	May relate to using passivity as a defense
Symbols of personal meaning	Imply that the mandala is more consciously drawn with favorite images vs more fully accessing the person's unconsciousness
	Each figure/image is placed at a specific stage of the MARI Great Round, and may be interpreted with specific implications depending on image color and its associated stage
Black/Yellow at Stage 2/3 (disk golf basket)	Things being diffuse; without a clear sense of ego boundaries / activation of energy for one's path
Green at Stage 4 (wind)	Associated with new beginnings; self-nurturing, feeling vulnerable

continued

Table 37 continued

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
Brown at Stage 7 (cross)	Stage is about balance, being expansive and integrative, fully conscious
Coral at Stage 10 (woman)	Suggests feelings of vulnerability
Black at Stage 11 (dog)	Represents defense against chaos; negating the sense of being overwhelmed
Brown at Stage 12 (cat)	Reflects letting go of negative issues and dynamics
Title: *"A Center of Importance Reflects on Life"*	Christian faith/belief system in the center which then reflects on all aspects of the individual's life; may also be reflective of the individual's belief of the need for structure and direction in the world at large

Note: Interpretative analyses given by MARI practitioners

The images in Mariano's mandala represented activities he engaged in for self-care, such as disk golf, walking out-of-doors, spending time with his pets, and sharing quality time with his wife. Placing the cross in the center of his mandala was an intentional act. In reference to this action Mariano stated: "As important as those things are, this [Christ, and his relationship with God] is the most important, and by having it all together it shows that… everything is together, not separate… it's all part of my life. It's the center of importance, but it reflects on my life." Mariano's interview described the images within his mandala; no thematic material was identified.

Chandra. Chandra indicated that her undergraduate academic and clinical training program had provided her with the opportunity of drawing mandalas as of means of processing personal experiences and providing self-care. In drawing this mandala Chandra said she "started in the middle because that felt good." She "liked the warmth of the yellow and the glowing kind of radiating energy of it." Chandra shared that her mandala provided her with a sense of "spiritual self-care" and "relational self-care." Chandra's mandala is shown in Figure 4.15; Table 38 provides a synthesis of the MARI analyses.

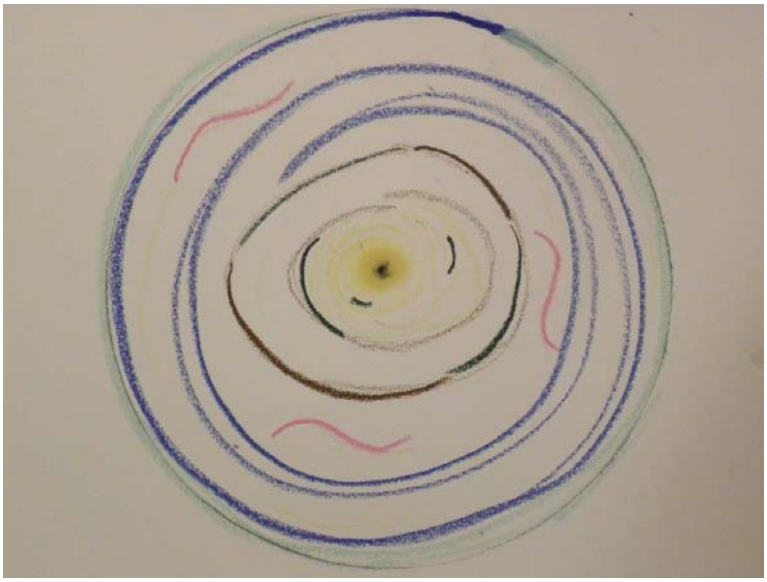

Figure 4.15. Chandra's mandala: "Found"

Table 38. *MARI Analysis of Chandra's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 5	Suggested by concentric circles, representative of engaging with a focus, setting boundaries for self-protection, and dealing with issues around power/powerlessness Brown at this stage can represent a sense of being disempowered
Black at center	May represent mystery, negation or powerlessness; a place of stillness or rest
Yellow circle surrounding black	May relate to using rationalization as a defense; attempting to bring awareness to what one needs to set boundaries around; struggle to find balance; sense of one's spirituality
Blue spiral	Suggestive of what may be getting activated in one's life (growth or change); blue reflects intuition, trusting (or not trusting) the process of change
Wavy lines	May indicate anxiety about the activation or forthcoming of change; a need to find comfort amidst the changing experiences of life
Title: *"Found"*	Relating to a sense of "found self" or "found other;" needing to form intimate connections without becoming enmeshed

Note: Interpretative analyses given by MARI practitioners

Emerging themes in Chandra's mandala represented fluidity, change, and forward motion. She indicated that understanding the concept of boundary was something she was "working with," and that she was "not always aware of [boundaries]." The Stage 5 representation of Chandra's mandala gives support to this goal and suggests her growing awareness of boundaries. Textual examples of identified themes in Chandra's mandala are presented in Table 39.

Table 39. *Identified Thematic Material in Chandra's Drawn Mandala*

Theme	Textual Example
Boundary	"I was wanting to have some really strong lines… like it was creating this stronger boundary."
	"I'm not always aware of the helpfulness of boundary and the fact that it can feel in many ways similar to embracing."
	"Sometimes when I think of boundary I think of pushing away, but it's containing… and like holding."
Movement	"These fluid parts in the middle feel really vital… there's movement. I want to bring that out."
Continual change	"… unending, like a deepness that you can't see the bottom of… it just keeps going… nothing ever stays the same."
Support	"[It] feels really important to be connected to people but not to be enmeshed."

Maude. Maude shared her mandala by first describing what she felt when she was drawing it. She indicated that she had been "thinking about the whole process of being traumatized, doing [her own personal] work, and then feeling in a healthy spot again." The effects of vicarious traumatization she experienced compromised her family relationships and the security she desired for her husband and daughter. Maude expressed her goal of ensuring "[her] home be a safe place for [her] family, and for [her] daughter, for [her], for [her] husband." In the lower right-hand area of the mandala she placed a bandage, symbolic of "the whole process of myself having to heal, my family having to heal." Maude's mandala is shown in Figure 4.16; Table 40 provides a synthesis of the MARI analyses.

Figure 4.16. Maude's mandala: "An Attempt at Balance'

Table 40. *MARI Analysis of Maude's Drawn Mandala*

MARI Stage/Image/Symbol/Color	Thematic Material / Possible Meaning
MARI Stage 6	Suggested by prominent diagonal line that cuts the mandala in disproportional halves Stage 6 suggests struggle, conflict, both within the self and others
Diagonal line through mandala	May convey the multitude of emotions, perspectives and energy the person is trying to use to keep these two parts separate in order to protect the family
Left-side of split	
Triangles pointing downward	Embodying the struggle, but feeling bruised or wounded
Wavy lines (green)	Trying to find ways to neutralize the struggle
Straight lines (black)	Negating the struggle
Right-side of split	
Three stick figures and house	Representing family, group affiliation, or community
Yellow hatch lines around family and house	Setting boundaries; issues of power vs powerlessness
Ochre-colored oval (bandage)	May refer to an achievement that feels heavy or tainted; contrasting colors of this image suggest the individual is moving away from a discomforting past
Title: *"An Attempt at Balance"*	Balance professional and personal life; mitigating the effects one has upon the other

Note: Interpretative analyses given by MARI practitioners

An Attempt at Balance illustrated Maude's desire to continue to do the work of a music therapist in difficult and challenging clinical settings. She stated, "I can do this work. I love what I do." While the effects of vicarious traumatization had patterned the thematic material that emerged in Maude's mandala, the resulting need to develop effective coping skills to mitigate those effects demarcated the same. During the verbal processing of the mandala, Maude affirmed that she is focused on both doing the work and trying to lessen its negative impact on her herself and her family. Textual examples of identified themes in Maude's mandala are presented in Table 41.

Table 41. *Identified Thematic Material in Maude's Drawn Mandala*

Theme	Textual Example
Difficulty of clinical work	"This is my stress in [trauma work]. It's kind of pretty because sometimes, a lot of the time, you don't really recognize that it's taking a toll on you, but it really is."
Boundary	"This is my protection, my wall."
Balance	"I feel a lot of pride in that I think our home is a safe place and I think I do a fairly decent job of having a good balance… not getting overwhelmed and letting that really affect my family and my home and my daily life, like it really was."
Healing	"… having to do my own work and get through that… getting counseling and finding those coping skills."

Self-Care Practices and Strategies

Data collected from the interviews identified many of the practices music therapists are utilizing as their personal self-care strategies. While all eight of the clinicians interviewed indicated that self-care was a part of their personal life, the level to which they reported practicing self-care varied. For example, Chandra indicated that she was "still trying to figure out" just exactly what is was she did for self-care, while Windsor stated that she had "established rituals [for self-care practices] that [she does not] allow anybody [to] break!"

Following a thorough analysis and synthesis of the interview data relative to self-care strategies, the following four categories grouped: (1) personal, (2) physical, (3) professional, and (4) psychological self-care strategies. The following tables provide descriptions and examples of these strategies synthesized from the personal self-care practices and experiences shared by participants.

Table 42. *Personal Self-Care Strategies*

Strategy	Description
Alone-time	Recognize needs of your personality; nurture the self.
Boundaries	Establish healthy boundaries in personal and professional life
Connections	Connect meaningfully with immediate and extended family, friends, and significant others,
Disconnect	Unplug from computers, smart-phones, iPads, and social-media from time-to-time.

continued

Table 42 continued

Strategy	Description
Personal Work	"Do your own work!" Seek counseling and personal therapy.
Reading	Reading for pleasure; self-help books.
Relationships	Socialize, "hang-out" with friends, engage spontaneity.
Ritual	Plan and schedule self-care activities; maintain routines.
Self-Advocate	Articulate needs; say "no" to unwelcomed events or things.
Spiritual	Prioritize spiritual pursuits; develop/increase faith beyond self.
Weekends	Take your weekends! Weekends are mini-vacations!

Table 43. *Physical Self-Care Strategies*

Strategy	Description
Deep-Breathing	Ground yourself with the breath.
Essential Oils	Beneficial in home, office, or car.
Exercise	Run, walk, work-out, lift weights, play team/individual sports, swimming, recreational things.
Gardening	Planting, harvesting; yardwork.
Laugh & Play	"Play is so important for self-care. Sometimes we downplay the importance of play and fun as an adult. Play is certainly something that helps me tune into the child in me." - Windsor
Pet Care	Caring for animals at home and elsewhere.
Proper Diet	Eat well.
Massages	Massages and visits to the spa are re-vitalizing and energizing.
Reduce Stress	"[It is] incredibly eye-opening how much damage stress can do to your body." – Maude

continued

Table 43 continued

Strategy	Description
Sleep	"Self-care, right now, means making sure that I get at least 7 hours of sleep every night." – Windsor
Time Outside	"I love being in the earth; anything to do with being in the earth, or being in the water, or experiencing nature." - Rowena
Yoga	Intentional and mindful physical exercises.

Table 44. *Professional Self-Care Strategies*

Strategy	Description
Debriefing	Process difficult work immediately with peers, colleagues, and supervisors.
Employer Support	Utilize Employee Assistant Programs (EAPs), Employee Wellness Programs, and adjunctive therapies available to you from your employer(s).
Professional Support	Establish and maintain relationships at work that provide a strong support system and professional network.
Schedule Work	Arrange your work schedule to include mini-breaks, time for debriefing, tending to unexpected situations; self-advocate; know your limitations.
Supervision	Solicit ongoing supervision with peers and colleagues.
Vacations	Planned vacations are as important as scheduled clinical sessions
Workshops	"Take advantage of self-care workshops that are around." Windsor

Table 45. *Psychological Self-Care Strategies*

Strategy	Description
Coping skills	Know yourself and the coping skills you need.
Decompress	"Decompressing means being able to look far away at something and just being in the open space." – Araceli
Creative Arts	Utilize the creative/expressive arts: write, draw, paint, dance, work with clay, make music, journal; encourage creativity within you.
Gratitude	Be grateful! Keep a "Gratitude Journal."
Honor Self	Recognize and honor the needs you have.
Meditate	Focused communication with your Higher power(s).
Mindfulness	Intentional connection to mind, body, and spirit.
Music-making	"Stay close to the craft!" – Rowena
Reductionize	Reduce stress, anxiety, and worry in your life.
Self-Compassion	Treat yourself with the same compassion you treat your clients.

Music Therapy Academic Program Directors

Data from the survey sent to academic program directors of academic and clinical music therapy programs approved by the American Music Therapy Association ($N = 79$), showed that 37.5% of survey respondents ($n = 16$) did *not* include a unit on self-care in their curricula. Respondents reporting this were from universities or colleges located in four of the seven regions of AMTA: Great Lakes Region, Mid-Western Region, Southeastern Region, and Southwest Region. In narrative comments made by these respondents, it appears that the professional competency requiring students to

"demonstrate critical self-awareness of strengths and weaknesses" focused on functional music skills, leadership/facilitation skills, and overall clinical/therapeutic skills (see Table 47).

All program directors responding to the survey within the New England, Mid-Atlantic and Western Regions of AMTA, reported the inclusion of a self-care unit or course in their curricula, and appeared to interpret the professional competency by focusing on an increase in self-awareness, healthy professional and personal practices, and self-care strategies (see Table 48).

Table 46. *Regional Programs with Unit/Module on Self-Care in Curriculum*

AMTA Region	*n*	%
Great Lakes	2	0%
Mid-Atlantic	3	100%
Midwestern	4	75%
New England	1	100%
Southeastern	2	50%
Southwestern	2	0%
Western	2	100%

Note: $n = 16$

Curriculum in approved AMTA music therapy programs is competency-based and designed around an extensive list of professional competencies. For undergraduate programs, the only competency appears to address personal growth and development, is the standard that states: "Demonstrate critical self-awareness of strengths and weaknesses" (Section 17.8). The results from this study indicated that the program directors who responded to the survey interpreted this competency in different ways.

Table 47 contains the responses from program directors who indicated their curricula did not contain a dedicated unit or module on self-care. Table 48 contains responses from program directors who indicated that they did have included a unit and/or module on self-care. The responses from the survey are presented verbatim.

Table 47: *Question: Please share a brief description of how the following AMTA Professional Competency is addressed in your curriculum: "Demonstrate critical awareness of strengths and weaknesses." (No self-care unit included)*

Director's Region	Textual Response
Southeastern	"The courses in my program are based in the competencies. This specific competency is addressed in "Voice for music therapy majors", "freshman seminar" the practicum courses and the affiliated internship."
Great Lakes	"Self-awareness of strengths and weaknesses is taught and practiced in every semester the students take applied music lessons. Individual feedback on functional skills is provided in several courses. Discussion of strengths and weaknesses occurs in clinical practicum courses and as the student identifies 1-2 goals for the semester and then evaluates progress in an essay. Finally, each senior completes a self-evaluation that lists various functional music skills, leadership/facilitation skills, and documentation skills."
Great Lakes	"We are an abilities based curriculum and students are given written and oral feedback regularly throughout their curriculum. they are then required to respond with self-assessment creating a culture of identifying this aspect of their development. Further, using the AMTA competencies, students regularly consult and respond to these issues on the Individual Training Plans."

continued

Table 47 continued

Director's Region	Textual Response
Midwestern	"Students evaluate their own progress in our clinical class by watching videos of their clinical sessions and completing a typed self-reflection."
Southwestern	"Our students self-evaluate with guidance regularly, most notably during 2 weekly practicum supervision meetings, an intensive self-direction project, and targeted self-evaluation tools such as one given during the middle of the practicum sequence, then another at the end in development of the Internship Agreement."

Note: Academic program directors who reported not having a specific unit or module on self-care included in their curriculum.

Table 48. *Question: Please share a brief description of how the following AMTA Professional Competency is addressed in your curriculum: "Demonstrate critical awareness of strengths and weaknesses." (Self-care unit included)*

Participant's Region	Textual Response
Southeastern	"New music therapy students attend an orientation prior to beginning music therapy core classes. In orientation, the importance of self-awareness, self-care, and resources for students (including the University Counseling Center) are highlighted. Our students complete the Strengths' Finders 2.0 Assessment in their first semester and discuss the results with their faculty adviser and classmates."
New England	"In each practicum course students complete a self-evaluation and this is compared with the supervisor's evaluation."
Midwestern	"Students self-evaluate formally twice each semester of clinical work, and ongoing formative evaluation of strengths and weaknesses each week with supervisor."

continued

Table 48 continued

Participant's Region	Textual Response
Midwestern	"Students are required to journal and complete self-reflective assignments throughout their education. This is discussed with instructors and supervisors at regular periods (i.e., midterms, finals, reviews, etc...)."
Midwestern	"Various evaluation processes including faculty, peer, and self-evaluation of skills."
Mid-Atlantic	"Through self-evaluations in class role play, self-evaluation in practicum and internship, conversations with practicum and internship clinical and academic supervisor, oral self-evaluation discussion during three individual clinical music skills evaluations."
Western	"All of our faculty are aware of the need for students to reflect on their own reactions and responses to clinical experiences. Our Humanistic approach to music therapy education gives us a foundation upon which to expect students to engage in self-critique. We also take a strength-based approach to education which is a positive way to foster awareness of weaknesses/areas of need."
	"Our practicum paperwork has a required component of personal reflection for each week's work."
Mid-Atlantic	"Our graduate program focuses on this at a more in-depth level than the undergraduate, but both make this a focus. At the undergraduate level, critical self-awareness is delved into in a course on supervision, ethics and issues of diversity. Students are required to examine the ways they are positioned in society in terms of power/privilege and oppression. In supervision they are required to write weekly journals exploring their understanding of what is going on interpersonally and intrapersonally during sessions. They are also involved in weekly group supervision and every three weeks are involved in individual video supervision."

Note: Academic program directors who reported that a specific unit or module on self-care was included in their curriculum.

The *AMTA Standards for Education and Clinical Training* (2014b) do not indicate where the competencies are addressed within the curriculum, but allow the program director to have autonomy and flexibility in making those decisions. Table 49 gives examples of where program directors may be including a unit or module on self-care within their curriculum. Again, examples are taken verbatim from responses.

Table 49. *Question: Where is self-care specifically addressed in the curriculum?*

Participant's Region	Textual Response
Southeastern	"Each semester, students are asked to set personal and professional goals and discuss strengths and weaknesses with their faculty adviser. Practicum supervisors are also asked to engage in dialogue with students regarding strengths and areas for improvement. Self-care is discussed in each of the core music therapy classes. Students read and discuss the chapter on self-care in Brian Baird's "Internship, Practicum, and Field Placement Handbook" in their first semester, and music therapy faculty refer back to the chapter in each subsequent core music therapy class."
New England	"*Introduction to Music Therapy:* Approximately 4 weeks of homework assignments in which students learn self-care through music: individual and dyad improvisations, using familiar songs, music & imagery. *Music Therapy II:* Song writing assignments for self-expression. *Music Therapy III:* Music & imagery assignments for self-expression. *MT Senior Seminar I, II:* Taken with internship. Self-care activities are required 6 days/week; of those 6 days, 3 must be self-care with music."
Midwestern	"We have a module in one of our clinical practice seminars that happens during junior/senior year for undergrads and during equivalency pre-internship."

continued

Table 49 continued

Participant's Region	Textual Response
Midwestern	"We speak about this within all of our courses from the perspective of being a healthy helper. We talk about services on campus and encourage all students to engage in counseling. We bring counselors to our classes to speak with students and demystify participation in counseling. We have units on healthy practices within methods courses, from the perspective of both helping the client and caring for the caregiver/self."
Mid-Atlantic	"Self-care is included in a Music Therapy Ethics course for graduates and undergraduates. This is presented as a discussion, then explored through presentations of ethical dilemmas that include issues of self-care. At the upper level graduate courses, a self-care component is addressed in advanced supervision in 3 successive courses. videos on Mindfulness and care for the caregiver/therapist are presented and students discuss their methods of self-care."
Western	"We offer an elective that focuses on relaxation and body awareness. One of the modules in Methods class focuses on self-care."
Mid-Atlantic	"A one credit course that focuses on preparing students for internship. They learn to complete internship applications, prepare for interviews and look at AMTA/CBMT documents r/t being a professional. In two of the class periods, we do music and imagery experiences [related to] self-care and self-supervision and talk about differences between therapy, self-care, self-supervision, professional supervision, and peer supervision. It is not enough time."
Mid-Atlantic	"Self-care is covered in the first year in an assignment called *self-care*. It is again covered in an upper level course focusing on music therapy with adult populations and in another course in relation to burnout. It is covered at the graduate level in a course on professional issues."

Note: Responses were given by program directors indicating that a specific unit or module on self-care was included in their curriculums.

CHAPTER 5

Discussion

This qualitative study explored the effectiveness of undergraduate academic and clinical training programs in music therapy for preparing students to work with trauma-related clinical populations. The study attempted to identify ways in which undergraduate programs are fostering the development of critical self-awareness and self-care strategies.

Findings from this study show that more than one-third of practicing music therapists self-identify their clientele as distressed and/or traumatized, and that nearly half of the clinicians who work with trauma-related populations are bachelor-level clinicians. Furthermore, the results revealed that all of the participants interviewed reported symptoms related to the negative effects of clinical work. This is consistent with the literature asserting that professional caregivers who provide therapeutic interventions for individuals who are distressed and/or traumatized are likely to experience a negative impact in their personal and professional lives resulting from the work they do (Adams et al., 2006; Bell, 2003; Dombo & Gray, 2013; Figley, 1995; Hafkenscheid, 2005; Hesse, 2002; Paavilainen et al., 2014; Saakvitne, 2002; Shah et al., 2007; Stamm, 1999). Potential hazards of trauma-related work include compassion fatigue (Bourassa & Clements, 2010; Figley, 1995; Newell & MacNeil, 2010; Tehrani, 2010), secondary traumatic stress (Bride, 2007; Dutton & Rubenstein, 1995; Figley, 1995; Newell & MacNeil, 2010; Rothschild, 2000), vicarious traumatization (Baird & Kracen, 2006; Baum et al, 2014; Bryne et al., 2006; Knight, 2013; Pearlman, 1999; Saakvitne, 2002;

Stebnicki, 2000) and burnout (Cherniss, 1980; Maslach, 1982; Maslach & Leiter, 1997; Sprang et al., 2007).

Through this study, I specifically desired to examine how undergraduate academic and clinical training programs in music therapy were preparing students for the potential personal and professional risks that are frequently a byproduct of clinical work with distressed and/or traumatized individuals. Research suggests that risks associated with clinical work may be minimized through education and increased awareness of the potential for such risks (Barnett et al., 2006; Capri et al., 2013; Clements-Cortez, 2002; Herman, 1992; Kantrowitz, 1997; Knight, 2013; Murphy, 2013; Newell & MacNeil, 2010). As a music therapy academic program director for the past thirteen years, it has come to my attention that many bachelor-level music therapists are working with distressed and/or traumatized clients. After many conversations, both formally and informally, with professional music therapists during their first five years of their clinical practice, I have been concerned as to whether undergraduate music therapy students were being informed about vicarious traumatization and other potential hazards of professional work. Additionally, I was interested in knowing if the practice of self-care was emphasized in AMTA Approved Programs, particularly given the fact that there is not a specific undergraduate competency for this skill. Due to the small number of program directors' responses it was not feasible to draw any conclusions to this matter.

Results of the survey sent to academic program directors revealed that music therapy training programs did not necessarily include instruction related to self-care. To further illustrate this finding, three of the interviewed participants indicated that

education on self-care was not addressed during their degree-programs, at least not that they remembered. This may indicate that graduates are entering the field without adequate resources to recognize the potential hazards of professional work. These finding are consistent with literature citing how clinicians suffer from the lack of self-care, and consequently how clients may be adversely affected by the omission of professional caregivers to make self-care an intentional practice (Barnett et al., 2006; Dileo, 2000; Hernandez et al., 2010).

Findings from this study show two dissimilar interpretations of an AMTA educational competency to develop a critical self-awareness of strengths and weaknesses. In interpreting this competency for implementation in curricula, music therapy program directors either interpreted it as (1) placing emphasis on "functional music skills, leadership/facilitation skills, and documentation skills," or (2) placing emphasis on "the need for students to reflect on their own reactions and responses to clinical experiences" (AMTA Program Director). Essentially, both areas of emphasis are appropriate for developing a "critical awareness of strengths and weaknesses." However, the literature cites that "education and training on the use of professional self-care to properly address the emotional and psychological risks associated with working… with vulnerable populations is often overlooked" (Newell and Nelson-Gardell, 2014, p. 428). The Professional Competencies for approved AMTA undergraduate training programs do not specifically contain language regarding the development of self-care practices and personal reflection to enable students to recognize their personal limitations. Competencies of this nature are articulated for advanced/graduate training programs.

This raises the question as to whether or not undergraduate programs are adequately preparing students to work with traumatized and/or distressed clients and trauma-related populations. It may be justifiably argued that competence levels in the area of self-awareness and self-care in music therapy academic and clinical training programs need to be as specifically stated in bachelor-degree programs similar to how they are in articulated in graduate-degree programs. In addition, it may be helpful to have a means of ensuring that all program directors are interpreting the competencies with comparable emphasis.

This study found that the largest concentration of therapists working with distressed and/or traumatized individuals live within the boundaries of the Western Region, a region where only two graduate programs currently exist. A recent report by the American Music Therapy Association (AMTA, 2014c) indicated that currently there are 74 undergraduate academic programs, and 46 graduate programs (38 master programs; 8 doctoral programs). Thirty-two-percent of the graduate programs are located in the Mid-Atlantic Region. Therefore, it is not surprising that the majority practicing music therapists in the Western Region are bachelor-level clinicians. The literature indicates that those with least experience (BA) are at a higher risk for experiencing adverse effects of professional clinical work (Cunningham, 2004; Newell & MacNeil 2010; Newell & Nelson-Gardell, 2014). Unfortunately, the results did not provide sufficient information to determine if bachelor-level clinicians were receiving sufficient education regarding potential risks of professional clinical work and resources to mitigate

those effects. These findings suggest that an examination of undergraduate curricula in warranted.

Results of this study identified numerous self-care practices and strategies that were being used by the participants. This is consistent with the literature that cites self-care as being a necessary and beneficial practice for clinicians working with trauma-informed populations (Austin, 2002; Figley, 2002; O'Callaghan et al., 2013; Saakvitne, 2002; Smith et al., 2007). Unfortunately, clinicians frequently become aware of the need for increased self-care only as a result of finding themselves in a professional or personal crisis. An example of this is an experience Maude shared:

> I was driving home from work and I got super dizzy and very disoriented, and I exited off of the highway … and I turned the wrong way into oncoming traffic on the frontage road. I didn't even know where I was or how I pulled my car over, and thank God was not in a wreck. I called my husband, but I couldn't tell him where I was. I just knew I was on my way home from work somewhere but I had no idea where I really was. After about 10 minutes I was still shaking and my speech started slurring, but I knew where I was… but everything was going in like slow motion. [Afterwards] I took some time off from work. I went back to work and [it happened again], not nearly as severe, but shaking and my speech was kind of slurring. They did all kinds of [medical testing] and they basically said 'your body was too stressed.'

To avoid these scenarios, education on the importance of, and need for, self-care must begin long before *student* becomes *clinician*. The absence of, or limited exposure

to, this education may be a contributing factor in the attrition rate for music therapists within the first five years of practice. Knight (2013) charged educators with the responsibility of ensuring students are informed of the challenges that may come with clinical work.

An interesting finding of the study was the similarity of identified thematic material in both the participant interviews and drawn mandalas. Of the five primary themes identified in the interviews, four of these were also emphasized in the arts-based responses. The theme of boundaries and the need for self-protection was more emphasized in the arts-based responses, although this was identified as a secondary theme throughout the interviews. Findings in the study suggest that clinicians may not have access to the resources needed to ensure self-protection, or the understanding of how protective barriers for the self are positioned in therapeutic work. Developing a self-awareness of this need using the creative arts, and more specifically the use of mandalas to bring to conscious awareness material that may be repressed, is cited in the literature (Bush, 1992; Fincher, 1991; Jung, 1973; Murrant, 2000).

Within the MARI analyses a number of indicators of vicarious traumatization were noted that included issues around power/powerless, vulnerability, interpersonal connections, self-esteem, and core beliefs and values. The existence of such symptoms in consistent with research advocating for increased self-awareness in health-care professionals in order to identify the potential impact of such occurrences (Campbell, 2013; Figley, 1995; Hafkenscheid, 2005; Miller, 1998; Moulden & Firestone, 2007; Newell & MacNeil, 2010).

The study did not utilize a formal protocol for triangulation of data, yet the consistency of identified thematic material within the interviews, drawn mandalas, and MARI analyses, do provide some level of trustworthiness for the findings.

Contributions to the Field of Expressive Therapies

This study presented the educational and clinical training experiences of eight board-certified music therapists related to the topic of self-care. Through personal interviews and drawn mandalas, clinicians shared how they came to understand the importance of self-care and how maintaining a routine practice of this enabled them to be more effective in their professional work and achieve a more harmonious balance in their personal lives.

The results suggest that while music therapists tend to have a more consensual definition of what it means to cultivate an awareness personal strengths and weaknesses, it appears that undergraduate music therapy academic programs do not necessarily connect such an awareness with an understanding of self-care. As a result, different levels of emphasis are placed on the acquisition and maintenance of personal self-care strategies in educational training programs. Even though graduate-level academic programs do place an emphasis on developing and practicing strategies for self-care, results of this study indicated that nearly half of music therapy clinicians treating distressed and/or traumatized individuals are bachelor-level entry. This suggests that many of these clinicians may have not been educated in the importance of self-care for mitigating the potential risks associated with clinical work in providing services to vulnerable populations.

Given that traumatic and stressful situations are unlikely to be abolished from our society, the need for effective clinicians in trauma-informed work will continue to exist. In order to maintain professional longevity, clinicians have an ever-prevalent need to increase self-awareness of their personal issues and sustain balance in their lives. The findings of this study may contribute to the field of expressive therapies by alerting clinicians of the need to establish routine self-care practices, as well as influencing educators to include self-care modules in their academic and clinical training programs. The study may also provide information to policy-makers within professional organizations who establish guidelines for the training of healthcare professionals.

Limitations and Recommendations

This study provided a limited profile of music therapists who self-identified as working with distressed and/or traumatized individuals. Demographic questions included variables as to gender, ethnicity, education, years of experience and age. It is recommended that when collecting data regarding gender, researchers provide options to more accurately reflect gender identity of participants. Transgender and non-binary are examples of such options rather than only having “male, female, and other.”

Attempting to create a profile of clinical populations served by music therapists, the survey sent to MT-BCs included a list of 15 populations most frequently served by music therapists and asked participants to self-identify whether they considered their clinical population to be distressed and/or traumatized. The results suggest that clinicians in several populations, other than crisis and trauma, identify their clientele as being

trauma-informed. To obtain an accurate reporting from clinicians who work in trauma, the research recommends that specific trauma-informed populations are clearly identified.

This study aspired to examine the undergraduate academic and clinical training participants had received in preparation for working with trauma-informed populations to determine if such training was adequate and effective. It is recommended that future research explore undergraduate training in other disciplines of the creative arts, such as drama, art and dance-movement therapy.

Participants represented all levels of educational training. To identify training specific to the bachelor-level music therapy clinician, it is recommended that future research focus with a specific level of education. Additional research is needed to provide an in-depth examination into the ways in which both undergraduate and graduate academic and clinical training programs are addressing the topic of self-care. Also, research to determine whether a correlation exists between educational experiences and the clinician's ability to mitigate potential risks associated with working in trauma-related populations, and/or contribute to the longevity of the clinician's professional practice, is recommended.

By selecting clinicians for interview purposes, who resided and practiced within each of the geographical membership areas of AMTA, it was the intention of the researcher to identify community factors which may contribute to the level of self-care an individual maintains. Also, in obtaining a sample that was diverse in age, gender, ethnicity, educational levels, and years of experience, the researcher was exploring what factors within these parameters may also contribute to an individual's level of self-care.

Questions that may have elicited this information were too limited within the semi-structured interviews. Further research is needed to determine if there are such existing factors which may have impact on of self-care practices.

An arts-based response solicited from the interviewed clinicians provided a means for giving validation to their personal stories. However, the study did not investigate whether this form of creative expression was an effective self-care strategy for mitigating the effects of vicarious traumatization and other negative consequences of trauma-informed work. Further research examining the specific effectiveness of this intervention for such purposes is recommended.

Having interviewed all participants in-person, I would encourage qualitative researchers to create such an opportunity. All of the participants commented on how meaningful the experience was for them, and that they felt valued and honored to participate in the study. For some, the interview itself actually became a means of self-care. As a researcher I felt I was able to authenticate their experiences and accurately report their contributions to the study.

Lastly, the researcher has acknowledged her personal bias in the fact that she is a program director of an AMTA approved music therapy undergraduate program. Given this fact, the researcher did not contribute responses to the online survey which was sent to all academic directors. Such participation may have influenced the findings of this study relative to what was reported by the educators. Unfortunately, the response rate for the online open-ended questionnaire (survey) sent to educators was low and resulted in a limited representation of the subject matter under investigation. This fact may have

contributed to a skewed representation of what is actually being taught in graduate and under-graduate programs relative to self-care. Additional research is needed to corroborate the initial results of this study.

Summary Statement

Working with trauma populations and individuals who are distressed for any one of a number of factors, is difficult and exacting work. It takes a toll on the professional caregiver. Without sufficient training and education to recognize the potential risks associated with this type of clinical work, practitioners may be subjected to the negative effects of burnout, compassion fatigue, secondary trauma, and/or vicarious traumatization. By ensuring that academic and clinical training programs include self-care modules, this may contribute to a reduction in the rate of attrition among professional counselors and therapists, thus ensuring that effective clinicians are available to provide treatment for those individuals who suffer from stressful and traumatic experiences.

APPENDIX A

SURVEY INVITATION TO BOARD-CERTIFIED MUSIC THERAPISTS

Invitation to Board Certified Music Therapists:

As a Board Certified Music Therapist, you are invited to participate in the research project titled "*Practicing the Practice: Meeting the Needs of the Clinician.*" The intent of this research study is to explore ways that academic and clinical training programs in music therapy are addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempts to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care affects their work with distressed or traumatized individuals.

Your participation will entail completing a 10-question online survey/questionnaire, which should require no more than 10-12 minutes of your time. In electing to complete the survey, you will have access to the Informed Consent document, to read and agree to before beginning the survey.

The study is being conducted in partial fulfillment of the requirements for a PhD in Expressive Therapies from Lesley University, Cambridge, MA. Initial questions may be directed to me, as primary investigator, or to my committee chair, Dr. Nisha Sajnani at nsajnani@lesley.edu.

Thank you in advance for your time and willingness to participate in this study.

With appreciation,

Maureen

Maureen C. Hearns, MA, MT-BC, FAMI
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APPENDIX B

INFORMED CONSENT BOARD-CERTIFIED MUSIC THERAPIST

Research Informed Consent

Survey – Board Certified Music Therapist

As a Board Certified Music Therapist, you are invited to participate in the research project titled "*Practicing the Practice: Meeting the Needs of the Clinician."* The intent of this research study is to explore ways that academic and clinical training programs in music therapy are addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempts to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care affects their work with traumatized individuals.

Your participation will entail completing a 10-question online survey/questionnaire, which should require no more than 5 minutes of your time. The intention of this component of the study is to gather general information that will generate a sample pool of potential research participants.

In addition

- you are free to choose not to participate in the research and to discontinue your participation in the research at any time.
- all personal identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.
- any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.
- you may be contacted by the researcher to participate further in the research through a personal interview. If selected, this interview would be conducted either in-person or via Skype. You would be responding to study-specific questions, followed by an arts-based response.
- if any problem in connection to the research arises, you can contact the researcher, Maureen Hearns, at 435-770-8884 and/or by email at mhearns@lesley.edu, or Lesley University sponsoring faculty, Dr. Nisha Sajnani, at nsajnani@lesley.edu.
- the researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

My agreement to participate has been given of my own free will and that I understand all of the stated above. My election to complete the online survey is indication of my consent to participate.

*There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138, Co-Chairs Robyn Cruz (*rcruz@lesley.edu*)* or Terry Keeney (tkeeney@lesley.edu).

APPENDIX C

BOARD-CERTIFIED MUSIC THERAPISTS ONLINE QUESTIONNAIRE

ONLINE SURVEY/QUESTIONNAIRE

Board Certified Music Therapists

1) Gender
2) Ethnicity
3) Age
4) City, state, country of residency
5) Did you graduate from an Approved American Music Therapy Association Academic Music Therapy Training Program?
6) In what region of AMTA was your university/college located?
7) Are you currently a practicing music therapy clinician?
8) How many years of clinical experience do you have?
9) To which clinical population(s) do you provide music therapy services?
10) Would you consider any of your clientele to be distressed or traumatized individuals?
11) Do you have at least one-year of clinical experience with the clientele you identify as being distressed or traumatized?
12) Would you be willing to participate further in this study via a personal interview with the researcher?

APPENDIX D

INFORMED CONSENT CLINICIAN INTERVIEW

Research Informed Consent

Clinician Interview

As a Board Certified Music Therapist, you are invited to participate in the research project titled "*Practicing the Practice: Meeting the Needs of the Clinician."* The intent of this research study is to explore ways that academic and clinical training programs in music therapy are addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempts to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care affects their work with distressed or traumatized individuals.

Your participation will entail responding to a semi-structured interview consisting of ten questions, followed by an arts-based response. The entire interview experience may require 60 – 90 minutes of your time, either in-person or via Skype.

By signing below, you consent to participate in the above-named/described study. Your consent also indicates that you have been duly informed and understand that

- you are agreeing to consent to a 60-90-minute interview with the researcher, describing your work with distressed or traumatized individuals and your understanding and/or use of self-care strategies.
- the interview will be audio-recorded for later transcription.
- all audio files and resulting transcriptions will be kept confidential, securely stored, and destroyed after 10 years.
- you will be given a draft of the initial transcription to proof and edit as needed to ensure an accurate and authentic transcription.
- your identity will be protected to the fullest extent possible.
- the interview experience will also include an arts-based response in the form of a drawn mandala.
- creative art products will be kept confidential and used anonymously only for purposes of presentation and/or publication, unless you grant explicit written permission to indicate otherwise.
- you agree to allow the researcher to seek collaborative professional consultation, if she chooses to do so, respecting your arts-based response.
- the interview may bring up feelings, thoughts, memories, and physical sensations. Therefore, possible emotional reactions may be anticipated, however, you are free to end the interview at any time. In the event that you find you have any unresolved distress, you will be provided with resources and referrals to assist you.
- this study will not necessarily provide any personal benefits to you. However, you may experience increased self-knowledge and other personal insights that you may be able to use in your personal and professional life. The results of the study may also help to

increase public and professional awareness of the needs and experiences of clinicians who self-identify as working with distressed or traumatized individuals.

In addition

- you are free to choose not to participate in the research and to discontinue your participation in the research at any time.
- all personal identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.
- any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.
- if any problem in connection to the research arises, you can contact the researcher, Maureen Hearns, at 435-770-8884 and/or by email at mhearns@lesley.edu, or Lesley University sponsoring faculty, Dr. Nisha Sajnani, at nsajnani@lesley.edu.
- the researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

My agreement to participate has been given of my own free will and that I understand all of the stated above. In addition, I will receive a copy of this consent form.

_____ _____ _____ _____

Participant's signature Date Researcher's signature Date

*There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138, Co-Chairs Robyn Cruz (*rcruz@lesley.edu*)* or Terry Keeney (tkeeney@lesley.edu). 29 Everett St., Cambridge, MA 02138

APPENDIX E

SURVEY INVITATION TO ACADEMIC PROGRAM DIRECTORS

Invitation to Academic Program Directors:

As a Music Therapy Academic Program Director, you are invited to participate in the research project titled "*Practicing the Practice: Meeting the Needs of the Clinician."* The intent of this research study is to explore ways that academic and clinical training programs in music therapy are addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempts to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care affects their work with traumatized individuals.

Your participation will entail completing a 3-question online survey, which should require no more than 10 minutes of your time. In electing to complete the survey, you will have access to the Informed Consent document, to read and agree to before beginning the survey.

The study is being conducted in partial fulfillment of the requirements for a PhD in Expressive Therapies from Lesley University, Cambridge, MA. Initial questions may be directed to me, as primary investigator, or to my committee chair, Dr. Nisha Sajnani at nsajnani@lesley.edu.

Thank you in advance for your time and willingness to participate in this study.

With appreciation,

Maureen

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435-770-8884

APPENDIX F

INFORMED CONSENT ACADEMIC PROGRAM DIRECTORS

Research Informed Consent

Survey – Academic Program Director

As a Music Therapy Academic Program Director, you are invited to participate in the research project titled "*Practicing the Practice: Meeting the Needs of the Clinician."* The intent of this research study is to explore ways that academic and clinical training programs in music therapy are addressing the subject of personal growth, as it relates to the development of critical self-awareness and self-care strategies. The study further attempts to identify which self-care strategies are being used by practicing clinicians and how a practice of self-care affects their work with traumatized individuals.

Your participation will entail completing a 3-question online survey, which should require no more than 10 minutes of your time.

In addition

- you are free to choose not to participate in the research and to discontinue your participation in the research at any time.
- no personal identifying information will be collected.
- any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.
- if any problem in connection to the research arises, you can contact the researcher, Maureen Hearns, at 435-770-8884 and/or by email at mhearns@lesley.edu, or Lesley University sponsoring faculty, Dr. Nisha Sajnani, at nsajnani@lesley.edu.
- the researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

My agreement to participate has been given of my own free will and that I understand all of the stated above. My election to complete the online survey is indication of my consent to participate.

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they

*arise. Contact the Committee at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138, Co-Chairs Robyn Cruz (*rcruz@lesley.edu*)* or Terry Keeney (tkeeney@lesley.edu).

APPENDIX G

ACADEMIC PROGRAM DIRECTORS ONLINE QUESTIONNAIRE

ONLINE SURVEY/QUESTIONNAIRE

Academic Program Directors

1) Please provide a brief description of how the following AMTA Professional Competency is addressed in your curricula: "Demonstrate critical self-awareness of strengths and weaknesses." [17.8]
2) Does your current curriculum include a unit(s) on self-care?

   If yes, please provide documentation of this unit(s) from your syllabi.

APPENDIX H

SEMI-STRUCTURED INTERVIEW GUIDE

SEMI-STRUCTURED INTERVIEW GUIDE

Board Certified Music Therapists

1) Provide a description of your current clinical work with distressed or traumatized individuals.
2) Did your music therapy training program provide education around personal growth?
3) Do you feel your educational experience enabled you to develop a level of critical self-awareness?
4) How was the concept of self-awareness identified and developed in your educational program?
5) Did your music therapy training program provide education respecting self-care?
6) How was self-care addressed in your academic training? Your clinical training?
7) Did you develop a practice of routine self-care during your academic and clinical training?
8) Do you feel that regular self-care enables you to be a more effective clinician?
9) Do you currently maintain a practice of routine self-care?
10) What strategies/practice of self-care do you utilize?

<u>Arts-Based Response</u>

Reflect upon the interview questions and experience by creating a visual representation/image through the drawn mandala.

APPENDIX I

CONSENT TO USE AND/OR DISPLAY ARTWORK

CONSENT TO USE AND/OR DISPLAY ART

CONSENT BETWEEN: _Maureen C. Hearns_ and _____.

Expressive Arts Therapy Doctoral Student **Artist/Participant's Name**

I, _____, agree to allow ___Maureen C. Hearns___.

Artist/participant's name **Expressive Arts Therapy Doctoral Student**

to use and/or display and/or photograph my artwork, for the following purpose(s):

- ☐ Reproduction and/or inclusion within the research currently being completed by the expressive arts therapy doctoral student.
- ☐ Reproduction and/or presentation at a professional conference.
- ☐ Reproduction, presentation, and/or inclusion within academic assignments including but not limited to a doctoral work, currently being completed by the expressive arts therapy doctoral student.

It is my understanding that neither my name, nor any identifying information will be revealed in any presentation or display of my artwork, unless waived below.

☐ I DO ☐ I DO NOT wish to remain anonymous.

This consent to use or display my artwork may be revoked by me at any time. I also understand I'll receive a copy of this consent form for my personal records.

Signed _____Date _____

I, Maureen C. Hearns agree to the following conditions in connection with the use of artwork:

Expressive Arts Therapy Doctoral Student

I agree to keep your artwork safe, whether an original or reproduction, to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession. I agree to return your artwork immediately if you decide to withdraw your consent at any time. I agree to safeguard your confidentiality.

Signed _____ Date _____

Expressive Arts Therapy Doctoral Student

Maureen C. Hearns, MA, MT-BC, FAMI
Expressive Arts Therapy Doctoral Student, Lesley University
211 East Center Street
Hyde Park, UT 84318
mhearns@lesley.edu

The Lesley University Internal Review Board can be contacted via the Co-Chairs, Robyn Cruz (rcruz@lesley.edu) and Terry Keeney (tkeeney@lesley.edu).

APPENDIX J

MANDALA M.A.R.I. ANALYSES

MARI Interpretation of Rowena's Mandala

This softly drawn mandala has much to convey. The deep rich peach color inside the circle provides a solid container for the smaller split circle in the deepest interior of the drawing. The split circle is yellow on one side, and pink and white on the other side. The outer rim is outlined in a light black ring.

From the perspective of the MARI, this mandala reflects Stages 4, 5 and 6, the "Quadrant of Becoming." The focus in this Quadrant of the MARI is on new beginnings and dealing with one's needs, met and unmet, and may include one's dependency on others; engaging with a focus, setting boundaries for self-protection, dealing with issues around power/powerlessness; and engaging with a struggle, either within the self, or with another.

The boundaries created by the black rim and the peach color around the split circle may reflect this person's awareness that there is a need for protection. The black circle forms a protective layer between the self inside the circle and the outer world. While there are no breaks or "windows" to the outside of the circle, the black line is also not heavily drawn, which would suggest a need for more serious protection from the outer world. The peach color surrounding the split circle feels supportive and soft, yet the color here suggests there may be a sense of vulnerability and a need for more energy in engaging with setting boundaries. The colors of the inner split circle may reflect a vulnerability, feeling reactive and stressed (pink) on one side, and having positive energy to deal with the struggle one is facing with awareness on the other side (yellow).

When the inner circle is considered also as a symbol surrounded by the calming peach (body color) boundary, this could also indicate a new awareness of oneself, and an awareness of the importance of connections, including connection with one's body. And a hesitancy around a new beginning.

I reviewed the mandala prior to looking at the transcript of your discussion with her (which was very engaged and rich!), and it was fascinating to see how closely her description matched up with what I had noted, though of course with more personal content. Her title "Protect the Personhood" with her noting that this is her light, is very much reflected in that inner split circle, as she is questioning how to connect with others in this new way, and not lose her sense of personhood. (Personal communication, Erin Johnson, July 13, 2016)

MARI Interpretation of Windsor's Mandala

This drawing was created without a drawn circle to respond to, and thus is not what we normally consider a mandala. I will not be able to adequately speak to what would have been within or outside the drawn circle. My reflections therefore are to be considered in light of these differences.

The drawing overall is lightly drawn (reflecting the person feeling tentative and uncertain or wanting to convey a lightness and playfulness), and a bit haphazard. This may reflect the stage of things being diffuse (Stage 2), without a clear sense of ego boundaries, lacking in form, growth in multiple forms (positive and negative), regeneration or regression. Stage 2 can also represent bliss, imagination, creativity, potential.

This drawing could represent growth, new beginnings with the flowers (4 of these in red), green grass and 2 trees on the left side of the drawing that seem to be in bloom. Another tree is off by itself on the right, and not as clearly drawn. The trees are not rooted, which is significant, as it may relate to whether the person feels not grounded at this time. Were this drawing in the mandala form, these nature images are often related to the stage (Stage 4) associated with new beginnings, getting one's needs met, or not, and possibly one's dependence on others.

There are also 12 stick figures in the drawing. The 3 blue ones in the bottom left corner seem to be sharing something (possibly jumping rope?). Some of the other figures such as the 4 purple ones in the middle appear to be either shooting a gun, or possibly playing a musical instrument with the last one faintly drawn so it is hard to tell what that figure is doing. Purple in the MARI is associated with spirituality/divinity, dependency, mourning, woundedness, or a sense of specialness or entitlement. The 1 blue figure in the bottom center right again appears to be either be shooting another blue figure who is carrying something, or both are playing musical instruments (it is really hard to tell). Blue can represent flow, intuition, love, passivity, wisdom. And then the other 3 figures on the right appear to be in communication with one another, one is blue, the other two are orange. Orange can represent ambition, power, energy, assertion. Blue and orange close together as a color combination may represent a conflict of some sort.

Were this drawn as a mandala, the numerous human figures (in this case stick figures), would represent self and others (Stage 9), and may have some information about the person's relationship with a community, a family, a work group, a religious or spiritual group. Stage 9 represents the area in our lives related to community, and also may be about what we are manifesting in our lives, and what we have accomplished or not accomplished.
It was great to see in her interview with you that these are musical instruments the figures are carrying! There is a great deal of emphasis on community. I wonder where she would place herself in the picture. (Personal communication, Erin Johnson, July 13, 2016)

MARI Interpretation of Tulsi's Mandala

This mandala has thickly drawn bold colors, and has a prominent split circle (Stage 6), with primarily orange at the top and blue at the bottom. The title "Just Keep Swimming," is written just outside the circle on the right side. There is a small image drawn in brown (fish?) connected with the peach/coral colored spiral up in the orange part of the drawing.

Mandalas drawn with two prominent halves relate to the stage of struggle, conflict, individuation/hero's journey, sexual identity, tension of the opposites. The top half of such a drawing in the MARI represents what is more conscious for the person, the lower half, what is more unconscious. Orange and blue in close proximity and so prominently in opposition to each other may represent a conflict (within the self, or between self and others) that may be passive- aggressive in nature. However, this drawing seems more cooperative between the parts, partly due to the waves that break up a strong line between the two. Orange in this stage can represent power, assertion, energy to deal with the conflict they are experiencing. Blue at this stage can indicate a passivity to engage with a struggle, more a desire to bring meaning vs energy for the conflict (hence the passivity part of "passive-aggressive). The orange part has a strong sun like quality, while the blue is oceanic and fluid.

The spiral symbol is characteristic of Stage 3, when energy for our path is activated (or not), and we are trusting the process (or not). The peach/coral color at this stage may represent a strong sense of sexuality, of sexual differentiation. It could also relate to embodying the struggle as it is part of this prominent Stage 6 mandala. If the color were more mauve (it is hard to tell from the picture on the computer), it would relate to anxiety about change happening very quickly.

The small brown fish is the only figure in the drawing and may represent the self (Stage 8). It is tied to the spiral by a rope-like cord and may indicate that change or energy activation is coming to the inner self, or is emanating from the inner self out into the world. The fish being on a cord or line could be seen as tethered in a positive way, or tied down, with one's movement limited, and not able to swim freely. Brown can represent a negative self-image, self-esteem issues, fertility, groundedness, or racial identity (particularly if the person is not Caucasian).

In your interview, the person definitely endorsed the importance of connection with nature and balance, which seems to be what they are moving toward! (Personal communication, Erin Johnson, July 13, 2016)

MARI Interpretation of Araceli's Mandala

The most distinguishing feature of this mandala is the central figure, resembling three leaves growing close together, reaching up toward the top of the circle. The largest is medium blue with dark blue at the base; the one on the left is medium purple with black at the base; and the one on the right is primarily yellow with a little red at the base. Each of the leaves has a back dot just above the top of the leaf. The rim of the circle is heavily outlined with dark blue and gray. The inner circle also has three bands of color, light green at the top, pink in the middle, and light yellow at the bottom.

The person emphasized the boundary of the circle by drawing over the pencil line with both dark blue and gray to make a very strong boundary, between the inner circle representing the self, and the area outside the circle representing the outer world. This purposeful outlining of the circle can be suggestive of Stage 5, which relates to engaging with a focus, setting boundaries for self-protection, and dealing with issues around power/powerlessness. In this stage, the dark blue color may relate to a tendency to engage in criticism of self or others in a compulsive way, and difficulty accessing their own intuition. The gray could relate to defending against pain and guilt, feeling stuck, or feeling numb.

The inner circle also reflects Stage 5, in the three bands of color. The green at the top may reflect a sense of trying to heal, and to defend oneself. The pink may relate to anxiety, a diffuse sense of anger, feeling vulnerable, and a sense of weak defenses. The light yellow can refer in this stage to a sense of feeling trapped, listless, low energy, as well as attempting to bring awareness to the need to set boundaries. Jewel tone colors here would give the sense that the person had more energy for the work that the stage represents. The pastel colors are a tentative, or weaker level of energy or perspective.

The image of the three leaves suggests Stage 8 due to the single prominent image that may represent the Self. Stage 8 often reflects the coming into full autonomy, maturation, identity, self-esteem, career issues. Blue at Stage 8 reflects intuition, wisdom, flow, trust. Purple at Stage 8 can reflect entitlement, spirituality, or mourning. Yellow at Stage 8 may reflect one's identification as an intellectual, rational person.

The interview was interesting in the person's identifying three major parts of their career, and this drawing has several places with three parts (three leaves, three bands of color). (Personal communication, Erin Johnson, July 14, 2016)

MARI Interpretation of Jakobe's Mandala

This mandala is quite abstract, with a fair amount of white space within the circle. There are a number of lines in different colors of varying thickness. Outside the circle is a green line and a dotted brown line that forms a half circle connecting with the mandala on the right side. This shape could remind one of an ear. There is one smaller green half circle on the left side, and another at the bottom of the mandala. The only place the rim of the circle is emphasized is on the bottom left lightly drawn in brown, and then more heavily drawn in dark blue about 3/4 of the way up toward the top of the circle. There is a more prominent abstract figure drawn in red partially outlined in dark blue.

The abstract and haphazard placement of lines and the few shapes most suggests Stage 2. Some qualities of Stage 2 are a sense of things being diffuse, without a clear sense of ego boundaries, lacking in form, growth in multiple forms (positive and negative), regeneration or regression. Stage 2 can also represent bliss, imagination, creativity, potential. Many colors are present including blue, green, purple, red, yellow and brown. Most of the lines are curving vs straight, suggesting more fluidity or flow.

There is a suggestion perhaps of green grass growing on the bottom right of inside of the mandala, in an area that roughly corresponds to Stages 1, 11 and 12 of the Great Round of the MARI. Green in Stages 1 and 12 represents healing, nurturance, growth.

The person definitely got into the feel and flow of drawing and this may be a great tool for them to use as part of their self-care. For some the mandala is less about creating a particular image that reflects something more representative, than it is about the experience of drawing itself. (Personal communication, Erin Johnson, July 15, 2016)

MARI Interpretation of Mariano's Mandala

The mandala has a prominent image of a cross drawn in brown, hatch marked, in the upper middle part of the circle. It is surrounded by yellow rays. There is a loose circle of blue surrounding the cross and yellow rays. Just inside the rim of the circle, there are several lines in dark green and dark blue providing an inner boundary. This emphasis on boundaries, both around the cross and around the inner rim suggests Stage 5. Stage 5 relates to engaging with a focus, setting boundaries for self-protection, and dealing with issues around power/powerlessness. The dark blue outlining the inner rim at Stage 5 can relate to a self-criticism, and to difficulty accessing intuition. Dark green can relate to endeavoring to heal self or others by ritualistic means, and to possible religious rituals which may offer some healing. The lighter blue surrounding the cross may relate to using passivity as a defense, and difficulty accessing intuition.

This mandala has a number of symbols which may have personal meaning for him, and he may have put them in to represent things of importance to him in his daily life (for example, the cross for someone who is a Christian). For this reason, this sort of mandala can be difficult to interpret, depending on the intention of the person, in the sense that it is more consciously drawn with favorite images vs more fully accessing the person's unconscious. My reflections below are therefore made with this qualification.

There is a figure of a woman outlined in mauve, in a coral dress, with no hands or feet, drawn at approximately Stage 10. Stage 10 relates to endings, major transition, letting go, loss, time to reassess life goals, and a descent back into the unconscious in search of renewal. Mauve often conveys a sense of anxiety about what the stage represents. So possibly anxiety about an ending or a major transition. Coral at this stage relates to feeling vulnerable, and also to letting go.

There is a figure of a black dog at approximately Stage 11. Stage 11 is about fragmentation, chaos, feeling overwhelmed, old patterns breaking apart, feeling powerless. Black at this stage represents the mystery, or a giving up or giving in to pain, defense against chaos, trying to negate the sense of overwhelm.

There is a figure of a brown lamb [dog] at Stage 12. Stage 12 represents completion, rebirth, peak experience, order out of chaos, the return of the hero, the transcendent. Brown at this stage reflects letting go of negative issues and dynamics, and the fertility of ideas.

There is an image between Stage 2 and 3 that I am unsure what it is. It is mainly black, with some gray bubbles going up to a yellow brick like image. Stage 2 may reflect things being diffuse, without a clear sense of ego boundaries, lacking in form, growth in multiple forms (positive and negative), regeneration or regression. Stage 2 can also represent bliss, imagination, creativity, potential. Stage 3 is about activation of energy for one's path.

At the area of Stage 4, there is an image of a green fish [leaf, blowing in the wind] Stage 4 is associated with new beginnings, getting one's needs met, or not, and possibly one's dependence on others. Green at Stage 4 can be about self-nurturing, trying to heal oneself, or feeling vulnerable and wanting to slow down a growth process.

The cross in the middle is representative of Stage 7, and is in fact one of the symbols for the stage. This stage is about balance, being expansive and integrative, full consciousness, feeling on top of the world, ready for relationship with a significant other. Brown at Stage 7 could indicate receptivity, trying to adjust to the world, low self-esteem, or grounded. Given the rays of light emanating from the cross, it makes sense that the interpretation would be more positive. Of course the cross often relates to the person's religious affiliation. (Personal communication, Erin Johnson, July 15, 2016)

MARI Interpretation of Chandra's Mandala

This mandala has two concentric circles in the center surrounding a yellow circle with a black center, and spiraling yellow lines around the yellow circle. The outer concentric circle is brown and black, the inner one is light brown. There is a medium blue spiral surrounding the concentric circles, that gradually becomes a light green line. There are 3 mauve colored short wavy lines within the blue spiral.

The presence of the concentric circles suggests Stage 5, this stage represents engaging with a focus, setting boundaries for self-protection, dealing with issues around power/powerlessness. Brown at Stage 5 can represent a sense of being disempowered, having low energy, or trying to create stability in their world. Black can represent mystery, negation or powerlessness.

The black at the center of the yellow circle may also represent negation or powerlessness, though due to its location at the center of the entire mandala, it can also relate to the mystery. The yellow surrounding it may relate to using rationalization as a defense, or attempting to bring awareness to one's focus or what they need to set boundaries around.

The spiral is representative of Stage 3, this stage can represent the activation of energy for the path we are taking, the beginning of discernment, energy moving inward and outward. The color reflects what may be getting activated in the person's life, and blue would reflect intuition, fluidity, trusting the process, yet also possibly wanting to slow the process of change. The light green would also reflect the desire to slow the process of change, as well as possibly control one's inner process. The wavy mauve lines could indicate some anxiety in this process, anxiety at about this activation of change and energy at this stage is quite common.

The interview was interesting in her focus on boundaries, as well as her spirituality, and this is reflected in the yellow in the center, and the black being a place of stillness or rest with energy going outward. (Personal communication, Erin Johnson, July 17, 2016)

MARI Interpretation of Maude's Mandala

This mandala has a prominent diagonal split, with both sides separated by a thick line resembling a wall, containing medium blue, dark blue, dark green, mauve and purple. The diagonal roughly runs from the area of Stage 3 (activation of energy) on the Great Round to stage 8 (maturation, career), making the left half smaller than the right. On the left half, there are small black lines coming out of the thick line, and wavy green lines going out as well. There are also 3 coral color triangles, and 7 smaller red violet triangles pointing down toward the thick line. It gives the impression that the triangles are coming in toward the thick diagonal line. On the right side of the diagonal line, there is a drawing of a house outlined in brown, three stick figures, one a male, the other a female, and the third a much smaller child size female, all are smiling. They are surrounded by a yellow hatched lines with a pink squiggly line going through the yellow lines. Outside the squiggly lines but still inside the yellow lines there is a small oval ochre image. There is also a medium blue line that starts at the left hand side of the diagonal line and goes around the rim on the right side, forming an inner circle that separates the left hand side even more.

Due to the prominent diagonal line that cuts the mandala in half, this is most representative of Stage 6. Stage 6 reflects struggle, conflict, both within the self and with others, sexual identity, and individuation. Interestingly the happy family on the left is effectively cut off or protected by the thick diagonal line from the strong energy coming in from the left.

The triangles and lines could be going either outward or inward from the diagonal line. Typically, we look at where the triangles are pointing, which is downward toward the diagonal line. The colors of the 3 larger triangles are coral, which could represent sexual arousal, or not being able to manifest the Oedipal struggle responsibly, or more positively could mean embodying the struggle. Red-violet color of the smaller triangles can reflect trying to resolve the struggle, but feeling bruised or wounded. Sometimes this could feel like self-sacrifice. The green wavy lines could reflect looking for ways to neutralize the struggle, while black relates to negating the struggle. So there is potential for conflict about how one is dealing with a struggle!

The three stick figures and house give the sense that they are part of a family, so Stage 9 may be reflected here, the stage of self and others, family, group affiliation, community. The black color chosen to outline the family could relate to a negative relationship with family, or a defensive posture. Or since they are all smiling, it could be a color that stood out well against the background. The brown color for the house could refer to feeling disillusionment, but also someone interested in sustainability, the land, and ecology. The ochre color for the oval image can refer to achievement that may feel heavy or tainted.

The yellow hatch lines around the family and house provide a circle containing them, and so suggests Stage 5, setting boundaries, focus, issues of power vs powerlessness. Yellow

can relate to using intellectualization as a defense, as well as attempting to bring awareness to one's focus or what one needs to set boundaries around. The pink squiggly line could reflect anxiety, vulnerability and a weak defense. The blue circle surrounding the whole right side could relate to using passivity as a defense, or having difficulty accessing intuition.

The diagonal line with its many colors is quite textured, and could convey the multitude of emotions, perspectives and energy the person is trying to use to keep these two parts separate, to protect the family.

In the interview it was fascinating to hear her affirm that she is focused on both doing the work and trying to lessen its negative impact on her herself and her family. (Personal communication, Erin Johnson, July 17, 2016)

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