Exploring the Effects of Music Therapists Working with Survivors of Sexual Trauma

by

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EXPLORING THE EFFECTS OF MUSIC THERAPISTS WORKING WITH SURVIVORS OF SEXUAL TRAUMA

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Abstract

The purpose of this study is to gain a greater understanding of the experiences of music therapists working with survivors of sexual trauma, and the potential secondary traumatic stress (STS), vicarious trauma (VT), burnout, and/or vicarious resilience (VR) that may arise. Three board-certified music therapists (MT-BC) currently working with survivors of sexual trauma were interviewed to gain an understanding of clinicians' experiences working with this population, and if/how explored phenomena are experienced within their work. Interviews were coded using In Vivo Coding and Interpretative Phenomenological Analysis. Implications of the results for clinical practice and future direction of music therapy research are discussed.

Keywords: music therapy, sexual trauma, secondary traumatic stress, vicarious trauma, burnout, vicarious resilience.

Exploring the Effects of Music Therapists Working with Survivors of Sexual Trauma

There is a significant amount of existing literature regarding professionals' experiences working with survivors of sexual trauma and the subsequent secondary traumatic stress (STS), vicarious trauma (VT), burnout and/or vicarious resilience (VR) that arises. However, there is limited research regarding these issues in music therapy. Not only is there limited research specifically regarding the experiences of music therapists working with survivors of sexual trauma, but there is also limited research regarding the experiences of music therapists working with survivors of trauma in general, and their subsequent STS, VT, and/or VR on a broader scale.

Based on the literature regarding the experiences of health care professionals in other disciplines, and music therapists' risk for burnout in trauma therapy, it is highly possible that music therapists working with survivors of sexual trauma experience STS, VT, and/or VR in their work. The purpose of this study is to gain a greater understanding of the experiences of music therapists who have worked with survivors of sexual trauma, and the impact of STS, VT, burnout, and/or VR on these professionals.

Literature Review

Symptoms Resulting from Sexual Assault and Trauma

Sexual assault can manifest in a variety of unwanted actions and behaviors. Koss et al. (1987) classified sexual assault through a variety of sexual acts including rape, attempted rape, intercourse obtained through purposeful intoxication, unwanted sexual contact through fondling, kissing, and grabbing, and misinterpretation of the desire for sexual contact. In many cases,

individuals who report sexual assault also report related trauma symptoms (Crowell & Burgess, 1996; Hanson et al. 1995; Koss et al., 1994; Ullman et al., 2007).

Trauma symptoms and responses to sexual assault can manifest in various ways. Responses to trauma may involve intense feelings of anxiety, helplessness, and fear; re-experiencing sensations related to the traumatic event through flashbacks, nightmares, and distressing recollections; and a heightened state of arousal and avoidance of situations related to the trauma (American Psychiatric Association [APA], 2013.) Trauma symptoms may manifest in an inability to experience joy, a belief that the world is unsafe, distrust in others, social detachment/withdrawal, isolation/avoidance, and a pessimistic attitude (APA, 2013). Common responses to traumatic events often include negative emotions such as guilt, shame, sadness, and indignation (Brewin et al., 2000).

Breslau et al. (1998) stated that sexual assault leads to some of the highest rates of post-traumatic stress disorder (PTSD) among civilian traumas. In a longitudinal research study conducted by Rothbaum et al. (1992), 95 sexual assault victims were examined and assessed for PTSD and related psychopathology immediately after their assaults. Their study showed that 94% of victims experienced trauma symptoms within two weeks post-assault, and 47% of victims experienced trauma symptoms within three months post-assault. Similarly, a study with a representative sample of sexual assault victims showed that more than half of the women who had ranked sexual assault as their worst traumatic event had experienced symptoms of trauma and PTSD during their lifetime. Results from this study suggested that rape may be more likely to result in PTSD than other traumatic events due to its specific traumatic characteristic: perceived life threat (Frazier et al., 1997).

Treatment for Sexual Assault

There is a wide variety of mental health and medical professionals who provide services for survivors of sexual trauma. Supportive counseling is thought to be one of the most beneficial treatments for victims of sexual trauma (Artime & Buchholz, 2016). Evidence-based treatments such as trauma-focused cognitive behavioral approaches, Cognitive Processing Therapy, and Eye Movement Desensitization and Reprocessing Therapy (EMDR) are additionally effective in treating survivors of sexual trauma. Support group work is a popular and advantageous form of therapy for those with psychosocial difficulties; groups specifically for survivors of sexual trauma are often offered at rape crisis centers. Other forms of treatment may include family therapy, creative arts therapy, hypnotherapy, and pharmacological treatment (Russell & Davis, 2007).

Persons who work with survivors of sexual trauma come from a variety of disciplines including but not limited to trauma therapists, crisis workers, rape victim advocates (women who assist rape victims in obtaining medical, criminal justice, and mental health services), nurses, criminal justice personnel, physicians, and educators (Canfield, 2005; Martsolf et al., 2010).

Many professionals who work with survivors of trauma face personal and professional challenges in response to their work. Offering support and assistance to those coping with emotional pain, crisis, or instability can take a significant toll on the emotional energy and coping resources of professionals providing care (Kadambi & Ennis, 2004). Reports provided by professionals working with survivors of trauma have suggested that clients' descriptions of their experiences of traumatic events can lead to profound changes in the way professionals perceive themselves, the world around them, and how they view and interact with their environments

(Black & Weinreich, 2000). Researchers investigating the effect that this work has on professionals have suggested that professionals may experience symptoms similar to PTSD symptoms exhibited by trauma survivors (Brady et al., 1999).

Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is a term used to describe the "natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first's traumatic experiences" (Figley & Kleber, 1995, p. 75). STS is a direct result of hearing emotionally shocking information from survivors (Canfield, 2005). Because STS symptoms are considered to be a normal response to engagement with traumatic information, many professionals experience STS, and may experience it for extended periods of time. Symptoms of STS are nearly identical to symptoms of PTSD, including symptoms of avoidance, arousal, and intrusion; the primary difference is that the victim of trauma may develop PTSD whereas the individual hearing the traumatic content may develop STS disorder (Jenkins & Baird, 2002).

Beckerman and Wozniak (2018) explored the range of experiences of STS and other related psychosocial consequences of 11 domestic violence workers. Interview questions focused on the participants' emotional experiences of working in a domestic violence shelter, particularly regarding psychological, cognitive, physical, and spiritual well-being. After analyzing data, four themes emerged: hypervigilance/fear of harm; impact on personal life; shift in worldview; and methods of coping. Trends amongst these four themes indicated a variety of symptoms on the continuum of STS, similar to those of PTSD.

Additionally, Ivicic and Motta (2017) evaluated the combined impact of personal trauma history, experience, exposure, and supervision on the development of STS in mental health professionals in the fields of psychology, social work, counseling, and creative arts therapy. Results revealed that between 23-27% of participants experienced STS in their work. A significant relationship was found between personal trauma history and symptoms of STS, suggesting a link between exposure to patient trauma and STS.

Lee, Gottfried, and Bride (2018) conducted a study to document the prevalence of STS in a national sample of clinical social workers. The researchers investigated the relationships between exposure to client trauma, STS, and the perceived physical and mental health of clinical social workers. Results revealed that clinical social workers frequently experienced intrusion, arousal, and avoidance symptoms. Further analysis revealed that the exposure to client trauma indirectly influenced the perceived physical and mental health of clinical social workers through STS.

Vicarious Trauma

Repeated exposure to trauma and experience with STS can lead to vicarious trauma (VT) (Canfield, 2005). VT is the process by which the inner experience of a professional is "profoundly and permanently changed through an empathic bonding with the client's traumatic experiences" (Kadambi & Ennis, 2004, p. 3). The construct of VT encompasses changes in the experience of self, others, and the world. While empathic engagement is necessary for psychotherapeutic intervention, it may also make healthcare professionals vulnerable to the detrimental effects of trauma. VT signifies notable changes in the psychological workings of professionals (Canfield, 2005).

Steed and Downing (1998) investigated VT effects experienced by 12 female therapists who worked with sexual assault survivors. Therapists' responses to hearing traumatic client material predominantly included anger, pain, frustration, sadness, shock, horror, and distress. Negative effects outside the therapeutic session were reported. Physiological effects included diminished energy levels, somatic complaints, and sleep disturbances. Eight respondents reported increased vigilance regarding their own safety and the safety of others. The participants of this study stressed the need for education and training in both management of sexual assault clients and the effects of VT.

Similarly, Wasco and Campbell (2002) explored the emotional reactions of rape victim advocates. Eight rape victim advocates were interviewed in order to understand emotional responses to repeated exposure to rape experiences. Semi-structured interviews focused on the description of the respondent's career, advocacy program, organization, and community; emotional reactions to their work; self-care routines; and factors influencing their continued involvement in this type of work. The findings identified contexts associated with instances of anger and fear described by rape victim advocates. These findings suggested that intense emotional reactions, often conceptualized within a VT framework, may serve as resources for those working with rape survivors.

Burnout

Burnout is a psychological syndrome that develops in response to interpersonal job stressors (Maslach et al., 2001). It relates to severe job-related stress that results in symptoms including emotional fatigue, cynicism (which may be directed towards clients, colleagues, and/or the work itself), and a decreased sense of self-efficacy (Awa et al., 2010; Stalker et al., 2007). A

variety of factors can lead to burnout, including work setting/population, years of experience, personality traits, and specific work factors (Gooding, 2019). Burnout has three main dimensions: overwhelming exhaustion, sense of ineffectiveness, and detachment from the job. Burnout can impact job performance, and negatively impact colleagues, causing greater personal conflict and interruption of job tasks. Additionally, burnout can impact an individual's quality of life through complications with physical health, anxiety, depression, and loss of self-esteem (Maslach et al., 2001).

Burnout tends to be more prevalent in younger trauma clinicians than in those over the age of 30 (Devilly et al, 2009). For clinicians, perceived social support has been found to be a significant predictor of burnout; for therapists, caseload satisfaction, job stress, and support of colleagues have been linked to burnout.

Munnangi et al. (2018) explored levels of burnout, stress, and job satisfaction in nurses caring for trauma patients at a trauma center. Findings revealed that significant relationships exist among perceived stress, burnout, and job satisfaction. The overwhelming and chaotic nature of the work environment significantly impacts burnout, job satisfaction, and perceived stress experienced by trauma nurses in a safety-net hospital. Munnangi et al. (2018) suggested that nursing administration should make a greater effort to understand the levels of burnout, and aim to improve work environments for trauma nurses in order to minimize stressors leading to burnout.

Vicarious Resilience

Working with survivors of sexual trauma also has the potential to positively affect professionals in unique ways. Vicarious resilience (VR) refers to the positive impact on/growth

of professionals resulting from exposure to clients' resilience (Hernández et al., 2007). When working with victims of trauma, professionals are often confronted with stories of hopelessness and powerlessness as well as resiliency and resourcefulness. Hernández et al. (2007) stated "understanding VR as a process equally as significant as VT underscores the complexity of trauma work and adds a valuable resource for empowerment and survival" (p. 239). VT and VR often co-occur naturally; VR is an effective means to counteract the greatly fatiguing nature of both VT and STS. The concept of VR may also benefit survivors of sexual trauma. Because many survivors are concerned about the negative effects of their trauma on their therapists, introducing the concept of VR can be deeply advantageous for their clinical processes (Hernández et al., 2007).

Michalchuk and Martin (2018) employed an interpretive phenomenological analysis to investigate and explore the lived experiences of VR and growth in six psychologists experienced in working with survivors of trauma. Results indicated that psychologists maintained VR by experiencing a shared journey with their clients, cultivating personal growth and purpose, and extracting positive meaning. The findings further described the psychologists' abilities to foster positive outcomes, both for themselves and their clients, through emphasizing and focusing on growth, resilience, and potential satisfaction.

Similarly, Edelkott et al. (2016) aimed to systematically examine the elements of VR within a sample of torture treatment clinicians. Thirteen torture treatment clinicians were interviewed to better understand the nature and variations of VR. Analysis of the interviews focused on the clinicians' perceptions of clients' resilience, and the clinicians' awareness of how these perceptions affected themselves. Four themes emerged: change in the clinicians'

self-perception/outlook on the world, altered thoughts about self-care, altered spirituality, and evolved views on trauma work. Results of the study suggested that VR can significantly, and positively, impact clinicians' personal lives in addition to their therapeutic work.

STS, VT, burnout, and/or VR can be experienced by sexual trauma clinicians in a variety of disciplines. Professionals working with survivors of sexual trauma may include creative arts therapists, such as dance therapists, drama therapists, art therapists, and music therapists (Ivicic & Motta, 2017). For purposes of this study, the treatment of sexual trauma symptoms will be explored within a music therapy context.

Music Therapy

The American Music Therapy Association (AMTA) defines music therapy as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (AMTA, 2019). Music therapy can accommodate a wide range of settings and populations, including but not limited to schools, rehabilitation facilities, medical and psychiatric hospitals, nursing homes, and hospice programs. Bruscia (2014) described four main methods of music therapy: improvisation, composition, re-creation, and receptive. All music therapy interventions, both active and receptive, fall under one or more of these four main methods.

The AMTA (2019) describes the professional requirements for practicing music therapists:

> A professional music therapist holds a bachelor's degree or higher in music therapy from one of over 70 [AMTA] approved college and university programs. The curriculum for the bachelor's degree is designed to impart entry level competencies in three main areas:

> musical foundations, clinical foundations, and music therapy foundations and principles as specified in the AMTA Professional Competencies. In addition to the academic coursework, the bachelor's degree requires 1200 hours of clinical training, including a supervised internship (Professional requirements for music therapists, para. 1).

Additionally, upon completion of the bachelor's degree, music therapists are eligible to sit for a national board certification exam to obtain the credential MT-BC, Music Therapist - Board Certified (AMTA, 2019). The credential MT-BC is granted by a separate organization, the Certification Board for Music Therapists (CBMT), to identify music therapists who have demonstrated the necessary skills, abilities, and knowledge to practice at the professional level (AMTA, 2019).

Music therapists often practice with one or more guiding theoretical orientations or approaches including, but not limited to humanistic, psychodynamic, holistic, cognitive behavioral, biomedical, and biopsychosocial (Bruscia, 2014). When working with trauma, music therapists may practice within the psychodynamic model of music therapy. This model aims to bring repressed, unconscious material into a state of awareness through the medium of music (DeBacker, 2004). Music is a medium that lies closely to where trauma and repressed thoughts reside, and is often able to reach deep, unconscious, archetypal material (Jung, 1981).

Music therapists working with survivors of trauma may additionally work within a neurobiological and/or neuropsychological approach. Behrens (2019) explained that implications from neuroscience research align with goals that focus on positive psychosocial neural changes, and music-based goals that validate the positive impact of music on the brain.

Music Therapy and Trauma

Music therapists serve survivors of various types of traumas, including sexual trauma. When working with survivors of trauma, it is critical for clinicians to have an understanding of the neurobiology of both trauma and music. MacFarlane (2019) stated "physiological responses to trauma are stored in a person's non-verbal memory and can be triggered by seemingly unrelated events as well as sensory or physiological tags related to the original traumatic event" (p. 24). When trauma-related physiological responses occur, the nervous system responds as if the traumatic experience is happening in the present moment; the brain is subsequently limited to function as if it is in survival mode (van der Kolk, 2014). Because music enters at a basic level of the brain, and does not require high cognitive awareness to impact the brain and body, rhythmic entrainment is considered to be an involuntary response which can be applied in a therapeutic manner to address trauma-related physiological responses (MacFarlane, 2019).

Music and music therapy have been identified as effective tools in addressing physiological symptoms of acute stress and trauma (Levitin, 2013). By incorporating the use of body-centered techniques in music therapy practice, music therapists can "deepen and expand treatment across multi-dimensional layers and levels of process to enhance trauma renegotiation in a safe and non-threatening way" (Stewart, 2019, p. 33).

When working with survivors of sexual trauma, it is critical for music therapists to create predictable, stable, and safe environments to meet their client's needs, and provide music experiences to stabilize, motivate, and support their clients (Keller et al., 2018). Music experiences within this population often work toward goals related to emotional regulation, self-efficacy, stabilization, and self-reflection/expression (Strehlow, 2019).

Music experiences provide opportunities for music therapists to support and regulate their clients' unbearable traumatic experiences. Strehlow (2019) stated "the therapist's task is to find a way to support [the client] throughout carefully planned music interactions and use words so that [the client] can overcome the traumatic feelings" (p. 71). Music experiences can be used as a tool to ground clients and provide opportunities for self-disclosure, can serve as a reminder to clients that they are in a safe place, can reduce isolation and feelings of detachment, and can elicit feelings of relief, satisfaction, and empowerment (Sorensen, 2015). Neurologically, music can be used to stimulate the parts of the brain that are negatively impacted by trauma to prompt neurogenesis and neuroplasticity; through these processes, the brain can begin its healing towards healthy functioning (Sorensen, 2015).

Music therapy can also be used to support clients' trauma indirectly, an approach to practice that aligns with trauma-informed care. Felittiet al. (1998) stated, "Trauma-informed care is a universal practice whereby health care settings and providers treat all patients in a compassionate and supportive way that assumes patients have experienced trauma" (p. 246). Professionals who work within this approach often aim to avert persistent traumatic stress responses in their clients during treatment. According to Bruce et al. (2018), "At a minimum, trauma-informed approaches endeavor to do no harm, that is, reducing potentially traumatic aspects of treatment and the delivery of care to avoid re-traumatizing patients" (p. 132). The trauma-informed approach additionally assumes survivors of sexual trauma want professionals to be sensitive about how challenging it can be to disclose intimate details to anyone, and want information, resources, and support regardless of disclosure (Markoff et al., 2005). The focus of

treatment within this approach may be on providing coping tools and reinforcing resiliency rather than on the specifics of the traumatic content itself.

Risk of Burnout in Music Therapists

Due to the intense, emotional nature of trauma, music therapists working with survivors of trauma are particularly at risk of burnout. Research on burnout among music therapists suggests that the burnout experiences of music therapists are congruent with that of other healthcare providers (Ferrer, 2017). When compared to the findings of a systematic review of burnout in mental health/trauma counselors, music therapists are at a slightly higher risk for burnout, particularly in terms of emotional exhaustion (Gooding, 2019). Research shows that those who experience less burnout and higher job satisfaction are more likely to stay within their field (Decuir & Vega, 2010).

Secondary Traumatic Stress, Vicarious Trauma and/or Resilience in Music Therapists

While there is a great deal of literature regarding professionals' experiences working with survivors of sexual trauma, and their subsequent STS, VT, and/or VR, there is limited research regarding these issues in music therapy. Not only is there limited research specifically regarding the experiences of music therapists working with survivors of sexual trauma, but there is also limited research regarding the experiences of music therapists working with survivors of trauma, and their subsequent STS, VT, and/or VR on a broader scale. Based on the literature regarding the experiences of health care professionals in other disciplines, and music therapists' risk for burnout in trauma therapy, it is highly possible that music therapists working with survivors of sexual trauma experience STS, VT, burnout, and/or VR in their work.

Purpose of the Study

The purpose of this study is to gain a greater understanding of the experiences of music therapists who have worked with survivors of sexual trauma, and the potential STS, VT, burnout, and/or VR that may arise. The following research question and sub-questions are addressed: Do music therapists working with survivors of sexual trauma experience STS, VT, burnout, and/or VR? If so, what is the nature of these phenomena? How do music therapists cope with the experienced phenomena?

Method

Epoché

While trauma encompasses a range of experiences, I chose to specifically focus on sexual trauma due to the recognition recently given to a previously suppressed group of survivors. While sexual trauma is far from a new occurrence, the #MeToo movement, a viral movement against sexual harassment/assault in 2017, brought light to just how many individuals have experienced sexual trauma within their lifetimes. As case after case of sexual trauma was revealed during this powerful movement, I began to wonder in what ways the victims were receiving support. More specifically, I wondered if music therapy had a role in the treatment/healing of sexual trauma. While I was initially intrigued by the survivor's experience in music therapy, I soon realized that accessing/communicating with a group of people regarding their traumatic experiences was neither feasible nor appropriate for a novice researcher. Knowing I still wanted to learn more about the relationship between sexual trauma treatment and music therapy, I decided to explore the therapist's experience in music therapy. I was particularly intrigued by the therapist's personal/emotional reactions to working with such a vulnerable group

of people. Based on literature I read regarding sexual trauma treatment in other disciplines, I wondered if/how music therapists working with survivors of sexual trauma experienced STS, VT, burnout, and/or VR within their work.

Participants and Recruitment

Three board-certified music therapists participated in this study by responding to six interview questions over the phone, via web conference, and via email. A full email list of board-certified music therapists was received from the Certification Board for Music Therapists (2019). All participants have worked with survivors of sexual trauma for at least three years, either currently or within the past five years. Participants self-selected based on the following criteria: populational experience, number of years in practice, and expertise in working with survivors of sexual trauma. Participants had to be 18 years old or older to participate in this study.

Participants' backgrounds of experience with populations differed, including music therapy with a range of ages and diagnoses in a variety of settings. Client ages ranged from children, adolescents, young/middle aged adults, to older adults. Multiple populational experience included children and non-offending family members at an outpatient children's advocacy center; adults on an acute mental health, addiction, and crisis management unit; and individuals with developmental disabilities who have survived trauma and abuse. Populational experience can be found in Appendix A. Despite differences in populations and settings, all participants currently work with survivors of sexual trauma.

An invitation letter (Appendix B), informed consent form with consent to audio recording and transcription (Appendix C), proposed interview questions (Appendix D), and definitions of

specific phenomena (Appendix E) were emailed to individuals who expressed interest to describe the purpose of study, steps involved, approximate interview length, and potential risks and benefits of participation. Three music therapists self selected for participation, self-reported eligibility, and technologically signed the informed consent form, agreeing to participate in this study. In the following sections, participants are labeled from 1-3 for confidentiality purposes. Demographic characteristics of participants are provided below (Table 1). All aspects of this research study have been reviewed and approved by the SUNY New Paltz Human Research Ethics Board.

Table 1

Demographic Characteristics of Participants

Participant	Gender	Population Served	Years of Experience
1	Female	Outpatient children's advocacy center: children and non-offending family members	19
2	Female	Acute mental health/addiction/crisis management unit: adults	20
3	Male	Adults with developmental disabilities; adults: group and individual sessions separated by gender	12

Design

In order to further explore music therapists' experiences working with survivors of sexual trauma, conducting interpretivist research was the most effective approach. At its core, interpretivism is a way for humans to construct knowledge and reality as they interpret their experiences in the world (Denzin & Lincoln, 2011). Interpretivist research focuses on gaining

deeper understanding and making meaning from what is uncovered through the research. According to Denzin and Lincoln (2011), "Qualitative research involves an interpretive, naturalistic approach to the world … qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (p. 3).

Through a phenomenological perspective, the world only has meaning that is ascribed to it by humans through their lived experiences. A key component of phenomenology is intentionality, referring to the intentional focus an individual experiences toward a particular phenomenon (Hiller, 2016). In the case of exploring music therapists' experiences of working with survivors of sexual trauma, a phenomenological perspective best allowed me to better understand the phenomena of STS, VT, burnout and/or VR.

Data Collection

This research is a qualitative, phenomenological, semi-structured interview study in which six open-ended questions were asked to capture the essence of working with survivors of sexual trauma (Appendix D). After obtaining informed consent, I conducted telephone and web conference phenomenological interviews, with follow-up email correspondence, to elicit views, opinions, and recalls of lived experiences from participants, and better understand if/how STS, VT, burnout, and/or VR is experienced within their work. Creswell (2014) lists advantages of this type of data collection, including the opportunities for participants to provide historical information, and the opportunity for the researcher to control the line of questioning. Similarly, Jackson (2016) stated, "Live, open-ended interviews are the preferred source of data because questions can be tailored to focus on the phenomenon under investigation and can be shaped in

the moment by the interviewer" (p. 446). Through phenomenological interviews, the researcher is best able to learn about participants' lived experiences while specifically focusing on the phenomena associated with their work. Semi-structured interviews were not time-limited.

Data Analysis

Interviews were audio-recorded using the *Voice Recorder* iPad app. I extracted themes through an In Vivo Coding process, using the participants' own language, utilizing interpretative phenomenological analysis (IPA). This approach to qualitative research focuses on the experience of specific phenomena. Themes were distilled through In Vivo Coding and used as evidence to identify potential STS, VT, burnout, and/or VR experienced by music therapists working with survivors of sexual trauma.

The data collection involved several steps of analyzing data specific to phenomenological inquiry (Jackson, 2016). Throughout the data collection procedure, I consulted with my research advisor to ensure fidelity to the research process. The data was analyzed in the following steps:

1) After completing each interview transcription, I invited participants to review their individual transcript for accuracy, and possibly clarify any responses provided during the interview. In doing this, I asked participants to confirm that the information they provided in the interview is accurately represented.
2) After transcribing each recorded interview, I read transcriptions for a general understanding of the participant's experiences, language, and views.
3) I re-read transcriptions, beginning to identify specific words/phrases, through In Vivo Coding, which revealed similarities between multiple participants.

4) I then analyzed these specific words/phrases to better understand their meanings and their relevance to the research question.
5) I condensed these meanings into five categorizations: STS, VT, Burnout, VR, and Methods of Coping.
6) I then developed specific themes within each category through re-examining specific words/phrases.
7) While reviewing all material, I noted similar responses and recurring statements across participants using different colored ink to represent different themes.

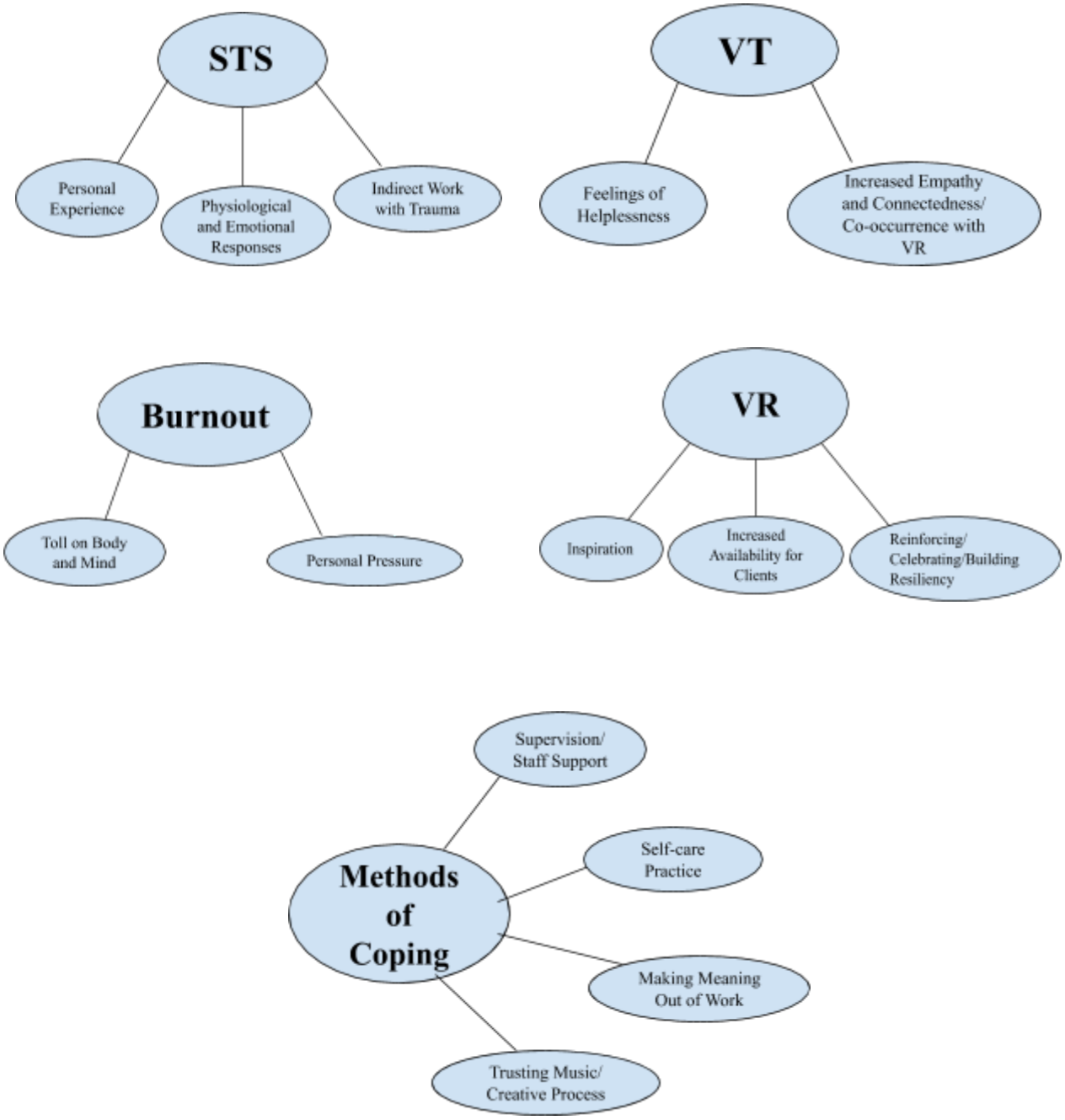
After highlighting similar quotes with colors, I categorized 14 specific themes into five broad categories (Appendix F). Utilizing IPA, and focusing on direct quotes of narrative experiences, connections were made between participants' responses and categorized into results of the research question.

Results

Results revealed five categories with 14 themes which address the research question and sub-questions: Do music therapists working with survivors of sexual trauma experience STS, VT, burnout, and/or VR? If so, what is the nature of these experiences? How do music therapists cope with the experienced phenomena? The 14 themes relate to the nature of the explored phenomena and the various methods of coping. Each general category includes two to four specific themes which explore the presence/nature of certain phenomena experienced by music therapists working with survivors of sexual trauma, and the methods of coping that are applied (Table 2).

Table 2

Categories & Themes



Secondary Traumatic Stress

When exploring the possibility of STS, three primary factors arose amongst participants: personal experience, physiological and emotional responses, and indirect work with trauma. While the first two factors support the belief that music therapists working with survivors of sexual trauma experience STS, the third factor considers the level of direct involvement with traumatic material as a key contributor to whether or not STS is experienced. Each factor contributes to the reasoning behind when STS is and is not experienced, and the ways in which STS manifests when it is.

Personal Experience

For two participants, the experience of STS partially resulted from their own personal feelings during the day/time of working with clients, and/or their own personal experience with sexual trauma. The effect of current, personal feelings/moods, and/or previous history of sexual trauma was noted in relation to experienced STS (Table 3).

Table 3

Quotations Illustrating Personal Experience

Participant	Supporting Quotations
Participant 1	I think also when I experience [STS], it also kind of depends on how I'm doing personally.
Participant 2	I guess I do a little bit, just in the fact that I have my own mental health issues. I was sexually molested as a child, and I have now been in recovery of my own body image, eating disorder, binge eating disorder, for 10 years. So, certainly, you know if a patient is sexually hitting on me, sometimes my perception is skewed at times.

Participant 1 noted that experienced STS can depend on personal factors, either internal thoughts/feelings and/or external experiences outside of the therapy. These personal factors may

contribute to the ways in which a client's traumatic experience is received and processed by the professional. Participant 2 explained that experienced STS is influenced by their own history with sexual trauma and mental health issues. Participant 2 noted that their perception of a client's response to sexual trauma can become skewed due to their own mental health history and traumatic experience.

Physiological and Emotional Responses

The second theme regards a professional's physiological and/or emotional responses to hearing a client's traumatic experience. For Participant 1, this manifestation of physiological and/or emotional responses during experienced STS was described:

> I think I experience it more… like I might feel a little bit of anxiety while listening to them talk about it in that immediate moment, just kind of like somatic symptoms. Somatic symptoms for me can include fatigue, muscle tension, anxiety like shortness of breath or feeling like my heart beat is going faster… it could also be an increased or decreased sense of hunger. Then, other times I would say that I experience a really deep sadness and sometimes I feel like I want to cry while the client is talking about things or expressing some things.

Both physiological and emotional responses are described by Participant 1 when reflecting on experienced STS. Participant 1 described the feelings of anxiety, somatic symptoms such as fatigue, shortness or breath, muscle tension, increased heart rate, and affected appetite, and deep sadness that often arise when hearing a client recall their sexual trauma. However, all three participants noted that music therapy is typically used to support their clients' trauma indirectly, taking the focus off of the specific traumatic material.

Indirect Work with Trauma

While two participants noted that the specifics of a client's sexual trauma can come up at times during music therapy, all three participants made clear that the focus of treatment was not on the specifics of traumatic material. Because the clients of all three participants do not typically share the details of their sexual trauma, STS is experienced on a less frequent scale. Each participant noted their indirect work with trauma (Table 4).

Table 4

Quotations Illustrating Indirect Work with Trauma

Participant	Supporting Quotations
Participant 1	I'm not sitting there and telling them to tell me their story. That's really not what we do.
Participant 2	I often won't ask for details of the sexual trauma - I just ask if they had any experiences with it in their past. Usually it's just a yes or no question. Since I work on an acute unit, we're just focused on crisis stabilization. I'd prefer they don't get into details of their sexual trauma, if they do - I often divert the focus on how it affects them today and what we can do to work through the PTSD, or whatever is going on for them. I may recommend that seek out a trauma specialist therapist or support group for survivors of rape, incest, molestation. So - I feel, with this line of questioning and divert details of their trauma, [STS] doesn't impact me personally. Maybe I'm just numb to it - but I also don't want them reliving the trauma while on the unit and feel it's best they handle that with a trained outpatient counselor. I approach every patient now pretty much knowing that they've had some trauma in their life, whether they admit that to me or not… which is fine, I'm not going to be their outpatient counselor or anything like that, but just to have a better understanding of where they're coming at and where their symptoms might be stemming from.
Participant 3	I think the focus of the music therapy that I do with these groups… it doesn't focus on their abuse so much. We talk a lot about safety, boundaries, things like that, but we don't talk about the specifics of their abuse. The therapist that works with them for the hour before I come in does.

Participant 1 noted that through a trauma-informed approach, clients are not specifically asked to share the intimate details of their trauma. As demonstrated in Table 2 and Table 3, Participant 1 has only experienced STS during moments when clients have willingly shared specific details about traumatic material; methods of coping with experienced STS are described in a later section. Similarly, Participant 2 explained that they prefer not to ask clients about the specifics of their sexual trauma for their own safety and well-being, but rather assume that all of their clients have experienced trauma; this approach to working with traumatic content aligns with the practice of trauma-informed care (Felitti et al., 1998). However, as shown in Table 2, Participant 2 has also experienced moments of STS, specifically when clients' trauma brings up their own issues regarding their personal history of sexual trauma. Participant 3 informed that music therapy sessions do not focus on the specifics of clients' sexual abuse. Because the details of clients' sexual trauma are seldom shared or expressed during music therapy, Participant 3 stated that they do not and have not experienced STS in their work.

Vicarious Trauma

Although all three participants are not typically exposed to the specifics of their clients' sexual trauma, the knowledge of the trauma in itself can lead to changes in the professionals' perceptions of the self, others, and/or the world. For the two participants who have, at times, been exposed to the details of traumatic material, the experience of VT is prevalent. When exploring the possibility of VT, two primary concepts were mentioned by these two participants: feelings of helplessness, and increased empathy and connectedness/co-occurrence with VR. Both of these factors contribute to the longer-term experience of VT compared to the in-the-moment experience of STS.

Feelings of Helplessness

Participant 1 shared experiencing feelings of helplessness when their perceptions of the self, others, and the world are impacted by VT. When working with a great deal of survivors of sexual trauma for a number of years, the long term feelings of helplessness may shape a professional's perception, as described by Participant 1:

> As humans, it hurts us if, if we have any heart at all, it hurts us to see other people suffering. You know, we want to do what we can, and sometimes that feeling of helplessness is to me like kind of one of the pieces of that vicarious trauma because that's something that we know we can't help. We can't go back in time and make that not happen for that person.

Participant 1 described the impact of being unable to change a client's history of sexual trauma, and the perceived feelings of helplessness that manifest as a result. However, Participant 1 went on to describe a co-occuring perception of increased empathy and connectedness that both arises through and balances this negative perception within VT.

Increased Empathy and Connectedness/Co-occurrence with VR

For two out of three participants, their experiences with VT have led to positive feelings of increased empathy for/connectedness with their clients, linking closely to VR. Participants 1 and 2 described this co-occurring perception (Table 5).

Table 5

Quotations Illustrating Increased Empathy and Connectedness

Participant	Supporting Quotation
Participant 1	You know, we're trying to work on these symptoms so, you know, it gives me increased empathy for them and also just kind of seeing progress over time. It helps that vicarious trauma. I think maybe that's one of the benefits of staying in it for a while.
Participant 2	I certainly feel a sense of connection sometimes to my patients because of my past. I think for me, personally, it helps me be a little more empathetic with them.

Participant 1 described their perception of increased empathy as a natural way to help balance feelings of helplessness experienced through VT. Additionally, Participant 1 noted the timeline of perceptions shaped by VT and VR, mentioning the benefits of staying in the work long enough for perceptions to shift and/or balance each other out. Participant 2 discussed their perception of increased empathy and connectedness, similar to that of VR, as a result of not only VT, but also their own mental health issues and history of sexual trauma.

Burnout

Through exploring the possibility of burnout, two primary concepts arose amongst all three participants: toll on body and mind, and personal pressure. Although elements of burnout have been experienced by all three participants, burnout specifically related to working with sexual trauma has only been experienced by two participants.

Toll on Body and Mind

The first theme relating to burnout regards the physical, mental, and emotional toll on the body and mind experienced from trauma-related work. For two out of three participants, this toll on the body and mind has been experienced (Table 6).

Table 6

Quotations Illustrating Toll on Body and Mind

Participant	Supporting Quotations
Participant 1	I see the excitement of that first year of being a therapist in this population, then second year it's like "oh I do this every day, wow," and then the third year it's like "um, what's happening?" and by the fifth year, I think people do experience some pretty hardcore burnout. You know, when you're first starting something new, there's so much excitement, but then when you realize you're doing it everyday and the clients just keep coming and the bad stuff just keeps happening. I found for myself that I experience burnout in a very physiological way which was… burnout changed my body for a minute. Like I felt like I kind of got physically very out of shape for a while. I feel like I was stuffing my feelings and I didn't even know it. I did not even know it. If you think about that many clients and hearing that many stories for a long period of time, like I think it was part of like professional growth to kind of get to the point where I was able to cope with that much of a person's pain and kind of figure out how to deal with that for myself. I think that I went through a stage where I probably wasn't capable of handling it all, so I just stuffed it, you know, food, whatever. Even though I was really, you know, trying to do a lot of things musically, self-care, exercise, all that stuff, you know it just… you know this kind of work takes a toll.
Participant 2	So, burnout, especially in adult units over the years, I'll get more irritable, my patience tolerance level gets very short, especially like when my staff members interrupt my sessions and things like that. It's really a wake-up call that I need an extra day off or what not else. For me with working with the children, I had no warning signs, like I was fine, fine, fine and then boom, I was out. I emotionally was vomiting, or I emotionally was numb, I guess is a better word for it. I just became completely numb. Well then, it was just pointless. I couldn't talk, I couldn't redirect patients, I couldn't lead sessions. It was just awful. I wasn't a big fan of adolescents. Although some people are able to do that really well and I wasn't one of them.

Participant 1 described their own timeline of burnout, describing the different stages they have experienced themselves, and have observed in other clinicians. During their fifth year of working with survivors of sexual trauma, Participant 1 first began to experience burnout, describing years five through ten to be particularly telling. Participant 1 noted the toll burnout takes on the mind when the days/months/years go by and the "bad stuff just keeps happening." The toll taken on the body was additionally described by Participant 1 in their discussion about burnout changing their body. Participant 1 described the physiological effects of burnout, emphasizing their tendencies to turn to food and "stuff [their] feelings" without even realizing their unhealthy coping mechanisms.

Participant 2 described the toll taken on the mind from burnout, attributing the age range of clients as a major factor. Participant 2 first described their experience of burnout with the current population they work with, noting experienced irritability and decreased patience tolerance level. Participant 2 then shared about the period in their career when they worked with children and adolescents; they described the toll burnout took on the mind, expressing mental/emotional numbness and, subsequently, their inability to effectively work with clients. When reflecting on this experience of burnout, Participant 2 explained that working with age groups that are not preferred, in this case adolescents, contributed to the experience and speed at which burnout occurred.

Personal Pressure

The second theme relating to burnout regards the personal pressure professionals put on themselves to work with clients as effectively and meaningfully as possible. For Participant 3, this contributor to/experience of burnout is unrelated to the sexual trauma experienced by clients,

likely due to the fact that their music therapy sessions do not focus on clients' experienced trauma. Participant 3 described their minimal experience with burnout:

> I mean sometimes I feel like I put pressure on myself to make the sessions as good as I can possibly make them. I think if I experience any stress, it's really from the pressure that I put on myself to always want to come up with really great activities that are really perfect for the group and… yeah, so that's pretty much it, but other than that, there's not really any burnout.

Participant 3 explained their only experience with burnout relates to personal pressure placed on themselves rather than the nature of the work. They described the constant need to create new, appropriate, meaningful activities for sessions, and the minimal burnout they experience as a result. Because Participant 3's music therapy sessions typically focus on teaching/reinforcing safety and boundaries for patients rather than focusing on the specifics of their abuse, it is less likely for Participant 3 to experience burnout relating to traumatic material.

Vicarious Resilience

The phenomenon of VR is experienced by all three participants as a direct result of working with survivors of sexual trauma. Through exploring the possibility of VR, three primary themes arose: inspiration, increased mental/emotional availability for clients, and reinforcing/celebrating/fostering resiliency.

Inspiration

Each participant noted the positive impact on their personal and professional lives experienced as a direct result of being exposed to clients' resiliency in the face of trauma. Two participants particularly emphasized the feeling of being inspired by clients' resiliency (Table 7).

Table 7

Quotations Illustrating Inspiration

Participant	Supporting Quotations
Participant 2	I mean the patients that I've worked with over the years, I mean their resilience is just amazing and, you know, nothing shocks me anymore. So certainly patients, the things that they go through and are able to overcome are just inspirational for me. Certainly, they've inspired me and hopefully I've inspired them to continue to live their lives to the best of their abilities with some sense of purpose in their life.
Participant 3	I think the thing that I take away from the groups the most is just enjoying their company, and just be inspired at, you know, just being around beautiful people. It's inspiring.

Both Participants 2 and 3 described feeling inspired by the resiliency their clients display in the face of sexual trauma. Both participants noted their amazement at their clients' ability to overcome traumatic experiences, while maintaining a positive outlook and willingness to receive treatment and care.

Increased Mental/Emotional Availability for Clients

The effect of VR has additionally been noted to enhance professionals' personal feelings of resiliency and increase mental and emotional availability for their clients. Participant 1 described the benefits of VR in terms of their work with clients:

> So, I feel like being more resilient just makes me more available for my clients. It makes me more present. I'm able to see things a little quicker. I think I work better. I can sympathize… the things that they're telling me. I can conceptualize cases much easier, get my treatment plans and interventions kind of lined up in my head a lot easier. So I

just think it makes me better in that way, in terms of thinking about how I see my clients. I think also the effect of vicarious resilience just on me personally is I feel much better as a human physically, emotionally, spiritually, all that. Life just feels a lot lighter.

Participant 1 noted the positive effects of VR on both personal well-being, and subsequently, professional capability. Participant 1 explained that witnessing clients display resiliency in the face of sexual trauma has enhanced their own feelings of resiliency. As a result of this enhanced feeling of resiliency, Participant 1 explained that they not only feel more mentally/emotionally available to effectively work with clients, but also feel physically, emotionally, and spiritually better and lighter as a human being.

Reinforcing/Celebrating/Fostering Resiliency

The third theme relating to VR regards professionals' reinforcement/celebration/fostering of their clients' resiliency. Two participants noted the critical and uplifting nature of this concept (Table 8).

Table 8

Quotations Illustrating Reinforcing/Celebrating/Fostering Resiliency

Participant	Supporting Quotations
Participant 2	So their unawareness sometimes… I feel awesome, you know, that I can bring that awareness to them. Not that, you know, again we're gonna do much with it, but just to have a better understanding of the reason behind their behaviors and their choices in their life. Sometimes other people are farther along, you know "hey, I came into the hospital before I took an overdose of pills." Well, that is something to celebrate, right? Like, you're making progress because the last 20 hospitalizations, you cut yourself or you attempted suicide or what not else. So I just really try to celebrate everybody's progress and their recovery.

Table 8 (continued).

	I feel like my role is just to really help them just build on where they're at, whether they have a lot of resiliency or not, and just help them to understand and maneuver in this life with the issues that are going on in their brain that's broken. Pretty much every patient, I try to remind them that "hey, I'm proud of you for even just coming in the hospital." Where I'm at now, most of them are there on a voluntary basis, so I really try to just give them a lot of kudos and thumbs up for that. That, to me, is how we build up resiliency, is by reinforcing the behaviors that work for us, and cutting out the neurons in our brain that don't work for us anymore.
Participant 3	That's where one of the things that I think music therapy comes in really handy because the therapist that sees them before I do talks to them, but I can reinforce what they're talking about with music so that they're getting that reinforcement from another part of their brain that is being affected. Oftentimes, they've been subjected to someone else's power, and so that person getting to experience power in a session… So that person gets to feel the experience of they're in control. They're not at somebody else's control. That's an important one. I think the other main one is that every single choice or opinion that they express is respected.

Participant 2 first noted the significance of bringing clients' resiliency into their awareness, and verbally making mention of their strength in the face of traumatic experiences. They went on to note the importance of celebrating clients' resiliency as evidenced by progress in treatment and willingness to heal. Participant 2 explained that through acknowledging, reinforcing and celebrating clients' strength, they are able to build up resiliency. Participant 3 explained the importance of reinforcing clients' resiliency through specifically tailored music therapy sessions and activities. Participant 3 went into detail about the various goal areas (safety,

control, boundaries, respect) that are meant to reinforce and build clients' resiliency through music and through the therapeutic process.

Methods of Coping

Amongst all participants, several themes arose related to methods of coping with experienced STS, VT, and/or burnout. The most prevalent methods of coping include: supervision/staff support, self-care practice, making meaning out of work, and trusting music/creative process.

Supervision/Staff Support

The first method of coping with experienced STS, VT, and/or burnout is communicating with colleagues/supervisors for mental and emotional support. Two participants described their experiences working with/confiding in fellow staff members/supervisors to process and cope with STS, VT, and burnout (Table 9).

Table 9

Quotations Illustrating Supervision/Staff Support

Participant	Supporting Quotations
Participant 1	Being in the moment, I mean you just can't get away from it, but I do feel like being able to appropriately process things and get through it with a lot of supervision. So, just kind of processing things for myself, processing things with my supervisor, my colleagues, and just kind of, you know, going through it that way is much easier now. It helps to have a fresh perspective on music therapy than an intern brings which is great for burnout actually- not so much for STS or VT. It helps me a lot to have another person there.

Table 9 (continued).

Participant 2	I really make sure I work with the treatment team that I have. So, the other nurses, staff… I feel like being a music therapist on the unit where we experience a lot of trauma sometimes and very stressful situations… we're supposed to go and communicate amongst ourselves of the events that happened, and to process our emotions with that. If I'm not okay, sometimes I'll go to my supervisor or director and just kind of process. Of course we always have employee assistance… EAP. Employment assistance program. So, I can always call that for more counseling or therapy if I need it. On the kids unit, we connected a lot. We were very close, making sure we had that emotional support amongst each other, which I think was awesome. It was just a great experience in that regard.

Both Participants 1 and 2 discussed the importance of having emotional support from colleagues, supervisors/directors, and interns to be able to effectively and meaningfully process emotions that arise through experienced STS, VT, and/or burnout. Both participants emphasized the benefits of being a part of a connected staff/agency, and being able to rely on others for mental/emotional support when indirectly, or at times directly, working with traumatic material.

Self-care Practice

The second theme regarding methods of coping relates to the importance of self-care practice. Self-care practices may vary greatly, and can be applied both inside and outside of work settings. Two participants described their different, yet equally beneficial, self-care practices (Table 10).

Table 10

Quotations Illustrating Self-care Practice

Participant	Supporting Quotations
Participant 1	I ground myself. I put my feet on the floor. I take a deep breath. Sometimes, I might focus in on myself for just a minute, take a deep breath, ground myself, count to three, and then get back to the client. I think it's undetectable to the client that I just have to kind of like check in with myself for a second just to make sure that I'm still present. I felt with the new clinicians that were coming into the center, there was like a new, fresh set of eyes and ears and thoughts about self-care. I felt like a different focus. So I felt like all of a sudden, we were kind of talking about it again, but in a different way. So, I sort of feel like the past 10 years or so, maybe eight years, there's been a really concerted effort on self-care and kind of the new research that's come out about how to make meaning out of the work and everything.
Participant 2	I've been through counseling throughout my adult life since college all the way up until now, and I think that's really helped me personally deal with any of those, you know turmoils in the past. What I learned from one of the social workers [in the children's unit] was that they would just schedule every four weeks an extra day off, like an extra mental health day. So I've done that ever since. So that's just something that I've carried on in my self-care practice and to help with that burnout, and it really does help. I just stick to that. I can feel it coming, and I think there's some mental assurance, I guess in my view of the work that it's kind of like a vacation coming up. So I know there's that extra day where I can just kind of breathe and do a lot of self-care. I've been rescuing foster dogs for the last two and a half years. That's also been very therapeutic for me in my personal life. I know some music therapists are in performing groups and this and that, for me, my joy comes when I'm at work and performing my instruments and singing and things like that, and providing music therapy. So for me, in my free time, I like to rescue dogs. So that's been my other joy when I'm not at work, is to rescue dogs. Dogs are the best therapy, other than music. Music is, of course, number one. [Music] is probably one of the tools that has helped me cope with life. One time my teenage son (several years ago) saw me performing with the church band

Table 10 (continued).

	(as they needed help) and I was smiling. He said he has never seen my smile that much before. I don't even realize sometimes how much music affects me as I just have done it my whole life.

Participant 1 first discussed the use of grounding techniques as self-care practice not only in the work setting, but even during music therapy sessions. Participant 1 noted the importance of grounding, both physically and mentally, breathing, and internally counting to calm themselves and re-establish mental and emotional presence. They went on to discuss the significance of their team of clinicians bringing forward new perspectives on self-care practice, further emphasizing the significance of supervision/staff support. The focus on new ideas about self-care, brought forward by fellow clinicians in recent years, allowed Participant 1 to reexamine both the importance of self-care practice, and how to incorporate it in and out of the workplace. Participant 1 noted how digging deeper into the newer self-care practices allowed them to create meaningful perspectives and make meaning out of work.

Participant 2 shared the importance of self-care practice in different ways than Participant 1. Participant 2 first described maintaining personal counseling, related to their own mental health issues and sexual trauma, as a critical part of their self-care practice. They emphasized the importance of personal counseling in terms of personal well-being, and subsequently, professional capability as a music therapist working with survivors of sexual trauma. Participant 2 then described the benefits of incorporating a mental-health day, every four weeks, to maintain self-care and provide mental assurance. Participant 2 shared that they began incorporating this concept when recommended by a former colleague, again emphasizing the importance of staff

support. This key component of Participant 2's self-care practice is used as an opportunity for Participant 2 to "breathe and do a lot of self-care" each month. Participant 2 finally noted the therapeutic benefits of both caring for dogs and playing music as part of their personal self-care practice. They noted that the musical component of self-care is fulfilled while providing music therapy sessions and playing music in a therapeutic way for themselves and their clients. Participant 2 emphasized the usefulness in playing music as a means of self-care throughout life, at times unaware of the depth of its positive impact on their well-being. Additionally, Participant 2 described fostering dogs as part of self-care practice outside of the work setting, noting the therapeutic benefits of caring for dogs, and the positive effect on their mental/emotional well-being.

Making Meaning Out of Work

The third theme not only relates to a professional's ability to make meaning out of their work, but also to its use as a method of coping with experienced STS, VT, and/or burnout. Two participants described their experiences with making meaning out of their work, and using these meaningful perspectives as a means of coping (Table 11).

Table 11

Quotations Illustrating Making Meaning Out of Work

Participant	Supporting Quotations
Participant 1	I do feel like working in this trauma setting has changed me and my perspective on a lot of things, but I feel like I've been able to make some pretty meaningful, or create meaningful perspectives within myself, and put the work into a context where it actually becomes more enjoyable, and I do get more fulfillment out of it as time passes.

Table 11 (continued).

	Just being able to feel like I am doing something worthwhile for people puts it all in perspective for me and I feel a sense of gratitude that I can do the work. I really enjoy it. I feel like I have been able to create a lot of meaningful perspective for myself as opposed to kind of like hiding from everything and everyone. So, I sort of feel like the past 10 years or so, maybe eight years, there's been a really concerted effort on self-care and kind of the new research that's come out about how to make meaning out of the work and everything. I just feel like that pushed me to really dig a little deeper, and I do feel like I am much healthier now, and definitely much better equipped to handle everything that I hear in sessions each time. I feel much more equipped to make meaning out of it because there's just so much. I think what helps is, especially with children, but I think with anyone who's actually open to being in therapy, is that when people are in therapy and they're doing the work, we see them get better if we're talking about psychological things that we're working on. I'm not working in medical music therapy, but in mental health, I do see people get better. I do see depression lift. I do see PTSD symptoms reduce and decrease. So, that really does help me also.
Participant 2	If I feel that it could be helpful to the patient to share my experience of strength and hope, then I will very minimally just to help validate, or you know, know they're not alone. I think sometimes when I share that with my patients, even in a group setting, because most of our sessions are group based, just to let them know that "hey, you're not alone," and this is how I cope with it. This is how I manage it, and I'm okay. I like to live my life as an example for them as well, so I think that really helps a lot with that. I'm not just preaching healthy coping skills, I'm an example of it.

Participant 1 first described how their ability to create meaningful perspectives, through both supervision/staff support and self-care practice, has significantly helped them cope with the experiences of STS, VT, and burnout within their work. This method of coping has allowed

Participant 1 to feel "much better equipped to handle everything" that comes up both during music therapy sessions, and while working with sexual trauma on a more general scale. Participant 1 elaborated on one of these meaningful perspectives, emphasizing how beneficial and meaningful it is to watch their clients progress, heal, improve, and grow throughout the therapeutic process, and how gratifying it is to feel a sense of "doing something worthwhile for people."

Participant 2 described the benefits of creating meaningful perspectives and using them as a method of coping in a similar way. The focus of Participant 2's perspective, however, regards their ability to connect with and inspire clients through the common experience of sexual trauma. Participant 2 explained that sharing their own experiences of strength and hope in the face of sexual trauma helps them to connect with, validate, and inspire clients in a meaningful way. They stated that self-disclosing to clients, when appropriate, and reminding them that they are not alone in their struggles, helps manage the experiences with STS, VT, and burnout.

Trusting Music/Creative Process

A final theme used as a method of coping relates to the experience of trusting the music/creative process of music therapy. Two participants described the ways in which they rely on the musical and creative nature of the work to cope with STS, VT, and/or burnout (Table 12).

Table 12

Quotations Illustrating Trusting Music/Creative Process

Participant	Supporting Quotations
Participant 1	You know, if I'm involved in music at the time, I find that if I'm making music at the same time they're making music, or like if we're working together on an improvisation or a song-writing kind of thing, I feel like I stay more grounded, and I don't have to maybe be so conscious about checking in with myself as when we're just kind of seated and I'm just hearing some things and there's not really any other thing going on. You know, music is the third party in the room, and when the music is involved, for me it's much easier to kind of have that divided focus. You know, as a therapist, you can get discouraged. If you stay in there long enough, and you can see enough success, then you kind of begin to trust the process even on a deeper level. When you start out, you know that music works, that music therapy is a valuable therapy for your client, but then after you see enough success, you're like "okay, I'm going to trust this process now because this person's pain is really terrible, but I'm going to trust that what I'm doing is going to contribute."
Participant 3	And the other thing is to really trust your creativity because you have to be creative to be a music therapist. It's a very creative field, which is one of the wonderful things about it. It's not like teaching. Teaching you could come in with a plan, and you could come in with a plan in music therapy, and you should, but you have to be very flexible because the client's not going to go in the direction you want them to go sometimes. So you have to kind of stay relaxed and kind of trust your creative fluidity because you have to learn to think laterally a lot.

Participant 1 described moments of experienced STS when exposed to the details of a client's sexual trauma during a music intervention. They recalled these experiences and noted that the presence of music as a "third party in the room" helps them cope with the experienced STS. Participant 1 explained that during these moments, the musicking between themselves and client(s) helps to ground them and maintain a necessary division of focus. On a more general scale, Participant 1 noted their ability to trust the creative process of music therapy over time,

and how this helps them cope with experiences of STS, VT, and burnout, and trust that their contribution to clients' care is meaningful.

Similarly, Participant 3 explained that their enjoyment of the creative process of music therapy helps them to cope with the minimal burnout they experience in terms of personal pressure. Participant 3 noted their constant need to create new music therapy activities, and the burnout they have experienced as a result. However, Participant 3 emphasized the value of trusting the music/creative fluidity of the music therapy process, and highlighted their enjoyment of/focus on the creative process as a method of coping.

Discussion

The research question and sub-questions of this study aimed to gain a greater understanding of the experiences of music therapists who have worked with survivors of sexual trauma, and the potential STS, VT, burnout, and/or VR that may arise. It is evident that several of these phenomena are experienced by music therapists working with this population, depending on the level of direct involvement with traumatic material and approach to therapy.

Interviews conducted with music therapists currently working with survivors of sexual trauma provided personal examples regarding whether or not the specific phenomena have been experienced, the nature of the experienced phenomena if applicable, and the methods of coping with experienced phenomena on a more general scale. After analyzing the information provided by participants, results were coded to identify themes in relation to each phenomenon, and general methods of coping.

Five primary categories, and 14 themes were identified through exploration of and analysis of data. Based on the content of the interview questions and the responses of all

participants, the five primary categories include: STS, VT, Burnout, VR, and Methods of Coping.

Secondary Traumatic Stress

Secondary traumatic stress includes three themes: personal experience, physiological and emotional responses, and indirect work with trauma. STS is a direct result of hearing emotionally shocking information from survivors (Canfield, 2005). Amongst a variety of disciplines, many professionals experience STS symptoms for extended periods of time, as they are considered to be a normal response to engagement with traumatic information. Baird and Kracen (2006) stated that the most thoroughly investigated workplace variable in the development of STS is exposure to traumatic material through time spent with traumatized clients. The results of the current study moreso highlight exposure to traumatic material as a key variable in the experience of STS than time spent with traumatized clients. Two out of three participants reported having experienced STS within their work, stated that they have experienced STS specifically when being exposed to clients' traumatic material, and discussed the significance of personal experience and physiological and emotional responses to traumatic material.

Baird and Kracen (2006) explained that variables impacting the development of ST include personal trauma history, years of experience working as a mental health professional, exposure to client material, and opportunities for supervision. For two out of three participants, the most prominent variable impacting the development of STS is personal experience/personal trauma history. Both participants noted their current and/or past personal experiences as contributors to their experiences with STS. These participants discussed the ways in which their current feelings, behaviors, and attitudes and/or past personal experiences with sexual trauma

affect their mental/emotional presence and ability to process the intimate details of traumatic material as they are exposed during the therapeutic process.

Jenkins and Baird (2002) noted that symptoms of STS are nearly identical to symptoms of PTSD, including symptoms of avoidance, arousal, and intrusion. However, for these two participants, symptoms of STS slightly differed. According to both participants, the nature of STS primarily presents as a physiological and emotional response to traumatic content. Various somatic symptoms, feelings of intense anxiety, and feelings of deep sadness were reported, emphasizing the physical, mental, and emotional detrimental nature of this phenomenon in a way that slightly differs from traditional symptoms of PTSD.

The unifying theme within this category relates to the level of direct exposure to traumatic content experienced by participants. All three participants made clear that music therapy is most often, if not always, used to support trauma indirectly. This indirect support of trauma indicates the need for a trauma-informed approach. The main elements of a trauma-informed approach in any service system are: recognizing the widespread impact of trauma exposure; identifying how trauma may impact clients, families, and staff in the system; applying this knowledge into practice/institutional policies; and preventing retraumatization (Substance Abuse and Mental Health Services Administration, 2015). Because all three participants typically practice in a way that supports trauma indirectly and aims to avert engagement with traumatic content, clients do not often disclose intimate details about their sexual trauma. This general lack of disclosure largely reduces participants' experiences with STS. Two participants noted that although they do not ask their clients to disclose details or accounts of sexual trauma, they are exposed to traumatic material at times within their work, depending on

a client's desire to disclose. During these moments of exposure to detailed traumatic material, STS has been experienced by these participants.

Vicarious Trauma

The second category, VT, includes two themes: feelings of helplessness, and increased empathy and connectedness/co-occurrence with VR. Kadambi and Ennis (2004) described VT as the process by which a professional's inner experiences are profoundly changed through an empathic bonding with clients' traumatic experiences. The inner experiences highlighted by the same two participants who have experienced STS relate to feelings of helplessness and increased connectedness/co-occurrence with VR. These two participants affirmed that they have experienced VT, and described the nature of the phenomenon.

The negative impact of VT is described by one participant as frequent feelings of helplessness. The participant explained that this attitude/feeling arises when repeatedly unable to change a clients' histories of sexual trauma. Canfield (2005) stated that VT often elicits strong reactions of grief and outrage, and a pervasive sense of helplessness in therapists. While Canfield (2005) explained that feelings of helplessness are most often exacerbated when clients are stuck in "repetitive, self-destructive reenactments over time during the course of therapy" (p. 88), results of the current study reveal that feelings of helplessness can manifest simply through repeatedly working with the disheartening reality of client histories.

Despite experiencing feelings of helplessness as a result of VT, participants' experiences differ from many of the traditional concepts associated with this phenomenon. McCann and Pearlman (1990) stated that VT leads to disruptions in a therapist's "sense of identity, worldview, spirituality, ability to tolerate strong affect, and central cognitive schemas (e.g., core

beliefs about safety, trust, esteem, control, and intimacy)" (p. 133). The two participants who have experienced VT did not describe significant shifts in cognitive schema as other professionals commonly do. Instead, the theme highlighted alongside feelings of helplessness involves the co-occurring perception of increased empathy and connectedness that arises through VT, linking closely to experienced VR.

VT and VR often co-occur naturally; VR is an effective means to counteract the greatly fatiguing nature of both VT and STS (Hernández et al., 2007). The co-occurring perception of increased empathy for/connectedness to clients can be viewed as a natural way to help balance negative perceptions such as feelings of helplessness experienced through VT. One participant mentioned the significance of professional longevity, stating that positive, co-occurring perceptions of VR may be experienced over time. This highlights the benefits of staying in the work long enough for perceptions to shift and balance. Another participant affirmed this perception of increased empathy and connectedness, similar to that of VR. However, for this participant, this co-occurring perception is not only a result of negative perceptions created through VT, but also their own mental health issues and history of sexual trauma.

Burnout

The third category includes two primary themes: toll on body and mind, and personal pressure. Maslach et al. (2001) defined burnout as a psychological syndrome that develops in response to interpersonal job stressors. While all three participants shared that they have indeed experienced burnout, only two participants have reported that they have experienced burnout directly related to working with trauma.

For these two participants, burnout has been primarily experienced through a toll on body and mind. Offering support and assistance to those coping with emotional pain, crisis, or instability can take a significant toll on the emotional energy and coping resources of professionals providing care (Kadambi & Ennis, 2004). Burnout can additionally impact an individual's quality of life through complications with physical health, anxiety, depression, and loss of self-esteem (Maslach et al., 2001). One participant emphasized the toll burnout has taken on their physical health/body, highlighting their tendencies to turn to food/stuff their feelings without realizing the presence of, nor the detriment of the behavior. This participant noted that stress experienced during a professional's early career can cause significant challenges, explaining that years five through ten are particularly telling in terms of if/how one experiences burnout, and how they cope with this experience. The participant explained that being in the early stages of a career, without the longer perspective of growth and change, may lead to more symptoms and experiences of burnout. Another participant described the toll taken on their mind from burnout, noting their frequent feelings of irritability and decreased patience tolerance level. They further expressed their experiences of mental/emotional numbness and the subsequent challenges that arise when working with clients. Maslach et al. (2001) stated that burnout can substantially impact job performance, leading to lower productivity and effectiveness, raising ethical concerns due to impaired competence. This decreased effectiveness and impaired competence is directly described by one participant when reflecting on their experience of burnout. As one participant noted the challenges endured by professionals during their early careers as a contributing factor to burnout, another noted working with age groups that are not preferred as a contributor to the experience and speed of onset of burnout.

The second theme related to burnout is the mental weight of personal pressure experienced by professionals, unrelated to the nature of working with trauma. One participant shared their experience with burnout, entirely unrelated to both the nature of working with survivors of sexual trauma, and the knowledge of clients' abuse. For this participant, burnout results from personal pressure placed on themselves to continuously create and provide music therapy activities that they feel are effective and meaningful for clients. According to Lazarus and Folkman (1984), the development of burnout occurs when a professional's work demands are greater than a person's coping resources. For this participant, the pressure placed on themselves to meaningfully meet their work demands, over a long period of time, has caused burnout. When this participant experiences burnout, the personal pressure to meaningfully fulfill job demands outweighs their ability to rely on methods of coping, described in a later section. This participant's lack of experienced burnout specifically relating to traumatic material aligns with the focus of trauma-informed care, and the use of music therapy to support trauma indirectly.

Vicarious Resilience

The fourth category includes three themes: inspiration, increased mental/emotional availability for clients, and reinforcing/celebrating/fostering resiliency. VR refers to the positive impact on/growth of professionals resulting from exposure to clients' resilience (Hernández et al. 2007). When working with trauma, professionals are not only confronted with stories of hopelessness and powerlessness, but also with stories of resiliency and resourcefulness. Unlike all other categories/phenomena, the experience of VR was noted by all three professionals, directly related to the nature of working with trauma.

The first theme highlights professionals personally feeling inspired by the resiliency and strength observed in their clients in the face of trauma. VR refers to the "positive meaning making, growth, and transformation of the therapist that results from exposure to clients' resilience throughout the course of the therapeutic process" (Hernández-Wolfe et al., 2010, p. 72). Two participants expressed feeling inspired and amazed by their clients' ability to overcome traumatic experiences, and their ability to maintain a positive outlook and willingness to progress, grow, and heal throughout the therapeutic process.

The second theme relates to the personal, and subsequent professional benefits of VR, including increased mental/emotional availability for clients. Hernandez-Wolfe et al. (2014) noted that professionals often experience a greater sense of personal and professional resourcefulness and self-efficacy after they begin working with survivors of trauma. Additionally, Rossi et al. (2011) posited that resourcefulness in therapy is a two-way dynamic in which both the therapist and the client contribute to the development of resilience. One participant highlighted the impact of VR on their personal well-being, explaining that witnessing clients display resiliency in the face of sexual trauma has enhanced their own feelings of resiliency. They further explained that as a result of their enhanced feeling of resiliency, they feel more mentally/emotionally available to effectively work with clients. Hernandez-Wolfe et al. (2014) supported this belief, stating, "[When] therapists focus on client resilience and growth, their capacity to remain present can also be enhanced" (p. 26). This participant's more available headspace directly results from feeling physically, emotionally, and spiritually better/lighter as a human being.

The final theme relates to reinforcing, celebrating, and fostering clients' resiliency in the face of trauma. Vandenberghe and Silvestre (2014) identified that therapists' positive emotions/personal experience with VR can improve therapist input in treatment by increasing resourcefulness and highlighting efforts for development. One participant highlighted the significance of bringing clients' resiliency into their awareness, verbally stating the client's strength and resiliency in the face of traumatic experiences. They noted the importance of celebrating clients' resiliency, pointing out progress in treatment and willingness to heal to all of their clients. The participant explained that through acknowledging, reinforcing and celebrating clients' strength, they are able to build up resiliency. A second participant further explained the importance of reinforcing clients' resiliency through music therapy sessions and activities. This participant explained the various goal areas that are meant to reinforce and build clients' resiliency through musical, creative, and therapeutic process. Pasiali (2012) stated that in order for music therapists to design interventions that may prevent undesirable outcomes for clients, it is critical to understand the processes involved in resilience and human adaptation. Through this, music therapists can design clinical approaches aimed at reinforcing clients' resiliency, providing clients with tools for the future, and creating positive learning opportunities.

Methods of Coping

Canfield (2005) noted that there is a need for adaptive methods of coping that reduce the negative effects trauma treatment often has on professionals. While exploring the ways in which professionals cope with experienced STS, VT, and/or burnout, four general themes were identified: supervision/staff support, self-care practice, making meaning out of work, and trusting music/creative process.

The first theme/method of coping with experienced STS, VT, and/or burnout relates to communicating with colleagues/supervisors for mental and emotional support. The availability of social support is a key component in the psychological well-being of mental health professionals (Collins & Long, 2013). In work settings, this may translate into the availability of supervision and/or the presence of positive and collaborative professional relationships. Two participants shared the importance of having emotional support from colleagues, supervisors/directors, and interns to be able to effectively and meaningfully process emotions that arise through experienced STS, VT, and/or burnout. When experiencing STS, VT, and/or burnout, there are benefits to being a part of a unified team and workplace, and being able to rely on others for mental/emotional support when indirectly, or at times directly, working with traumatic material (Collins & Long, 2013).

The second theme/method of coping relates to the importance of personal self-care practice. Through various self-care practices, therapists often identify ways to reduce anxiety (Clark et al., 1994), and focus inward (Rogers, 1980). For two participants, self-care practice is applied both inside and outside of the workplace. One participant described the use of grounding techniques as self-care practice in the work setting. Berceli and Napoli (2006) stated that using mindfulness inside and outside of the workplace may help professionals learn "effective self-directed techniques to maintain equanimity" (p. 153). Rothschilds (2006) further explained that grounding the self by becoming aware of in-the-moment personal reactions/changing body states may significantly reduce STS and allow therapists to focus on promoting well-being. The participant broke down this technique within their self-care practice, describing the importance of physically and mentally grounding and breathing deeply to calm themselves and

re-establish/revive mental and emotional presence. This participant additionally noted the ways in which digging deeper into the self-care practice allowed them to create meaningful perspectives and make meaning out of work. Another participant shared the importance of personal counseling as a critical part of self-care practice. Killian (2008) stated that the therapeutic processing of personal traumas and training in identifying/handling one's own emotional states and reactions may greatly reduce the risk of STS, VT, and burnout. The participant emphasized the importance of personal counseling in terms of personal well-being, mental health, and history with sexual trauma, and subsequently, professional capability in the workplace. This participant additionally shared their incorporation of a mental-health day, every four weeks, as a key component of self-care practice, and described the therapeutic benefits of both caring for dogs and playing music as part of their personal self-care practice in both in and out of the workplace. Thomas and Morris (2017) discussed specific, individualized self-care strategies utilized by professionals, and emphasized the therapeutic value of professionals using art, music, movement, and other expressive modalities as part of self-care practice.

The third theme relates to a professional's ability to make meaning out of their work, and using these meaningful perspectives as a method of coping with experienced STS, VT, and/or burnout. Sim et al. (2016) highlighted common cognitive coping strategies utilized by professionals, such as gaining self-awareness, adjusting perspectives, and thinking about their work in new/different ways. This method of coping has allowed two participants to feel better equipped to handle and work through experienced STS, VT, and/or burnout. Frankl (1984) described professionals' desire to create meaning out of painful experiences, specifically highlighting the common need to find meaning in suffering. One participant elaborated on these

meaningful perspectives, emphasizing how beneficial it is to watch clients progress, heal, improve, and grow throughout the therapeutic process. Another participant elaborated on their perspectives, highlighting how helpful it is to connect with their clients through the common experience of sexual trauma. This participant explained that self-disclosing to clients, when appropriate, and reminding them that they are not alone in their struggles helps manage their experiences with STS, VT, and burnout. McCormack and Adams (2015) explained that professionals often seek to accept, understand, and connect with their clients by engaging with and honoring central aspects of therapeutic work such as relationships and meanings.

The final theme/method of coping relates to the experience of trusting the music/creative process of music therapy. Brescia (2004) explained that the ideas of trusting in the therapeutic process, taking risks, listening to self and to the client, and self-awareness are all part of the creative process of music therapy. One participant described the experience of feeling STS within music therapy sessions; they noted that the presence of music as a third party helps to cope with the experienced STS by grounding and allowing them to maintain a necessary division of focus. This participant additionally described their ability to better trust the creative process of music therapy over time, and trust that their contribution to clients' care is meaningful. Another participant explained that their enjoyment of the creative process of music therapy helps them to cope with the burnout they experience in terms of personal pressure, and the constant need to create new, meaningful music therapy activities. This participant emphasized the value of trusting the music/creative fluidity during the music therapy process, and highlighted their enjoyment of the creativity of the work as a method of coping. Brescia (2004) stated that the therapist's trust and "intuitive knowledge not only informs the creative process of the music

itself, but also informs the therapist's sense of how to guide or direct the client toward growth within the music therapy process" (p. 109).

Stance of the Researcher

My perspective and understanding of each of the four explored phenomena has evolved continuously throughout the research process. As I researched the different phenomena for the literature review, I gained a deeper understanding of how prevalent each phenomenon is for professionals working with survivors of trauma in a variety of disciplines. With this knowledge, I believed that music therapists working with survivors of sexual trauma would be no different, generally affirming the presence of each of the explored phenomena. As I gathered and analyzed responses from all participants, it became apparent to me that the presence of each phenomenon for music therapists working with survivors of sexual trauma is not as black-and-white as I first thought. The trauma-informed approach and minimal level of direct involvement with traumatic content, that is common amongst all three participants, impacted experiences with explored phenomena in ways that I did not anticipate.

I gained a better understanding of the purpose of trauma-informed care, and the reasoning for music therapists to use music therapy to support clients' trauma indirectly. At the start of this research, I hoped to learn more about both the use of music therapy with survivors of sexual trauma, and the effects of this work on the music therapists themselves. Through listening to, transcribing, coding, and analyzing participant responses, I have gained a clearer understanding of how music therapy is provided for this population, how this work impacts music therapists, and why/how specific phenomena are experienced.

As a soon-to-be new music therapist in the field, my own process interviewing, transcribing, and analyzing data was telling of the perception shifts I may experience as a professional. As participants disclosed personal information and shared about their experiences working with survivors of sexual trauma, I too felt many of the emotional and physiological reactions discussed in relation to STS. However, as participants emphasized the VR they experience within their work and the meaningful perspectives developed as a result, I felt an increased sense of inspiration and resiliency, thereby allowing the natural balance of perceptions to occur within myself as described by participants.

Limitations

The results from this study are based on responses from three participants. This small sample size was primarily due to my one-semester time constraint. The length of time needed to transcribe, code, analyze, and present all data was considered when determining an appropriate and desired sample size. A larger sample size would likely have provided a wider range of perspectives, greater credibility, and increased dependability of the results.

Another limitation was the technological means of gathering interview responses. All three participants responded to interview questions through a combination of phone calls, web conferences, and follow-up emails. All participants live/work in various sections of the country, eliminating the possibility for in-person interviews. The technological methods of phone calls, web conferences, and emails lack humanistic qualities that may have enhanced communication between participants and myself. Meeting with each participant in person could have provided more opportunities for the interviewer to further explain meanings/questions, and/or observe the facial affect and body language of participants when providing responses.

Implications for Clinical Practice

The possibility for music therapists working with survivors of sexual trauma to experience STS, VT, burnout, and/or VR is apparent. However, the frequency of experiencing the explored phenomena, particularly STS, VT, and burnout, is largely dependent on the level of direct involvement with/exposure to clients' traumatic material. As research on this topic is limited, this study aimed to examine if these phenomena are experienced by music therapists working with sexual trauma, how they experienced, and the ways in which music therapists cope with these experiences. The themes presented as results are valuable tools for gaining a deeper understanding of both the nature of/reasoning behind explored phenomena, and the various ways in which music therapists effectively cope. The results additionally highlight the unifying experience of VR amongst music therapists, regardless of therapeutic approach and direct involvement with traumatic content. We can infer that while STS, VT, and burnout are possible and probable for music therapists directly hearing intimate details of clients' trauma, VR is most commonly experienced, emphasizing the positive and rewarding component of working with this population.

Recommendations for Future Research

Through these phenomenological perspectives, readers gain insight from detailed experiences and accounts recalled by participants. It is important to note that each participant's experiences with explored phenomena are unique, complex, and individualized. Future research on the topic, and these specific phenomena, can expand the findings through a larger sample size, and follow-up interview questions pertaining to the categories and themes presented in this study.

Future research including participants who provide primary therapy for survivors of sexual trauma may additionally expand the findings. Because all three participants practice within a trauma-informed approach, exploring the experiences of music therapists who provide primary therapy, rather than supportive therapy, may reveal different results.

Conclusion

Results of this study indicate that music therapists working with survivors of sexual trauma primarily experience STS, VT, and burnout depending on their direct involvement with clients' traumatic material. Additionally, they consistently experience VR when working with this population. Results from this study suggest that music therapists have experienced STS, VT, and burnout related to the nature of their work when they have been directly exposed to traumatic content. Because all three participants work within a trauma-informed approach, direct involvement with clients' traumatic experiences is not always, or for some ever, experienced. For music therapists who have experienced direct exposure to traumatic content, STS, VT, and burnout is experienced in relation to the work. The nature of STS, VT, and burnout is portrayed through professional and personal experiences of physiological and emotional responses, feelings of helplessness, and toll on body and mind, amongst other experiences. For music therapists who have not experienced this direct involvement, STS, VT, and burnout are less likely and less often experienced. However, for all music therapists, regardless of therapeutic approach, the experience of VR is noted, and benefited from on personal and professional levels.

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Appendix A

Populational Experience

Participant #	Population
Participant 1	Children's advocacy center; children and non-offending family members; outpatient basis; court-involved; mental health baseline: TF-CBT model.
Participant 2	Mental health and addiction unit; adults; acute setting; crisis management unit.
Participant 3	Developmental disabilities; adults; group and individual sessions separated by gender.

Appendix B

Email Invitation Letter

Music Therapists,

My name is Caroline Greco and I am a music therapy graduate student at the State University of New York at New Paltz. I am in the preliminary stages of conducting a research study in which I will be exploring the lived experiences of music therapists who work/have worked with survivors of sexual trauma, and the possible secondary traumatic stress (STS), vicarious trauma (VT), burnout, and/or vicarious resilience (VR) that may arise.

I am looking for three to four participants for this study. Participants should be board-certified music therapists who have worked with survivors of sexual trauma for at least three years. Participants may be currently working with this population, or have worked with this population within the past five years. Participants will be selected based on the following criteria: populational experience, number of years in practice, and expertise in working with survivors of sexual trauma. Participants must be 18 years old or older to participate in this study.

I plan to conduct face-to-face, telephone, and/or web conference interviews to elicit views, opinions, and recalls of lived experiences from participants, and perhaps better understand if/how STS, VT, burnout, and/or VR is experienced within their work. The interviews will be audio recorded so they can be transcribed and analyzed. All participants must consent to audio recording. All information will remain confidential.

If you meet these criteria and are interested in participating, please reply to this email within ten days. For questions or concerns, please contact me at grecoc1@hawkmail.newpaltz.edu, or my thesis advisor, Heather Wagner, PhD, MT-BC at wagnerh@newpaltz.edu.

Thank you,
Caroline Greco

Appendix C

Informed Consent Form with Consent to Audio Recording & Transcription

Title of Study

Exploring the Possibility of Secondary Traumatic Stress, Vicarious Trauma, Burnout, and/or Vicarious Resilience in Music Therapists Working with Survivors of Sexual Trauma

Summary of Key Information

For this research study, consent is being sought by board-certified music therapists who have worked with survivors of sexual trauma for at least three years within the past five years. Participation is voluntary. The purpose of this study is to gain a greater understanding of the experiences of music therapists who have worked with survivors of sexual trauma, and the potential secondary traumatic stress (STS), vicarious trauma (VT), burnout, and/or vicarious resilience (VR) that may arise. If you agree to participate in this study, you will be interviewed by the researcher about your experience working with survivors of sexual trauma. The interview will take approximately one hour and can occur in person, over the phone, or via web-conference depending on your preference. Once your interview is transcribed, you will be asked to review the transcript for accuracy and possibly clarify any responses provided during the interview. This process will take approximately 30 minutes. There are no anticipated risks to your participation other than the potential for minimal discomfort while responding to certain interview questions. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose. You will not directly benefit from your participation in this research study. However, the information gained from this study may provide others with a deeper understanding of music therapists' experiences of working with survivors of sexual trauma.

Researcher Information

Caroline Greco, Music Therapy Graduate Student, Bachelor of Science
State University of New York at New Paltz
grecoc1@hawkmail.newpaltz.edu

Faculty Advisor
Heather Wagner, PhD, MT-BC
wagnerh@newpaltz.edu

Purpose of Study

You are being asked to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will

involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

The purpose of this study is to gain a greater understanding of the experiences of music therapists who have worked with survivors of sexual trauma, and the potential STS, VT, burnout, and/or VR that may arise. The following research question and sub-questions will be addressed: Do music therapists working with survivors of sexual trauma experience STS, VT, burnout, and/or VR? If so, what is the nature of these experiences? How do music therapists cope with the experienced phenomena?

Participants

Participants will include three to four board-certified music therapists who have worked with survivors of sexual trauma for at least three years. Participants may be currently working with this population, or have worked with this population within the past five years. Participants will be selected based on the following criteria: populational experience, number of years in practice, and expertise in working with survivors of sexual trauma. Participants must be 18 years old or older to participate in this study.

Study Procedures

If you agree to participate in this study, you will be interviewed by the researcher about your experience working with survivors of sexual trauma. The interview will take approximately one hour and can occur in person, over the phone, or via web-conference depending on your preference. Interviews will be audio-recorded using the *Voice Recorder* iPad app. Once your interview is transcribed, you will be asked to review the transcript for accuracy. This process will take approximately 30 minutes. If needed, you may also be asked to clarify any responses provided in the interview. This will take approximately 30 minutes.

Potential Risks and Discomforts

There are no anticipated risks to your participation other than the potential for minimal discomfort while responding to certain interview questions. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

Potential Benefits

You will not directly benefit from your participation in this research study. However, the information gained from this study may provide others with a deeper understanding of music therapists' experiences of working with survivors of sexual trauma.

Confidentiality

All information obtained in this study is strictly confidential unless disclosure is required by law. In addition, the Human Research Ethics Board, the sponsor of the study (e.g. NIH, FDA, etc.), and University or government officials responsible for monitoring this study may inspect these records. The information collected about you will be coded using an assigned number. Your identifiable information will be kept separately from the rest of your data.

The audio recordings and transcriptions will be stored in password-protected devices. The researcher is required to keep this data for three years. After three years, it will be destroyed.

Your consent will be asked for audio recording. The researcher will transcribe the tapes and may provide you with a copy of the transcription upon request. You have the right to review and edit these transcriptions. Sentences that you ask the researcher to leave out will not be used and will be erased from all relevant documents.

Please sign below if you are willing to have this interview audio recorded. You may not participate in this study if you are not willing to have the interview recorded.

Name: _____

Signature: _____

Date:_____

Participation and Withdrawal

Your participation in this project is voluntary. Even after you agree to participate in the research or sign the informed consent document, you may decide to leave the study at any time without penalty. The researcher will retain and analyze the information you have provided up until the point you have left the study unless you request that your data be excluded from any analysis and/or destroyed. You may choose not to answer any questions and may refuse to complete any portions of the research you do not wish to for any reason.

Rights of Research Participants

If you have questions at any time about this study, or you experience adverse effects as a result of participating in this study, you may contact the researcher whose contact information is provided on the first page. For questions about your rights as a research participant, contact the State University of New York at New Paltz Human Research Ethics Board (which is a group of people who review the research to protect your rights) at 845-257-3282. The Human Research Ethics Board of the State University of New York at New Paltz has determined that this research meets the criteria for human subjects according to Federal guidelines.

One copy of this document will be securely stored separately from all other research data.

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature _____ Date _____

Researcher's signature _____ Date _____

Appendix D

Interview Questions

1. How many years of experience do you have working with survivors of sexual trauma?
2. Describe your current position, including setting, general characteristics of clients, and any other pertinent information regarding the population.
3. Have you experienced STS within your work?
    a. If yes, what is the nature of the STS?
    b. How do you cope with the experienced STS?
4. Have you experienced VT within your work?
    a. If yes, what is the nature of the VT?
    b. How do you cope with the experienced VT?
5. Have you experienced burnout within your work?
    a. If yes, what is the nature of the burnout?
    b. How do you cope with the burnout?
6. Have you experienced VR within your work?
    a. If yes, what is the nature of the VR?
    b. How do you feel the experienced VR impacts your work?

Appendix E

Definitions

Secondary Traumatic Stress (STS): STS is a term used to describe the "natural consequence of caring between two people, one of whom has been initially traumatized and the other whom is affected by the first's traumatic experiences" (Figley & Kleber, 1995, p. 75). STS is a direct result of hearing emotionally shocking information from survivors (Canfield, 2005). Symptoms of STS are nearly identical to symptoms of PTSD, including symptoms of avoidance, arousal, and intrusion (Jenkins & Baird, 2002).

Vicarious Trauma (VT): Repeated exposure to trauma and experience with STS can lead to vicarious trauma (VT; Canfield, 2005). VT is the process by which the inner experience of a professional is "profoundly and permanently changed through an empathic bonding with the client's traumatic experiences" (Kadambi & Ennis, 2004, p. 3). The construct of VT encompasses changes in the experience of self, others, and the world.

Vicarious Resilience (VR): VR refers to the positive impact on/growth of professionals resulting from exposure to clients' resilience (Hernández et al., 2007). When working with victims of trauma, professionals are often confronted with stories of hopelessness and powerlessness as well as resiliency and resourcefulness.

Burnout: Burnout is a psychological syndrome that develops in response to interpersonal job stressors (Maslach et al., 2001). It relates to severe job-related stress that results in symptoms including emotional fatigue, cynicism (which may be directed towards clients, colleagues, and/or the work itself), and a decreased sense of self-efficacy (Awa et al., 2010; Stalker et al., 2007). Burnout has three main dimensions: overwhelming exhaustion, sense of ineffectiveness, and detachment from the job.

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Appendix F

Color-Coding Example

Color	Theme
Red	Personal Experiences (STS)
Orange	Indirect Work with Trauma (STS)
Yellow	Physiological and Emotional Responses (STS)
Green	Feelings of Helplessness (VT)
Purple	Increased Empathy and Connectedness/Co-occurrence with VR (VT)
Pink	Toll on Body and Mind (Burnout)
Gray	Personal Pressure (Burnout)
Blue	Inspiration (VR)
Bright Green	Increased Mental/Emotional Availability for Clients (VR)
Bright Purple	Reinforcing/Celebrating/Building Resiliency (VR)
Pale Orange	Supervision/Staff Support (Method of Coping)
Pale Yellow	Self-Care Practice (Method of Coping)
Pale Green	Making Meaning Out of Work (Method of Coping)
Pale Purple	Trusting Music/Creative Process (Method of Coping)