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Training Music Therapists and Music Therapy Students to Provide Trauma-Informed Care: Training Development and Pilot Feasibility Study

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TRAINING MUSIC THERAPISTS AND MUSIC THERAPY STUDENTS TO
PROVIDE TRAUMA-INFORMED CARE: TRAINING DEVELOPMENT AND PILOT
FEASIBILITY STUDY

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THESIS

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A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Music in the
College of Fine Arts
at the University of Kentucky

By

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Lexington, Kentucky

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2020

ABSTRACT OF THESIS

TRAINING MUSIC THERAPISTS AND MUSIC THERAPY STUDENTS TO
PROVIDE TRAUMA-INFORMED CARE: TRAINING DEVELOPMENT AND PILOT
FEASIBILITY STUDY

Adverse childhood experiences are considered a serious public health problem
and can lead to complex trauma. Due to the prevalence of adverse childhood experiences
in the general population, it is likely music therapists frequently treat clients who have
experienced trauma; however, there appears to be no published research on music therapy
training and education regarding validated trauma-informed approaches. This study
examined the impact of a three-hour educational training on music therapists' knowledge
of trauma-informed care and perceptions of preparedness to practice trauma-informed
music therapy. Seven training attendees chose to participate and completed a pre-test and
post-test covering demographic information, knowledge, perceptions, education, and
feedback. Data were statistically and descriptively analyzed and reported. Participants
demonstrated significant improvement in knowledge from pre- to post-test. Participants'
perceptions of their ability to practice trauma-informed music therapy were significantly
higher on four test items. These results suggest that this training may have a positive
influence on music therapists' knowledge of trauma-informed care and perceptions of
preparedness to practice trauma-informed music therapy. Future researchers should
replicate the study with a larger sample and examine how music therapists apply
information on trauma-informed care in practice.

KEYWORDS: music therapy, trauma-informed care, adverse childhood experiences,
trauma-informed music therapy, training

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01/24/2020
Date

TRAINING MUSIC THERAPISTS AND MUSIC THERAPY STUDENTS TO
PROVIDE TRAUMA-INFORMED CARE: TRAINING DEVELOPMENT AND PILOT
FEASIBILITY STUDY

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1.

INTRODUCTION

Adverse childhood experiences (ACEs) are considered a serious public health

problem (Centers for Disease Control and Prevention [CDC], 2019; Stefanski & Mason,

2017) and can lead to complex trauma. According to the Substance Abuse and Mental

Health Services Administration (SAMHSA), trauma "results from an event, series of

events, or set of circumstances that is experienced by an individual as physically or

emotionally harmful or threatening and that has lasting adverse effects on the individual's

functioning and physical, social, emotional, or spiritual well-being" (2014, p. 7).

Individuals who have experienced complex trauma, including repetitive ACEs, are often

treated in medical clinics, hospitals, schools, and community-based programs. Such

inpatient and outpatient settings commonly employ music therapists, meaning music

therapists frequently treat clients who are displaying emotional, behavioral, social, and

physical problems related to trauma; however, there appears to be no published research

on the education of music therapists to use validated trauma-informed approaches with

these clients (AMTA, 2018; Pasiali, 2014).

Music therapy is the evidence-based use of music as the tool to accomplish

individualized goals within a therapeutic relationship (American Music Therapy

Association, 2020). Music therapists complete a bachelor's degree or equivalency

program at an AMTA-approved school, followed by 1,200 clinical internship hours, then

must complete and pass a comprehensive exam to earn the credential of board-certified

music therapist (MT-BC). The majority of known early music therapists in the 19th and

20th centuries served hospitalized patients and veterans returning from World War I

1

(Davis & Gfeller, 2008); therefore, music therapists in the United States have been offering services to clients experiencing trauma since the field's establishment.

Over time, the way people who are in helping professions, such as music therapy, have understood and treated trauma has changed. For many decades, the trend in treatment for clients experiencing trauma was institutionalization, then medication. Many clinicians believed children lacked the cognitive capacity and social maturity to remember traumatic events and understand their meaning (Buss et. al, 2015). Clients who had experienced trauma were often only treated for the troublesome behaviors and symptoms that resulted from adaptations made unconsciously by the individual early on to avoid re-experiencing traumatic events (Levenson, 2017). A more recent approach is known as trauma-informed care. Trauma-informed care (TIC) is a framework for providing care that acknowledges the pervasiveness of trauma and recognizes trauma's enduring impact as an influencing factor in the development of a person's identity (Keesler, 2014). Practitioners engaging in TIC are sensitive to the possibility that trauma-related issues may manifest, even if they are not related to the client's current needs, and actively seek to avoid re-traumatization (Bath, 2008; Keesler, 2014).

If music therapists were able to better understand the impact traumatic experiences have upon their clients, then they could better assist clients in recovery. Related professions, such as psychology, social work, and special education, have recognized the need for training in TIC and are increasingly including TIC in post-secondary education curricula (SAMHSA, 2014; Wilson & Nochajski, 2016). A lack of understanding trauma-informed principles increases the risk of re-traumatization to the client (SAMHSA, 2014). Improved knowledge of the prevalence of ACEs and

understanding of their vast impact upon the client may facilitate more appropriate and trauma-sensitive intervention design and implementation, which could lead to better treatment outcomes. Music therapists could benefit from learning the most appropriate trauma-informed practices for approaching treatment planning and implementation with clients who have experienced ACEs and trauma. Therefore, the researcher sought to develop a training protocol and pilot test to determine the influence and feasibility of an educational training on music therapists' knowledge of TIC and perceptions of preparedness to practice trauma-informed music therapy.

Purpose

The purpose of this study was to develop a training protocol on trauma-informed care for music therapists and then pilot test its effectiveness and feasibility at preparing music therapists to gain knowledge and understand the implications of trauma-informed care. The research questions were:

1. To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' knowledge regarding trauma-informed music therapy?

2. To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' perceptions of their ability to provide trauma-informed music therapy?

To further develop this training protocol, the researcher asked two exploratory questions:

3. What did music therapists find most helpful about the training?

4. What suggestions did music therapists have for future trainings?

Operational Definitions

Abuse is defined as maltreatment resulting in injury, death, or emotional harm or risk
    (Department of Health & Human Services Children's Bureau, 2019).

Acute trauma, also called *Type I trauma,* is defined as trauma resulting from exposure to
    one overwhelming/traumatizing event, possibly leading to post-traumatic stress
    disorder (Bath, 2008).

Adverse Childhood Experiences are defined as "traumatic childhood events such as
    abuse, neglect, and witnessing experiences like crime, parental conflict, mental
    illness, and substance abuse that can result in long-term negative effects on
    learning, behavior and health" (Robert Wood Johnson Foundation, 2018, para. 1).

Complex post-traumatic stress disorder (CPTSD) can develop following exposure to a
    series of extremely threatening or horrific events, resulting in symptoms such as
    intrusive memories/reliving event, avoidance, hypervigilance, and emotional and
    behavioral issues (Buxton & Turnbull, 2018).

Complex Trauma, also referred to as *Type II trauma* results from prolonged exposure to
    perpetuated traumatizing situations and can have lasting negative impacts on an
    individual's life (Bath, 2008). Experiencing complex trauma may lead to
    Complex Post-Traumatic Stress Disorder (CPTSD).

Household dysfunction encompasses the exposure in the household during childhood to at
    least one of the following: substance abuse, mental illness, violent treatment of
    mother/stepmother, divorce, and/or incarcerated household member (Center for
    Disease Control, 2016).

Music therapy is defined 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 (American Music Therapy Association, 2020).

Neglect is defined as any confirmed or suspected act or omission by a caregiver that deprives a child of basic age-appropriate needs, resulting or potentially resulting in physical or psychological harm (Child Welfare Information Gateway, 2018).

Post-traumatic stress disorder is a disorder that may follow exposure to one event that the individual experienced as physically harmful or threatening. This disorder can result in a variety of symptoms including fearfully and repetitively experiencing the event, behavioral, and emotional symptoms (DSM-5, 2013).

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (SAMHSA, 2014, p. 7).

Trauma-informed care (TIC) is an approach to treatment with clients who have experienced trauma in which care providers realize how trauma can impact individuals and groups, recognize the signs of trauma, respond by using trauma-informed approaches, and actively seek to resist re-traumatization (SAMHSA, 2014).

CHAPTER 2.

REVIEW OF LITERATURE

There appears to be no published research on training music therapists to provide trauma-informed care (TIC). However, scholars from related disciplines such as social work, psychology, and special education have published bodies of research on trauma, adverse childhood experiences (ACEs), TIC, and the education of students to implement trauma-informed practices. In this chapter, the researcher reviewed trauma and ACEs, their impact upon multiple domains of clients' lives, higher education related to trauma-informed care, and presented the theoretical foundation for this study.

Defining Trauma

The American Psychological Association defines trauma as a person's emotional response to a horrible event such as an accident, rape or natural disaster (2018); however, this definition does not encompass every aspect of the term, nor does it accurately describe the lasting impact traumatic experiences can have upon the individual (Pai, Suris, & North, 2017). When many people think of trauma, an image of the returning veteran with critical injuries or a blunt force car crash survivor spring to mind (Boles, 2017); however, this is not necessarily the case. The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a very holistic definition of trauma that is more encompassing:

> Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. (2014, p. 7)

Scholars studying trauma describe two broad categories of trauma: Type I and Type II. According to Bath (2008), Type I trauma is acute and results from exposure to one overwhelming/ traumatizing event. This acute trauma is what most often leads to post-traumatic stress disorder as described in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (*DSM-5*), the most current diagnostic tool published by the American Psychiatric Association (Boles, 2017). By contrast, Type II trauma (often referred to as complex trauma) results from prolonged exposure to perpetuated traumatizing situations (Bath, 2008). However, the *DSM-5* does not distinguish between acute and complex trauma. The *DSM-5* also provided no firm timeline or set measurement criteria for diagnosis of complex trauma or complex PTSD, which may further complicate treatment (Buss et. al, 2015). Therefore, many healthcare providers are advocating for inclusion of a new related disorder or an expanded description of PTSD to be included in the *DSM* in order to accommodate the differentiation between the current PTSD criteria and early complex trauma (Zelechoski et. al, 2013).

Unlike the *DSM-5*, the *International Classification of Diseases 11th Revision (ICD-11)*, a manual provided by the World Health Organization (WHO) used for documenting diagnoses, diseases, and symptoms, included a separate diagnosis for complex post-traumatic stress disorder (CPTSD; ICD-11, 2018). Complex PTSD (CPTSD) is included as a sub-category related to PTSD, categorized under mental, behavioral, or neurodevelopmental disorders–disorders specifically associated with stress (ICD-11, 2018).

Clients who have had adverse childhood experiences (that may lead to complex trauma) were the target population of this pilot training. Complex trauma is exactly as the

name describes—complex. Buss, Warren, and Horten (2015) explained that children from birth through age five are especially susceptible to experiencing complex trauma due to their high level of dependence upon a caregiver, rapid rates of development, and limited, underdeveloped coping skills. There are also a number of different causes of complex trauma, including chronic abuse and/or neglect, bullying, living in poverty, prolonged exposure to family/household dysfunction, loss of family members, placement in the foster care system, dislocation as a refugee, or witnessing repeated spousal violence (Boles, 2017; Levenson, 2017). The training development portion of this study focused on providing trauma-informed care for clients with a specific type of trauma that occurs in childhood or youth called Adverse Childhood Experiences (ACEs), which include abuse, neglect, and family dysfunction (Milot, St. Laurent, & Éthier, 2016). Prolonged or repeated exposure to ACEs may lead to complex trauma.

Adverse Childhood Experiences

According to Levenson (2017), experiencing trauma at an early age increases the risk for medical, psychological, social, and behavioral problems later in life. Although the forms of trauma listed earlier (i.e., bullying, living in poverty, loss of family members, placement in the foster care system, and/or dislocation as a refugee) are all concerning and important, the researchers who conducted the original ACEs study were very specific about the forms of trauma included. These traumatic experiences are grouped into three categories: neglect, abuse, and household dysfunction (Felitti et al., 1998).

Abuse. According to the ACE study, abuse was the most common form (28.3%) of ACEs reported (Felitti et. al, 1998). For the purposes of this study, abuse is defined as maltreatment resulting in injury, death, or emotional harm or risk (DHHS Children's

Bureau, 2019). Abuse is divided into three categories under ACEs: physical, emotional and sexual. Physical abuse was the most reported (28.3%), followed by sexual abuse (20.7%), then emotional abuse (10.6%; Felitti et. al, 1998). This finding was supported by Hussey and Guo (2005) in their study of child characteristics and treatment in the foster care system, which also stated that physical abuse was the most commonly documented form of abuse (17.6%). Baker, Archer, and Curtis (2007) found that, in residential treatment, 20% of youth reported having experienced sexual abuse, 36% reported sexual and physical abuse, 9% reported sexual abuse and neglect, and 36% reported having experienced physical and sexual abuse as well as neglect.

Neglect. For the purposes of this study, neglect was defined as any confirmed or suspected act or omission by a caregiver that deprives a child of basic age-appropriate needs, resulting, or potentially resulting, in physical or psychological harm (Child Welfare Information Gateway, 2018). Of the 17,000 ACE study participants, nearly 25% experienced at least one form of neglect (CDC, 2016). Hussy and Guo (2005) found that neglect was the most commonly documented form of ACE among youth in residential treatment programs (41.2%). Typically, younger children are neglected most often, and more girls suffer from neglect than boys (Child Welfare Information Gateway, 2018; Zelechoski, 2013).

Neglect can be divided into two categories: emotional and physical. Emotional neglect encompasses abandonment and/or failure by the caregiver to attend to necessary emotional or psychological needs. Almost 15% of ACE study participants reported experiencing emotional neglect (CDC, 2016). Physical neglect may include a lack of appropriate supervision and/or failure by the caregiver to provide necessary education,

medical care, food/nutrition, shelter, and/or clothing (Child Welfare Information Gateway, 2018).

Household Dysfunction. Household dysfunction is a broader category describing specific problems in the home. The researchers who conducted the initial ACE study described five categories of household dysfunction: witnessing violence against the mother and having a member of the household experience substance abuse, divorce, mental illness, or incarceration (Felitti et. al, 1998). The most common form of household dysfunction was termed "substance abuse" (26.9%), although many professionals now prefer the term substance use (CDC, 2016; Felitti et. al, 1998). The second most common household dysfunction was divorce or separation (23.3%; Anda et. al, 2006; Felitti et. al, 1998). Chang and colleagues (2019) found that a greater percentage of men in their study reported having experienced family (household) dysfunction (36.87%) in childhood compared to women (27.39%).

Prevalence. Understanding the ACE categories is important when interpreting data about their prevalence. Complex trauma, such as repeated ACEs, can have severe negative impacts upon development (Milot et. al, 2016). Bath (2008) found that many people receiving services in child welfare, mental health, special education, and justice settings have experienced complex trauma. More recently, Sacks, Murphey, and Moore (2014) reported that 46% of children had experienced at least one ACE. Tullberg, Kerker, Muradwii, and Saxe (2017) found that 98% of children in the child welfare systems have had at least one ACE. Furthermore, Clarkson and Freeman (2014) found that 70% of those in the child welfare system have experienced at least three ACEs. Chang and colleagues (2019) found that men (45.92% of men surveyed) were significantly more

likely to report having experienced abuse (physical, emotional, or sexual) and violence as children than women (27.48% of women surveyed). In addition, Baglivio (2014) reported that 97% of juvenile offenders have had ACEs.

Nearly half of the children in the United States (46%) have experienced at least one ACE (Sacks et. al, 2014). A more recent study by McCormick, Carroll, Sims, and Currier (2017) indicated 58.7% of participants had experienced one or more ACE. Zelechoski and colleagues (2013) found that between 50–70% of youth in residential treatment programs have been exposed to trauma. ACEs are becoming a chronic problem, as all those who have been exposed to ACEs are at risk for problems in development and of developing chronic health and relational problems.

Impact of Early Trauma (ACES)

Early exposure to pervasive traumatic events can cause problems in multiple aspects of a child's development. According to Levenson (2017), experiencing complex trauma, including ACEs, at an early age increases the risk for medical, psychological, social, and behavioral problems later in life. Anda and colleagues (2006) described a graded relationship between the number of ACEs and negative long-term health problems, meaning that the risk for negative health outcomes increases with each additional ACE. Exposure to ACEs involving caregivers can disrupt the way children perceive themselves and others, also preventing them from developing secure attachment and leading to trust and relationship issues later in life (Grossman, Spinazzola, Zucker, & Hopper, 2017; Milot et. al, 2016). Milot and colleagues (2016) explained that failure to develop a secure attachment with caregivers can negatively impact the ability of a child to express emotions and develop self-regulation skills, which can lead to dissociation in

11

young adulthood (Grossman et. al, 2017). Hogdon, Blaustein, Kinniburgh, Peterson, and

Spinazzola (2016) expressed concern for the development of other comorbid diagnoses

for clients with traumatic experiences, such as mood, anxiety and disruptive behavior

disorders.

According to Bath (2008) and Chang and colleagues (2019), many adverse

behaviors (i.e., hyperarousal, concentration problems, triggered outbursts, anger, lack of

impulse control) are the result of biopsychological changes in the brain during

development caused by prolonged stress responses and hyperarousal. Over time,

hyperarousal and increased cortisol levels can lead to depression and complex PTSD

(Anda et. al, 2006; Chang et. al, 2019). Clinicians now know that clients who have

experienced complex trauma, possibly as a result of multiple ACEs, are not necessarily

displaying troublesome behaviors purposefully, nor to elicit frustrated responses (Bath,

2008). Trauma can manifest as poor emotional regulation, lack of social attachments,

decreased impulse control, slower cognitive processing, negative coping behaviors,

boundary violations, mental disorders, chemical dependency, teenage unplanned

pregnancy, sexually transmitted infections, and higher risks for suicide (Anda et. al,

2006; Chang et. al, 2019; Levenson, 2017). Information about types and prevalence of

ACEs and associated risks is summarized in Figure 1.
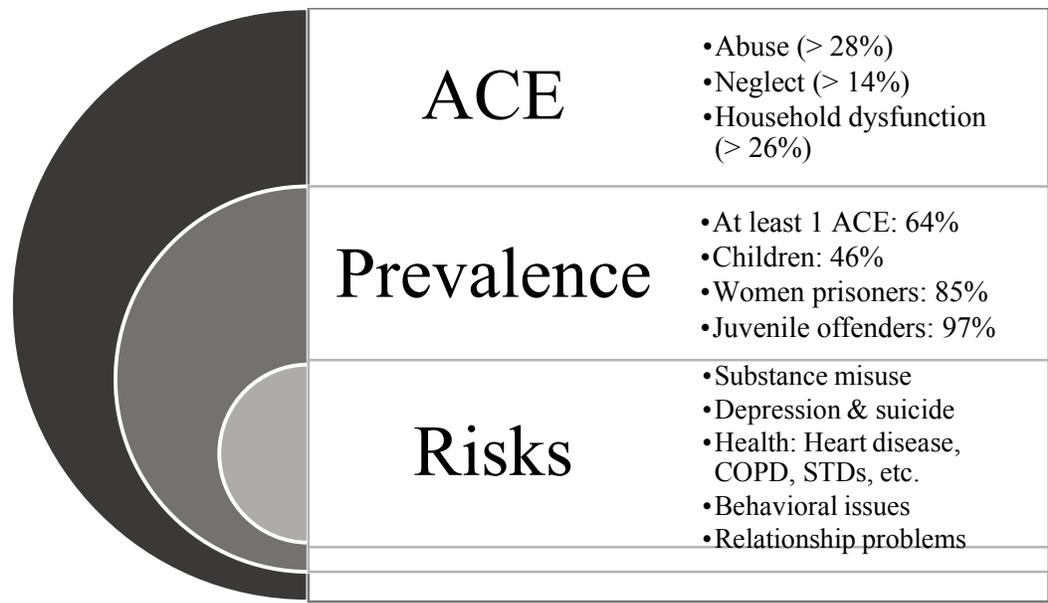
Figure 1. Adverse Childhood Experiences

Buss and colleagues (2015) suggested that many survivors of complex trauma are first diagnosed with a different disorder such as anxiety, depression, attention deficit hyperactive disorder, or oppositional defiant disorder due to their symptomology. According to Zelechoski and colleagues (2013), due to the presentation of symptoms and likelihood of co-occurring disorders, diagnosing clients who have had ACEs remains a challenge. The ICD-11 assisted by narrowly defining CPTSD so that clinicians can delineate more accurate and beneficial diagnosis and treatment (Buxton & Turnbull, 2018). To do so, it is important for clinicians to gather a full picture of the client's life. With this information in mind, researchers and clinicians have developed a new system called Trauma-Informed Care for treating clients who have had ACEs and other types of trauma.

Trauma-Informed Care

According to researchers' recent findings, earlier techniques to address early trauma were ineffective for lasting, successful recovery (Corrigan & Hull, 2015). Fecser

stated that "trauma-informed organizations recognize how traditional management and treatment approaches may exacerbate problems and organize services to be more supportive and avoid re-traumatization" (2014, p. 42). Trauma-Informed Care (TIC) or practice requires clinicians to understand the impact trauma can have across multiple domains (SAMHSA, 2014). Practitioners who engage in TIC seek to create a safe environment and positive therapeutic relationship, without risk for physical harm or re-traumatization, through empowering the client to build coping and functional skills (Wilson & Nochajski, 2016). According to Fecser (2014), for TIC to be fully effective, the approach must be adapted by every part of an organization, including its management and service delivery systems. Hogdon and colleagues (2016) found that a specific trauma-informed approach appeared to reduce depression, anxiety, anger, and behavior disruptions. In addition, the trauma-informed approach also benefited caregivers (Hogdon et. al, 2016). The pillars of TIC shown in Figure 2 embody the mindset of the trauma-informed approach, which can be used across settings and disciplines: safety, trust, choice, collaboration, and empowerment.
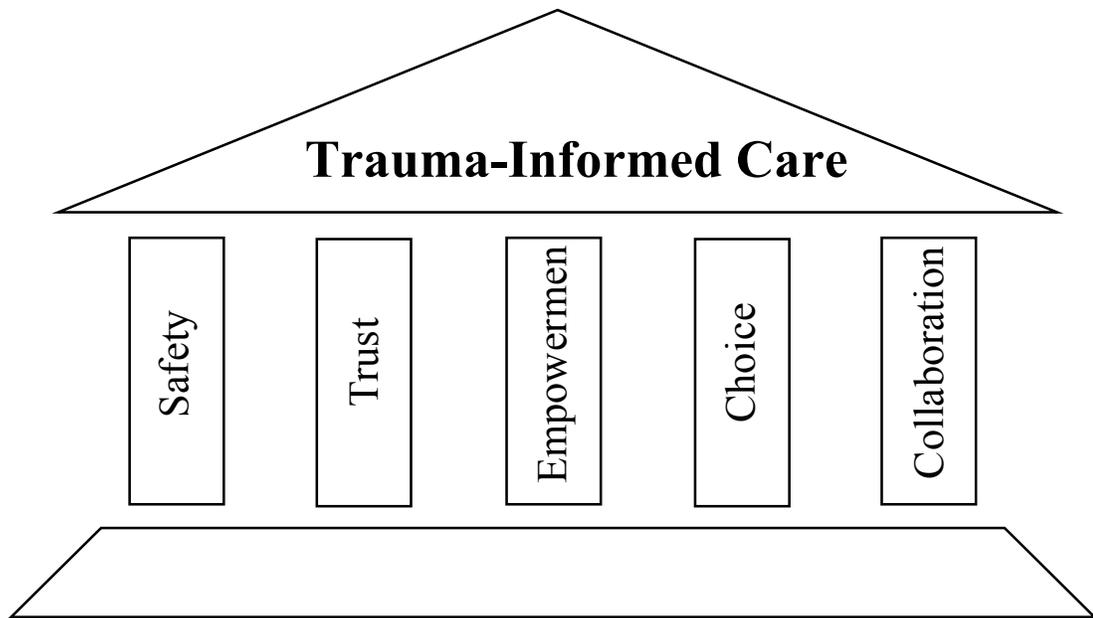
Figure 2. Pillars of Trauma-Informed Care

Safety

As previously mentioned, people who have had ACEs have often encountered

violence of some sort and lack the ability to trust others. They may appear hyper-vigilant

or hyper-aroused (Bath, 2008). Milot and colleagues (2016) reported that clients who

have had ACEs need a secure emotional base to restore a feeling of security. Therefore,

establishing a safe environment is imperative. According to Levenson (2017), a safe

environment enables "trust, choice, collaboration, and empowerment," which allows the

client to experience relationships in a new safe way (p. 106). Buss and colleagues (2015)

also described how safety and stability may be protective factors that let the client know

they are not in any harm. The trauma-informed clinician must always be cognizant of the

effects trauma has had upon the psychosocial and coping development of the client and

take efforts to prevent re-traumatization. Levenson (2017) described a safe environment

as being warm, welcoming, and serene; it has friendly staff, good lighting, and disability

15

accommodations. In a safe environment, people use respectful language and boundaries, and relationships are consistent, predictable, and non-shaming.

Trust

If clients with complex trauma did not develop fundamental trusting relationships early in life, they may experience problems with autonomy, initiative, competence, and intimacy (Levenson, 2017). By providing safety, respect, and acceptance, the clinician can earn trust over time. Levenson (2017) believed it was important for the trauma-informed clinician to present ideas and expectations clearly in order to decrease any anxiety the client may feel. As with all client-therapist relationships, the client should be made aware of how personal information will be kept confidential and the therapist should allow the client to disclose personal details at their own pace. Following these guidelines helps clients know that the clinician understands their needs, is willing to move at their pace, and will validate their strengths. Fostering relationships in which the client develops secure attachment may also help the client to develop better emotional regulation (Buss et. al, 2015).

Empowerment

It is the clinician's responsibility to highlight the strengths of the client and validate the positive choices they make. The focus is moved from fixing problem behaviors to reinforcing strengths (Levinson, 2017). Once empowered, the client begins taking ownership of their recovery and develops lasting coping skills and survival strategies that will contribute to functioning daily in society (Levenson, 2017). Boles (2017) expressed that it is also important to reinforce the supports the client already has in place by helping them continue to thrive.

Choice

One way to empower clients is to provide choices about care that promote autonomy and reinforce independence, moving the client from a victim mindset to that of an overcomer (Levenson, 2017). In a trauma-informed approach, clients are active participants in their recovery experience. Boles (2017) articulated that, "trauma is not happening 'to' them, but rather, 'around' them because they have the capacity to interrupt the potential cycle of trauma" (p. 251). The ability to practice making choices and gaining new coping strategies can also help clients improve impulse control and problem solving (Levenson, 2017). Ways to offer clients choices include asking their preferences about the treatment space, guiding informed decision-making, assessing readiness for change, and processing through certain preferences.

Collaboration

Since TIC is patient-centered and strengths-based, it requires sharing power between clinician and the client in order to create a healing alliance (Levenson, 2017). There is an inherent risk of re-traumatization within the traditional client-therapist relationship due to the power imbalance, where the therapist holds most of the power. The therapist may need to remind clients that they can ask questions, decline services, and make requests, and that they have a say in their treatment (Levinson, 2017). Bath (2008) described multiple collaborative methods that could be incorporated into a trauma-informed approach, including the Collaborative Problem-Solving model for affect management skills, the Response Ability Pathways, and other Life Space Crisis Intervention models (which will be described later in this paper) to support self-regulation skills.

Buss and colleagues (2015) also encouraged clinicians to involve the client's family or current support system in the healing process for the support of the client and to help ensure lasting changes are being made. Collaboration with caregivers can have a positive impact on caregivers by decreasing stress and increasing positive adaptive skills, thereby also positively increasing support of the client (Hogdon et. al, 2016). The following interventions are trauma-informed approaches that are evidence-based.

Trauma Interventions from Related Disciplines

While there is little available research on music therapy and TIC, scholars from related disciplines such as psychology, social work, and special education have developed evidence-based trauma-focused and trauma-informed interventions to better serve clients who have experienced ACEs or trauma. Psychologists developed child-parent psychotherapy, the collaborative and proactive solutions model, and trauma-focused cognitive behavioral therapy (Greene, 2018; Joiner & Buttell, 2018; NCTSN, 2012). The attachment, self-regulation, and competency model resulted from collaborations between psychology and social work (Hogdon et. al, 2016). The life space crisis intervention and response ability pathways approaches were developed through collaboration of all three disciplines (Long, Fecser, & Brendtro, 1998). Some of these approaches are focused on fostering resilience in children who have experienced trauma, whereas others focus on fostering appropriate and supportive relationships and interactions for those of all ages.

Attachment, self-regulation, and competency

The basis for the attachment, self-regulation, and competency (ARC) model is attachment theory, which is based on the idea that secure attachment to caregivers is a

vital part of typical development (Hogdon et. al, 2016; Pasiali, 2014). Clients who are

unable to securely attach to caregivers during childhood may suffer many of the negative

symptoms previously discussed. According to Bartlett and colleagues (2018), ARC

combines the three strategies of attachment, self-regulation, and competency to develop

objective interventions for clients ages 2–21 years.

Child-parent psychotherapy

Child-parent psychotherapy (CPP) is a trauma-informed approach also based on

attachment theory, as well as psychodynamic, developmental, trauma, social learning,

and cognitive behavioral theories (NCTSN, 2012). CPP was developed for treating

children ages 0–5 years experiencing complex interpersonal trauma within the parent-

child relationship (Bartlett et. al, 2018). CPP is designed to strengthen the bond between

the child and caregivers, empower the caregivers to change, and support the child's

mental health. Bartlett and colleagues (2018) reported that CPP has shown to be effective

at reducing behavior problems and PTSD symptoms, decreasing avoidance and resistant

behaviors, and improving attachment to caregivers.

Collaborative and proactive solutions

The collaborative and proactive solutions (CPS) model, formerly known as the

collaborative problem-solving model, is a trauma-informed approach that is proactive and

requires collaboration (Greene, 2018). The model is effective for children who

demonstrate challenging behaviors, but can be applied with clients of all ages. Dr.

Greene, the model developer, posits that challenging behavior occurs when expectations

surpass a person's capacity or skills to respond adaptively and appropriately (2018).

Neither the challenging behavior nor diagnosis are the focus; rather, the client learns the

skills needed to respond appropriately. The CPS model concentrates on providing the person and caregiver with the skills they need to solve a problem or meet expectations (Greene, 2018). CPS can be applied to all varieties of situations and settings (i.e., in the classroom, on the job, decision-making).

Life Space Crisis Interventions

Life space crisis intervention (LSCI) is a trauma-informed interactive therapy method based in neuroscience that teaches how to successfully manage crises with children displaying challenging self-defeating behaviors (Long et. al, 1998). Practitioners in LSCI seek to change the client's and caregiver's mindset from seeing a stressful situation as problematic to seeing the same situation as a learning opportunity (Long et. al, 1998). LSCI teaches caregivers how to help clients and children work through stressful moments by improving self-awareness and regulation skills (Verté & De Moor, 2013). According to Long and colleagues (1998), this strategy allows clients to form relationships based on trust and respect.

Response ability pathways

The response ability pathways (RAP) strategy was developed from research on resilience, neuroscience, and child development (Joshua Foundation, n.d.). Lee (2013) stated that traumatized children do not respond well to coercion and punishment due to their painful experiences. The RAP is based on the Circle of Courage, which uses the key elements of belonging, mastery, independence, and generosity to create a restorative environment that promotes resilience (Lee, 2013). By fostering a restorative and trusting environment, staff and caregivers can prevent future incidence and provide traumatized children with skill they need to be successful.

Trauma-focused cognitive behavioral therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based, goal-oriented treatment for children primarily ages 3–18 years who have experienced trauma. According to Bartlett and colleagues (2018), TF-CBT combines orientations from attachment theory, cognitive-behavioral therapy, exposure therapy, and family therapy models to create a holistic approach for treating children with complex and unique experiences. TF-CBT providers utilize the acronym, "PRACTICE," to summarize components of this therapy, which stands for "psychoeducation and parenting skills, relaxation, affective regulation, cognitive coping skills, trauma narration, in vivo mastery, conjoint child-parent sessions, and enhancing safety and future development" (Bartlett et. al, 2018, p. 112). According to Joiner and Buttell (2018), practitioners of TF-CBT use interventions such as reframing, cognitive processing, parental support/treatment, and stress management techniques. Researchers have found TF-CBT to significantly reduce PTSD symptoms, depression, and behavior problems for clients (Joiner & Buttell, 2018). Joiner and Buttell (2018) also stated that TF-CBT also improves caregiver competency. Each of these interventions require training in psychology-related fields, such as music therapy.

<center>**Music Therapy for Clients with ACEs**</center>

Although literature on using music therapy specifically with clients who have had adverse childhood experiences is limited, there is research available with varying descriptions of traumatic experiences that would be considered ACEs. Desmond, Kindsvatter, Stahl, and Smith (2015) suggested that creative and expressive arts provide "a developmentally appropriate medium for children to process experiences that they

<center>21</center>

may not have the developmental capability about which to communicate through talk

therapy" (p. 440). Since music therapy is strengths-based and inherently expressive, it

seems well-suited for treating clients who have had ACEs (Hanser, 1999). Standley and

Walworth (2010) also stated that music therapy techniques may psychologically benefit

clients adjusting to trauma. Additionally, music therapists often work in settings where

they are likely to serve clients who have had ACEs, including residential treatment

facilities, community organizations and care centers, music therapy clinics and private

practice, schools, and healthcare facilities (AMTA, 2018; Yinger & Powers, 2019).

Pasiali (2013, 2014) has published bodies of research on music therapy and its

effects on family function, expression, attachment, and resilience, which are all important

aspects of treatment with clients who have had ACEs. Resilience is the ability to

withstand and adapt successfully to adverse environmental stressors (Masten, 2014). Key

to the treatment of clients who have had ACEs is developing secure attachment and

promoting resilience. In order to foster resilience, music therapists can prevent trauma

and re-traumatization by knowing the signs of trauma manifestations, educating parents

on appropriate development and regulation skills, supporting and facilitating attachment

relationships between children and caregivers, and helping with skill/asset-building. Once

clients feel safe and a therapeutic relationship is established, music therapists can assist

clients in developing protective factors that lead to improved outcomes. These protective

factors can include a sense of self-efficacy, perceived control, integrating traditions, and

the opportunity to improve adaptive skills and regulatory strategies (Pasiali, 2013). Music

therapists can also promote resilience through teaching positive coping skills and

strategies and mediating relationships. For example, Pasiali (2014) explained how music

can be used as a form of non-verbal communication until the client is able to verbally process their experience to create a meaningful life story.

According to Yinger and Powers' (2019) integrative review of 22 research articles on children who had ACEs and received music therapy, the most common music therapy interventions used to treat clients with ACEs were improvisation ($n = 14$), songwriting ($n = 10$), and playing instruments ($n = 9$). Desmond and colleagues (2015) explored other interventions such as singing, drumming, lyric analysis, movement, music imagery and sandplay, vibroacoustic therapy, and music-assisted relaxation. These interventions can be adapted to meet individual needs at the client's preferred pace and comfort level.

In addition to treatment, Jacobsen and McKinney (2015) developed and piloted a new music therapy tool to assess parent–child interactions in cases of emotional neglect. To do so, they studied 52 child-parent dyads, 18 of which were in a residential center for emotional neglect. After observing two videoed music therapy sessions for each dyad, Jacobsen and McKinney determined that their assessment, which they adapted from the assessment of parenting competencies (APC) and called the APC-R, was a reliable and valid method of assessing these interactions. The APC-R assessment session was monitored for joint play, turn taking, and complex communication. This method could be standardized and included as an assessment model within a trauma-informed framework.

Training in Related Post-Secondary Education

As healthcare providers acknowledge the importance of Trauma-Informed Care (TIC), it is increasingly being included in post-secondary education for related professions, including social work. TIC is being integrated into many social work curricula across the United States. The Substance Abuse and Mental Health Services

Administration also implemented TIC into their KAP Keys curriculum, available online (SAMHSA, 2014). Stefanski and Mason (2017) also piloted a curriculum about TIC for pediatric residents.

Wilson and Nochajski (2016) examined a recently implemented TIC-centered curriculum at a Masters of Social Work (MSW) program in western New York. Wilson and Nochajski (2016) studied first-year and advanced-year MSW students who had completed their first-year training prior to the TIC curricular implementation. They used a true or false questionnaire to assess knowledge and found positive benefits for first-year MSW students, although a ceiling effect was observed regarding student knowledge of and attitudes toward TIC (Wilson & Nochajski, 2016). Wilson and Nochajski (2016) used a 12-item Likert-type scale to assess attitude, and a 0-100-point competency scale to assess self-efficacy, finding that implementing a trauma-informed approach when working with clients had a positive impact on student self-efficacy and behavioral intentions in both groups of students. A 100-point scale was used to assess participants' behavioral intentions regarding implementing TIC approaches in social work practices. When presented with these scenarios, first-year students showed the greatest amount of change in their behavioral intentions regarding using trauma-informed interventions (Wilson & Nochajski, 2016).

Stefanski and Mason (2017) piloted a curriculum on adverse childhood experiences with pediatric residents. Their curriculum was presented in two parts that included an online module, a multimodal workshop, a video, and games. Information presented included the impact of stress on development, the ACE study, screening for ACEs, interventions, resilience, and improving functional skills (Stefanski & Mason,

2017). Participants in Stefanski and Mason's (2017) study reported that the interactive activities and provided resources were the most helpful. The biggest change in practice was regularly screening patients for ACEs, in addition to providing more resources and service access for families who had ACEs (Stefanski & Mason, 2017).

Although it is important to continue using and teaching TIC in social work, other professionals who are likely to encounter clients who have had ACEs could benefit from having training in TIC. Teaching other professionals about TIC would also contribute to continuity of care. Music therapists are likely to encounter clients who have had ACEs; therefore, they would benefit from receiving training in TIC.

Music Therapy Training on Trauma-Informed Care

As previously stated, it is common for music therapists to work with clients who have had adverse childhood experiences due to their prevalence. While research supports the inclusion of TIC in post-secondary education curricula of related disciplines (i.e. social work, pediatric residency; Wilson & Nochajski, 2016; Stefanski & Mason, 2017), there appears to be no published research on the effectiveness of training and how prepared music therapists feel to successfully treat clients who have had ACEs using trauma-informed practices. However, music therapy has been shown to be effective for improving child-caregiver relationships, developing secure attachment, promoting resiliency, and developing self-regulation skills, all catalysts for successfully treating clients who have had ACEs (Desmond et. al, 2015; Pasiali, 2013; Pasiali, 2014; Yinger & Powers, 2019).

As such, the purpose of this study was to develop a training protocol on trauma-informed care for music therapists and then pilot test its effectiveness and feasibility at

preparing music therapists to gain knowledge and understand the implications of trauma-informed care. The research questions were:

1. To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' knowledge regarding trauma-informed music therapy?

2. To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' perceptions of their ability to provide trauma-informed music therapy?

To further develop this training protocol, the researcher asked two exploratory questions:

3. What did music therapists find most helpful about the training?

4. What suggestions did music therapists have for future trainings?

CHAPTER 3.

METHOD

The purpose of this study was to develop a training protocol on trauma-informed care for music therapists and then pilot test its effectiveness and feasibility at preparing music therapists to gain knowledge and understand the implications of trauma-informed care. The University of Kentucky Institutional Review Board (IRB) approved this study. In this chapter, the researcher described the method used to address this aim, including development of the training, participants, data collection, and approach to data analysis. To answer the research questions and further develop the training, the researcher elected to do a pilot training since there appeared to be no prior published studies related to trauma-informed care in music therapy. The researcher developed questionnaires to determine feasibility and effectiveness of the training.

Training Development

The researcher and faculty advisor developed the educational training piloted in the present study to begin to address the lack of research on training music therapists to provide trauma-informed care. The researcher developed the knowledge-based pre-test and post-test from the learning objectives given during the training, as well as the perception test items using available research from related disciplines (Stefanski & Mason, 2017; Wilson & Nochajski, 2016; AMTA, 2013). These questionnaires were given to attendees at a pilot training presentation at AMTA's southeastern regional conference. Using these pilot questionnaires, the researcher determined that more questions were needed to ascertain the overall effectiveness of the training. The original knowledge pre-test and post-test Question 1 ("Name at least one way to foster a safe

27

environment in music therapy") was divided into two parts to gain a more thorough understanding of safety ("Name at least on way to create a physically safe environment in music therapy and one way to foster an emotionally/mentally safe environment"). Also, the following two feedback questions were added to the post-test to allow participants to give their opinion on what was most and least effective about the training:

3. What information presented today was most useful for your current practice as a music therapist?

4. What would you change about this training?

The educational training lasted three hours, in accordance with continuing education (CMTE) requirements provided by the Certification Board for Music Therapy (CBMT), and was available to board-certified music therapists as well as music therapy students and interns. During development of the present study, the researcher attempted to include in the educational training the topics presented by Stefanski and Mason (2017), such as the impact of stress on development, the ACE study, screening for ACEs, interventions, resilience, and improving functional skills. Due to the time constraint, the researcher did not include games or an internet module in the present study training; however, the presentation was still multimodal with experiential learning, videos, and discussion elements. The training presentation was divided into sections as follows: understanding the research on ACEs and resilience, the five pillars of TIC, trauma-informed music therapy for children, and trauma-informed music therapy for adults.

Understanding the research on adverse childhood experiences and resilience

The researcher presented current literature and information about ACEs and resilience for 25 minutes. This included an overview of the three types of ACEs and their

subcategories: (1) abuse (physical, emotional, and/or sexual), (2) neglect (physical and/or emotional), and (3) household dysfunction (mental illness, incarcerated relative, mother treated violently, substance abuse, and/or divorce). Statistics on the prevalence and impacts of ACEs were also presented. Three aspects supporting resilience in clients were described: preventing, promoting, and protecting.

Five pillars of Trauma-Informed Care

The faculty advisor presented about the five pillars of TIC (i.e., safety, trust, empowerment, choice, and collaboration) for 25 minutes. Experiential techniques, such as videos, case studies, group discussion, and practicing techniques guided by the faculty advisor, were used to assist participants in understanding the different ways an event can be perceived by clients.

Trauma-Informed Care for children

The faculty advisor gave an hour-long presentation on providing TIC with children, relating to music therapy. This included potential goal areas, applicable techniques, and considerations for therapy. The importance of providing structure and having patience with the amount of time it takes to build trust was emphasized. At the end, participants were given a case example and discussed how it related to the information presented and what they believed to be the best course of action for their client.

Trauma-Informed Care for adults

The researcher presented for 40 minutes on providing TIC to adults receiving music therapy. This section included information about the manifestation of early trauma in adulthood, the importance of self-care for the therapist and the client, advocating for

29

TIC, and applicable goals and techniques. At the end, participants watched a video that detailed a case example with an adult client, then discussed how the case example related to the information presented and what they believed to be the best course of action for their client.

Participants

Participants were recruited using convenience sampling, which is a non-probability sample acquired from known convenient data sources (Lavrakas, 2008). The researcher and faculty advisor compiled a list of email addresses of known board-certified music therapists and music therapy students in a mid-size city in the southeastern region of the United States. An informational advertisement was emailed to 34 potential participants (see Appendix A) describing the educational training and study. This initial email included a Doodle poll for potential participants to complete to determine the best date to conduct the educational training. A follow-up email was sent one week later, detailing the final date and time the educational training would be held, as well as the informed consent document.

Since some participants were students in the music therapy program directed by the faculty adviser, steps were taken to minimize the potential for undue influence in recruiting potential participants. Specifically, the researcher and faculty advisor were not present while the research assistant obtained consent and administered pre- and post-tests and additional study questionnaires. Board-certified music therapists and music therapy students/interns could attend the training without participating in the research study. Willing participants signed the informed consent document.

Nine potential participants attended the educational training. Of those in attendance, seven opted to be included in the study. The remaining two attendees declined to participate because they were unable to stay for the entire presentation. Inclusion criteria for board-certified music therapists consisted of the following: being at least 18 years old, having graduated from an AMTA-approved university program, and possessing certification through the Certification Board for Music Therapy (CBMT). Inclusion criteria for music therapy students and interns consisted of the following: being at least 18 years old and attending an AMTA-approved university program. No attendees were excluded. Only questionnaires from attendees who signed the informed consent document were included in the analysis (20.59% response rate of those invited to participate).

Instrumentation

The questionnaire tools used for this study were designed by the researcher, guided by the available literature, and consisted of four sections: (1) demographic information, (2) music therapy education/background/current work, (3) pre- and post-test addressing knowledge of trauma-informed music therapy, and (4) pre- and post-test assessing perceptions of preparedness to practice trauma-informed music therapy (see Appendices B–E). All post-test questions were the same as the pre-test, with the addition of feedback questions at the end (see Appendix E).

Demographics questionnaire

Response options for the demographics questionnaire were based on the 2018 American Music Therapy Association (AMTA) Member Survey and Workforce Analysis (AMTA, 2018). The demographics questionnaire contained two sections: 1) demographic

information about the participant and 2) information about the participant's current practice and previous education and training. The *demographics* section consisted of three multiple-choice questions that collected information regarding age, gender identity, and racial identity.

The *current practice* section consisted of nine questions: six about current practice and three about prior education and training. The top of the *current practice* section displayed this definition: For the purposes of this study, Adverse Childhood Experiences are defined as "traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse that can result in long-term negative effects on learning, behavior and health" (see Appendix B; RWJF, 2018, para. 1). This definition was given so participants had a better understanding of what clientele the questionnaire was referring to. This section was used to gather information on the participant's music therapy experiences about related education, years of practice, affiliated region, current and previous work settings, and current ages served.

Pre-test

This section contained six open-ended prompts assessing the music therapists' knowledge of trauma-informed music therapy and nine statements assessing the music therapists' perception of their ability to practice trauma-informed music therapy using a five-point Likert-type scale.

Knowledge. This section contained six open-ended writing prompts, two of which required multiple responses. Writing prompts assessed participants' knowledge of how to address several of the five pillars of trauma-informed care within music therapy

32

practice (Levenson, 2017). Briefly, the five pillars are safety, trust, empowerment, choice, and collaboration. Three prompts related to the ability to apply principles of TIC with children, and three prompts related to applications with adults who have had ACEs. The questionnaire displayed two sections beginning with the following prompts: "When working with a child who has had adverse childhood experiences" and "When working with an adult client who has had adverse childhood experiences" and included three additional prompts within each section.

Perceptions. This section contained nine "I feel confident I can…" statements for participants to rate on a Likert-type scale from one (strongly agree) to five (strongly disagree; see Appendix D). This scale was used to assess the confidence of participants to provide trauma-informed music therapy to clients who have had ACEs. Statements related directly to content presented in the educational training.

Post-test

This section contained the same six knowledge-based prompts and nine items regarding the participants' perceptions of their preparedness to practice trauma-informed music therapy as the pre-test. The post-test ended with two additional open-ended questions for participants to supply feedback on what information they found most useful and recommendations for future trainings.

Procedures

The research assistant explained the information in the informed consent document, answered any questions, and obtained signed consent forms upon attendees' arrival. Following informed consent, all attendees were given the knowledge-based pre-test. Study participants were given an additional pre-test on perception of ability to

practice Trauma-Informed Care (TIC) and the demographics questionnaire (described on page 29). Once the documents were collected by the research assistant, the researcher and faculty advisor entered and presented the training course.

After presenting the training course, the researcher and faculty advisor exited the room and the research assistant delivered the knowledge-based post-test, including two feedback questions, to all attendees. Study participants were given an additional post-test on perception of ability to practice trauma-informed music therapy. The research assistant removed participant names from each document, replacing them with serial letters, and coded participant responses using a key provided by the researcher in order to minimize the risk of bias.

Data Analysis

Quantitative

Participants were given a total score of correct answers out of 9 possible points for the knowledge tests. Each correct response on the knowledge-based tests was worth one point. Using the key provided by the researcher, the research assistant gave participants a numeric score as follows: the number of correct responses out of nine possible points. Individual scores from the knowledge tests were combined into total scores for the pre- and post-test for analysis. The perception items were analyzed independently since those responses were already numerically ranked. To examine differences between pre- and post-test scores, the researcher used a non-parametric Wilcoxon signed ranks test.

Qualitative

In order to answer research questions three and four, the researcher and a committee member with a background in qualitative research used an inductive approach to conduct a content analysis of the two feedback questions from the post-test, which referred to elements of the training that participants found most helpful and the elements they would change or like more of. The researcher began by entering each response to the feedback questions by question number into separate Microsoft Word documents. One of the committee members and the researcher followed the approach to content analysis described by Elo and Kyngäs (2008), which consists of three main phases: preparation, organizing and reporting. First, the researcher and committee member used open coding to determine commonalities in participant responses. All the written responses ($n = 14$) were read independently and notes were made on potential themes. After comparing initial observations and reaching agreement on how to categorize elements of the written responses, the researcher and committee member again read all written responses independently and attempted to classify each written response. The researcher then compared the classifications, discussed any discrepancies with the committee member, and generated themes from the feedback offered by participants. This quantitative and qualitative data was used to better understand the impact of the training course.

CHAPTER 4.

RESULTS

In this pilot feasibility study, music therapists' knowledge of trauma-informed practices and perceptions of preparedness to practice trauma-informed music therapy with clients who have had adverse childhood experiences (ACEs) were examined to determine the influence of the training developed by the researcher. Following a demographics questionnaire, participants responded to pre- and post-test prompts regarding knowledge of Trauma-Informed Care (TIC) and perceptions of preparedness to practice trauma-informed music therapy with clients who have had ACEs. In this chapter, the researcher presents quantitative and qualitative findings.

Participants

Nine people attended the training. Two did not attend the entire session and therefore did not complete the informed consent document. In total, there were seven participants in this study. Board-certified music therapists ($n = 3$, 42.9%) and music therapy students and interns ($n = 4$, 57.1%) attended the educational training and responded to the study questionnaires.

Demographic Information

All seven of the participants fell into the age range 18–29 years and identified as White/Caucasian. The majority of participants identified as women ($n = 5$, 71.4%) and only two identified as men (28.6%). Table 1 presents detailed demographic information.

Table 1
Demographic Information

	n	%
Age		
18–29	7	100.0
Gender		
Women	5	71.4
Men	2	28.6
Racial identity		
White/Caucasian	7	100.0

Music therapy background and current work

All three of the participants who indicated they were currently board-certified had been practicing five years or less. Of the four participants who were not board-certified music therapists, two reported being in internship (28.6%), one indicated having completed internship, but not yet attaining certification (14.3%), and one indicated being a student (14.3%). Of those participants who indicated affiliated region ($n = 6$), the majority reported an affiliation with the southeastern region of AMTA ($n = 5$, 83.3%). One participant reported an affiliation with the midwestern region (16.7%).

Of those who described their education and training ($n = 6$), half of the participants ($n = 3$, 50%) indicated their university courses and/or internship minimally prepared them to practice a trauma-informed approach, and half reported feeling moderately prepared ($n = 3$, 50%); one study participant did not respond to the question about education and training. In response to the open-ended questions about education, three participants reported that trauma-informed care was "touched on" in their undergraduate courses, along with other approaches; two participants reported it was not covered; and one participant reported having had lectures on trauma-informed care since it aligned closely with music therapy philosophies. With regards to continuing education

about trauma-informed care, four participants reported having none, one participant reported having received training through foster and adoption care licensing related to TIC and working with children who have experienced sexual assault, and one participant reported attending a course on "recognizing and reporting trauma" required by their employer. Appendix I lists the complete responses to *Education and Training*, questions two and three.

When indicating current work, participants were allowed to select more than one option and/or self-describe. Regarding work setting, three participants (42.9%) selected "prefer to self-describe" and described a local clinic. Other work settings reported were private practice ($n = 2$, 28.6%) and hospital ($n = 1$, 14.3%). One participant was a student, and therefore did not have a work setting. Table 2 displays detailed information regarding participants' music therapy background, self-reported educational preparedness, and current practice.

Table 2

Background and Current Practice in Music Therapy

	n	%
Current Practice (*n* = 7)		
Board-Certified		
< 5 years	2	28.6
< 1 year	1	14.3
Intern	3	42.9
Student	1	14.3
Affiliated region (*n* = 6)		
Midwestern	1	16.7
Southeastern	5	83.3
Primary practicing location (*n* = 6)		
Hospital/medical	1	16.7
Private practice	2	33.3
University clinic	3	50.0
Educational preparedness (*n* = 6)		
Minimally prepared	3	50.0
Moderately prepared	3	50.0
TIC in curricula (*n* = 6)		
No	2	33.3
Some	3	50.0
Yes	1	16.7
TIC continuing education (*n* = 6)		
None	4	66.7
Social services training (personal)	1	16.7
Employment training requirement	1	16.7

Note. TIC=trauma-informed care. Educational preparedness and inclusion of TIC in curricula were self-reported. These reflect the participant's personal perceptions.

Quantitative Analysis

Research Question 1

To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' knowledge regarding trauma-informed music therapy?

The research assistant scored participants' tests using the key provided by the researcher. Each correct response was worth one point (from nine possible points) and the

resulting sum was the participants' score. Results of a Wilcoxon signed-ranks test indicated that music therapists thought that their knowledge of trauma-informed care on the post-test ($M = 6.71$, $Mdn = 7$, range: 5–9) was significantly greater than on the pre-test ($M = 4$, $Mdn = 5$, range: 2–6; $z = 2.375$, $p = 0.018$, $r = .635$). Table 3 displays detailed pre- and post-test scores and descriptive statistics.

Research Question 2

To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' perceptions of their ability to provide trauma-informed music therapy?

Participants assigned a score from 1 (strongly agree) to 5 (strongly disagree) to statements regarding their perceptions about TIC at pre- and post-training. Results of a Wilcoxon signed-ranks test indicated that music therapists thought that their perception of preparedness to practice trauma-informed music therapy with clients who have had ACEs on post-test items one, two, four, and seven was significantly lower (improved) than on the pre-test. Participants had significantly improved ($p = 0.03$, $r = 0.57$, $z = 2.12$) perceptions of ability to "evaluate the impact of trauma on clients' development" on the post-test item one ($M = 1.86$, $Mdn = 2$, range: 1–2) than on the pre-test ($M = 2.71$, $Mdn = 3$; range: 2–4). Participants' perceptions of ability to "practice effective self-care in order to recognize and address compassion fatigue and/or secondary traumatic stress" were significantly improved ($p = 0.04$, $r = 0.55$, $z = 2.07$) on the post-test item two ($M = 1.57$, $Mdn = 2$, range: 1–2) than on the pre-test ($M = 2.57$, $Mdn = 2$, range: 2–4). Music therapists' perceptions of ability to "justify the techniques I use in music therapy according to trauma theory" on post-test item four ($M = 1.86$, $Mdn = 2$, range: 1–3) was

significantly improved from the pre-test ($M = 3.14$, $Mdn = 3$, range: 2–5; $p = 0.02$, $r = 0.60$, $z = 2.25$). Music therapists' perceptions of ability to "encourage and assist clients in developing healthier coping strategies to manage the effects of ACEs" on post-test item seven ($M = 1.57$, $Mdn = 2$, range: 1–2) were significantly improved from the pre-test ($M = 2.33$, $Mdn = 2$, range: 2–3; $p = 0.03$, $r = 0.60$, $z = 2.24$). Table 3 displays detailed pre- and post-test scores and descriptive statistics.

Table 3
Responses to Knowledge and Perception Questions

	Pre-test			Post-test				
	Mdn	*M*	*SD*	*Mdn*	*M*	*SD*	*p*	*r*
Knowledge	5.0	4.00	1.83	7.0	6.71	1.80	.027	.63
Perception Q1	3.0	2.71	0.76	2.0	1.86	0.38	.034*	.57
Perception Q2	2.0	2.57	0.79	2.0	1.57	0.53	.038*	.55
Perception Q3	3.0	2.43	0.79	2.0	1.71	0.49	.059	.51
Perception Q4	3.0	3.14	1.07	2.0	1.86	0.69	.024*	.60
Perception Q5	2.5	2.33	0.82	1.5	1.57	0.55	.059	.51
Perception Q6	2.0	2.67	1.21	2.0	1.71	0.41	.102	.44
Perception Q7	2.0	2.33	0.52	1.5	1.57	0.55	.025*	.60
Perception Q8	2.0	2.33	0.52	2.0	1.86	0.52	.102	.44
Perception Q9	2.0	2.17	0.75	2.0	1.86	0.41	.157	.38

Note. The *p* values and effect sizes (*r*) are the results of the Wilcoxon signed rank tests.
* $p < .05$.

Qualitative Analysis

Research Question 3

What did music therapists find most helpful about the training?

To better understand what participants found most helpful from the training, the researcher worked with a committee member to conduct a content analysis, which consisted of three phases: preparation, organizing, and reporting. Three themes emerged from the data: (1) *philosophy of Trauma-Informed Care* (TIC; $n = 4$), (2) *practical interventions and tools* ($n = 4$), and (3) *understanding adverse childhood experiences* (ACEs; $n = 2$). Theme 1 (*philosophy of TIC*) included comments related to the principles of and philosophies underlying TIC presented during the training. For instance, one participant wrote, "As a student, I will now strive to universally design labs and session plans with trauma-informed consideration." Theme 2 (*practical interventions and tools*) included comments about various techniques and music therapy tools presented. Theme 3 (*understanding ACEs*) included comments about the impact of ACEs and how they present differently. For example, one participant reported they learned "how to apply a trauma-informed practice with children specifically and how it differs from working with adults."

TIC philosophy
- ACT response
- involving caregivers
- justifying practices
- universal design

Interventions & Tools
- emotion regulation
- grounding

Understanding ACEs
- ACE scores
- children v. adults
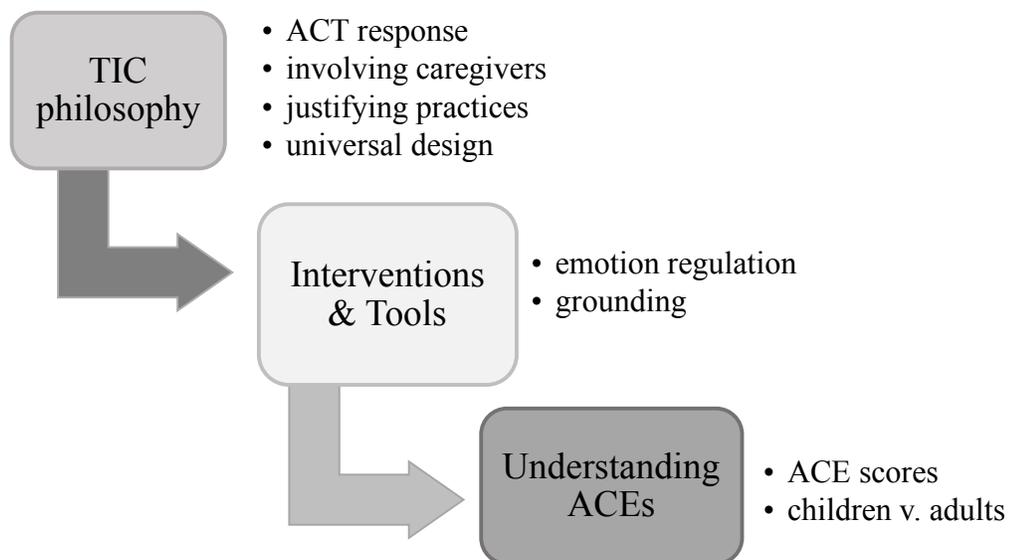
Figure 3. Reported Training Benefits

Research Question 4

What suggestions did music therapists have for future trainings?

To better understand the suggestions participants made for future trainings, the researcher and committee member conducted a content analysis, resulting in three themes: (1) more critical thinking exercises/case examples ($n = 2$), (2) more music therapy-specific adaptations ($n = 2$), and (3) more information on trauma in adult clients ($n = 1$). For instance, one participant said, "I really enjoyed the critical thinking practices through case study group discussions. I would enjoy more opportunities similar to this," which was seconded by another participant. Please refer to Appendix H for a complete list of participant responses.

CHAPTER 5.

DISCUSSION

The purpose of this study was to develop a training protocol on Trauma-Informed

Care (TIC) for music therapists and then pilot test its effectiveness and feasibility at

preparing music therapists to gain knowledge and understand the implications of trauma-

informed care. The researcher developed the pilot training for this study from available

research in music therapy, social work, psychology, and special education. Participants

responded to prompts regarding knowledge of TIC and perceptions of preparedness to

practice trauma-informed music therapy before and after the training to determine the

training's influence. This chapter presents interpretation of the resulting data, discussion

of feasibility of the training, recommendations for improvements to the training and

future research, and limits to the current study.

Research Question 1

To what extent did a 3-hour training session influence board-certified music

therapists' and music therapy students' knowledge regarding trauma-informed music

therapy?

The quantitative results of this pilot feasibility study provide support for the use

of this educational training to improve music therapists' knowledge of trauma-informed

music therapy for clients who have had ACEs. The combined results of the knowledge-

based pre- and post-tests suggest that such training may improve music therapists'

understanding of how to approach and treat clients who have had ACEs. The

improvement in knowledge indicates that this training was beneficial in improving music

therapists' understanding of trauma-informed care. This knowledge may help them apply

this approach with clients who have had ACEs, who music therapists often treat (AMTA, 2018).

Participants appeared to gain the most knowledge regarding providing a safe environment for clients. This topic was covered in detail during the training when discussing introducing the five pillars of TIC, then discussed again during discussion of adults and children. The repetition of the material and discussion during both case examples may have contributed to participants' success on this question. The second most-improved question was item five, which had participants list three goal areas common for these clients. Goal areas for children and adults were explicitly covered during the training, therefore participants most likely better understood the question and remembered the areas discussed as being broad categories, rather than referring to specific objectives.

Two of the most common questions answered incorrectly were about the therapeutic relationship and the therapeutic alliance (knowledge questions 4 and 6), both of which were discussed with adults. Participants could have also confused the therapeutic relationship and alliance given the similarity in terminology. Since participants requested more time to discuss adults, lack of time may have contributed to this misunderstanding. Presenters offering similar trainings in the future should take this into consideration and allocate more time to discussing the therapeutic relationship and therapeutic alliance.

There appeared to be no change in results on question two, regarding collaborating with a child's family; however, different participants answered correctly on the post-test than on the pre-test. Question two asked participants for a reason to

communicate with parents and/or caregivers, which Levenson (2017) suggested could be beneficial in developing a support system and ensuring progress transfers to the home environment. The fluctuation in responses could be due to confusion about the wording of the question. Those who answered correctly on the pre-test, but incorrectly on the post-test may have second-guessed their response while reflecting during the training. Those whose answers improved could have gained a greater understanding of TIC from the training or had time to reflect upon their answer. While some participants whose responses to this question were marked incorrect listed valid reasons to communicate with parents, the reasons given were not specific to this training. Correct answers encompassed fostering meaningful connection in relationship, similar to those described by Bath (2008). Future researchers should try narrowing the question within the scope of the study to improve clarity for respondents.

Research Question 2

To what extent did a 3-hour training session influence board-certified music therapists' and music therapy students' perceptions of their ability to provide trauma-informed music therapy?

Of all the questions related to perceptions, participants demonstrated the greatest change on perception item four, in which participants indicated their perceived ability to "justify the techniques used according to trauma theory." Given that most participants had little to no training on TIC prior to this study, this response is expected. The second most-improved item was number two, in which participants' indicated their level of confidence to "practice effective self-care in order to recognize and address compassion fatigue and/or secondary traumatic stress." Moore and Wilhelm (2019) found that music

therapy students perceive higher levels of stress than other undergraduate students and burnout is common among music therapy professionals; therefore, self-care was covered explicitly during this training to help decrease the risk for practitioners to experience secondary traumatic stress. In future presentations, the researcher recommends that the focus on self-care be retained.

At pre-test, participants reported feeling minimally to moderately prepared to practice TIC; no participants indicated feeling very prepared to practice trauma-informed care. While it is important to note that participants represented only two universities, Clements-Cortes (2015) also found that pre- and post-internship music therapists had anxiety about applying theories in practice and counseling skills, both of which are important to TIC. The overall quantitative results provide support for the use of this educational training to improve music therapists' perception of preparedness to practice trauma-informed music therapy with clients who have had ACEs, with improved perceptions after less than three hours of educational instruction. According to the Wilcoxon signed ranks test, participants had significantly improved perceptions on four post-test items. Participants showed improvement on all remaining items, but these differences were not significant.

Participants reported having the least amount of confidence on post-test items one (evaluation) and four (sociocultural factors). Item one had participants rate their ability to "evaluate the impact of trauma on clients' development." In retrospect, this item does not accurately reflect the music therapists' scope of practice unless the music therapist is collaborating with a psychologist (or other diagnostician) or has prior training that supports advanced competency in this specific area (AMTA, 2015). Therefore, this result

could be expected. Evaluation was only briefly discussed as part of a broad overview of

the impact of ACEs because of time and the vast amount of information being presented.

If this item remains a part of the questionnaire, researchers should consider rewording the

question to more accurately reflect the scope of music therapy practice. For example,

music therapists often conduct assessments to determine if music therapy is an

appropriate treatment for the client and to create appropriate treatment plans (AMTA,

2015). This delineation should be made clear in future presentations, along with more

thorough information on appropriate assessment and collaboration, such as Stefanski and

Mason detailed in their pilot curriculum (2017). In item four, participants indicated their

perceived confidence in understanding "the interaction of sociocultural factors on clients

who experienced ACEs." Although some sociocultural factors were covered briefly while

presenting information about ACEs, they were not discussed explicitly since they weren't

one of the primary purposes of the training. However, the scope of music therapy practice

includes assumptions that music therapists will practice ethically and be respectful of

clients' values (AMTA, 2015). Therefore, including information on sociocultural factors

impacting ACEs and delineating the link between socio-economic status and ACEs is

important and should still be discussed future trainings.

Research Question 3

What did music therapists find most helpful about the training?

Three themes emerged from the content analysis: (1) *philosophy of Trauma-Informed Care (TIC)*, (2) *practical interventions and tools*, and (3) *understanding adverse childhood experiences (ACEs)*. Theme one (*philosophy of TIC*) included comments about to the underlying philosophies of TIC, as well as related philosophies

such as universal design. One benefit of TIC is that the approach functions well with all populations, not just those who have had ACEs; therefore, incorporating a trauma-informed approach will benefit all music therapy clients, whether or not they have a history of trauma. *Practical interventions and tools* included comments that identified specific interventions and goals such as grounding, emotion management/regulation, resources, and ACT limit setting. Stefanski and Mason (2017) also found that the resources provided were reported as very beneficial. Bath (2008) reported that those who have had ACEs often have poor self-regulation and emotional coping skills. One participant expressed that they would pass on "tools for grounding and emotion management" to their clients, connecting this knowledge to empowering their clients as Levenson (2017) suggested. Limit setting is a technique commonly used in therapy with children in which the professional or caregiver A — acknowledges the child's feelings, wishes, and wants, C—communicates the limit, and T—targets acceptable alternatives. This technique provides structure, as described by Levenson (2017), while still validating the child's experience. It also teaches acceptable behaviors, which empowers the client to make changes (Levenson, 2017; Bath, 2008).

Theme 3 (*understanding ACEs*) included comments about ACE scores and understanding the difference between treating children and treating adults who have had ACEs. The CDC reports that ACEs have a huge impact on future violence and lifelong health. The financial burden associated with the treatment of poor health outcomes due to maltreatment is similar to that of other leading health problems, like stroke and diabetes (CDC, 2016). While most music therapists are not responsible for diagnosing health issues, ACEs were explicitly covered in this training because it is important for music

therapists to be able to recognize the signs and impact of ACEs on clients and society. By recognizing these impacts, music therapists can develop more appropriate and effective treatment plans for clients who have had ACEs and other forms of trauma.

Research Question 4

What suggestions did music therapists have for future trainings?

Three themes emerged from the content analysis: (1) more critical thinking exercises/case examples ($n = 2$), (2) more music therapy-specific adaptations ($n = 2$), and (3) more information on trauma in adult clients ($n = 1$). Given the time constraints of the present study, it was only possible to include one case example for adults and one for children. The three-hour time limit also allowed only a few minutes for attendees to discuss each case. Participants expressed the desire for more opportunity to discuss case examples, therefore, future presenters should consider offering a longer presentation or break a larger presentation into multiple parts. More time would also allow presenters to cover more music therapy specific techniques and adaptations, especially on adults. The majority of the second half of the presentation covered children, since over half of AMTA members surveyed reported working with children (AMTA, 2018). Future presentations might spend equal time on children and adults.

Limitations

The current pilot feasibility study had several limitations. In the context of a pilot feasibility study, which by design has a small sample size ($n = 7$), several conclusions regarding limitations should be addressed. First, results from this study should not be generalized; rather, they should be used to further develop training regarding Trauma-

Informed Care (TIC) for music therapists. Additionally, results of a pilot feasibility study should be interpreted cautiously.

Secondly, due to participants' lack of prior study of trauma-informed care, participants may have rated their perceptions of preparedness higher on the pre-test than is actually true. This phenomenon is similar to the Dunning-Kruger effect, in which individuals believe they are smarter and more capable than they actually are (Dunning, 2011). Participants may have rated their perceptions high on the pre-test due to not realizing the extent of what they did not know. Participants may also have had difficulty separating TIC from theoretical model often applied in music therapy during the pre-test, as the two may display similarly. For example, the biopsychosocial model, which is a theoretical framework and practical guide to care that observes the complex interaction of biology, psychology, and socio-economic factors upon an individual in order to provide the best holistic care, is often used in music therapy (Borrell-Carrió, Suchman, & Epstein, 2004). The principles of the biopsychosocial model are similar to those of TIC in observing a client's history and subjective experience and how those interact with biology and psychology to bring the individual to their present state (Nemesh, 2017). TIC is also relatable to a human-centered approach as they both focus on the client's subjective experience and needs, not only on clinical symptom presentation (Hargraves, 2018).

Likewise, it is possible that taking a pre-test may, in itself, positively affect post-test scores; a phenomenon known as pre-test sensitization (Salkind, 2010). There was no control group due to the pre-test/post-test design, therefore results should be interpreted cautiously. Without a control group and larger sample, it is impossible to determine what

effects were purely from the training alone. There was also high collegiality observed among attendees and presenters, which may have impacted how honestly participants responded to test items.

Time was a limiting factor for this study. Since participant recruitment proved difficult, a longer training may have made scheduling and attendance even more problematic. Therefore, an attempt was made to match the format of the training with the pre-2019 standards set by CBMT, which specified music therapists must have a minimum of 150 minutes of direct instruction for a continuing education course. However, many participants (*n = 4*; 66.7%) noted in feedback a desire to have more time to discuss case examples and trauma-informed music therapy for adults. Future researchers may consider offering this training in multiple parts, over a longer time period, or develop an online training (e-course) to be offered in one or multiple parts. Multiple training parts could be distributed over the course of a few days to a semester.

Suggestions for Future Research

This study was designed to collect information about the training's feasibility and impact this training may have on music therapists' knowledge of trauma-informed care and perceptions of preparedness to practice trauma-informed music therapy with clients who have had ACEs. Since this was a pilot feasibility, future research should be done with larger samples to better determine effectiveness and whether results may generalize to other music therapists. The researcher had difficulty recruiting participants for this present study; therefore, future researchers may consider offering this training online or at a conference with a high attendance rate where there will be a larger sample pool. The training could be expanded, as there is plenty of important relevant information available,

and offered as a webinar or e-course through an organization such as the American Music Therapy Association (AMTA).

To further examine how participants applied this training, future research should determine what and how the participants applied this knowledge in their own practice. The follow-up should also assess music therapists' successes in and barriers to making trauma-informed practice changes, like the survey performed by Stefanski and Mason (2017). Other methods could be used to gain a more descriptive picture of application, such as a qualitative study using participant interviews.

During this training, the experiences listed included witnessing crime, which was not included in the original study (Felitti et. al, 1998). The researcher recommends the definition for ACEs be altered to accurately reflect the specific experiences described in the original ACE study. Although the definition of trauma was purposefully narrowed for this study, future research ought to address other issues related to providing trauma-informed music therapy since the current body of research is very limited and music therapists are known to work with clients who have had trauma (AMTA, 2018). Furthermore, music therapists who practice TIC could be interviewed, along with their clients, to examine the benefits and challenges in providing and receiving trauma-informed music therapy.

Implications for Education and Clinical Training

Based on the results of this study, it seems feasible to offer a 3-hour training to impart basic knowledge about TIC practices relevant to music therapists; however, more time may be necessary to adequately cover specific techniques for both children and adults. Half of the study participants, which were from the same two universities, self-

reported they felt no more than minimally prepared by their prior education to practice

TIC. Given that at least 51% of American Music Therapy Association members reported

working in settings where they are likely to encounter these clients (i.e., mental health,

schools, medical, & private practice; AMTA, 2018), training in TIC is not only feasible

but important to ethical and appropriate music therapy treatment. Based on the perception

of preparedness to practice results, feedback responses, and ratings on the education

questionnaire, music therapists would most likely benefit from receiving more education

on trauma-informed music therapy for clients who have had ACEs.

Training Improvement

One way to improve this training includes determining the best delivery method

for this information. Even though participants' scores showed improvement after only

three hours, multiple participants reported a desire to have more time. For instance, the

training could be extended or offered over multiple sessions to cover important

information more thoroughly. While this could be done in-person, possibly at a major

conference, the training could be developed into a webinar or e-course. Any of these

options would allow more time for information to be presented and for participants to

discuss the information and ask questions. Music therapists may also benefit from

incorporating this information into the general and/or graduate curriculum for music

therapy. This could be done in a variety of ways including as a course, as a unit within a

course, or as a research assignment or opportunity.

Other ways to improve this training include allowing more time and opportunities

for critical thinking and group discussion, which was suggested by multiple participants.

This would allow participants to think through more practical application for clinical

practice using the information presented. The validity of the test for knowledge

acquisition should be completed prior to a larger study in order to improve the training.

Conclusion

All participants in the present study demonstrated improved knowledge and

perceptions of preparedness to practice trauma-informed music therapy with clients who

have had ACEs. Participants reported the specific interventions given and case example

discussion as most beneficial. They expressed a desire for more time to review case

examples and discuss trauma in adult clients.

The most useful components to music therapists in this study appear to be the

prevalence and impact of ACEs, trauma-informed techniques that can be applied in music

therapy, and considering the pillars of trauma-informed care (TIC) when developing

treatment plans. One participant commented that, while the music therapist may not know

whether or not a client has had ACEs, the trauma-informed approach can be beneficial to

all clients (universal design). Since participants also appreciated music therapy-specific

applications, more could be offered in the future. It appeared that the concept of the time

it takes to build trust with clients who have had ACEs was also valuable information,

which one participant wrote not to take this personally. Emphasis on the importance of

the therapeutic relationship and therapeutic alliance was also valuable.

Presentation of this material in an educational workshop format appears to have

an impact on music therapists' knowledge of TIC with clients who have had ACEs and

music therapists' perception of ability to practice TIC with these clients. As other related

professions have recognized the importance of Trauma-Informed Care and implemented

education on these practices, the profession of music therapy should take note. More

education should be offered in the future to improve ethical music therapy treatment.

These results can be used to improve upon music therapy practice and education, leading

to more effective music therapy treatment for clients who have had ACEs.

APPENDICES

Appendix A: Education Training Advertisement

Dear colleagues:

I would like to invite you to attend a free 3-hour educational presentation entitled *Trauma-informed music therapy for clients who have had adverse childhood experiences* that Dr. Yinger and I plan to host at the University of Kentucky. This presentation has not been pre-approved by CBMT, but we will provide you with a certificate and learning objectives so that you can submit this presentation as a non-approved educational course for CMTE credit. If you attend, I will request your permission to analyze the pre- and post-tests you complete before and after this presentation as part of my thesis research, but you may still attend the presentation even if you do not want to take part in the research study. You will have an opportunity to learn more about my study and decide if you want to participate at a later date.

If you are interested in attending this presentation, please take a few minutes to submit your availability to attend training 3-hour course in late September. Your input will help us to schedule the presentation during a time when the most people can attend. If you are not interested in attending the presentation, please do not submit your availability. By submitting your availability, you are NOT committing to participate in my study, just expressing your interest in learning more about this topic.

If you have questions, please email McKenna Wilson at mckenna.wilson@uky.edu or Olivia Yinger at olivia.yinger@uky.edu.

Please click here to complete the survey.

Thank you for your consideration.

Best,

McKenna Wilson, MT-BC

Neonatal Intensive Care Unit Music Therapist

Name: _____

Trauma-informed music therapy for clients who have had adverse childhood experiences (ACEs)

Demographics Questionnaire

Demographics

1. Gender
   a. Male
   b. Female
   c. Transgender
   d. Prefer to self-describe:
   _____

2. Ethnicity
   a. African American
   b. Asian
   c. Hispanic
   d. Native American
   e. Pacific Islander
   f. White
   g. Prefer to self-describe:
   _____

3. Age
   a. 18 – 29
   b. 30 – 39
   c. 40 – 49
   d. 50 – 59
   e. 60 – 69
   f. 70

For the purposes of this study, Adverse Childhood Experiences are defined as "traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse that can result in long-term negative effects on learning, behavior and health" (RWJF, 2018, para. 1).

Current Practice

1. Please describe what trauma-informed music therapy looks like for you:

2. How long have you been practicing as a board-certified music therapist?

3. Region Served

   a. Great Lakes

   b. Midwestern

   c. Southeastern

   d. Other:

   _____

4. Place of Employment

   a. Hospital/Medical Clinic

   b. Rehabilitation Facility

   c. Psychiatric Facility

   d. Military Contractor

   e. School District/Contractor

   f. Private Practice

   g. Hospice

   h. Prefer to Self-Describe:

   _____

5. Please describe your experiences working with clients who have had Adverse Childhood Experiences:

6. Why are you interested in learning about trauma?

Education and Training

1. To what degree would you say your baccalaureate or equivalency courses and/or internship prepared you to practice a trauma-informed approach?

   a. Not prepared

   b. Minimally prepared

   c. Moderately prepared

   d. Very prepared

2. Was the Trauma-Informed Care approach included in your academic program? How?

3. Please describe any continuing education you have completed related to Trauma-Informed Care:

Appendix C: Knowledge-Based Questionnaire

Name: _____

Trauma-informed music therapy for clients who have had adverse childhood experiences (ACEs)

Pre-test

When working with a child who has had adverse childhood experiences:

1. Name at least one way to create a physically safe environment in music therapy and one way to foster an emotionally/mentally safe environment.

2. Name at least one benefit of communicating with and involving the child's family.

3. Name at least one important consideration when designing a music therapy treatment plan.

When working with an adult who has had adverse childhood experiences:

4. Name at least one way you can foster a safe and trusting therapeutic relationship.

5. Name three goal areas that you might address.

6. Name at least one way to build a strong therapeutic alliance.

Appendix D: Perception-Based Questionnaire

Name: _____

Trauma-informed music therapy for clients who have had adverse childhood experiences (ACEs)

Perception of Preparedness to Practice

Please respond to the following statements as honestly as possible by indicating the number that corresponds to your feeling for each statement:

1=Strongly Agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly Disagree

1. I feel confident I can evaluate the impact of trauma on clients' development.
2. I feel confident I can practice effective self-care in order to recognize and address compassion fatigue and/or secondary traumatic stress.
3. I feel confident I can understand the impacts of ACEs on clients' current behaviors and/or cognitive issues.
4. I feel confident I can justify the techniques I use in music therapy according to trauma theory.
5. I feel confident I can understand the interaction of sociocultural factors on clients who experienced ACEs.
6. I feel confident I can develop a treatment plan for clients experiencing ACEs
7. I feel confident I can encourage and assist clients in developing healthier coping strategies to manage the effects of ACEs.
8. I feel confident I can communicate effectively with a client's family members and/or guardians when appropriate to improve support for clients experiencing ACEs.
9. I feel confident I can advocate for my clients' trauma-specific treatment and needs.

Appendix E: Feedback Questionnaire

Feedback

1. What information presented today was most useful for your current practice as a music therapist?

2. What would you change about this training?

Appendix F: IRB Certificate of Approval

University of Kentucky | Office of Research Integrity
IRB, RDRC

Modification Review

Approval Ends: 9/9/2020   IRB Number: 47947

TO: McKenna Wilson, MMT
    Fine Arts - Music
    PI phone #: ▮▮▮▮▮▮▮▮▮▮
    PI email: mckenna.wilson@uky.edu

FROM: Chairperson/Vice Chairperson
    Nonmedical Institutional Review Board (IRB)

SUBJECT: Approval of Modification Request

DATE: 10/15/2019

On 10/15/2019, the Nonmedical Institutional Review Board approved your request for modifications in your protocol entitled:

Effectiveness of Trauma-Informed Care Training on Music Therapists' Knowledge and Perception of Preparedness

If your modification request necessitated a change in your approved informed consent/assent form(s), the new IRB approved consent/assent form(s) to be used when enrolling subjects can be found in the "All Attachments" menu item of your E-IRB application. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.]

Note that at Continuation Review, you will be asked to submit a brief summary of any modifications approved by the IRB since initial review or the last continuation review, which may impact subject safety or welfare. Please take this approved modification into consideration when preparing your summary.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" available in the online Office of Research Integrity's IRB Survival Handbook. Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI's web site. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at 859-257-9428.

Appendix G: Informed Consent Document

Consent to Participate in a Research Study

**KEY INFORMATION FOR EFFECTIVENESS OF TRAUMA-INFORMED CARE
TRAINING ON MUSIC THERAPISTS' KNOWLEDGE AND PERCEPTIONS**

We are asking you to choose whether or not to volunteer for a research study about
trauma-informed music therapy. We are asking you because you are a pre-service or in-service
music therapist who is attending a training workshop for music therapists on working with clients
who have had Adverse Childhood Experiences. This page is to give you key information to help
you decide whether to participate in the research component of this training. We have included
detailed information after this page. Ask the research team questions. If you have questions later,
the contact information for the research investigator in charge of the study is below.

WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?
By doing this study, we hope to learn whether a three-hour training course helps prepare
music therapists to practice trauma-informed music therapy. The training, which is not a part
of the research, will last approximately three hours. Your participation in the research
component related to the training is expected to take an additional 30 minutes.

**WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS
STUDY?**
There are no rewards for participating in this study. The training may benefit music
therapists' current and future work with clients who have had adverse childhood experiences.

**WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR
THIS STUDY?**
This study poses minimal risk for participants to experience secondary traumatic stress due to
the content of the training. You will be reminded of the risk and training content prior to the
study. You are free to leave the training at any time. Completion of the pre- and post-tests,
both the ones administered during the course of the regular training and the ones administered
as part of the research study, is completely voluntary.

DO YOU HAVE TO TAKE PART IN THE STUDY?
Participation in the study is completely voluntary. You will not lose any services, benefits, or
rights you would normally have if you choose not to volunteer. For in-service music
therapists, declining to participate in the research component of the study will not affect
whether or not you could submit the training for CMTE credit with CBMT. As a student, if
you decide not to take part in this study, your choice will have no effect on your academic
status or class grades.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

The person in charge of this study is McKenna Wilson, MT-BC a graduate student of the
University of Kentucky, School of Music, Division of Music Education and Music
Therapy. If you have questions, suggestions, or concerns regarding this study or you want to
withdraw from the study her contact information is: mckenna.wilson@uky.edu. You may also
contact the thesis advisor for this study, Dr. Olivia Yinger of the University of Kentucky,

Department of Music Therapy. Her contact information is: olivia.yinger@uky.edu or 859-218-0997.

If you have any questions, suggestions or concerns about your rights as a volunteer in this research, contact staff in the University of Kentucky (UK) Office of Research Integrity (ORI) between the business hours of 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428

DETAILED CONSENT

ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?
If you are not a pre-service or in-service music therapist who attends the researchers training on trauma-informed care, then you would not qualify for this study.

WHERE WILL THE STUDY TAKE PLACE AND WHAT IS THE TOTAL AMOUNT OF TIME INVOLVED?
The research procedures will be conducted at the University of Kentucky Fine Arts Library. You will need to come one time during the study for the educational training. The total amount of time this visit will take is about 3.5 hours one day in late September. The training is three hours long and the pre- and post-tests are expected to take approximately 30 minutes.

WHAT WILL YOU BE ASKED TO DO?
The 3-hour trauma training is a continuing education opportunity for music therapists that the researchers have offered in the past and that in-service and pre-service music therapists may attend as an educational opportunity without participating in the study. As such, the training in itself and the pre-test and post-test, which ascertain whether attendees learned key information from the training, are not part of the research procedures. If you attend and consent to participate in the research study, you will be asked to complete a form with demographic information and answer questions about your perceptions of your ability to provide trauma-informed care, in addition to the original pre- and post-tests. Consenting to participate in the research study allows the researchers to use information from both the standard pre- and post-tests and the additional perception and demographic research questions for purposes of the research study. Everyone who attends the training will receive the same content. Research participants will be asked to complete an additional pre- and post-test and preparedness questionnaire, but completion of these activities is voluntary.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
This study poses minimal risk for participants to experience secondary traumatic stress due to the content of the training. Participants are free to leave at any time. Completion of the pre- and post-tests is completely voluntary. There is also minimal risk for identifying information to be taken from the pre- and post-tests.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?
You may not may not get any personal benefit from taking part in this study. However, if you take part in this study, information learned may help others.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?
If you do not want to be in the study, you may still attend the educational training.

WHAT WILL IT COST YOU TO PARTICIPATE?
There are no costs associated with taking part in this study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

When we write about or share the results from the study, we will write about the combined information. We will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing what information that you gave us. To protect your confidentiality, paper records will be stored in a lock box in the researcher's home. Electronic data will be stored in a secure OneDrive folder. We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data obtained via the Internet. You should know that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to share your information with officials of the University of Kentucky, who may look at or copy pertinent portions of records that identify you.

CAN YOU CHOOSE TO WITHDRAW FROM THE STUDY EARLY?

You can choose to leave the study at any time. You will not be treated differently if you decide to stop taking part in the study. If you choose to leave the study early, data collected until that point will remain in the study database and may not be removed. The investigators conducting the study may need to remove you from the study. This may occur for a number of reasons. You may be removed from the study if you are not able to follow the directions.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

There are no rewards or payment for taking part in this study.

WILL YOU BE GIVEN INDIVIDUAL RESULTS FROM THE RESEARCH TESTS/SURVEYS?

Generally, tests used for research purposes are not meant to provide results that apply to you alone.

WHAT ELSE DO YOU NEED TO KNOW?

If you volunteer to take part in this study, you will be one of about twenty people to do so. The primary researcher is McKenna Wilson, a graduate student who is being guided in this research by thesis advisor, Dr. Olivia Yinger. There may be other people on the research team assisting at different times during the study.

WILL YOUR INFORMATION BE USED FOR FUTURE RESEARCH?
Your information collected for this study will NOT be used or shared for future research studies, even if we remove the identifiable information like your name. Your information collected for this study will NOT be used or shared for future research studies, even if we remove the identifiable information like your name.

INFORMED CONSENT SIGNATURES

This consent includes the following:
Key Information Page
Detailed Consent

You are the subject or are authorized to act on behalf of the subject. You will receive a copy of this consent form after it has been signed.

_____   _____

Signature of research subject *or, if applicable,*   **Date**

research subject's legal representative

_____

Printed name of research subject

_____   _____

Printed name of authorized person obtaining informed consent   Date

Appendix H: Feedback Responses

Feedback Question 1

What information presented today was most useful for your current practice as a music therapist?

- As a student, I will now strive to universally design labs and session plans with trauma-informed consideration.
- How to apply a trauma-informed practice with children specifically and how it differs from working with adults.
- More info on ACE scores… same score and same experience
- Got things/interventions/tools I can immediately take back to work and use
- All was very beneficial – equal
- Information on involving parents in treatment
- I found the tools to pass along to clients for grounding and emotion management were very helpful; and understanding the patience that's required
- Standard ways to structure a session to support clients who have/may have experienced trauma
- ACT response method
- Justification for therapy techniques (ex. Positive social skills transfers to baggage about the world) goal

Feedback Question 2

What would you change about this training?

- N/A
- I really enjoyed the critical thinking practices through case study group discussions. I would enjoy more opportunities similar to this.
- I wish we could have done more case examples but time wasn't on our side. Overall <u>SO</u> stellar.
- More music therapy specific adaptations: how does this look in session; how do you adapt interventions; what does it change language.
- Maybe spend a little more time on trauma in adults
- I think this training was already very valuable. Maybe intervention/music examples could be added.
- Nothing; great handouts, very clear, and transferrable

Appendix I: Education & Training Responses

2. Was the Trauma-Informed Care approach included in your academic program?

   How?

   - Briefly discussed in a classroom setting
   - Was touched on in my undergrad, we interviewed a social worker and MT who dealt with lots of trauma.
   - Yes – some trauma informed lectures and MT philosophically is not far-off aligned from trauma informed
   - It was mentioned in conjunction with other approaches, but not focused on more so than others.
   - Can't recall.
   - No

3. Please describe any continuing education you have completed related to Trauma-

   Informed Care:

   - Foster and adoption care licensing
   - Sexual abuse training
   - A course on recognizing and reporting instances of trauma/abuse was required at my employment facility.

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September 2019 – present	Down Syndrome of Southern Kentucky *Kindergarten Readiness Facilitator,* *Music Therapy Independent Contractor*
November 2018 – August 2019	Edge Music Therapy *Music Therapy Independent Contractor*
June 2016 – October 2016	Childcare Network *Wobbler Lead Teacher*
July 2015 – May 2016	Old Union School *General Music Teacher, K-1 Instructor*

SCHOLASTIC ACHEIVEMENT

September 2019	2020 World Congress of Music Therapy Paper Presentation
May 2019	CFA Student Research/Creative Activity Support Grant Recipient
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May 2014	Summa Cum Laude graduate
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