BENEFITS AND CHALLENGES OF IMPLEMENTING A TRAUMA-INFORMED APPROACH WITHIN PEDIATRIC MUSIC THERAPY: AN INTERPRETIVE PHENOMENOLOGICAL STUDY

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ABSTRACT

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The purpose of this study was to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals. Four music therapists participated in this study through semi-structured interviews. Utilizing an adaptation of Smith et al.'s (2022) protocol for interpretive phenomenological analysis, several themes emerged: defining elements of trauma-informed care, the benefits and challenges of implementing a trauma-informed approach within a pediatric inpatient medical setting, strategies for overcoming these challenges, and the need for more music therapy specific training and education on trauma-informed care. Several subthemes were identified for each theme. Subtheme topics included: safety, recognizing the impact of trauma, patient autonomy, the inclusion of family, positive traits and actions to address challenges, and the importance of trauma-informed care. These findings underscore the necessity for further research on the subject of trauma-informed music therapy.

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CHAPTER I

INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) defines a traumatic event as "exposure to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 271). According to Copeland et al. (2007), two-thirds of children will experience at least one traumatic event by the time they reach 16 years of age. Unfortunately, due to the COVID-19 pandemic, these percentages are expected to rise (Galea et al., 2020; Park et al., 2021; Tsamakis et al. 2021). Galea et al. (2020) urged that after the COVID-19 pandemic, a new pandemic "will quickly follow it—that of mental and behavioral illness" (p. 818).

Tsamakies et al. (2021) discussed several ways that the COVID-19 pandemic adversely affected children. First, children are especially susceptible to environmental changes, and the stressful conditions created by the pandemic can adversely affect mental health development. Additionally, loneliness and the duration of loneliness is a strong predictor of mental health problems. Children who experienced quarantine or enforced isolation experienced higher levels of posttraumatic stress and were five times more likely to require mental health services (Tsamakies et al., 2021). Tsamakies et al. (2021) further posited that isolation was particularly relevant as many children did not attend school in person nor had regular social interactions during their sensitive developmental periods due to the pandemic. Additionally, Galea et al. (2020) noted that while stay-at-home orders were necessary to control the pandemic, it is likely that the prevalence of child abuse rose due to prolonged cohabitation at home with limited opportunities to seek outside help. Unfortunately, disadvantaged children who already experienced trauma in their childhood were disproportionately affected by the pandemic

(Tsamakis et al., 2020). Children who experienced trauma during the COVID-19 pandemic may experience more negative outcomes in the future.

Effects of Childhood Trauma

Felitti et al. (1998) conducted one of the first large-scale research studies that examined the correlation between childhood trauma and adverse adult health outcomes. More than half of the participants self-reported that they experienced one adverse childhood experience (ACE), and one-fourth of the participants self-reported that they experienced two or more ACEs. Felitti et al. (1998) found a positive correlation between the amount of ACE exposure and each examined adult health risk behavior and disease, including "ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease" (p. 245).

To better understand childhood trauma's long-term impact, it is essential to explore how complex trauma, characterized by exposure to multiple traumatic events, contributes to challenges across various domains of functioning. The concept of complex trauma refers to exposure to multiple sequential or simultaneous traumatic events and the psychophysiological effects of exposure to these traumatic events (National Child Traumatic Stress Network [NCTSN] Complex Trauma Task Force, 2003). The NCTSN lists several different types of trauma: physical abuse, early childhood trauma, bullying, medical trauma, complex trauma, community violence, natural disasters, refugee trauma, intimate partner violence, sex trafficking, sexual abuse, traumatic grief, and terrorism and violence (NCTSN, n.d.a). Cook et al. (2005) found that children with a complex trauma history experience challenges in seven distinct domains of functioning: attachment, biology, cognition, affect regulation, dissociation, behavioral control, and self-concept.

Attachment

During the early stages of development, the caregiver-child relationship provides the foundational context through which children form their earliest psychological depictions of themselves, others, and their interactions with others (Cook et al., 2005). This modus operandi is known as attachment, or an attachment style. When trauma occurs in the caregiver-child relationship, an insecure attachment style can form. An insecure attachment style is often characterized by "problems with boundaries, distrust and suspiciousness, social isolation, interpersonal difficulties, difficulty attuning to other people's emotional states, and difficulty with perspective taking" (p. 392). Additionally, the attachment style an individual develops because of their own childhood trauma will often impact the attachment style they will form with their children (Toof et al., 2020).

Biology

Children who have experienced complex trauma may experience a myriad of physical symptoms. They may complain of chronic health conditions such as stomach issues and headaches (NCTSN, n.d.b). Older children and adolescents with complex trauma histories may experience analgesia, which is the inability to feel pain, touch, or internal sensations. Conversely, they may also have unexplained chronic pain in various parts of their body without any identifiable physical cause.

The areas responsible for executive functioning in the brain are the most rapidly developing parts of the brain during adolescence (Cook et al., 2005). Cook et al. (2005) notes that the features of executive functioning include:

> Conscious self-awareness and genuine involvement with other people, ability to assess the valence and meaning of complex emotional experiences, and ability to determine a

> course of action based on learning from past experiences and an inner frame of reference informed by understanding others' perspectives (p. 393).

However, a traumatic event can alter the architecture of the areas of the brain responsible for executive function due to toxic stress.

Toxic Stress

Toxic stress is the intense, frequent, or prolonged activation of the body's stress response (National Scientific Council on the Developing Child [NSCDC], 2014). Cortisol, a hormone released to help the body respond to stressful events, is essential to survive as it mobilizes energy, activates immune responses, and can enhance memory. However, when children experience chronic stress, the repeated and prolonged activation of cortisol can suppress immune function, impair memory, and lead to muscle atrophy and bone mineral loss. Additionally, toxic stress caused by traumatic events during critical developmental periods can change the architecture of the brain. The NSCDC (2014) notes:

> In the extreme, such as in cases of severe, chronic abuse, especially during early, sensitive periods of brain development, the regions of the brain involved in fear, anxiety, and impulsive responses may overproduce neural connections while those regions dedicated to reasoning, planning, and behavioral control may produce fewer neural connections. Extreme exposure to toxic stress can change the stress system so that it responds at lower thresholds to events that might not be stressful to others, and, therefore, the stress response system activates more frequently and for longer periods than is necessary, like revving a car engine for hours every day (p. 2).

For example, sustained levels of cortisol released due to chronic stress have been linked to atrophy in the hippocampus, the part of the brain responsible for memory and learning, and less

glucocorticoid receptors in the hippocampus (Cook et al., 2005; Finsterwald & Alberini, 2013). Glucocorticoid receptors play an important role in the stress response because the body returns to a hormonal homeostasis when cortisol binds to these receptors (Finsterwald & Alberini, 2013).

Cognition

The negative effects trauma has on the brain is also reflected in several studies demonstrating the negative effects trauma has on cognitive development of children (Cook et al., 2005). Toddlers and infants who have experienced neglect may experience delays in milestones regarding receptive and expressive language due to the lack of positive sensory stimulation during critical developmental periods (Culp et al., 1991). Children and adolescents diagnosed with post-traumatic stress disorder (PTSD) due to experiencing abuse or witnessing violence often display deficits in their executive function, attention, and abstract reasoning (Beers & De Bellis, 2002). According to a nationwide study, students who self-reported experiencing a significant childhood trauma had a high school dropout rate of 19.27%, which was significantly greater than their peers who did not self-report childhood trauma and whose high school dropout rate was 12.97% (Porche et al., 2011).

Affect Regulation

Affect regulation refers to accurately identifying internal emotional experiences, distinguishing between different levels of arousal, understanding these emotional states, and appropriately labeling them (Cook et al., 2005). Within the first 30 months of life, children who have undergone complex trauma may demonstrate difficulties in recognizing their own and others' emotional states when compared to children of the same age who have not experienced such trauma (Beeghly & Cicchetti, 1994). After appropriately labeling an emotional state, children need to express their emotions to regulate or modulate their internalized experience

(Cook et al., 2005). However, children who have complex trauma histories also often struggle with expressing their emotions and self-soothing. Children who have experienced neglect may also struggle with self-regulation, as they may have never had it modeled for them (NCTSN, n.d.b) Instead, children may cope by "dissociation, chronic numbing of emotional experience, dysphoria and avoidance of affectively laden situations (including positive experiences), and maladaptive coping strategies (e.g., substance use)" (Cook et al., 2005, p. 29). Therefore, these children may escalate quickly to innocuous stressors and appear emotionally labile. Unfortunately, childhood abuse appears to not only increase the risk of major depressive disorder, but also increases the risk of a protracted illness, treatment-resistant depression, and earlier onset of depression (Putnam, 2003; Wiersma et al., 2009; Zlotnick et al., 1995).

Dissociation

Dissociation is a state in which somatic sensations are outside of an individual's conscious awareness, emotions and thoughts are disconnected from the inner self, and behavioral repetitions occur without conscious self-awareness nor planning (Cook et al., 2005). During a traumatic event, children may dissociate (NCTSN, n.d.b).

> They may perceive themselves as detached from their bodies, on the ceiling, or somewhere else in the room watching what is happening to their bodies. They may feel as if they are in a dream or some altered state that is not quite real or as if the experience is happening to someone else. Or they may lose all memories or sense of the experiences having happened to them, resulting in gaps in time or even gaps in their personal history. At its extreme, a child may cut off or lose touch with various aspects of the self (para. 10).

Children may then automatically dissociate as a coping mechanism when faced with reminders of the trauma or other stressful situations. This may prevent children from remaining fully

present in their daily life, impacting social relationships, learning, and classroom behavior. Unfortunately, dissociation can place a child at risk for further abuse due to the severed connection to the outside world and can affect the child's ability to self-regulate and develop healthy attachment due to the severed connection to their introspective world (Cook et al., 2005). Additionally, dissociation has been associated with decreased levels of neurotransmitters and their metabolites in cerebrospinal fluid and lower hippocampal volume in the brain (Demitrack et al., 1993; Stein et al., 1997).

Behavioral Control

Children with complex trauma histories may show over-controlled or under-controlled behavioral patterns (Cook et al., 2005). Crittenden and DiLalla (1988) stated that overcontrolled behavior can manifest in abused children as young as two years of age. These behaviors include compulsive compliance with adult requests, rigid bathroom rituals, stringent control of food intake, and inflexibility to changes in routine. Childhood abuse is also associated with the development of oppositional behavioral disorder (Cook et al., 2005).

Self-Concept

The psychological effects of trauma compounded by the associated challenges secondary to the trauma may lead to children feeling helpless, unlovable, incompetent, and defective (Cook et al., 2005). As a result of this fractured sense of self, children may expect further rejection and hatred from others. Children may also blame themselves for the trauma they have experienced. Unfortunately, this can manifest in problems seeking and engaging in social support. It also can prevent children from developing goal oriented and future-oriented mindsets if they view the world as a hostile place and their efforts as futile (Cook et al., 2005). Due to the deleterious

effects of trauma and the prevalence of trauma, researchers developed the theoretical model of trauma-informed care (Menschner & Maul, 2016).

Trauma-Informed Care

The concept of trauma-informed care (TIC) encompasses several definitions and is often referred to as trauma-informed approaches, trauma-informed practice, or trauma-sensitive care (Hanson & Lang, 2016). One definition of TIC within child services is providing "a safe, supportive environment to staff and consumers that reflects available research about the prevalence and effects of trauma exposure and the best methods for supporting children and families exposed to trauma" (Hanson & Lang, 2016, p. 96). This safe and supportive environment is also reflected in the Substance Abuse and Mental Health Services Administration's (SAMSHA, 2014) six pillars of implementing a trauma-informed approach within organizations that "have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences" (p. 3):

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender issues

The first principle of safety means that everyone within an organization feels physically and psychologically safe, including the staff and the people they serve. This includes a safe physical setting and interpersonal interactions that promote a sense of psychological safety. The physical setting must be experienced by staff and clients as safe, inviting, and support the

collaborative aspect of trauma-informed approach through shared spaces. SAMSHA (2014) also emphasized the importance of the organization understanding how clients define and experience the concept of safety. The second pillar, trustworthiness and transparency, emphasizes the importance of openness and accountability in all organizational decisions and operations to cultivate trust among clients and staff. A key factor for establishing a sense of safety and trust is peer support. Peers refers to individuals who have lived experiences of trauma and are sometimes referred to as trauma survivors. SAMSHA (2014) stated that peer support allows peers to use their lived experiences and stories to promote healing and recovery. Collaboration and mutuality emphasize the need for shared governance and leveling power differentials between staff within an organization because everyone can contribute to creating a trauma-informed environment.

Empowerment, voice, and choice are important principles on which to build strengths and experiences in both clients and individuals in a trauma informed organization (SAMSHA, 2014). Furthermore, these principles underscore the importance of prioritizing the needs of those it serves; promoting resilience; and acknowledging and the ability of individuals, organizations, and communities to heal from trauma. Due to the prevalence of trauma, shared experiences of trauma may exist among an organization's leadership, employees, and clients. Therefore, the organization should strive to empower staff and clients. To empower clients, the organization should first recognize "power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment" (SAMSHA, 2014, p. 11). Then, clients can be supported in shared decision-making, choice, and goals to formulate a treatment plan. Furthermore, staff should support the development of the client's self-advocacy skills and operate as "facilitators of recovery rather than controllers of recovery" (p. 11). The

organization can empower staff through work-force development and ensuring that staff have access to resources and support to do their work well. SAMSHA further acknowledged that this is a parallel process, as staff need to feel safe and supported as much as the people receiving services.

The final pillar, cultural, historical, and gender issues, is a call to action to actively move past cultural stereotypes and biases based on factors such as race, ethnicity, sexual orientation, age, religion, gender identity, geography, etc. Additionally, the organization should embrace and acknowledge the healing value of traditional cultural connections and recognize and address historical trauma. Furthermore, the organization should have processes that are responsive to the ethnic, racial, and cultural needs of the individuals they serve. For example, all screening tools, assessments, and treatment plans should be culturally appropriate and culturally relevant for the individual served.

Hanson and Lang (2016) compared several different definitions of TIC within the literature. The authors identified the following common core components of TIC across three broad domains: "workforce development (training, awareness, secondary traumatic stress); trauma-focused services (use of standardized screening measures and evidence-based practices); and organizational environment and practices (collaboration, service coordination, safe physical environment, written policies, defined leadership)" (p. 96). These components are consistent with NCTSN's (n.d.c) list of essential actions for a trauma-informed practice:

1. Routinely screen for trauma exposure and related symptoms
2. Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms

3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment

4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma

5. Address parent and caregiver trauma and its impact on the family system

6. Emphasize continuity of care and collaboration across child-service systems, and

7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness (para. 2).

It is important to note that TIC is not designed to treat trauma itself, but instead provides a conceptual framework for providers to remain aware of trauma-related issues and regularly screen for trauma-related issues within their clinical practice due to the high prevalence of trauma (Harris & Fallot, 2001).

Music Therapy, Trauma, and Trauma-Informed Care

Music therapy in the United States has a long history of working with clients with a trauma history (McFerran et al., 2020). Several historical innovators within the music therapy field, including but not limited to Margaret Anderton, Isa Maud Ilsen, Harriet Ayer Seymour, and Willem Van de Wall, treated World War I veterans (Knight et al., 2018). This trend continued into World War II as several organizations began providing music for therapeutic use to soldiers and veterans. Today, music therapists continue to work with several types of people with a trauma history (McFerran et al., 2020). Additionally, due to the prominence of trauma, music therapists working in various settings will encounter clients with a trauma history.

Pediatric Music Therapy

According to the American Music Therapy Association (AMTA) 2021 Workforce Analysis (2021a), 19% of music therapists work within a medical setting. These medical settings include pediatric hospitals. For this study, pediatric music therapy is defined as music therapy occurring within the setting of a pediatric medical hospital. Music therapists working within pediatric medical settings are likely to interact with clients who not only have a trauma history but may actively experience trauma from their hospitalization.

One type of childhood trauma listed by the NCTSN is medical trauma (n.d.a). The NCTSN (n.d.d) also stated that up to 80% of children and families experience a traumatic stress response after an injury, a painful procedure, or a life-threatening illness. Additionally, 15-20% of children and siblings and 20-30% of parents experience persistent traumatic stress reactions that "impair daily functioning and affect treatment adherence and recovery" (para 2). Several common goals for music therapists working with pediatric patients may help ameliorate childhood medical trauma, such as promoting positive coping skills, procedural support, non-pharmacological pain and anxiety management, emotional expression, and normalization of the hospital environment (AMTA, 2021b).

Supporting Literature

Prior to the COVID-19 pandemic, a lack of music therapy specific literature existed focused on TIC, despite the profession having a rich history working with people who have trauma history. Specifically, Beer and Jones (2017) referred to "trauma-informed approaches" as a "fairly new" area of music therapy practice (p. 103). However, since the start of the pandemic, the amount of available music therapy literature focusing on TIC has grown. In fact, TIC was one of AMTA's 2021 conference themes (AMTA, n.d.).

Additionally in August 2022, the first book in English co-edited by Beer and Birnbaum (2023) surrounding music therapy and trauma-informed care was published. Contributing authors discussed various theories and perspectives of trauma-informed practice and its implications when working with different clients across the lifespan. Each chapter is written by a different author who provides recommendations for clinical practice through their lived experiences as clinicians providing trauma-informed music therapy. Within the book, only one chapter specifically discussed trauma-informed approaches within a pediatric hospital (Sandheinrich & Kennington, 2023). In the chapter, Sandheinrich and Kennington posit that a trauma-informed approach is recommended when utilizing songwriting interventions with pediatric patients with cancer or sickle cell disease. No other music therapy methods nor pediatric patient populations were discussed within the book. With the growing available research surrounding trauma-informed approaches and music therapy, a gap still exists surrounding how music therapists navigate the challenges and benefits of implementing a trauma-informed approach within a pediatric hospital.

CHAPTER II

LITERATURE REVIEW

Trauma-Informed Approaches Within Pediatric Settings

Marsac et al. (2017) posited that pediatric settings are an ideal environment to implement trauma-informed approaches because of the prevalence and negative effects of trauma, as well as the obligation of pediatric health care providers to promote healthy childhood development. Benefits of implementing a trauma-informed approach within a pediatric setting include minimizing the potential of medical care causing further trauma or triggering trauma responses, offering support to both the patient and their family, promoting healthy coping mechanisms, and preparing the patient for the recovery process. Marsac et al. (2017) also stated that when a trauma-informed approach is combined with a family-centered approach, it not only improves the overall quality of care and well-being of the patient and their family, but also healthcare professionals and support staff.

Reduce Distress, Promote Emotional Support, and Remember the Family Protocol

According to the NCTSN (2014):

> All health care providers treating children, regardless of discipline, should be trauma informed. This means that they should incorporate an understanding of traumatic stress and related responses into their routine encounters with children and families. Trauma-informed health care professionals should be able to provide basic interventions to children and families that will minimize the potential for ongoing trauma and maximize continuity of care (p. 7).

The Distress, Promote Emotional Support, and Remember the Family (DEF) protocol was developed by NCTSN (2014) to aid pediatric providers in implementing trauma-informed care

with the goal of identifying, preventing, and treating traumatic stress responses. After ensuring that a child's basic physical health needs are being met (the A-B-C's), healthcare providers can support the patient's health and recovery by focusing on the next steps, referred to as "D-E-F." The steps of the DEF protocol stand for reduce distress, promote emotional support, and remember the family.

For each step of the D-E-F protocol, the NCTSN (2014) recommended several action steps. Recommendations for reducing patient distress include:

1. Actively assess and treat pain utilizing the hospital's protocol and standardized screening measures for childhood stress disorders and pain
2. Communicate the treatment plan to the child using developmentally appropriate language and provide the child with choices regarding the treatment plan when possible
3. Assess the child's understanding of the situation and clarify any misconceptions
4. Inquire about the child's fears and concerns
5. Provide the child reassurance and realistic hope
6. Pay attention to grief and loss

The NCTSN (2014) highlighted that the cognitive and developmental level of the child is an important consideration when reducing distress because young children process information differently than adults. For example, many preschool-aged children may associate pain with punishment. When they are in pain, they may feel like they did something wrong or somehow caused their illness or injury. Because of these associations, they may become frustrated or mad with providers when undergoing painful procedures, like shots or IV placements, and become traumatized by the experience. Therefore, it is important to help the patient gain a

developmentally appropriate understanding of the situation when reducing distress before painful procedures.

Suggestions for providing emotional support include involving the patient's parents when appropriate. Health-care providers can help promote emotional support by empowering parents to spend time with their child, comfort their child, and have open communication with their child regarding their child's fears. Providers should also encourage the child to engage in developmentally appropriate activities, if possible, and make appropriate referrals to psychosocial staff and community-based resources. Recommendations for "remembering the family" include assessing the family's strengths, resources, and other life stressors, as well as encouraging the family to utilize available resources.

Music, Trauma, and the Brain

Advances in neuroscience have resulted in several insights of how the brain processes music and trauma. Swallow (2002) conceptualized two neurological responses to traumatic events: the high road response and the low road response. The high road response is a slow process that involves the hippocampus and the cerebral cortex. The hippocampus is the brain structure that facilitates memories and learning, while the cerebral cortex is the outermost layer of the brain that contains the frontal, parietal, temporal, and occipital lobes (Cleveland Clinic, 2022a). Collectively, the cerebral cortex processes information and facilitates several high-level processes within the brain, including conscious thought, reasoning, intelligence, personality, language, memory, and decision-making. Based on Swallow's (2002) high road response, when the hippocampus and cerebral cortex receive information from the lower parts of the brain, they relate the traumatic event to past experiences to plan and execute an appropriate response for present or future experiences.

The low road response is a faster process that occurs at an unconscious level and prepares the body for fight, flight, or freeze. In the low road response, the stimuli travel directly to the thalamus and then to the amygdala. The thalamus is "the main sensory pathway to the brain," and the amygdala is a structure responsible for emotions, particularly fear (Swallow, 2002, p. 48). When stimuli from the traumatic event travels through the thalamus and the amygdala, it activates the sympathetic nervous system which prepares the body for fight or flight by releasing epinephrine, acetylcholine, and noradrenaline to increase heart rate, improve oxygen delivery, active energy storage in the liver, and slow down digestion (Cleveland Clinic, 2022b). However, repeated and unexpected exposure to noradrenaline can damage the cells of the amygdala, which may lead to impaired functioning, overactivation, and a conditioned fear response. An overactive low road response is consistent with the NSCTDC's (2014) concept of toxic stress and how toxic stress from traumatic events can negatively impact brain functioning and structure.

Swallow (2002) further argued that when working with clients who have a trauma history, the therapeutic use of music may be appropriate because the brain releases endorphins and adrenocorticotrophin (ACTH) while listening to music. These hormones can have a therapeutic effect on a damaged amygdala. Bensimon (2023) further expanded on this neurological-based rationale for music therapy, stating that music may function as an agent for therapeutic change on a preconscious level because music can bypass the non-activated parts of the brain involved in the high road response, and have a visible impact on the primitive brain, or the parts of the brain involved in the low road response.

Clinical Recommendations for Trauma-Informed Music Therapy With Children

Yinger (2023) outlined several clinical recommendations for trauma-informed music therapy practices when working with children across a variety of settings. They emphasize that

that “given the prevalence of ACEs, trauma-informed music therapy practices should be implemented with all children, regardless of whether the music therapist has knowledge of their ACE score” (p. 54). Furthermore, trauma-informed music therapists can avoid retraumatizing children, provide a presence and space that is conducive to healing, and create experiences that foster resiliency. Additionally, it is crucial to minimizing power dynamics in trauma-informed music therapy. This is especially important when working with children as an inherent power differential exists between adults and children. Therefore, the music therapist should remain aware of this power dynamic and the child’s other intersectional identities to avoid oppressive power dynamics.

To help minimize the power dynamics between the adult music therapist and the child client, Yinger (2023) recommended following the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2015). The competencies include:

1. Self-awareness of the music therapist
2. Understanding the child’s worldview
3. Focusing on the therapeutic relationship
4. Utilizing music therapy interventions and advocacy for the client within and outside the treatment setting to promote resilience

To increase self-awareness, the music therapist should seek to understand how their own privilege, biases, beliefs, and personal trauma may shape their worldview. It is also crucial to try to understand what is important to the client and their family within the given context and timeframe. When building the therapeutic relationship, the music therapist should strive to build one with the child as well as their family and help develop the child’s relationship with their family when possible. Yinger (2023) also emphasized that implementing advocacy efforts helps

provide clients with protective and promotive factors related to resilience. They stressed that advocacy efforts should focus on improving access to essential resources such as food, healthcare, childcare, jobs, housing, and education, as recommended by the Centers for Disease Control and Prevention (2019). They also emphasized that, "in the United States, ending racist policies, mass incarceration, police violence, and gun violence [are] also crucial to preventing future traumatization" (p. 53).

Perry and Ablon's Sequence of Engagement

When working with children who have been traumatized or are eliciting a trauma response, Yinger (2023) recommended utilizing Perry's Sequence of Engagement (Perry & Ablon, 2019). The three sequential steps of engagement are regulate, relate, and reason. First, the music therapist can help promote sensory regulation by providing materials that engage multiple senses. Second, the music therapist can relate and build a therapeutic relationship with the child by engaging in child-directed musical play. Third, only after ensuring that the child feels safe and regulated within the therapeutic relationship, may the therapist engage the child in cognitively demanding tasks.

Perry and Ablon (2019) provide rationale for this sequence of engagement because all information from the body is first processed as sensory experience in the lower parts of the brain (the brain stem, diencephalon, and limbic regions). These regions of the brain are responsible for integrating, processing, and responding to neural input from both the primary senses (visual, tactile, gustatory, olfactory, and auditory input) and neural input from the body's internal sensory system. Therefore, the lower parts of the brain comprising these regulatory networks have an essential role in the human stress responses. Once the lower parts of the brain receive information, it either responds directly to this information or sends the information to the higher

parts of the brain for a response. The higher part of the brain, the cortex, is where critical thinking and problem solving occur. Conversely, the lower and more simple parts of the brain have fewer options on how to respond to this sensory information (i.e., flight or fight).

When considering the neurologic rationale for these steps of engagement, Perry and Ablon (2019) also discussed the importance of neuroplasticity. Neuroplasticity refers to the brain's capacity change, particularly in response to new experiences or learning. This change occurs through various molecular processes such as the generation of new neurons, new neuron connections through synapses, and pruning existing synaptic connections to make the neuronal connections more efficient. Through these changes, the brain makes sense of the individual's external and internal experiences and makes strong associations between sensory information and patterns of neural activity. Perry and Ablon (2019) further explained, "an individual connects things like touch or sound with an image or a feeling, and the brain stores all these associations" (p. 20). Therefore, when the individual receives new information, the brain either assimilates it into the existing neural networks that contain these associations and makes these associations stronger or modifies existing connections or creates new connections to accommodate the new information. Neuroplasticity explains why "a person who has a history of developmental trauma can have a profound feeling of threat or fear triggered by any sight, sound, smell, or sensory input that was present during their original traumatic experiences" (p. 20).

The sequential process of Perry and Ablon's (2019) rules of engagement takes into consideration the fact that all information enters the brain from the bottom and moves to the top as well as the concept of neuroplasticity. This directly contradicts many common top-down therapeutic approaches that aim to first engage the top parts of the brain, like the cortex, in practical discussion first. Because of the brain's processing direction, the therapists should first

engage the client in a sensory regulation activity (brain stem level activity) before engaging the client relationally (a midbrain level activity), and then finally inviting the client to engage in reasoning and solving a problem collaboratively (a cortical activity). However, Perry and Albon cautioned, "if one violates this sequence or does it out of order, it is unlikely that there will be access to the cortex" (2019, p. 26). Through the repeated application of this process of engagement, the brain makes new connections that may become stronger than the old ones through neuroplasticity.

Trauma-Informed Music Therapy with Pediatric Patients

Scant literature exists on how trauma-informed approaches affect the implementation of different music therapy methods or experiences within a pediatric music therapy setting. However, Sandheinrich and Kennington (2023) discussed the benefits of using a trauma-informed approach when utilizing clinical songwriting with pediatric cancer and sickle cell patients through a community outreach program, Kids Rock Cancer. They stated that Kids Rock Cancer's approach organically evolved into a trauma-informed approach due to the unique goals that clinical songwriting can achieve. They posited that the key components of trauma-informed care focus on increasing a client's empowerment, autonomy, and control. Additionally, when a child with cancer or sickle cell disease receives treatment, "the child's emotional complexities are often ignored, and choice is taken away leaving them feeling isolated" (p. 76). However, songwriting can quickly build rapport, establish a sense of safety and trustworthiness, and enhance the likelihood of engagement and emotional exploration. Additionally, the songwriting experience can also give patients a safe space to reflect and relate to different aspects of their trauma. Therefore, therapists can use songwriting to achieve trauma-informed goals like enhanced feelings of safety, resiliency, autonomy, and empowerment. Sandheinrich and

Kennington (2023) also listed several clinical recommendations for trauma-informed music therapists when using clinical songwriting with children with cancer and blood disorders, including focusing on building rapport and a therapeutic relationship, having cultural awareness, providing unconditional positive regard, understanding the long and short-term aspects of the diagnosis, collaborating with the client's care team, and focusing on the process instead of the product.

Trauma-informed approaches to music therapy have gained interest in the music therapy community and research community since the COVID-19 pandemic. The prevalence of trauma necessitates that music therapists use a trauma-informed approach. The neurological basis of trauma and how the brain processes music indicates the use of music therapy with people who have experienced trauma. Although a growing amount of research exists surrounding trauma-informed music therapy when working with children (Holly, 2023; Kruger et al., 2018; Perez-Martinez, 2023), more research is needed surrounding trauma-informed music therapy within pediatric environments and how music therapists can navigate integrating this approach in their clinical practice within the pediatric healthcare setting.

Purpose Statement

The purpose of this study was to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals.

Research Question

The following research question guided this study: How do music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals?

CHAPTER III

METHODOLOGY

Research Design

Phenomenological research is a design of interpretivist inquiry where the researcher describes the lived experiences of people regarding a specific phenomenon (Creswell & Creswell, 2018). Thus, the researcher describes what all participants in a study have in common when experiencing a phenomenon (Creswell et al., 2007). The researcher collects data from participants who have experienced the specific phenomenon and creates a composite description from the collective experiences of the individuals. Phenomenology has strong philosophical underpinnings from Heidegger, Husserl, Merleau-Ponty, and Satre, as well as theoretical underpinnings from hermeneutics, the theory of interpretation and understanding text (Smith et al., 2022).

This study utilized an adaptation of Smith et al.'s (2022) approach to interpretive phenomenological analysis (IPA). IPA involves a double hermeneutic approach as the researcher tries to make sense of the participant, while the participant tries to make sense of a phenomenon. A double hermeneutic approach was selected since no singular approach exists for "trauma-informed" music therapy. Therefore, the researcher interpreted the aspects, benefits, and challenges of operating from this approach within a pediatric setting while seeking to understand how the participant interpreted what operating from a trauma-informed approach means to them and how it has influenced their clinical practice.

Inclusion Criteria

To best understand how music therapists implement a trauma-informed approach within pediatrics, the inclusion criteria for this study included:

1. Board Certified Music Therapists
2. Minimum of one year's experience working in an inpatient pediatric hospital (part-time or full time) in the United States
3. Have the ability to read, write, and communicate in English
4. Intentionally implement a trauma-informed approach to music therapy

Based on a phenomenological design and the time constraints to complete this study, the researcher recruited four participants for individual semi-structured interviews.

Data Recruitment and Procedures

The researcher recruited potential participants through social media posts on the Facebook groups "Music Therapists Unite!" and "Music Therapy in Pediatrics," the Certification Board for Music Therapists' (CBMT) email list, and snowball sampling. Interested individuals contacted the researcher through email and set up an individual time for an online consent form meeting. The online consent form meeting occurred over the teleconference platform Zoom and lasted approximately 15 minutes. The researcher sent the Zoom link individually to potential participants, required a password to join the session, and created a waiting room to minimize the risk of hacking or Zoom bombing.

During the consent form meeting, the researcher reviewed the consent form (see Appendix A) and encouraged the potential participant to ask any questions they may have about the study. The researcher asked the potential participant to email the consent form back to the researcher within one week if they were still interested in participating in the study. Once a consent form had been signed and returned to the researcher, the researcher scheduled an interview over Zoom at the participant's earliest convenience. The researcher also sent the

interview questions before the interview took place. The following are questions the researcher asked the participant during the interview:

Demographic Questions:

1. In which region(s) do you practice music therapy?
2. How long have you been a music therapist?
3. How long have you worked in an inpatient pediatric hospital?
4. Have you received any formal training on trauma-informed music therapy or trauma-informed approaches? If so, when and where?

Music Therapy Practice Questions:

1. What is your definition of trauma-informed care?
2. What factors (if any) influenced your decision to implement a trauma-informed approach?
3. If applicable, how have your patients benefited from your implementation of a trauma-informed approach?
4. If applicable, how have other coworkers benefited from your implementation of a trauma-informed approach?
5. If applicable, what challenges have arisen when working with patients while implementing a trauma-informed approach?
6. If applicable, what challenges have arisen when working with other coworkers while implementing a trauma-informed approach?
7. If you have experienced challenges implementing a trauma-informed approach, how did you respond?

8. Is there anything else you would like me to know regarding your experience of navigating the benefits and challenges of implementing a trauma-informed approach within an inpatient pediatric hospital?

The interviews were video and audio recorded using Zoom's record function with the closed caption option turned on so the researcher could use the transcription during the interview transcription step in the data analysis.

Data Analysis

An adaptation of Smith et al.'s (2022) approach to interpretive phenomenological analysis was utilized to analyze the transcripts. The protocol included these ten steps:

1. The participant member checked their transcript
2. The researcher read and re-read a single transcript several times without making any notes to immerse themselves in the data
3. Then, the researcher made exploratory notes while maintaining an open mind. This process resembled an open textual analysis, as the goal of this process was to produce comprehensive and detailed notes. Smith et al. (2022) emphasized no strict rules exist for this fluid process and that the researcher should be equally concerned with the process of engaging with the transcript as they are with the outcome of producing notes that the researcher will use later in the analysis. They suggest that exploratory notes will often consist of three categories: (1) descriptive, (2) linguistic, and (3) conceptual notes. (1) Descriptive notes include basic summaries of the data based on the explicit claims of the participants. Descriptive notes are often the initial notes the researcher makes, as the notes "take things at face value" and highlights "the objects which structure the participant's thoughts and experiences" (p. 83). (2) Linguistic

notes take into consideration the unique properties of language such as pauses, verb tenses, pronoun use, tone, repetition, etc. (3) Conceptual notes often take the form of questions to consider different and potential meanings, moving past the descriptive and superficial notes

4. The researcher constructed experiential statements from the exploratory notes and the transcript of the interview. Experiential statements are experiential because they relate directly to the participants experiences or to the experience of the participant making sense of certain experiences. These statements are often expressed as phrases that provide a concise and expressive summary of the transcript and exploratory notes. Experiential statements are clearly rooted by the original words in the transcript and exploratory notes, as experiential statements represent the participants original words and the researcher's interpretation
5. The researcher found connections across different experimental statements and grouped them into personal experience themes (PETs). Once these connections were made, the researcher named the PETs and consolidated and organized them in a table
6. The researcher submitted the table of PETs to their thesis chair for feedback and approval
7. The participant member checked their PETs
8. The researcher repeated steps 1-7 for each successive interview
9. Then, the researcher developed group experimental themes (GETs) from the personal experimental themes (PETs) by analyzing how the PETs overlapped with each other. The researcher named the GETs and consolidated and organized them in a table

10. The researcher submitted the table of GETs to their thesis chair for feedback and approval

Positionality Statement of the Researcher

As part of the double hermeneutic process, it is important to locate myself, my background, and how my intersecting identities and experiences may affect my interpretation of the data. I am a white, neurotypical, able-bodied, cis-gender female. I have lived in suburban and urban areas of the South and Northeast for most of my life. English is the only language I speak fluently. I became a board-certified music therapist in 2022 and most of my clinical experience has been in hospital settings. I am also a neurologic music therapist (NMT), which guides a lot of my clinical practice. I have a direct relationship with this topic as I currently work at a pediatric medical hospital and strive to implement a trauma-informed approach to music therapy.

I cannot remember the first time I heard the term "trauma-informed care," as the term seems ubiquitous in the cultural zeitgeist of the United States. However, I remember the first time I studied trauma-informed approaches in school. I remember intensely resonating with the subject during an upper-level music therapy graduate class. As someone who is always fascinated with the neuroscience behind human phenomenon, trauma-informed music therapy felt like a coherent framework to base my therapeutic practice on due to how music and trauma affect the brain. However, as I researched more about this approach, I struggled to find music therapy specific literature on the subject.

As I started my music therapy career in a pediatric hospital, I strove to generalize the information from other disciplines regarding trauma-informed approaches in my clinical practice. Some benefits I personally experienced was a deeper and more empathetic understanding and awareness of trauma responses, how they can present in children in the

hospital environment, and how to help children navigate through a trauma response. Additionally, I feel like I can build rapport more quickly with families and children by validating, reflecting, and acknowledging that their current situation may be very overwhelming and traumatizing while also acknowledging other life stressors and traumas.

However, I have encountered some challenges in implementing a trauma-informed approach in a pediatric hospital. The biggest personal challenge I face in implementing this approach is a lack of time due to the fast-paced hospital environment. Sometimes little time exists for an assessment due to the urgency of a situation. At other times, patients are only seen once before they are discharged. Other challenges include even getting in the room of a patient due to their complex medical needs and scheduled therapies. Frequent interruptions to music therapy sessions also happen due to patients' complex medical needs and scheduled therapies.

I firmly believe in the importance of implementing a trauma-informed approach to music therapy when working with pediatric patients, as children deserve to feel safe and not experience re-traumatization when seeking medical care. My personal experience with the subject made me curious what other benefits and challenges other music therapists face when implementing this approach. Additionally, if music therapists have faced challenges, what strategies have they implemented to overcome these challenges so that I, and other music therapists who strive to be trauma-informed in this setting, can learn and better our clinical practice.

Trustworthiness

To establish trustworthiness in my analysis of the data for this study, I provided member checking opportunities for each participant. Each participant received a copy of their transcript to review and edit to ensure it matches their lived experiences. I also provided participants an opportunity to review their personal experience themes and encouraged them to provide

feedback or revisions, so the personal experience themes align with their lived experiences and perspectives. Additionally, I submitted all themes to my thesis chair for review and feedback.

I kept a document of reflexive notes in a Google Doc on my school cloud-based Google Drive account to help bracket out my own experiences and biases during data analysis. This document acted as a research journal to provide me insights into my thoughts and reactions throughout the research process. I engaged in reflexive journaling after each interview and throughout the data analysis process (see Figure 1 for example). Creswell and Creswell (2018) suggested that engaging in reflexive note-writing can help the researcher become aware of and reflect on their own personal experiences and feelings during the research process and how it may shape the interpretation of the data. Additionally, whenever questions or challenges arose during the research process, I consulted with my thesis chair to provide objective feedback.

Figure 1

Example of Reflexive Journal Entry

Jul 31, 2023

I am already starting to notice some overlap among the participants. It's interesting that R mentioned frequent interruptions and limited time for sessions today, as N echoed the same sentiment in her interview. I know that this is a personal challenge I have encountered when implementing a trauma-informed approach, so I need to be careful to not project my own experiences into the analysis later on. I also see several ways in which the participants differ from each other. For example, N and B really emphasized that a benefit of trauma-informed care was the ease of creating a safe space, but R reflected on the challenges of creating a safe space within the context of a greater medical system. It would also be interesting to explore if there are differences based on the primary age group or diagnosis that the music therapist works with, as some therapists only cover certain units of a hospital and others cover multiple units.

Ethics

This research was approved by the researcher's thesis committee and Texas Woman's University Institutional Review Board.

CHAPTER IV

RESULTS

Timeline of Recruitment

Recruitment occurred from May to July of 2023. The researcher posted the approved recruitment message (see Appendix B**)** twice to the Facebook groups "Music Therapists Unite!" and "Music Therapy in Pediatrics" in late May and early June of 2023. No interested potential participants reached out to the researcher at that time.

Subsequently, the researcher acquired the CBMT email list, which contained 9,726 emails of board-certified music therapists. The researcher then emailed the recruitment message to the CBMT list. Eight music therapists responded to the recruitment email. However, two interested potential participants did not meet the inclusion criteria. Additionally, one potential participant did not respond to requests to schedule a consent session and another potential participant completed the consent session but did not follow through with the interview and was lost to follow up.

The researcher then reached out to the music therapy faculty at Texas Woman's University to identify additional potential participants through snowball sampling. One interested potential participant emailed the researcher in response to snowball sampling; however, the participant later excused themselves before the consent process as they did not meet the inclusion criteria. Therefore, a total of four music therapists ultimately participated in this study.

Participant Demographics

A total of four participants were interviewed for this study. Pseudonyms were chosen by each participant to protect their anonymity. See Table 1 for the participants chosen pseudonyms and pertinent demographic information

Table 1

Participant Demographics

Pseudonyms	AMTA region	Years as a MT-BC	Years in an inpatient pediatric hospital	Received formal training on TIC
B	Western	5	4	No
M	Great Lakes	21	11	Yes- at previous job and current job for required training, not music therapy specific
N	Great Lakes	7	1	Yes- in internship for required training, not music therapy specific
R	Southwestern	3	3	No

Analysis Process

The researcher conducted semi-structured interviews from July to August 2023 (see Appendix C for interview questions). After the researcher interviewed the participants on Zoom with the closed captioning feature on, the researcher received an automated transcript of the meeting. The researcher then listened to the interview several times on her Zoom cloud account with the playback speed set to half speed to correct the automated transcript. Once the transcript was as accurate as possible to the audio recording of the interview, the researcher emailed each participant their transcript for review. Of the four participants, two participants made edits to their transcript. Each participant approved their transcript.

After the researcher received the member-checked transcript, the researcher read and re-read the transcript several times. This occurred over the series of two to three days for the researcher to immerse themselves in the data. Then, the researcher made exploratory notes on the transcript by creating comments on a Google document of the transcript (see Figure 2).

From these exploratory notes and the transcript of the interview, the researcher constructed personal experiential themes. The researcher then organized these personal experiential themes, along with the supporting text for each personal experiential theme, in a separate Google document (see Figure 3). Once complete, the researcher emailed her thesis chair the Google document for peer-checking. Once, the researcher implemented the feedback received from her thesis chair, the researcher emailed the document of personal experiential themes to the respective participant for member checking. Of the four participants, none of them made changes to their personal themes. See Appendix I for all personal experiential themes.

Figure 2

Example of Exploratory Noting

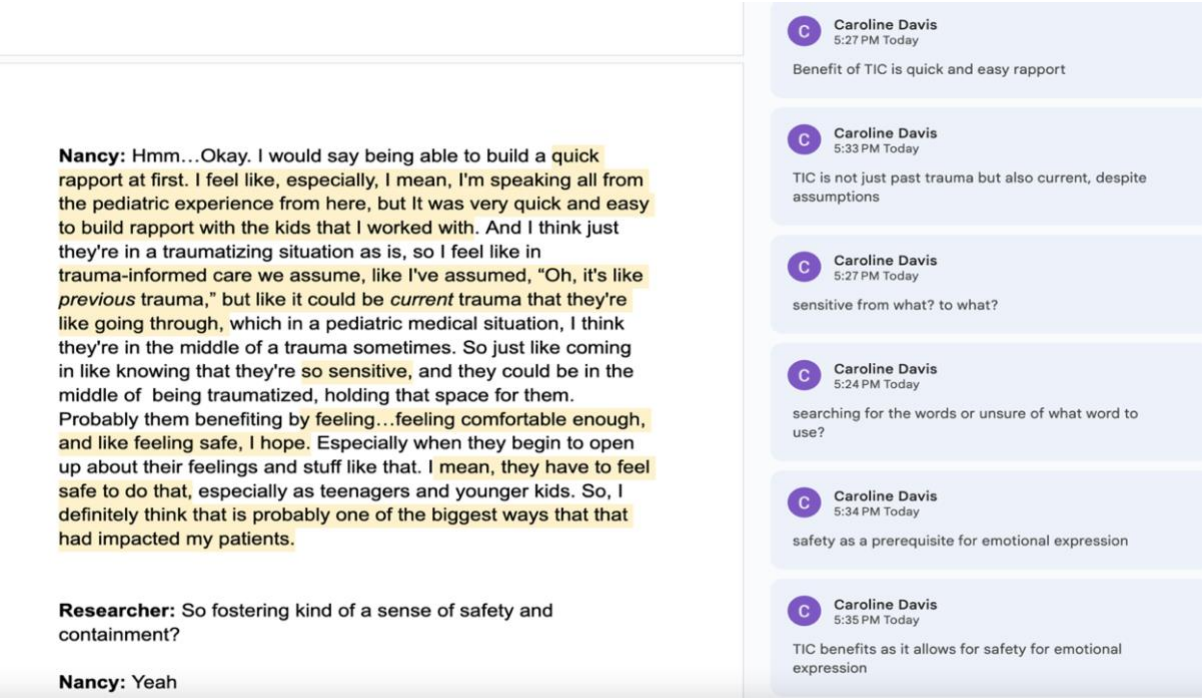

Figure 3

Example of Organizing Personal Experiential Themes with Supporting Text

- Benefits of Trauma-Informed Care
  - Feels inherent to creating therapeutic presence
    - *"It just makes good common sense when working with the parents, and when working with the infants."*
    - *"I guess, the first time I heard of trauma-informed care, I don't remember when that was, but having kind of heard of just even the title, I was like, 'Yeah, we should all be practicing that.' Like, you know, in our everyday relationships, that should be the norm."*
  - Advocates for patients' unique needs
    - *"And you know the infants can't speak up for themselves, and I watch the way their little bodies respond to painful procedures, to music therapy to help them kind of come through it, you know, when they become quiet and alert."*
  - Validates parents' emotions and experiences and increases rapport
    - *"I think one, I give them validation, you know. I ask them how they're coping with the NICU experience. And a lot of them say, 'This was so unexpected. It's really hard for me to leave my baby.' And I just say, 'Of course, you're not alone in that, you know, a lot of parents feel that way. And it's very understandable. And they just sort of like, the shoulders drop a little bit."*
    - *"And so that sense of validation and understanding, I think, increases rapport, and increases their comfort level."*

This process repeated itself for each successive interview. After all personal experiential themes were approved by the thesis chair and the individual participant, the researcher started the process of creating group experiential themes.

The researcher analyzed the personal experiential themes for similarities across participants. The researcher copy/pasted all personal experiential themes in a Google document and created groupings of the personal experiential based on how the themes overlapped (see Figure 4). Then, the researcher named these groups, thus creating group experiential themes. The researcher organized the group experiential themes, along with their supporting texts, in a table on a Google document. The researcher then shared the document of the group experiential themes for peer-checking and final approval.

Findings

The findings of this study are presented through group experiential themes (see Table 2). Based on the iterative data analysis, five overarching group experiential themes were discerned: defining elements of trauma-informed care, benefits of trauma-informed approaches, challenges of trauma-informed approaches, strategies to overcome challenges, and need for music therapy trauma-informed training and education. Several subthemes were identified for each theme.

Theme 1: Defining Elements of Trauma-Informed Care

An integral part of IPA is the double hermeneutic approach, as the researcher tries to make sense of the participant, while the participant tries to make sense of a phenomenon. As no singular definition of "trauma-informed" care in music therapy exists, several defining elements were discovered during the iterative analysis of this IPA study. All four participants discussed defining elements to their understanding of trauma informed care in music therapy within

Figure 4

Grouping Personal Experiential Themes Based on Overlap

Defining Elements of Trauma-Informed Care

- Shifting from a pathology perspective to focusing on someone's backstory and current experiences - B
  - *"It's shifting the perspective from like… a pathology point of view, like what's wrong with you, to what has happened to you, and understanding somebody's backstory. And then I add to that, because I work in the NICU, what is happening to you? Because I-it seems like trauma is in real-time existence and it's moving and changing as the days go by. So yeah, what's happened to you, and what is happening to you?"*
  - *"Versus the diagnostic medical model where we look at somebody who has generalized anxiety. Like yeah- and why? Like, what's the context of that?"*
  - *"Going in with the frame of mind that this person is bringing their experiences with them into the room, and statistically speaking, there's at least a 75-ish% chance that they have experienced at least one trauma (or more like 99% with the pandemic)."*
- Contextualizes trauma responses and prevents further traumatization -N
  - *"Approaching every client aware that there might have been some trauma and being able to identify what those symptoms might look like, and being able to know how to navigate through those triggers in our sessions and groups, and be able to empathize and hold that space to not re-traumatize. So I think that's how I would define it."*
  - *"So I feel like in trauma-informed care we assume, like I've assumed, 'Oh, it's like previous trauma,' but like it could be current trauma that they're like going through, which in a pediatric medical situation, I think they're in the middle of a trauma sometimes. So just like coming in like knowing that they're so sensitive, and they could be in the middle of being traumatized, holding that space for them."*
- Recognizing and responding to the effects of previous lived experiences- R
  - *"I think that trauma-informed care, is taking into consideration someone's, or patients, in this case, like lived experience prior to me meeting them and taking that into account for the care or services that I provide to them, and letting that really inform and guide where our interventions go, or kind of my perspective of them in the therapeutic relationship, and just really every aspect of their care, and seeing them as a person with having a lot of background, that I may or may not be aware of."*
  - *"You see so much and kind of recognize that how a person, a parent or child, responds to me in that moment is not just because of who I am and what I'm bringing in there, but so many things could have happened in that day alone. Even apart from everything that happened up until that very point."*
- Creating a safe environment -M
  - *"approaching everybody, but especially as a professional, with mindfulness and gentle approaches that will ensure that they feel safe, ensure that they can- that they engage fully."*
  - *"TIC is working to ensure safety in the therapeutic relationship"*
    - Use of music to create a safe environment
      - *"We use music so much to support it- with repetition and anticipatory tempos, phrases, or progressions. I think that's one of the awesome things about music is that it can really give a lot of different queues to help with patients anticipating what's going to be happening to them, around them, or in their- to their bodies."*
- Incorporates family and culture - M
  - *"Incorporating whatever experiences they might have had, whether it's cultural, their home languages, or family members present. I want it to be child and family-centered and I think that goes really well with trauma-informed."*

Table 2

Group Experiential Themes and Subthemes

Themes	Subthemes
1. Defining Elements of Trauma-Informed Care	1. Understanding and addressing the impact of past and present traumatic experiences in a way that avoids re-traumatization. 2. Safety as an aspirational standard a. Use of music to create a safe space 3. Incorporates family and culture 4. An intrinsic component to the therapeutic relationship
2. Benefits of Trauma-Informed Approaches	1. Promotes patient autonomy through collaboration and respecting and validating "no" 2. Increased rapport with patients and families through validation 3. Better success in creating a safe environment for patients, family, and staff a. Engaging parents to promote a sense of safety b. Can provide consistency over multiple hospitalizations c. Protects staff from vicarious trauma 4. Helps reframe patient and family's responses and therapist and staff's reactions

Themes	Subthemes
3. Challenges of Trauma-Informed Approaches	1. Limited time and frequent interruptions 2. Earning and reconstituting an environment of trust and safety a. Omnipresence of technology b. Navigating conflicts between patient families and staff 3. Balancing validation, patient autonomy, and emotional safety with other goals a. Conflicts with parents b. Uncertainty of when to provide additional resources or support c. Conflicts within a multidisciplinary team i. Challenges advocating for emotional safety over efficiency and the status quo
4. Strategies to Overcome Challenges of Implementation	1. Having perseverance, acceptance, flexibility, and setting healthy boundaries
5. Need for More Music Therapy Trauma-Informed Training and Education	1. Importance of including trauma-informed approaches in music therapy education 2. More CMTEs and continuing education opportunities

pediatric inpatient hospitals. The four subthemes were: understanding and addressing the impact of past and present traumatic experiences in a way that avoids re-traumatization, safety as an aspirational standard, incorporates family and culture, and an intrinsic part of the therapeutic relationship. See Appendix D for subthemes and supporting text.

Subtheme 1: Understanding and Addressing the Impact of Past and Present Traumatic Experiences in a Way That Avoids Re-Traumatization

Three of the four participants explicitly spoke about the importance of understanding past trauma, how the effects of trauma may present within clinical situations, and the importance of avoiding retraumatization. They also acknowledged they may or may not know about trauma before working with the patient. N reflected on the importance of knowing how trauma responses may present during music therapy sessions:

> Approaching every client aware that there might have been some trauma and being able to identify what those symptoms might look like and being able to know how to navigate through those triggers in our sessions and groups and be able to empathize and hold that space to not re-traumatize it.

The recognition that previous trauma can influence an individual's behavior was also evident in R's statement, “How a person, a parent or child, responds to me in that moment is not just because of who I am and what I'm bringing in there, but so many things could have happened in that day alone.” B also noted how past trauma and trauma responses present and influence their work in the NICU. They[1] shared a story about an infant who had repeated peripherally inserted central catheter (PICC) line placement procedures in the infant’s arms. Whenever the infant’s arm was touched, the infant would “freak out.” B emphasized the importance of realizing that

[1] Participants were not asked to disclose their gender identity. Therefore, the third-person pronoun “they” is used for each participant.

this infant was not “being dramatic” or a “pain,” but was having a “very appropriate” response considering the previous repeated procedures. The awareness of past trauma and its effects are crucial elements to B, N, and R’s understanding and implementation of trauma-informed care.

B and N also reflected on the importance of not only recognizing the effects of past trauma, but also present trauma. N expressed that a common misconception about trauma-informed care is that it only focuses on past trauma, but trauma-informed care should also address current trauma.

> So I feel like in trauma-informed care we assume… “Oh, it's like previous trauma,” but it could be current trauma that they're going through, which in a pediatric medical situation, I think they're in the middle of a trauma sometimes. So just like coming in knowing that they're so sensitive, and they could be in the middle of being traumatized, [and] holding that space for them.

B noted the importance of recognizing the effects of current trauma as well as past trauma by stating that they define trauma-informed care as “What is happening to you? Because I-it seems like trauma is in real-time existence and it's moving and changing as the days go by. So yeah, what's happened to you, and what is happening to you?” B also emphasized the importance of holding space for reactions caused by present trauma, “I think with the babies… it's allowing them… the time to go through the natural biological process of coming through a trauma.” Recognizing the effects of current and past trauma, and skillfully navigating these effects without causing further traumatization is a fundamental aspect of B, N, and R’s implementation of trauma-informed care.

Subtheme 2: Safety as an Aspirational Standard

B and M emphasized that their commitment to safety is integral to their understanding of trauma-informed care. To M, trauma-informed care means, "Approaching everybody, but especially as a professional, with mindfulness and gentle approaches that will ensure that they feel safe, ensure that they can engage fully." They also stated that trauma-informed care is "working to ensure safety in the therapeutic relationship." This commitment to creating safety in the therapeutic relationship is also reflected in their desire to create a safe environment. They expressed that as music therapists, music can help support a safe environment through "repetition and anticipatory tempos, phrases, or progressions" and "different queues to help with patients anticipating what's going to be happening to them, around them, or…to their bodies." M also expressed that "having a safe space" was a key element to implementing a trauma-informed approach. Both B and M emphasized that in trauma-informed care safety is an aspirational standard to strive for, both in the therapeutic relationship but also in the physical environment.

Subtheme 3: Incorporates Family and Culture

Each participant emphasized that incorporating family and culture is crucial to their understanding of implementing a trauma-informed approach. M discussed that incorporating family members and culture helps ensure the transference of therapeutic goals to outside settings. B, N, and R, also discussed the importance of supporting parents through "understanding that trauma for them" (the trauma of having a child in the hospital), becoming a "safe space" for the parents, and making sure that they feel "heard." B conveyed the importance of including parents in the therapeutic process by stating, "parents are the patients." Each participant underscored the pivotal role of incorporating family and culture in their implementation of trauma-informed care,

as it facilitates the transference of therapeutic progress beyond the clinical setting and prioritizes the wellbeing of both patient and family.

Subtheme 4: An Intrinsic Component to the Therapeutic Relationship

B and R shared that trauma-informed care feels intrinsic to creating a good therapeutic relationships. B stated that trauma-informed care should "be the norm" and makes "good common sense." R similarly expressed that trauma-informed care "totally makes sense" and that "we should have this all the time, and already have this." Therefore, a defining element of trauma-informed care is that it aligns with prevailing wisdom on creating therapeutic relationships and should be a standard of practice.

Theme 2: Benefits of Trauma-Informed Approaches

Each participant shared several benefits they experienced from their implementation of a trauma-informed approach. They reported benefits to their patients, their patients' families, their coworkers, and themselves. The following four subthemes explore these benefits: promotion of patient autonomy through collaboration and respecting and validating "no;" increased rapport with parents and families through validation; better success in creating a safe environment for patients, family, and staff; and helpful reframing of patient's and family's responses and therapists and staff's reactions. See Appendix E for subthemes and supporting text.

Subtheme 1: Promotes Patient Autonomy Through Collaboration and Respecting and Validating "No"

Three participants shared that a benefit of implementing a trauma-informed approach was the promotion of patient autonomy. M emphasized the importance of a collaborative approach within trauma-informed care, and not "having the power and them being forced to do it." Therefore, this collaborative approach can help empower patients. N and R also emphasized the

importance of validating and giving choice, especially in terms of participating in music therapy. They both noted that pediatric patients often lose a sense of autonomy and control due to medical interventions. However, by implementing a trauma-informed approach, they provide patients with choice and the option to not participate in music therapy, which can help patients regain a sense of control over their current situation. R conveyed this sentiment when asked if they experienced benefits from their implementation of a trauma-informed approach.

> Recognizing a person's autonomy and choice in that therapeutic relationship, and the care that we provide. And allowing that where that might have been taken away in a lot of different- in some other forms or other ways. And so, being one person to that, they can genuinely say no to, and not have that effect…even my perception of them, can be really helpful and beneficial.

They furthermore emphasized that, "It is actually part of our intervention when people turn away our services."

This sentiment is reflected in a story N shared about working with a patient with a tracheostomy. They shared that this patient was "forced to have a trach in her throat, [and] all kinds of IVs in her whole body" so "at least one thing [the patient] could have a choice over is me not doing music therapy with her." She later shared that by respecting and validating her decision, there was more rapport and trust within the therapeutic relationship. The implementation of trauma-informed approaches can help empower patients and help patients feel more in control through collaboration, choices, and validation of those choices.

Subtheme 2: Increased Rapport with Parents and Families Through Validation

A common theme among all participants was that trauma-informed approaches resulted in increased rapport. M conveyed that the benefits of implementing a trauma-informed approach

is “better success in rapport building, therapeutic relationship, trust, and follow through in attempting anything we're doing.” N also answered that a major benefit of implementing a trauma-informed approach was “being able to build a quick rapport at first.” B shared that validating parents’ experiences of their child’s hospitalization “increases rapport, and increases [the parent’s] comfort level.” R expressed similarly, stating that they have been able to connect with parents and help them “feel heard in like day-to-day conversations” by recognizing the impact on parents from “the giant trauma of having [their] child in the hospital.” The significant benefit of increased rapport through validation can strengthen the therapeutic relationship.

Subtheme 3: Better Success in Creating a Safe Environment for Patients, Family, and Staff

The creation of a safe environment for patients, family, and staff was another reported benefit of implementing a trauma-informed approach in a pediatric hospital. N stated that one of the biggest benefits of implementing a trauma-informed approach to music therapy is that it creates an environment where patients have felt safe enough to “open up about their feelings.” They conveyed this sense of safety is a prerequisite for emotional expression. N also shared a story about creating a safe environment for a patient by engaging and empowering a parent to be involved in music therapy sessions. They articulated, “instead of re-traumatizing and putting uncomfortable stimuli onto this boy, utilizing his mom as a helper, like prompting her to hold him…was great.” This further validates one of the themes discovered in the defining elements of trauma-informed approaches, incorporating the family. Furthermore, N shared that the therapeutic relationships they built with patient families over numerous admissions provided families with a sense of consistency and a continuum of care that helped patients and families perceive the hospital as a safe environment.

B stated that a benefit of implementing a trauma-informed approach is that parents and other staff see the therapist as a safe space to express their emotions. M also further elaborated on this sentiment, noting that a trauma-informed approach helps create a safe space for staff as it can prevent vicarious trauma. As a supervisor, M shared that their implementation of trauma-informed approaches has helped them adopt a proactive stance to prevent vicarious trauma and staff burnout. They shared that they are "much more aware of what we're asking our interns to do" and "are really mindful about like who is covering what unit" as they do not "want to create more trauma." The implementation of a trauma-informed approach has helped these participants create a safe environment for their patients, their patients' families, and the staff they work alongside.

Subtheme 4: Helps Reframe Patient and Family's Responses and Therapist and Staff's Reactions

The implementation of trauma-informed approaches has allowed B and R to maintain a protective personal distance from difficult encounters at work. R conveyed that trauma-informed approaches have helped them "be a better clinician in not taking things too personally," as patients' and families' interactions may be more influenced by their previous experiences than the therapist's current presence. They further expanded that they share this knowledge to interns they supervise:

> A lot of stuff, again, may happened that day already, even before we walk in. I think it allows them to also have that empathy or just sensitivity, and also not let it get to them too hard where they're perseverating on things and not able to kind of move past maybe an awkward encounter or… a teen that just said something offhandedly, or is really harsh, or- and things like that.

B similarly noted that their implementation of trauma-informed care has helped staff reframe difficult situations with parents of patients.

> Trauma-informed care can lower the stress level because the perspective can change... It's not, “Oh, this is a bad parent.” It's…this parent has postpartum mood disorder or is battling the balance between this baby and their other kids at home.

They also stated their implementation of trauma-informed care can provide a more supportive and empathetic perspective when staff might perceive parents as not acting “optimally, as the staff would like to see them acting.” This “alternate story” may prompt staff to “reflect” and “maybe grow a compassionate arm towards a parent” by putting a story in context, despite compassion fatigue. The implementation of a trauma-informed approach has helped B and R reframe challenging situations at work and share this perspective with staff to provide more empathetic care to patients and their families.

Theme 3: Challenges of Trauma-Informed Approaches

Several challenges of implementing trauma-informed care in a pediatric medical setting were discovered during the data analysis process. Most of the challenges were due to the unique environment of a pediatric hospital. Three subthemes were identified: limited time and frequent interruptions; earning and reconstituting an environment of trust and safety; and balancing validation, patient autonomy, and emotional safety with other goals. See Appendix F for subthemes and supporting text.

Subtheme 1: Limited Time and Frequent Interruptions

Limited time and frequent interruptions were a common theme among N and R. N discussed that a challenge of implementing trauma-informed care was limited time with a patient

due to the length of the patient's hospital admission. They stated that it was harder to a trauma-informed approach with acute care patients versus chronic patients.

> I was able to implement easier with my long-term, more chronic kids because I was able to see them a lot longer. Like some of them were there for months and would come in every couple of months. And so it was easier to build that rapport, to understand what they were going through, for them to trust me, to help work through all kinds of stuff and emotions, which is a lot harder to do in just one acute session- just a one-time thing.

N and R also reflected that the challenges of limited time were compounded by frequent interruptions to music therapy sessions. R conveyed this challenge:

> I think, not being able to sometimes hear the whole story, I think, because, just having limited time with patients…There's so many interruptions as well, where sometimes we might be kind of getting to a really important memory or a kid in the middle of telling a story, and then it's time to do vitals, or it's time for labs, or they need to go for a procedure.

N also shared that interruptions from medical staff during music therapy sessions was "a huge challenge" to implementing a trauma-informed approach, as staff might not be aware of "the psychosocial things that music therapy targets." Limited time and frequent interruptions were a significant impediment to implementing a trauma-informed approach, as it does not allow the opportunity to "hear the whole story" or create a safe space for the therapeutic session.

Subtheme 2: Earning and Reconstituting an Environment of Trust and Safety

A major challenge to implementing a trauma-informed approach for N and R was also the ability to earn an environment of trust and safety and the ability to rebuild that environment when faced with challenges. R discussed sometimes feeling a "stigma" from patients and

families that they are “just another staff member.” They further expressed that when this “framework” is already established for a patient, patients and families may feel like they cannot trust anyone within the hospital, which limits their ability to “get in the room” and build rapport. N reflected the challenge of “getting in the room” when working with teenager patients, as teenagers “can be very resistant.” They stated, “The hardest challenge, for sure, is the patient. If they're not willing, it's not going to happen.” One factor N attributes to facing resistance from patients is the omnipresence of technology:

> I would say maybe that's a challenge too, just like modern technology. A lot of the teenagers had phones, iPads. Even the kids have phones and iPads, and a TV. And so having access to all of that technology and then… being offered a service that could be really supportive. But having that resistance, that was definitely a huge challenge for me.

Another factor that contributed to difficulties earning an environment of trust and safety was navigating conflicts between patient families and staff. R shared a story in which a patient’s mom was experiencing challenges and difficulties with medical staff. They conveyed that it was a hard balance between reflecting and validating the patient’s mom’s perspective and not “throwing staff under the bus.” R pondered if the mother “perceived [them] as just another person who…reflected with her, but was not really, <u>really</u> in her corner.” R noted that when a conflict exists between medical staff and patients and their families, it can become a major barrier to overcome.

> Sometimes also in the patients or families themselves, where the trust is already broken, and it's really hard to change their mind. But recognizing that's also part of their autonomy of like they've chosen to, like, this is their experience of it. I can't necessarily change that for them if they're not willing to see that.

Both N and R faced significant challenges establishing and reconstituting a sense of safety and trust due to preconceived notions, resistance from patients, and navigating conflicts with patients, their families, and other staff.

Subtheme 3: Balancing Validation, Patient Autonomy, and Emotional Safety With Other Goals

Each participant discussed challenges implementing a trauma-informed approach due to conflicting goals. These challenges include conflicts with parents, internal conflicts, and conflicts with the multidisciplinary team. N shared a story in which she encountered a conflict with a patient's mother. The patient's mother wanted the patient to engage in music therapy, but the patient declined. This resulted in tension and conflict when N honored the patient's autonomy.

> There was one time where she was having a really bad day, and I went to see her and her mom was there. And she had- the patient had a blanket over her head, and her mom was like, "Play the music anyways." I was like, "No… like this is a back and forth process, like I'm not going to sing at her." And it was- It was very weird for me, cause it was almost like she's definitely telling me she doesn't want to do this, and she's doing that to everybody. And her mom's like, "Well, she's gonna keep doing that to everybody." And I just thought for a parent to want me to force something onto her, like how traumatizing… her mom was like upset with me, but I didn't care, because I didn't want it to hurt my rapport with her.

N further reflected that a unique challenge of implementing a trauma-informed approach within a pediatric hospital is navigating when the patient's wishes differ from their parent or guardian's wishes.

B expressed feeling inner conflict on when to provide validation for a patient or family and when to provide additional resources and support. They stated, “In the beginning, I think validation is the right way to go and at some point…then it needs to be guided in a direction that would be beneficial. For me, the balance is not always clear.” They further expanded on the challenges of balancing validation and providing a more directive approach, stating that they do not want to “solutionize” somebody, but they also want to be “as supportive as possible.” They shared one instance in which they decided to provide additional resources and support:

> One time I directed a parent to talk to the nurse manager because she- I didn't want to just say, “That sounds hard.” I was like, “Let's take this a step further. Here's the stuff you can take if you want it.” Um… yeah, I get concerned about people feeling invalidated if I make a comment like that. And staying stuck, if I just validate and don't… offer a next step, or just check in about self-care, or um…something around those lines where there's like movement.

The internal conflict of determining when to offer validation versus adopting a more directive approach by providing additional resources or support can pose a challenge in implementing a trauma-informed approach. When not adopting a more directive approach, a fear can follow of becoming "stuck" and impeding therapeutic progress. However, by adopting a more directive approach and offering additional resources and support, a fear of "overstepping boundaries" can exist.

Another challenge to implementing a trauma-informed approach is integrating this approach within the goals of a multidisciplinary team. M noted this challenge by sharing that sometimes they feel “forced to choose between TIC and thinking, ‘we must meet the goals.’ Or ‘we must follow the treatment plan.’” This challenge can occur during multidisciplinary rounds

when the team collaborates on “medical care as well as social supports.” M shared the importance and challenge of trying to be “objective and not having our own subjective opinions or biases come in as we are figuring out how we can best support patients and families.”

R also shared difficulties implementing a trauma-informed approach when collaborating within a multidisciplinary team. They shared challenges in advocating for emotional safety over efficiency and the status quo. In one story, R advocated against the use of medical restraints for a patient. However, R faced resistance from staff. They shared:

> I remember being on the neurology floor and just watching this child get tied down with restraints because the nursing staff just did not think they would benefit from anything else. And essentially just kind of having to be there and support while they're doing that. Because there was just a closed mindset to like, “This isn't gonna change” like, “This is just what we do.” There's not really a regard for that emotional safety or kind of how are we taking this into account. Or have we tried other things because this feels like just the faster way to get something done?

They further explained that convincing medical staff to adopt a trauma-informed approach can be challenging because it may contradict precedent and it demands extra effort to learn and adopt this approach.

A major challenge to implementing a trauma-informed approach within a pediatric setting is navigating conflicting goals. These conflicts may arise from disagreements from patients and their parents or the internal struggle of providing validation or debating the need for a more directive approach. Additionally, challenges implementing a trauma-informed approach may exist when working within a multidisciplinary team that has established precedents and efficiency goals.

Theme 4: Strategies to Overcome Challenges of Implementation

N and R discussed several strategies to overcome the challenges of implementing a trauma-informed approach within pediatric hospitals. These included qualities such as perseverance, acceptance, flexibility, as well as setting healthy boundaries. See Appendix G for subtheme and supporting text.

Both therapists acknowledged the importance of perseverance. They noted the importance of continually showing up for their patients, even when faced with initial resistance. As a result, they can build trust overtime so that one day the patient may feel safe enough to confide in their music therapist. N also noted that flexibility is important as well as perseverance. They provided an example of this flexibility by adapting their music therapy methods to better align with their patient's interests:

> [Resistance from teenage patients] made me implement more of a like techie- like I got a drum machine and would bring a laptop, and we would make beats and raps, and they loved it because I was meeting them where they're at with their technology.

Along with perseverance and flexibility, R noted the importance healthy boundaries and accepting that a music therapist cannot control every aspect of a patient's hospital experience. This acceptance comes with the acknowledgement that part of the role of a music therapist in a pediatric hospital is to help patients and families debrief after a traumatic situation. R explained:

> Maybe part of my job is just being there to pick up pieces at that point. Like, I can't control what other people do, so, it's like, maybe we can help them to calm down afterward or debrief something that happens like later on.

R noted that this acceptance can be difficult, as it may require hope that patients are receiving support elsewhere. However, this acceptance is necessary because it creates a healthy boundary

for the music therapist. R stated, “it really is out of my scope at that point, or beyond my control of being able to fix whatever had happened in that.” Another healthy boundary R shared as a strategy to overcome the challenges associated with implementing a trauma-informed approach is “choosing battles.” They explained that this decisiveness can prevent burn-out, which ultimately allows therapists to “stay in the game” and continue advocating for their patients.

Theme 5: Need for More Music Therapy Trauma-Informed Training and Education

The final major theme discovered during the data analysis process was the call for more music therapy specific resources on trauma-informed approaches. Participants noted that these resources are not only needed in music therapy education, but also in continuing education and professional development opportunities. See Appendix H for subthemes and supporting text.

N and R remarked that they did not receive education on trauma-informed approaches during their music therapy education. N expressed concern over this:

> I just want to make note that I definitely think to further our field and the quality of our therapists and the work we're putting out, it should definitely be something that's implemented in the degree program.

R also expressed similarly, stating:

> I think we would all really benefit from having more training on this, because if it feels like it is a newer thing. Because I was in school right from 2015 to 2019 for my formal music therapy training. And maybe we talked concepts around this, but we never talked directly about this.

M, N, and R also conveyed a desire for more continuing education opportunities surrounding trauma informed approaches specific to music therapy. M shared that part of the required, yearly continuing education at the hospital they work at has “modules focusing on

trauma-informed care." They noted, "I've also attended in-services presented by CCLSs and RNs about TIC. So I've learned from different lenses and disciplines. I haven't had an MT-BCs take on it." This experience seems to be shared by N, as they expressed, "It's like required of almost every other job. But then we don't have a music therapy specific one. So that could be really helpful." The need for more music therapy specific resources on trauma-informed care in education and continuing education resonated strongly with M, N, and R, as it can further the field of music therapy and improve the standard of care provided to people who seek music therapy.

CHAPTER V

DISCUSSION

The purpose of this study was to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals. Four music therapists participated in this study, and the findings were derived utilizing interpretative phenomenological analysis. Five main themes were discovered: defining elements of trauma-informed care, benefits of trauma-informed approaches, challenges of trauma-informed approaches, strategies to overcome challenges, and need for music therapy trauma-informed training and education. Several subthemes were also discovered for each main theme. The following discussion relates key elements of the research findings to existing literature surrounding trauma-informed approaches and music therapy.

Sense of Safety

Each participant discussed the concept of safety within their implementation of a trauma-informed approach, whether it was a defining element, a benefit, or a challenge. The concept of safety as an aspirational standard within trauma-informed care is consistent with SAMSHA's (2014) six pillars of implementing a trauma-informed approach and Hanson and Lang's (2016) domains of trauma-informed care. Some participants also reported creating a sense of safety by manipulating certain elements of music. The creation of a safe space through music is supported by Rossetti's (2023) definition of environmental music therapy to "create a soundscape conducive to feelings of safety and well-being" (p. 107).

Several participants reported better success in creating a safe environment for patients, families, and staff. N shared that engaging parents in music therapy sessions can result in the patient feeling safe. The inclusion of family members to create a safe environment is also

supported by the D-E-F protocol (NCTSN, 2014). Another finding was that providing consistency and a continuum of care over multiple hospitalizations helped patients and families feel safer at the hospital. This consistency is in alignment with the NCTSN's (n.d.c) recommendation that trauma-informed services should "emphasize a continuity of care" (para. 2). Another noted benefit was staff feeling safe due to active efforts to protect staff from vicarious trauma. Preventing vicarious trauma in staff is supported by Hanson and Lang's (2016) core components of trauma informed care, NCTSN's (n.d.c) list of essential actions for trauma-informed practice, and SAMSHA's (2014) concept of trauma-informed care.

However, some participants reported difficulties establishing and re-establishing an environment of trust and safety within the context of the larger medical system. One contributing factor could include that music therapists working in pediatric hospitals often focus on mitigating the effects of medical trauma. According to the NCTSN (n.d.d), up to 80% of children and families experience a traumatic stress response after an injury, a painful procedure, or a life-threatening illness. Additionally, 15-20% of children and siblings and 20-30% of parents experience persistent traumatic stress reactions that "impair daily functioning and affect treatment adherence and recovery" (para 2). Therefore, it is reasonable to expect challenges in creating a perception of a safe environment for patients and their families in the hospital, especially if they have already been traumatized by previous experiences within that same environment.

Recognizing the Impact of Trauma

In this study, a defining characteristic of trauma-informed music therapy was understanding and addressing the impact of past and present trauma. This theme is consistent with existing literature of defining trauma-informed care and recommendations for trauma-

informed clinical practice (Hanson & Lang, 2016; Harris & Fallot, 2001; Marsac et al., 2017; NCTSN, 2014; NCTSN, n.d.c; SAMSHA, 2014; Yinger, 2023). Several participants reported that recognizing the effects of trauma helped them validate the emotions and lived experiences of patients and families. This validation resulted in an increase in therapeutic rapport. Additionally, by recognizing the effects of trauma, participants reported developing a protective emotional buffer from personal reactions stemming from difficult interactions at work. This buffer arose due to the acknowledgment that these difficult interactions may be more influenced by an individual's previous experiences than the participants' current presence. The findings of this study align with current literature underscoring the importance of understanding the impact of past and present trauma, and the effects this understanding has on both therapeutic rapport and the emotional resilience of music therapists.

Patient Autonomy

A common theme among participants was the importance of patient autonomy. Several participants reported their implementation of a trauma-informed approach promoted patient autonomy by collaborating with the patient and providing the patient with several choices. The importance of collaboration and giving choices when implementing a trauma-informed approach is supported by SAMSHA's (2014) pillars of trauma-informed care, "collaboration and mutuality" and "empowerment, voice, and choice" (p. 3), as well as the recommendations outlined in the D-E-F protocol (NCSTN, 2014).

Conversely, some participants discussed challenges advocating for patient autonomy. These challenges often emerged when collaborating with medical staff. Contributing factors could include the staff's priority to stabilize a patient's physical health first before addressing their mental health (NCTSN, 2014), coupled with the push for efficiency from hospital policy

makers to maximize profits (Jacobs et al., 2006). Other conflicts emerged when a patient's wishes differed from their parents. These conflicts can be challenging to navigate in a pediatric hospital since children do not have the same rights as their parents, and parents must provide consent for their child to receive medical care, with a few exceptions (Maradiegue, 2003).

Inclusion of Family

Every participant discussed the importance of working with families when implementing a trauma-informed approach. Participants shared that their inclusion of family and parents was instrumental in their understanding of trauma-informed care. The inclusion of family in trauma-informed care is well established (SAMSHA, 2014; NCTSN, 2014; NCTSN, n.d.c; Marsac et al. 2017). Some participants shared that including family helped create a sense of safety and strengthened their ability to implement trauma-informed approach, while other participants shared that conflicts within the family limited their ability to create a safe environment or advocate for patient autonomy. Despite these challenges, every participant emphasized the importance of including parents and family, with a particular focus on understanding the unique dynamics within each patient's family.

Social Justice: A Divergent Theme

Participant M was the only participant who shared that advocating for social justice issues was a fundamental component to their understanding of trauma-informed care. This is supported by the SAMSHA's (2014) final pillar of trauma informed care, "cultural, historical, and gender issues" (p. 11). This pillar emphasized the need for organizations to move beyond cultural stereotypes and biases; to remain responsive to the racial, ethnic, and cultural needs of those served; and to acknowledge and address historical trauma. Additionally, music therapists

have emphasized the significance of advocating for social justice issues within a trauma-informed care approach (Edwards, 2023; Scrine & Koike, 2023; Yinger, 2023).

A potential explanation for why participant M addressed social justice issues in their interview while others did not could be linked to their personal experiences related to the geographical location of their place of employment. They shared:

> Our hospital is near [anonymized location where a Black man was murdered]. When the uprising happened, we had to board up our hospital. We had the National Guard there. With weapons. We had to increase police presence…We as staff pushed back some. This response was not making many people feel safe.

They further emphasized, "I really do think it's part of our job to be advocating for our patients." Their firsthand experience of encountering the intersection between social justice and trauma-informed practice and their hospital's reaction to that injustice underscore the importance of social justice advocacy and trauma-informed care within a healthcare setting. Furthermore, their belief that music therapists should advocate for their patients aligns with existing literature (Edwards, 2023; Scrine & Koike, 2023; Yinger, 2023).

Overcoming Challenges in Trauma-Informed Care

Overall, several traits were identified that helped music therapists when confronted with challenges in implementing a trauma-informed approach: perseverance, acceptance, and flexibility. Additionally, participants emphasized the importance of setting healthy boundaries. Although this discovery has not been discussed in the existing literature surrounding trauma-informed music therapy in pediatric hospitals, these qualities along with setting healthy boundaries are generally positively regarded and deemed important in helping professions (Bruscia, 2013; Duckworth et al., 2007; Harrison & Westwood, 2009; Jiang et al., 2023).

Perseverance is frequently studied in terms of 'grit,' a personality trait that encompasses passion for long-term goals and perseverance (Duckworth et al., 2007). Researchers have identified grit as a vital character strength for achieving success in life (Jiang et al., 2023). Acceptance and setting healthy boundaries are also recognized as highly beneficial, especially for mental health professionals. Harrison and Westwood (2009) identified several protective factors that help prevent vicarious trauma for mental health therapists. Among these factors are acknowledging the limits of one's sphere of influence and maintaining healthy work and personal life boundaries. These findings align with the strategies mentioned in this study regarding acceptance and healthy boundaries. For music therapists, flexibility is also a highly regarded value, as Bruscia (2013) stated, "Having the flexibility to move from verbal to musical to other nonverbal channels of communication is a hallmark of music therapy" (p. 82). The findings of this study not only illuminate the essential traits and practices necessary to overcome challenges in implementing a trauma-informed approach within pediatric hospitals, but also underscore their broader significance across multiple areas of allied health care services.

Importance of Trauma-Informed Care

Each participant emphasized the importance of implementing a trauma-informed approach. Some participants expressed that trauma-informed care is fundamental to their understanding of how to create effective therapeutic relationships. They also shared their belief that everyone who works with people should be trauma informed. This sentiment is reflected by the NCTSN's (2014) recommendation that, "all health care providers treating children, regardless of discipline, should be trauma-informed" (p. 7) as well as Yinger's (2023) recommendation that "trauma-informed music therapy practices should be implemented with all children, regardless of whether the music therapist has knowledge of their ACE score" (p. 54).

Three participants shared their belief that limited resources are available surrounding music therapy and trauma-informed care and that a need exists for more music therapy specific literature, trainings, and education on trauma-informed approaches. The fourth participant initially expressed this belief too, but later clarified their opinion during the member checking process.

> I thought of something today. I said something about not having found any good trainings on trauma-informed MT in the interview. I am at [anonymized music therapy conference] and have realized that there are trainings out there, and a recently released edited book. So I sort of recant that statement. It's just that I haven't gotten into our literature enough yet or found the right CMTEs yet. I plan to change that.

Perhaps this participant's shift in opinion highlights the evolving landscape of the concept of trauma-informed music therapy and the ongoing commitment from music therapists to enhance their knowledge in this important area.

Limitations

Significant limitations of this study include a low number of people expressing interest in participating in this study and time constraints. Ideally, this study would have had a sufficiently large enough number of participants to achieve data saturation, the point in the research process when new data no longer reveals additional information (Charmaz, 2006). However, since saturation was not reached due to time constraints and a limited number of individuals expressing interest in participating in this study, results of this study should be generalized with caution.

Recommendations for Future Research

As of this writing, limited research exists surrounding trauma-informed music therapy in pediatric medical settings. One area for future research is a prevalence study on how many music therapists work in inpatient pediatric hospitals, and how many identify as operating from a trauma-informed lens. Additionally, more research is needed to explore the perceptions, benefits, and challenges of trauma-informed music therapy from the patient's and family's point of view.

Future research could also explore the clinical implications of trauma-informed music therapy assessments or music therapy interventions, such as improvisation and music-assisted relaxation. Other recommendations include investigating effective patient advocacy and conflict resolution within a multidisciplinary team. Finally, as significant variance exists in this setting, future research should focus on including more perspectives. For example, some music therapists in this study worked by themselves as an independent contractor for a hospital, while others were part of a large team of music therapists employed by the hospital. Additionally, some participants only worked with specific age ranges or diagnoses, while others worked with all pediatric patients in the hospital, regardless of age or diagnosis. Therefore, future research should include more perspectives to account for the variance found in this setting.

Conclusion

The purpose of this study was to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals. Four music therapists participated in this study through semi-structured interviews. Utilizing interpretive phenomenological analysis, several themes and subthemes were identified regarding the definition of trauma-informed care, benefits and challenges of implementing a trauma-informed approach within an inpatient pediatric medical setting, strategies for overcoming these

challenges, and the need for more music therapy specific training and education on trauma-informed care. These findings were consistent with existing literature surrounding music therapy and trauma-informed care. Additionally, results from the current study may assist music therapists interested in implementing a trauma-informed approach in pediatric health care as well as provide recommendations on how to overcome challenges of implementing a trauma-informed approach.

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APPENDIX A

CONSENT FORM

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Benefits and Challenges of Implementing a Trauma-Informed Approach within Pediatric Music Therapy: An Interpretive Phenomenological Study

Principal Investigator: Caroline Davis, B.F.A., cdavis53@twu.edu
Faculty Advisor: Rebecca West, PhD, rwest2@twu.edu, (940) 898-2507

Summary and Key Information about the Study
You are being asked to participate in a research study conducted by Caroline Davis, a graduate student at Texas Woman's University, as a part of her master's thesis. The purpose of this study is to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient hospitals.

You have been invited to participate in this study because you are:

- a board-certified music therapist
- have worked within an inpatient pediatric hospital for at least one year (full-time or part-time) in the United States
- have the ability to read, write, and communicate in English
- intentionally implement a trauma-informed approach to music therapy.

As a participant you will be asked to complete a semi-structured interview with student researcher. The interview will occur over the video program Zoom at a time and location convenient to you, will be video and audio recorded and transcribed, and may last up to 60 minutes. You will select a pseudonym to protect your confidentiality. You will be asked to change your name on Zoom if it is not your pseudonym before the researcher begins recording during the interview process. You will have the opportunity to check your interview transcription and request changes or adjustments. You will not be compensated for your participation. Potential risks of this study include loss of confidentiality emotional discomfort.

Your participation in this study is completely voluntary. You may rescind your decision to complete this study at any time without penalty. Please feel free to ask the researcher any questions you have about the study at any time.

Total Time Commitment of Study:
The total length of time for each section consists of:

- The consent session over Zoom will take no longer than 30 minutes
- The semi-structured interview over Zoom will take no longer than an hour
- The member checking session for the transcript of your interview to be done via email will take no longer than 30 minutes
- The member checking session for the personal themes derived from the transcript of your interview to also be done via email will take no longer than 30 minutes.

In total, the time commitment should take no longer than 2.5 hours over four sessions.

Initials

Description of Procedures

As a participant in this study, you will read through the consent form and indicate your voluntary consent to participate in the study described above. If you are interested in completing the interview, you will provide your name and contact information. Once you have signed the consent form, you and the student researcher will identify a time that is convenient to you to conduct the interview. The interview will occur over the video platform zoom and will be recorded. The interview will last up to 60 minutes.

During the interview, the researcher will ask you the following 4 demographic questions:

1. In which region(s) do you practice music therapy?
2. How long have you been a music therapist?
3. How long have you worked in an inpatient pediatric hospital?
4. Have you received any formal training on trauma-informed music therapy or trauma-informed approaches? If so, when and where?

Then, the researcher will ask you the following 8 semi-structured interview questions:

1. What is your definition of trauma-informed care?
2. What factors (if any) influenced your decision to implement a trauma-informed approach?
3. If applicable, how have your patients benefited from your implementation of a trauma-informed approach?
4. If applicable, how have other coworkers benefited from your implementation of a trauma-informed approach?
5. If applicable, what challenges have arisen when working with patients while implementing a trauma-informed approach?
6. If applicable, what challenges have arisen when working with other coworkers while implementing a trauma-informed approach?
7. If you have experienced challenges implementing a trauma-informed approach, how did you respond?
8. Is there anything else you would like me to know regarding your experience of navigating the benefits and challenges of implementing a trauma-informed approach within an inpatient pediatric hospital?

Based on the research design, the researcher will ask follow-up questions for clarification or additional discussion depending on the participant's answers during the interview.

Once the student researcher has transcribed your interview, you will have an opportunity to review it and provide any feedback or revisions. The student researcher will also share the personal themes derived from your interview with you once all data has been analyzed to ensure it matches your experience. You will have the opportunity to review it and provide any feedback or revisions. The total time of commitment to engage in this study is 2.5 hours.

Potential Risks

Because the study will be conducted through email and Zoom, there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

Initials

There is an increased risk of loss of confidentiality due to the researcher using her personally owned, password-protected computer to collect and store data on her school cloud-based Google drive account. The researcher will use her personally owned, password-protected computer to conduct and record the interviews, with the Zoom option "record to the cloud" enabled, in order to automatically store the video/audio recording and the transcription of the interview to the student researcher's school cloud-based Google drive account. It is possible that the researcher's personally owned, password-protected computer could be stolen or hacked. This increases the risk of a data/information breach.

There is a risk of loss of confidentiality for you if your computer or electronic device is stolen or hacked. You can choose when and on what device you communicate with the researcher.

There is an additional risk of loss of confidentiality due to member checking (sending the transcript of your interview and the themes derived from the transcript of your interview for review) through email since the responses will be linked back to you.

There is increased risk of loss of confidentiality because you will be emailing the signed consent form.

Confidentiality will be protected to the extent that is allowed by law.

All video/audio recordings and the transcribed interview will be stored on the student researcher's school cloud-based Google drive account in a locked folder, accessed from the student researcher's personally owned, password-protected computer. At no point will the student researcher or advisor download or store any data on their personal computer or the hard drive of their computer. Only the student researcher and advisor will read the transcribed interview. A master list of all participants and their designated pseudonyms will be stored electronically on the advisor's school cloud-based Google drive account separate from the consent forms. Signed consent forms will be stored separately from all collected information on the advisor's school cloud-based Google drive account. The analysis for the interview will be stored electronically in a separate locked folder on the student researcher's school cloud-based Google drive. All transcripts, master lists, consent forms, and all other research correspondence and data will be destroyed three years after the study is finished. Once the researcher confirms that each transcript is completed and accurate, the researcher will delete the audio/video file for each interview. All files stored digitally will be trashed and permanently deleted from the student researcher's and advisor's school cloud-based Google drive.

A risk associated with using the Zoom platform is the risk of hacking, or "Zoom bombing," by others. Steps to minimize this risk will be made in the Zoom settings in which all scheduled meetings will be generated with a unique meeting ID and password only shared between the student researcher and the participant. In addition, the student researcher will set up a waiting room requiring all attendees to be personally admitted by the student researcher, negating any potential hackers and uninvited individuals. Finally, the student researcher will lock the meeting once the participant has entered the virtual room as a final safeguard against potential hackers or uninvited individuals.

_____
Initials

Another potential risk of this study is emotional discomfort from the interview questions asked. You may skip any interview questions you feel uncomfortable answering. You may take breaks as needed during the interview. During the interview process, you can share as much or as a little as you are comfortable with. Additionally, you can redact or change anything in the transcript of your interview that you may feel is too personal or recognizable.

No physical, psychological, social, legal, or other types of risks are anticipated.

Participation is completely voluntary, and participants have the right to withdraw from the research without consequences of any kind or loss of benefits to which the subject is otherwise entitled.

If we choose to publish the results from this study, your name or any other identifying information will not be included. Any personal information collected from this study will not be used or distributed for any reason including future research. TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time without penalty. There will be no compensation for participation in this research.

TWU Disclaimer Statement

The researchers will try to prevent any problems that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Questions Regarding the Study

You may print a copy of this consent form to keep. If you have any questions about the research study, please feel free to contact myself at cdavis53@twu.edu or Rebecca West, PhD, MT-BC, my faculty advisor at rwest2@twu.edu or at (940) 898-2507. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

_____ _____

Signature of Participant Date

*Please mark your initials in the appropriate spot below to indicate whether or not you would like to be emailed the results of this study:

_____: Yes, I would like to be emailed the results of this study after its completion

_____: No, I would not like to be emailed the results of this study after its completion

If you would like to be emailed the results of this study, please provide us with the email address to which you would like the results to be sent:

Email: _____

APPENDIX B

RECRUITMENT MESSAGE

Dear Music Therapists,

My name is Caroline Davis, and I am a graduate music therapy student at Texas Woman's University. You are invited to participate in my thesis, a research study titled: Benefits and Challenges of Implementing a Trauma-Informed Approach Within Pediatric Music Therapy: An Interpretive Phenomenological Study.

The purpose of this phenomenological study is to understand how music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient medical hospitals.

The following research question will guide this study: How do music therapists navigate the benefits and challenges of implementing a trauma-informed approach within pediatric inpatient medical hospitals?

To be eligible to take part in the study, individuals must be:

- a board-certified music therapist
- 18 years or older
- have worked in an inpatient pediatric hospital for at least 1 year (full time or part time) in the United States
- intentionally implement a trauma-informed approach to music therapy.

If you meet all of the inclusion criteria of the study and are interested in participating, please email me at cdavis53@twu.edu and we will go over the consent form together to ensure any questions or concerns have been answered. The researcher is looking for five participants. The researcher will select the first five participants that reach out to the researcher. If any of the participants decline to participate, the researcher will select the next participant based on the order of the emails received using the email timestamps of potential participants' initial emails expressing interest in the study. If you agree to participate in the study, we will set up a time to conduct a semi-structured interview. Participation in this research study is voluntary.

The consent form session will occur over zoom. In order to increase security and prevent zoom bombing from occurring, the researcher will email you a link to the virtual room. You will wait in a virtual waiting room for the researcher to confirm your email address. Once you are admitted to the room, the researcher will also lock the room to prevent anyone else from joining. The semi-structured interview will also occur over the video program Zoom at a time and location convenient to you, and will be video and audio recorded and transcribed, and may last up to 60 minutes. The same safety procedures as the consent meeting will also occur for the semi-structured interview.

In order to minimize the risk of exposure and to ensure the confidentiality of the interview, the participant will select a pseudonym and change it on Zoom to protect their confidentiality prior to when the researcher starts recording. You will have the opportunity to check the interview transcription and request changes or adjustments. You will also have the opportunity to review the personal themes derived from the transcript of your interview. The following demographic questions will be asked during the interview:

1. In which region(s) do you practice music therapy?
2. How long have you been a music therapist?
3. How long have you worked in an inpatient pediatric hospital?
4. Have you received any formal training on trauma-informed music therapy or trauma-informed approaches? If so, when and where?

Then, the following semi-structure interview questions regarding your music therapy practice will be asked:

1. What is your definition of trauma-informed care?
2. What factors (if any) influenced your decision to implement a trauma-informed approach?
3. If applicable, how have your patients benefited from your implementation of a trauma-informed approach?
4. If applicable, how have other coworkers benefited from your implementation of a trauma-informed approach?
5. If applicable, what challenges have arisen when working with patients while implementing a trauma-informed approach?
6. If applicable, what challenges have arisen when working with other coworkers while implementing a trauma-informed approach?
7. If you have experienced challenges implementing a trauma-informed approach, how did you respond?
8. Is there anything else you would like me to know regarding your experience of navigating the benefits and challenges of implementing a trauma-informed approach within an inpatient pediatric hospital?

Based on the research design, the researcher will ask follow-up questions for clarification or additional discussion depending on the participant's answers during the interview.

Because the study will be conducted through email and Zoom, there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

Participation is completely voluntary, and participants have the right to withdraw from the research without consequences of any kind or loss of benefits to which the subject is otherwise entitled. A risk associated with using the Zoom platform is the risk of hacking, or “Zoom bombing,” by others. Another potential risk in this study is you may experience discomfort from the questions asked.

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There will be no compensation for participation in this research.

The total length of time for each section consists of:

- The consent session over Zoom will take no longer than 30 minutes
- The semi-structure interview over Zoom will take no longer than an hour
- The member checking session for the transcript of your interview to be done via email will take no longer than 30 minutes
- The member checking session for the personal themes derived from the transcript of your interview to also be done via email will take no longer than 30 minutes.

In total, the time commitment should take no longer than 2.5 hours over four sessions.

This research has been approved by Texas Woman's University's IRB. If you have any questions or concerns about this research study, please feel free to contact either myself or Dr. Rebecca West at the contacts listed below.

Thank you for your consideration!

Caroline Davis MT-BC
Cdavis53@twu.edu

Rebecca West, Ph.D, MT-BC
Thesis Committee Chair
Rwest2@twu.edu

APPENDIX C

INTERVIEW QUESTIONS

Demographic questions:

1. In which region(s) do you practice music therapy?
2. How long have you been a music therapist?
3. How long have you worked in an inpatient pediatric hospital? Have you received any formal training on trauma-informed music therapy or trauma- informed approaches? If so, when and where?

Music therapy practice questions:

1. What is your definition of trauma-informed care?
2. What factors (if any) influenced your decision to implement a trauma-informed approach?
3. If applicable, how have your patients benefited from your implementation of a trauma-informed approach?
4. If applicable, how have other coworkers benefited from your implementation of a trauma-informed approach?
5. If applicable, what challenges have arisen when working with patients while implementing a trauma-informed approach?
6. If applicable, what challenges have arisen when working with other coworkers while implementing a trauma-informed approach?
7. If you have experienced challenges implementing a trauma-informed approach, how did you respond?
8. Is there anything else you would like me to know regarding your experience of navigating the benefits and challenges of implementing a trauma-informed approach within an inpatient pediatric hospital?

APPENDIX D

DEFINING ELEMENTS OF TRAUMA-INFORMED CARE: SUBTHEMES AND SUPPORTING TEXT

1. Understanding and addressing the impact of past and present traumatic experiences in a way that avoids re-traumatization.

"I think that trauma-informed care, is taking into consideration someone's, or patients, in this case, like lived experience prior to me meeting them and taking that into account for the care or services that I provide to them, and letting that really inform and guide where our interventions go, or kind of my perspective of them in the therapeutic relationship, and just really every aspect of their care, and seeing them as a person with having a lot of background, that I may or may not be aware of." – R

"You see so much and kind of recognize that how a person, a parent or child, responds to me in that moment is not just because of who I am and what I'm bringing in there, but so many things could have happened in that day alone. Even apart from everything that happened up until that very point." – R

"Approaching every client aware that there might have been some trauma and being able to identify what those symptoms might look like, and being able to know how to navigate through those triggers in our sessions and groups, and be able to empathize and hold that space to not re-traumatize. So I think that's how I would define it." -N

"So I feel like in trauma-informed care we assume, like I've assumed, 'Oh, it's like previous trauma,' but like it could be current trauma that they're like going through, which in a pediatric medical situation, I think they're in the middle of a trauma sometimes. So just like coming in like knowing that they're so sensitive, and they could be in the middle of being traumatized, holding that space for them." -N

"It's shifting the perspective from like… a pathology point of view, like what's wrong with you, to what has happened to you, and understanding somebody's backstory. And then I add to that, because I work in the NICU, what is happening to you? Because I-it seems like trauma is in real-time existence and it's moving and changing as the days go by. So yeah, what's happened to you, and what is happening to you?" -B

"I think with the babies… it's allowing them to like… giving them the time to go through the natural biological process of coming through a trauma." -B

"There was a baby who just had a PICC line placed yesterday, and then today it had to be moved because it was too far in, and I was there for both. And then, just recognizing that, you know the arms getting touched, and he's already starting to freak out. And knowing that this is, this is...this is very appropriate for him. You know he's not being a pain… Babies aren't dramatic. Babies are simply responding to their environment, you know?" -B

"Versus the diagnostic medical model where we look at somebody who has generalized anxiety. Like yeah- and why? Like, what's the context of that?" -B

"Going in with the frame of mind that this person is bringing their experiences with them into the room, and statistically speaking, there's at least a 75-ish% chance that they have experienced at least one trauma (or more like 99% with the pandemic)." -B

2. Safety as an aspirational standard

"Approaching everybody, but especially as a professional, with mindfulness and gentle approaches that will ensure that they feel safe, ensure that they can- that they engage fully." -M

"TIC is working to ensure safety in the therapeutic relationship." -M

"Having a safe space is really important." -B

   a. Use of music to create a safe space

"We use music so much to support it- with repetition and anticipatory tempos, phrases, or progressions. I think that's one of the awesome things about music is that it can really give a lot of different queues to help with patients anticipating what's going to be happening to them, around them, or in their- to their bodies." -M
3. Incorporates family and culture
"Incorporating whatever experiences they might have had, whether it's cultural, their home languages, or family members present. I want it to be child and family-centered and I think that goes really well with trauma-informed." -M
"And if family is there, or incorporating family, incorporating culture I think, results in a better therapeutic relationship, and then better chances that it will happen outside of therapy setting too." -M
"Recognizing how that impacts a lot of the parents that I work with I think really makes a difference in my ability to connect with them and help them to feel heard in like day-to-day conversations or just getting to meet them." -R
"You're supporting the parents and understanding that trauma for them." -N
"Parents are the patients." -B
"We are a safe space for the parents" -B
4. An intrinsic component to the therapeutic relationship
"It just makes good common sense when working with the parents, and when working with the infants." -B
"I guess, the first time I heard of trauma-informed care, I don't remember when that was, but having kind of heard of just even the title, I was like, 'Yeah, we should all be practicing that.' Like, you know, in our everyday relationships, that should be the norm." -B
"It totally makes sense, I think, within the humanistic model, and like- like we should have this all the time, and already have this." -R

APPENDIX E

BENEFITS OF TRAUMA-INFORMED APPROACHES: SUBTHEMES AND SUPPORTING TEXT

1. Promotes patient autonomy through collaboration and respecting and validating “no”
“There's a collaboration, not just me having the power and then them being forced to do it.” -M
“Recognizing a person's autonomy and choice in that therapeutic relationship, and the care that we provide. And allowing that where that might have been taken away in a lot of different- in some other forms or other ways. And so, being one person to that, they can genuinely say no to, and not have that effect kind of their care, or what they receive, or even my perception of them can be really helpful and beneficial.” -R
“It is actually part of our intervention when people turn away our services” -R
“She's already having to be forced to have a trach in her throat, all kinds of IVs in her whole body, like at least one thing she could have a choice over is like me not doing music therapy with her. And so I said… ‘Well, I want a very firm response, because I want to give her complete control of this situation and the choice.’ So I said, ‘If you don't want to take your blanket off your head, that's fine. I just need to see your hand nod yes or no, like tell me, yes or no, and I will be out, or I will stay.’ And like she, she ended up going no. And I was like, ‘Okay. I appreciate that and I respect that.’” -N
2. Increased rapport with patients and families through validation
“I would say being able to build a quick rapport at first.” -N
"I think one, I give them validation, you know. I ask them how they're coping with the NICU experience. And a lot of them say, 'This was so unexpected. It's really hard for me to leave my baby.' And I just say, 'Of course, you're not alone in that, you know, a lot of parents feel that way. And it's very understandable.’ And they just sort of like, the shoulders drop a little bit." -B

"And so that sense of validation and understanding, I think, increases rapport, and increases their comfort level." -B

"And I think also with the parents that are coming in too, like these parents, whether they're younger parents, older parents, or everywhere in between, they have experienced a lot in their life. And so then you add on the giant trauma of having your child in the hospital, especially your infant, after seeing a lot of infants, like the trauma, of finding out that something is wrong, or not even finding out something is wrong until the baby is here, and then having to go through that whole process, the trauma of birth, and like that whole process, and then just everything and seeing things happen to your child while you're recovering from that whole process, I think can be a lot. And so, recognizing how that impacts a lot of the parents that I work with I think really makes a difference in my ability to connect with them and help them to feel heard in like day-to-day conversations or just getting to meet them." -R

"Better success in rapport building, therapeutic relationship, trust, and follow through in attempting anything we're doing." -M

3. Better success in creating a safe environment for patients, family, and staff

"Probably them benefiting by feeling…feeling comfortable enough, and like feeling safe, I hope. Especially when they begin to open up about their feelings and stuff like that. I mean, they have to feel safe to do that, especially as teenagers and younger kids. So, I definitely think that is probably one of the biggest ways that that had impacted my patients." -N

"We are a safe space for the parents, because I mean, at least in, I- I don't wear scrubs. I wear like kind of business cas, and that automatically sets me apart from the other staff who do wear scrubs. You know I'm not coming cloaked in navy blue." -B

"Also a safe place for the staff to off gas if something is going on. And they know I'm a good listener, and I think that just sort of like becomes the safe space for them too. So it gives them a place to off gas." -B

   a. Engaging parents to promote a sense of safety

"And he- he was more receptive because she was there. Had she not been there? He was like screaming. If Mom was not there, he was screaming because he was so scared. Which I can understand. So it was a really nice way of like, instead of re-traumatizing and like putting uncomfortable stimuli onto this boy, utilizing his mom as a helper, like prompting her to hold him, like she wouldn't hold him, but then I would prompt her to hold him, and then it was great." -N

b. Can provide consistency over multiple hospitalizations

"They ended up back, you know, in peds, unfortunately, because they're just sick, and they were so excited to like see me, and so many times like they would ask for me before I even knew they were like in the hospital, like before I even saw the name, like I've got a text that's like, 'So and so's here and asking for you,' and like when they would see me like their face would light up, and, like that to me, showed that, like the continuum, like really helped reduce the trauma for the family, and probably the patient, even though they were tiny babies." -N

c. Protects staff from vicarious trauma

"Thankfully he told me during supervision that it was too much hearing so many traumatic stories. I'm like, 'You are so right!' He didn't have to disclose that he's had any trauma it just makes me much more aware of what we're asking our interns to do. I don't want to create more trauma." -M

4. Helps reframe patient and family's responses and therapist and staff's reactions

"And so I think, keeping that in mind like, for one helps me be a better clinician in not taking things too personally" – R

"A lot of stuff, again, may happened that day already, even before we walk in. I think it allows them to also have that empathy or just sensitivity, and also not let it get to them too hard where they're perseverating on things and not able to kind of move past maybe an awkward encounter or something that's, yeah, or a teen that just said something offhandedly, or is really harsh, or- and things like that." -R

"If somebody was like, 'Oh my God, the mom did this,' like we have, um, we've had kind of a trend of parents not acting optimally, as the staff would like to see them acting. And I might just say, like, 'Wow, it sounds like she really has a lot of anxiety, and she's having a hard time connecting,' and that often will stop, or slow, or pause the conversation. And I think it gives them an opportunity to reflect, whether or not they do I don't know, but to maybe grow a bit of a compassionate arm towards a parent- knowing full well that a lot of the nurses that I work with have been doing this for a long time, and probably have compassion fatigue and it can just, you know, I think, being able to put a story or like a context with somebody's story eases the stress a little bit?" -B

"Trauma-informed care can lower the stress level because the perspective can change... It's not like, 'Oh, this is a bad parent.' It's…this parent has postpartum mood disorder, or is battling the balance between this baby and their other kids at home." -B

APPENDIX F

CHALLENGES OF TRAUMA-INFORMED APPROACHES: SUBTHEMES AND SUPPORTING TEXT

1. Limited time and frequent interruptions
"And then sometimes, too, I think, not being able to sometimes hear the whole story, I think, because, just having limited time with patients, I think, and like, there's so many interruptions as well, where sometimes we might be kind of getting to a really important memory or a kid in the middle of telling a story, and then it's time to do vitals, or it's time for labs, or they need to go for a procedure. And that kind of safe space is kind of broken, or needs to be like readjusted once that happens or it just does not take place." -R
"I was able to implement easier with my long-term, more chronic kids because I was able to see them a lot longer. Like some of them were there for months, and would come in every couple of months. And so it was easier to like build that rapport, to understand what they were going through, for them to trust me, to help work through all kinds of stuff and emotions, which is a lot harder to do in just one acute session- just a one-time thing." -N
"There was a lot of interruptions. That was definitely a huge challenge…" -N
"It made me curious about the training… and if they go through any type of trauma-informed care, like mental health training, or anything, because a lot of- they always seem to interrupt like that, and be very not aware of— the psychosocial things that music therapy targets." -N
2. Earning and reconstituting an environment of trust and safety
"I think part of it sometimes is the trustworthiness, like safety. I think sometimes like being one out of 50 people in a patient or like family's room that day. There's a lot of like, maybe something of a sigma like, 'Oh, they're just another staff member.' And so sometimes that just kind of like, that like framework is already there for a patient or family, and when they feel like they

can't trust like really anybody at the hospital, I feel that sometimes kind of gets in the way of even getting to build that rapport or to kind of get in the room at that point." -R

"I think when you're building trust and safety, especially with teenagers, they can be very resistant, and…um, but I like that about them, so it makes me want to dig deeper." -N

"The hardest challenge, for sure is the patient. If they're not willing, it's not going to happen." -N

a. Omnipresence of technology

"I would say maybe that's a challenge too, just like modern technology. A lot of the teenagers had phones, iPads. Even the kids have phones and iPads, and a TV. And so having, like access to all of that technology and then… being offered a service that could be really supportive. But having that resistance, that was definitely a huge challenge for me." -N

b. Navigating conflicts between patient families and staff

"She mentioned an incident that she had with staff. And I was just kind of really trying to reflect, and like on one hand, not throw staff under the bus, but also not invalidating like Mom's perception of that. I'm just trying to really hear her out and kind of the way that she was describing how she felt really unheard, and kind of questioning the care that was being provided to her daughter." -R

"I wonder if sometimes, like she perceived me as just another person who just kind of like, you know, reflected with her, but was not really really in her corner." -R

"Sometimes also in the patients or families themselves, where the trust is already broken, and it's really hard to change their mind. But recognizing that's also part of their autonomy of like they've chosen to, like, this is their experience of it. I can't necessarily change that for them if they're not willing to see that." -R

"And so I wondered if that was like a barrier. Like that trust had kind of been, you know, broken or kind of shifted, I think, just because of all the stuff that had happened. So yeah, definitely a barrier in that" -R

3. Balancing validation, patient autonomy, and emotional safety with other goals

   a. Conflicts with parents

      "But then there was one time where she was having a really bad day, and I went to see her and her mom was there. And she had- the patient had a blanket over her head, and her mom was like, 'Play the music anyways.' I was like 'No… like this is a back and forth process, like I'm not going to like sing at her.' And it was- It was very weird for me, cause it was almost like she's definitely telling me she doesn't want to do this, and she's like doing that to everybody. And her mom's like, 'Well, she's gonna keep doing that to everybody.' And I just thought for a parent to want me to force something onto her, like how traumatizing… her mom was like upset with me, but I didn't care, because I don't want it to hurt my rapport with her." -N

      "I tried to take her side. Yeah, and let her make her choice known. So yeah." -N

   b. Uncertainty of when to provide additional resources or support

      "And I have a concern that… to some extent when validating, can I-I, do I over validate? You know? I don't want to solutionize somebody, and I want to be as supportive as possible, so I don't want to just leave it at validation if there is like a nudge for self-care or… One time I directed a parent to talk to the nurse manager because she- I didn't want to just say, 'That sounds hard.' I was like, 'Let's take this a step further. Here's the stuff you can take if you want it.' Um… yeah, I get concerned about people feeling invalidated if I make a comment like that. And staying stuck, if I just validate and don't… offer a next step, or just check in about self-care, or um…something around those lines where there's like movement." -B

      "In the beginning, I think validation is the right way to go and at some point, like I'm talking about a parent, like at some point, then it needs to be guided in a direction that would be beneficial… For me, the balance is not always clear" -B

"And just knowing again, where is that balance and where do I stop? Because I have a pretty good idea of when music therapy is indicated, it's just the… the balance of providing care and not overstepping boundaries. And that goes with the babies, the parents, and the staff." -B

c. Conflicts within a multidisciplinary team

"I think feeling forced to choose between TIC and thinking, 'we must meet the goals.' Or 'we must follow the treatment plan.'" -M

"During multidisciplinary rounds we collaborate medical care as well as social supports. There are a lot of opinions. We need to be sure that we are being objective and not having our own subjective opinions or biases come in as we are figuring out how we can best support patients and families." -M

- Challenges advocating for emotional safety over efficiency and the status quo

"The ones who are more experienced or seasoned and just have their way of doing things. I remember being on the neurology floor and just watching this child get tied down with restraints because the nursing staff just did not think they would benefit from anything else. And essentially just kind of having to like be there and support while they're doing that. Because there was just a closed mindset to like, 'This isn't gonna change' like, 'This is just what we do.' There's not really a regard for that emotional safety or kind of how are we taking this into account? Or have we tried other things because this feels like just the faster way to get something done." -R

"'I don't have the energy to learn this new thing or invest in this kind of thought process and so I'm gonna do what I've always done.' Which I think like makes sense, I can understand that, but it's just difficult to when we come in these ways, or use these buzz words. And it just kind of sounds kind of corny or cheesy to some of those staff that that just wasn't part of like their training at all, or their experience, and kind of how they provide that." -R

APPENDIX G

STRATEGIES TO OVERCOME CHALLENGES OF IMPLEMENTATION: SUBTHEME AND SUPPORTING TEXT

1. Having perseverance, acceptance, flexibility, and setting healthy boundaries
"Continuing to show up, I think, and like, recognize like, yeah, this is fair for her to do that. And like, I'll be here if she wants me to ask, and if it feels right in the timing, and then, if she's given me signals that this is not the timing, then she's fine, just trusting that she hopefully has other support elsewhere, or like it really is out of my scope at that point, or beyond my control of being able to fix whatever had happened in that" -R
"I think, just continuing to introduce and show that you care, and show that you're willing goes a really long way, especially with pediatrics." -N
"There were some clients that I met 4 or 5 times before they even wanted me to come in their room and talk." -N
"It's like they might need to see you 5 times before they're like, 'Okay, I trust her. She can come in and play with me.'" -N
"Like, they can refuse me an indefinite amount of times. I'll- I'll keep checking in at least, you know?" -N
"Which made me implement more of a like techie- like I got a drum machine and would bring like a laptop, and we would make beats and raps, and like they loved it because I was like meeting them where they're at with their technology. So, you know we can combat our challenges." -N
"Maybe part of my job is just being there to pick up pieces at that point. Like, I can't control what other people do, so, it's like, maybe we can help them to calm down afterward or debrief something that happens like later on." -R
"Really I think choosing battles. Just so we can stay in the game and not burn out of having to advocate all the time, or- or also like from that too, just kind of re-evaluating." -R

APPENDIX H

NEED FOR MORE MUSIC THERAPY TRAUMA-INFORMED TRAINING AND EDUCATION: SUBTHEMES AND SUPPORTING TEXT

1. Importance of including trauma-informed approaches in music therapy education
"It's almost like it's up to the agencies that we work for to train us on that, rather than music therapy. Because I've not had it like in school, we didn't really do a lot with it." -N
"I just personally think it's extremely important as music therapists to know about it and to utilize it. And I kind of fell into it because of my internship. And I'm just. I'm curious about other music therapists and like their training." -N
"I just want to make note that I definitely think to further our field and like the quality of our therapists and like the work we're putting out, it should definitely be something that's implemented in like the degree program." -N
"I feel like it's a big buzzword that's been coming up in recent years, and so it makes sense, like I didn't have that in school." -R
"I think we would all really benefit from having more training on this, because if it feels like it is a newer thing. Because I was in school right from 2015 to 2019 for my formal music therapy training. And like, maybe we talked concepts around this, but we never talked like directly about this."- R
2. More CMTEs and continuing education opportunities
"And I haven't seen a lot of like CMTEs and stuff like that." -N
"Yeah, it's like required of almost every other job. But then like we don't have like a music therapy specific one. So that could be really helpful. Like, we have, like we have CBMT ethics. You know, we have, like 3 designated ethics credits, like, why couldn't they designate trauma-informed care credits, or something like that?" -N
"I wonder where that deficit is. I think, in like having formal training on this rather than just like, 'I picked this up on the job.'"-R

“More recently at the hospital, we've had to do yearly, continuing education where we have modules focusing on trauma-informed care. I've also attended in-services presented by CCLSs and RNs about TIC. So I've learned from different lenses and disciplines. I haven't had an MT-BCs take on it.”- M

APPENDIX I

PERSONAL EXPERIENTIAL THEMES

B's Themes

- Definition of Trauma-Informed Care
    - Shifting from a pathology perspective to focusing on someone's backstory and current experiences
        - *"It's shifting the perspective from like… a pathology point of view, like what's wrong with you, to what has happened to you, and understanding somebody's backstory. And then I add to that, because I work in the NICU, what is happening to you? Because I-it seems like trauma is in real-time existence and it's moving and changing as the days go by. So yeah, what's happened to you, and what is happening to you?"*
        - *"Versus the diagnostic medical model where we look at somebody who has generalized anxiety. Like yeah- and why? Like, what's the context of that?"*
        - *"Going in with the frame of mind that this person is bringing their experiences with them into the room, and statistically speaking, there's at least a 75-ish% chance that they have experienced at least one trauma (or more like 99% with the pandemic)."*

- Benefits of Trauma-Informed Care
    - Feels inherent to creating therapeutic presence
        - *"It just makes good common sense when working with the parents, and when working with the infants."*
        - *"I guess, the first time I heard of trauma-informed care, I don't remember when that was, but having kind of heard of just even the title, I was like, 'Yeah, we should all be practicing that.' Like, you know, in our everyday relationships, that should be the norm."*
    - Advocates for patients' unique needs
        - *"And you know the infants can't speak up for themselves, and I watch the way their little bodies respond to painful procedures, to music therapy to help them kind of come through it, you know, when they become quiet and alert."*
    - Validates parents' emotions and experiences and increases rapport
        - *"I think one, I give them validation, you know. I ask them how they're coping with the NICU experience. And a lot of them say, 'This was so unexpected. It's really hard for me to leave my baby.' And I just say, 'Of course, you're not alone in that, you know, a lot of parents feel that way. And it's very understandable. And they just sort of like, the shoulders drop a little bit."*
        - *"And so that sense of validation and understanding, I think, increases rapport, and increases their comfort level."*
    - Validates and contextualizes trauma responses while preventing further trauma
        - *"I think with the babies… it's allowing them to like… giving them the time to go through the natural biological process of coming through a trauma."*
        - *"There was a baby who just had a PICC line placed yesterday, and then today it had to be moved because it was too far in, and I was there for both. And then, just recognizing that, you know the arms getting touched, and he's already starting to freak out. And knowing that this is, this is...this is very*

appropriate for him. You know he's not being a pain… Babies aren't dramatic. Babies are simply responding to their environment, you know?"

- *"Overstimulation is always a concern, and especially because they're so at risk for that, anyway. I don't want to add fuel to that fire, and give their nervous system something else to overcome, you know? Do no harm."*

- Provides a safe space for staff and parents
  - *"We are a safe space for the parents, because I mean, at least in, I- I don't wear scrubs. I wear like kind of business cas, and that automatically sets me apart from the other staff who do wear scrubs. You know I'm not coming cloaked in navy blue."*
  - *"Also a safe place for the staff to off gas if something is going on. And they know I'm a good listener, and I think that just sort of like becomes the safe space for them too. So it gives them a place to off gas."*
- Encourages staff to have a compassionate perspective
  - *"If somebody was like, 'Oh my God, the mom did this,' like we have, um, we've had kind of a trend of parents not acting optimally, as the staff would like to see them acting. And I might just say, like, 'Wow, it sounds like she really has a lot of anxiety, and she's having a hard time connecting,' and that often will stop, or slow, or pause the conversation. And I think it gives them an opportunity to reflect, whether or not they do I don't know, but to maybe grow a bit of a compassionate arm towards a parent- knowing full well that a lot of the nurses that I work with have been doing this for a long time, and probably have compassion fatigue and it can just, you know, I think, being able to put a story or like a context with somebody's story eases the stress a little bit?"*
  - *"Trauma-informed care can lower the stress level because the perspective can change... It's not like, 'Oh, this is a bad parent.' It's…this parent has postpartum mood disorder, or is battling the balance between this baby and their other kids at home."*

- Challenges Implementing Trauma-Informed Care
  - Uncertainty of when to provide additional resources or support
    - *"And I have a concern that… to some extent when validating, can I-I, do I over validate? You know? I don't want to solutionize somebody, and I want to be as supportive as possible, so I don't want to just leave it at validation if there is like a nudge for self-care or… One time I directed a parent to talk to the nurse manager because she- I didn't want to just say, 'That sounds hard.' I was like, 'Let's take this a step further. Here's the stuff you can take if you want it.' Um… yeah, I get concerned about people feeling invalidated if I make a comment like that. And staying stuck, if I just validate and don't… offer a next step, or just check in about self-care, or um…something around those lines where there's like movement."*
    - *"In the beginning, I think validation is the right way to go and at some point, like I'm talking about a parent, like at some point, then it needs to be guided in a direction that would be beneficial… For me, the balance is not always clear"*
    - *"And just knowing again, where is that balance and where do I stop? Because I have a pretty good idea of when music therapy is indicated, it's just the… the balance of providing care and not overstepping boundaries. And that goes with the babies, the parents, and the staff."*
  - Concerns about invalidating co-workers' perspectives

        - *"I get concerned that making those comments, like I said before, like what I said to a staff member, like, 'Wow It sounds like Mom has a lot of anxiety,' or whatever, could be construed as me not listening to them, or invalidating the point of view... I get concerned about people feeling invalidated if I make a comment like that."*
        - *"The offering of another story I get… cautious with. Because, I don't, nobody has reported this to me, but I get concerned that they feel invalidated. If I present this alternate point of view."*
    - Knowing when to stop music therapy
        - *"It's knowing when to stop. And like when there's been enough stimulation. For example, another baby getting a PICC line, wasn't responding very much to music therapy. Was responding to sweet-ease, but not music therapy per se, and I wish I had stopped sooner… Because, like after the third time that she didn't seem to be responding, I wish I had just said, 'She's not responding, I'm going to see my way out.' But instead, I kept thinking, 'Well, maybe if I change the technique, maybe something will work.' But it didn't. So knowing when to stop."*
        - *"Like letting them sleep it off- like knowing when to stop music therapy, I think, is really important. They've had enough stimulation and sometimes, if, like a baby, if she's been admitted, and then all this crap has happened, and they become quiet and alert, I'll interact with them for a little bit, but at some point, I'm just like, 'Okay, that's enough.'"*
        - *"I don't want to overstimulate and then, further, the trauma, you know?"*
        - *"I think the hard part in the NICU is the babies can't tell you how they're responding other than their cues. They can't verbalize, 'I didn't like it when you did this' or 'I don't like it when this happens,' or 'Can you stay?', or 'Can you stop?' You know, other than like some of the 'halt hand' or whatever."*
        - *"And just knowing again, where is that balance and where do I stop? Because I have a pretty good idea of when music therapy is indicated, it's just the… the balance of providing care and not overstepping boundaries. And that goes with the babies, the parents, and the staff."*

M's Themes

- Defining elements of trauma-informed care music therapy
    - Creating a safe environment
        - *"approaching everybody, but especially as a professional, with mindfulness and gentle approaches that will ensure that they feel safe, ensure that they can- that they engage fully."*
        - *"TIC is working to ensure safety in the therapeutic relationship"*
            - Use of music to create a safe environment
                - *"We use music so much to support it- with repetition and anticipatory tempos, phrases, or progressions. I think that's one of the awesome things about music is that it can really give a lot of different queues to help with patients anticipating what's going to be happening to them, around them, or in their- to their bodies."*
    - Incorporates family and culture
        - *"Incorporating whatever experiences they might have had, whether it's cultural, their home languages, or family members present. I want it to be child and family-centered and I think that goes really well with trauma-informed."*
        - *"And if family is there, or incorporating family, incorporating culture I think, results in a better therapeutic relationship, and then better chances that it will happen outside of therapy setting too."*
    - Advocacy for social justice issues
        - *"Our hospital is near [anonymized location where a Black man was murdered]. When the uprising happened, we had to board up our hospital. We had the National Guard there. With weapons. We had to increase police presence. And like knowing that we are in like an [location anonymized] hospital working with pediatric patients, we as staff pushed back some. This response was not making many people feel safe."*
        - *"There's just such a wide range of interpretation. It's hard to articulate. But I'm glad we're having the conversations."*

- Benefits of trauma-informed care
    - Increased rapport, collaboration, and trust with patients
        - Improves the therapeutic relationship through trust and safety
            - *"Better success in rapport building, therapeutic relationship, trust, and follow through in attempting anything we're doing."*
        - Addresses power dynamics through collaboration and advocacy
            - *"I really do think it's part of our job to be advocating for our patients."*
            - *There's a collaboration, not just me having the power and then them being forced to do it."*
    - Protects staff from vicarious trauma
        - *"Thankfully he told me during supervision that it was too much hearing so many traumatic stories. I'm like, 'You are so right!' He didn't have to disclose that he's had any trauma it just makes me much more aware of what we're asking our interns to do. I don't want to create more trauma."*
        - *"And I think we are really mindful about like who is covering what unit. And if one of us facilitated 3 heartbeat recordings this week, then maybe they're not going to do another. Maybe one of us can do one."*

- Challenges of trauma-informed care
    - Conflicting goals within a multidisciplinary team
        - *"I think feeling forced to choose between TIC and thinking, 'we must meet the goals.' Or 'we must follow the treatment plan.'"*
        - *"During multidisciplinary rounds we collaborate medical care as well as social supports. There are a lot of opinions. We need to be sure that we are being objective and not having our own subjective opinions or biases come in as we are figuring out how we can best support patients and families."*

N's Themes

- Definition of Trauma-Informed Care
    - Contextualizes trauma responses and prevents further traumatization
        - *"Approaching every client aware that there might have been some trauma and being able to identify what those symptoms might look like, and being able to know how to navigate through those triggers in our sessions and groups, and be able to empathize and hold that space to not re-traumatize. So I think that's how I would define it."*
        - *"So I feel like in trauma-informed care we assume, like I've assumed, 'Oh, it's like previous trauma,' but like it could be current trauma that they're like going through, which in a pediatric medical situation, I think they're in the middle of a trauma sometimes. So just like coming in like knowing that they're so sensitive, and they could be in the middle of being traumatized, holding that space for them."*

- Benefits of Implementing Trauma-Informed Care
    - Builds rapport and a safe environment to explore and express
        - *"I would say being able to build a quick rapport at first."*
        - *"Probably them benefiting by feeling…feeling comfortable enough, and like feeling safe, I hope. Especially when they begin to open up about their feelings and stuff like that. I mean, they have to feel safe to do that, especially as teenagers and younger kids. So, I definitely think that is probably one of the biggest ways that that had impacted my patients."*
            - Parental involvement to promote a sense of safety
                - *"And he- he was more receptive because she was there. Had she not been there? He was like screaming. If Mom was not there, he was screaming because he was so scared. Which I can understand. So it was a really nice way of like, instead of re-traumatizing and like putting uncomfortable stimuli onto this boy, utilizing his mom as a helper, like prompting her to hold him, like she wouldn't hold him, but then I would prompt her to hold him, and then it was great."*
    - Promotes patient autonomy
        - Respecting and validating "no"
            - *"She's already having to be forced to have a trach in her throat, all kinds of IVs in her whole body, like at least one thing she could have a choice over is like me not doing music therapy with her. And so I said…'Well, I want a very firm response, because I want to give her complete control of this situation and the choice.' So I said, 'If you don't want to take your blanket off your head, that's fine. I just need to see your hand nod yes or no, like tell me, yes or no, and I will be out, or I will stay.' And like she, she ended up going no. And I was like, 'Okay. I appreciate that and I respect that.'"*
    - Continuity of care
        - *"They ended up back, you know, in peds, unfortunately, because they're just sick, and they were so excited to like see me, and so many times like they would ask for me before I even knew they were like in the hospital, like before I even saw the name, like I've got a text that's like, 'So and so's here and asking for you,' and like when they would see me like their face would light*

up, and, like that to me, showed that, like the continuum, like really helped reduce the trauma for the family, and probably the patient, even though they were tiny babies."

- Challenges of Implementing Trauma-Informed Care
    - Resistance from patients
        - *"I think when you're building trust and safety, especially with teenagers, they can be very resistant, and..um but I like that about them, so it makes me want to dig deeper."*
        - *"The hardest challenge, for sure is the patient. If they're not willing, it's not going to happen."*
            - Omnipresence of technology
                - *"I would say maybe that's a challenge too, just like modern technology. A lot of the teenagers had phones, iPads. Even the kids have phones and iPads, and a TV. And so having, like access to all of that technology and then… being offered a service that could be really supportive. But having that resistance, that was definitely a huge challenge for me."*
    - Balancing parental wishes and patient autonomy
        - *"But then there was one time where she was having a really bad day, and I went to see her and her mom was there. And she had- the patient had a blanket over her head, and her mom was like, 'Play the music anyways.' I was like 'No… like this is a back and forth process, like I'm not going to like sing at her.' And it was- It was very weird for me, cause it was almost like she's definitely telling me she doesn't want to do this, and she's like doing that to everybody. And her mom's like, 'Well, she's gonna keep doing that to everybody.' And I just thought for a parent to want me to force something onto her, like how traumatizing… her mom was like upset with me, but I didn't care, because I don't want it to hurt my rapport with her."*
        - *"I tried to take her side. Yeah, and let her make her choice known. So yeah."*
    - Time limitations due to duration of hospitalization
        - *"I was able to implement easier with my long-term, more chronic kids because I was able to see them a lot longer. Like some of them were there for months, and would come in every couple of months. And so it was easier to like build that rapport, to understand what they were going through, for them to trust me, to help work through all kinds of stuff and emotions, which is a lot harder to do in just one acute session- just a one-time thing."*
    - Interruptions to the session from other staff
        - *"There was a lot of interruptions. That was definitely a huge challenge…"*
        - *"It made me curious about the training… and if they go through any type of trauma-informed care, like mental health training, or anything, because a lot of- they always seem to interrupt like that, and be very not aware of— the psychosocial things that music therapy targets."*

- Strategies to overcome challenges
    - The importance of patience and perseverance
        - *"I think, just continuing to introduce and show that you care, and show that you're willing goes a really long way, especially with pediatrics."*
        - *"There were some clients that I met 4 or 5 times before they even wanted me to come in their room and talk.*

        - *“It's like they might need to see you 5 times before they're like, ‘Okay, I trust her. She can come in and play with me.’”*
        - *“Like, they can refuse me an indefinite amount of times. I'll- I'll keep checking in at least, you know?”*
    - Adapting methods to align with patient interests
        - *“Which made me implement more of a like techie- like I got a drum machine and would bring like a laptop, and we would make beats and raps, and like they loved it because I was like meeting them where they're at with their technology. So, you know we can combat our challenges.”*

- Need for music therapy trauma-informed training and education
    - Importance of including trauma-informed approaches in music therapy education
        - *“It's almost like it's up to the agencies that we work for to train us on that, rather than music therapy. Because I've not had it like in school, we didn't really do a lot with it.”*
        - *“I just personally think it's extremely important as music therapists to know about it and to utilize it. And I kind of fell into it because of my internship. And I'm just. I'm curious about other music therapists and like their training.”*
        - *“I just want to make note that I definitely think to further our field and like the quality of our therapists and like the work we're putting out, it should definitely be something that's implemented in like the degree program.”*
    - More CMTEs and continuing education opportunities.
        - *“And I haven't seen a lot of like CMTEs and stuff like that.”*
        - ***“****Yeah, it's like required of almost every other job. But then like we don't have like a music therapy specific one. So that could be really helpful. Like, we have, like we have CBMT ethics. You know, we have, like 3 designated ethics credits, like, why couldn't they designate trauma-informed care credits, or something like that?”*

R's Themes

- Definition of Trauma-Informed Care
    - Recognizing and responding to the effects of previous lived experiences
        - *"I think that trauma-informed care, is taking into consideration someone's, or patients, in this case, like lived experience prior to me meeting them and taking that into account for the care or services that I provide to them, and letting that really inform and guide where our interventions go, or kind of my perspective of them in the therapeutic relationship, and just really every aspect of their care, and seeing them as a person with having a lot of background, that I may or may not be aware of."*
        - *"You see so much and kind of recognize that how a person, a parent or child, responds to me in that moment is not just because of who I am and what I'm bringing in there, but so many things could have happened in that day alone. Even apart from everything that happened up until that very point."*

- Benefits of trauma-informed care
    - Helps to reframe patient's responses and therapist's reactions
        - *"And so I think, keeping that in mind like, for one helps me be a better clinician in not taking things too personally"*
        - *"A lot of stuff, again, may happened that day already, even before we walk in. I think it allows them to also have that empathy or just sensitivity, and also not let it get to them too hard where they're perseverating on things and not able to kind of move past maybe an awkward encounter or something that's, yeah, or a teen that just said something offhandedly, or is really harsh, or- and things like that. "*
    - Promotes patient autonomy through giving choices
        - *"Recognizing a person's autonomy and choice in that therapeutic relationship, and the care that we provide. And allowing that where that might have been taken away in a lot of different- in some other forms or other ways. And so, being one person to that, they can genuinely say no to, and not have that effect kind of their care, or what they receive, or even my perception of them can be really helpful and beneficial."*
        - *"It is actually part of our intervention when people turn away our services"*
    - Provides validation and emotional support for parents during traumatic experiences
        - *"And I think also with the parents that are coming in too, like these parents, whether they're younger parents, older parents, or everywhere in between, they have experienced a lot in their life. And so then you add on the giant trauma of having your child in the hospital, especially your infant, after seeing a lot of infants, like the trauma, of finding out that something is wrong, or not even finding out something is wrong until the baby is here, and then having to go through that whole process, the trauma of birth, and like that whole process, and then just everything and seeing things happen to your child while you're recovering from that whole process, I think can be a lot. And so, recognizing how that impacts a lot of the parents that I work with I think really makes a difference in my ability to connect with them and help them to feel heard in like day-to-day conversations or just getting to meet them."*

- Challenges of trauma-informed care
    - Fostering and reconstituting an environment of trust and safety
        - *“I think part of it sometimes is the trustworthiness, like safety. I think sometimes like being one out of 50 people in a patient or like family's room that day. There's a lot of like, maybe something of a sigma like, ‘Oh, they’re just another staff member.’ And so sometimes that just kind of like, that like framework is already there for a patient or family, and when they feel like they can't trust like really anybody at the hospital, I feel that sometimes kind of gets in the way of even getting to build that rapport or to kind of get in the room at that point.”*
        - *“Sometimes also in the patients or families themselves, where the trust is already broken, and it's really hard to change their mind. But recognizing that's also part of their autonomy of like they've chosen to, like, this is their experience of it. I can't necessarily change that for them if they're not willing to see that.”*
        - *“And so I wondered if that was like a barrier. Like that trust had kind of been, you know, broken or kind of shifted, I think, just because of all the stuff that had happened. So yeah, definitely a barrier in that”*
            - Navigating conflicts between patient families and staff
                - *“She mentioned an incident that she had with staff. And I was just kind of really trying to reflect, and like on one hand, not throw staff under the bus, but also not invalidating like Mom's perception of that. I'm just trying to really hear her out and kind of the way that she was describing how she felt really unheard, and kind of questioning the care that was being provided to her daughter.”*
                - *“I wonder if sometimes, like she perceived me as just another person who just kind of like, you know, reflected with her, but was not really really in her corner.”*
    - Limited time and frequent interruptions
        - *“And then sometimes, too, I think, not being able to sometimes hear the whole story, I think, because, just having limited time with patients, I think, and like, there's so many interruptions as well, where sometimes we might be kind of getting to a really important memory or a kid in the middle of telling a story, and then it's time to do vitals, or it's time for labs, or they need to go for a procedure. And that kind of safe space is kind of broken, or needs to be like readjusted once that happens or it just does not take place.”*
    - Challenges advocating for emotional safety over efficiency and the status quo
        - *“The ones who are more experienced or seasoned and just have their way of doing things. I remember being on the neurology floor and just watching this child get tied down with restraints because the nursing staff just did not think they would benefit from anything else. And essentially just kind of having to like be there and support while they're doing that. Because there was just a closed mindset to like, ‘This isn't gonna change’ like, ‘This is just what we do.’ There's not really a regard for that emotional safety or kind of how are we taking this into account? Or have we tried other things because this feels like just the faster way to get something done.”*

        - *"'I don't have the energy to learn this new thing or invest in this kind of thought process and so I'm gonna do what I've always done.' Which I think like makes sense, I can understand that, but it's just difficult to when we come in these ways, or use these buzz words. And it just kind of sounds kind of corny or cheesy to some of those staff that that just wasn't part of like their training at all, or their experience, and kind of how they provide that."*

- Strategies to overcome challenges of implementation
    - Perseverance, acceptance, and healthy boundaries
        - *"Continuing to show up, I think, and like, recognize like, yeah, this is fair for her to do that. And like, I'll be here if she wants me to ask, and if it feels right in the timing, and then, if she's given me signals that this is not the timing, then she's fine, just trusting that she hopefully has other support elsewhere, or like it really is out of my scope at that point, or beyond my control of being able to fix whatever had happened in that."*
        - *"Maybe part of my job is just being there to pick up pieces at that point. Like, I can't control what other people do, so, it's like, maybe we can help them to calm down afterward or debrief something that happens like later on."*
        - *"Really I think choosing battles. Just so we can stay in the game and not burn out of having to advocate all the time, or- or also like from that too, just kind of re-evaluating."*

- Need for music therapy trauma-informed training and education
    - *"I feel like it's a big buzzword that's been coming up in recent years, and so it makes sense, like I didn't have that in school."*
    - *"I think we would all really benefit from having more training on this, because if it feels like it is a newer thing. BecauseI was in school right from 2015 to 2019 for my formal music therapy training. And like, maybe we talked concepts around this, but we never talked like directly about this."*
    - *"I wonder where that deficit is. I think, in like having formal training on this rather than just like, 'I picked this up on the job.'"*