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Music Therapists Behind Locked Doors: The Role of Trauma Exposure and Current Music Therapy Practices in Correctional and Forensic Psychiatry

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MUSIC THERAPISTS BEHIND LOCKED DOORS: THE ROLE OF TRAUMA
EXPOSURE AND CURRENT MUSIC THERAPY PRACTICES IN
CORRECTIONAL AND FORENSIC PSYCHIATRY

by

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MUSIC THERAPISTS BEHIND LOCKED DOORS: THE ROLE OF TRAUMA
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CORRECTIONAL AND FORENSIC PSYCHIATRY

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Western Michigan University, 2015

The purpose of this descriptive study was to explore the role trauma exposure has on the possible development of symptoms of Vicarious Traumatization (VT) in the lives of Board Certified Music Therapists employed in correctional and forensic settings. Research was conducted through completion of an electronic survey. Additionally, the researcher sought to identify current music therapy practices as well as differences between practicing in forensic settings and correctional settings. The participants involved in this study were Board Certified Music Therapists who work in forensic and correctional settings. Survey invitations were electronically sent to 133 prospective participants as listed on either the American Music Therapy Association or Certification Board for Music Therapists' data bases. Six of the invitations returned as "undeliverable" leaving 127 as delivered. Twenty nine music therapists (n=29) participated in this study. Results were separated by type of work setting to determine any differences and/or similarities. Although 29 persons completed the survey, one did not identify with either forensic or correctional setting. Data showed 19 respondents identified working in a forensic setting, while the remaining 9 identified with correctional settings. While there were a number of similarities and differences between the two settings, the findings indicate overall, music therapists have been exposed to violence,

trauma, and high stress at their jobs.   In regards to treatment objectives, music therapists in each setting focus on developing healthy coping skills and interpersonal skills.   A noted difference is that forensic music therapists tend to address goals that can help their clientele succeed when reintegrated back into the community, while correctional music therapists are more likely to focus on issues of anger management, self-regulation and quality of life while their clients are incarcerated.

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Deanna K. Bush

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CHAPTER I

INTRODUCTION

In 1987, a report by Thaut identified that music therapists had recently entered the

field of correctional psychiatry. He stated that this area is "a new professional

environment that holds unique challenges, rewards and obstacles for music therapy

practice" (p. 44). Throughout the years since, music therapy has continued to play a role

in the treatment of mentally disordered prisoner/patients in correctional and forensic

psychiatry. More recently, Codding (2002) conducted a survey to gather information

about professional music therapists employed in correctional and forensic settings.

Although the results from the survey provided relevant information in regards to

demographics, beliefs and values, there was not an attempt to differentiate how music

therapy services were delivered in each setting.

In 2007, Silverman conducted an online survey to evaluate how current trends in

psychiatric music therapy compared to an earlier study (Braswell, Maranto, & Decuir,

1979) that focused on institutions in which music therapists worked. Also, comparisons

were made with a study that discussed contemporary trends in mental health (Euper,

1970). At the time of his 2007 survey, Silverman reported that 21% of music therapists

were working in the psychiatric field, which was the highest percentage of all settings.

He found that music therapists in his study indicated working with a lower number of

psychiatric patients than reported in the 1979 study. He explained it as being a result of

the deinstitutionalization movement in the 70s. Silverman also noted the role and

function of the music therapist had evolved from the earlier models which included

involvement in a more collaborative interdisciplinary team approach. In 1970, Euper

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identified this as a problem area. This information indicates a shift in the profession,

most likely to become current with newer models presenting in psychiatric treatment.

While the Silverman (2007) study includes relevant information for the

psychiatric music therapist, there is very little information available in the extant

literature regarding current music therapy treatment practices with forensic patients who

are now inhabiting psychiatric settings in the United States. Additionally, there is very

little research that discusses other factors that can influence the work music therapists do

in correctional and forensic settings. However, Annesley and Jones (2012) discussed the

challenges faced by therapists in high secure settings. First, patient offenses can

influence the therapeutic relationship in that they involve deceit, manipulation, or the

abuse of others. Also, the population in high secure settings pose grave and immediate

risks to others which may include severe life threatening physical and sexual violence,

arson, hostage taking and self-injurious behavior, including suicide.   They also discussed

that therapists who are routinely exposed to disturbing and graphic material presented

through patient descriptions, victim statements and witness statements, should be aware

of the possible effects on themselves such as burn-out or vicarious traumatization.

Background of the Study

According to Pearlman and Saakvitne (1995), Pearlman and McCann (1990)

coined the phrase of vicarious traumatization to describe "the cumulative transformative

effect upon the trauma therapist of working with survivors of traumatic life events" (p.

31). Vicarious traumatization (VT) implies that there have been changes in the

therapist's enduring ways of experiencing self, others, and the world as a result of

prolonged trauma work. Because of similar symptomology, VT has been compared to

burn out, PTSD, secondary stress, and compassion fatigue. VT is also often compared to the act of countertransference. Although no specific assessment tool was found for diagnosing VT, the American Counseling Association (2011) compiled a fact sheet that include symptoms of VT. These may include, but are not limited to; free floating anger, losing sleep over patients, dreaming about their clients and clients' traumatic experience, overwork, exhaustion, blaming others, poor communication, withdrawal and isolation from colleagues, difficulty having rewarding relationships, detachment, low motivation and hopelessness.

The literature indicates that over the previous decade, VT has become an interest of study in many areas. There are many types of professionals who work with traumatized clientele, including music therapists. Unfortunately, very little literature was found in regards to VT, secondary stress syndrome, or compassion fatigue within the field of music therapy. In a literature review, Clements-Cortes (2013) explored burn-out in music therapists in relationship to their work, individual and social factors. It was reported that music therapists can experience burn-out due to a number of reasons including; increased work stress, insufficient pay, work overload, personality traits, unrealistic expectations, age and years of experience, lack of rewards and lack of support. Exposure to trauma was not mentioned as a precipitating event for burn-out. Additionally, Fowler (2006) explored the possible relationship between professional well-being and factors such as; age, level of education, income, and attitudes regarding the workplace. She found that music therapists who had the greatest professional longevity tended to engage in healthy coping strategies (e.g., healthy diet and adequate rest) that can assist in the increase of professional well-being.

Even though music therapists in forensic or correctional settings most likely do not process therapeutic issues as deeply as a psychotherapist would, per se, they do have continuous exposure to the characteristics of trauma. It is understood that VT prominently occurs when the therapist is working with victims of trauma, however, it should be noted that many prisoners/patients who have inflicted harm onto others, have been victims themselves at some point in life.

It is possible that music therapists may encounter symptoms of VT or, at the very least, experience symptoms/characteristics of countertransference or burnout. Because of the emotionally draining work associated with this setting, it stands to reason that it could have some type of physical and/or emotional effect on music therapists' well-being. The long-term effects of working in each setting, and the shift in clientele, may be included in the "unique challenges" or "obstacles" categories that Thaut (1987) spoke of earlier. Since Thaut's report is over 25 years old, it would be interesting to know how, and if, the role and responsibilities of music therapists in this setting have evolved over the years in conjunction with the changes in the system.

Correctional and Forensic System Changes

A report released by the National Institute of Mental Health indicated that in 2012, there were an estimated 9.6 million adults aged 18 or older in the United States with a severe mental illness, which is a representation of 4.1 percent of all US adults. According to Horowitz (2013), the United States Department of Justice reported in 2006 more than half of prison and jail inmates had experienced mental health problems at mid-year 2005. This includes 705,600 State prisoners, 78,800 Federal prisoners, and 479,900 in local jails. These numbers are over four times the number reported by the United

States Department of Justice in 1998. There is additional evidence that suggests the number of mentally ill offenders continues to grow within the prison system. A survey conducted by Torrey, Kennard, Eslinger, Lamb, and Pavle (2010) revealed there are over three times more mentally ill persons in jails and prisons than who are in hospital settings. The authors declared that "America's jails and prisons have become our new mental hospitals" (p. 1). Since the deinstitutionalization movement that heightened in the 1970's, the roles of the psychiatric facility and correctional/forensic settings have become somewhat blurred. In an effort to "normalize" psychiatric patients by moving them into the community, the numbers of prisoners with mental illnesses have risen. In addition, as these individuals become involved with the criminal justice system, psychiatric hospitals are being called upon to help treat mentally disordered offenders so they can proceed within the criminal justice systems. Unfortunately, as patients were moved out into society, psychiatric hospitals were closed down nationwide, leaving fewer treatment options. In 2001, it was reported that in the past decade, forty mental institutions were closed while more than 400 new prisons had opened. In the 1970's, the state of Michigan's mental institutions held 28,000 patients while its prisons held 8,000 inmates. At the time of the 2001 report, 3,000 patients were in mental hospitals, and there were more than 45,000 inmates in state prisons (The Sentencing Project, 2002). As the prison population continues to grow, other factors may have contributed to the rise in the number of mentally disordered prisoners including increased restrictions on civil commitment criteria, lack of adequate resources, the role of police, and society attitudes (Phan, 2012). The aforementioned statistics tend to support the idea that prisons have indeed become the institutions that previously housed the mentally ill. Having said this,

the other side of the coin shows that despite the astounding increased numbers of mentally disordered offenders (MDO) in jails and prisons, the psychiatric settings (including inpatient hospitals, outpatient clinics, and other forensic settings), have experienced an increase in the number of persons who are, or who have been, involved in the criminal justice system. It is unfortunate that lack of funding, lack of resource availability, and lack of mental health treatment programming in the prison system, may be the cause of mentally disordered inmates not receiving proper treatment while incarcerated.

Correctional and Forensic Settings Defined

How are forensic individuals being treated as compared to those in correctional settings? First, one must differentiate between each setting. For this study, a correctional setting was defined as a facility that confines persons convicted and sentenced of criminal behavior, persons who are awaiting trial, and those who are convicted and receiving treatment for a diagnosed mental illness. A forensic setting was defined as a psychiatric facility that provides diagnostic services to the criminal justice system and psychiatric treatment for defendants (Center for Forensic Psychiatry, 2013) with a mental illness who are involved with the criminal justice system (Linhorst & Turner, 1999). Because of these differences, it stands to reason that there are different treatment needs for individuals in each setting type, requiring a diverse offering of treatment modalities, including music therapy.

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Purpose of the Study

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The purpose of the present study was to explore whether exposure to trauma has elicited any symptoms of vicarious traumatization in music therapists who work in

correctional and forensic psychiatry. This study did not involve implementation of any assessment or testing tools specific to measuring burn out, compassion fatigue, or vicarious traumatization. It was designed as a means of gathering information to determine whether or not there is a need for further exploration of this topic in the field of music therapy. Additionally, the researcher sought out to explore current music therapy treatment approaches, including any differences of providing treatment between each setting type of correctional and forensic psychiatry as well as treatment procedures presented in past research.

Research Questions

To further explore the role of vicarious traumatization and the practices of music therapists in the correctional and forensic settings, the following research questions were developed;

1. Do music therapists who provide treatment in correctional and forensic settings experience symptoms of vicarious traumatization?

2. Do music therapists use different treatment approaches in correctional settings from those delivered in forensic settings?

CHAPTER II

REVIEW OF LITERATURE

Working with people who have experienced physical or emotional harm can be challenging, and research has suggested that this experience extends to those providing treatment to perpetrators of abuse (Moulden & Firestone, 2007). Violence is increasing in forensic psychiatric settings despite the fact that they are secure facilities (Morrison, Morman, Bonner, Taylor, Abraham, & Lathan, 2002). Threats to a health worker's safety and security can be verbal and/or physical. The target of assault and verbal abuse varies by experience, job function, and training. Nurses in various positions have been targets of both verbal and physical assault with the most prevalent being student nurses with minimal training. In addition, nurses working night shifts have experienced more violence than those working day shifts, and supervisory nurses have experienced more violence than general duty nurses (Arnetz, Arnetz, & Peterson, 1996). According to the American Association of Critical Care Nurses (2004), *The Bureau of Labor Statistics* identified that health care and social services workers have the highest rate of non-fatal assault injuries in the workplace. Additionally, forty eight percent of assaults committed in the workplace are by patients. Such violence is said to have negative effects in the organization such as low employee morale, increased job stress, increased worker turnover, reduced trust of management, reduced trust of co-workers, and hostile work environments.

Clinician confidence is essential for good therapy with aggressive patients because confidence enables the clinician to obtain adequate access to internal resources (Thackrey, 1987). Feeling safe and having confidence to manage aggression are perhaps

prerequisites for all therapeutic interactions (Martin & Daffern, 2006). With the increase of number of incidents of violent attack on health care professionals, there is an added stress of the immediacy of the threat of assault and the long-term consequences. In addition, the frequency of exposure to aggression in the workplace can have a cumulative effect on the victims (Rippon, 2000). In fact, the greater the frequency and severity, the greater the probability of significant psychological trauma (Meichenbaum, 1994).

A person's reaction to emotional trauma is complex and difficult to predict. A person's age, past exposure to trauma, social support, culture, family psychiatric history and general emotional functioning are some variables related to individual response to trauma. Not all people cope with trauma in the same way. Some may demonstrate the ability to be resilient, while others become negative by allowing the traumatic event to become the main defining moment in their lives. As a result, this can mark the beginning of entrenched emotional distress, maladaptive behavior, and/or dysfunctional relationships. Following exposure to a traumatic event, most individuals may experience temporary preoccupation with the event, and may have some involuntary intrusive memories (Bicknell-Hentges & Lynch, 2009).

Interestingly, similar symptomology is being explored in regards to the effects trauma work has on healthcare workers. It is said that the effects of trauma exposure were first observed in the late 1970's in emergency and rescue workers who displayed symptoms similar to the trauma victims they helped (Moulden & Firestone, 2007). In the past decade there has been an increased awareness of the psychological impact on mental health professionals working in the field of trauma. It is said that professionals working with traumatized clients are vulnerable and at risk of developing trauma symptoms that

are similar to those experienced by their clients (Buchanan, Anderson, Uhlemann & Horwitz, 2006). This type of symptomology has taken on several different names which include burnout, vicarious traumatization, secondary traumatic stress, and compassion fatigue.

Trauma

According to the American Psychiatric Association, the Diagnostic and Statistical Manual for Mental Disorders-5 (2013), post- traumatic stress disorder (PTSD) is listed in a new chapter focusing on trauma and stress disorders. It states the criteria for the PTSD diagnosis includes exposure to events that involved actual or threatened death, serious injury, or sexual violation. The exposure must result from one or more of the following scenarios; direct experience with the event, witness to the traumatic event in person, learning that the traumatic event happened to a family member or close friend, and experience of first hand repeated or extreme exposure to aversive details about the traumatic event. PTSD poses a threat to the physical integrity of self or others, and this can involve fear, helplessness, or horror. Common symptoms of PTSD include anxiety, startle responses, fatigue, sleep disturbance, intrusive thoughts, difficulty concentrating, and problems controlling anger (Killian, 2008).

Everyone has been, or will be exposed to some type of trauma in their lives. Therapists virtually in all settings work with clients who are survivors of trauma (Trippany, White-Kress & Wilcoxon, 2004), and continuously hear repeated stories of traumatic events of their clientele. Repeated exposure to stories of human cruelty can challenge therapists in the areas of their basic faith and sense of vulnerability (Canfield, 2005). In their study with outpatient mental health clients, Davidson and Smith (as cited

in Killian, 2008) found that 84% to 94% reported having a history of trauma such as sexual abuse, domestic violence, exposure to combat zones, and displacement. This implies that professionals who are regularly in contact with trauma survivors routinely listen to difficult descriptions of their traumatic events and could eventually experience acute distress. Historically, counselors' reactions to trauma have been characterized as forms of burn-out or countertransference (Trippany, White-Kress & Wilcoxon, 2004). The definition of countertransference focuses on the individual characteristics of the clinician with the assumption that unresolved personal conflicts account for the clinician's reaction (McCann & Pearlman, 1990). In regards to burnout, common factors contributing to its development include the isolation of the work, difficult or demanding clients, heavy workload, the need to constantly be empathetic, and bureaucratic and administrative factors (Deutsch, 1984). Over time, however, it has been noted that neither countertransference nor burnout alone adequately accounts for the impact on the clinician of the graphic material presented by the traumatized client (Cunningham, 2003).

Countertransference, Burnout, and Vicarious Traumatization

The literature indicates that there are many similarities and differences between countertransference, burnout, and vicarious traumatization (VT). According to Pearlman and Saakvitne (1995b), countertransference is a frequently proposed, but "under-addressed" explanation of VT which involves the therapist's responses to the client. In contrast, vicarious traumatization is actually related to changes taking place in the therapist's life. Processes that are suggested to be involved in the interaction between countertransference and VT include decreased self-awareness, increased defenses, and challenges to identity and beliefs. Although burnout can share the same characteristics,

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including producing feelings of disconnection with the world and exhaustion, it is said to be temporary and preventable (Kadambi & Truscott, 2003). Important differences between VT and burnout are described as follows: burnout is more of a result of general psychological stress of working with different clients (Figley, as cited in Pearlman & Saakvitne, 1995a), and VT is seen as a traumatic reaction to specific client presented information, and occurs only among those who work specifically with trauma survivors. Burnout may occur in persons in any profession (McCann & Pearlman, 1990). Additionally, burnout is related to a feeling of being overloaded secondary to client problems and is said to have an onset that is a gradual result of emotional exhaustion. VT reactions are related to specific client traumatic experiences has a sudden onset of symptoms that may not be detectable at an earlier stage. Lastly, burnout does not lead to changes in trust, feelings of control, issues with intimacy, and intrusive imagery, all of which are fundamental to VT (Rosenbloom, Pratt & Pearlman, as cited in Trippany, White-Kress, & Wilcoxon, 2004). Other elements that have shown to increase the risk of distress and burnout include contact with suffering patients, verbal and physical abuse by patients, bullying by colleagues, the need to hide negative emotional responses, risk of litigation, role of conflicts between professions, and organizational changes (Firth-Cozens & Payne, 1999).

Vicarious Traumatization

Vicarious traumatization has been an area of study to better understand the emotional and/or physical responses of trauma work among therapists or other professionals who deal with traumatic events on a regular basis. These may include, but are not limited to, emergency medical technicians, fire fighters, police officers, criminal

defense lawyers, medical personnel, sexual assault workers, suicide hotline staff, prison personnel, and all others who engage empathetically with victims and survivors (Pearlman & Saakvitne, 1995b). When dealing with trauma, vicarious traumatization refers to alterations that occur in the cognitive schemas (manifestations of psychological needs) of trauma therapists/workers (McCann & Pearlman, 1990). These schemas that allow a person to better understand their experiences include thoughts, beliefs, and interpretations about one's self, others, and the world. In regards to VT, the cognitive schemas include safety, trust, esteem, control, and intimacy, which are viewed as the most vulnerable (Robinson-Keilig, 2014). According to McCann and Pearlman (1990), exposure to trauma clients and their traumatic experiences alter how therapists construct these five core schemas. Also, the reactions of the therapists can also depend on the significance of these schemas to themselves.

Schema Disruption

McCann and Pearlman (1990) identified that beliefs, expectations, and assumptions about the world are "central" to the concepts of the effects of victimization. When a therapist works with trauma victims, changes in themselves may be subtle, or they may be more abrupt. It depends on the degree of discrepancy between the client and the traumatic memories of the therapist's schemas already in place. Following are brief descriptions, based on the writings of McCann and Pearlman (1990), of how disruptions in the identified schemas can be associated with particular emotions or thoughts of the person in the helping role.

Dependency/Trust

Professionals who work with victims are exposed to many cruel ways that people deceive, betray, or violate the trust of other people and in the ways people undermine those dependent on them, such as children. These characteristics may disrupt the professional's schemas about trust, making them more suspicious, cynical, or distrustful of others.

Safety

Visions of threats or harm to innocent people involve a loss of safety and may disrupt or challenge this schema for the professional, especially if they have a strong need for security in their life. Also, if they work with victims of random violence, they may have an increased sense of vulnerability.

Power

When someone is victimized, they often find themselves in helpless situations, or being more vulnerable. Continued exposure to traumatic situations as such, may leave the therapist feeling powerless, especially if they possess the strong need to have power. Because of this, they may feel threatened, therefore, seek power through dominating situations in their social and/or work lives.

Independence

Survivors of trauma, such as victims of rape or other crimes, often find themselves experiencing disruption in their need for independence, thereby restricting their own freedom of movement and diminishing their autonomy. This can affect the therapist who has a strong need for independence in that identification with these clients who have lost a sense of personal control and freedom can be painful.

Esteem

Esteem refers to the need to perceive others as compassionate and worthy of respect. The victimized person may experience decreased esteem for other people, or the human race all together. For the professional, he or she may become more bitter, cynical or pessimistic. This diminished view of mankind may also produce feelings of anger towards the human race as they reflect on the potential maliciousness of others.

Intimacy

Trauma victims often feel a strong sense of alienation from other people. The professionals who work with such victims may experience similar feelings as a result of continued exposure to the visualizations and realities they are presented with. Also, they may experience a separateness from family, friends, or coworkers. Not being able to discuss such imagery because of confidentiality, may act as a barrier to having a connection with others.

Frame of Reference

Victims of trauma often repeatedly try to understand why the trauma happened to them. The therapist may also try to understand why the trauma happened to that individual. It is important for the professional to refrain from focusing on the possible motives of the assailant/perpetrator and to not "victim blame" as a way for them to gain an understanding of why it happened. This could be damaging to the client-therapist relationship, as well as being non-productive in the healing process of the victim.

The Memory System and Disruptions in Imagery

Professionals who continuously listen to the experiences of the victims may internalize the memories of their client, which may alter their own memory systems

temporarily or permanently. These alterations can become intrusive or disruptive to their psychological and interpersonal functioning. The imagery system of the professional may be altered in VT. They may experience their client's imagery in pieces without context or meaning. The most painful images for therapists may be centered on their own schemas related to their need areas.

Because of the disruptions in imagery, the professional may experience uncomfortable feelings including sadness, anxiety, or anger. They may or may not be aware of these emotional reactions, therefore can experience denial and/or emotional numbing.

The aforementioned schemas provide a theoretical conceptualization of the profound psychological impact of working with trauma victims. Just as trauma alters its victims, therapists who work with the victims may be permanently altered by the experience (McCann & Pearlman, 1990).

Risk Factors, Coping, and Prevention of VT

According to Newell & MacNeil, (2010), there are risk factors that may contribute to the development of VT for clinicians and other helping professionals. It has been suggested that practitioners with a pre-existing anxiety disorder, mood disorder, or personal trauma history (particularly child abuse and neglect) may be at greater risk of experiencing VT. At a higher level, there are organizational features identified as risk factors as well, including; organizational setting and bureaucratic constraints, inadequate supervision, lack of availability of client resources, and lack of support from professional colleagues (Dunkley & Whelan, 2006).

Robinson-Keilig (2014) explained in a study about disruptions to interpersonal functioning in mental health therapists that there is very little descriptive information available. In a survey of 215 mental health professionals, Follette, Polusny, and Milbeck (1994) reported that 24.2% utilized "withdrawing from others" as a way to cope when working with survivors of sexual abuse. In a separate study of 135 therapists and health professionals, Rich (1997) found that 35.7% removed themselves from friends and family, and 36.1% felt that their sex lives were less satisfying.

Unaddressed VT can result in cynicism, despair, and a loss to society of the hope and positive actions it fuels. Since therapists can expect to lose balance in their lives while working with trauma, they need to have a strong support system in their professional life as well as in their personal life (Pearlman & Saakvitne, 1995a). It is imperative that a clinician working with victims of trauma learn ways to cope with the tough subject matter they are presented with daily. In a research review, Moulden & Firestone (2007) reported that a number of studies conclude that positive coping strategies do help alleviate negative effects of trauma work. In addition, they found that negative and positive forms of coping can be related to increased symptoms of VT.

In an article about trauma work with sexual offenders, Kadambi and Truscott (2003) suggest that having strong connections with colleagues and professional associations can serve to offset the stress and isolation of working with sex offenders. In addition, organizational strategies such as regular staff meetings, offender-specific supervision, and having educational opportunities for those working with sexual offenders can help in coping with traumatization associated with working with sexual offenders. Therapists working with this population can be presented with many

challenges, and can be impacted by having disruptions in their own lives, which is why having personal coping strategies is so important to the prevention of the negative effects (Moulden & Firestone, 2010) that can occur.

Overall, research indicates that having team supervision and additional training would be an effective way to reduce symptoms of, or prevent VT. Unfortunately, it also suggests that many places are lacking in this area. The professional must be able to acknowledge, express, and work through the tough experiences in a supportive environment if they are going to prevent or improve the potentially damaging effects of their work (McCann & Pearlman, 1990).

VT in Correctional and Forensic Settings

According to Moulden and Firestone (2007), secure settings such as prisons and secure hospital setting are associated with having a greater presence of VT as compared to community settings, which may be a direct result of the tough environment, isolation, or ongoing dangerousness of the population. Also, many of the prisoners/patients have experienced trauma in their own lives. Not only are some workers potentially exposed to physical trauma in these environments, they may also become exposed to the trauma of their clientele. Over the years there has been a shift in these setting types as well as how they are serving these populations. Specifically, there has been an increase in the number of prisoners with a mental illness in correctional facilities, and an increase in the number of offenders in the forensic population within hospital settings.

James and Glaze (2006) wrote that every 5 or 6 years the Bureau of Justice Statistics (BJS) conducts an inmate survey to collect information about the prevalence of mental illness in the state and federal prison systems as well as in local jails. With the

information from the survey, they compiled a special report that included the BJS data from state and federal prisoners dated 2004, and from a survey of local jail inmates dated 2002. The report indicated that more than half of all prison and jail inmates surveyed, had a mental health problem. Forty three percent of state prisoners and 54% of jail inmates reported experiencing symptoms that met the criteria for mania, while 23% of state prisoners and 30% of jail inmates reported symptoms of major depression. Additionally, an estimated 15% of state prisoners and 24% of jail inmates reported symptoms of psychotic disorder with female inmates having higher rates of mental health problems than males. Because of the astounding growth of mentally ill prisoners, correctional facilities are having to explore options to treat these individuals. Timmerman and Emmelkamp (2001) noted that high number of prisoners and "mentally disturbed" offenders experienced severe traumatic events (i.e., coming from lower socio-economic statuses, broken homes, parental neglect, brutality, humiliation and alcoholism). Also, in a case study of 12 murderers with dissociative identity disorder it was revealed that all of them suffered severe physical and/or sexual abuse as a child (Lewis, Yeager, Swica, Pincus, & Lewis 1997).

Historically, the prison systems were meant to be "sinister and punitive"; their function was not to be a hospital, but to act as a deterrent to committing unlawful crimes (Gunn, 2000). In a PBS *Frontline* documentary *The New Asylums* (Navasky, O'Connor, & Mangini, 2005), it was stated "Prison doesn't exist to provide mental health treatment, prison exists to provide safety to the community." In the same documentary, however, the Director of the Ohio Department of Corrections claimed that mental health treatment in prisons is better than what the inmates can receive in the community. Nevertheless, a

vast majority of mentally ill inmates across the nation continue to receive little to no treatment. Condelli, Dvoskin, and Holanchock (1994) identified that adequate treatment programs were "virtually non-existent" for most mentally ill inmates.

Despite the problems, there can be positive aspects of the prison system such as providing education and rehabilitation services (Gunn, 2000). According to Condelli and colleagues (1994), attempts were made in New York State to improve services by adding therapies such as milieu, individual and group therapies as well as recreation therapy, task and skills training, and educational and vocational instruction. The general goal of the aforementioned services was to decrease disruptive and harmful behaviors. Overall, it was suggested that the Intermediate Care Programs in New York State prisons were meeting their mission of reducing harmful behaviors as well as serious rules infractions, suicide attempts, correctional discipline and three mental health services: crisis care, seclusion, and hospitalization. Gater (2006) explored how some prisons and jails are treating their forensic inmates. It was reported by several officials that a number of states are putting the "pieces to the puzzle" together by developing better treatment options. These include newer, more effective drugs, cognitive behavioral therapy where inmates learn ways to cope and to manage anger and stress, and learn self-management skills to better deal with their illness. In Missouri, one facility offers a continuum of care which includes transitional and aftercare upon release of the inmate. In Georgia, treatment alternatives include group treatment, activity therapy, greenhouse therapy, pet therapy, and classes. Of course, the type of treatment one receives is based on two criteria; the inmate's diagnosis and the offerings of the facility in which they are housed (Gator, 2006).

Despite the challenges, the treatment of the mentally ill prisoner has progressed over the years. In Larned, Kansas, a federal court required the state of Kansas to create an environment "suitable for the treatment of the mentally ill." As a result, the Larned Correctional Mental Health Facility was born in 1992. This facility provides a wide range of treatment programs for inmates including group and individual counseling, activity therapy, and music therapy. Also, specialized groups such as anger management and substance abuse counseling are offered (Scott & O'Connor, 1997). In Michigan, the Center for Forensic Psychiatry (CFP), is a specialized facility where criminal defendants go to receive court ordered evaluation and treatment in regards to competency to stand trial and criminal responsibility. As part of the treatment milieu, the CFP offers supportive case management, group therapy, activity therapy, education programs and work therapy. The goals of treatment groups vary from socialization to education and to insight (Clark, Holden, Thompson, Watson, & Wightman, 1993).

According to Graham-Howard, Knabb, and Welsh (2011), treatment needs of mentally disordered offenders (MDO) are interpreted by their legal status. A person who is an "insanity aquittee" will have treatment goals that differ from a defendant receiving competency restoration services. Mentally disordered offenders also require treatment that is directly related to their crimes. A person charged with domestic violence will have different treatment needs than a patient who is a serial arsonist. In addition, the treatment goals for MDO's will differ with respect to a broad range of psychiatric diagnoses (Graham-Howard et al., 2011). Way, Dvoskin, and Steadman (1991) explored the topic of forensic inpatients being served in the United States. The authors reported that a

greater number of individuals who have been criminally charged or convicted of a crime subsequently are admitted to hospitals for treatment.

Like the jail and prison systems, the role of the public psychiatric hospital has undergone changes since the era of deinstitutionalization. Because of changing treatment needs and patient type, the function of hospitals are being redefined. They are becoming providers of mostly long-term facilities for people who have more serious treatment needs such as severe mental illness and unmanageable behaviors that cannot be managed in other placement types. In addition, hospitals are spending more of their resources on the forensic patient (Linhorst & Turner, 1999). Fisher, Geller, and Pandiani, (2009), identified several patient populations that have become prominent in state psychiatric hospitals and will "likely define" the hospital's mission in the future. These include people with past criminal justice involvement, a growing forensic population, sexually dangerous persons, and the "difficult to discharge" population. They explained that forensic patients are committed by the criminal courts because they have been found incompetent to stand trial, or they have been found not guilty by reason of insanity. Other patients may be court ordered for a pretrial psychiatric evaluation, convicted as guilty but mentally ill, and convicted defendants who committed sex crimes (Linhorst & Turner, 1999). According to Ficken and Gardstrom (2002), there were 5400 individuals found "not guilty by reason of insanity" and 3200 were found "incompetent to stand trial or IST" in 1986. One can assume that since the 1980's these numbers have continued to increase. In fact, between 1988 and 2008, the Vermont state hospital reported that forensic patients accounted for a 50 % increase in its admissions while Massachusetts reported a 379 % increase, and New York, 309 % (Fisher, Geller & Pandiani, 2009).

Neville and Vess (2001) reported that forensic psychiatric inpatients are difficult to treat because they are involuntarily committed as few would seek treatment on their own. In addition, this population is expensive to treat. In California's maximum security forensic state hospital, the average annual cost is $105,000 per patient. In Broward County, Florida, reports indicate that it costs more to house the mentally ill prisoner because of different needs including increased staffing and medications. It costs $80.00 per day for a "regular" prisoner while it costs $130.00 for a prisoner with a mental illness. In Texas, it costs $22,000.00 per year to house average prisoners and it costs between $30,000.00-$50,000.00 per year for those with mental health needs (Torrey, Kennard, Eslinger, Lamb, & Payle, 2010). According to the National Alliance for the Mentally Ill (NAMI), prisoners with mental illness can cost the nation $9 billion dollars on average per year. One Ohio county jail reports that the annual cost for prescription drugs, used to treat mental health issues, exceeded the cost to feed those prisoners (Torrey et al., 2010).

According to Ficken and Gardstrom (2002), the National Association of State Mental Health Program Directors Research Institute, Inc. reported in 2000 that over thirty-five states are now providing acute, intermediate and long-term services to forensic inpatients. Treatment conducted under the jurisdiction of the criminal justice system is different from traditional mental health treatment for which most clinicians have been trained. Because of this, a need for clear understanding of the criminal justice system's perspectives and goals related to the treatment of mentally ill offenders exists. Both the criminal justice system and forensic clinicians generally expect that the mentally ill offenders receiving treatment will gain some understanding of the role of their psychiatric disorder in past and potential future dangerous behavior (Lamb, Weinberger, & Gross,

2004). Diagnostically, a person who is IST typically will fall into one of two categories: first, acute major mental disorders such as schizophrenia or mania and second, dementia or developmentally disabled affecting mental capacity (Bloom, Williams & Bigelow, 2000). In a literature review about treatment alternatives for MDO's, Graham-Howard and colleagues (2011) summarized 10 approaches utilized with this clientele. The researchers focused on the "theoretical underpinnings, interventions, empirical support, and strengths and weaknesses" of each treatment modality. They felt that the review would provide forensic clinicians with what is available in the field, as well as what is current. Amongst their reviewed approaches were: behavioral therapy, cognitive therapy, therapeutic community, and psychoanalytic therapy, to name a few. The list also included "new and emerging" treatment modalities that were supported by research such as music therapy. It was summarized that music therapy with the MDO population has many strengths, including: offering an alternative to more traditional treatment interventions, helping offenders express themselves through non-talking based approaches, and the ability to better relate to others through common interests. Also, music may be calming, which can help offenders explore anger and frustration in more effective ways, as well as develop safe ways to cope with stressors. In the same article, a noted weakness of music therapy was the lack of empirical validation as an efficacious treatment for MDO's.

Music Therapy in Correctional and Forensic Settings

The use of music therapy in the correctional and forensic setting is limited, as is the state of the current research literature in the United States to support it. Codding (2002), conducted a survey to collect demographic information from music therapists

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across the United States who work in correctional and forensic settings. She focused on obtaining information in regards to patterns of educational background, employment history, and conditions of employment in corrections/forensic settings. In addition, she was interested in patient demographics and the values of music therapists in these settings. In the literature that is available, the terms correctional psychiatry and forensic psychiatry are often paired together. However, most studies focus on the correctional setting leaving the forensic setting out. There is very little information of how music therapists treat those in the forensic setting. Even though she was collecting information from music therapists in both the correctional and forensic settings, Codding (2002) chose not to differentiate when presenting results.

Similarly, in his chapter about music psychotherapy, Thaut (1999) chose to focus his attention more on the correctional setting. He did differentiate between the two areas through definition. Correctional psychiatry was defined as "work with prisoners who have been found guilty of their charges and sentenced by the court but have a psychiatric diagnosis" (p. 249), and "forensic psychiatry involves psychiatric evaluations of prisoners and treatment of patients with criminal records who have been found not guilty by reason of insanity" (p. 249). In his definitions, Thaut did not mention the ruling of being found incompetent to stand trial (IST), perhaps because this ruling was probably not as prevalent then as it is now. This type of ruling indicates that a forensic patient has not yet been to trial. When these individuals have been deemed IST, it is the belief of the court that they cannot face their charges because they lack a full understanding of their charges as well as the complexity of the court processes due to their current mental state, or level of cognitive functioning during the time of their alleged crime. Not having a full

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understanding of the process or not having the ability to communicate with their attorney could interfere with the individual's right to a fair trial. Since this ruling has become more prevalent, it would be beneficial to explore how these individuals are being treated.

How can an incarcerated person benefit from music therapy in a correctional or forensic setting? Thaut (1999) identified that music experiences in correctional settings can be used therapeutically to alter mood, anxiety, and thoughts about self. He also identified some of the possible music therapy goals which include, but are not limited to: increase self-esteem, learn respect for others, provide a means for self-expression, reduction of aggressive and hostile behavior, induce mood change, and provide a non-threatening and motivating reality focus. Additionally, he noted that information specifically designated for corrections could be applied to the forensic setting with adaptations to accommodate the differences between the settings. These differences may include institutional rules, goals, therapeutic milieu, and background of the patients. Daveson and Edwards (2001) studied the role of music therapy in prisons by conducting a survey with female prisoners who agreed to participate by attending regular music therapy sessions over a 12 session period then completing surveys to describe their experiences at the end. They found through the self-reporting measures, that music therapy helped the participants increase levels of relaxation, reduce stress, and increase self-expression. Similar goals are targeted in the treatment program at the Atascadero State Hospital in California. According to Reed (2002), their treatment focuses on improving reality contact, building self-esteem, and ego-strength, improving cognitive task skills, and developing pre-vocational and vocational work skills. Groups included music listening (soul and rock), Gospel Choir Group, music improvisation group, and

rhythm improvisation group. She summarized that improvements could be seen in the cognitive, psychological, behavioral, and social functioning of the patients. Also, patients who were isolated and socially impaired improved their overall functioning level. In Texas, the North Texas State Hospital (NTSH) admits patients to a maximum secure unit if they have been found IST, NGRI, or dangerous by another state facility. Fulford (2002) described the music therapy program at NTSH offers a variety of interventions such as improvisation, songwriting, anger management, relaxation, group performance, movement, and musical games. Goals may include communication skills, improving mood, self-esteem, and emotional expression. In addition, relaxation skills and improving attention span are also addressed.

In some cases, music therapy is used to reach specific target groups such as sexual offenders. For example, Watson (2002) reported utilizing drumming as a treatment modality with this clientele to help prevent recidivism. More specifically, drumming was used to provide non-threatening opportunities for nonverbal self-expression, positive group/social experiences, leadership opportunities, cooperation, confrontation and a release for intense emotions.

In the Netherlands, Arts Therapies such as drama, art, music, dance, movement therapies, and psychomotor therapies are increasingly used in psychiatric and forensic settings as alternatives to traditional verbal forms of psychotherapy. Arts therapies are said to facilitate processing at a non-verbal, unconscious level and provide a broader range of methods to evoke and reprocess patient's emotions than traditional forms of therapy. In the forensic setting, music therapy specifically focuses on aggression and social interaction (van den Broek, Keulen-de Vos & Bernstein, 2011). According to

Hakvoort (2002), music therapy is a fully recognized part of the therapeutic program in all forensic clinics in the Netherlands. The main focus of music therapy treatment is to change the behaviors that have led to assault. She explained that because music is strong in stirring emotions, it can bring emotions like irritation and rage to the surface. An advantage of music is that it is easily accessible to their patients. While engaged in music therapy, she stated that the behavior of the patient and his cognitive reactions can be observed and reported to the rest of the team. Also, the music can help the patients become aware of the causes of their anger, identify the first symptoms of their anger, and learn coping strategies to deal with anger. Group music therapy can be used to enhance social interaction and coping skills, while individual sessions can enhance anger management skills. The use of musical instruments and parameters offer the opportunity to express aggression in a constructive way. Aggressive energy can be a part of the musical process as the music therapist can take part in the aggressive musical outburst and contain it, thereby providing a feeling of security when exploring aggression (Smeijsters & Cleven, 2006). Music can work as a motivator, inspirer, reinforcement, or even "seducer". Music therapy has to meet the standards of psychiatric treatment and therefore tends to be cognitive-behavioral in orientation. Also noted is the fact that music therapy be delivered in a safe environment (Hakvoort & Bogaerts, 2013).

Hakvoort, Bogaerts, Thaut, and Spreen (2013) explored whether or not music therapy could have a positive effect on coping skills, anger management, and dysfunctional behavior in forensic patients. They conducted an explorative study with a pre- and post-test design, randomly assigning patients to a treatment group or a control group. What they found was patients assigned to the experimental group had the

tendency to utilize more positive coping skills than in the control group. Also, the experimental group tended to demonstrate less avoidance coping skills needing less of a need to "withdraw" from the presented social interaction. It was discussed that a "core assumption" on the functions of music is that it is utilized to express various emotions, trigger cognitions, or to contain behaviors.

Music therapists who work in either a correctional facility or forensic facility have the tendency to be at risk each day. Since the environment can be dangerous, the music therapist must be mindful of his/her surroundings at all times. Fulford (2002) explained that due to the nature of the patients being served at NTSH, special measures need to be taken to ensure safety including locking up potentially dangerous equipment, such as guitar strings, picks, drum sticks and mallets. Not allowing patients the use of ball point pens is also listed as a safety measure. Everything is accounted for to ensure the safety of everyone. Not only should the environment be safe, Thaut (1999) explained that the music therapist must have knowledge about typical prisoner/patient behaviors, power structures among the inmates, manipulative behavior, prison jargon, development of different prisoner personalities formed during incarceration, and should be familiar with the criminal record of the prisoner/patient. If the aforementioned are not known, it may lead to failure when developing a therapeutic relationship. Furthermore, if this relationship is not foundationally strong, it could put the therapist at risk. In addition, a music therapist may experience feelings of ambivalence toward the prisoner which may include anger, cynicism, punitive attitudes, or they may experience overwhelming empathy. Both attitudes will make the therapist less efficient (Thaut, 1999). In Codding's (2002) demographic study, she provided a comment section for the

participants to add any additional information if they desired. Two of the five comments listed stood out as thought provoking. First, "Working in forensic/corrections is not for those with fragile personalities. You must not feel threatened to be around mass murderers, rapists, con artists, etc." (p. 65) and second "An area for further study might be how music therapists in these settings deal with their feelings, and with people who have committed horrible crimes and are likely to commit others" (p. 65).

CHAPTER III

METHOD

This chapter describes the methods that were used to conduct this study.

Participants

Prospective participants (*N*=127) for this study were professional music therapists who were currently employed in correctional and/or forensic settings and listed on the American Music Therapy Association and/or Certification Board for Music Therapists' databases in 2014. A total of 137 email addresses were obtained. Six addresses returned as "undeliverable". After comparing both lists for possible duplicate email addresses, 4 that appeared on both the AMTA and CBMT lists were eliminated. An overall total of 10 addresses were excluded from the mailing list. Potential participants were residents of the United States of America.

Procedure

An invitation to complete a 52 item independently created survey (see Appendix A), was distributed to participants via an e-mail, which also included a link to access the survey on www.surveymonkey.com. The invitation (see Appendix B) that was sent to prospective participants included a description/purpose of the study and explained that participation in this study was voluntary and anonymous. To provide participants with further assurance in regards to their anonymity, a link to Survey Monkey's terms and conditions of privacy was included. It was noted that if at any time a participant felt discomfort due to questions being asked in regards to trauma experiences, they could abort the survey without any penalties. Participants were given a three week time frame

in which to complete the survey. At end of the second week, the same group was sent a final e-mail message as a reminder to participate if they were interested in doing so.

The actual survey tool was divided into three sections focusing on demographics, treatment procedures, and trauma exposure of the music therapist. Questions presented in the demographic section included, but were not limited to, items such as setting type, age range, level of experience, and region of practice. The treatment procedures section included questions in regards to assessment, types of interventions, types of music utilized, and the amount of treatment groups/individual sessions they provide each week. Lastly, some of the topics explored in regards to trauma exposure included experience with trauma, witnessing trauma, coping in a stressful work setting, and support when dealing with traumatic experiences. The final question of the survey asked respondents to provide any additional information they felt would be helpful to the researcher.

Data Collection

Data from this survey were collected through www.surveymonkey.com. There were several options for reading survey results including reading anonymous individual surveys, overall group results, and the option of a design that automatically categorized responses from music therapy practices in the correctional setting and responses from those in the forensic setting in the form of a filter provided by the website. All three of the above options were utilized for the analysis of the findings. The first question of the survey asked respondents to indicate whether they were associated with a correctional or forensic setting. The aggregate data were analyzed and reported using frequency counts or a simple percentage format within tables, graphs, and written in descriptive narrative.

CHAPTER IV

RESULTS

Invitations to participate in the survey were electronically sent to 133 potential

participants. Email addresses that were obtained with approval from the organizations of

AMTA and CBMT were cross referenced to detect duplicate email addresses. As a

result, 4 were eliminated from the invitation list. Six of the 133 were returned as

"undeliverable" which then decreased the number of actual invitations to 127. Twenty

nine individuals chose to volunteer in this research, therefore creating a 23% response

rate. Since one person chose not to answer the identifying question, that individual's data

was not included in all of the analysis. Twenty-eight surveys were analyzed when each

setting was being discussed separately, while 29 surveys were analyzed when both

groups were discussed as a whole.

Demographic Information

Nineteen participants (68%) reported working in the forensic setting while 9

(32%) were employed in correctional settings. Figure 1 shows a division of the specific

types of facility or program each respondent works. Respondents who chose "other" as

their response provided additional information to assist in the clarification of their facility

type. These included; psychiatric hospital in a prison, not currently employed just

moved, per diem at a psychiatric hospital and teaching at a university, state hospital

within the Department of Corrections, juvenile detention center, forensic psychiatric

hospital and youth correction rehab. Of all respondents, 79% were female.
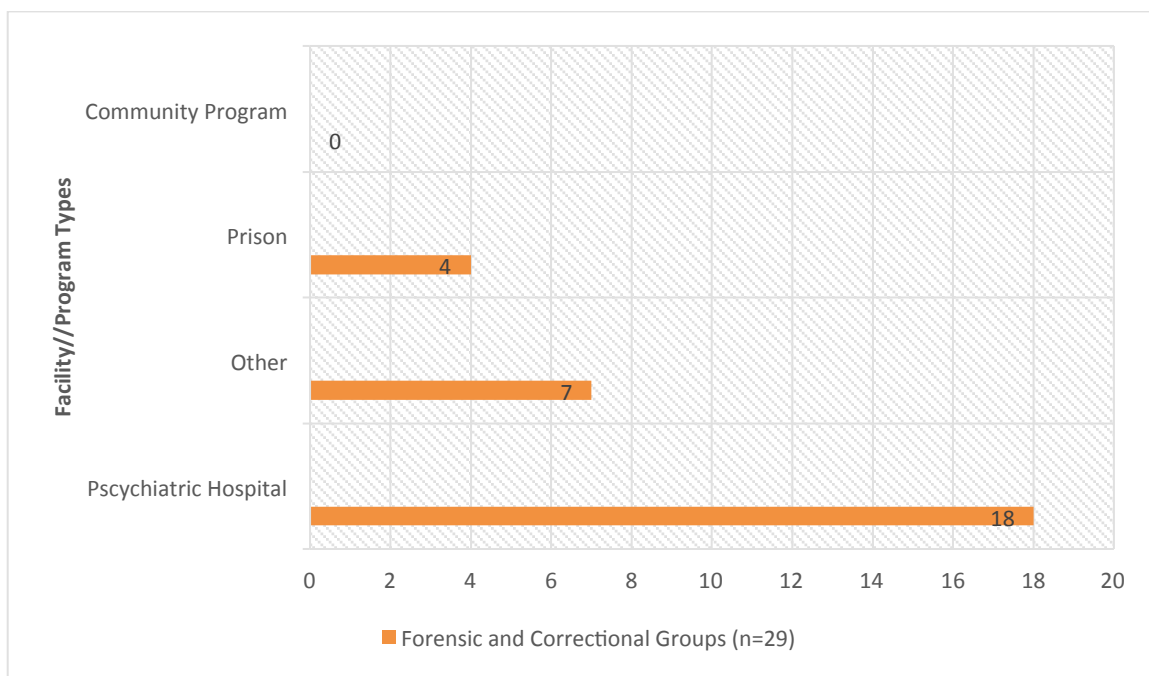
Figure 1. Division of facility/program types.

In regards to employment type, 18 (95%) of the forensic participants stated they were full time employees while 8 (89%) of the correctional participants were full time. No one indicated that they were contractual in either setting type; however, two participants indicated they worked part time. Fifty-three percent of respondents in the forensic setting specified having been in their current positions for 1-5 years compared with 56% for those employed in the correctional setting. In the correctional setting, the number of years worked did not exceed 10. A small amount (15%) of those in the forensic group reported having worked for 11-20 years.

Figure 2 visually shows the geographic locations of the participants. The Western Region which is comprised of the following states; Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, Washington and the U.S. Territories and outlying areas of the Pacific Ocean, had the largest number of participants in this survey. There were no

participants from the New England region.
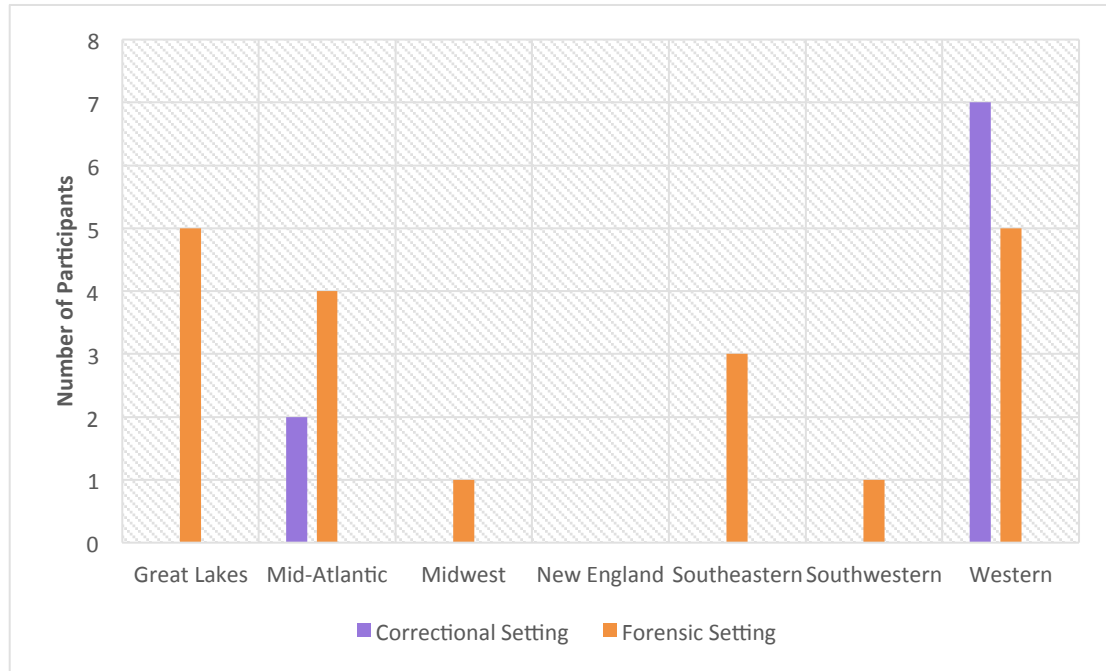
Figure 2. Survey participants by setting type in region of practice.

Additionally, ten participants in the forensic setting and 6 participants in the correctional setting indicated that their facility employs 5 or music therapists. Seventy-nine percent of forensic participants indicated working with both male and female clientele, while correctional participants had a higher percentage working with the male population exclusively.

The final question in the demographic section of the survey asked participants to identify whether or not they had any specialized training or certifications that helped to enhance their work. Table 1 describes the various additional training and certifications listed, and is divided by setting type. Yoga instructor was the only additional certification that was duplicated in the participant responses.

Table 1

Additional Specialized Training and Certifications as Listed by Participants

Forensic Setting	Correctional Setting
Brain injury specialist	Behavior Analysis Certificate
Certified Group Fitness Coach	Bonny Method of Guided Imagery
Certified Personal Trainer	Dialectical Behavior Therapy
Certified Yoga Instructor	Licensed Professional Counselor
Cross Modal Treatment	National Board for Certified Counselors
CTT	Ongoing training in Corrections in safety and
Dialectical Behavior Therapy	wellness.
Extensive Training in Forensic Psychiatry	
Group Psychotherapy (YALOM)	
Meditation and mindfulness training	
MSW-Counseling skills	
Non-aggressive Crisis Prevention	
Substance abuse	
Trauma Informed Care	
Verbal De-escalation techniques	
Via Hope Recovery Model	

Treatment Procedures

Participants specified that a variety of assessment tools are utilized within each

setting. According to responses from music therapists in forensic settings, 36% complete

Activity Therapy assessments and 32% complete a Multi-disciplinary assessment. Other

assessment tools mentioned were Rehab Services and Recreational assessments. In the

correctional setting the majority (67%) stated that they complete a multidisciplinary

assessment. Overall only one respondent indicated using a music therapy specific

assessment. The majority of the forensic music therapists provide treatment in the group

setting 6-10 times per week and individual sessions 1-5 times. In the correctional setting,

the majority reported providing 1-5 treatment groups weekly (see Figure 3).
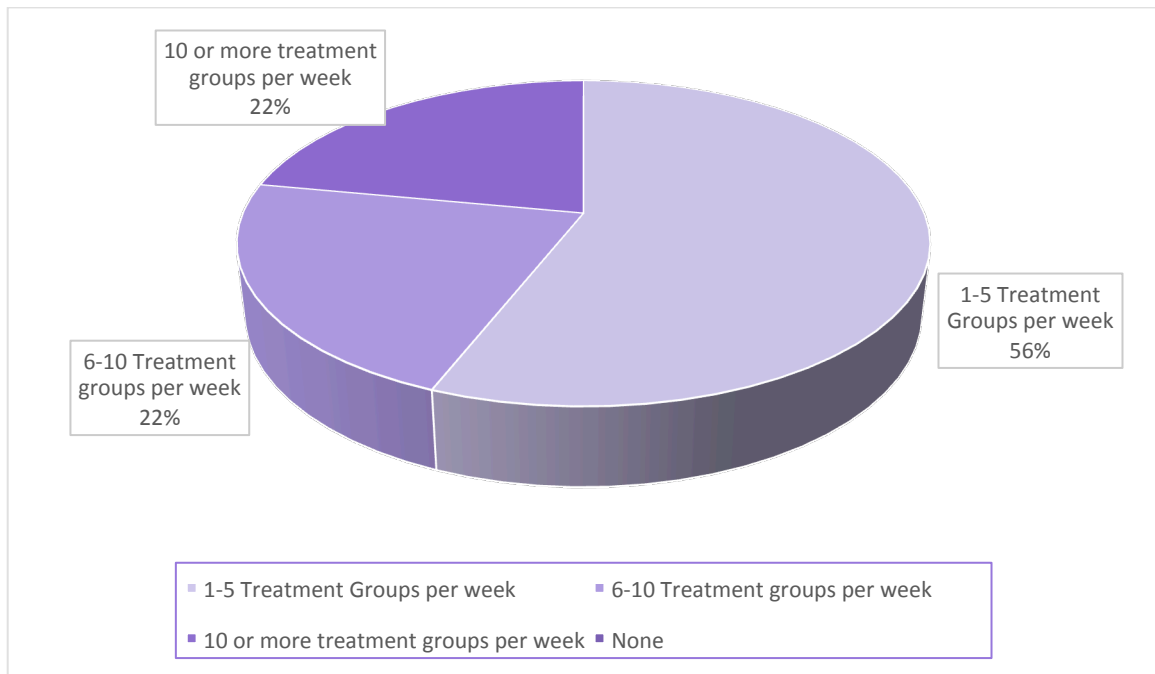
Figure 3. Number of groups provided in the correctional setting.

A combined total of 26 participants indicated that their clients/patients are somehow included in the treatment planning process. The ways in which this occurs included attendance to team meetings, helping to develop their own goals, having a say in which types of groups they attend, and having discussions about what they are working on. One respondent commented, "Treatment plans are not determined by creative arts therapists."

Table 2 shows the types of treatment objectives that are addressed in both forensic and correctional settings. Development of healthy coping strategies was the response chosen most for each setting type while interpersonal skills was second. It should be noted that although each group chose the provided objectives similarly, there were slight variations. For example, the forensic group indicated a focus on competency restoration and the correctional group identified quality of life as differing treatment objectives.

Table 2

The Top Five Music Therapy Treatment Objectives in Forensic and Correctional Settings

Music Therapy Treatment Objectives			
Forensic Settings N=19	%	Correctional Settings N=9	%
Development of healthy coping strategies	84	Development of healthy coping strategies	100
Interpersonal skills	53	Interpersonal skills	56
Self-expression	47	Anger management	44
Community reintegration	32	Self-regulation	44
Competency restoration	32	Self-expression	33
		Quality of life	33

When participants were asked to choose their top three musical choices, nineteen (66%) respondents chose to include their three music choices in the area provided for "other." The remainder of respondents made one music choice. However, it should be noted that the researcher overlooked providing an option that allowed respondents to choose more than one response. It was found that music selections used by the participants were similar in each setting type. In fact, each chose Rap, Rock, Pop, and R&B as their music of choice. Other music styles mentioned were country and relaxation. One notable distinction is that rock music was the number one choice for the forensic setting while pop music was chosen the most in the correctional setting.

Safety was an issue in both setting types. Overall, 55% (n=16) of the respondents indicated being limited in a number of ways regarding the types of equipment they can utilize in their practice. These included the following; patients cannot touch the instruments, MT is limited to using an MP3 player, speakers and a small keyboard, all

CD's must be counted due to being considered contraband due to being able to use as a weapon if broken, no wire string guitars or metal instruments, no electronics, facility purchased instruments only, and no sharp objects.

Figure 4 provides a sample of the types of interventions being implemented in each setting type. Participants were asked to choose their top five. Similarities and differences are apparent between groups. For example, while music performance was essentially rated the same, instrumental ensemble was more prevalent in the forensic setting. Passive interventions such as music listening and songwriting were represented higher in the correctional setting. Instrumental and/or vocal training, music and movement, and choir, were shown to be practiced in the forensic setting only. Neither setting identified providing music education within their practices. Write in responses not included in the chart were music games and use with other creative therapies.
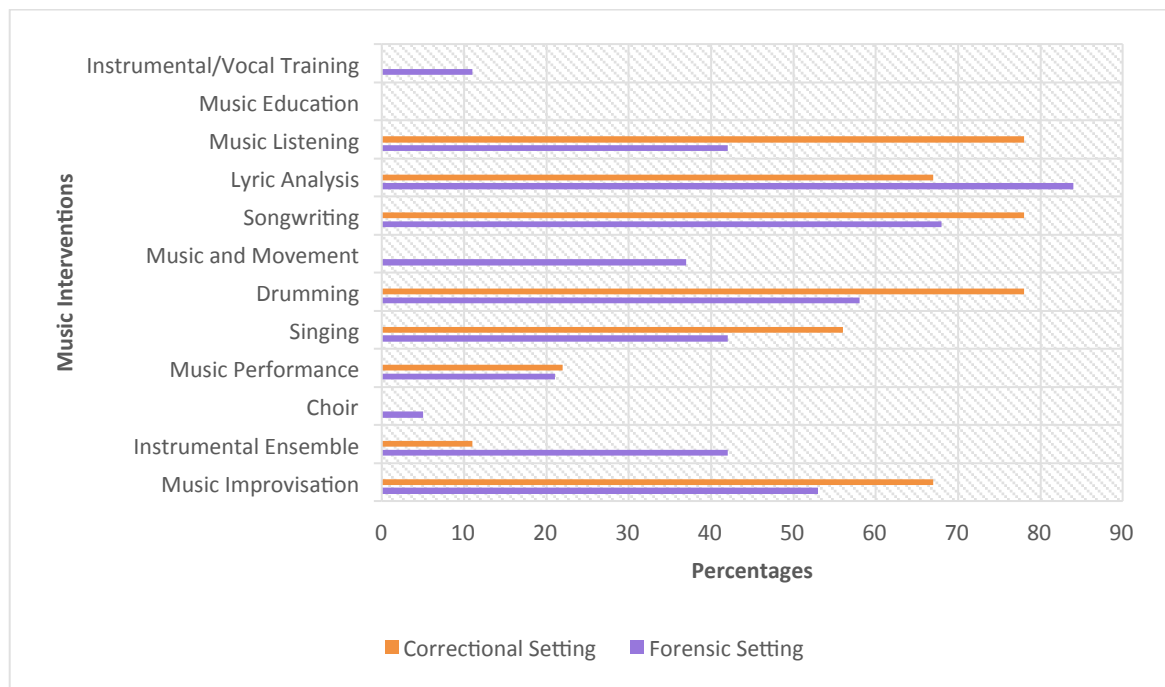

Figure 4. Types of interventions implemented in each setting type.

Based on the participants' responses, it would appear that collaboration with other disciplines occurs in each setting type. The recreation therapist was chosen as the discipline music therapists collaborate with the most receiving 15 responses. Second were psychologists (receiving 11 responses) followed by social work (receiving 9 responses). Other disciplines noted were art therapists, occupational therapists, and dance therapists. Five respondents in the correctional group indicated not collaborating with other disciplines at all.

The final question posed in this section was, "Do you find it challenging to find current continuing education information/opportunities relating to correctional and forensic populations?" From the forensic group (N=19), 13 marked "yes" and from the correctional group (N=9), 6 marked "yes".

Trauma Exposure

The findings from this research suggest that music therapists who are employed in forensic and correctional settings are exposed to traumatic events. Of those responding to this survey, 79% of forensic music therapists and 56% of correctional music therapists reported having been either verbally or physically victimized at work. Figure 5 shows the types of trauma witnessed in each setting.

The data indicate that debriefing occurs within each setting type after a traumatic event. In fact, 79% of forensic music therapists reported having some type of debriefing compared to 78% of the correctional music therapists. Participants were provided a comments section to provide more information if they desired. Table 3 describes the types of debriefing opportunities offered in the forensic and correctional settings.
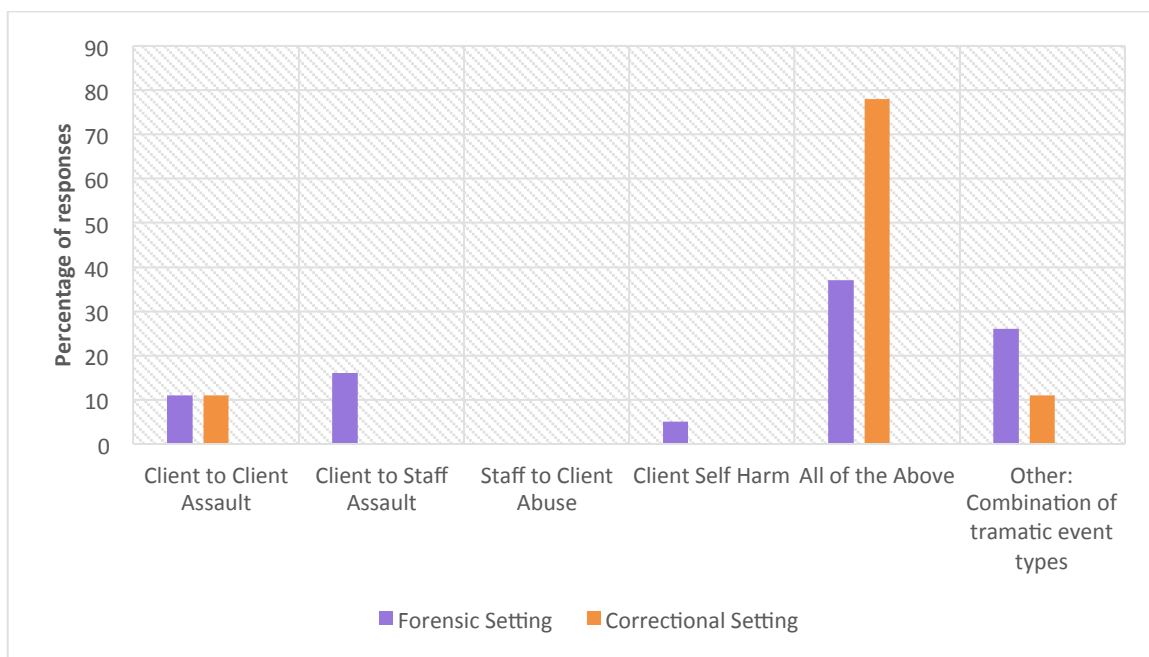
Figure 5. Types of trauma witnessed by music therapists in forensic and correctional settings.

Table 3

Debriefing Opportunities Offered in the Forensic and Correctional Settings

Debriefing Types	
Forensic Setting	Correctional Setting
Debriefing only offered after a death	Debriefing in shift change report
Meet as a team	High paced facility, debriefing is short.
Staff involved debriefing	Can contact counselors and other staff about the
When they think to/remember to	traumatic event.
Team of staff available to staff involved in the traumatic event	
Staff get contacted by someone on a team and are provided with opportunity to discuss the trauma	
Short debriefing during team meeting	
Support our staff program for traumatic events	
Employee assistance program	
Offered opportunity to talk if needed	
Provided with a phone number to call for support, but are not encouraged to do so	
Minimal debriefing-lots of room for Improvement	

How respondents felt about safety and support within their work setting is depicted in Table 4, which combines both setting types together. As mentioned previously, one participant did not identify with either forensic or correctional setting. While that data was excluded from the individual setting responses, the responses from this individual have been included with the aggregate data. Fourteen participants "agreed" with feeling comfortable while working with the criminal population, yet only 9 "agreed" with feeling safe at work. More than half (n=15) of the participants feel properly trained to work with this population and identified their environment as dangerous. In regards to facility support, 19 respondents "agreed" that they feel supported by their supervisor, but when asked about their level of agreement with how supported they feel by their facility administration, responses were more evenly distributed amongst the responses ranging from "agree" to "disagree." In fact, "somewhat disagree" is the choice that elicited most responses (n=9) for this question.

Table 4

Ratings of How Music Therapists Feel in Regards to Safety and Support Within Their Work Setting

Statements	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Participants N=29
I feel safe at work	9	15	4	1	29
I feel comfortable working with the criminal population	14	13	2	0	29
I feel properly trained to work with this population	15	10	4	0	29
My work environment is dangerous	15	9	3	2	29

Table 4—Continued

Statements	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Participants N=29
My work environment causes me stress	13	13	2	1	29
I feel there is ample research to support my work in this setting	5	14	5	5	29
I feel supported by my supervisor	19	3	4	2	29
I feel supported by the facility administration	6	8	9	6	29
I trust my colleagues	14	12	3	0	29

A question grid with "yes", "no", and "not applicable", response choices was

devised as a method of determining the effect, if any, of working in high stress settings

such as forensic and correctional facilities. Table 5 provides a thumbnail view of how

music therapists emotionally respond in such settings. The questions were derived from

general symptomology lists of vicarious traumatization presented in supporting literature.

All participants (n=29) indicated that they have had clients disclose information

regarding their traumatic events to them. Twenty-four participants specified having an

emotional reaction to information shared with them by their clients. Additionally, over

half (55%) of participants stated they have experienced bad dreams or nightmares relative

to work.   In regards to therapists personal experience with trauma, the majority of

participants (n=20) stated they had faced their own trauma either at work or outside of

work. Eight participants indicated not having experienced any traumatic events.

Twenty-five participants reported having a strong support system both professionally and personally.

Table 5

Emotional Response to Trauma in Forensic and Correctional Music Therapy

Trauma based questions	Yes	No	Not Applicable	Participants N=29
Have any of your clients disclosed traumatic events they have experienced to you?	29	0	0	29
Have you experienced a traumatic event either at work or outside of work?	20	8	1	29
Do you discuss traumatic life events experienced by your clientele during treatment groups/individual sessions?	26	3	0	29
Do you have a better understanding of your clients because of experiencing similar traumatic life events yourself?	11	9	9	29
Have you been affected emotionally by something one of your clients have told you during treatment?	24	5	0	29
Have you had bad dreams/nightmares about anything associated with your job?	16	13	0	29
Has your opinion of mankind changed since you started working with this population?	19	10	0	29
Have your personal relationships negatively been affected because of the work you do?	5	24	0	29
Has the quality and/or productivity of your work ever diminished because of the effects of your job?	15	13	0	28
Do you feel you have a strong personal support system both inside and outside work?	25	4	0	29
Do you feel you have a strong professional support system at work?	25	4	0	29
Do you have any trouble separating your work life from your home life?	8	21	0	29

It appears that music therapists in forensic and correctional settings spend time teaching patients/prisoners healthy coping strategies (see Table 2). Figure 6 represents how music therapists in these settings cope with the daily stressors that are associated with their jobs. When participants were asked to choose their top 5 strategies for coping, the responses that elicited the most responses were music (24), spending time with family/friends (21), exercise (18), watching television (17), and relaxation techniques (12). Items listed in the "other" category comment box provided included being with

pets, walking, yoga, and talking with spouse about events at work. Choices that can be

categorized as negative coping skills received a low number of responses. For example,

4 respondents chose drinking alcohol as a coping strategy, and no one chose gambling or

smoking as methods of dealing with work related stress. Items listed in the "other"

category comment box provided included being with pets, walking, yoga, laughing yoga,

meditation, creative writing, travel, and talking with spouse about events at work.
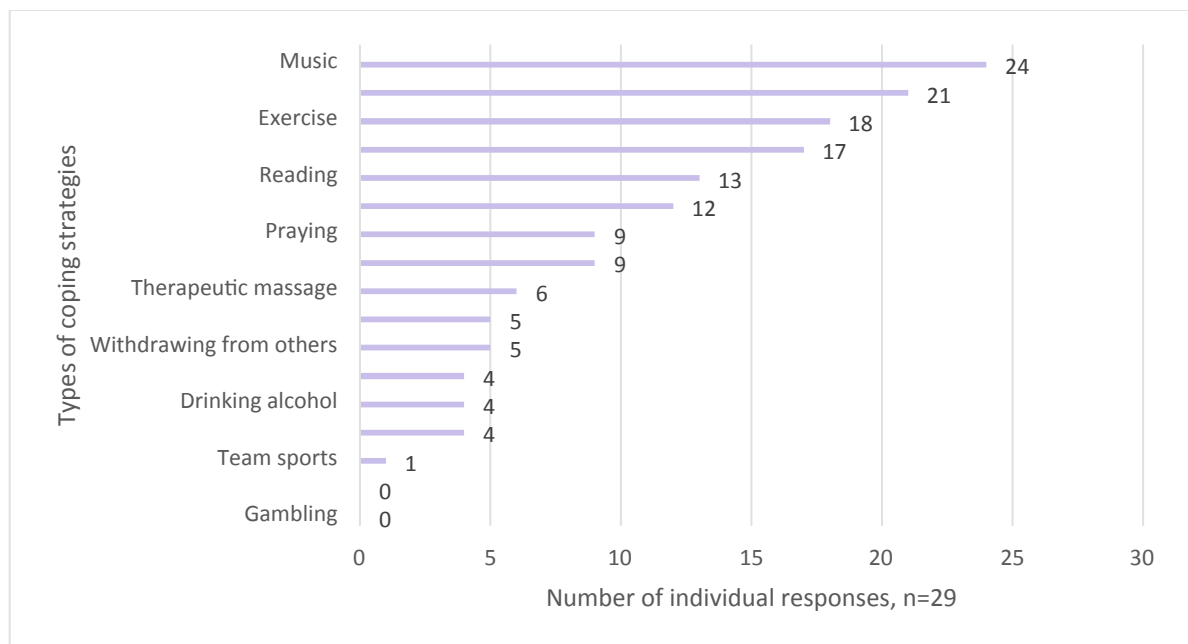
Figure 6. Coping strategies for music therapists in forensic and correctional settings.

Figure 7 shows a comparison of how rewarding music therapists in forensic and

correctional settings feel their work is. A visible difference is the majority of music

therapists (n=8) in the forensic settings expressed that their work was rewarding, while

the same response received the lowest number (n=2) amongst the correctional music

therapists.   For correctional music therapists, the majority (n=5) chose "somewhat

rewarding" as their answer, this response collected the lowest number of chosen

responses from music therapists in the forensic settings. As noted, no one chose "not rewarding" as their response.
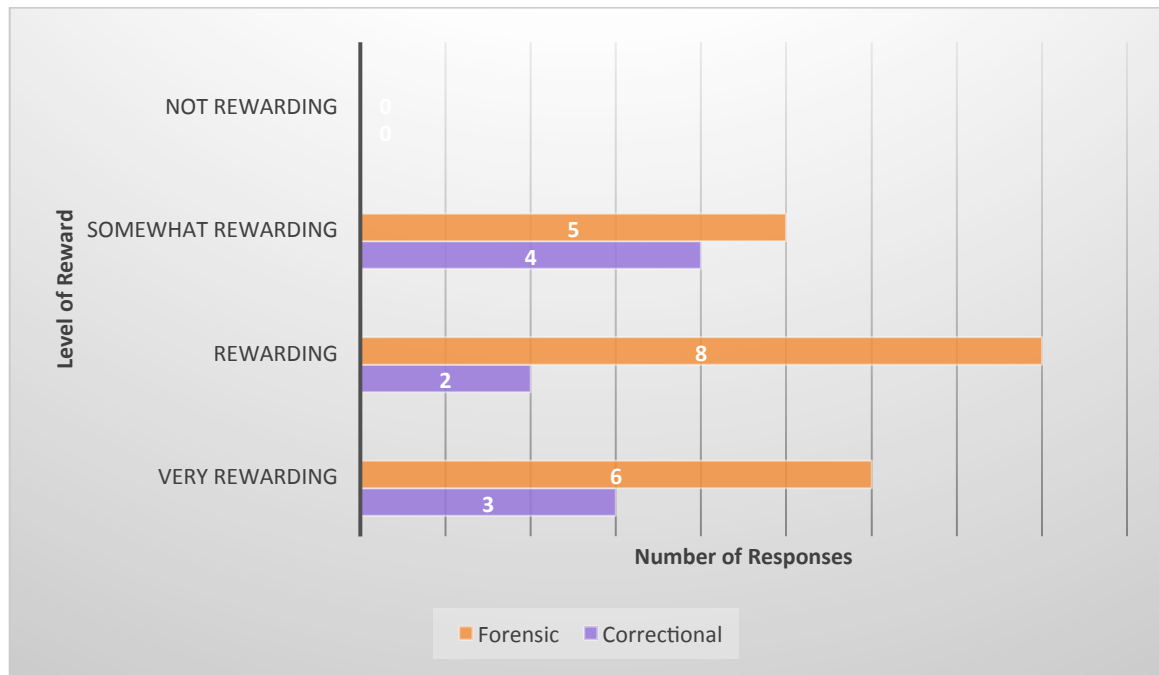
Figure 7. Comparison of levels of reward between correctional and forensic settings.

Participants were asked to indicate how much impact their work has on their clientele. Sixty-eight percent of music therapists (n=13) from the forensic group and 66% (n=6) of the correctional music therapists feel they have some impact on their clientele. One person from the correctional group did not feel their work had any impact on their clientele.

In regards to support in the work place, 100% of the respondents in each setting type, forensic and correctional, indicated that they have regular department staff meetings. The majority of music therapists (67%) in the forensic setting specified not receiving any type of direct supervision for their work. In contrast, 67% in corrections reported that they did receive regular supervision. Some respondents from the latter group included commentary in respect to the types of supervision they receive. These

included; brief observation with minimal feedback, meeting with supervisor one time per month, supervision from supervisor and other therapists, bi-weekly supervision as needed, supervisor is always available, bi-monthly lunch meetings, monthly meetings with supervisor, weekly supervision by a psychologist and continued trainings for trauma focused cognitive behavioral therapy combined with music therapy techniques.

One question on the survey attempted to learn why a music therapist would accept a position in a knowingly high stress, dangerous setting. Figure 8 explains the reasoning behind why the music therapists involved in this study chose this area of work. The majority of respondents (n=9) in forensic settings chose "all of the above" while the majority of respondents in the correctional settings chose "I was interested in working with this population" and "none of the above." If a respondent chose "none of the above," they were provided a space where they could share their own reason for accepting a position within a forensic or correctional setting. Responses given include; "They needed a music therapist and I was available," "My job changed after I had been there for a while," "The hospital where I work was just a psychiatric hospital. In the past 5 years it has become a forensic psychiatric hospital," "Because of the level of pay," "A transfer," and "I'm experienced, trained, and interested in working with the psychiatric, developmental and medical populations."
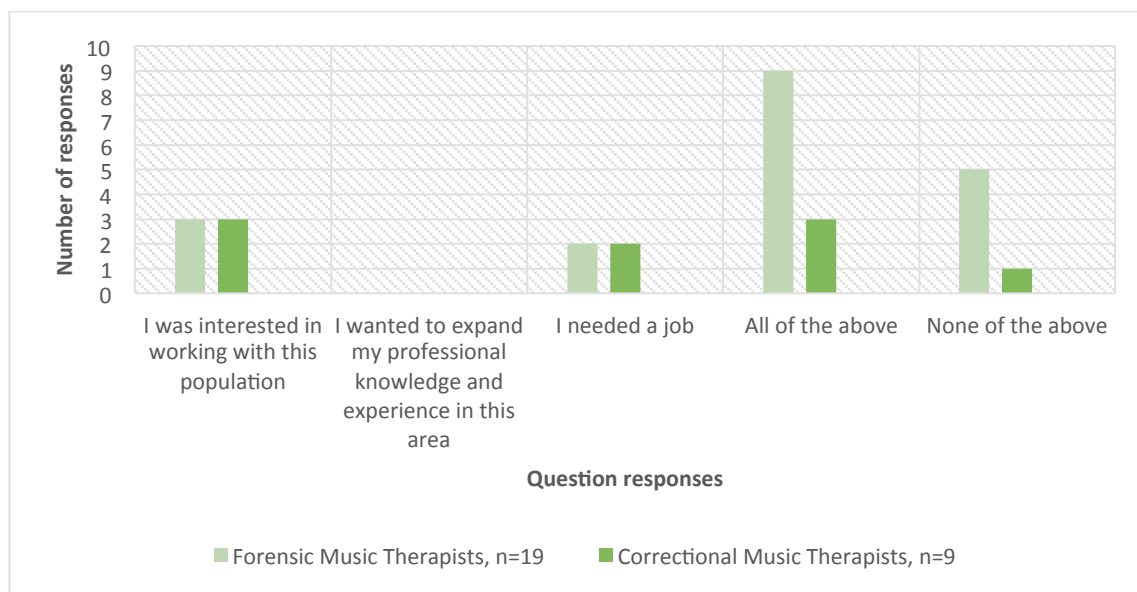
Figure 8. Reason for choosing this area of work in forensic and correctional settings.

When asked if the respondents had ever heard of vicarious traumatization, 52% of total respondents stated they had heard of it. Respondents were asked explain how they had heard of vicarious traumatization. Table 6 shows the comments that were provided.

Table 6

Statements of How Participants Knew About Vicarious Traumatization

This is when client/patient trauma affects staff personally enough to change how they might respond/react, so staff need to be honest with themselves and team members about their reactions and have their own coping mechanisms to stay focused on patient needs.

Being traumatized by hearing of others' trauma.

Facility is in the process of trying to gain level of trauma informed.

Learned through my studies.

We have had in-services on Trauma and the work we do is to be based on Trauma-informed care.

The Rehab services department I am with has requirements for competency and credentialing and trauma is one of the areas we have yearly requirements to fulfill through in-services.

Unsure - probably readings.

I have read about it.

I am part of our trauma care team at our institute.

As the final questions, participants were asked to provide any information they deemed helpful to this research. Table 7 includes a representation of these comments as they were written in comment box provided.

Table 7

Additional Commentary by Participants

I feel greatly prepared for working in forensics by training at other facilities/conferences, and moderately prepared by training at my current facility.

The individuals I work with have certainly changed my opinions of mankind. I work with individuals who have committed very serious crimes and are seen by the public and media as "monsters". These very same individuals are folks that I have the utmost respect for. They are kind, intelligent, resilient individuals who were dealt some of life's most difficult cards…they make every day at my job never feel like "work."

I find the work with forensics challenging. It feels like half a hospital, half a jail. Many people have been around for so long, and are so stable, the only thing keeping them in the hospital are the charges. It is difficult to think about recovery concepts when many people will be stuck in the hospital for an indefinite period of time. I have not sought out training for working with this particular population, I provide the same interventions as for other members of the adult population.

Working with this population has changed my view of humanity, but more in the sense of witnessing the trauma all of my patients have experienced, as opposed to their crimes changing my view. Also, I find that not only is there a lack of support by my administration, I work in an environment where you are expected to experience trauma and it is just "part of the job." Therefore, you are expected to just deal with it. I have also noticed that when a staff person is injured, there is often an assumption that they must have provoked the incident in some way. So, when you are hurt, you also may experience some form of shame or fear of judgement from your co-workers or boss.

I believe there are many work settings where music therapists should be working at a master's entry level.

Over the years, stress between co-workers can be challenging. It's easy for the negative prison environment to affect us all.

It is very challenging to work 12 hours a week doing music therapy groups in the correctional setting. I have groups with as many as 13 very violent men in one room with me. Many of the patients have the diagnosis of Antisocial Personality Disorder, Borderline Personality Disorder and Narcissism. Having to treat these individuals is draining…I hope the experiences in music therapy will somewhat help improve impulse control, release stress and give them some insight into their behavior in order for them to function safely in society.

Working with trauma patients should require additional specialty training…no undergraduate MT's should be working with trauma clients. I feel it the duty of AMTA to protect clients who are not properly trained in dealing with trauma for the client and not trained in dealing with it for themselves.

CHAPTER V

DISCUSSION

The purpose of the present study was twofold. The first objective was to explore whether or not music therapists experience symptoms of vicarious traumatization (VT), a phenomenon most frequently associated with the psychology and social work professions. The second purpose of this study was to identify the forensic and correctional settings and investigate any changes that have occurred over the years regarding the differences and/or similarities between each setting. Past research has mentioned both entities; however, it is the correctional setting that has been the focal point.

The responses in this study were separated to allow for comparisons in each setting through a filter offered on Survey Monkey. The majority of music therapists identified themselves as working in the forensic arena (n=19) as opposed to corrections (n=9). One person chose not to answer the identifying question for unknown reasons. In regards to the larger number of forensic participants, it is difficult to determine whether or not this is a change that has occurred over the years since previous research has mostly focused on corrections and very little on forensics. It is possible that the ever changing needs of society has played a role in the shift. The deinstitutionalization movement that began in the 1970's had a direct effect on closures of mental institutions which, in turn, increased the numbers of mentally ill persons entering the jail and prison settings.

In 1987, Thaut discussed the emergence of music therapy into the field of correctional psychiatry. Codding (2002) noted that new music therapy programs were being included in existing clinical programs for incarcerated inmates. Since then, music

therapists have continued to not only practice in correctional settings, but have expanded into forensic programs as well. In fact, the majority of respondents in this study indicated working in forensic settings. These settings were noted to be psychiatric hospitals in and outside of prisons, forensic psychiatric hospitals, juvenile detention, and youth correctional facilities. Because information regarding forensic settings were not discussed in previous research, it is unknown if the setting/program types were the same as compared to the present study. As music therapists continue to work with this population, they continue to face challenges as Thaut (1987) discussed earlier. In these high stress settings, ongoing work with dangerous clientele could result in being victimized and/or exposed to trauma in some way. The long term effects of working in these settings is relatively unknown, but may present themselves through job burnout, countertransference, compassion fatigue or vicarious traumatization.

As explained by Pearlman and McCann (1990), vicarious traumatization is said to have long term effects in the lives of trauma therapists. Ongoing exposure to the traumatic events of their clientele could be detrimental to the wellbeing of the therapist. Additionally, listening to the details of others' traumatic experiences can affect the therapist in the long run.

It was evident from the data presented herein that music therapists do indeed experience trauma within the work they do in both forensic and correctional settings. In fact, 69% of the respondents said, "yes" when asked if they had been victimized at work. In a follow up question, respondents indicated their experiences included involvement with, or witness to; assaultive interactions between prisoner/patients and staff, between prisoner/patient and prisoner/patient, and prisoner/patient self-inflicted trauma.

Respondents indicated having experienced one or more of these incidents in their work. There were some who identified with all of the traumatic events presented.

Symptoms of vicarious traumatization can affect one in a number of ways such as having difficulty talking about their feelings, difficulty falling and/or staying asleep, losing sleep over patients, dreaming about their clients/their clients' traumatic events, withdrawal and low motivation (American Counseling Association, 2011). Pearlman and Mac Ian (1995) explained that vicarious traumatization "implies changes in the therapist's enduring ways of experiencing self, others, and the world" (p. 558). The aforementioned list is a small sampling of symptoms, behaviors, and effects related to vicarious traumatization. Although no specific assessment tool was found that would determine the effects of vicarious traumatization, music therapists should pay attention to their own reactions and behaviors in regards to the work they do. Respondents in this study indicated experiencing symptoms of vicarious traumatization which included having bad dreams/nightmares, withdrawing from others, dreaming about patients, and being emotionally affected by information that was shared in their sessions. In a narrative response, one respondent expressed having a different view of mankind, but in a way that favored his/her clientele. He/she explained that the individuals they work with have committed "very serious" crimes and are seen as "monsters." However, they have found them to be "kind, intelligent and resilient individuals who were dealt some of life's most difficult cards."

It was encouraging to learn that music therapists engage in a wide variety of activities that can help alleviate symptoms of vicarious traumatization. These included, but are not limited to, music, exercise, spending time with family and friends, playing

with pets, watching television and engaging in relaxation techniques. Respondents identified having strong support systems in place, both professionally and personally. It is important to have professional support to help deal with the stress of working within the correctional and forensic populations. The majority of respondents felt supported by their supervisors, but not by their facility administration. It would have been beneficial for respondents to have a space to explain why they do not feel supported by administration. Unfortunately, this research did not specifically allow for that. One possible explanation for this finding could be due to upper administration not being directly involved in treatment. Also, administrators may be viewed as making unpopular decisions without consulting and listening to their workers first. Lastly, if workers seek out support from their administrators and not receive proper assistance and/or understanding, this could lead to a negative perception. One comment made by a participant in regards to traumatic events, indicated that they are "expected to just deal with it and noticed that when a staff person is injured, there is often an assumption that they must have provoked the incident in some way." The same respondent indicated that one could be confronted with some "form of shame or fear of judgement from your co-workers or boss."

Another way to help prevent vicarious traumatization would be to have debriefing opportunities after a traumatic experience at work. Participants from the forensic settings indicated having more debriefing opportunities than those in the correctional setting. These opportunities ranged from "only after a death on my unit" to a "Support our Staff Program" developed to deal with traumatic situations.

As mentioned earlier, this study sought to explore what treatment procedures are being utilized today, and to clarify any clinical differences between forensic and correctional settings. The number of groups versus individual sessions was higher in the forensic setting. It was specified that in the forensic setting, music therapists provide 6-10 groups and 1-5 individual sessions each week. Participants in the correctional settings indicated they provide the same number of group sessions as they do individual sessions, which was 1-5 per week. An observed difference is that the majority of correctional music therapists are providing less groups. However, two respondents indicated providing more than 10 groups each week.

Thaut (1999) discussed the types of objectives and music therapy treatment procedures that could be effective in a correctional setting. These included, but were not limited to, using music to therapeutically alter mood, decrease anxiety, and improve thoughts about self. Possible music therapy goals could include: increase self-esteem, learn respect for others, provide a means for self-expression, reduction of aggressive and hostile behavior, induce mood change, and provide a non-threatening and motivating reality focus. In her research, Codding (2002) described numerous treatment objectives listed by music therapists working in correctional and forensic settings. Among those included were the following: provide a non-threatening, motivating reality focus for use of leisure time and release of energy, promote personal self-esteem, promote acts of self-control within a structured environment, provide for appropriate release of tension, stress, or anxiety, and learn to accept responsibility for oneself. In this study, participants in both settings categorized their top treatment objectives as development of healthy coping strategies and interpersonal skills. After that, the order began to differ from one another.

Anger management was a high choice for the correctional group, but was lower on the list for the forensic group. Perhaps forensic patients are less volatile because of gaining stability in a hospital setting where they are a part of a treatment oriented program. Whereas mentally ill prisoner/patients do receive medication and some programming, they may not participate in a full treatment program as offered in a hospital setting. For the forensic group, self-expression was next on their choice list followed by community reintegration and competency restoration. These were not mentioned in previous research. In corrections, self-regulation, self-expression and quality of life were their choices in order of importance. It is clear that the goals for each setting differ in that forensic music therapists tend to focus on success outside the hospital setting while the correctional music therapists focus on improving and maintaining aspects of oneself and quality of life while incarcerated. Other treatment areas chosen by both groups, but not high on the list, were substance abuse, reality processing, and although low on the list, recidivism prevention. Neither recidivism prevention nor competency restoration appeared in earlier articles by Codding (2002) or Thaut (1987). Treatment objectives that focus on aspects of self, development of coping skills, and work with aggressive/anger tendencies were evident in the 1980's, the early 2000's, and remain to be important aspects of treatment now.

Overall, the findings from this research indicate that music therapists do indeed experience trauma, whether it be from hearing about the traumatic experiences of their clientele, witnessing trauma, or being traumatized themselves. These occurrences, combined with a high level of work stress, could put clinicians at risk for developing vicarious traumatization. The survey results also reveal that music therapists have an

array of healthy coping strategies in place to help alleviate negative feelings from the work they do. It is hoped that these therapists continue to practice self-care to prevent developing vicarious traumatization in themselves. It is also hoped that the administration in both correction and forensic facilities takes a more proactive role in prevention of trauma and support when trauma occurs within these facilities.

It would be beneficial to further explore vicarious traumatization amongst music therapists not only in the forensic and correctional settings, but in other settings as well. At some point, trauma affects everyone's lives. Trauma manifests in many ways, be it through accidents, loss, domestic violence, death of a loved one, victimization, and through experiences of others, to name a few. These specific types of personal trauma were not investigated within this research. Therefore, it would be beneficial to further examine the traumatic experiences of music therapists as a way to better understand their own reactions to trauma, as well as prevent negative long-term effects.   Lastly, it would be beneficial for students of music therapy to be educated in regards to recognizing symptoms of vicarious traumatization and preventative measures to avoid it.

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Appendix A

Survey Invitation Letter

Dear Music Therapy Colleague,

My name is Deanna Bush, MT-BC, and I am a graduate student at Western Michigan University, Kalamazoo Michigan. As part of fulfilling my educational requirements, I am conducting a survey to complete my graduate thesis. The purpose of my study is to gather information from professional music therapists who are employed in either a correctional or forensic setting in regards to trauma exposure and current music therapy practices in these settings. Prolonged work in these settings may expose music therapists to situations perceived as stressful, traumatic, and may even have long-term effects. This study may identify if further research would benefit music therapists.

You were contacted for possible participation in this study because you are a board certified music therapist and reportedly are employed in either a correctional or forensic setting. Use of all email addresses for this study were obtained with the permission of either the Certification Board for Music Therapists (CBMT) or the American Music Therapy Association (AMTA). If you do not fit this criteria or do not have at least one year of experience in either setting, you are excused from participating in this study.

Participation in this study is completely voluntary. It is estimated that it may take 20 minutes to complete this 52 item anonymous online survey. You may complete the survey at your convenience, in one or more sittings. The survey is divided into the following three sections: demographic information, treatment procedures, and trauma exposure. There is a section at the end of the survey for you to add any comments that you feel would be useful to further assist in this study. If you choose to leave comments, please do not include your name or other identifying information.

Some questions in this survey may cause discomfort to the participants who have experienced direct trauma in their experience. If this happens, you may choose to stop at any time. There are no penalties for not completing this survey. Participating in this study may bring no direct benefit to you other than the knowledge that you have contributed to the possibility of bringing awareness of the effects of trauma exposure to the surface. Additionally, you may play an important role in identifying what music therapy techniques are currently being used.

Data collected for this survey is protected by www.surveymonkey.com through a Secure Sockets Layer (SSL) which ensures that all data passed between the web server and browsers remain private and integral. In addition, the same website utilizes Norton and TRUSTe protection. The researcher will receive the data by logging onto the website. There will be no identifying information exchanged. Electronically collected data will be stored on the researcher's password protected computer. Data will be burned onto a CD

as there will be no physical copies of the survey available to the researcher. Data will be stored in a secure location in the PI's office on the Western Michigan University campus for at least three years upon the closure of this study. The SurveyMonkey Privacy Statement can be viewed at the following address: http://www.surveymonkey.com/mp/policy/privacy-policy/

It is requested that you complete this survey within 3 weeks. The survey will close at midnight, Eastern Standard Time on March 9, 2015. The researcher(s) will send one email reminder after two weeks to all potential respondents. You may receive these reminders even if you have already completed the survey. If you have already completed the survey when the reminder is sent, please disregard the notice.

This consent document was approved by the Western Michigan University Subjects Institutional Review Board on December 9, 2014. Do not participate after March 9, 2015.

If you have any questions or comments in regards to this research, please feel free to contact principal investigator Professor Brian Wilson at 269-387-4679 or by email at brian.l.wilson@wmich.edu, or student investigator Deanna Bush at deanna.k.bush@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions or problems arise during the course of this survey.

Once you have read and agreed to the terms of this survey, please proceed by clicking on the following link to the survey: https://www.surveymonkey.com/r/6ZZTR7B
This link is uniquely tied to this survey and your email address. Please do not forward this message.

Thank you in advance for your participation!

Principal Investigator: Professor Brian Wilson, MT-BC, Western Michigan University
Student Investigator: Deanna K. Bush, MT-BC, Western Michigan University

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list.
https://www.surveymonkey.com/optout.aspx?sm=Z3f_2fUh8GIoLZ6E70CxmYDw_3d_3d

Appendix B

Survey Instrument

Survey Instrument

For the purpose of this survey, a **correctional setting** will be defined as a facility that confines persons convicted and sentenced of criminal behavior, persons who are awaiting trial, and those who are convicted and receiving treatment for a diagnosed mental illness.

A **forensic setting** is defined as**,** a psychiatric facility that provides diagnostic services to the criminal justice system and psychiatric treatment for defendants (Center for Forensic Psychiatry, 2013) with a mental illness who are involved with the criminal justice system (Linhorst & Turner, 1999).

General Demographic Information

Please indicate the setting in which you work

    A. Correctional
    B. Forensic

    1. Do you currently work in a:
      A. Prison
      B. Psychiatric Hospital
      C. Community Program
      D. Other: please explain:_____

    2. What is your employment type in the correctional or forensic setting in which you are employed?
      A. Full time
      B. Part time
      C. Contractual
      D. If contractual, how many hours do you work each week in a correctional or forensic setting?_____

    3. How long have you worked in this setting?
      A. 1-5 years
      B. 6-10 years
      C. 11-15 years
      D. 16-20 years
      E. 20+ years

    4. Are you
      A. Female
      B. Male

    5. In what region do you practice?

A. Great Lakes
B. Mid-Atlantic
C. Midwest
D. New England
E. Southeastern
F. Southwest
G. Western

6. **How many Board Certified Music Therapists are employed in your correctional/forensic setting?**
   A. 1
   B. 2
   C. 3
   D. 4
   E. 5 or more

7. **Have you earned any non-music therapy specific specialized training, certifications or licensure that may enhance your work in the forensic or correctional field?**
   A. No
   B. Yes   *Please explain*_____

8. **Do you work with**
   A. Males
   B. Females
   C. Both

Treatment Procedures

9. **What type of admission assessment do you complete?**
   A. Music therapy specific
   B. Multi-disciplinary
   C. Activity therapy
   D. Expressive arts therapy
   E. None
   F. Other:
      Please explain:_____

10 **How many treatment group sessions do you conduct each week in a correctional or forensic setting?**

A. 1-5
B. 6-10
C. 10 or more
D. None

11. How many individual sessions do you conduct each week in a correctional or forensic setting?
    A. 1-5
    B. 6-10
    C. 10 or more
    D. None

12. Are your clients directly included in the treatment planning process?
    A. Yes, How?_____.
    B. No, Why not?_____.

13. When treating correctional or forensic clientele, what are your main treatment objectives? (Please select your top 3 responses)
    A. Self-expression
    B. Building self-esteem
    C. Development of healthy coping strategies (i.e., stress reduction, healthy leisure, wellness)
    D. Anger management
    E. Quality of life while incarcerated
    F. Building interpersonal skills
    G. Recidivism prevention
    H. Community reintegration
    I. Competency restoration
    J. Reality processing
    K. Substance abuse
    L. Self-regulation
    M. Other: Please explain_____

14. Do you mostly use
    A. Live music
    B. Recorded music
    C. An equal amount of live and recorded music

15. What type of music do you primarily use? (Choose your top 3)
    A. Pop   F. Classical
    B. Rock   G. Jazz
    C. R&B   H. Folk
    D. Rap   I. Other. Please explain_____

E. Country

16. **Are you limited on the types of equipment you can use in your correctional or forensic setting for safety reasons?**
   A. Yes
   B. No
   C. Sometimes
   D. Please explain your response:_____

17. **When delivering music therapy treatment, what interventions do you utilize? Please choose your top 5 from the following list;**
   A. Music improvisation
   B. Instrumental ensemble
      history, etc.)
      (Rock band, hand bells, etc.)
      training
   C. Choir
      explain_____
   D. Music performance
   E. Singing
   F. Drumming
   G. Music and movement
   H. Songwriting
   I. Lyric analysis

   K. Music listening
   L. Music education (theory,
   M. Instrumental and/or vocal
   N. Other: Please

18. **Do you collaborate with other disciplines in any of your treatment groups?**
   A. Yes
   B. No
   C. If yes, how often?_____

19. **If you answered yes to question 17, which discipline (s) do you collaborate with during your treatment groups? (please choose all that apply)**
   A. Social Worker
   B. Occupational Therapist
   C. Recreation Therapist
   D. Psychologist
   E. Nursing
   F. Art Therapist
   G. Dance Therapist

   H. Other
   I. Not applicable

20. **Do you find it challenging to find current continuing education information/opportunities related to correctional or forensic populations?**
   A. Yes
   B. No

Trauma Exposure—

For the purpose of this survey, the definition presented by the American Psychiatric Association for post-traumatic stress disorder (PSTD) will be utilized to define trauma, traumatic events, and trauma exposure. The definition is as follows,"*PSTD is when a person has experienced, or witnessed an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and which involved fear, helplessness, or horror.*"

Please choose the best response to the following statements:

	Agree	**Somewhat Agree**	**Somewhat Disagree**	**Disagree**
21. I feel safe at work				
22. I feel comfortable working with the criminal population				
23. I feel properly trained to work with this population				
24. My work environment is dangerous				
25. My work environment causes me stress				
26. I feel there is ample research to support my work in this setting				
27. I feel supported by my supervisor				
28. I feel supported by the facility administration				
29. I trust my colleagues				

30. Have you ever been victimized at work? (This may include verbal and/or physical victimization)
   A. Yes
   B. No

31. **What type of traumatic events have you been involved in, or witnessed at work? (Please check all that apply)**

    A. Client to client assault   F. All of the above

    B. Client to staff assault   G. None.

    C. Staff to client abuse   H. Other: Please

        explain_____

    D. Client self-harm

32. **After a traumatic event such as a client to staff assault, does your facility provide any organized debriefing sessions for staff?**

    A. Yes, please explain_____

    B. No

To the best of your knowledge, please choose the best response for the following questions:

	Yes	No	Not Applicable
33. Have any of your clients disclosed traumatic events they have experienced to you?			
34. Have you experienced a traumatic event either at work or outside of work?			
35. Do you discuss traumatic life events experienced by your clientele during treatment groups/individual sessions?			
36. Do you have a better understanding of your clients because of experiencing similar traumatic life events yourself?			
37. Have you been affected emotionally by something one of your clients have told you during treatment?			
38. Have you had bad dreams/nightmares about anything associated with your job?			
39. Has your opinion of mankind changed since you started working with this population?			
40. Have your personal relationships negatively been affected because of the work you do?			
41. Has the quality and/or productivity of your work ever diminished because of the effects of your job?			
42. Do you feel you have a strong **personal** support system both inside and outside work?			
43. Do you feel you have a strong **professional** support system at work?			
44. Do you have any trouble separating your work life from your home life?			

45. **How do you cope with the stressors related to any traumatic experiences of your job? Please check your top 5 responses**.

A. Exercise	I. Therapeutic massage	R.
Other:explain__		
B. Eating	J. Spending time with friends/family	
C. Praying	K. Withdrawing from others	
D. Music	M. Drinking alcohol	
E. Relaxation techniques	N. Smoking	
F. Therapy	O. Gambling	
G. Team sports	P. Watching television	
H. Shopping	Q. Reading	

For the following three questions, please fill in the blank with the best response

46. I find the work I do with the correctional/forensic population as_____.
    A. Very rewarding.
    B. Rewarding
    C. Sometimes rewarding
    D. Not rewarding

47. I accepted my current position in a correctional/forensic setting because_____.
    A. I was interested in working with this population.
    B. I wanted to expand my professional knowledge and experience in this area
    C. I needed a job
    D. All of the above
    E. None of the above, please explain_____

48. I feel the work I do in a correctional/forensic setting has_____on the lives of my clientele.
    A. Great impact
    B. Some impact
    C. Minimal impact
    D. No impact

49. Do you receive any type of ongoing direct supervision for the work you do in your music therapy sessions?
    A. Yes. Please explain;_____
    B. No

50. Do you have regular staff meetings?
    A. Yes. Please explain_____
    B. No

51. Have you heard of vicarious traumatization?
    A. Yes. Please explain_____

B. No

52. Please provide any additional comments that you think I may find helpful.
    A. No thank you.
    B. Comments_____

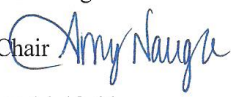_____

_____

Appendix C

HSIRB Approval Letter

WESTERN MICHIGAN UNIVERSITY

Date: December 9, 2014

To: Brian Wilson, Principal Investigator
       Deanna Bush, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 14-12-11

This letter will serve as confirmation that your research project titled "Music Therapists Behind Locked Doors: The Role of Trauma Exposure and Current Music Therapy Practices in Correctional and Forensic Psychiatry" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., *you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study*)." Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: **December 8, 2015**