

Healing Trauma with Music: A Qualitative Study on How People Have Used Music in
Their Personal Healing Journey from Trauma

by

Tracey Coulter

B.Mus., University of Victoria, 2001

B.A., University of Victoria, 2006

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

MASTER OF ARTS

in the Department of Educational Psychology and Leadership Studies

© Tracey Coulter, 2010

University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy
or other means, without the permission of the author.

Healing Trauma with Music: A Qualitative Study on How People Have Used Music in
Their Personal Healing Journey from Trauma

by

Tracey Coulter
B.Mus., University of Victoria, 2001
B.A., University of Victoria, 2006

Supervisory Committee

Dr. Timothy Black (Dept. of Educational Psychology & Leadership Studies)
Supervisor

Dr. Susan Tasker (Dept. of Educational Psychology & Leadership Studies)
Departmental Member

Supervisory Committee

Dr. Timothy Black (Dept. of Educational Psychology & Leadership Studies)

Supervisor

Dr. Susan Tasker (Dept. of Educational Psychology & Leadership Studies)

Departmental Member

Abstract

This study examines how traumatized individuals have experienced some healing from trauma using music, on their own. Its significance is in its unique findings, contributing to the extensive body of trauma literature. Qualitative methodology and thematic analysis were used in this study.

Five individuals who had experienced traumatic events took part in narrative interviews and were asked to tell the story of how they used music as part of their healing journey. Findings show use of music to emotionally regulate, to cope, and to connect and disconnect from people.

Further research in the field is suggested including investigating professional musician's music use to heal from trauma, music's role in healing depression, and possible crisis intervention use of music.

Table of Contents

Title.....	i
Supervisory Committee.....	ii
Abstract.....	iii
Table of Contents.....	iv
Acknowledgments.....	vi
CHAPTER 1: INTRODUCTION.....	1
Introduction to the Topic.....	1
Statement of the Problem.....	2
Purpose of the Study.....	4
Descriptions of Constructs and Definitions of Key Terms.....	5
Trauma.....	5
Music.....	7
Healing.....	11
Researcher Context.....	12
CHAPTER 2: LITERATURE REVIEW.....	17
Introduction.....	17
Trauma.....	17
Post Traumatic Stress Disorder.....	21
Coping and Stress.....	22
Healing and Self-Healing.....	23
Healing with Trauma Therapies and the Tri-Phasic Model.....	26
Phase Two Therapies.....	27
Music.....	32
Music Therapies and Trauma.....	38
Chapter Summary.....	41
CHAPTER 3: METHODOLOGY.....	42
Introduction.....	42
Qualitative Research Positioning.....	42
Narrative Positioning.....	45
Thematic Analysis Positioning.....	47
Transcription.....	48
Interview Procedure: The Narrative Interview.....	48
Data Analysis: Thematic Analysis.....	49
Participants.....	52
Methodological Credibility.....	54
Ethical Implications.....	57
Chapter Summary.....	58
CHAPTER 4: RESULTS.....	59
Primary Themes and Supporting Quotes.....	61
1. To Emotionally Regulate.....	61
1.a To Soothe and Calm.....	61
1.b To Feel Energized, Uplifted, Up.....	62
2. To Cope.....	63

3. To Connect to People.....	64
4. To Disconnect from People.....	65
Notable Categories of Responses.....	65
5. As a Way to Return to the Past.....	66
6. To Feel Validated	66
7. To Daydream or Fantasize	67
Chapter Summary.....	68
CHAPTER 5: DISCUSSION AND CONCLUSION	69
Introduction.....	69
Findings in Relation to Previous Literature.....	69
Unique Findings of the Present Study	70
To Cope.....	70
To Disconnect from People.....	71
To Feel Energized, Uplifted, Up	71
Findings Supported by Previous Literature	72
To Soothe or Calm.....	72
To Connect to People.....	73
Notable Categories of Responses.....	73
As a Way to Return to the Past	73
To Feel Validated	74
To Daydream or Fantasize	74
Researcher Context	75
Strengths and Limitations of the Present Study	76
Recommendations for Future Research.....	79
Implications for the Field of Counselling Psychology	80
Summary and Conclusion.....	81
Bibliography	83
Appendix A: Phone Conversation Script	97
Appendix B: Recruitment Poster	99
Appendix C: Interview Questions.....	100
Appendix D: Consent Form.....	101
Appendix E: Counselling Resources.....	104

Acknowledgments

In the last two and a half years I have struggled and grown more than I ever thought possible. In Mozart's *The Magic Flute*, the protagonist Pamino must face the Trials by Water and Fire to gain knowledge of the Mysteries; like Pamino I hope what I have learned in this endeavour will open doors for me to further Mysteries.

First, I would like to thank my friends and family who, though I have kept mostly to myself during this process, have always made it clear that they are proud, and cheered me on the entire time. I would also like to thank the makers of Diet Dr. Pepper for creating the fuel that ran the engine that wrote the work; if only I had gotten some sponsorship.

This work would not be possible without the bravery, strength, and wisdom of the five people who were willing to sit and share their stories with me. I thank all of you for your generosity. I would like to thank my committee member Dr. Sue Tasker for her enthusiasm and thorough editing throughout the writing. I would especially like to thank my supervisor Dr. Tim Black – his knowledge, support, and willingness to sit and just talk it out were invaluable to me. Thank you.

And of course to my husband and partner, Will. Your loving, gentle nature, wicked sense of humour, and amazing cooking abilities have made this whole process an actual possibility. Without you, this work would not be.

Lastly, I thank music. This work is a testament to its power – not only in the lives of the participants, but in mine as well.

Music my rampart, and my only one.
- Edna St. Vincent Millay

CHAPTER 1: INTRODUCTION

Why waste money on psychotherapy when you can listen to the B Minor Mass? – Michael Torke

Introduction to the Topic

How do people heal from trauma? As a research topic, “trauma” spans history, psychology, philosophy, as well as the fine arts. Human suffering has always been of interest to individuals and communities, and how we make meaning of it touches almost every field; scholars of religion, science, the humanities and the arts have contemplated and attempted to understand the fear, horror, or helplessness in the face or threat of harm to ourselves or those around us. Following the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual Third Edition’s (DSM-III; APA, 1980) inclusion of Post-Traumatic Stress Disorder as an Anxiety Disorder, research in the field has been extensive. A number of journals are dedicated solely to trauma research (e.g., *The Journal of Trauma*; *The Journal of Trauma & Dissociation*; *Journal of Traumatic Stress*; *PTSD Research Quarterly*; *Trauma, Violence & Abuse*; and *Traumatology*) often with a focus on the effects of trauma on individuals and which therapeutic modalities are most effective and efficient. These can range from behavioral interventions such as exposure therapy (Eye Movement Desensitization and Reprocessing (EMDR) is an example) to cognitive interventions (such as reworking trauma-related assumptions or perceptions) (Foa, Keane, Friedman, & Cohen, 2009; Wilson, Friedman, & Lindy, 2001). Creative therapies such as music therapy are also discussed in the field as trauma interventions, for example Blake and Bishops’ (1994) article “The Bonny Method of Guided Imagery and Music (GIM) in the Treatment of Post-Traumatic Stress Disorders (PTSD) with Adults in a Psychiatric Setting,” and Sutton’s (2002) book “*Music, Music Therapy and Trauma: International Perspectives*.” What has yet to be specifically studied, however, is how

people who have experienced trauma heal on their own. What can we learn about peoples' experiences of healing from trauma in the absence of formal therapeutic interventions? I was particularly interested in how people, without the help of formal music therapy, have experienced healing from trauma using music as part of their journey. Combined with new research into music and expressive therapy for individuals with trauma (Baker, 2006; Bensimon, Amir, & Wolf, 2008; Carey, 2006; Orth, Doorschodt, Verburgt, & Drozdek, 2004, as cited in Johnson, Lahad, & Gray, 2009), the focus of the present study is on how individuals, without the use of formal music therapy, used music in their healing from trauma as part of a metaphorical healing journey.

Statement of the Problem

The previous research on trauma includes many discussions on definitions of trauma (Black, 2004; Briere & Scott, 2006; Herman, 1992; Kirmayer, Lemelson, & Barad, 2007; Scaer, 2005), and specific therapeutic modalities for people diagnosed with PTSD (Bensimon et al., 2008; Black, 2004; Blake & Bishop, 1994; Foa et al., 2009; Spates, Koch, Cusack, Pagoto, & Waller, 2009). Shalev (2000) states that more than 60% of individuals with PTSD “spontaneously” recover, but there exists a gap in the literature regarding how traumatized individuals heal without the use of therapy. Research shows that, when exposed to traumatic events, individuals who are unable to act in self-preservation (i.e., fight, flight or freeze) are most likely to develop PTSD symptoms (Bovin, Jager-Hyman, Gold, Marx & Sloan, 2008). Numerous studies have demonstrated that trauma therapies are effective (Foa et al., 2009), including therapies that involve music (Bensimon et al., 2008; Sutton, 2002). Inspired by the work of Prochaska and DiClemente (1983, 1993), who developed their trans-theoretical model of change by

studying smokers who had quit on their own, I asked those who felt they had healed some trauma on their own how they used music to aid them in doing so. It is important to note that my question is not how people achieved complete healing from trauma on their own with no therapeutic interventions. Rather, my question is how people have used music, on their own, to achieve some healing from trauma. Healing trauma and quitting smoking are not parallel. Being a smoker or not is a true dichotomy; one either smokes or does not. Healing, as will be examined more throughout the present study, is a process that can take a life time, and may never be completed, but that does not mean an individual has not experienced healing.

The role music plays in the present study is unique. Every culture on Earth has music of some kind, and research supports certain biological ties between music and speech (Brown, Martinez & Parsons, 2006; McMullen & Saffran, 2004), as well as between music and emotion (Bensimon et al., 2008; Crowe, 2004; Peretz, 2001; Sloboda & Juslin, 2001). Many, if not most therapies use this connection between language and emotion; most therapy or counselling sessions involve speaking, often speaking about emotions. Given this, when we consider that language and music are connected (Brown et al., 2006; McMullen & Saffran, 2004) and music and emotion are as well (Bensimon et al., 2008; Crowe, 2004; Peretz, 2001; Sloboda & Juslin, 2001) the use of music in therapeutic context (in an informal, non-music therapy setting, or used by traumatized individuals on their own) was a natural development for trauma research, delving into a rich and largely unexplored area.

Purpose of the Study

The purpose of the present study was to fill the gap in the literature regarding how individuals who have not engaged in formal music therapy used music as an aid in their healing journey from trauma. While formal music therapy was an exclusion category, other counselling/trauma interventions such as EMDR and trauma counselling, were not. This exclusion decision was based on my interest in people who had used music on their own exclusively, while their entire healing journey did not have to be exclusively on their own; this is to allow for the complexity healing may have. Using narrative interviewing, I directly asked participants, who reported that they had used music in their healing from trauma, how they saw music as part of their healing story, how they specifically used music, and why they thought they used music in this way. My first hope in doing the present study was to expand the existing body of knowledge on trauma therapies, which has mainly focused on more commonly used therapeutic and counselling modalities. My second hope was to inform practitioners who work with traumatized populations, specifically in the area of what is termed “resource-building.” Resource-building (e.g., helping clients to create feelings of emotional safety and a stronger sense of self) is a vital part of most trauma therapies (Herman, 1997). Examples of techniques used to accomplish this include imagery, relaxation techniques, and external materials such as a small object to carry around in a pocket or a known crisis line to call when needing to talk. Exploring music as an option for clients who are trying to heal from trauma could potentially broaden and enrich clients’ available resources and networks of safety (i.e. what helps them ground, feel safe, and/or support them in everyday living activities such as childcare, employment, and housing). In addition to the technical aspects of trauma

treatment (e.g., building safety and resources), within the field of counselling psychology and in the current era of managed care, there is increasing economic pressure for both effective and highly efficient therapeutic approaches. With cuts to community programs (Morrow, Hankivsky, & Varcoe, 2004) and limits set on counselling provided by insurance companies (Csiernik, 2002), music may be a way to ease the burden on already-stretched financial resources by supporting clients to heal on their own outside of the time spent with a counsellor in session. Lastly, it was my hope to contribute to our understanding of the human experience and our ability to move through and beyond our pain and trauma with our own strengths and gifts, specifically with the gift of music. To begin the larger examination of the research question, the key terms and constructs must be defined.

Descriptions of Constructs and Definitions of Key Terms

The following descriptions of the key terms *trauma*, *music*, and *healing* have guided the present study and were supported by my participants' voices and experiences.

Trauma

The construct of trauma originally inferred physiological hurt through accidents and war. However, in the 20th century, the term trauma has come to include psychological pain and distress (Micale & Lerner, 2001). For the purposes of the present study, my definition of trauma was informed by Criterion A1 and A2 of the DSM-IV-TR's (2000) diagnostic criteria for PTSD. Criterion A1 defines a traumatic event as "involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about

unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (p. 463). Criterion A2 requires that the individual’s response to the event involve intense fear, helplessness, or horror (or in children, the response must involve “disorganized or agitated behavior” (p. 463). Criteria A1 and A2 thus define the traumatic event which needs to have occurred in order to assign a diagnosis of Post-Traumatic Stress Disorder (PTSD). Criteria B through F describe the effects this traumatic event may have on an individual in the months and years following the event. An individual may then be diagnosed with PTSD if they meet the threshold of symptoms, which include: some re-experiencing of the event, three symptoms of avoidance or numbing, two symptoms of increased arousal, all for a length of longer than one month and which cause significant distress or impairment in different areas of functioning (social or occupational).

Though not an inclusion criterion for the present study, PTSD is the diagnosis given to those who have experienced traumatic events and who have been negatively affected by them for a period of more than one month. The DSM-IV-TR (2000) defines PTSD as “the development of characteristic symptoms following exposure to an extreme traumatic stressor” (p. 463). Some of the aspects of a PTSD diagnosis are psychological distress when exposed to internal or external cues that either remind the individual of or resemble the original traumatic event: flashbacks; avoidance of anything associated with the trauma; feeling detached from others, activities, and the future; as well as some physiological aspects such as hyper-vigilance, difficulty sleeping and irritability or outbursts of anger. While the present study was not specifically focused on participants who have been diagnosed with PTSD, this construct heavily informs much of the trauma

literature and I would have been remiss to exclude it as a possible interview topic with my participants. Though none were formally diagnosed with PTSD, most participants were aware of the disorder and the possibility they may have been diagnosed with it had they had gone through a formal assessment.

My reasons for including Criterion A1 and A2 in the present study's definition of trauma were to connect the present study to the larger body of knowledge on trauma, which is informed by these criteria. I also used these criteria to keep the focus of "trauma" on the notion of *violence* (rooted in the Latin *violare* – to outrage or dishonor) whether it is a threat to the individual's integrity of self or body, or against another. I also wanted to acknowledge and disengage from the casual use of "trauma" to describe inconvenient or annoying events. An example of this casual use would be like the comment "I just took [a professor's] exam and now I know what being raped feels like," (<http://community.feministing.com/2009/05/rape-is-not-synonymous-with-an.html>) or "I took a summer sewing class that traumatized me and I refused to ever sew again," (<http://www.beginners-quilting.com/quilting-supplies.html>). While the test taker may have felt there was some wrongdoing, failing a test does not equal the terror and violence of an actual sexual assault. This is not to say these circumstances may have been highly distressing and had an impact on the individuals' lives, but equating a terrible sewing class with a trauma diminishes the seriousness and mental health complications of traumatic events as described by DSM-IV-TR.

Music

One of the most important constructs for the present study, and one that has challenged artists, philosophers and scientists alike, is the term "music." The Canadian

Oxford Dictionary's first definition of music is "the art of combining vocal or instrumental sounds (or both) to produce beauty of form, harmony, and expression of emotion" and the second definition is "the sounds so produced" which grounds the notion that music is uniquely auditory in nature. In English, music is a metaphor for the appearance of natural order within science (for example, "the music of the spheres" to describe the movement of celestial bodies), news, or information we most want to hear (as in "music to one's ears") or even to come to terms with, or accept something as inevitable (as in "face the music"). According to social constructivist thought, social reality is created by language and dialogue. Hence, my personal understanding of music that I brought to the dialogue with participants expanded on the constructs of music participants brought to the dialogue as well.

In looking at "Music" as a general field of inquiry, one can categorize different aspects of music (creation, performance, consumption) in terms of the proximal relation to the levels of contact with a piece of music. First and foremost, music must be created. Composers, Disc Jockeys (DJs), songwriters, electronic musicians, and improvisers create music and may have certain intentions for how the music will be heard or understood, or they may not. One step removed from the creation of music is performance. Performers (who may or may not be the creators) take the music from the page, instructions, or cheat book (used by jazz musicians to improvise on known songs) and perform the piece; this performance may be counter to what the original creator intended (if that intention is even known) or interpreted as the performer desires. This performance may add the performer's personal intentions for the music to the original creator's intentions for the piece. At the farthest distance from the actual act of creating

music, we have the consumption of music. Anyone who listens to a piece of music can be said to “consume” it and they may add their own intentions or understandings to their listening, which may or may not be very different from those of the songwriter or composer. These different proximal distances from, levels of contact with, or actions upon created music complicate and expand the notion of what music is and the different interactions individuals may have with it. For the purposes of the present study, I define music as intentional sounds using structured tonal systems that we know as “scales” or “keys” created by people, performed by people, and consumed by people with the intention to express or experience something, which may range from intense emotions to simple pretty background noise. Music cannot be defined solely on the creator’s intentions, nor the listener’s interpretation(s). An example of this would be Beethoven’s Fifth Symphony, which begins with three short notes on the same pitch followed by one longer one a few tones lower; this is then repeated with the whole phrase dropped by one semi-tone (the smallest pitch change in western music). Many musicologists (and possibly Beethoven himself, as his friend and contemporary Anton Schindler stated) interpret this as a pounding at the door of “fate” (Hoffman, 1810 & Schindler, 1840, as cited by Chantler, 2002). But, what about someone who has only heard it as the BC Lotto 6/49 commercial from the 1980s with the word “BIG” on every note? No doubt Beethoven did not create the symphony for its eventual use in a lottery commercial to remind people of how much money they could win by playing, but their consumption is informed by the performer’s and interpreter’s actions, which were themselves informed by the notion of “fate” or gravitas. But is this intensity inherent in Beethoven’s musical

phrase? The challenge of defining and describing musical meaning is expressed by DeNora (1986):

[t]he issue of musical meaning is characterized by paradox: at the level of the listening experience music seems infinitely and definitely expressive while, at the level of taxonomic analysis, the same music seems perpetually capable of eluding attempts to pin it to semantic corollaries. There is, in other words, a tension between the apparent validity (at the level of listening) and the apparent invalidity (at the level of empirical analysis) of music's symbolic capacity. (p. 84)

Here, DeNora acknowledges the cultural belief of music's expressive capability which may seem to be an obvious and inherent part of the notion of "music", yet attempts to pin down a universal "language" of music (taxonomic analysis) have failed (Cooke, 1960, as cited in DeNora, 1986). An example of this would be the aria from the Goldberg Variations by Bach, renowned for its beauty, especially in Glenn Gould's performance, yet it was originally written to lull to sleep an insomniac (Creston, 1970). The core difficulty in defining music once and for all is the two apparently mutually exclusive ideas of (a) clear musical understanding for the listener which seems apparent, obvious, and innate, and (b) music's elusive inability to then be clearly described in such terms. The present study embodies this same tension and elusiveness. Participants, in describing the songs they used to heal, spoke of the "inherent" meaning behind the songs. I would often make a note of the songs and listen to them later. Despite repeatedly listening to the songs, I did not necessarily "get" the same meaning or emotional valence my participants had, which provides evidence for the constructivist notions regarding the co-constructed nature of social truth and shared meaning.

Healing

The word “heal” comes from the Old English *hælan* meaning to “make whole, sound and well” (<http://www.etymonline.com/index.php?term=heal>) and is related to the word “whole.” The modern meanings of the word heal are “(of a wound or injury) become sound or healthy again” as well as “cause (a wound, disease, or person) to heal or be cured, or be made sound again” and “alleviate sorrow” and “recover from mental trauma” (Canadian Oxford Dictionary, 2004). These definitions focus on recovering from damage or resolving a lack of harmony. With my specific focus on participants who have experienced self-healing using music, I define the construct of self-healing as a participant’s act of resolving some element of psychological injury on their own (hence the “self” part), to be distinguished from resolving psychological injury with the help of formal therapy or counselling. This is to highlight the present study’s focus on individuals’ experiences of using music to achieve some healing themselves. I am also including the notion of “journey” to acknowledge that participants may not be fully healed from their trauma. The concept of “health” ranges from “free of disease” to the current zeitgeist which tends to frame health around holistic wellness of the body, mind, and spirit with an emphasis on a bio-psycho-social model (Bircher, 2005). I have employed the metaphor of a healing “journey” to acknowledge health as a non-static state and one that is always at risk of changing due to aging, possible accidents or injuries, and the possibilities of disease or infection we all may experience in our lives. “Self-healing journey” also recognizes the possibility that traumatic events individuals thought were resolved may resurface and require further processing (acknowledgement of the memory, understanding it in the story of the individual’s life, grieving the event, telling family

members and friends about it). Such resurfacing of past traumas may result following increased stress levels and life events, such as marriage, having children, deaths of loved ones (especially if these events are connected to the original traumatic experiences), and anniversary dates of the traumatic events themselves. An example of trauma resurfacing would be a woman who believes she has worked through the memories of being abused by her mother, only to have traumatic memories and symptoms return when her own daughter reaches the age at which her own abuse began. The construct of self-healing must be further expanded to include the meaning the current study's participants shared with respect to their own healing. All five participants acknowledged, very early in the interviews, that they would never be "fully" healed from what had happened, because they could not go back and erase what happened. My general sense of how they made meaning of their "healing" was that they viewed it as the ability to "resolve" or to "let go" of what had happened, and to "put it in the past".

The three constructs of trauma, music, and healing, form the theoretical foundation of the present study. I have articulated the definitions of these constructs in a way that acknowledges their complexity, informed by my investigation into the relevant literature, and I have subsequently added nuances and meaning that the participants in the study shared with me. My personal experiences with trauma, music, and healing will be discussed in more detail in the following section on researcher context.

Researcher Context

Due to the qualitative nature of the present study, I was an integral part of co-constructing the research interviews, interview transcription, and data analysis. Therefore, it is vital to describe my personal interest in the present study, as well as to

reflect on and articulate my role in the co-construction of the interviews and final results of the study with my participants. According to the social constructivist view, social reality is co-constructed through language and dialogue (Creswell, 2009). Hence, I was an active co-creator of the research process alongside my participants, as we co-constructed the stories and meanings of using music as part of their self-healing journey. As such, I offer my reflections on my context as the researcher in the current study.

I received a B.Mus in Music History and Literature from the University of Victoria, with a focus on harpsichord and musical rhetoric. Before this, I played a number of instruments including piano, guitar, cello, and voice and have always been involved in music in some form or another since the age of four. It is also around this age that I first experienced trauma through the death of a son of a close family friend. We spent many hours together as children, while one of our mother's would be working, and this experience of loss was fused with the fact that both of us were ill children. I had many terrifying experiences of being in the hospital for periods of time with routine medical interventions for juvenile asthma. Throughout my life I have encountered many deaths, including witnessing, first-hand, two suicides and being told about my own father's sudden death of a heart attack in 2005. Because of this, I personally have had an extensive relationship with both trauma and music, and used music for parts of my own healing. It was only in reflecting back to my life that I realized I would use music to process specific memories or emotions, or to create a sense of safety for myself. Because of my awareness that western music is based around stability which is then disrupted, and then returned to, I would use this structural knowledge to come into contact with "stuck" or difficult feelings to process, and then experience them as the music progressed, feeling

them resolve as did the musical tension. I had certain songs or pieces for certain moods or “needs” depending on my situation. Given my experience with both music and traumatic events, the current study is imbued with my personal understanding and meaning-making of how music can be used in healing from trauma.

I have also been exposed to trauma as a volunteer and as a professional in my adult life. My work with trauma as a helper/practitioner began in 2006 when I began volunteering with the Victoria Women’s Sexual Assault Centre (WSAC) as a member of the Sexual Assault Response Team (SART). I supported recent survivors of sexual assault at Victoria General Hospital as well as at local police stations. I was then hired as an auxiliary crisis line support worker, as well as an auxiliary crisis counsellor, where I worked with women who, while not necessarily recently assaulted, had experienced forms of sexual assault or abuse in the past and were having difficulty with specific memories or life circumstances. Combined with this experiential knowledge, I have also taken a course in trauma from the University of Victoria in the Counselling Psychology department. Both of these experiences have informed my knowledge and understanding of trauma and trauma therapies by grounding what I had experienced in my life in theories of our bodies’ and minds’ responses to trauma, how traumatic memories are stored and activated, and the possible ways in which I personally had healed.

In regards to self-healing, I value and respect people’s abilities to find solutions to their situations or problems. As a practicing counsellor, I support my clients in discovering and using their personal strengths and I believe that some of the best therapy happens when clients begin to trust themselves again and understand their bodies’ natural responses. An example of this is when clients at WSAC are educated around how the

sympathetic nervous system and brain is activated when the clients are “triggered” (why they may “space out” during sexual activity or have a panic attack whenever they see a man wearing similar clothes to their assaulter) and when they learn the best ways for them to relax their bodies and minds and become aware of the present moment and physical surroundings. This skill can empower survivors to be able to return to work, feel they are gaining back control of their bodies and minds and know they are not “insane” but that they are reacting perfectly naturally to an “insane” situation. These previous experiences in working with traumatized individuals substantially helped to create one of the lenses through which I approached the current study. For example, I imagined that I would develop a theme around using music as relaxation and connect this with the literature around grounding and relaxation techniques.

In terms of what I expected to find in the present study, I imagined that participants would describe what music means to them personally, not necessarily just in terms of trauma and healing. Most often, if participants discussed the general notion of music vis-à-vis their healing process, it was to describe music as a “drug,” “medication,” or “balm”. I also expected to find similarities between what participants had done with music and what many trauma therapies find to be effective. An example of this is “grounding” where clients are asked to be aware of their breath, body and physical surrounding, and the processing of traumatic memories while in safe environments; but instead of the therapy session as the safe space, I expected that music would create the temporary “safe space.” I expected there would be differences between people who play music, listen to music, and write music, though I was unsure about what the differences might be. I was also aware that my study was only looking at individuals who had

positive experiences with music in their healing journey. There may be individuals who have been “hurt” rather than healed by music, or who have no connection to music at all. However, it was beyond the scope of the current study to explore the full spectrum of possible relationships traumatized individuals have to music. In the following chapter, I review the relevant literature in the areas of trauma, music, healing etc.

CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter will examine the research surrounding the three core constructs of the current study as well as review the related topics of trauma therapies, a more complete discussion on the challenge of defining music, and the impact music has on emotional responses.

Trauma

“Trauma” is a modern notion; originally connected to strictly physical traumas in the world of medicine. It was in the nineteenth century that “trauma” was also conceptualized as “nervous shock,” an idea that developed out of new knowledge of the nervous systems, as described by Lerner and Micale (2001).

In practical and specific terms, the DSM-IV-TR (2000) describes a trauma as “involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The individual’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior” (PTSD Criterion A, p. 463). This definition (or slight variations on it) is used throughout the literature on psychological trauma (Briere & Scott, 2006; Black, 2004; Blake & Bishop, 1994; Bovin et al, 2008). By this definition, trauma is an event that leads to certain known physiological responses such as increased heart rate, and release of “fight, flight, or freeze” neurotransmitters (Briere & Scott, 2006;

Herman, 1997; Scaer, 2005). These sympathetic nervous system (SNS) responses underlie the thoughts and behaviors as described by the DSM-IV-TR's criteria for a diagnosis of PTSD. Trauma also impacts an individual's relationships with intimate partners, children, family, friends, and co-workers (Briere & Scott, 2006; Herman, 1997). Finally, trauma affects an individual within the larger systems of employment, health services and benefits, and community involvement (APA, 2000; Bensimon et al., 2008).

In addition to the physiological effects of trauma on the individual, it is well-understood that social responses to traumatic events can negatively impact individuals' experiences following the event. Ahrens (2006) interviewed sexual assault survivors who had received negative responses to their assault disclosures that reinforced self-blame and put in question the veracity of their assault claims. This lack of validation and support was often found by Ahrens to increase self-blame for the assault, induce guilt for upsetting the person to whom they disclosed, and to stop survivors from discussing or sharing their experiences of assault with both professionals (such as medical personnel or police) and people close to them (such as family, friends, and partners).

The literature on trauma largely refers to some kind of activation of the SNS in response to an event wherein the individual experiences a sense of helplessness or an overwhelming of their internal resources (Briere & Scott, 2006; Herman, 1997; Scaer, 2005). In differentiating individuals who were or who were not traumatized following a traumatic event, Bovin et al. (2008) state that individuals who were not traumatized were able to act or engage in behaviours in the moment that were self-preserving or allowed them to maintain their integrity, such as successfully getting away from an attacker. Yet, research by MacNair (2002) shows soldiers can become traumatized by their own self-

preserving and principled actions (i.e., killing or wounding enemy soldiers). It could be argued these soldiers were able to act in their defense and in fact, it was this ability to do so that caused the trauma. The hurt or death at their own hands not only fits the DSM-IV-TR's Criterion A for a traumatic event, but also may leave the soldiers with a new and disturbing view of who they are – someone who has killed someone: a murderer. It is the inability to make sense of what they have done that threatens their self-preservation (i.e. sense of self). These defensive acts may be seen as a double trauma: first, the soldiers' lives were threatened, and then their integrity of self was further threatened by their defending acts.

Briere and Scott (2006) concretize the DSM-IV-TR definitions of traumatic stressors. The authors include, "combat, sexual and physical assault, robbery, being kidnapped, being taken hostage, terrorist attacks, torture, disasters, severe automobile accidents, and life-threatening illnesses, as well as witnessing death or serious injury by violent assault, accidents, war, or disaster. Childhood sexual abuse is included even if it does not involve threatened or actual violence or injury" (p. 3). Briere and Scott critique the DSM-IV-TR's definition as underestimating the amount of trauma in the general population due to its exclusion of "extreme emotional abuse, major losses or separations, degradation or humiliation, and coerced (but not physically threatened or forced) sexual experiences" (p. 4). Depending on the developmental stage and age of the individual, something that would not be traumatic to most people can fit the criterion of a sense of horror, helplessness, or threat to self and integrity for others. For example, a six year old's mother dies. Since children have dependence on caregivers for their basic, vital needs (Brisch, 2002), a child may experience this as traumatic. The loss of a parent for an

adult may be upsetting and painful, but a child is likely to experience an overwhelming sense of loss and possibly experience terror, helplessness, or both. Of course, potentially traumatic events are mitigated by how safe and secure a child feels in their relationship with caregivers (Lieberman & Knorr, 2007). Nonetheless, it is unfortunate the DSM-IV-TR does not take the developmental stage or chronological age into full consideration; especially given that the DSM definition of PTSD provides the basis for most trauma research.

In the current study, I used the DSM-IV-TR's Criteria A1 and A2 definition of trauma, with the added consideration of developmental age at which the traumatic event occurred. This could have meant including events that participants experienced as a child but which still resonated as "traumatic." Though I added this nuance to the definition, all of my participants experienced events that fit the DSM-IV-TR's definition of trauma without this added developmental component. My reasons for choosing this definition were to (a) avoid the overuse and dilution of the term "trauma" to describe any upsetting event or experience; (b) to keep intact the notion of "violence" towards the body and sense of self whether it is an act of violence, threat of violence, or violation of the self; and (c) to be able to add this study to the already existing body of trauma knowledge, most of which use the DSM-IV-TR's diagnostic criteria for PTSD. Although I did not seek participants who had been diagnosed with PTSD, nor did I screen for PTSD symptoms, a discussion on the diagnosis of PTSD is warranted given the study's focus on the experience of trauma.

Post Traumatic Stress Disorder

The DSM-IV-TR (2000) requires specific criteria for a diagnosis of PTSD. The diagnostic criteria include experiencing a traumatic event (see the earlier discussion on Criteria A1 and A2); a sense of intense fear, helplessness or horror; persistent re-experiencing of the trauma; persistent avoidance of related stimuli; increased arousal and general numbness; and these must all be present for more than one month. Not everyone who has experienced traumatic events fits these criteria, but that is not to say they were not negatively impacted by these experiences. Black (2004) questions the dichotomy of the diagnosis (either someone has PTSD, or they do not) and the fact that this focus ignores sub-syndromal PTSD (having PTS symptoms but missing one or more criteria), which can have deleterious effects on an individual's quality of life and relationships. Further, Shalev (2000) states that often an individual can lose their diagnosis of PTSD by no longer fulfilling the "avoidance" criteria. One must ask if that means they are no longer in need of treatment? Nevertheless, while much of the literature on trauma and its treatment focuses on individuals who fit the diagnosis of PTSD (Bensimon et al., 2008; Black, 2004; Blake & Bishop, 1994; Foa, Keane, Friedman, & Cohen, eds., 2009; Spates et al., 2009), the research is not consistent in application of treatment modalities (i.e., how EMDR or exposure therapy is applied) (Black, 2004) nor do the researchers all use the same assessment instruments. A number of instruments exist to assess for PTSD diagnosis or recovery, such as the Clinician Administered PTSD Scale (CAPS; Blake, Weather, Nagy, Kaloupek, Gusman, Charney, et al., 1995), and the PTSD Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993) among others. These instruments require 20 to 45 minutes to complete and must be administered by those

specifically trained to do so. To use the result of such diagnostic assessments as a sole indicator of diagnosis or recovery from PTSD belies the complexity of diagnostic challenges as well as the complexity of the notion of healing. For example, the instruments require the individual to be able to recall all of the traumatic events, which may not be possible due to trauma events too numerous to count or due to “blocking out” a specific time of life (i.e. having no memories between four and seven years old when the individual knows they were abused).

Coping and Stress

One area of research that is conceptually related to the area of trauma is that of coping and stress. While not a specific element of most trauma therapies, it is necessary to include a discussion of the literature on “coping and stress” within the discussion on trauma because “stress” is an intrinsic part of the aftermath of trauma, and is part of the diagnosis of PTSD, since the symptoms of the disorder are essentially indications for not coping well with the stress after a traumatic event. Folkman, Lazarus, Gruen and Longis (1986) describe stress as, “a relationship between the person and the environment that is appraised by the person as taxing or *exceeding his or her resources and as endangering well-being*” (p. 572, italics mine). This definition describes stress as the interaction of an individual and an external event where the individual makes a cognitive evaluation of the situation as a threat to their well-being. This definition is quite similar in many ways to the trauma literature’s definition of trauma, with one important difference: the trauma literature defines this “evaluation” as a pre-cognitive process involving the “fight, flight or freeze” mechanism for survival (Briere & Scott, 2006; Herman, 1997; Scaer, 2005). In

his latest work, *Stress and Emotion: A New Synthesis*, Lazarus (1999) discusses trauma in the following way:

My theoretical views mandate that the essence of trauma is that crucial *meanings* have been undermined. These meanings have to do with feelings of unworthiness, the belief that one is not loved or cared about, and perhaps among the most important, people who are traumatized no longer believe they are able to manifest any control over their lives. (p. 129)

This description of trauma still focuses on a cognitive force as the foundation of trauma, rather than the event itself; it is clear that the literature of stress and coping has a very different view of trauma's origins than the trauma literature holds. In regards to the notion of "coping", Folkman et al. describe it as, "the person's cognitive and behavioral efforts to manage (reduce, minimize, master, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person's resources" (p. 572). Research by Runtz (1997) into trauma and coping indicates that both positive and negative coping strategies impact survivors of childhood maltreatment and long-term adjustment, an important one being social supports. A fuller exploration of the substantial coping and stress literature is beyond the scope of the present study.

Healing and Self-Healing

As described in the previous chapter, "healing" is defined in terms of resolving psychological injury to the extent possible, or repairing either physical or psychological hurt or damage. Volkman (1993) reflects Hans Selye's view on healing as a force of nature from his 1956 book "The Stress of Life":

This concept of a healing force from within has vast philosophical, moral and spiritual implications. Such a theory implies that healing begins within the organism as a spontaneous move toward wellness. Pain and symptoms become signs of healing as well as illness, and disease is returned to its

original definition of “dis-ease.” The role of the physician or healer is also redefined. Rather than being viewed as an outside individual called in to “treat” an invasive external disease, the modern healer aligns with the ancient shaman as ally of a much greater healing force to which she or he may only act as catalyst. (p. 244)

From this view, “healing” means to align with natural tendencies or drives to make whole; with the therapist as a guide or support, and “symptoms” as indicators of an individual’s attempts to heal in different ways.

It is interesting to note that a search on Amazon.com for “healing” yields 1,780 products, mainly self-help books. Research shows many of these books to be ineffectual, and sometimes iatrogenic (Redding, Forman, & Gaudiano, 2008), and yet the continued popularity of the genre reveals the desire by many to gain healing on their own with minimal support. It is probable people still feel shame at needing professional help and desire to do the work by themselves. While I am using the term “self healing” throughout the present study, it is important to separate this from the common use of the similar phrase, “self help.” Many if not most of the books written as “self help” available are based on therapies created by trained professionals who then publish the material for lay people to use themselves. This is much more like “therapy by proxy” since a therapist is still involved by way of exercises, activities, and the educational materials. I am specifically interested in how individuals, of their own volition and without the guidance of a trained professional, used music on their own.

In looking at the notion of “healing” it may be important to note that physiologically, our bodies often heal themselves even when medical care is provided. A cast is placed on a broken limb to stabilize it, but it is the body that mends the bone. In regards to therapy, Irvin Yalom (2002) describes the similarity: “I did not have to inspirit

the patient with the desire to grow, with curiosity, will, zest for life, caring, loyalty, or any of the myriad of characteristics that make us fully human. No, what I had to do was to identify and remove obstacles. The rest would follow automatically, fueled by the self-actualizing forces within the patient” (p. 1). This is not to say that once healing has taken place, the traces of the hurt or trauma have disappeared. To continue with the bone analogy, an x-ray would still show a mark where the break occurred and the limb may not work in exactly the same way as it did before. For myself, healing is not the end result, but the journey towards the highest level of functioning that is possible in consideration of the trauma that has occurred.

The definition I used for “healing” is based on the idea of “the journey towards as much wellness or wholeness as possible from the trauma.” This definition incorporates the participants’ own descriptions of their healing; many felt they would never be who they were before the trauma, but that the event was in the past and “done,” and that they achieved this closure, in part, by using their own resources. The notion of “making whole” within this context of healing and trauma, for me, means gaining the ability to function in life at a level *comparable* to how individuals functioned before the trauma, and where they are minimally limiting how they currently live their lives (career choices, desire for intimate relationships, avoidance of certain places or activities) because of their traumatic experience(s). An example of minimal limiting could be being able to take a job around the corner from where an individual was assaulted, but choosing to walk on the other side of the street rather than exactly where the assault occurred.

Healing with Trauma Therapies and the Tri-Phasic Model

Safety, remembrance and mourning, and reconnection with life outside of the traumatic event make up the phases of Herman's tri-phasic model for trauma therapy described in her seminal book "Trauma and Recovery" (1997). A Google Scholar search for this book states the book is cited by 4166 references; the importance of this work and model in regards to trauma research cannot be overstated. Herman sees these three phases as a "convenient fiction, not to be taken too literally" (p. 155), and recognizes the commonalities between these and previously described stages for trauma therapy, such as Janet's 1889 work on hysteria, and Brown and Fromm's 1986 work on complicated post-traumatic stress disorder. In regards to this model, Herman is clear that the model is not necessarily linear or that clients only go through it once, and that as Sgroi (1989, as cited in Herman, 1997) stressed, it may be more akin to a spiral, with every new encounter with the three phases becoming less emotionally charged or intense. If participants' use of music to heal facilitated the stages of this model (linear, spiral or recursive), this may have been evident in their narratives. De Nora (1999) states that individuals commonly have favorite musicians, albums, and songs, which they turn to when needed. I wondered if participants' experiences of returning to specific albums or artists would follow Herman's recursive "spiral" of going through the three phases of recovery, as new memories emerged or when their life circumstances were reminiscent of the original trauma. Consider the example cited previously of the woman who experienced abuse as a child, who then experiences a return of symptoms when her own daughter approaches the age at which the woman was abused.

The first phase, *safety* involves clients' learning new skills for relaxation, grounding (awareness of their body and its sensations/perceptions in the present moment). It also may involve establishing or maintaining stability in their living situation, career, and personal life (Briere & Scott, 2006). The second phase, *remembrance and mourning* occurs in a number of ways with different therapies. The goal of this phase is to activate the traumatic memories while in a safe environment, leading to the decrease in the emotional intensity as the client remembers (Briere & Scott, 2006). The third phase is *reconnection with ordinary life*. This involves clients' reintegration into their life situations such as home, work and leisure after the work done in phase two. This may entail making plans for their future and what they may hope to do now that they have accomplished some healing.

Phase Two Therapies

Given that the current study asked participants how they have used music as part of their healing journey, a review of established trauma therapies and how they hypothesize they create healing, is warranted. A plethora of therapies exist to treat trauma including Dialectical Behavioral Therapy (DBT; Harned & Linehan, 2008), Trauma-Focused Cognitive Behavioral Therapy (Seidler & Wagner, 2006), group psychotherapy, (Foy, Schnurr, Weiss, Wattenberg, Glynn, Marmar, & Gusman) mindfulness-based trauma therapies, (Follette, Palm, & Pearson, 2006) and pharmacotherapy, (Stewart & Wrobel, 2009). (For more, see Foa et al., 2009). I have chosen a few therapies to discuss in further detail that use different approaches to facilitate the second phase (remembrance and mourning) of the tri-phasic model.

Eye movement desensitization and reprocessing, and exposure therapy.

Eye Movement Desensitization and Reprocessing (EMDR) was developed by Shapiro (1989, as cited in Rogers & Silver, 2002) and the research on it is robust (Black, 2004; for research meta-analyses see Bradley et al., 2005; Van Etten & Taylor, 1998). The eight stages of EMDR described by Spates, Koch, Cusack, Pagoto and Waller (2009, pp.280-281) can be superimposed onto the tri-phasic model. Originally, it was thought that EMDR produced a reduction in traumatic symptoms via bilateral stimulation of either the visual field, auditory field, or via tactile tapping. To date however, EMDR researchers have not been able to give a definitive answer as to why the therapy works, and what exactly is happening for the client during the alternate tactile “tappings”, eye movements, or auditory tones. More recent research by Gunter and Bodner (2008) hypothesized the efficacy of EMDR may be based on working-memory, where the eye movements work as a distraction while attempting to hold the distressing memory in mind. If future research supports the work of Gunter and Bodner, the theory that EMDR’s efficacy comes from bilateral stimulation (stimulating both sides of the brain simultaneously) (Gunter & Bodner, 2008) may be disregarded and lead to completely new forms of trauma therapy. In approaching this study, I speculated that the role of distraction could have been important when considering the role that music may play in participants’ lives in the present study. For example, using an iPod on a crowded bus that has previously led to panic attacks would be considered a “distractive” use of music, or singing along to a song while remembering a traumatic event may lessen the intensity of the memory much like EMDR’s eye movements.

In Rogers and Silver (2002), exposure therapy is defined as “systematic and repeated confrontation with phobic stimuli” (as cited from Craske, 1990, p. 107) and a

“subgroup of cognitive-behavioral therapy including flooding, implosion, and systematic desensitization” (p. 44). Rogers and Silver continue by questioning the differences between exposure therapy and EMDR, concluding that while sharing some similarities, EMDR is a form of information processing rather than an exposure therapy (p. 56). This is questionable considering a main component of EMDR is actual exposure to the memory; the fact that EMDR makes explicit the steps for the memory’s transformation does not negate this fact. Exposure therapy aligns itself with the Emotional Processing Model, which states that fears and anxieties come from “pathological ‘fear structures’ held in memory” that “contain information about stimuli and responses as well as information about the meaning of the relationships between these elements” (p. 45), and calls for prolonged and repeated exposure to the fears while not allowing for the client to become diverted away by other memories. The imperative to keep the client focused on the specific memory and not allowing for new images or sensations is a departure from EMDR; the client starts with the image in mind, but is instructed not to keep focused on the image but to allow their mind and body to go where it needs to go (Black, T., personal correspondence, May 20, 2009). A complete discussion on the controversy between these two therapies is beyond the scope of this study. However, what the two therapies share is the ability to facilitate the second phase of the tri-phasic model, remembrance/mourning, where exposure to the memory is the central focus.

Narrative therapy.

Though not a form of therapy specifically created for trauma work, narrative therapy does offer a particular view and specific techniques to explore and deconstruct clients’ trauma narratives and their themes (Merscham, 2000; Schauer, Neuner, & Elbert,

2005). Narrative theory describes humans as “storied beings” (Cavarero, 2000) who “live our lives by stories we tell about ourselves and that others tell about us. Narrative therapy is reviewed here due the connection with the narrative style interviews conducted in the current study and the positioning of myself as both a counsellor and a researcher who understands that humans are indeed “storied beings.” These stories “actually shape reality in that they construct and constitute what we see, feel, and do” (Corey, 2009). Corey (2009) states the goal in narrative therapy is for clients to change the language and story of their lives to create new possibilities for the future and new ways to experience the past. To use the tri-phasic framework, narrative therapy could focus not only on the second phase (remembrance and mourning) but also on the last phase of reintegration in life, with a specific focus on making meaning of the traumatic event or at minimum, recognizing the reality and fact of the event. When looking at the narratives of trauma, we see the emphasis on stories of “conversion/growth” where through the trauma, people can see their world differently, gain a larger sense of existential problems of being a human living within society, and to become more than they were (Crossley, 2000). This implies a kind of appreciation of the trauma for opening up the client to a different world, with a further implication or understanding that the traumatic experience may have been worth the pain, or necessary for this to happen. Crossley goes on to describe Franck’s (1998) discussion of trauma stories as “located in a ‘horizon of moral significance,’” which is higher than the mundane world of bills, chores, and planning for the future and returns people to what “truly” matters in life (pg. 167). Similar in nature to the previous “conversion/growth” narrative, this narrative adds that a traumatic event is a kind of road to a “true life”. One wonders if this is the case: are people who assault, abuse, and torture

others not to be punished, but thanked instead? Another trauma story within the narrative work discussed by Crossley is that of the “restitution” narrative, focused on finding a remedy, cure, or solution to the trauma, and is the “culturally preferred narrative” of our time; criticism of this story by Franck is that clients engaged with this narrative are “bordering on denial” (p. 174). This can be seen in the traumatized client who desires to have the memories removed or erased from their lives. These three narratives (conversion/growth, moral significance/change perspective, restitution) are some of the ways clients may make sense of, or integrate their stories of trauma, into their lives, and we must ask who or what is served in doing so. If part of trauma therapy involves integration into life, does that mean a rationalization for the pain, or could it be a chance for empowerment through action, such as an earthquake survivor initiating a fundraiser for Haiti? Crossley makes a case for a more explicit and conscious discussion within trauma therapy of this meaning making, which could possibly be seen as similar to the last stage of Herman’s tri-phasic model.

I speculated the current study may have found music had an important role in participants’ narratives of how and if they had created meaning, gained understanding of how their trauma had changed them, or helped them reconnect to their life and person before the traumatic event. By its nature, music is narrative in form. Even without words, music can tell a story. An example of this would be Berlioz’s “Symphonie Fantastique” which at one point musically depicts a beheading (Temperley, 1971). An individual who relates to the lyrics of a song may tell a story about themselves, to themselves or others through listening or performing it. In the case of songwriters, their experiences may

inspire their lyrics and melodies to tell their story. All of these factors combine to make the discussion of narrative approaches and epistemologies relevant to the current study.

Music

Creating a definitive answer to the question, “what is music?” is not only beyond the scope of this study, but most likely beyond the scope of one individual, genre, era, or culture. I looked to how others have defined it by searching online databases for “music”. The first three searches in these databases (<http://www.quotegarden.com/music.html>, <http://ezinearticles.com/?Top-50-Music-Quotations&id=5069>, and http://www.brainyquote.com/quotes/topics/topic_music.html) contained ideas of music ranging from music as a diversion or way to pass time, to the only reason to keep living.

Daniel Levitin, music lover and psychologist, has this to say of music:

There is no known culture now or anytime in the past that lacks it, and some of the oldest human-made artifacts found at archaeological sites are musical instruments. Music is important in the daily lives of most people in the world, and has been throughout human history. Anyone who wants to understand human nature, the interaction between brain and culture, between evolution, mind, and society, has to take a close look at the role that music has held in the lives of humans, at the way that music and people co-evolved, each shaping the other. Musicologists, archaeologists, and psychologists have danced around the topic, but until now, no one has brought all of these disciplines together to form a coherent account of the impact music has had on the course of our social history. (2008, p.3)

While not a specific definition of music, Levitin highlights the cultural, relational, and evolutionary considerations when discussing music, including the importance of lullabies to soothe both baby and mother (p.126). Oliver Sacks, another music-loving scientist states in his book, *Musicophilia* (2007) “no matter whether music is exaptations [“features that evolved by selection for one purpose and were later adapted to a new purpose” (http://www.nature.com/nrg/journal/v4/n4/glossary/nrg1041_glossary.html)]

as Stephen Jay Gould would assert, or what Stephen Pinker would describe as a simple co-opting of previously developed and evolutionary brain systems, no one could argue that music remains fundamental and central in every culture” (p. xi). Music is often seen as having many cognitive overlaps with language; Brown et al.’s (2006) work shows many similar areas of the brain active during improvised musical and linguistic phrases. The main difference between language and music found in this study was language tasks favouring the left hemisphere, and music favouring the right, though Brown et al. state much more work needs to be done in this field. McMullen and Saffran (2004) speculate that similar learning and memory mechanisms are at work in language and music. Research into emotions and music offers similar findings to Brown et al.’s as well as enhances understanding of music and the brain. However, before looking into music and emotion, it is vital to first address the concept of “emotion”.

As with music, there is much controversy surrounding the definition of “emotion”. Kleinginna and Kleinginna (1981, p. 355, as cited in Sloboda & Juslin, 2001) reviewed 92 definitions of “emotion” in a number of sources and from these created the following definition:

Emotion is a complex set of interaction among subjective and objective factors, mediated by neural/hormonal systems, which can (a) give rise to affective experiences such as feelings of arousal, pleasure/displeasure; (b) generate cognitive processes such as perceptually relevant effects, appraisals, labeling processes; (c) activate widespread physiological adjustments to the arousing conditions; and (d) lead to behavior that is often, but not always, expressive, goal-directed, and adaptive. (p. 75)

Within this “meta-definition” there is both internal and external stimuli (subjective and objective factors), which, when sensed by an individual, create perceptions of these sensations. These perceptions are then ascribed values of pleasantness or unpleasantness

that are subsequently responded to, creating a sequence of events precipitated by the original stimuli. The processing of “trauma” is similar in many ways: both involve physiological arousal and a cognitive perception of the meaning of this arousal, as previously described in this chapter (Micale & Lerner, 2001; Scaer, 2005). Emotions, defined this way, along with trauma appear to be processed by individuals in a similar manner; namely, both are “mediated by neural/hormonal systems” which may lead to adaptive behavior (like the release of adrenaline and the “fight, flight or freeze” response). Music can fill the role of external stimuli in this definition and is known to create emotional responses within people (DeNora, 1999; Peretz, 2001). The fact that music can create emotional responses in people is the crux for the following discussion on how music impacts people physiologically, neurologically, and behaviourally; how we “use” music in our daily lives; which includes the music therapies specifically used for treating trauma.

DeNora (1999) interviewed 52 women “on the practices of musical use in daily life, and to examine music as an organizing force in social life” (p. 33). From these interviews, DeNora found that “one of the first things music does is to help actors to shift mood or energy level, as perceived situations dictate, or as part of the ‘care of self’” (p. 37) as well as “[music’s] specific properties – its rhythms, gestures, harmonies, styles, and so on – are used as referents or representations of ‘where’ [interviewees] wish to go, emotionally, physically, and so on” (p. 38). One interviewee described listening to music she described as sad, when she also felt low, as “looking at yourself in a mirror being sad” (p.41) and as a means to increase the emotion, have it plateau, and then subside. In doing this, interviewees described using music to control the quality and time limit for

the emotion within their musical choices. This intentional use of music to create emotional responses and to facilitate their subsidence looks very similar to the memory exposures of EMDR and exposure therapy (and second phase in the tri-phasic model). DeNora also found the interviewees used music to de-stress, as a form of distraction or to “seal” environments from other stimuli, and to create specific aesthetic environments, all of which mirror the “safety and stabilization” phase of Herman’s trauma model, as well as link to the “coping and stress” literature (Folkman et al., 1986; Lazarus, 1999). Strikingly, some also used music to support remembering of events and to reflect on whom one is in relation to these events (e.g., the loss of a child, the death of a parent, or a difficult and painful relationship). This type of remembering mirrors the second phase of Herman’s tri-phasic model.

Theoretically, Western music relies, initially on the creation of a tonal “base” or centre, combined with other musical features such as rhythmic structure and melody. Tension or interest in the listener is created when the music moves away from the stability of the tonal center into connected, yet different territory (in tone base, melody, and/or rhythmic structure), and this tension is released when there is movement back to the original base (Rosen, 1997). An example of this would be the Beatles, “I Wanna Hold Your Hand”. The main chorus establishes the tonal base, which then moves to different tonal territory at the beginning of the line “And when I touch you I feel happy inside” and this “disruption” continues and intensifies until the repetition of the word “high” before returning to the original verse. Charles Rosen (1988) states that though these two “bookends” of stability look the same, they are intrinsically different, with the latter changed by the experience of tension and unfamiliarity. This sequence of “stability,”

“intensity,” and “resolution” appears to mirror the tri-phasic model of trauma therapy, the stages of EMDR and exposure therapy, and the use of music in the everyday lives of women researched by De Nora (1986). Moreover, all of the aforesaid describe how people experience stimuli and integrate it into their lived experience. In approaching this research, I anticipated that this integration may have played a part in participants’ experiences with healing some of their trauma with music.

Research by Sloboda (1991, 1992, 2000), Goldstein (1980), Meyer (1956), and Narmour (1990) found that listening to music can induce physical stimulation and behavioral manifestations of emotion like weeping and piloerection (goosebumps). In addition, Meyer found that “[music’s] movement in a particular direction creates expectation for further movement in that direction” (Meyer, 1956 as cited in Sloboda & Juslin, 2001). This expectation is theorized by Sloboda et al. (year?) to be the reason for tension and emotional activation when music moves from the stable ground into new, less stable tonal areas, and when, according to Meyer, the music does not do as the listener expects it to do.

Peretz (2001) described EEG studies done by Schmidt and Trainor (2001) and Tsang, Trainor, Santesso, Tasker, and Schmidt (2001) where the right hemisphere was found to be more active when listening to music expressing fear or sadness while the left hemisphere was more activated by music expressing joy and happiness (p. 119). It is interesting to note that research exists demonstrating the asymmetrical activation of the right hemisphere in those who have experienced trauma, when asked to recall the traumatic memories (Schiffer, Teicher & Papanicolaou, 1995). Buss (2003) shows in primates a greater right hemispheric activation is associated with higher levels of cortisol,

one of the chemicals associated with fear and anxiety. Perhaps the activation of the right hemisphere when listening to frightening or sad music could facilitate the recall of traumatic memories. We know that trauma causes physiological damage in an individual (Briere & Scott, 2006; Bovin et al., 2008; Scaer, 2005), and we know that music can heal physiological damage (Chou & Lin, 2006; Crowe, 2004; Sutton, 2002). Perhaps then music can heal trauma. This makes music unique from the other arts; these innate responses to music (both rhythm and melody) create changes in the body that looking at a painting or creating a sculpture do not accomplish. When considering the physiological impact of trauma, music's ability to change physiology makes it stand out from the other arts as particularly capable of healing trauma.

For the purposes of the present study, I defined music in two parts: for what it is, and what people use it for. In discussing "what music is," I took a page from innovative and highly influential 20th century composer Edgard Varèse, who famously defined music as "organized sound" (as cited in Levitin, 2006). However, I went one step further and defined it as "sound organized around known tonal systems we call 'scales' or 'keys' with a movement from, and back towards a base 'home' tone." The definition of music combines rhythm and melody, often in the two musical modes we know as "major" and "minor", or also known as "happy" or "sad," respectively. For the second part, I used the definition of sociologist Tia DeNora who argues that, "music is a cultural resource that actors may mobilize for their on-going work of self-construction and the emotional, memory and biographical work such a project entails" (1999, p. 32). Despite my investigation into the academic and philosophical definitions of the term music, it is interesting to note that, throughout the interviews, none of the participants offered their

own definitions of music beyond describing it as “a medication” or “drug” to aid their healing. It is clear that music can have a tremendous impact on the lives of individuals. What then of the intentional use of music in therapeutic contexts?

Music Therapies and Trauma

Modern music therapy began in the mid-1700’s with Louis Roger’s “A Treatise on the Effects of Music on the Human Body” and went on to become a credentialed profession in 1981 with the formation of the Certification Board for Music Therapists (Crowe, 2004). Music therapy is defined by the National Association for Music Therapy as “the specialized use of music in the service of persons with needs in mental health, physical health, habilitation, rehabilitation, or special education” and that the purpose is “to help individuals attain and maintain their maximum levels of functioning” (1982, p. 2 as cited in Crowe, 2004, p. 12). In this way, music therapy is often used with persons with physical, mental, and developmental disabilities (such as Alzheimer’s and Cerebral Palsy) with little overlap to counselling or psychotherapy. This is to say that music therapy, in its most common incarnation, is dissimilar to the modalities used for psychotherapy (i.e. music therapy is more often used for physical or cognitive impairments than it is for relational issues or mood disorders). This difference is the reason why I have not explored in depth the specifics of music therapy.

A number of trauma-specific creative therapies are discussed by Johnson, Lahad, and Gray (2009), including Helen Bonny’s Guided Imagery and Music (GIM) model. Despite the fact that Johnson et al. do not specifically focus on music therapy and do not explore whether or not different creative arts have differing effects on treatment outcomes, the GIM model shares many similarities to both EMDR and exposure therapy

such as relaxation exercises and use of imagery. Bonny describes her method as “a process which utilizes relaxation techniques and classical music to stimulate imagery in working toward therapeutic goals” (1993). Blake and Bishop (1994) describe the four parts of a GIM session: prelude (assessment of a client’s internal resources and ability to set goals for therapy); relaxation/induction (listening to music, describing images that surface and speaking with the therapist who helps in resolving images and then brings client back to the present here-and-now), and postlude (process of session through client’s interpretation, and general discussion or exploration with therapist). The Bonny Method of GIM follows general guidelines of other trauma therapies such as the previously described EMDR and exposure therapies, with the unique inclusion of music as the “containment of the experience [of the session]” (Blake & Bishop, 1994, p.126). GIM appears to be a marrying of music use described by DeNora (1999) as a way to “seal” off space, and a therapeutic setting and memory activation found in EMDR and exposure therapy. There is an unfortunate dearth of research done with GIM on trauma outside of psychiatric and medical settings within the last decade. The existing research found GIM useful for decreasing cortisol levels (stress hormones linked to activation of the sympathetic nervous system which is one of the systems at work in our “fight or flight” response) in people experiencing anxiety (McKinney, Antoni, Kumar, Tims, & McCabe, 1997), and inducing relaxation (Chou & Lin, 2006). GIM characteristics such as imagery and relaxation may be similar to some experiences this study’s participants may have had in their personal healing with music.

Bensimon, Amir, and Wolf (2008) carried out a study of group drumming for soldiers diagnosed with PTSD, looking at the benefits of the drumming on PTSD

symptoms. The researchers used three different data sources: video tapes (which were then analyzed for time spent in different rhythms and solo/group drumming), participant interviews, and therapist-researcher self-report. Bensimon et al. found that the act of group drumming increased a sense of connection; gave access to traumatic memories in a non-intimidating way; offered an acceptable way to “drum through the rage” (p. 44); as well as gain back a sense of control. Isolation and feeling “out of control” are two of three symptoms of PTSD described by Bensimon et al. in this study; alexithymia or the difficulty in translating emotions into words, is the third. These researchers drew on the studies of Storr (1992), Volkman (1993), Vanderkolk and Fischer (1995), and Johnson (1987) to postulate that because both “music and trauma are sensorially mediated ... [m]usic therapy might function as a means of sensory approach to traumatic memories as a detour of linguistic and logical mediation” (p.36). That is, that the difficulty in recalling traumatic memories and expressing them verbally can be alleviated by their expression through musical means. Research demonstrates that sad or frightening music and traumatic memories both correlate with relatively higher activity in the right hemisphere (Peretz, 2001; Schiffer, Teicher & Panapnicolaou, 1995; Schmidt & Trainor, 2001; Tsang, Trainor, Santesso, Tasker & Schmidt, 2001) making it, at least theoretically possible, that music could activate or facilitate the recall or connection with traumatic memories. What Bensimon et al. do not ask is whether participants used music on their own before the experiment, whether interest in music was a possible reason for participating in the study, or what their relationship to music was previously to the trauma. These questions may have provided a more nuanced picture on who may benefit from music therapy for trauma: almost anyone, or participants who already loved music

and had it in their lives? Knowing participants' previous experiences with music is important to consider since participants' previous relationships to music or positive experiences playing music may have played a large part in their willingness to engage in the work or already lead them to "know" that music would help them.

Chapter Summary

In this chapter I have discussed the main constructs associated with my proposed study as well as the previous research and studies surrounding my proposed research question. These constructs cover three main areas: trauma (including trauma therapies and the diagnosis of trauma-related PTSD), music (including research on the connections between music and emotion and the use of music therapies for traumatized clients), and healing (including the notion of self-healing). These three areas are the foundation for my research question as well as delineating the gap in research I have endeavored to fill by carrying out the current study.

The following chapter outlines this study's methodology, including detailed description on research design and the procedures I used to select participants, and the interviewing and analysis processes.

CHAPTER 3: METHODOLOGY

Introduction

In this chapter I will describe the qualitative research position, and why this methodology is congruent with my research question. I will also describe the narrative approach to research to illustrate why I used this specific form of interview process with my participants. Following this, I will lay out my rationale and procedures for thematic analysis of the narrative interviews as well as the procedures for these interviews. Next, I will describe my participants and recruitment, and explain the processes for assessing and establishing qualitative method credibility. Finally, I will discuss the ethical implications of the study and how I carried out the research ethically, before concluding the chapter.

Qualitative Research Positioning

The argument between qualitative and quantitative inquiry regarding which method is the gatekeeper for “truth,” is critiqued in Black’s 2008 article, “Applying AQAL to the Quantitative/Qualitative Debate in Social Sciences Research”. Using the work of Ken Wilber and Integral Theory, Black maintains that the debate between quantitative and qualitative inquiry is “founded upon an inadequate or partial definition of the term “empiricism,” a misreading of the word “paradigm,” and the ways in which “validation” of knowledge have been perhaps inappropriately limited in the social sciences” (p. 2). Black continues by stating that the common view of “empiricism” is, in fact, “narrow empiricism” by using only one of the “eyes” of knowing, that of the eye of the flesh (use of the five senses) and the disregard of the other two: the eye of the mind (logic, reason, mathematics) and the eye of the spirit (spiritual experiences, oneness of the Spirit) (Wilber, 1999). The social sciences’ use of qualitative inquiry falls into “broad

empiricism” since the only way to “see” the data in this type of research is through the “eye of the mind.” To illustrate this Black states:

Individual subjective interiors are invisible to the physical sense, and as such, are invisible to the hard sciences. To illustrate this invisibility we can take the experience of sadness as an example. The experience of sadness does not have simple location in the world. One may observe tears, a downward turned mouth, and sobbing. One may measure the chemicals released in a tear, the angle at which the mouth turns down, and the increase in blood pressure with each heave and sob, but none of these can tell the observer about the individual’s interior experience of sadness. Interior subjective experiences (e.g., thoughts, emotions, beliefs, values) are not visible to the physical sciences, but that does not mean they are not real. (p.3)

Quantitative approaches are limited to only investigate topics suitable for “narrow empiricism” (i.e., focusing only on physical evidence and self-report/self-assessment measures of thoughts, emotions, beliefs, and values). Qualitative’s inclusion into “broad empiricism” allows for the deeper exploration of interior subjective experiences such as Black’s example of sadness, and the current study’s focus on the interior subjective experience of music in self-healing from trauma. As well, quantitative methods, argued to be only interested in what can be measured, use mathematics for data and statistical analysis. These concepts do not exist in the material world and are in fact part of the “eye of the mind” of logic and mathematics, contradicting the assumption of “objectivity” and use of only the five senses.

To put it simply, qualitative research answers the questions quantitative methods, by their nature, cannot answer (Creswell, 2009). Rather than looking for generalizability, qualitative researchers are interested in participants’ meanings with respect to that upon which the research question focuses (Creswell, 2009). Creswell further describes qualitative research characteristics as: taking place in a natural setting (i.e., field work involving face-to-face interactions), using multiple sources of data (i.e., interviews,

observations), having an emergent design (i.e., the interview questions may change as can other design elements), the researcher as key instrument (i.e., researcher collects data themselves and rarely uses previously used instruments or questionnaires), interpretive in nature (i.e., researcher personal background is present throughout and acknowledged, and data are interpreted through this), taking a holistic stance (i.e., reporting multiple perspectives, and developing a complex picture of the research), and inductive data analysis (i.e., often no specific, a priori hypothesis but rather having a “bottom up” approach by gathering information first, and then exploring and analyzing for patterns) (Creswell, pg. 175). These characteristics highlight the “everyday” aspects of qualitative inquiry; researchers interact with the participants in participants’ own settings and reality, and as fellow human beings with their own biases and assumptions. The current study does not contain all of these characteristics, such as taking place in a natural setting or having an emergent design. I conducted and recorded interviews at the University of Victoria with specific questions for participants. It was interpretive in nature, with me directly involved in the research; my own personal biases and previous experiences and knowledge informed my interpretations. The current research also took a holistic approach as I was open to the possible complexities of participants’ interviews and their multiple perspectives.

Given the nature of my question, “How have participants who have experienced trauma and not participated in formal music therapy used music as part of their healing journey?” a qualitative approach was the best fit. Values, personal meaning, and the desire to know how the participants saw music as part of their healing are at the mind and heart of the question. As an inquiry into how individuals make this meaning, quantitative

methods were insufficient as well as irreconcilable with studying any one individual's interior world. The qualitative inquiry included narrative interviews (data collection) and thematic content analysis (data analysis).

Narrative Positioning

Rather than attempt to fit within the positivistic world-view of quantitative methods, narrative researchers seek to co-construct narratives or “life stories” with participants as “co-researchers”(Chase, 2005). Narrative research does not necessarily focus on *a priori* hypotheses (though researchers may have assumptions and speculations on what they may find) since the point of the co-construction is to create an *in vivo* narrative, taking into account space, geography, time, and mood (Chase, 2005). Narrative is a part of qualitative inquiry, with some explicit additions and foci as will be described here.

Narrative methods of investigation began in Sociology and Anthropology in the early 20th century (Chase, 2005). Chase (2005) describes narrative inquiry as follows:

Contemporary narrative inquiry can be characterized as an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods – all revolving around an interest in biographical particulars as narrated by the one who lives them. (p. 651)

Hence, the crux of a narrative approach is in the spirit of the research (that of interest in “biographical particulars”) rather than as a specific set of methodological steps. Using narrative interview without narrative analysis (creation of first-person narratives by the researcher which must be accepted by the original participant as fully telling their story) is completely acceptable according to narrative research approaches (Chase, 2005).

Polkinghorne (1988) states that we understand ourselves, the world around us, and our place within it, by making meaning through narratives. It is fitting then to use narrative-style interview questions, since with the semi-structured interview form participants will still answer in the form of stories (Mishler, as cited in Chase, 1995). However, a semi-structured interview, with its cognitively-focused questions (i.e., questions that ask participants to think about the issue), may lead participants to answer the questions cognitively and analytically. I was interested in a fuller story of how participants used music as part of their healing; that is, I was interested in emotional, spiritual, and physical aspects as well. A narrative approach helped me engage my participants on these multiple levels because when asked to tell the story of how they have used music as part of their healing (a narrative question), participants were free to engage in the question as they so chose.

Chase (2005) describes the five major narrative approaches as: (a) focused on the “relationship between individuals’ life stories and the quality of their lives” which often entails the use of specific psychological instruments or tests; (b) highlighting of “‘identity work’ that people engage in as they construct selves within specific... contexts;” (c) answering of “how” and “what” questions looking at specific aspects of people’s lives; (d) narrative ethnography which involves long-term personal involvement in a community; and (e) autoethnography, “where researchers also turn the analytic lens on themselves and their interactions with others ... but perform their own narratives about culturally significant experiences” (Chase, 2005, pp. 658-660). The current study fell into Chase’s third approach because I focused on the one aspect of *how* the participants used

music to help them heal (rather than how they experienced living in the world as someone who has experienced trauma).

Thematic analysis and narrative interview worked together to help me answer the present research question. The dialogue process with participants was a discrete, co-constructed event separate from the act of analysis; once I had co-created the audio-taped interviews (i.e., the data), I began the analysis process. I began with the act of transcription and then moved on to the development of themes from the collected narratives.

Thematic Analysis Positioning

Boyatzis (1998) describes thematic analysis as an explicit coding of qualitative information that may range from a simple list of themes to a complex model involving causal relationships (p.vi). He continues:

Thematic analysis is a way of seeing. Often, what one sees through thematic analysis does not appear to others, even if they are observing the same information, events, or situations. To others, if they agree with the insight, the insight appears almost magical. If they are empowered by the insight, it appears visionary. If they disagree with the insight, it appears delusionary. Observation precedes understanding. Recognizing an important moment (seeing) precedes encoding it (seeing it as something), which in turn precedes interpretation. Thematic analysis moves you through these three phases of inquiry. (p.1)

Here Boyatzis acknowledges the subjectivity of thematic analysis as well as the explicit and necessary steps to performing thematic analysis: observing in order to gain understanding, seeing the value in a moment in order to code it, and with that coding come to an interpretation. Though not concrete or operationalized, these directions structured the analysis method. With a long, implicit history in the social sciences,

thematic analysis most often utilizes analyses of previously written texts, or the recording, transcription, and coding of audio or videotapes; I coded audiotapes of the narrative interviews.

Transcription

Lapadat and Lindsay (1999) describe the tape-transcribe-code-interpret cycle (TTCI) as emerging from new technology, with researchers waving the flag of a new ability to quantify, and therefore able to position themselves in a positivist stance (p. 67). This is not the case according to Ochs (1979) however, who stated that the recording devices do not remove the human interpretation from the process, but simply remove it one step further away (as cited by Lapadat & Lindsay, 1999). Indeed, Kvale views transcriptions “as interpretive constructions arrived at through choices made by the researcher” (as cited by Lapadat & Lindsay, 1999, p. 74). Due to my acknowledgment of myself in the interview process, I was well aware that my personal experiences, beliefs, and biases would also play a role in the transcription process, and most definitely in the interpretation. Taken together, I co-constructed all aspects of the research with my participants.

Interview Procedure: The Narrative Interview

The narrative interview procedure involved the fleshing out of the one, central request I had for participants: tell me the story of how music has played a part in your healing journey from trauma. I expected the stories to be given to me in non-linear chunks, depending on memory and saliency for the participants. I was aware of the story telling process, which has a beginning, middle, and end; if participants had difficulty answering the question, I prompted them to expand parts of their stories for clarification,

as well as to reconnect the narrative back to the research question. To know when I had the full story from my participants, I asked the question, “With what you have told me, would you say that I know your story?” the answer to which dictated the remaining time and material of the interview.

Interviews took place at the University of Victoria in April and May 2010. Interviews and explanation of informed consent were audio taped. The original audiotapes were kept in a locked filing cabinet and audio copies and transcripts were kept on a password-protected computer.

Data Analysis: Thematic Analysis

Braun and Clarke (2006) ask researchers to answer the five following questions before analysis, and some of them even before data collection: (a) what counts as a theme; (b) do I want to focus on a “rich description of the data set, or a detailed account of one particular aspect;” (c) will I perform inductive or theoretical thematic analysis; (d) will I focus on semantic or latent themes; and (e) is my epistemological stance essentialist/realist, or constructionist (p. 82-85).

From the data collected in response to asking researchers to decide what counts as a theme, Braun and Clarke (2005) report the “keyness” of a theme does not necessarily depend on quantifiable measures (i.e., how often it is seen in data sets) but rather on its importance to the overall research question (p. 82). These authors also ask the reader to make explicit our understanding of “prevalence” as either the frequency with which the possible theme shows up anywhere, or how many participants articulated the possible theme. I used the latter understanding of “prevalence” in the present study, and developed

a theme when I saw it in two thirds of the interviews (i.e., as I had five participants, three endorsements were necessary in order for it to be considered a theme).

Braun and Clarke's second question, "rich description of the data set, or detailed account of one particular aspect" directly relates to the research question (p.83). My research question focuses on one specific aspect of healing from trauma (i.e., *how* participants used music as part of their healing) as opposed to a larger, general question of "healing from trauma." As such, my thematic focus and answer to the second question is that of a "detailed account of one particular aspect."

For their third question, Braun and Clarke (2005) frame "inductive versus theoretical thematic analysis" as another consideration for qualitative researchers (p. 83). The inductive approach, Braun and Clarke state, may have themes with little connection to the questions asked of participants, and furthermore, are "not driven by the researcher's theoretical interest in the area or topic" (p. 83). The authors acknowledge this inductive approach fails to acknowledge the challenge of researchers freeing themselves from their theoretical backgrounds and underpinnings. The "theoretical" approach is "driven by the researcher's theoretical or analytic interest in the area, and is thus more explicitly analyst-driven" (p. 84) and lends itself to a detailed description of a specific data aspect. I used this theoretical thematic analysis approach due to its fit with the present study's research question, the existing literature, and my acknowledgment of my personal analytic interests and biases.

Braun and Clarke also ask the researcher to decide whether to focus on "semantic" or "latent" themes (p. 84). "Semantic" themes are identified and their significance interpreted, only through "explicit or surface meanings of the data, and the

analyst is not looking for anything *beyond* what a participant has said or what has been written” (p. 84). “Latent” thematic analysis “goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, and conceptualizations – and ideologies – that are theorized as shaping or informing the semantic content of the data” (p. 84). Because of my desire to focus on a contextualized understanding of what was said during the interviews, I used semantic thematic analysis. This form, according to Braun and Clarke (2005) acknowledges interpretation on the part of the researcher as a means “to theorize the significance of the patterns and their broader meanings and implications, often in relation to previous literature” (p. 84).

Lastly, Braun and Clarke (2005) ask if the research will be conducted in an essentialist/realist paradigm or a constructionist paradigm (p. 85). As previously discussed, I acknowledged the co-constructive nature of the interviews as a social production through the use of language and discourse. Braun and Clarke’s five questions for researchers to ask of themselves before beginning their research guided me through the analysis process and clarified for myself *why* I developed the themes I did, while I developed them.

In the same article, Braun and Clarke lay out six phases of thematic analysis:

1. Familiarization with the data (transcriptions, repeated readings)
2. Generation of initial codes (looking through all data, and coding as much as possible)
3. Develop themes (essentially looking for connections between the codes, and grouping them)
4. Develop themes (two levels – check for themes creating a coherent pattern, and then check if the coherent pattern accurately reflects data set)

5. Define and name themes (refine themes into their essences and do analyses on each theme)

6. Produce the report

After transcribing the interviews, I read each one six times to become submersed in the readings. Following this, I coded the text of each transcript as to whether or not the particular section of speech was a possible answer the research question. I then took the results of this “yes/no” code and began grouping “yes” quotes into similar categories, making small notes as to what I believed tied these quotes together. From here, through reflection and meeting with my supervisor I developed and refined the themes further to the point where I had created a name and definition for each theme. Finally, I performed the endorsement check with my participants.

Braun and Clarke’s analysis procedure allowed me to systematically move from immersion with the transcripts to refining the themes I developed; this mirrored the move from first person involvement and participation in the interviews to third person analysis and reporting.

Participants

Ethical approval was received from the Human Research Ethics Board of the University of Victoria to complete this study. To be considered for the study, participants needed to have experienced trauma. However, I also screened for the length of time since the trauma of two years or longer since the trauma occurred; my ethical purpose here was to co-construct a narrative with my participants while not re-traumatizing them or causing harm. This also kept the study within the bounds of the University of Victoria’s Tri-Council Policy regarding minimal risk to participants

(<http://www.pre.ethics.gc.ca/eng/policy-politique/tcps-eptc/section1-chapitre1/#1C1>); specifically, that if a participant “can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research, then the research can be regarded as within the range of minimal risk”.

In regards to the involvement of music in their lives, participants needed to have used music on their own or with non-professional groups as a form of self-healing. However, other forms of therapy or trauma therapy were not exclusion criteria because the current study was interested in examining the metaphor of the “self-healing journey”; how individuals used music therapy was beyond its scope.

I recruited participants through posters placed throughout the University of Victoria campus, (especially in the Department of Music), the Victoria Conservatory of Music and Camosun College. These posters defined trauma in the same way as defined in the present introduction and literature review, and described by way of examples including sexual assault, abuse, automobile accident, natural disaster, or a serious medical diagnosis, such as cancer. The clear definition and examples of traumatic events were included to decrease the likelihood of potential participants being rejected for inclusion after contacting me. Twelve people contacted me in regards to the study, but only five (41.7%) were both appropriate and willing to fulfill participation requirements. Of the twelve initial respondents, three were deemed by me to be inappropriate: two due to lack of previous traumatic event (both described using music to heal from depression with no previous traumatic event) and one due to her lack of stability in life (lack of stable housing and present involvement in the legal system around the traumatic event).

After showing initial interest in the study and fitting all criteria, another three respondents failed to return further phone calls and were not contacted again. The last of the twelve contacted me too late to be involved in the interview portion of the study.

My participants were five Caucasian adults (four women and one man) between 22 and 48 who had experienced trauma, who had not participated in any formal music therapy, and who had used music as part of their personal healing journey from the trauma. Some had received formal trauma therapy (EMDR), some had tried counselling and found it ineffective and some were still in counselling, none of which included music therapy. The four female participants described only listening to music to achieve some healing, and the one male participant described some playing and composing as well as listening to achieve some healing. All stated they felt they had experienced some healing from their trauma with music and were able to articulate what this healing “looked” like or how they knew that some healing had occurred in response to their use of music.

Methodological Credibility

When regarding the integrity of research within quantitative inquiry, the common terms and criteria are validity, reliability, and generalizability. Krefting (1991) calls for the use of different criteria for qualitative inquiry based on Guba’s (1981) model: credibility, transferability, dependability, and confirmability.

The first of these, credibility, speaks to the researcher’s need for “representing those multiple realities revealed by informants as adequately as possible” (Krefting, 1991, p. 215). Credibility can be achieved by showing findings to those familiar with the phenomenon or topic being discussed, people Ken Wilber would call, “the community of the adequate” (2007). The study is credible “when it presents such accurate descriptions

or interpretation of human experience that people who also share that experience would immediately recognize the descriptions” (Krefting, p. 216); this differs from the parallel quantitative view of “internal validity.” Transferability is described by Krefting as occurring when findings “fit into contexts outside the study situation that are determined by the degree of similarity or goodness of fit between the two contexts” (p. 216). This parallels the quantitative concept of “external validity” or generalizability. The third criterion, dependability, while analogous to reliability, does not ask to control for variability, but to be able to account for and track it. Krefting’s last criterion, confirmability is focused on the neutrality of the data, rather than the neutrality of the investigator, and is said to be achieved when the requirements for both truth value (credibility) and applicability (transferability) are met.

All of Krefting’s criteria will be taken into account in this current study. In regards to credibility, Krefting (1991) cites Aamodt’s (1982) statement that a “qualitative approach is reflexive in that the researcher is part of the research, not separate from it... [and] [t]he investigator, then, must analyze himself or herself in the context of the research” (p. 218). Krefting suggests using a field journal, a practice in which I engaged. My field journal contained reflections of my thoughts and feelings around the research in order for me to become aware of my personal biases and possible assumptions. Another way to achieve credibility according to Krefting (1991), and as described earlier, is to check with members for accuracy of depictions and themes. After I analyzed participants’ initial interview transcriptions, I either had a second, face-to-face conversation with my participants or sent themes via email (participants chose whichever method they preferred), to check for accuracy of the themes I developed from the transcripts.

In order to address transferability I, as Krefting suggests, provide as much background information as possible on my participants in this final body of the research so readers may know to what other groups or communities the findings I describe could be transferred.

I followed Krefting's recommendation and performed audits (having colleagues and other researchers check the research plan) on thematic categories and methodology, a technique described by Krefting to address both dependability and confirmability. Throughout the thematicizing process I met frequently with my supervisor in order to fulfill this recommendation. Another step I took to address dependability in the study was to perform a code-recode procedure which entails coding a section of transcript, leaving it for at least two weeks, code the same section again, and compare the two results. I recoded five pages from each transcript for the "yes/no" code as to whether or not the section of transcript gave a possible answer for the thesis question, then compared these to my original "yes/no" codings. All quotes that were coded as "yes" in the original coding were also coded as "yes" in this recode check except for one quote that would have been coded as "to cope". This quote was from a participant who did not originally endorse the theme "to cope" and who did not in the end add a final endorsement to this theme. This indicates dependability of my original coding to be relatively high. Lastly, to address confirmability, I used at least three participant interview quotations to support any themes I developed, as well as the previously mentioned auditing process also used to address dependability, which Krefting also describes as "a major technique for establishing confirmability" (p. 221).

Ethical Implications

To minimize the risk for participants, I recruited participants whose traumatic experience(s) occurred a minimum of two years previous to the study; the nature of the research question requires interviewing only people who have experienced some healing from this trauma as well. I relied on participants to decide if they had experienced some healing as well as using informed consent before beginning the interviews. I also asked participants before beginning to describe their experience, “how do you know you have healed from the trauma in some way?”. Most described feeling as if the experience was part of their past rather than their present, that they could speak about it without feeling like they were “in” it, and that they had made meaning of it in some way. Due to my previously described training and education, I am familiar with best practices for supporting people during crisis or active engagement with traumatic memories. If a participant had experienced high levels of distress during our interview, I was to immediately cease the interviewing process and move towards supporting them (they would have also no longer been a participant in the study). No participants needed this procedure; only one felt the need to take a small break to drink some water. I also gave each participant a list of community supports (such as crisis lines, the Women’s Sexual Assault Centre, Men’s Trauma Centre and Citizens’ Counselling) if they had wished to meet with a counsellor, though none of them indicated they were going to use these services afterwards.

Other possible risks or inconveniences for my participants were the amount of time necessary for the two interviews. I minimized the time inconvenience by working

with the schedules and availability of my participants. Participants were also informed of their ability to withdraw at any time during the study without consequence.

In regards to benefits, there were no explicit gains for participants for being part of the study. I imagine some may have appreciated the chance to tell their story if they had never had the venue to do so. I gifted every participant with a CD compilation of healing music chosen by me. This was to show my gratitude for their time and sharing their experiences with me.

Chapter Summary

In this chapter I have described the qualitative research positioning, as well as the specificities of narrative research and thematic analysis. After making explicit the fit between these methodologies, I described the procedures I followed for narrative interviews and thematic analyses, as well as who my participants were and their recruitment process. I then described the qualitative forms of reliability and validity: credibility, transferability, dependability, and confirmability laid out by Krefting and how I addressed these. I finished the chapter with a discussion on the ethical concerns and considerations of the study and how I minimized the risks to participants.

CHAPTER 4: RESULTS

Narrative interviews were completed with five participants who had experienced a traumatic event as per the DSM IV-TR's Criterion A1 and A2 within the PTSD diagnosis. The five participants ranged in age from 22 to 48, with four women and one man. Four of the participants had experienced a relational traumatic event (where the participants were assaulted or abused directly at the hands of another person, such as physical abuse or sexual assault). The remaining participant was in a serious car crash. All participants were able to describe with relative ease how they had used music as part of their self-healing journey from trauma.

As described in the Methodology chapter, narrative interviews were conducted, asking the participants to “tell me the story of how you used music as part of your self-healing journey from trauma”. After completion, I transcribed the interviews and then used the thematic analysis as described by Braun and Clarke (2006). During this coding and thematicizing, I developed the following four themes, one with two sub-themes for a total of six. These themes were reviewed by my supervisor to ensure *auditability* (the ability of the primary researchers procedures to be clearly followed), which also ensured the dependability of the study (Krefting, 1991). Following Krefting's process to assess credibility, all themes were validated by each of the participants to reflect their experiences.

The four main themes (one of which has two sub-themes) were all endorsed by at least three out of the five participants, with only one being endorsed by all five. These four main themes were: 1. To Emotionally Regulate (with sub-themes 1.a To Soothe and Calm, and 1.b To Feel Energized, Uplifted, Up); 2. To Cope; 3. To Connect to People,

and; 4. To Disconnect From People. The two sub-themes for the first theme were combined into one super-ordinate theme due to their connection to emotional state, differentiating them from the other themes. I chose not to combine the last two themes into one theme representing “relationship regulation” due to their lower levels of endorsement by participants and lack of overlap by participants in both categories (only one participant endorsed both). When checking with participants on their endorsing quotes, I asked them to check the other themes for which they did not have an endorsing quote. From this, “To Feel Energized, Uplifted, Up” went from three endorsements to four, “To Cope” went from three endorsements to four, and the last two, “To Connect to People” and “To Disconnect to People” remained at three each. Only one theme was fully endorsed by all five participants – “To Soothe and Calm.”

In addition, three other notable themes emerged, which were only endorsed by two of the five participants. The three themes were: 1. As a Way to Return to the Past; 2. To Feel Validated, and; 3. To Daydream or Fantasize. When checking with participants on their individual endorsing quotations, I asked them if they would also endorse these, based on their description and the other participants’ endorsing quotes. “As a Way to Return to the Past” received two more endorsements to make a total of four, “To Feel Validated” received one more endorsement to a total of three, and “To Daydream or Fantasize” remained at two endorsements.

It is important to note that throughout the interviews, participants told their stories of how they had used music as part of their healing, which intertwined with their experiences of being a person in the world who had experienced trauma, their experiences of receiving formal therapy such as EMDR and counselling, as well as their

experiences they have had with music before their traumatic event occurred. By including these acknowledgements, I wish to recognize the impact of trauma on an individual's daily life, in relation to themselves, their moods, and people in their lives, all of which is substantiated by the DSM-IV-TR's symptom list of PTSD. Though none of the participants were formally diagnosed with PTSD, as a counsellor with experience working with traumatized individuals, many of whom have been diagnosed with PTSD, all of the participants described or expressed similarities to PTSD symptoms during their healing process.

The following are the titles and descriptions of the themes, as well as the supporting, verbatim quotes, all of which were validated by participants during data analysis.

Primary Themes and Supporting Quotes

1. To Emotionally Regulate

Participants described using music to both calm or soothe and energize themselves, depending on the state they were in and what state they wished to be in.

1.a To Soothe and Calm

Participants described using music to soothe themselves or to calm themselves down when dealing with difficult situations, or painful thoughts or feelings related to their experiences of trauma. (Theme validated initially by all five participants)

- Melony: "I would put on the Neil Diamond anytime I wasn't certain about the way things were, I was uncomfortable, like I said visiting my dad or whatever, anytime I was uncomfortable or not sure what to do, if I put on Neil Diamond CD it would enable me to calm down."

- Rooa: “I think this probably ties back to the music videos too, that was gentle and easy and um, and, and just a little more soothing.”
- Bob: “[O]ften I think that times when I’m seeking [music] out um, is not the time that I’m ready to deal with [the abuse] and heal it so sometimes it’s just to soothe [okay] like a pacifier, almost, you know.”
- Sarah: “[Listening to music] would almost allow me to kind of self soothe a bit.”
- Tamara: “It’s like a, yeah, just a comforting like uh... having music in the background is like a soothing, it’s almost like if you think like you’re rocking like with a kid.”

1.b To Feel Energized, Uplifted, Up

Participants described using music to intentionally change their mood from a negative, low feeling related to having experienced a traumatic event, to a more positive, upbeat, or energetic mood. (Theme validated initially by three participants, then endorsed by four after final check).

- Melony: “I used it when I was uncomfortable at my dad’s house, I used it when I was troubled as a teenager or anything else, I’ve always used Neil Diamond to make myself happy”
- Rooa: “I remember this like, very, very explicitly. I didn’t have um, speakers at my parent’s house but I remember turning up my laptop as loud as it would go and listening to that song before I went because it, it had that energizing quality to me, like it just put me in a more energetic mood”
- Tamara: “Like the music would make me hyper, like the music... I would want to dance around the house so to change my mood, if it’s a song I really like. So

the lyrics can impact me, the beat can impact my mood and make me feel really upbeat”

2. *To Cope*

Participants described using music to cope with the impact of the traumatic experience(s) and that this helped them get through a certain situation from which they were unable to remove themselves. Sometimes this use of music involved listening to the same song or album on repeat to keep the music going for the length of time needed to get through the situation. (Theme validated initially by three participants, then endorsed by four after final check).

- Melony: “I would listen to my dad’s Neil Diamond CD, this is where the healing part comes in, because that’s how I would make it through the visits with my dad, is listening to Neil Diamond over and over and over again”
- Rooa: “[T]here’s these little stairs outside of the surgery and I remember and I remember feeling [my iPod] hit my hip and I took it out and I just, um, plugged it in and at this point I was like, crying, and like snotty [mhmm] like, losing my, losing my shit altogether and it just really, um, like it was sort of a... I, I don’t even know what I played, like it might have been like, recently played – that option on your iPod or something, or most commonly played or whatever – I don’t even remember what songs they were [...] – I remember at the time feeling really like... um... this is just gonna hap- we’re just gonna have to survive this, like, not like – yay, we’re gonna do this! But like – this is just how it’s gonna have to be, like – you’re gonna have to do something about [getting mom home after her surgery], we can’t just sit out here and cry all day so we need to just

accept that something's gonna happen and we've gotta, we just gotta get through this”

- Tamara: “I think that [music is] healthy and I'm aware that it's, it's a coping that works for me so um, you know, some people never find the things that work but for me and I [unclear]. It's another part of my coping bouquet”

3. To Connect to People

Participants described using music to connect to, or to feel connected to people in their lives. Two of the participants stated during the interviews that they had difficulty connecting with people due to their traumatic experiences. This music was often playing during the connecting. (Theme validated initially by three participants, and remained at three endorsements after final check).

- Melony: “[L]istening to Neil Diamond as a family was really good and that, I can remember those times because that's what made me really happy, I was like, yay, we're listening to Neil Diamond, we're a family, you know, that's how I associated being a family”
- Bob: “I've wanted to talk to [my son] about the things that happened before, kind of, as he became older and um the last few times I've seen him I've been trying to talk about it and there's kinda been a wall there but through, through music that we shared just in this last visit um, I realized that that connection's never [mmm] it's never gone, you know, that we have that connection cuz the music that he played, he learned himself, is all the songs I used to play when [laugh] we he was a little boy, you know”

- Sarah: “[W]hen I um started being, getting closer to my partner and stuff, we really connected over music as well. And that was a really big thing that has brought me together with people, now”

4. To Disconnect from People

Participants described using headphones with music to disconnect themselves from people in public, and to non-verbally indicate that they did not wish to communicate or engage with others. All three participants described this use during their traumatic experiences or shortly after (within the first year afterwards). (Theme validated initially by three participants, and remained at three endorsements after final check).

- Rooa: “Um, and also too I think [wearing headphones while listening to music] was a very obvious, like “please don’t speak to me” message”
- Sarah: “[I]t’s a way that, you know, people do it all the time now, but for me, for a very long time [listening to music on headphones has] been a way I can kind of shut things out, that too. Whether it was, you know, in my bedroom back in the day or now if I don’t want to talk to people I can just stick headphones in”
- Tamara: “I would still have my headphones on at the back of the bus [as a teenager] and I would just like... so, if I think back, I had music on almost 24/7 so I think it was a bit of uh, just dissociating and not hearing it and not... so, cutting myself off [from people]”

Notable Categories of Responses

As previously discussed, these responses did not meet the threshold for full development as a theme, but are worth noting for possible future research. When asked, the first two became endorsed by the majority of participants (four of five, and three of

five, respectively) while the last, “To Daydream or Fantasize” received no other endorsements.

5. As a Way to Return to the Past

Some participants described using music as a way to return to their past, either negative or positive, where they could then connect to the feelings and memories from that time connected to the traumatic event. (Validated initially by two participants, then endorsed by four after final check).

- Rooa: “Yeah, and like a little bit of a bridge cuz like for a minute I can almost, or for four and a half minutes [laughter] I can sort of almost go back to where I was although I don’t think I could ever, like I mean, barring another shitty event like that, um I don’t think I could ever really fully submerge myself back into what it was like back then but that song kind of provides a little bit of a bridge to that time [right] and in that I think it, it really reminds me like, you might be having a shitty day today but you had shitty days that were unlike anything anyone should ever fathom”
- Tamara: “Yeah, totally, bring me back. So I can hear a song – oh yeah there’s a memory there – so it’s almost like certain songs are almost like for a me a photo album [yeah] of memories [okay] good and bad! You can hear a song and ugh! You know, and you can feel it in your body and everything and you’re right there”

6. To Feel Validated

Participants described using music to feel validated by the performance.

Participants described music mirroring their own experiences or feelings, leaving them

feeling validated or understood in relation to their traumatic experiences. (Validated initially by two participants, then endorsed by three after final check).

- Sarah: “And they were honest. Like I felt, some sort of, I don’t know, genuine spirit out of [okay] out of the songs and the lyrics and it just, it felt very real to hear, or it felt validating to know that other people had issues and that other people had feelings”
- Tamara: “Yeah, and I used it to... I really connected with it. Like, I think of songs that I connected with the lyrics, like yeah, that’s exactly how I feel, like almost like that validation”

7. To Daydream or Fantasize

Participants described using music to facilitate daydreams to counteract the impact of the traumatic event. These daydreams were positive feelings of strength, love, and happiness. (Validated initially by two participants, and remained at two endorsements after final check).

- Tamara: “Yeah, it’s almost like, little girls who watch Cinderella and all those fairy tales and you’re just like, oh... and for me I would listen to this music and that would be my Cinderella, like, oh, wouldn’t it be nice if I had a prince charming who thought that you know”
- Roaa: “I’m a little bit of a daydreamer, and I like using music as a facilitator [mhmm] for the daydreams and so I think that that song really could kind of bring me to like chill, like I’m floating down a river on a, on an innertube or um I’m at a barbecue at my friend’s house and like [mhmm] you know I can almost taste the veggie dog and Corona you know that kind of like, it just really facilitated a lot of

um... positive, but soothing [mhmm] um, thoughts and you know those daydreams, [the song] really kind of facilitated that nicely”

Chapter Summary

This chapter has described the themes that emerged during the thematic analysis process supporting by participants’ quotes. What follows is an in-depth examination of these findings in comparison to existing literature as well as an explication of the results.

CHAPTER 5: DISCUSSION AND CONCLUSION

Introduction

This chapter will explore the unique contributions of the present study to the current body of literature as well as how this study's findings support and extend the previous literature. Following this will be a discussion on the strengths and limitations of the study. Then researcher context in respect to the current study's findings will be addressed, as will implications for future research, and implications for the field of counselling. The chapter will end with a final summary and conclusion.

Findings in Relation to Previous Literature

The results of this study, as described in Chapter 4, illustrate that participants used music as part of their healing journey from trauma. The current study fills a gap in the literature, as described in Chapter 2 and, although causality cannot be established, this study may be the starting point that informs the literature on individuals' subjectively reported experiences of music as part of their healing and may act as the basis for further, empirical research.

Many of the ways the participants described using music were to alleviate or lessen many of the symptoms that are described by the DSM-IV-TR as criteria for PTSD (p. 468): psychological distress related to the traumatic event, recurrent and intrusive recollections of the event, physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event, and feelings of detachment. The themes related to these symptoms are "To Emotionally Regulate" (which is the super-ordinate theme for "To Soothe and Calm" and "To Feel Energized, Uplifted, Up") and "To Connect to People".

*Unique Findings of the Present Study**To Cope*

Participants described using music “to cope” in situations where they felt stuck and unable to remove themselves; this is not a concept discussed in trauma therapy literature, though it is discussed at length in the coping and stress literature. The unique position of listening to music as a passive activity may lend itself to this specific use; indeed, participants described only needing to press play or put the song on repeat over and over to use music in this part of their healing. The little amount of energy required to use music in this manner may allow individuals who are physiologically and emotionally spent to, at a minimum, stave off losing whatever energy they have left to be able endure the situation. Literature on coping (Folkman et al., 1986; Lazarus, 1999; Lazarus & Folkman, 1984) often discusses stress and coping with little mention of the notion of “trauma” as described in the current study and previous incarnations of the DSM. Furthermore, the body of literature on trauma does not address the possible role of coping in relation to trauma *healing* or trauma therapy, though much research exists on maladaptive coping of individuals from traumatic events (Filipas & Ullman, 2006; Littleton, Horsley, John, & Nelson, 2007; Victorson, Farmer, Burnett, Ouellette, & Barocas, 2005). The present study’s finding that traumatized individuals use music to “cope” indicates that neither the trauma literature nor the stress and coping literature shows the full picture; clearly the chasm between the two topic areas needs to be further bridged in order to gain a fuller understanding not only of “coping” but of “trauma” and “stress” as well.

To Disconnect from People

Three participants described using music to intentionally disconnect from people. No literature exists relating using music in this way, nor does any therapy or literature on trauma discuss disconnecting from others as part of the healing process. The literature described throughout the current study, in fact, states the opposite – that feeling estranged from others is a symptom of PTSD and has a negative impact on the individual (DSM-IV-TR, 2000). Perhaps the specificity of how music is used, specifically with headphones while surrounded by people describes a way the participants adapted to being in public while feeling overwhelmed by others, as well as by memories and feelings connected to their traumas. It is interesting to note that only one participant endorsed using music to both connect and disconnect from people and it would be of interest to specifically research this question in more depth. This overlapping participant also described herself as having social anxiety caused by her traumatic experiences; perhaps being able to decide when and where she connected with people helped alleviate her anxiety and distress.

To Feel Energized, Uplifted, Up

De Nora's work (1986; 1999) shows a common motivation her participants described using music for was to become happier and more energetic. There is no research on using music to increase energy or mood for trauma therapy, though Schmidt and Trainor (2001) and Tsang et al. (2001) show that listening to happy music is associated with a shift to greater relative left frontal cortical activation, indicating a brain-based shift in (or induction of) affect. It is important to note that the music, as participants described it during the interviews, would likely be labeled as "happy" or at least in the

major, “happy” tonality, such as Neil Diamond’s “America” or Bedouin Sound Clash’s “When the Night Feels My Song.” Musical trauma therapies (like the Bonny Method) focus on processing traumatic memories rather than lessening symptoms or supporting clients in changing mood. The present study’s findings show that music’s ability to change affect from a low mood to a happier, more energetic mood was helpful and was part of the participants’ healing journeys.

Findings Supported by Previous Literature

To Soothe or Calm

Much research finds that people use music to soothe or calm themselves. McKinney et al. (1997) described the Bonny Method of GIM as guided musical relaxation, and the study by Chou and Lin (2006) show music induces relaxation. De Nora (1986; 1999) described participants using music to change their mood, one of which was to a more calm state. There is also much anecdotal and historical knowledge to substantiate this finding (Levitin, 2008).

Affect regulation (the ability to intentionally increase some internal feelings while decreasing others) is considered an important skill for people who have experienced trauma to learn during therapy. A particularly important skill trained up in therapy is to induce relaxation when feeling overwhelmed or physiologically aroused (Briere & Scott, 2006; Herman, 1997). The current study’s findings demonstrate that music helped the participants regulate their emotional states and more specifically, to intentionally induce relaxation.

To Connect to People

As stated earlier, the DSM-IV-TR describes the difficulty in connecting with people as a common effect of trauma (2000). Briere and Scott (2006) state that relational disturbances are common among those with “earlier childhood maltreatment” (p. 153). The three participants who endorsed and gave supporting quotes for this theme described their traumatic experiences as involving childhood physical, emotional, and sexual abuse between the ages of approximately four years of age (but may have been earlier but no memories existed before that age) to twelve years of age. The other two participants, who did not endorse this theme, described traumatic events that occurred in their late teens and early twenties. We cannot assume that this constitutes evidence that music is effective therapy for early childhood trauma, but that more research is warranted in this area. Bensimon et al.’s 2008 study showed an increased sense of connection to other group members through drumming together; participants who endorsed this theme described playing the music while feeling connected to others, and that the music playing was instrumental in feeling connected.

*Notable Categories of Responses**As a Way to Return to the Past*

Four participants eventually endorsed this category of response as part of their healing with music. Herman (1997) describes the second phase of the tri-phasic model as “remembrance and mourning”, and while this notable category does not discuss mourning specifically, mourning often involves the revisiting of past memories. The supporting quotes for this category of response describe using music to also return to

positive memories; whether this is also related to “remembrance and mourning” is also not clear. What *is* clear is the need for this finding to be specifically investigated.

To Feel Validated

When directly asked, this notable category of response received three endorsements during the final participant check. As described in Chapter 2, the work of Ahrens (2006) describes the importance of positive social responses for the person who experienced trauma to support healing. The participants who contributed quotes to this response category described feeling unsupported or unworthy of support from the community around them, and that the music would give them the validation of their experiences they were looking for. Considering the importance of this validation, and the possibility that many individuals who have experienced trauma will not receive validation, music may play a crucial role in feeling understood and validated by an external experience.

To Daydream or Fantasize

This notable category remained at only two endorsements when participants were directly asked if they could endorse it. The notable category is similar to the Bonny Method of GIM for trauma (Blake & Bishop, 1994; Johnson et al., 2009) with its focus on imagery that emerges while the client’s mind wanders while listening to music. This category did not receive a majority of endorsements and while interesting, does not represent the experiences of the present study’s participants. The daydreams and fantasies described by the participants who did endorse this category focused on who they could be or the life they could have without the traumatic event impacting them, rather than focus on past experiences as does the Bonny Method.

Researcher Context

As described in previous chapters, I had a number of assumptions and beliefs regarding what I would find during this investigation. I expected to find similarities between how participants used music to heal from trauma and what trauma therapists do in helping clients deal with trauma. I expected to find differences between those who listen to music, perform music, and write music although I was not able to explore these differences given that the majority of participants only listened to music, and only one did any kind of music writing. Throughout Chapter 2, I described the stability and tension within music itself, and expected that this feature of music may come into play with participants describing using music to increase an uncomfortable or distressing feeling related to the trauma, and then to release it as the music returns to a stable tonality. None of the participants were formally trained in music as I am, and this expectation was not fulfilled. The expectation is directly related to my own training and education in musical theory and rhetoric and is more emblematic of my own experiences with trauma and music, rather than that of my participants. Research on the Bonny Method of GIM music therapy (Blake & Bishop, 1994; Johnson et al., 2009) also describes using music's inherent tension and stability for therapeutic ends. This therapeutic modality is of course lead by the counsellor, who is musically trained. Unless previously trained and educated, the average person who uses music to heal from trauma will most likely not be aware of the underlying structure of the music and then intentionally use this structure in their healing.

One finding that arose from the current study's findings that I did not expect is using music to "cope" in a situation in which participants felt stuck and needed to "get

through”. None of the trauma literature addressed this and, while it could be argued that the theme of coping is similar to the first stage (safety) of the tri-phasic model of trauma therapy, I do not believe this to be so. Rather, the calming/soothing theme from the findings is more relevant to this first stage. “To Cope” as described by the participants here does not speak to calming, relaxation, or a decrease in physical activation, all of which link “To Soothe or Calm” to the “safety and stabilization” phase. Rather it simply speaks to “getting through” a troubling time, which is very different from inducing a state of relaxation and calm.

Mechanisms or therapeutic targets associated with therapies described in Chapter 2 (e.g., narrative, EMDR and exposure therapy) and used for stage two of the tri-phasic model, were not supported by and do not correspond with the present study’s findings. This is most likely due to my education in counselling as I held a bias that the participants would create their healing much in the same way established therapies encourage healing.

Strengths and Limitations of the Present Study

As discussed throughout this chapter, many of the findings of this study are not discussed in previous literature. The investigation of this relatively unexplored area is the main strength of the present study. The depth of the study’s findings allowed by the qualitative nature of the study is another strength and points to a number of future research possibilities discussed in detail later in this chapter. Lastly, the present study’s focus on how participants used music *themselves*, as opposed to researching how an established therapeutic modality impacted the participant’s healing, offers a unique view into how individuals affect their own healing from trauma.

Due to the qualitative methodology of the study, which allowed for depth in the results by using a bottom-up approach and providing descriptive data, some limitations do need to be taken into account.

The nature of the recruitment limited possible participants in many ways. First, posters were the only form of recruitment; therefore only people with a certain level of literacy were able to consider participation. Posters were displayed in a rather limited area, which also decreased the amount of people who would know about the study: the University of Victoria, Camosun College, and the Victoria Conservatory of Music. Four of the participants held or were working towards undergraduate degrees while the fifth participant was working towards a specialized, post-secondary diploma. In light of the limited poster locales, it follows that individuals with higher educations would be most likely to participate. As most of the participants were students (with one participant who was an artist) the applicability of these findings is limited to these participants; as such the transferability of the findings from this homogenous group is somewhat limited. All of my participants were able to reflect on their experiences, not only during the interview, but during their healing as well. Many described a healing experience which they then attributed to the music to which they were listening to and from there learned how best to use music in their future healing. These individuals were also able to, when seeing the recruitment poster, reflect on how this fit with their own experience and then decide to contact me. These traits may be unique to only a certain segment of the population, and must be acknowledged as possible limitations.

The small participant number, which is in line with qualitative methodology, does not lend itself to findings being generalized to the larger population of people who have

experienced trauma. Quantitative research developed from these current findings, with a larger sample would allow for more generalizability, and provide more data to support the present findings.

Another factor to be taken into account when considering the present study's findings is the process of self-selection for study participation. As volunteers, all the participants felt they had the time and energy to be part of the study, which may be reflected in their ability and time to reflect on the research question. I can imagine that people who were stressed out, overworked, or in any other kind of distress did not choose to participate and their experiences are not reflected in the findings. Along with this self-selection factor is the exclusion of some possible participants during the phone interviews, as described in Chapter 3. Excluding participants according to the study's criteria followed my ethical and methodological guidelines, but it also further narrowed the diversity of participants, along with the limited locations in which I put up posters.

As a relatively inexperienced interviewer who may have appeared nervous or novice, the participants may have wanted to "help" me by agreeing with my perception checks when I was in fact not correct, or perhaps to "shield" me from negative stories or details of their trauma experiences. Furthermore, it is also possible the participants chose to leave out details they did not feel safe or comfortable sharing.

Lastly, my own inexperience as a primary researcher using qualitative methodologies such as narrative interviews, coding, and theme development, is a limitation as well. To minimize this, I took graduate-level courses in research methods as well as pilot-tested the interviewing process. The methods and procedures were also closely supervised by qualified and experienced faculty members. The validation

processes I incorporated (member checking and auditability measures) add to the credibility of the current study's findings.

Recommendations for Future Research

Some recommendations for future research have been described throughout this chapter in the discussion on the findings in relation to previous literature. In conducting and completing the present study, I have become aware of a number of gaps in the current study's focus and I have become aware of different questions to ask that will expand upon the role of music for people's healing journey from trauma.

Firstly, due to the exclusion of people who contacted me who had experienced *depression* and not trauma, but who had used music to heal themselves, I suggest this as a possible topic for future research. Depression and trauma have relatively high rates of comorbidity (Briere & Scott, 2006) and it is possible the ways to heal depression may be similar to the ways to heal from trauma; this connection could be investigated. Furthermore, much of the participants' transcripts described how music affected their healing or how music had healed them with no intentional acts or decisions made on the participants' parts to create healing *at that moment*. For example, participants spoke about how listening to a song or being at a concert created spontaneous changes of feelings or shifts in perceptions, but that their intention in going to the concert was not an intentional act of healing, but was a social act, or simply for the intent to enjoy the music. These parts of the interview did not answer the research question so were not developed into themes. Additionally, since no participants in the current study were professional musicians and only one wrote songs or played an instrument, speaking directly to professional musicians may expand our understanding of how individuals use music to

heal from trauma. None of the literature explored in Chapter 2 in relation to music's tonality, disruption, and return to tonality was expressed or mentioned by participants, most likely due to their lack of musical knowledge. Speaking to individuals who perform music and/or do extensive composing for their healing would also expand our understanding of this phenomenon and may differ from the current study's participants substantially. Finally, as the current study relied on the reflexivity and memory of the participants to describe their experiences, it would be fruitful to research how music could possibly be used as part of crisis intervention shortly after a traumatic event has occurred as a more immediate therapeutic intervention by crisis teams or front line crisis workers. Due to music's impact physiologically as described in the present study's literature review, (Chou & Lin, 2006; Crowe, 2004; Sutton, 2002) music may be uniquely effective in these situations. This of course has ethical considerations which need to be taken into account. Chosen music may already have a specific meaning to the individual in crisis, and this may be at psychological odds with the situation (i.e. the song played is the song to which they walked down the aisle at their wedding). This example could possibly support one individual (bring them mentally to a warm, loving memory) or forever taint the memory of their wedding to the present traumatic event. Music's ability to change meaning and memory in an individual cannot be taken lightly and research in this area would need to be carefully considered.

Implications for the Field of Counselling Psychology

The current study was born out of my desire to contribute to counselling psychology's understanding of trauma and the possible role music can play in trauma therapy. First, therapists would do well to ask trauma clients about the role of music in

their lives, to see if music could be a possible therapeutic intervention for emotional/affect regulation or reconnection with life, and to support clients in attempting to feel connected to others when not in session (i.e. “on their own”). As a passive experience, trauma clients do not have to exert any energy, learn a new skill or remember anything beyond pressing “play” in order to begin using music for their healing – for those who are highly triggered, distressed and unable to remember how to ground, it may be able to bring them down to a point where they can ground in other ways or go on with their day, which are both important aspects of trauma therapy as described by Herman (1997) and Briere and Scott (2006). As well, beyond the specifics of trauma counselling or therapy, more general therapies could be enhanced by using music as an emotional regulator when clients are not in session and a way to generally connect to (or disconnect from) others. Lastly, the specific question of the present study, of using music as part of one’s healing journey, and the fact that five people spoke to me about how they used music for the described purposes, is a strong reminder to all practitioners to explore the strengths and wisdom our clients may already possess, and who simply need support to be reminded of.

Summary and Conclusion

Little research has been done on music’s impact on trauma survivors, with none looking at how individuals have use music as part of their healing. Therefore, the current study helps illuminate previously unexplored territory. The current study supports previous work on how individuals use music in their everyday lives as well as the effects music can have on a traumatized individual’s body, thoughts, feelings, and behaviour.

During the thematic analysis, four themes (one with two sub-themes) were developed and endorsed by at least three out of the five participants. Three notable categories of responses were also developed but did not reach the threshold for thematic inclusion. This study's findings indicate that people who have experienced trauma describe using music as part of their personal healing journey in a number of different areas of their lives.

Bibliography

- Aamodt, A.M. (1982). Examining ethnography for nurse researchers. *Western Journal of Nursing Research, 4*, 209-220.
- Ahrens, C.E. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *The American Journal of Community Psychology, 38*, 263-274. doi: 10.1007/s10464-006-9069-9
- American Psychiatric Association (1980). *Diagnostic and statistic manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, DC: Author.
- Barber, K. (ed.) (2004). *Canadian Oxford Dictionary*. Don Mills, Ont: Oxford University Press Canada.
- Baker, B. (2006). Art speaks in healing survivors of war: The use of art therapy in treating trauma survivors. *Journal of Aggression, Maltreatment and Trauma, 12*, 183-198.
- Bensimon, M., Amir, D., & Wolf, Y. (2008). Drumming through trauma: Music therapy with post-traumatic soldiers. *The Arts in Psychotherapy, 35*, 34-48. doi: 10.1016/j.aip.2007.09.002
- Bircher, J. (2005). Towards a dynamic definition of health and disease. *Medicine, Health Care and Philosophy, 8*, 335-341. doi: 10.1007/s11019-005-0538-y
- Black, T. G. (2004). Psychotherapy and outcome research on PTSD: Understanding the

- challenges and complexities in the literature. *Canadian Journal of Counselling*, 38(4), 277-288.
- Black, T.G. (2008). Applying AQAL to the quantitative/qualitative debate in social sciences research. *Journal of Integral Theory and Practice*, 3(1), 1-14
- Blake, D.D., Weathers, F.W., Nagy, L.M., Kaloupek, D.G., Gusman, F.D., Charney, D.S., et al. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress*, 8, 75-90.
- Blake, R.L., & Bishop, S.R. (1994). The Bonny Method of Guided Imagery and Music (GIM) in the treatment of post-traumatic stress disorder (PTSD) with adults in a psychiatric setting. *Music Therapy Perspectives*, 12(2), 125-129.
- Bonny, H.L. (1993). Body listening: A new way to review the GIM tapes. *Journal of the Association for Music and Imagery*, 2, 3-13.
- Bovin, M.J., Jager-Hyman, S., Gold, S.D., Marx, B.P., & Sloan, D.M. (2008). Tonic immobility mediates the influence of peritraumatic fear and perceived inescapability on posttraumatic stress symptom severity among sexual assault survivors. *Journal of Traumatic Stress*, 21(4), 402-409. doi: 10.1002/jts.20354
- Boyatzis, R. (1998). *Transforming qualitative information*. Thousand Oaks, CA: Sage Publications.
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *The American Journal of Psychiatry*, 162(2), 214-227.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment*. Thousand Oaks, CA.: Sage Publications.
- Brisch, K. (2002). *Treating attachment disorders: From theory to therapy*. New York, NY: Guildford Press.
- Brown, D.P., & Fromm, E. (1986). *Hypnotherapy and hypnoanalysis*. Hillsdale, NJ: Lawrence Erlbaum.
- Brown, S., Martinez, M.J., & Parsons, L.M. (2006). Music and language side by side in the brain: A PET study of the generation of melodies and sentences. *European Journal of Neuroscience*, 23, 2791-2803. doi: 10.1111/j.1460-9568.2006.04785.x
- Bruner, J. (1987). Life as narrative. *Social Research*, 54(1), 11-32.
- Buss, K.A., Malmstadt Schumacher, J.R., Dolski, I., Kalin, N.H., Goldsmith, H.H., & Davidson, R.J. (2003). Right frontal brain activity, cortisol, and withdrawal behavior in 6-month-old infants. *Behavioral Neuroscience*, 117(1), 11-20. doi:10.1037/0735-7044.117.1.11
- Carey, L. (2006). *Expressive and creative arts methods for trauma survivors*. London: Jessica Kingsley Publishing.
- Cavarero, A. (2000). *Relating narratives: Storytelling and selfhood*. New York, NY: Routledge.
- Chantler, A. (2002). Revisiting E.T.A. Hoffmann's musical hermeneutics. *International Review of the Aesthetics and Sociology of Music*, 33(1), 3-30.
- Chase, S. (1995). Taking narrative seriously: Consequences for method and theory in interview studies. In R. Josselson, & A. Lieblich (Eds.), *Interpreting experience:*

- The narrative study of lives vol. 3* (pp. 1-26). Thousand Oaks, CA: Sage Publications.
- Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N.K. Denzin, & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 651-679). Thousand Oaks, CA: Sage Publications.
- Chou, M., & Lin, M. (2006). Exploring the listening experience during guided imagery and music therapy of outpatients with depression. *Journal of Nursing Research*, *14*(2), 93-102.
- Cooke, D. (1960). *The language of music*. New York, NY: Oxford University Press.
- Corey, G. (2009). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Thomson Brooks/Cole.
- Craske, M.G. (1999). *Anxiety disorders: Psychological approaches to theory and treatment*. Boulder, CO: Westview.
- Creston, P. (1970). Music and mass media. *Music Educators Journal*, *56*(8) 35-106.
- Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.
- Crossley, M.L. (2000) *Introducing narrative psychology: Self, trauma and the construction of meaning*. Philadelphia, PA: Open University Press.
- Crowe, B. (2004). *Music and soul making: Toward a new theory of music therapy*. Lanham, MD: Scarecrow Press.
- Csiernik, R. (2002). An overview of employee and family assistance programming in Canada. *Employee Assistance Quarterly*, *18*(1), 17-33.
- doi: 10.1300/J022v18n01_02

- DeNora, T. (1986). How is extra-musical meaning possible? Music as a place and space for “work”. *Sociological Theory*, 4(1), 84-94. Retrieved from <http://www.jstor.org/stable/202107>
- DeNora, T. (1999). Music as a technology of the self. *Poetics*, 27, 31-56.
- Exaptations. (n.d.). In *Nature glossary online*. Retrieved from http://www.nature.com/nrg/journal/v4/n4/glossary/nrg1041_glossary.html
- Filipas, H.H., & Ullman, S.E. (2006). Sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence*, 21(5), 652-672. doi: 10.1177/0886260506286879
- Foa, E.B., Keane, T.M., Friedman, M.J., & Cohen, J.A. (eds.) (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies, 2nd edition*. New York, NY: The Guilford Press.
- Foa, E., Riggs, D., Dancu, C., & Rothbaum, B. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*, 6, 459-474.
- Folkman, S., Lazarus, R.S., Gruen, R.J., & DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology*, 50(3), 571-579.
- Follette, V., Palm, K.M., & Pearson, A.N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 24(1), 45-61.
- Foy, D.W., Schnurr, P.P., Weiss, D.S., Wattenberg, M.S., Glynn, S.M., Marmar, C.R., & Gusman, F.D. (2001). Group Psychotherapy for PTSD. In J.P. Wilson, M.J.

- Friedman & J.D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 183-202). New York, NY: The Guilford Press.
- Frank, A.W. (1998). Stories of illness as care of the self: A Foucauldian dialogue. *Health, 2*(3), 329-348.
- Goldstein, A. (1980). Thrills in response to music and other stimuli. *Physiological Psychology, 8*, 126-9.
- Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review Paper, 29*, 75-91.
- Gunter, R.W., & Bodner, G.E. (2008). How eye movements affect unpleasant memories: Support for a working-memory account. *Behavior Research and Therapy, 46*, 913-931. doi:10.1016/j.brat.2008.04.006
- Harned, M.S., & Linehan, M.M. (2008). Integrating dialectical behavioural therapy and prolonged exposure to treat co-occurring borderline personality disorder and PTSD: Two case studies. *Cognitive and Behavioral Practice, 15*, 263-276.
- Harper, D. (n.d.). Heal. In *Online Etymology Dictionary*. Retrieved from <http://www.etymonline.com/index.php?term=heal>
- Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Hollister, D. (2004). Music. In *Ezine @rticles online*. Retrieved from <http://ezinearticles.com/?Top-50-Music-Quotations&id=5069>
- Johnson, D.R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7-13.
- Johnson, D.R., Lahad, M., & Gray, A. (2009). Creative therapies for adults. In E.B. Foa, T.M. Keane, M.J. Friedman, & J.A. Cohen (Eds.), *Effective treatments for PTSD:*

Practice guidelines from the international society for traumatic stress studies (pp. 479-490). New York, NY: The Guilford Press.

Kirmayer, L.J., Lemelson, R., & Barad, M. (2007). Introduction: Inscribing trauma in culture, brain, and body. In L.J Kirmayer, R. Lemelson, & M. Barad (Eds.), *Understanding trauma: Integrating biological, clinical, and cultural perspectives* (pp. 1-20). Cambridge, UK: Cambridge University Press.

Kleinginna, P.R., & Kleinginna, A.M. (1981). A categorized list of emotion definitions, with a suggestion for a consensual definition. *Motivation and Emotion*, 5, 345-371.

Krefting, L. (1990). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45(3), 214-222.

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage Publications.

Lapadat, J., & Lindsay, A. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry*, 5, 64-86. doi: 10.1177/107780049900500104

Lazarus, R. (1999). *Stress and emotion: A new synthesis*. New York, NY: Springer Publishing.

Lerner, P., & Micale, M. (2001). Trauma, psychiatry, and history: A conceptual and historiographical introduction. In M. Micale, & P. Lerner (Eds.), *Traumatic pasts: History, psychiatry and trauma in the modern age, 1870-1930* (pp. 1-27) Cambridge, UK: Cambridge University Press.

Levitin, D.J. (2006). *This is your brain on music*. Toronto, Ont: Penguin Group.

- Levitin, D.J. (2008). *The world in six songs*. Toronto, Ont: Penguin Group.
- Lieberman, A.F., & Knorr, K. (2007). The impact of trauma: A developmental framework for infancy and early childhood. *Psychiatric Annals*, 37(6), 416-422.
- Littleton, H., Horsley, S., John, S., & Nelson, D.V. (2007). Trauma coping strategies and psychological distress: A meta-analysis. *Journal of Traumatic Stress*, 20(6), 977-988.
- MacNair, R.M. (2002). *Perpetration-induced traumatic stress: The psychological cost of learning to kill in war and society*. Boston, MASS: Little, Brown.
doi: 10.1080/1040265022011822 4
- Marie, A. (2009, May 11). Rape is not synonymous with anything difficult [Community posting]. Retrieved from http://community.feministing.com/2009/05/11/rape_is_not_synonymous_with_an/
- McKinney, C.H., Antoni, M.H., Kumar, M., Tims, F.C., & McCabe, P.M. (1997). Effects of guided imagery and music (GIM) therapy on mood and cortisol in healthy adults. *Health Psychology*, 16(4), 390-400.
- McMullen, E., & Saffran, J.R. (2004). Music and language: A developmental comparison. *Music Perception*, 21(3), 289-311.
- Merscham, C. (2000). Restorying trauma with narrative therapy: Using the phantom family. *The Family Journal: Counselling and Therapy for Couples and Families*, 8(3), 282-286. doi: 10.1177/1066480700083013
- Meyer, L.B. (1956). *Emotion and meaning in music*. Chicago, IL: Chicago University Press.

- Micale, M., & Lerner, P., (eds.). (2001). *Traumatic pasts: History, psychiatry and trauma in the modern age, 1870-1930*. Cambridge, UK: Cambridge University Press.
- Mishler, E.G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.
- Morrow, M., Hankivsky, O., & Varcoe, C. (2004). Women and violence; The effects of dismantling the welfare state. *Critical Social Policy*, 34(3), 358-384.
doi: 10.1177/0261018304044364
- Music. (n.d.). In *Brainyquote online*. Retrieved from http://www.brainyquote.com/quotes/topics/topic_music.html
- Music. (2010, September 9). In *The Quote Garden online*. Retrieved from <http://www.quotegarden.com/music.html>
- Narmour, E. (1990). *The analysis and cognition of basic melodic structures*. Chicago, IL: University of Chicago Press.
- National Association for Music Therapy. (1983). *Standards of clinical practice*. *Music Therapy Perspectives*, 1(2), 13-16.
- Ochs, E. (1979). Chapter 3: Transcription as theory. In E. Ochs, & B.B. Schieffelin (Eds.), *Developmental pragmatics* (pp. 43-71). New York, NY: Academic Press.
- Orth, J., Doorschodt, L., Verburgt, J., & Drozdek, B. (2004). Sounds of trauma: An introduction to methodology in music therapy with traumatized refugees in clinical and outpatient settings. In J. Wilson, & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 443-480). New York, NY: Brunner/Routledge.

- Peretz, I. (2001). Listen to the brain: A biological perspective on musical emotions. In P.N. Juslin, & J.A. Sloboda (Eds.), *Music and emotion: Theory and research* (pp. 105-134). Oxford, UK: Oxford University Press.
- Polkinghorne, D.E. (1988). *Narrative knowing and the human sciences*. New York, NY: State University of New York Press.
- Prochaska, J.O. & DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390-395.
- Prochaska, J.O. & DiClemente, C.C. (1993). In search of how people change: Application to addictive behaviors. *Journal of Addictions Nursing, 5*(1), 2-16.
- Redding, R.E., Herbert, J.D., Forman, E.M., & Gaudiano, B.A. (2008). Popular self-help books for anxiety, depression and trauma: How scientifically grounded and useful are they? *Professional Psychology: Research and Practice, 39*(5), 537-545.
doi: 10.1037/0735-7028.39.5.537
- Rogers, S., & Silver, S.M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology, 58*(1), 43-59.
- Rosen, C. (1988). *Sonata forms*. New York, NY: W.W. Norton & Company.
- Rosen, C. (1997). *The classical style: Haydn, Mozart, Beethoven*. New York, NY: W.W. Norton & Company.
- Runtz, M.G., & Schallow, J.R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect, 21*(2), 211-226.
- Sacks, O. (2007). *Musicophilia*. Toronto, Ont: Vintage Canada.

- Scaer, R.C. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York, NY: W.W. Norton & Company.
- Schauer, M., Neuner, F., & Elbert, T. (2005). *Narrative exposure therapy*. Toronto, Ont: Hogrefe & Huber.
- Schiffer, F., Teicher, M.H., & Papanicolaou, A.C. (1995). Evoked potential evidence for right brain activity during the recall of traumatic memories. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 7, 169-175.
- Schindler, A. (1966) *Beethoven as I knew him*. (D.W. McArdle, Trans.). New York, NY: Norton. (Original work published in 1840).
- Schmidt, L.A., & Trainor, L.J. (2001). Frontal brain electrical activity (EEG) distinguishes valence and intensity of musical emotions. *Cognition and Emotion*, 15(4), 487-500.
- Seidler, G.H., & Wagner, F.E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine*, 35, 1515-1522.
- Selye, H. (1956). *The stress of life*. New York, NY: McGraw-Hill.
- Sgroi, S.M. (1989). Stages of recovery for adult survivors of child sexual abuse. In A.M. Sgroi (Ed.), *Vulnerable populations*, vol. 2. (pp.111-130). New York, NY: Lexington Books.
- Shalev, A. (2000). Measuring outcome in posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 61, 33-39.

- Shapiro, F. (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy & Experimental Psychiatry*, 20, 211-217.
- Sloboda, J.A. (1991). Music structure and emotional response: Some empirical findings. *Psychology of Music*, 19, 110-120.
- Sloboda, J.A. (1992). Empirical studies of emotional response to music. In M. Riess-Jones, & S. Holleran (Eds.), *Cognitive bases of musical communication*, (pp. 33-46). Washington, DC: American Psychological Association.
- Sloboda, J.A. (2000). Musical performance and emotion: Issues and developments. In S.W. Yi (Ed.), *Music, mind, and science* (pp. 220-238). Seoul, Korea: Western Music Research Institute.
- Sloboda, J.A., & Juslin, P.N. (2001). Psychological perspectives on music and emotion. In P.N. Juslin, & J.A. Sloboda (Eds.), *Music and emotion: Theory and research* (pp. 71-104). Oxford, UK: Oxford University Press.
- Spates, C.R., Koch, E., Cusack, K., Pagoto, S., & Waller, S. (2009). Eye movement desensitization and reprocessing. In E.B. Foa, T.M. Keane, M.J. Friedman, & J.A. Cohen (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp.279-305). New York, NY: The Guilford Press.
- Stewart, C.L., & Wrobel, T.A. (2009). Evaluation of the efficacy of pharmacotherapy and psychotherapy in treatment of combat-related post-traumatic stress disorder: A meta-analytic review of outcome studies. *Military Medicine*, 174(5), 460-469.
- Storr, A. (1992). *Music and the mind*. St. Louis, MO: MMB Music.

- Sutton, J.P. (2002). *Music, music therapy and trauma: International perspectives*. London, UK: Jessica Kingsley Publishers.
- Temperley, N. (1971). The “Symphonie Fantastique” and its program. *The Musical Quarterly*, 57(4), 593-608.
- Thomas, E. (n.d.) *Are your quilting supplies making your life easier or harder?* Retrieved from <http://www.beginners-quilting.com/quilting-supplies.html>
- Tsang, C.D., Trainor, L.J., Santesso, D.L., & Tasker, S.L. (2001). Frontal EEG responses as a function of affective musical features. *Annals of the New York Academy of Sciences*, 930(1), 439-442.
- Van der Kolk, B.A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Background and experimental evidence. *Journal of Traumatic Stress*, 8, 505-525.
- Van Etten, M.L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology and Psychotherapy*, 5, 126-144.
- Victorson, D., Farmer, L, Burnett, K., Ouellette, A., & Barocas, J. (2005). Maladaptive coping strategies and injury-related distress following traumatic physical injury. *Rehabilitation Psychology*, 50(4), 408-415. doi: 10.1037/0090-5550.50.4.408
- Volkman, S. (1993). Music therapy and the treatment of trauma-induced dissociative disorders. *The Arts in Psychotherapy*, 20, 243-251.
- Wilber, K. (1999). *The marriage of sense and soul: Integrating science and religion*. New York: Broadway Books.
- Wilber, K. (2007). *A brief history of everything*. Boston, MASS: Shambhala.

Wilson, J.P., Friedman, M.J., & Lindy, J.D. (Eds.) (2001). *Treating psychological trauma and PTSD*. New York, NY: The Guilford Press.

Yalom, I. (2002). *The gift of therapy*. New York, NY: HarperCollins.

Appendix A: Phone Conversation Script

The following is an example of the script to be used when participants (P) initiate contact with the primary researcher, Tracey Coulter (TC); exact wording and order may change slightly depending on participants' responses:

TC: "Thank you for taking the time to call. Can I tell you a bit more about this study before we talk about setting up an interview time?"

P: "Sure"

TC: "First, just to help me get an idea of what you might have experienced, do you mind telling me in very general terms what experience with trauma you had that you feel comfortable being interviewed about?"

P: "I was in a car crash five years ago."/"I caught my partner cheating on me"

TC: "Thanks for sharing with me. That is the kind of experience I am looking to talk to people about in my study. Can I tell you a bit more about the study?"/"That sounds like it was a painful experience for you. Unfortunately, I'm looking to specifically talk with people who have experienced situations where they felt their lives or the lives of others were in danger. I really appreciate the time you took to contact me."

P: "Sure." or "Actually, no thanks."/"Oh, okay."

TC: "This study is trying to get a better understanding of how people who have experienced trauma have used music as part of their healing on their own, without seeing a music therapist. The interviews will be taped, and there will be lots of room for you to tell me the story of your experience in the way that you wish to do so. I also want to let you know in case you were not aware, there will be two interviews. The first one is expected to take about an hour to two hours, and the second is expected to take up to another hour, so your total time will be up to three hours. How does all this sound to you?"

P: "That sounds okay to me." or "I actually did work with a music therapist."/"I think that's going to be too much for me to be able to do right now."

TC: "Would you like to go ahead and set up the first interview?" or "Thanks for letting me know that. My study is to talk to people who have used music on their own. I really appreciate the time you took to contact me."/"Would you rather not participate?"

P: "Sure."/Yes, I think I would rather not"

TC: "Great. We can meet at UVic in a private room for recording the interview." "That's not a problem at all. I really appreciate you taking the time to phone me."

P: "UVic would work for me."

TC: "What day/time would work for you this or next week?"

P: "I'm free on Thursday at 5:30"

TC: "I'm free then too. Thursday at 5:30, at [specific room location]. Do you have any other questions for me at all?"

P: "No, I think I'm fine for now."

TC: "Ok. Well, if anything comes up between now and when we meet, please feel free to give me a call. My home phone number is 250-893-3847. Thank you for taking the time to call and talk with me. I'm looking forward to meeting with you in person. I'll see you next Thursday at 5:30."

Appendix B: Recruitment Poster

Have you used music as part of your self-healing from trauma?

I would really like to hear from you.

My name is Tracey Coulter and I am doing my M.A. in Counselling Psychology at the University of Victoria.

I am interested in talking to people who have:

- 1) experienced a traumatic event more than two years ago, like a car accident, physical or sexual assault, or witnessing a severe injury or death where your or some one else's life or integrity were endangered and,
- 2) used any kind of music in any way as part of their self-healing, without using music therapy (other kinds of therapy are fine).

This kind of research is important in informing support services on ways to be effective and supportive when working with clients who have experienced trauma.

If the previous description sounds like you and you are willing to share your story with me, I would really appreciate hearing from you.

For more information or to schedule an interview, please contact Tracey Coulter, 250-893-3847



University
of Victoria

Appendix C: Interview Questions

Preamble:

Throughout this interview I'm going to be asking you to tell me your story about your experience of using music as part of your self-healing from trauma. Feel free to start your story at whatever point in your life that you think your story of this experience begins. Through the interview I will be asking clarification and prompting questions to make sure that I understand you, that you have said all you want to and if you need help in telling your story. We will know when we're done here today, which I will check with you before we finish up.

Potential prompts and clarifiers:

Do you mind telling me a bit more about...

How was it for you when...

Is this what you meant by ...

Do you mind repeating...

Additional questions to ask as necessary:

Why do you think you chose to use music in this way?

What other thoughts/feelings/behaviours were present in the story?

How does _____ fit into the larger story of your healing with music?

At the end of the interview:

Now that we have had some time to talk, have you told me your story? Do I know everything you want me to know so that this story feels finished to you?

Education Psychology and Leadership Studies
University of Victoria
PO Box 3010
Victoria, BC V8W 3N4

Participant Consent Form

Project Title: Healing Trauma with Music: A Qualitative Study on How People Have Used Music in Their Personal Healing Journey from Trauma

Researcher(s): Tracey Coulter, Graduate Student
 Faculty of Educational Psychology & Leadership Studies
 University of Victoria
 (250) 893-3847; tcoulter@uvic.ca

Supervisor: Dr. Tim Black
 Faculty of Educational Psychology & Leadership Studies
 University of Victoria
 (250) 721-7829; tblack@uvic.ca.

Purpose(s) and Objective(s) of the Research:

- Learn and understand more about how people who have experienced trauma used music as part of their self-healing journey
- This research will be personally asking participants, who experienced a traumatic event and used music as part of their self-healing from this, to describe the story of how this happened as well as what they see as music's unique role in this.
- To fulfill part of the requirements for the primary researcher's graduate degree

This Research is Important because:

- To help better inform how professionals who specialize in trauma work, to help support clients and expand possible resources for clients to perform some of the work on their own.

Participation:

- You are being asked to participate in this study because you experienced trauma no less than two years ago and have used music as part of your self-healing from this trauma
- Participation in this project is entirely voluntary.
- Whether you choose to participate or not will have no effect on your position [e.g. employment, class standing] or how you will be treated.

Procedures:

- You will be asked to think back and describe your experiences surrounding the traumatic experience as well as your use of music to heal from this
- The interview will consist of a few pre-scripted questions; however, the majority of the interview will be more open-ended to allow for freedom in responses.

- Interviews will be audio-taped for transcription purposes, and written notes may also be taken
- After this first interview, you will be asked to meet with me a second time when you will be given the opportunity to review how I interpreted what was said during the interview, and may add or change anything that does not fit with your experiences.
- **Duration: 1 ½ - 2 hours for initial interview; ½ - 1 hour for follow-up; 1 ½ - 3 hours total**
- **Location: University of Victoria**
- **Inconvenience: the time that you will be investing into coming and travelling to both interview sessions, and depending on your family situation, there may be a need to arrange child-care.**

Compensation:

- I will supply a mixed CD of “healing music” to all participants (whether they fully complete the necessary interviews or not) as way to show my appreciation for your time
- It is unethical for me to provide undue compensation or inducements to research participants.
If you would not participate if the compensation was not offered, then you should decline.

Benefits:

- Furthering understanding of how people heal from trauma on their own.
- Help better inform how current support services might work more effectively in supporting client who have experienced trauma.
- The opportunity to have your experiences heard and validated as important

Risks:

- It is anticipated that there will be minimal risks to you by participating in this research; however, due to the personal nature of the interviews, you may feel fatigued or stressed and/or experience emotional responses including embarrassment when discussing this time in your life
- **Risk(s) will be addressed by:** The primary researcher is a counsellor-in-training at the University of Victoria, as well as a trained crisis counsellor, and will be as sensitive as possible throughout the interview process. Either the participant or the researcher can stop the interview at any time if proceeding with the interview may be harmful. If your emotional responses indicate the need for further support, the primary researcher will help participants contact appropriate services.

Researcher’s Relationship with Participants:

- It is possible, though not anticipated that you may have a previous relationship with Tracey Coulter, the primary researcher. I have been involved in the music community of Victoria for a large part of my life. If you happen to know me, Tracey Coulter, please do not feel obliged to participate in this study out of any sense of obligation and would not participate otherwise.

Withdrawal of Participation:

- You may withdraw at any time without explanation or consequence.
- If you choose to withdraw, your data will not be used and any record of your participation (e.g., audio-tape, field notes, etc.) will be destroyed.

- If you choose to withdraw, the previously described compensation will not be affected and you will still receive the CD as thanks for your time you did spend participating.

Continued or On-going Consent:

- Before beginning the previously described follow-up interview, you will be asked to initial and date your original consent form to show your on-going consent.

Anonymity and Confidentiality:

- Due to the nature of the interviews, the primary researcher will know your identity. To keep your anonymity beyond these interviews, you will be asked to take on a pseudonym of your choice during the interview, which will be used on all subsequent data and records
- Everything you say during the interview will remain confidential with the following exceptions: if you inform me that a child is in need of protection, or if you or another person intend to harm yourself or another person.
- We may also be asking, if you are comfortable doing so, to tell others who might want to participate about this study. If you choose to do this, the people you talk to will subsequently know of your own participation. Please know there is no compulsion for you to do this.
- All records (e.g., audio-tapes, transcripts) will be labeled with participants' pseudonyms and kept in secure locations, either in locked filing cabinets for hard-copies or password-protected personal computers for digital records, to which only the principal researcher will have access. Any personally identifying information will also be removed from the transcripts and formal documents.

Research Results May be Used/Disseminated in the Following Ways:

- Directly to participants for confirmation of interview analysis
- As a published article
- In a Masters-level thesis & class presentations
- In presentations at professional meetings.

Questions or Concerns:

- Contact the researcher(s) using the information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545
ethics@uvic.ca

Consent:

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix E: Counselling Resources

Victoria Counselling Resources**Citizens' Counselling Centre 250-384-9934**

The Centre offers individual and couples counselling to adult residents of Greater Victoria. Counselling is available days, evenings and weekends. Our volunteer counsellors are trained to work with the following life issues: relationship/communication, changes in status or roles, (grieving/loss, divorce, marriage, career changes), situational depression, conflict resolution, stress and anxiety management, anger, self esteem and assertiveness. CCC operates on a sliding fee scale based on family income.
citizenscounselling.com

Men's Trauma Centre 250-381-6367

The Men's Trauma Centre is a non-profit society based in Victoria, B.C. Canada. The Men's Trauma Centre exists to provide treatment and support services to adult and late adolescent males who are survivors of physical, emotional or sexual trauma as well as support for our clients' significant others. We also consult with community and government groups in the areas of prevention, treatment, legal issues and other matters relating to the sexual violation of males. MTC operates on a sliding scale based on income. (Alana Samson, M.A.)
menstrauma.com

NEED Crisis and Information Line 250-386-6323

NEED provides 24 hour emotional support, crisis intervention services and community resource information. They are a telephone-only support and information service, staffed by volunteers professionally trained to offer emotional support.
needcrisis.bc.ca

Victoria Mental Health Intake (VIHA) 250-370-8175

Provides specialized services for Schizophrenia, mood disorders and anxiety, among others. VIHA refers to external program for addiction services as well. Referrals to intake can only be made by physicians.
http://www.viha.ca/mhas/locations/victoria_gulf/cms.htm

Women's Sexual Assault Centre 250-383-5545

Victoria Women's Sexual Assault Centre has highly qualified trauma specialists who provide services to individuals impacted by sexual assault and abuse. (Jude Marleau, M.A., Barb Peck, M.A., Linda Jennings, M.ED)
vwsac.com

University of Victoria Counselling Services 250-721-8341

Based on a commitment to student learning, as well as social, personal, and ethical development, our mission evolves from that of the University. We foster student success, engagement, and well-being through programs focused on students' developmental needs, individual and group counselling, and crisis intervention and emergency response. We respect the dignity and worth of all individuals and embrace human diversity within a warm, accepting, and confidential environment. Services are only available for UVic students. (Susan Dempsey, M.A., Janet Sheppard, M.A., Rita Knodel, Ph.D)

coun.uvic.ca