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Relationship Exploration through Music: Music Therapy Treatment Considerations for Adolescents with Attachment Trauma

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Honors Thesis

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Abstract

Interpersonal relationships are key to navigating our understanding of ourselves, others, and the world. However, our ability to form and maintain healthy relationships depends greatly on our experiences as children. Attachment theory suggests that our initial relationships and their characteristics can impact our sense of comfort and safety in later attachments (Bretherton, 1992). Challenges and trauma in attachment at a young age may hinder a child's development into adulthood where interpersonal relationships are key to navigating our academic, professional, and personal environments. If left unaddressed, these challenges can become exacerbated in adolescence as teenagers form more concrete understandings of themselves and the world (Dubois-Comtois, et al., 2013). Understanding the lasting psychological impact of attachment trauma is necessary to discovering appropriate and effective ways of addressing these struggles. With a focus on equity and accessibility in mental healthcare, this study is centered in music therapy treatment with teenage clients facing attachment trauma and the role of music as a communicative resource and symbolic object for attachment. This study features findings from an undergraduate honors thesis project, supplemented by research at the University of Oxford, and includes a review of attachment theory and relevant music therapy literature and reflexive content analysis of interviews with credentialed music therapists working with this client group in orders to gain insight to the modern practices of music therapists working with adolescents with attachment trauma to better understand a) how music therapists describe their lived experience of facilitating treatment with adolescents with attachment trauma, and b) what music therapists' identified, salient considerations towards practice are when providing music therapy services for teens with attachment trauma. Findings indicate that music therapy treatment facilitation for adolescents with

attachment trauma largely depends on the manifestation of cyclical relationships between the client, therapist, music, and their ecologies, the degree of clinician autonomy, and the accessibility to and application of resources and support related to this clinical work.

Statement of Positionality

At the time of writing, I identify as a white, queer, neurodivergent, spiritual, American, with English as my first language. I grew up in a suburban home with two parents and a younger sibling, who have consistently expressed care and support for all of my personal and academic aspirations. I carry immense privilege and actively aim to deconstruct and decenter my white, colonialist, ableist, and capitalist values inherent to my historically and systemically oppressive culture. As this undergraduate honors thesis represents my upbringing into academia, I imagine there will be considerable room to critique potentially non-inclusive language or research practices that are articulated within this paper. I would like to sincerely acknowledge and apologize for the unintentional perpetuation of harm that may be evident, and I graciously implore readers to offer grace as my values lie within critical and anti-oppressive practices within every aspect of my life. Through the process of research and writing, I became aware of personal biases and oppressive facets of this work and the related literature and clinical practices referenced herein, and made some evolutions. However, I also recognize that there is more change needed, and anticipate that my own views, language, and practices will likely continue to evolve in response to increased awareness and participation in constructive conversations pertaining to diversity, equity, inclusion, justice, and advocacy.

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Introduction

Relationships are found at the core of human behavior, and human lives could be mapped through the significance of particular relationships. Attachment is a particular "domain" within relationships that describes an increased degree of intimacy, comfort, and safety that characterizes the relationship and is necessary for human development, compared to non-attachment relationships (Fearon & Schuengel, 2021, p. 25). Therefore, John Bowlby and Mary Ainsworth's development of attachment theory articulates the psychological foundations for relationship formation (Ainsworth & Bowlby, 1991). Their theory, influenced by Freud and other prominent psychologists of the time, emphasizes the importance of caregiver attachment and the role such relationships play upon an individuals' development. As the presence of these relationships are important, experiences of trauma within these relationships also have a profound impact on individuals' life development. Attachment trauma refers to both trauma that takes place in relationships (often early attachment relationships) and the adverse long-term effects of such trauma on the capacity to develop and maintain secure attachment relationships (Allen, 2013).

Adolescence marks a junction where attachment patterns and the dominance of certain relationships change, as the significance of friendships, partnerships, and other types of relationships emerge. Our attachment experiences throughout life shape future relationships, both with ourselves and others. Opportunities to recognize, address, and reconfigure internalized patterns of attachment are key to creating future healthy attachments that become further independent from attachment experiences in the past. Various therapeutic modalities and resources, such as music therapy, can motivate

adolescents to increase insight into their attachment patterns and work through challenges, such as attachment trauma, as they begin to redefine and discover new attachments for themselves. The intent of this research is an investigation of music therapists facilitating treatment with teens with attachment trauma in order answer the following questions: a) how do music therapists describe their lived experience of facilitating treatment with adolescents with attachment trauma, and b) what are music therapists' identified, salient considerations towards practice when providing music therapy services for teens with attachment trauma? To approach these questions, the researcher conducted a qualitative analysis of relevant music therapy literature and five semi-structured interviews with music therapists with varied experiences and expertise working with this particular client group. Findings indicate that music therapy treatment facilitation for adolescents with attachment trauma largely depends on the manifestation of cyclical relationships between the client, therapist, music, and their ecologies, the degree of clinician autonomy, and the accessibility to and application of resources and support related to this clinical work. This research also illuminates limitations and areas in need of further investigation, including, music therapy practices with teens with attachment trauma in: a) working with multicultural groups, b) providing short-term treatment that addresses attachment trauma, and c) de-centering the white gaze from initial understandings of attachment security and health.

Literature Review

The following literature review describes the functions of attachment during adolescence, attachment trauma, and how attachment trauma may be addressed through music therapy. A music therapy case study analysis, including clients ranging from ages

8-27 years old, with mentioned relational challenges, was conducted to further understand music therapists' perceptions and experiences of treatment with this client group. This review affirms the varied affordances of music therapy for teens with attachment trauma to form healthier relationships with self and others.

Attachment within a Developmental Spectrum

Though previous attachment experiences may influence future relationships, attachment orientation and behaviors often change over time. The Strange Situation Procedure (SSP) originally identified three classifications of attachment: insecure-avoidant, insecure-anxious, and secure, with disorganized eventually added as an additional insecure classification (Jacobvitz & Hazen, 2021). These attachment orientations and the behaviors associated with them represent internal models of self and others, known as internal working models (IWMs) (Bowlby, 1969). Though these classifications were originally believed to be set characterizations, researchers have learned that attachment is actually more fluid and has the potential to evolve over time. Accordingly, the dimensional perspective of attachment illustrates attachment as a matter of degrees more than classifications, and suggests that natural changes in relational engagement and distress can affect attachment orientation and behaviors (Raby et al., 2021). In alignment with the dimensional perspective, a longitudinal study of attachment in high-risk families demonstrated that security may be gained later in life, even if security was not established in attachment relationships earlier in life (Van Ryzen et al., 2011). This discontinuity of attachment and the opportunity for change opens the door for therapeutic treatment to be effective in addressing attachment trauma, with adolescence acting as a key pivot point for change.

This new understanding of multifinality in attachment suggests that attachment security evolves over time and may be affected by various attachment relationships, caregiving environments, and experiences. Just as early attachment security does not imply invulnerability to later insecurity, adolescents and adults may regain security in relationships, despite insecurity or attachment trauma earlier in life. Therapeutic treatment encouraging the reworking of internal working models and reconstruction of attachment relationships can offer increased opportunities for this recovered security in adolescence and adulthood that ultimately can lead to additional positive outcomes in various health domains (Van Ryzen et al., 2011). This internal understanding and reworking of IWMs can be described as mentalizing, a shift from emotional reactivity to cognitive and rational assessment and evaluation of attachments (Allen, 2013; Head & Orme, 2023).

Defining Attachment Trauma

Attachment trauma impacts many families and often alters child development. Attachment trauma refers to both trauma that takes place in relationships (often early attachment relationships) and the adverse long-term effects of such trauma on the capacity to develop and maintain secure attachment relationships (Allen, 2013). Experiences of abuse and neglect, whether intentionally inflicted or not, are often at the root of attachment trauma. In addition to potential physical harm or the act of physical deprivation that is often identifiable, the covert essence of this experience is the victim being “afraid and alone” (Allen, 2013). Attachment trauma occurs when an individual is psychologically alone while enduring severe emotional distress (Allen, 2013). Attachment trauma often manifests as patterns of relational distrust in adolescents.

Because trust and predictability are lacking in the relationship in which the trauma occurs, they are more likely to be distrustful in future relationships, often making it more difficult for traumatized individuals to find comfort and security in future relationships (Allen, 2013). In a therapeutic setting, this distrust is likely to impact the therapeutic process and relationships, and requires patience from the therapist.

The intergenerational transmission of attachment plays a key role in attachment development and an individual's susceptibility to attachment trauma. A caregiver's unresolved attachment trauma can influence attachment interactions with children, often unknowingly and unintentionally leading to further attachment trauma across generations. The internal persistent fear and aloneness within a traumatized caregiver, though it may go unnoticed by other adults, is often perceived by children and infants as psychological unavailability, leading the child to experience attachment trauma themselves (Allen, 2013). Breaking this intergenerational cycle of attachment trauma may seem implausible, however, adolescence marks an optimal pivot point for such change to occur.

Adolescent Attachment Trauma

This review emphasizes adolescent development through the lens of attachment theory. However, there are biological, social, and ecological factors, such as socio-ecomonic status, stress, or changes in health, that contribute to an adolescent's level of security that are beyond the scope of this review (Van Ryzen et al., 2011). Adolescent individuation involves developmentally necessary social, cognitive and emotional changes that occur to help adolescents discover their own identities and separate from caregivers and other important figures, which is significant in attachment development (Dubois-Comtois et al., 2013). With such immense changes occurring during this

process, it is necessary that adolescents and caregivers redefine and negotiate their relationship to take individuation into account while maintaining security in these relationships. To protect adolescents' processes of individuation and growing independence, attachment often becomes a "state of mind" or "symbolic" element rather than a physical presence for adolescents (Dubois-Comtois et al., 2013, p. 2). Individuation changes the fundamental question surrounding mental attachment representations from: how accessible is my attachment figure, to: "Can I get help when I need it in a way that doesn't threaten my growing need for autonomy?" (Allen, 2021, p. 165).

Along with a focus on exploration, attachment hierarchies become more "multidimensional" during adolescence as peers and romantic partners enter attachment networks (Allen & Tan, 2016). Typically, adolescents gradually deemphasize the attachment relationship with parents and achieve security through the addition of other positive relationships (Allen & Tan, 2016). It is important for this gradual shift in hierarchy to occur as these new peer and romantic relationships help establish the individual's overarching attachment state of mind. This addition of significant attachment relationships can encourage teens to more objectively reevaluate cognitions, memories, and affective reactions related to diverse attachments in a healthy manner (Allen & Tan, 2016). Often, this healthy and developmentally appropriate negotiation of attachment and autonomy unintentionally leads to insecurity and attachment challenges within families, and specifically, parent-child relationships (Allen & Tan, 2016). If security can be maintained or created in caregiving relationships with adolescents, there are often resulting health and lifestyle benefits that serve the adolescent throughout their life.

A longitudinal study focused on attachment discontinuity across time found that secure parental attachments throughout infancy and adolescence were correlated with higher peer competence and less stress in adolescence and adulthood (Van Ryzen et al., 2011). Similarly, achieving security in adolescent relationships, despite insecure attachment bonds in infancy, has also been associated with positive developmental outcomes and high social functioning in adulthood, such as superior peer competence, recovered security in adult relationships and higher levels of relationship competence (Van Ryzen et al., 2011). Because adolescence marks an important period for change to occur, identifying and addressing attachment trauma is essential for holistic development and growth.

Neurobiological Effects of Music

Music as a human product and process has existed since the beginning of our species. Evolutionary musicologists suggest that both music and language developed from a proto-musical ancestor, and musicality evolved as a survival skill and act of intersubjectivity (Dunbar, 1996, 2003, 2012; Cross, 1999, 2003; Falk, 2000, 2004; Balter, 2004; Bannan, 2012; Trevarthen, 2002). Humans possess a natural "communicative musicality" that begins with caregiver and infant communication to offer opportunities for attunement and to form necessary healthy attachments at birth (Trevarthen & Malloch, 2000). Often through babbling, caregivers and infants use parameters of music such as pulse, pitch, and timbre-gestures to form vocal narratives of shared emotions and experiences. Throughout life, music offers a "direct way of engaging the human need to be sympathized with," through a natural biological impulse (Trevarthen & Malloch,

2009, pg. 11). The natural communicative affordances of music render it a relational medium that can offer opportunities for emotional co-regulation.

As the brain develops through childhood and adolescence, perception and understandings of music evolve as well. There is evidence that infants are sensitive to emotion, intensity, and expressive behaviors exhibited in experiences where communicative musicality is at play (Murray & Trevarthen, 1985; Nadel et al., 1999). By age four, children are able to accurately perceive and identify emotions such as happiness, anger, sadness, and fear in music (Cunningham & Sterling, 1988; Boone & Cunningham, 2001). Throughout childhood and into adulthood, individuals develop responsivity to more style-specific musical cues, such as mode, to aid in determining emotions in music. This ability to perceive emotions through music engagement opens the door for individuals to be psychologically held in less comfortable emotions, often without feeling the intensity of personally activated emotions (Eerola & Vuoskoski, 2013). This music-emotion experience can create the opportunity for adolescents to develop regulation and coping skills that are typically underdeveloped among those who have attachment trauma. Acting as a more controllable emotion-inducer in supportive, therapeutic contexts, music can biologically trigger different areas of the brain to access emotions, regulate emotions, and strengthen communication skills which can empower teens to deepen relationships with themselves and others (Davidson et al., 1979; Trevarthen & Malloch, 2000).

Music Therapy with Teens with Attachment Trauma

Despite the frequency and developmental significance of childhood attachment trauma, treatment specifically for teenagers remains underdeveloped. Therapeutic

interactions with adolescents with attachment trauma most often emerge in clinical settings where more recognizable diagnoses or reasons for referral are relevant. Working through attachment trauma maybe a primary treatment objective with any client or group, particularly teenagers transitioning into adulthood, and therefore may be especially relevant with adolescents engaged with music therapy through in psychiatric treatment settings, foster care programs, private practices, housing shelters, schools, hospitals, forensic settings, residential care facilities, and various child welfare programs (Eyre, 2013; Krüger, 2020). Creative-arts therapies, such as music therapy, are unique from verbally-mediated therapies in that they offer opportunities for play and both somatic and cognitive engagement in order to continue this neurobiological development. These features of music therapy invite adolescents to externalize their internalized thoughts, emotions, and mentalizations, using music as an interactive regulation tool to grant more autonomy and expressive freedom for communicating these internalizations in healthy ways (Haen & Webb, 2019; Fruchard & Lecourt, 2003; Uhlig, 2011).

Functions of Music

According to Krüger (2020), at a societal level, music can provide a space for protest and change, which symbolically aligns the process of refiguring IWMs while addressing adolescents' need for autonomy amidst the process of individuation. Engagement with music can help adolescents distinguish themselves from attachment figures, while also determining to which communities they may belong. This personal relationship with music can position music to serve as a transitional object and be used as a resource both within and outside therapy sessions, often in the form of songs that provide security and connection, or artifacts such as original lyric sheets (Dvorkin, 1991).

Music as a transitional object can generate personal meaning and aid in emotional regulation (Winnicott, 1971). Similarly, when the client has primary control of music experiences, a transitional space may be offered in music therapy treatment to promote security and allow for greater expressivity and exploration (Verfaille, 2016). The role of music as an object and relationship external from the client-therapist relationship can offer opportunities for control and autonomy to traumatized adolescents, while simultaneously enabling a deeper therapist-client relationship (Rogers, 2003). The relationships formed between both the therapist and client, and client and music, are what prompt health-oriented changes that lie at the heart of music therapy treatment (Bruscia, 2014). These relationships may serve adolescents, both across the lifespan, and when specifically addressing attachment trauma.

Similar to the emotional limits of music-induced emotions, music experiences can help to safely contain externalized experiences, emotions, thoughts, mentalizations, and questions regarding security (Uhlig, 2011). Part of the process for addressing attachment trauma is learning to grow through it instead of the trauma consuming and stunting one's growth. This containment via music can grant autonomy and separation from the trauma, enhancing internal security of self and regulation skills to better independently manage trauma (Head & Orme, 2023). Beyond serving as a relational medium to address attachment trauma, music has the potential to inspire many positive mental health effects related to mood and socialization. These may include promoting externalization, security, and individuation in adolescents, which can optimize mood and help develop socialization skills that can ultimately enhance the development of healthy relationships in the future.

Music Therapy Case Study Analysis

Music therapy treatment involves music experiences to inspire health-oriented change. The methods of music therapy– receptive, re-creative, improvisation, and composition– categorize specific ways of engaging with music for assessment, treatment, and evaluation purposes. The receptive method involves listening and responding to music, re-creation involves the act of reproducing precomposed music, improvisation involves spontaneous music making, and composition involves creation of an original musical product (Bruscia, 2014). In music therapy, multiple methods and method-variations can be combined throughout treatment to address the needs of the client. As attachment trauma is often uncovered during the therapeutic process, and other goals and reasons for referral are often prioritized, there are limited accounts of music therapy processes and experiences of therapists and adolescent clients with identified attachment trauma. Case studies pertaining to a range of ages (8-27 years old) with mentioned relational challenges were selected for review. Treatment approaches varied across these cases, though similar understandings and applications of the music therapy methods were identified. For adolescents with attachment trauma, each method may afford different opportunities to promote mentalizing and form healthier relationships with self and others.

Receptive[1]

As identified in the literature, receptive music therapy method-variations offer relational affordances and are largely helpful in the assessment process for enabling both

[1] The following remaining sections of this literature review are based largely on research originally conducted by the author for the University of Dayton Berry Summer Thesis Institute (2022). The content in its original form may be accessed here: [https://ecommons.udayton.edu/cgi/viewcontent.cgi?article=1008&context=uhp_bsti].

the client and therapist to deepen their understanding of the adolescent's cultures, identities, and IWMs by assessing their verbal or symbolic responses to the music (Henderson, 1991; Dvorkin, 1991; Nirensztein, 2003). According to Fruchard and Lecourt (2003), "the fact that the piece of music proposed is exterior to both the therapist and the client, and is offered as a support that mediates the relationship," helps the client demonstrate vulnerability in forming a therapeutic relationship, while still maintaining boundaries and a feeling of safety and control in the space (p. 242). In receptive experiences, the music is central to the treatment process and can function as an object, independent of the therapist, to mirror and validate the teen's emotions and experiences, while the therapist is able to guide the client through verbal or somatic exploration of their mental representations of themselves, others, and the world (Dvorkin, 1991). Song listening, song discussion, song communication, and movement to music experiences have been shown to demonstrate therapeutic affordances for this group. Meanwhile, music relaxation or Guided Imagery and Music (GIM) have relatively limited applications for this client group, due to the introspective and reflective nature of these method-variations, which can be too abstract for younger clients (Scheiby, 1991; Lefebvre, 1991).

At the core of receptive music therapy experiences is the premise that music can elicit various psychological, physiological, and emotional responses, and various musical properties can prompt different responses (Bruscia, 2014). For instance, adolescents tend to show more direct emotional responses toward vocal music (Fruchard & Lecourt, 2003), particularly within hip-hop and rap genres, instead of strictly instrumental music (Krüger, 2020; Uhlig, 2011). The lyrical and rhythmic emphasis in rap and hip-hop can

be extremely supportive to the client– validating, psychologically holding, and mirroring their behaviors or emotions, as well as essentially acting as a metaphoric baby blanket to provide comfort (Scheiby, 1991). For adolescents, these symbolic connections with music often manifest as a parasocial contact, with music acting as a mirror of their own identity (Pasiali, 2013; Ruud, 1997; Scheiby, 1991; Chen et al., 2018).

Though receptive experiences afford unique relationship building opportunities between the therapist and client, as this relationship and treatment develops and evolves, adolescents are often inclined to "create something" instead of continuing with listening and verbal processing (Erkkilä, 2011, p. 203). Frequently, adolescents in music therapy have already met with other health professionals and "may be tired of talking about [their] problems" (Erkkilä, 2011, p. 199). Thus, after the initial stages of the treatment process, more active methods of musical engagement may afford new opportunities for healthy development.

Re-Creative

In music therapy with adolescents with attachment trauma, re-creative method-variations typically include adapted music lessons and music performances to showcase musical growth. Based on this survey of literature, it seems that teenage clients often gravitate towards product-oriented approaches to music therapy, particularly experiences that result in an original creation or performance. Piano and guitar lessons are often popular with this client group, and teenage clients tend to enjoy learning the instrument through re-creating familiar songs (Lefebvre, 1991). Similarly, as clients become more skilled in their vocal or instrumental technique, recording or performing covers of familiar songs results in a product and accomplishment that the client can retain and share

both inside and outside of the therapy session, ultimately encouraging positive change in their internal model of self. These re-creative experiences involving precomposed music often lead to client interest in creating original music during sessions, either spontaneously or through a planful composition process.

Improvisation

Improvisation, or extemporaneous music making, can allow both the therapist and adolescent to discover, communicate, and reflect upon their IWMs and attachment experiences. Often, overwhelming and complex emotions and thoughts are better expressed and understood through more abstract and somatic forms of communication. Scheiby (1991) suggests that improvisation originates from a "natural impulse," and organically engages the whole self– mind, body, and spirit, which can encourage the truest form of self to emerge (pp. 294-295). Through improvisation, the adolescent may be able to externalize feelings that they may perceive as forbidden or dangerous (Bruscia, 1987); therefore enabling communication through an emotionally-charged experience that might have been thwarted in other contexts or by other care providers due to being seen as behavioral dysregulation or "acting-out" (Oldfield, 2011).

Reminding teens that it is okay to "play chaos" is important for validating teens' experiences and eventually demonstrating that they can exist within, move to, and move away from this chaos and the feelings associated with it (Kowski, 2003, p. 93) In-the-moment musicking, as an experience, is centered around play and expression. Play is incredibly important to the development of the brain, strengthening neurobiological capacities such as self-regulation, development of imagination, meaning making, social competence, community membership, and personal identification (Marks-Tarlow, 2010).

However, when traumatized, healthy childhood play is often thwarted, along with this brain growth, which perpetuates attachment and social challenges. Ultimately, improvisation experiences afford new possibilities for interpersonal and intrapersonal dialogues through play that can provide a foundation for self-transformation throughout treatment and beyond (Scheiby, 1991).

These improvisations can be structured using a theme or referent, or without any identified focus external to the music itself (non-referential). Both improvisation structures offer unique affordances to continue this necessary neurobiological development through play. Non-referential instrumental improvisation can enable projection of internal states onto the music itself, whether or not it's interpreted or processed by the client (Schönfield, 2003). Meanwhile, referential improvisation experiences, due to the innate structure and direction provided by the theme itself, can guide the client towards focused and contained creative expression, with less risk of overwhelming the client (Scheiby, 1991). Drawing meaning from the music process and product is what often leads to insight regarding IWMs and attachment experiences in all improvisation experiences.

Musical Qualities in Improvisation. In drawing meaning from improvisation experiences, particular musical qualities, properties, and decisions within the improvisation may illuminate IWMs and indicate clients' needs. In the literature, these musical qualities, properties, and decisions may include the use of leitmotifs, decisions surrounding rhythm and tempo, the implementation of musical secure bases, and the choice of sound media for the improvisation. Ultimately, client choices, behaviors, and

musicality within the improvisation experience may reveal something about the client and their attachment experiences.

According to Nirensztein (2003), leitmotifs, a recurrent theme or musical idea, can play a substantial role in the externalization of IWMs. In the assessment process, Jenny, a child victim of sexual abuse, often improvised musical "ditties" on a xylophone that resembled nursery rhymes (p. 129). Rogers (2003) interpreted these ditties or leitmotifs as a demonstration of her anxiety and an attempt to please the therapist (acting as the only adult in the room). Similarly, the repetition of these familiar ditties also demonstrated Jenny's challenge to find her own voice, as her individuation process was stunted by the trauma she experienced (Rogers, 2003).

Non-melodic musical qualities of improvisations, such as rhythm and tempo, can also provide useful insight into the client's IWMs. In an instrumental improvisation, Patricia, a teenage client from the Xhosa Tribe in South Africa, chose 6/8 as the desired meter for the improvisation. Henderson (1991) interpreted this musical choice and quality as an expression of Patricia's need for comfort, as 6/8 often provides a rocking feel, resembling a caregiver rocking a baby. Ultimately, a client's spontaneous musical choices can illustrate their current mental state, resources, and needs throughout the treatment process.

Several authors describe their use of musical elements to provide secure bases and support. In Rogers' work with Jenny, the use of a repeated musical "cell," containing three pulsed chords, acted as a secure base that was external to the therapist and client (2003, p. 133). Similarly, Linda, a teenager with a history of attachment trauma, was encouraged to improvise on piano and divide the keys. Linda improvised and used a

singular key or range of keys as a secure base, and the other pitches for musical exploration, and symbolically, exploration of her IWMs. Having a secure and predictable musical home base consistently available afforded Linda the opportunity to take her time exploring the piano and creatively coming up with her own improvised melodies (Dvorkin, 1991). Musical secure bases can originate from the client or the therapist's music, and include a consistent, reliable, and replicable musical structure that can simultaneously provide comfort and a launchpad for further exploration.

Particularly for teens willing to engage vocally, musical dialogues and stories can help displace significant emotions and events, while still affording symbolic and musical processing. Dvorkin (1991) defines musical dialogues as the client and therapist engaging in free associative verbal processing but with a melodic and metric component that supports the musical phrase. Projective musical stories, monologues, or songs often contain a metaphorical account of the client's experiences with attachment figures (Henderson, 1991). By verbalizing with the support and containment of a musical setting, clients are often able to better comprehend and reflect upon their experiences and behaviors, as the musical elements afford expanded emotional expressivity and connection.

Music therapists may facilitate vastly different improvisation experiences that offer unique affordances to promote mentalizing. Within each specific method-variation, interpreting both the musical process and product as externalizations of IWMs is key to help the client develop transferable skills of improved healthy expression and emotional awareness, as they identify their own IWMs and consider ways of moving forward.

Composition

Similar to improvisational and re-creative method-variations, composition experiences can provide a reflection of the client's psyche. Composition experiences are characterized by a process of development, decision making, and adjustments toward creating a musical product. The development and ongoing processes inherent to composition experiences with adolescents often take multiple sessions to complete, and may not be realistic in all treatment settings. In individual music therapy sessions with an adolescent with attachment trauma, composition experiences were primarily utilized with clients who participated in treatment for months or years (Dvorkin, 1991; Scheiby, 1991; Uhlig, 2011). The composition itself served as a product representing their growth and development through treatment, which often contributed to positive change in their IWM of self.

Composition can enable symbolic and verbal expressive processes and allow the teenager to create a tangible product. While improvisation primarily supports externalization of IWMs, the creation and development process of composition experiences can help to reflect and rework them. Composition can occur through recording original music, writing music, creating a method of notation, or transforming a pre-composed song by composing original lyrics (Bruscia, 2014). Such processes have the capacity to unlock the adolescent's emotional world, but more importantly, afford the opportunity for learning and adaptation (Uhlig, 2011). In composition experiences, the client has autonomy to change their lyrics, harmonies, melodies, or any musical component at any time. For clients that often do not have much of a voice in controlling their life circumstances or making choices to impact their future, this experience can be extremely empowering.

The music a client creates can act as transitional objects to absorb and reflect their thoughts, emotions, and behaviors. Dvorkin provides a therapist perspective:

> While the therapist is the transitional object in verbal therapy based on object relations theory, the use of the song in this manner freed my role in the therapy process and the way in which I could relate to Linda during the various stages of therapy (1991, p. 259).

While the active composition process affords an abundance of transitional and transformative experiences and knowledge, the completed composition itself is often valued by the client because it is a product they can retain, even after treatment termination. Through modern technology, clients have the potential to access and engage with their composition at will, and employ the skills they learned or honed in music therapy to continue composing outside of therapy as a method of expression. However, there were limited references to short-term treatment involving composition experiences with teens with attachment trauma in surveyed literature. Thus, recommendations for treatment adaptations are lacking.

Adolescent Group Music Therapy

Within the already limited research pertaining to music therapy treatment for teens with attachment trauma, there is considerably less literature articulating treatment practices in group therapy compared to individual treatment. Music is quintessentially situated in social and cultural frameworks, which may afford opportunities to experience belongingness and community, especially for adolescent groups with relational and social challenges (Krüger, 2020). Recent group music therapy studies pertaining to adolescents in Taiwan and Korea with attachment challenges have indicated group music therapy's

beneficial effects on peer attachment, relieving depression, reducing cortisol (a hormone associated with emotional stress), alleviating attachment insecurity, improving interpersonal relatedness and mental health, and decreasing psychosocial maladaptation (Chen et al., 2018, 2022; Kim et al., 2006). Kim et al. (2006) investigated the development of a music therapy group of Korean adolescent girls with attachment difficulties and found that music as a medium promotes interpersonal relatedness, which was reported by observing therapists and group members themselves. This particular study also outlines the changes in group dynamic and observed interpersonal connectedness from session to session, specifically highlighting the gradual shift towards increased trust and attention toward one another and music experiences (Kim et al., 2006).

Facilitating treatment for one adolescent in an individual session is markedly different from facilitating music therapy treatment and experiences with a group of teens with similar experiences of attachment trauma (Haen & Webb, 2019). Engaging in musical expression within a group can empower participants to begin the mentalizing process. The challenges associated with this process often manifest within the evolution of the group dynamics often including both resistance and eventual support of one another to transcend attachment patterns (Haen & Webb, 2019). McFerran (2019) echoes this experience in her own practice, sharing that group music therapy has led to increased emotional connectivity and identity validation, though not without challenges for both the group members and therapist.

Music therapy may encourage group members with traumatic experiences to identify internal and external resources to support their healing while also reframing their

use of music in a way that is supportive of the mentalizing process. Commonly identified method-variations in the literature that support such aims include group improvisation and group songwriting, group song discussion, group singing, group drumming, song communication, relaxation, and group and ensemble performances (Gardstrom, 2013; De Rea-Kolb, 2013; Rogers, 2013; Zanders, 2013; McFerran, 2019). These experiences afford opportunities for teen group members to truly experience music *with* one another, balancing the challenging task of processing their trauma with the opportunity to "feel good about themselves" and "love their music," which is important for building the resources that support mentalizing (McFerran, 2019, p. 146).

Literature Summary

The broad and devastating impacts of attachment trauma on adolescents, as well as the great affordances of treatment to address such trauma during the adolescent developmental window, has received little attention in the literature. Studies suggest that attachment impacts all areas of health, and our attachment orientations may evolve over time, particularly through adolescence. Though music therapy can uniquely benefit emotional regulation and externalization that support the process of mentalizing, limited literature on music therapy treatment for adolescents with attachment trauma exists. Furthermore, the literature that does exist does not accurately reflect the varied identities of the clients music therapists are serving, treatment settings and group sizes, or modern practices of therapists (McFerran, 2018). Insights and modern perspectives drawn from the clinical experience of music therapists working with adolescents with attachment trauma are needed to further develop and improve the efficacy of music therapy for this significant clinical group.

Method

Research Design

To define and describe the experiences of music therapists working with adolescents with attachment trauma, this study is rooted in phenomenology. Phenomenology is a widely-used and effective research method that serves to identify a specific phenomenon and bring meaning to people's lived experiences related to that phenomenon. It has been applied to music therapy research since the 1980s, and is commonly used to examine many clinical and educational topics (Jackson, 2016). Reflective accounts of lived, human experiences are valuable for deepening understandings and identifying truths pertaining to this topic, especially because current and relevant literature articulating music therapy practices for teens with attachment trauma is limited.

Participant Recruitment and Selection

The researcher conducted five semi-structured interviews with experienced music therapists to gain insights and perspectives on modern clinical experiences of music therapists working with teens with attachment trauma. To select interview participants, the primary researcher acquired a list of music therapists currently board-certified in the U.S. from the Certification Board for Music Therapists. A message and IRB-approved survey was sent to 9,763 music therapists, and 110 responses were received (~1.1%). In order to purposively sample interview participants, variables such as years of experience, clinical setting, geographic location, and typical duration of treatment were considered. Five music therapists were selected and sent an official invitation to participate (see Appendix A) and an informed consent letter (see Appendix B).

Study participation eligibility requirements included legal adult age in the United States, current music therapy board-certification, and self-reported music therapy experience working with adolescents with attachment trauma. In the initial survey, interested participants were asked to describe the nature of their work to better contextualize their clinical experiences with this particular clinical group. The researcher also opted for video interviews, which required participants to also have reliable internet service and a video conferencing platform, such as Zoom ©.

Table 1

Participant Demographics

Name:	**Pronouns:**	**Region:**	**Treatment Setting:**	**Experience with Clinical Group (in years):**
Karley	she/her	WR/MWR	Inpatient Facility/ Residential Facility/ Parenting Program	4
Kim	she/her	GLR	Inpatient Facility	7
Megan	she/her	MAR	Non-Profit Organization	2
Kayla	she/her	GLR	School, Inpatient Psych, Correctional Facility	1.5
Elizabeth	she/her	GLR	Special Education School	23

Participants had the option to provide a pseudonym or use the name they prefer. These choices are reflected in Table 1. Interview participants represented four different AMTA regions, and held both a wide range of clinical experiences, leading to seven unique treatment settings discussed in the study, and time spent in clinical practice with this clinical group ranged from two to twenty-three years.

Data Collection

Data were collected through individual, semi-structured video interviews with each participant that lasted approximately one hour. During all interviews, participants had their video feature on, enabling the researcher to observe non-verbal cues, as well as their verbal content. All interviews were recorded for transcription and analysis purposes.

Interview question topics included: a) participant music therapy education and training background and positionality, b) characteristics of relevant clinical experience, c) treatment findings, d) relationships and attachment experiences throughout treatment, and e) the role of the music therapist throughout treatment. The researcher constructed 15 interview questions (see Appendix C) prior to the data collection process in order to guide the interviews, though not all questions were used in every interview, and participants often discussed topics that were not predetermined.

Data Analysis

Interviews were transcribed, and the transcriptions were analyzed using the reflexive thematic analysis as defined by Braun and Clarke (2022). Braun and Clarke emphasize and celebrate the flexibility and interpretative nature of identifying, analyzing, and reporting patterns within qualitative data, while encouraging researchers to critically interrogate their research practices in this analysis process. There are six phases to

reflexive thematic analysis: a) familiarizing yourself with the dataset, b) coding, c) generating initial themes, d) developing and reviewing themes, e) refining, f) defining, and g) naming themes, and writing up (2022). Because this particular research study required an investigation of patterns in music therapy practice, Braun and Clarke's reflexive thematic analysis was deemed to be a meaningful and appropriate framework for this study, and these phases guided the analysis process.

Findings

As previously stated, modern and realistic descriptions of music therapists' experience in clinical practice with teens with attachment trauma is largely absent from the literature. First-hand insights and perspectives drawn from the clinical experiences of music therapists working with adolescents with attachment trauma are needed to further develop and improve the efficacy of music therapy for this significant clinical group. This led to the development of the following research questions:

1. How do music therapists describe their lived experience of facilitating treatment with adolescents with attachment trauma?
2. What are music therapists' identified, salient considerations towards practice when providing music therapy services for teens with attachment trauma?

Survey Analysis

Content drawn from the IRB-approved recruitment survey is presented to contextualize and generalize the treatment configurations and settings that situate music therapists' work with teens with attachment trauma. 110 responses to the IRB-approved Google Form survey electronically delivered to credentialed therapists in the United States were received, representing 27 US states and Canada. Respondents were

encouraged to describe (via written narrative) their treatment setting, the typical duration of treatment, years of experience working with teens with attachment trauma, and demographic patterns or salient sociocultural identities of the clients with whom they work. After analyzing narrative responses pertaining to treatment settings, the overwhelming majority of therapists identified working within hospitals or psychiatric units (see Table 2). Along with treatment settings, the duration of treatment within these settings were hypothesized to impact clinical practices significantly. A significant group (at least 45.5%) of respondents identified working in short-term treatment facilities, with short term being operationally defined as fewer than 3 months. It is notable that 22.7% of respondents did not describe a typical duration of treatment, leaving this survey item blank.

A range of clinical settings and treatment durations were vastly underrepresented in music therapy literature. However, according to survey and interview results, treatment settings and durations largely affect treatment configuration and practices for music therapy with teens with attachment trauma. With the nature of modern acute psychiatric care where speedy remission is the focus, treatment approaches and goals for teen patients with attachment trauma engaged in primarily group therapy in short-term care settings will likely differ dramatically from goals and approaches in settings where long term and individualized treatment is more possible (Adepoju, Kim, & Starks, 2022). It is necessary to gain insight into where modern music therapists are interacting with teens with attachment trauma, as this knowledge fills gaps in the lack of the more modern and practical treatment settings described within the literature.

Table 2

Treatment Setting Survey Results

Treatment Setting	Percent of Responses
School	11.9%
Private Practice	11.0%
Residential Treatment Facility	12.8%
Non-Profit Organization	6.4%
Telehealth Services	3.7%
Palliative/Hospice Care	0.9%
Hospital/Psychiatric Units	42.2%
Multiple Settings	11.0%

Interview Analysis

The interview analysis yielded three themes: cyclical relationships, autonomy, and a desire for resources. The consideration and development of these themes led to the primary argument: music therapy treatment facilitation for adolescents with attachment trauma largely depends on the manifestation of cyclical relationships between the client, therapist, music, and their ecologies, the degree of clinician autonomy, and the accessibility to and application of resources and support related to this clinical work. In this section, theme development will be briefly described and references to examples in the literature that support these themes will be presented.

Cyclical Relationships

Relationships are inherently complex and non-linear in their formation and development. Thus, characterizing, understanding and addressing trauma within relationships is equally complex and non-linear. Therapeutic relationships are fed and characterized by both the therapist's and client's identities, experiences, and external relationships, and ultimately cultivate the treatment process. Furthermore, in the interview and analysis process, it was clear that, rather than particular therapeutic practices leading to particular therapeutic outcomes, music therapy treatment with teens with attachment trauma is more often characterized by messy cyclical patterns. The presence and manifestation of cyclical relationships within and beyond music therapy is representative of the interconnected and messy nature of music therapy with teens with attachment trauma.

For music therapy with teens with attachment trauma, relationship formation and evolution between client and therapist is fundamental to the therapeutic experience. The identities and experiences of therapists and client(s) that characterize this interpersonal relationship are radically unique with every client and therapist. Interview participant, Elizabeth, suggested that with multidimensional individuals entering relationships with one another, "mutual respect" for each other's full selves is ultimately what drives the therapist-client relationship in a way that is affirming and supportive of addressing attachment trauma. This mutuality is characterized by both the therapist and client sharing pieces of themselves to one another. For instance, Kayla discussed the importance of consistency and reliability of the therapist, as these pillars of practice

enhance trust and safety, which can ultimately encourage clients to then share more of themselves with the therapist.

Cyclical relationships are also apparent in musical relationships in the therapeutic space. Nearly all interview participants shared that in music therapy treatment for this client group music *is* a manifestation of the relationship between therapist and client. Clients and therapists, before entering the therapeutic environment, already possess some relationship with music that they bring to the table and should be honored in therapy. Then, in the session, music is often the avenue for processing attachment experiences or experiencing relationships, ultimately creating a shared music experience that can embody the therapist-client relationship. These music experiences can also impact the therapist's or client's personal relationship with music, and impact other social relationships as they bring new musical experiences and ideas to their social spaces. In a description of music-centered music therapy, Aigen (2005) reflects on the "connective power" of music:

> [Music] makes the relationship possible on an intrapersonal level as well as on an interpersonal one, between therapist and client, among clients, and between clients and people in their life outside of therapy (p. 90).

As clients with attachment trauma are often engaged with therapeutic services in addition to music therapy, this musical relationship, fueling the therapeutic relationship can "level the playing field," and help cultivate that mutual respect that is fundamental to the therapeutic process, according to interview participant Elizabeth. As Aigen articulates, "in a musical relationship, the primary message from the therapist to the client is *I am*

here to help you make music, rather than *I am here to change you, fix you, control you, or heal you*" (2005, p. 120).

Interview participants also described a cyclical pattern of client resistance. The American Psychological Association defines resistance as an obstruction of the therapist's methods of practice brought forth in therapy, through the client's communication or behavior (2018). Four out of five interview participants identified resistance as a common occurrence in their work with teens with attachment trauma. However, they also identified that the context of resistance may be more informative than the behavior itself. Kim discussed her experiences with resistance while working in a psychiatric treatment unit, and recommended a compassionate response towards resistance, viewing this as a learned strategy for emotional protection. Resistance early on in treatment often signals distrust, which may be expected at the relationship onset. However, resistance later in treatment may indicate trust development or a "breakthrough." Kim and Kayla have both witnessed resistant behaviors that they believed were indicative of the client feeling safe and grounded enough to "act out" while trusting that their therapist would not abandon them. These behaviors are often misinterpreted as aggression or disrespect. However, when provided context, such acting out behaviors often embody therapeutic growth.

These cyclical relationships exist in both therapist observations of client behaviors, as well as therapist treatment considerations and practices. Cyclical relationships can be observed from various lenses and perspectives, requiring the capacity to reflexively "zoom in and out" to notice these various micro- and macro-cycles present in this clinical work. Along with the micro-cycles evident in client behaviors, micro-

cycles are evident in the ways in which music therapy experiences and relationships between client and therapist inform one another. For instance, within the limit of a single experience or session, the client's and therapist's relationships with music can be developed and deepened through specific music therapy experiences and methods. Furthermore, there are macro-cycles that indicate the interconnectedness of broad treatment components and considerations. After further "zooming out" to consider the full treatment process, participants noted that these musical relationships also inform overarching aims and approaches of treatment, as well as the role(s) a therapist may embody within a session.

At a macro-level, it is evident that the presence and manifestation of cyclical relationships within and beyond music therapy is representative of the interconnected and messy nature of music therapy with teens with attachment trauma.

This interview analysis indicated that cyclical and interconnected relationships exist with regard to the development of therapeutic relationships, treatment aims, therapist approaches to treatment, and therapist roles assumed during the course of treatment. However, the degree of autonomy experienced by music therapists in their work settings appeared to have the strongest impact on how music therapists shaped and structured their practices

Clinician Autonomy

Clinician job autonomy is defined as the "degree of freedom" in clinical decision-making that employees or contractors have in their work (Kim, 2016, p. 18; Moregeson & Humphrey, 2006). This degree of freedom has a significant impact on music therapy practice and the experience of the music therapy clinician. As previously established,

music therapy treatment with teens with attachment trauma is largely individualized to the particular client's or group's needs. These teens have themselves experienced a lack of autonomy and control in their experiences of trauma, so clinician autonomy to support client's in-the-moment needs is necessary to begin addressing their core treatment needs. Furthermore, interview data indicated that the degree of clinical autonomy affects music therapists': a) aims and approaches to treatment, b) theoretical orientations, c) treatment goals, d) experience or intervention design and facilitation, e) treatment configuration, f) expectations and choice regarding other roles that may be assumed, g) self-care practices, and h) the likelihood of burnout.

Music therapy is often one component of a general treatment plan that may include other treatment modalities and resources. Music therapists often have no authority over the "home" environment a client returns to after therapy or the degree of involvement in treatment planning granted to clients. Karley and Megan identify agency and accessibility as the primary pillars to enable expanded client autonomy and control. They recommend that overarching treatment goals and aims should be co-constructed with the client. Similarly, three participants described the importance of approaching treatment with the intent to further the accessibility of music as a resource or realm where clients *can* have agency and control. This may include allowing clients to borrow instruments for an extended period of time, creating artifacts during therapy that can be retained by the client, or developing musical skills that clients may engage with outside the therapy space. As music therapists supporting teen clients in mentalizing, music often enhances this challenging and reflective process.

Karley suggests that therapists must be realistic about treatment goals and potential affordances and benefits of treatment. Interview data suggests that clinicians believe their autonomy is positively correlated with the efficacy of treatment and music therapist sustainability in this treatment context. To affirm this claim, client perspectives are needed. Every interview participant referenced experiences of burnout related to their work. Along with experiencing immense fulfillment, participants shared feeling "exhausted," "detached with love," "isolated," and "pressured" in this work. In the present U.S. medical system, a significant portion of working with teens with attachment trauma revolves around acute crisis care, rather than prevention. Music therapists are often placed into a prescribed treatment timeline with goals predetermined by medical systems or provider expectations that are largely detached from the complexity and nuance of actual client individual needs, as well as their social and environmental situations. This relationship between lack of autonomy and increased potential for burnout was affirmed by Kim's (2016) study surveying 163 music therapists' experiences regarding job demands, job autonomy, social support, burnout, and turnover intention. Kim found that job autonomy and job demands are significantly associated with burnout (2016). Ultimately, music therapists have varying levels of autonomy and agency in their clinical practice which ultimately affects treatment efficacy and clinician sustainability of practice.

Clinician Resources and Support

In addition to limited clinical autonomy, music therapists working with this clinical group may have a large caseload and limited options for collaboration, supervision, or support. Music therapists working with teens with attachment trauma

must find ways to be in a compassionate relationship with teens for whom safe and healthy relationship development is essential, but likely very unfamiliar and difficult. In order to be meaningfully engaged in these relationships, understand the scope of this work, and authentically practice from an attachment-informed perspective, music therapists need resources, education, and professional support to inform and guide their practice.

Most interview participants shared that they were the only music therapist on site, so finding sufficient supervision or peer support is a challenge. Possible explanations the participants provided for this lack of sufficient support included limited peer staff, the degree of burnout among peers and supervisors, or challenges due to discrimination. Despite barriers to access supervision and limited agency to advocate and find support, all interview participants described supervision and professional support as essential resources for preventing burnout and navigating countertransference. The value of support and supervision is also reflected in modern music therapy literature and portraits of practice. Flynn (2023) shares the importance of supervision for coping with the perpetual systems of harm interwoven in U.S. healthcare. She shares that supervision helped her cope with the experience of "providing music therapy in a profit-driven healthcare industry that often seemed at odds" with her personal values (Flynn, 2023, p. 86). Interview participants frequently described their frustrations with systems of harm present in their clinical settings. Access to supportive resources and relationships is essential for both sustaining music therapists' work in these important areas of treatment, as well as advancing the efficacy of treatment itself.

Proper training and an understanding of scope are additional supportive elements for this work. Every interview participant shared that they were underprepared for the intense and psychotherapeutic nature of this clinical work. Yet, as depicted through the diversity of interview participants, both new professionals and experienced clinicians are facilitating music therapy with teens with attachment trauma across a variety of clinical settings, with limited resources, models, or theories to guide their practices. Fundamental questions about the efficacy and scope of music therapy treatment with teens with attachment trauma are largely unanswered. With limited educational resources and treatment models designed for working with individuals with attachment trauma, what level of treatment can or should be activated depending on treatment context (i.e., music therapy frequency and duration)? How can music therapists be educated on diversity, equity, and inclusion initiatives and practices to best serve the socio-cultural diversity of teen clients? Without evidence-based grounding for clinical decisions, there is an increased potential to do harm.

Mentalizing-Informed Music Therapy. Mentalizing-Informed Music therapy (MIMT) is an attachment-informed music therapy treatment model. MIMT, as outlined by co-authors Head & Orme (2023), employs a methods-based approach, incorporating Bruscia's definitions of improvisation, re-creation, composition, and receptive music therapy methods, informed by Mentalization-Based Treatment, which is a borrowed concept to music therapy. In this approach, therapists are encouraged to adopt a mentalizing-informed stance that is characterized by openness, curiosity, nonjudgement, and authenticity, to nurture feelings of safety in the therapeutic relationship (Head & Orme, 2023; Allen et al., 2008). As adolescents are entering vulnerable spaces and

frames of mind in music therapy, it is important for therapists to maintain an unconditional positive regard and supportive role to the teen. Additionally, it is likely that teens with attachment trauma have been labeled as *difficult*, *reckless*, or a *burden* by other caregivers or providers. Therefore, offering a safe haven where they are fully accepted is foundational to the treatment process.

From a mentalizing-informed approach, therapists serve as attachment figures that traumatized teens need but often struggle to find. Effective attachment figures, therefore, effective therapists, exhibit contingent marked mirroring – reflecting the client's actual mental state in an authentic way (Head & Orme, 2023). Contingent marked mirroring aligns well with the practice of the iso-principle in music therapy (Davis, Gfeller, & Thaut, 1999). Through the iso-principle and MIMT stances of reflection, openness, and understanding, the therapist is able to co-regulate mood by using music to reflect the arousal state of the adolescent. In adopting a MIMT approach, the therapist provides contingent marked mirroring through their presence, while the music meets the teen's attachment needs via the iso-principle (Head & Orme, 2023).

Though Head & Orme's MIMT is a viable attachment-informed music therapy approach, knowledge of MIMT and other developing attachment-informed theories, principles, and practices may guide and support music therapists in their own practices. Attachment-informed practice resources are in increasing demand, as therapists from many disciplines recognize the salience of attachment experiences in relationship to health. Relationships are central to human existence and therapeutic treatment, thus, greater education regarding the various constructs and experiences within relationships are essential for improved therapy with teens with attachment trauma.

Conclusion

After reviewing both relevant literature and conducting interviews with music therapists working with teens with attachment trauma, findings suggest that music therapy treatment facilitation for adolescents with attachment trauma depends on the manifestation of cyclical relationships between the client, therapist, music, and ecology, the degree of clinician autonomy, and the accessibility to and application of resources and support for music therapists engaged in this clinical work.

Nonetheless, this area of research and clinical practice requires further investigation. First, there is a need to investigate the original pathogenic perspective of attachment classifications. Bowlby and Ainsworth's theory proposes a level of universality of their four classifications, secure attachment being the most optimal or "healthy." However, using similar attachment assessments, psychologists found different attachment styles to be dominant in different cultures and locations. For instance, avoidant attachment was over represented in north Germany (Grossmann et al., 1985), while anxious attachment appeared more frequently in Japan (Miyake, Chen, & Campos, 1985) and Israeli kibbutzim (Sagi et al., 1985). Knowledge of socialization strategies in cultures and societies other than the predominantly Western middle-class, where individualist values are prioritized, are largely unexplored in academic literature, yet much of the difference in attachment classification dominance pertains to cultural emphasis on collectivist versus individualistic values (Keller, 2021). Because Bowlby's theory focuses on the effects of familial relationships, the cultural variations on the definition and constitution of a 'family' plays a large role in attachment styles. Thus, attachment classifications based on a heteronormative nuclear family unit and rooted in

individualistic values as more healthy or optimal, can perpetuate heterosexism, white supremacy, and a colonial framework.

There is a need to gather perspectives from both teen participants and music therapists within varied multicultural communities to further understand how attachment trauma may affect adolescents and how therapists can ethically and effectively support traumatized teens' mental health, processing of attachment trauma, and sense of autonomy and belonging. The benefits of music and music therapy treatment on adolescent mental health can apply to various clinical groups, though have important implications for adolescents with attachment trauma. Special consideration to the cultural contexts and preferences of adolescents in treatment is key to establishing a therapeutic space of trust and belonging that can provide the groundwork for further exploration and reconfiguration of internal models of attachment and the promotion from emotional reactivity towards attachment experiences and relationships to cognitive and rational assessment of relationships and ultimately, healthier attachments.

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APPENDIX A

Invitation to Participate

INVITATION TO PARTICIPATE IN RESEARCH

Surveys and Interviews

Research Project Title: Music Therapy Treatment Considerations for Adolescents with Attachment Trauma

You have been asked to participate in a research project conducted by Jaylee Sowders, an undergraduate student from the University of Dayton, in the Department of Music.

> The purpose of this study is to further research the resources and needs of adolescents with attachment trauma and their participation in music therapy. Interviews with music therapy professionals with experience with this particular clinical group will be conducted to gather information regarding clinical practices and clinician expertise. Findings from these interviews will be incorporated into an undergraduate thesis project that will be published in a written online format and presented orally.

You should read the information below, and ask questions about anything you do not understand, before deciding whether or not to participate.

- Your participation in this research is voluntary. You have the right not to answer any question and to stop participating at any time for any reason. Answering the questions will take approximately 60 minutes.

- You will be compensated for your participation.
- This is a recorded interview, however you may request to remain anonymous and to not have your recording used publicly.
- You are only eligible to participate if you are over the age of 18 and are a credentialed music therapist.

Please contact the following investigators with any questions or concerns:

Jaylee Sowders, Primary Investigator (513) 377-0044 sowdersj1@udayton.edu

Professor Willenbrink-Conte, Faculty Advisor (937) 229-3921 jwillenbrink1@udayton.edu

If you feel you have been treated unfairly, or you have questions regarding your rights as a research participant, please email IRB@udayton.edu or call (937) 229-3515.

APPENDIX B

Informed Consent Letter

UNIVERSITY OF DAYTON - CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF STUDY: Music Therapy Treatment Considerations for Adolescents with Attachment Trauma

We are inviting you to be a part of a research study led by Jaylee Sowders at the University of Dayton. Participation is not required. Please read the information below to learn more about the study. Before participating, ask questions about anything you do not understand.

PURPOSE OF THE STUDY

The purpose of this study is to further research the resources and needs of adolescents with attachment trauma and their participation in music therapy. Interviews with music therapy professionals with experience with this particular clinical group will be conducted to gather information regarding clinical practices and clinician expertise. Findings from these interviews will be incorporated into an undergraduate thesis project that will be published in a written online format and presented orally.

PROCEDURES

If you choose to take part in this study, you are committing to a one time interview with university student, Jaylee Sowders. This interview will be approximately 60 minutes in duration. During this interview, Jaylee will ask questions and you are asked to answer

truthfully and as thoroughly as possible. Interviews may be held via the online video conferencing platform Zoom © or in-person. The interviews will be audio recorded, and video will be additionally recorded, if utilizing Zoom ©. Interview participants must be credentialed music therapists with significant clinical experience working with adolescents with attachment trauma.

POTENTIAL RISKS AND DISCOMFORTS

While no significant risks have been identified for participants in this study, you may experience emotional distress while discussing challenges associated with your clinical experiences. These risks will be minimized through the opportunity to review the questions before the interview per participant request, allowing for breaks in the interview as necessary, and you may choose to skip or decline to answer any questions throughout the interview process. You also have the right to withdraw from the study at any time.

ANTICIPATED BENEFITS TO PARTICIPANTS

Anticipated benefits for participation in this study include support of undergraduate research at the University of Dayton, and the opportunity to provide input and expertise that could encourage improved and more thoughtful music therapy practices with adolescents with attachment trauma.

PAYMENT FOR PARTICIPATION

Participants will be compensated $100 for participation in an interview. This funding is provided by the University of Dayton Honors Program, and details regarding payment will be provided before the interview. This one-time payment will be provided after the completion of the interview. If you choose to withdraw from the study, compensation will not be

provided. However, if Jaylee chooses to withdraw you from the study after the completion of the interview, you will still receive compensation. This payment is taxable income; please see details below.

CONFIDENTIALITY

You have the option to request remaining anonymous in any publications or presentations. Otherwise, information and data collected through the interview may appear in the written thesis and related presentations by Jaylee. Where content from interviews is presented, you will be properly cited for your contributions. However, you may choose to have your contributions remain anonymous. Video and audio recordings of your interview will not be shared publicly, but will be shared with the research advisor. Recordings will be maintained on a secure, password protected personal device.

PARTICIPATION AND WITHDRAWAL

You may choose voluntarily whether or not you wish to participate in this study and may withdraw your participation at any time without penalty.

IDENTIFICATION OF INVESTIGATORS

Please contact one of the investigators listed below if you have any questions about this research.

Jaylee Sowders, Primary Investigator: (513) 377-0044 sowdersj1@udayton.edu

Joy Willenbrink-Conte, Faculty Advisor: (937) 229-3921 jwillenbrink1@udayton.edu

RIGHTS OF RESEARCH PARTICIPANTS

You may contact the Institutional Review Board (IRB) at the University of Dayton if you have questions about your rights as a research participant: (937) 229-3515 or irb@udayton.edu.

SIGNATURE OF RESEARCH PARTICIPANT (*or legal guardian*)

I have read the information above. I have had a chance to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form. **I certify that I am at least 18 years of age.**

Name of Participant (please print)

_____

Address _____

Signature of Participant _____ Date_____

SIGNATURE OF WITNESS

My signature as witness certifies that the Participant signed this consent form in my presence.

Name of Witness (please print)_____

Signature of Witness _____ Date_____

RESEARCH INCENTIVES ARE TAXABLE

If you expect to or have earned more than $600 in research incentive income (for employees, via research incentives only) from the University of Dayton this calendar year, **you are not eligible to receive the incentive for participating in this study unless the researcher completes the proper documentation and submits it for processing. You may not receive the incentive directly from the researcher.**

By signing below, I acknowledge that I understand that the incentive payment I receive for participating in this research study is taxable income and it is my responsibility to report it to the IRS as required by federal law.

Name of Participant (please print)_____

Signature of Participant _____

Date_____

APPENDIX C

Interview Questions

Background Information

1. What pronouns do you use and how do you prefer to be addressed?
2. Can you describe your clinical training and background? What prepared you for the demands of this work? How has professional support played a role in your development as a clinician?

Characteristics of Relevant Clinical Experience

3. What is your experience interacting with teenagers with attachment challenges?
4. In what treatment settings and geographic locations have you engaged in this work?
5. Generally when working with this particular client group, what was the frequency and duration of sessions? What was the typical (or range of) treatment duration?
6. In your clinical experience, have you interacted with this client group primarily in individual, group, or family therapy? Do you typically facilitate one configuration more frequently?
7. What are some of the salient demographic characteristics of teens with attachment challenges with whom you've worked? Have you found there to be any particular demographic patterns among the clients with whom you've worked? Feel free to share more specific examples or characteristics of a particular client if you find that to be relevant.

8. In treatment, have you ever been the client's primary therapist or provider, or do you find that clients are usually involved with other services as well as music therapy?

Treatment Findings

9. How do you address attachment trauma with teens in your clinical practice? What language do you use to articulate the treatment aims associated with attachment?
10. Have you identified any beneficial methods, variations, approaches, theoretical orientations, techniques, or principles that have been effective for addressing attachment challenges? This can include general patterns or more specific vignettes with particular clients.

Relationships and Attachment Experiences throughout Treatment

11. How would you describe the manifestation of relationships within music therapy treatment? Have you noticed patterns between the therapist-client relationship or even the client-music relationship? Could you provide examples of how these relationships develop in a healthy and beneficial way?
12. In my research, I have found that clients may attach to various "objects" inherent to music therapy. This may include specific instruments, songs, experiences, the therapist themself, or peers. Have you experienced this in your work? If so, what were the relational objects and what unfolded as a result of this relationship formation?

The Role of the Therapist throughout Treatment

13. In my research, I have found that music therapists have often assumed additional roles to provide more holistic support and advocacy for their clients. Have you

found yourself engaging in any of these additional supportive roles? If so, what were the different roles that you assumed?

14. I can imagine for clients who have previously been challenged with forming healthy and supportive relationships, termination may be a challenging and complex process. Can you describe some of your strategies and practices during the termination process?
15. Countertransference when working with this particular clinical group can be a challenge along with the mere emotional gravity of assessing and treating adolescents with relationship-related trauma or challenges. What are some resources or practices that you have found to be helpful for your own self-care as a therapist?