7-2021

Trauma Informed Practice in Music Therapy

Annie Heiderscheit

Kathleen M. Murphy

Trauma Informed Practice in Music Therapy

Annie Heiderscheit[1] and Kathleen M. Murphy[2]

[1]Music Department, Augsburg University

[2]Music Department, State University of New York at New Paltz

Author Note

Annie Heiderscheit, Ph.D., MT-BC, LMFT is the Director of Music Therapy & Associate Professor, Augsburg University

Annie Heiderscheit https://orcid.org/0000-0002-8311-7188

Kathleen M. Murphy is the Program Director for Graduate Studies in Music Therapy, & Assistant Professor, State University of New York at New Paltz

Kathleen M. Murphy https://orcid.org/0000-0002-4396-5772

Correspondence concerning this article should be addressed to: Kathleen M. Murphy, State University of New York at New Paltz, Music Department, 800 Hawk Drive, New Paltz, NY 12561-2442. Email: murphyk@newpaltz.edu

Abstract

The 2019 *National Survey on Drug Use and Health* reports that 9.5 million Americans aged 18 and older have been diagnosed with more than one mental disorder. Music therapists working in mental health treatment settings are likely to work with individuals who have a complex diagnosis defined here as two or more of the following: depression, eating disorder, generalized anxiety disorder, substance use disorder, eating disorders, and severe mental illness. Additionally, adverse childhood events or post-traumatic stress disorder often complicate the clinical profile. Given this, a trauma-informed approach to music therapy treatment is necessary to improve outcomes and minimize harm. The risks, contraindications, and ethical considerations necessary to effectively treat and care for these clients in music therapy will be reviewed. Methods of identifying, assessing, and treating these complex clinical issues in music therapy are discussed with the goal of helping clinicians understand: 1) where treatment needs to begin to ensure therapeutic goals addressing primary issues prior to addressing secondary issues, and 2) the appropriate use of music therapy methods. The necessity for music therapists to understand the power of the music in the music therapy process is explored, to ensure that clinicians are meeting client needs, not triggering symptomatology, traumatic memories, or experiences. The importance of a clinician knowing their scope of practice, when they are adequately trained and prepared to work with clients with complex disorders, and how to utilize support such as consultation and supervision to support their effective treatment with client(s) is presented.

Music Therapy and Complex Diagnosis: A Trauma Informed Approach to Treatment

The 2019 *National Survey on Drug Use and Health* reports that 9.5 million Americans aged 18 and older have been diagnosed with more than one mental disorder (Substance Abuse and Mental Health Service Administration (SAMHSA, 2020). Music therapists working in mental health treatment settings are likely to work with individuals who have a complex diagnosis defined here as two or more of the following: depression, eating disorder, generalized anxiety disorder, substance use disorder, eating disorders, and severe mental illness. Individuals who have complex diagnoses have difficulties across many areas of functioning (Watt et al., 2013) Additionally, exposure to traumatic events underlies many of these disorders (e.g., Brown et al. 2008; Johnson et al., 2010; Khoury et al., 2010; Manning & Gagnon, 2017; Racine & Wildes, 2015). The combination of clinical issues associated with each disorder requires an integrated treatment approach that is based on the principles of trauma informed care (e.g., Baird, 2018: Brewerton, 2019; Schäfer & Najavits, 2007). SAMHSA (2014) also recommended a trauma-informed approach and developed guidelines for implementation in behavioral health settings. Therefore, the purpose of this paper is to review the principles of trauma informed practices. Ways of working with trauma are beyond the scope of this paper. Music therapists working from a trauma-informed stance understand there is a possibility that their clients may be a survivor of trauma, and that trauma affects a person's whole being. We begin this paper with an overview of the principles underlying trauma informed practice, followed by a discussion of assessment and music therapy goals and methods consistent with trauma informed care.

Trauma Informed Care

Trauma informed care or a trauma informed approach is not a form of psychotherapy (Classen & Clark, 2017). Rather it provides a conceptual framework that recognizes any person seeking therapy may be a trauma survivor and considers the impact of trauma on physical, emotional, and spiritual well-being (Herman, 1997; Classen & Clark, 2017; Malchiodi, 2020). A trauma informed approach is based on the assumptions that therapists: 1) have a basic understanding of trauma and its wide-reaching effects, 2) recognize the signs of trauma, 3) apply the principles of a trauma informed approach, and 4) seek to avoid re-traumatization (SAMHSA, 2014). Trauma informed therapists typically adhere to six key principles: 1) safety, 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice and choice; and 6) cultural, historical, and gender issues (Classen and Clark, 2017; Fallot & Harris, 2008: SAMHSA, 2014). Adherence to these principles will minimize the risk of re-traumatization, facilitate the development and maintenance of the therapeutic relationship, and improve outcomes.

Safety

Physical and emotional safety, being protected from both internal and external threats, is a key element of trauma informed care. Therefore, music therapists must create a therapeutic environment in which the client feels physically and emotionally safe to minimize triggers. This includes consideration of "images, smells, noise, and even color of a space" (Bent-Goodley, 2018, p, 6). In addition, music selections must be considered carefully so as not to inadvertently cause the client to feel unsafe (Silverman, et al. 2020).

Trustworthiness and Transparency

Trust. Trust is the basis of healthy and helpful therapeutic relationships. Individuals who have experienced interpersonal trauma, including adverse childhood events are more likely to have trouble trusting others (Gobin & Freyd, 2014; Pearlman & Courtois, 2005). Trust is established by having reliable, predictable, and clear boundaries (Classen & Clark, 2017, p. 515) which helps the client know what to expect (Bent-Goodley, 2019). Additionally, stability in the provision of services, e.g., day/time of sessions, availability of the therapist outside of sessions, and policies regarding payment and cancellation, help to maintain boundaries and facilitate the development of a trusting relationship.

Transparency. Transparency is the second ingredient in the development of a trusting relationship. This includes an explanation of the music therapist's approach to and rationale for treatment (Classen & Clark, 2017) including goals and choice of music therapy methods (Pearlman & Courtois, 2005) Transparency also involves the effect of the client's story on the music therapist (Classen & Clark, 2017). Trauma survivors seemingly know when a therapist is not being transparent about negative reactions or feelings (Dalenberg, 2000). A smile, which may be given as a sign of support, might be misinterpreted as a signal the therapist is not taking the client seriously. There are other challenges that present themselves when working with clients who have a trauma history including difficulties hearing client's stories, and learning of self-destructive or dissociative behaviors (Classen & Clark, 2017). Finally, clients may reenact their trauma history and patterns of relating with the abuser within a music therapy session (West, 2013). Countertransference reactions, those somatic, emotional, unwarranted, or

inexplicable reactions to the client (Bruscia, 2015), are normal. However, it is incumbent upon the music therapist to seek supervision or personal therapy to maintain a safe and trustworthy therapeutic space.

Peer Support

SAMHSA (2014) defines peers as "individuals who have lived experiences of trauma" (p. 11). Peers, often referred to as trauma survivors, can offer and receive support to help manage the recovery process. Peer support groups may be facilitated by professionals (e.g., McCormack & Katalinic, 2016) or by non-professional staff or volunteers (e.g., Alaggia et al., 1999), a peer support provider (Mourra et al., 2014) or a self-help, trauma survivor run group (Davidson et al, 2006). Group music therapy may offer some of the same benefits as participation in a peer support group. Qualitative research findings suggest that adolescents admitted to an inpatient mental health unit reported participation in group music therapy facilitated positive peer connections (Rosado, 2019). Adult cancer patients participating in group music therapy noted peer support as a psychological benefit (Pothoulaki et al., 2012). Participation in peer support programs help those who have experienced trauma and have a mental disorder understand that they are not alone in or the cause of their experiences (Sullivan et al., 2018).

Collaboration and Mutuality

Survivors of trauma are controlled by the traumatic situation. In the case of domestic or intimate partner violence harmful acts are done to the survivor (Classen & Clark, 2007), or the survivor is put is a "position of submission and coercion" (Pemberton & Loeb, 2020, p. 122.) This power dynamic may be relived in the therapeutic relationship if the music therapist does not work to flatten the hierarchy (Elliot et al., 2005). For example, therapeutic relationships in which the client feels they must do as the therapist asks may activate a stress response similar to what is/was experienced in the traumatic situation (Perry, 2009). Therapeutic relationships that embrace equality between the therapist and client and allow for shared decision making can be healing and create a model for other relationships (Pemberton & Loeb, 2020; SAMHSA,2014). Collaboration also enhances empowerment, another hallmark of trauma informed care. Purdon (2006) also discusses the importance of treating clients who have experienced trauma in an egalitarian fashion. She notes this involves, listening, asking about hopes and fears, and providing information regarding options within the music therapy sessions. Therefore, Music therapy orientations and approaches that allow for flexibility and joint decision making are most appropriate when working from a trauma informed approach.

Empowerment, Voice and Choice

Empowerment provides clients with opportunities to take charge of their life by making conscious choices and controlling their actions in interpersonal and social arenas (Bent-Goodley, 2019; Elliott et al. 2005; Gutierez et al., 1998). Cattaneo and Chapman (2010) offer this description of empowerment:

> An iterative process in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action toward that goal, and observes and reflects on the impact of this action, drawing on his or her evolving self-efficacy, knowledge and competence related to the goal (p. 647).

Empowering clients means providing choices so they can have a voice in their therapeutic process and overall treatment. As noted by Bent-Goodley (2019), it provides opportunities for clients to feel validated and encouraged (p. 6).

Providing clients with choice is a key element of trauma informed care and may offer protection against retraumatization (Najavitis, 2019). Choice is taken away from clients who have experienced trauma; they did choose to be traumatized, nor did they have any say in the symptoms they may experience (Classen & Clark, 2017; Elliott et. al 2005; Najavits, 2019). Providing clients with a choice of music experiences, length and format of sessions, and other aspects of the therapeutic process are basic ways to allow clients to say to yes to what they deem will be helpful, and no to what they deem will not (Elliott et. al 2005; Najavits, 2019). It is incumbent upon music therapists to be flexible in their approach to treatment, so that choices can be offered and the clients voice heard.

Cultural, Historical, and Gender Issues

"Culture has significant implications for music therapy, because culture influences the therapeutic relationship and further affects the whole music therapy

process – assessment, treatment and evaluation (A-Kim, 2020; p. 11). Music therapists must understand their clients' cultural context, recognize the impact of historical trauma (emotional and psychological wounding across generations, and offer gender responsive services (Brave Heart, 2003; Elliott et al, 2005; SAMHSA, 2014). The meaning given to violence and trauma varies by culture (Briere & Scott, 2015). Elliott et al. (2005) remind clinicians that several factors influence how violence and trauma are viewed including "sexual orientation, religion, age, economic class, disability status, and race/ethnicity" (p. 469). These factors also contribute to treatment barriers and community resources.

Trauma-Informed Assessment

The process of completing the trauma assessment, allows a clinician to understand the current trauma symptoms, the negatives of trauma exposure (Amirkhan & Marckwordt, 2017; Goodman, 2017), determine risk of suicide, assess self-harm (Clark et al., 2015), current level of functioning (Dass-Brailsford, 2007), and the client's environment and available support system (Afana, et al., 2020). This helps a clinician to understand and determine if a client is utilizing avoidant or maladaptive coping skills, as well as what those skills include (Amirkhan & Marckwordt, 2017; Goodman, 2017). This underscores the ways in which the client generally feels about how they are able to cope with limited and available resources (Anderson et al., 2018).

A trauma informed assessment is an essential first step in the therapeutic process as it serves multiple functions. The assessment is an initial step in creating a sense of safety, identifying if the client is at-risk, and developing a treatment plan that is focused on recovery (Brown et al., 2013; Clark, et al., 2015; Hopper, 2017). Completing a detailed assessment helps a clinician understand a client's current level of function

(related to affect dysregulation and coping skills), identify current stressors, self-regulatory behaviors, interpersonal skills (Curran, 2013; Kerig, 2013), and the extent of trauma exposure and its effects (Briere & Scott, 2015). A trauma informed assessment also focuses on identifying the client's strengths and resources to support their resilience and foster a sense of empowerment (Clark, et al., 2015; Curran, 2013; Hopper, 2017). The assessment is vital to understand the client's symptoms and reactions associated with their trauma, comorbid disorders, and their available internal and external resources. Additionally, the therapist needs to understand that any type of trauma work should not begin until the client has sufficient coping skills in place and has a sense of competence implementing these skills (Curran, 2013; van der Kolk, 2014).

Music Therapy Treatment: Goals and Methods

A thorough trauma informed assessment provides the information needed to determine and develop the music therapy treatment plan. Understanding the client's current level of functioning and coping strategies ensures the clinician will begin the therapeutic process addressing the primary therapeutic needs of the client. The initial goals in the therapeutic process need to address any safety concerns or risks that have been identified (Briere & Scott, 2015; Clark, et al., 2015; van der Kolk, 2014). The next section will focus on three areas related to trauma informed care and approach. These areas are key and have been identified as factors and play an important role in the ability of individuals to manage symptoms related to mental illness and trauma. These include coping (e.g., Kuper et al., 2020), resilience (e.g., Ungar & Theron, 2020), and emotion regulation (e.g., Cludius et a., 2020).

Coping

Coping has been defined as the behavioral and cognitive strategies individuals use to manage or alleviate stressful situations (Lazarus & Folkman, 1984; Thompson & Jaque, 2019). Coping strategies may be adaptive (positive) or maladaptive (negative). Clients that have limited adaptive coping strategies will need to develop these skills in order to respond and manage stress and negative effects associated with their trauma (Briere & Scott, 2015; Mattson, et al., 2018; Thompson & Jaque, 2019). In the process of developing coping skills, placing greater emphasis on client's thoughts and feelings may promote more active engagement in developing new coping strategies (Booker, et al., 2020). When clients are able to acknowledge their thoughts and feelings, they recognize the need to use coping oriented strategies, rather than coping avoidant strategies (Mattson, et al., 2018). The development of adaptive coping-oriented skills is predicative of post trauma growth (PTG) and facilitates overall PTG, which improves a client's current level of functioning and long-term adaptation (Mattson, et al., 2018).

The use of music and music therapy methods may be a helpful and effective means of coping (Davis, 2010; Garrido, et al., 2015; XXXX & XXXX, 2015; McFerran & Teggelove, 2011) though there is a paucity of research demonstrating the efficacy among individuals with complex mental disorders. Descriptive data from pilot studies suggest that cognitive behavioral music therapy groups may have a positive impact on the development and use of positive coping skills in patients with complex mental health diagnoses (Hakvoort et al., 2015; Silverman, 2019: Silverman, 2011). There is a substantial body of research which supports the use of music therapy on stress management and anxiety reduction. For example, vocal re-creation and vocal

improvisation were found to significantly decrease salivary cortisol, a bio-marker of stress in chemically dependent individuals (Taets et al., 2019). Music listening was found to significantly reduce stress in hospitalized alcohol-dependent clients (Hwang & Oh, 2013). This suggests that singing, vocal improvisation, and music listening may be useful as coping skills for individuals with complex mental disorders.

Resilience

Resilience, defined as the ability to adapt to life challenges despite significant adversity (Shiner & Masten, 2012) or the ability to bounce back from adversity, is a key factor in the maintenance of mental health. The importance of resilience in successful recovery for individuals who have complex clinical diagnoses has been well documented in the literature (e.g., Las Hayas et al. 2016; Roberts et al. 2002; Zweben et al. 2015). There are several biopsychosocial factors that are associated with resilience (see Southwick et al., 2015) that are positively influenced by participation in music therapy. For example, music listening and active music making has been shown to reduce levels of cortisol, decrease self-reported levels of stress, increase dopamine levels, and foster a sense of connection with others (e.g., Fancourt et al., 2016; Leggae, 2015; Menon & Levitan, 2005; Pearce et al. 2015; Winkleman, 2003). Landis-Shack and colleagues (2017) note that music therapy methods share the same resilience-enhancing mechanisms for recovery as mindfulness and other relaxation techniques. Given this, music therapists working with individuals who have complex clinical diagnoses may want to include music therapy methods such as music relaxation with or without imagery, music guided breathing, vocal and instrumental re-creation, and group drumming. A modified approach to the Bonny Method of Guided Imagery and Music (GIM) may be indicated for some

clients to help clients build resources, which will enhance their resilience (Beck et al., 2018).

Emotion Regulation

Emotion regulation refers to how individuals experience and express emotions (Gross, 1998). According to Frenzel & Stephens, (2013) “emotions are multidimensional constructs comprising affective, psychological, cognitive, expressive, and motivational components" (p. 5). Frijda (1994) and Jenkins & Oatley (1996) further suggest that emotion is an affective response to something of importance that has occurred in an individual’s life. Emotions may be experienced along a continuum from pleasant to unpleasant, and each person’s affective reaction to an emotion is unique. Emotional regulation involves the ability to monitor, evaluate, and modulate emotional reactions as well as the regulation of physiological processes and behaviors related to emotional expression (e.g., Eisenberg, 2004). It also refers to how individuals influence their own and other people’s emotions (Gross, 1998). Emotional regulation deficits, or dysregulation is a common feature in many mental disorders (Aldao et al., 2010; Cludius et al. 2020). Recent studies have linked maladaptive emotional regulation strategies to depression, anxiety, eating disorders, and substance use disorders (Aldao & Nolen-Hoeksema, 2012; Aldao et al. 2010). While not specifically mentioned in the above cited studies, depression and anxiety are often symptoms associated with chronic mental illness and posttraumatic stress disorder. Therefore, emotional regulation is considered a transdiagnostic process meaning it is present in more than one mental disorder, and contributes to the maintenance of psychopathology (Harvey et al. 2004; Sloan et al., 2017).

There is a significant body of research that supports the use of music for emotional self-regulation (see Saarikallio, 2010 for a detailed discussion). Based on this, Marik & Stegemann (2016) suggest that music may be an important tool, and music therapy methods are important interventions in addressing emotional dysregulation. Engaging in music either passively (listening) or actively (creating) increases blood flow to the pleasure centers of the brain, increases endorphin production, and reduces cortisol production thereby helping clients to manage negative emotions and mood (Landis-Shack et al. 2017). Clients who participate in music therapy can begin to learn how to name, tolerate, explore, and express various emotions through participation in improvisation, song discussion, and composition methods. A modified approach to the BMGIM may also facilitate emotional exploration and expression. Music therapists can assist clients in developing playlists that can be used outside of the therapy room to modulate mood and emotional reactions (XXXX & XXXX, 2015).

Trauma Informed Clinical Case Study

The following clinical case study demonstrates the implementation of a trauma informed assessment and therapeutic process. Based on the clinical assessment and evaluation of the safety risks, a music therapy treatment plan was developed with therapeutic goals to address the primary needs, strengths and preferences of the client. Music therapy methods were then implemented based on the needs and preferences of the client. This clinical case illustration focuses on the trauma informed care approach implemented and not the trauma work. The music psychotherapeutic work focused on working through this client's early childhood trauma is published elsewhere (XXXX,

2015) and will not be reviewed or explored, since the focus of this article is on the trauma informed care approach.

Context of Clinical Case

The clinical case presented is of a client that presented for evaluation at an eating disorder (ED) specialty clinic and following that evaluation was admitted into outpatient eating disorder treatment. During the evaluation appointment, the client meets with a therapist, dietitian, physician, and psychiatrist. This team assesses the client's level of ED symptom use, medical stability, mental health status, current level of coping, and treatment history. Following the assessment, the treatment team provides diagnoses and treatment recommendations. In this case, the intake team recommended outpatient ED treatment, which consisted of the client attending weekly appointments with a primary therapist, dietitian, and physician, and monthly appointments with the psychiatrist for review and management of pharmacological treatment. The outpatient team communicated regularly regarding challenges and progress in the treatment process.

In this clinical case, the music therapist served as the client's primary therapist and utilized music therapy as the primary therapeutic modality to address the client's needs. This case illustration includes the client's history, complex profile, and the music therapy based trauma informed approach implemented from assessment to treatment is discussed. The music therapy methods utilized in this trauma informed approach were tailored to the preferences and to meet the needs of the client to help her develop coping skills she would be able to integrate and utilize in her daily life. Information provided regarding the use of methods provides an illustration of how they can be utilized within a trauma informed approach and detailed descriptions of what the music therapist is not

provided, as the methods were adapted in numerous ways to meet the needs of the client in this case.

Client History

Angie was a 27-year-old white female, married with a one-year-old son when this treatment process began. Following her intake assessment at the eating disorder clinic she began outpatient treatment and had her first session with the music therapist. In her initial therapy assessment, she reported she was a registered nurse, worked in the surgical area and that she loves her work, and feels she is very good at her job. She also shared that this is the one part of her life where she feels confident and capable in her skills and abilities.

Angie was first diagnosed with Anorexia Nervosa (AN) at age fourteen and at this point in time her eating disorder (ED) symptoms included restricting her food intake, purging, and over exercising. She was also diagnosed with Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) at this same time and this was when she encountered her first episode of outpatient treatment for her eating disorder. Angie was in and out of outpatient eating disorder treatment throughout high school and college, and reported short periods of time when her ED symptoms subsided. She shared that when her depression and anxiety worsened, or life became stressful, that her ED symptom use would return.

After college, Angie began working and got married, she did continue to restrict her food intake and over exercise. However, when she found out she was pregnant, she was able to use this as motivation to stop her symptom use as she recognized that her ED symptom use could harm the fetus. Throughout her pregnancy she did not use ED

symptoms, but it was at this point she began using self-injurious behavior (SIB) as a means of coping and would cut herself when she felt overwhelmed. Following the birth of her son, she began restricting her food intake, purging, over exercising again. When the use of these symptoms and SIBs intensified, she decided it was time to seek treatment. Angie shared she felt a great deal of shame about all of her symptom use and that she had not disclosed this to anyone in her life, her husband was not even aware of her symptom use. Her reduced nutritional intake, purging, and overexercising placed Angie at risk for medical complications if the severity of these symptoms increased. She reported utilizing in SIBs 1-2 times per week and denied any thoughts of suicide, which indicated there was no threat of imminent danger. Angie also disclosed that between the ages of 4-5 years old she was sexually abused by the spouse of the woman who was her childcare provider. The experience of the abuse was complicated by the fact the childcare provider was a close friend of her mother.

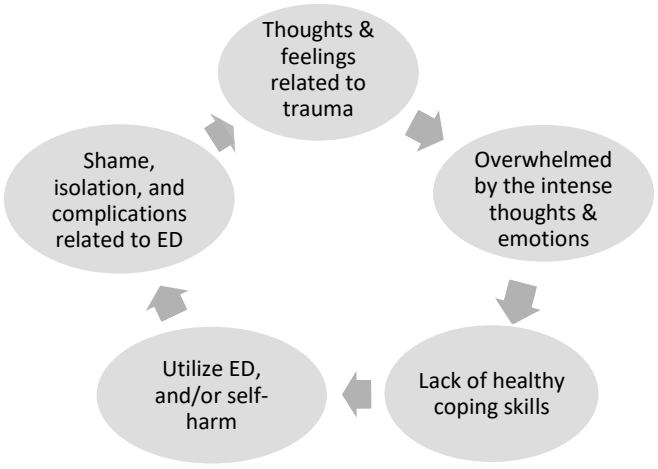
Treatment Process

It was evident from Angie's trauma informed assessment that she was struggling to cope and her ED symptoms and SIBs served as her primary coping skills. This necessitated focusing her treatment plan on helping her develop coping skills that could replace the current negative skills she was using. This process began by helping Angie understand when, and why, she turned to using these symptoms and behaviors and to develop her awareness of when she was vulnerable and at risk.

Figure 1 illustrates the cycle that Angie experienced when her thoughts and/or feelings were overwhelming. Depicting this cycle helped Angie to understand and recognize what was triggering her ED symptoms and SIBs, and how the cycle was being

perpetuated by isolation and feelings of shame. Additionally, as she began to understand this cycle, she was able to see that her current (negative) coping skills were also part of the problem and she needed to develop new skills in order to interrupt this cycle. The process of illustrating this cycle helped to foster transparency, build trust in the therapeutic relationship, and empowered Angie to make a choice to change and focus on developing new coping skills.

Figure 1: Angie's process of coping



The next step in Angie's therapeutic process focused on developing adaptive coping skills, which would allow her to relinquish her negative coping skills. This phase of music therapy focused on exploring and learning various ways of using music as a tool to cope, and then practice implementing these skills in her everyday life. The music therapy methods utilized were selected based on Angie's needs, interests, strengths, and music preferences which are identified in Table 1. These methods were co-created and tailored to actively engage Angie in shaping the experiences, which empowered her in

making choices, and fostered a sense of safety and trust throughout this therapeutic process.

Table 1

Angie's Strengths, Interests, and Music Preferences

Strengths	**Interests**	**Music Preferences**
Motivated to engage in treatment and to make changes in her life	Learning to use music in new and different ways to foster her health and wellbeing	Listens to and enjoys music from different genres (popular, folk, contemporary/new age, jazz, and some classical)
A desire to learn new and different ways to cope	Discovering how to use her inner resources	Enjoys music integrated nature sounds
Understanding of the body and the stress and relaxation response	Enjoys journaling (writing and drawing)	Prefers acoustic music, but does like some synthesized/electronic music
Some understanding of how music fosters relaxation response (learning in nursing training & practice)	Developing skills that can be implemented at home or at work as needed	Sings to her son to help him fall asleep at night and finds this soothing

Table 2 details provides a brief description of the music therapy methods utilized, description of the method, the therapeutic need or needs address, how they helped Angie, details regarding the music, and the trauma informed principle underlying the use of the method. The methods are listed in Table 2 are in the order in which they were implemented in the therapeutic process. The music experiences utilized were co-created and adapted in multiple ways throughout the therapeutic process. For example, several different direct music imaging experiences were created and recorded based on Angie's preferred images and music. The myriad ways that the methods were adapted and tailored to meet Angie's therapeutic needs are not detailed further in this manuscript

and it is important to acknowledge that the flexibility inherent in music and the methods provided the opportunity for Angie and the music therapist to work creatively and reflexively in the process.

The process of co-creating the music experiences with Angie allowed the music therapist to teach her about the therapeutic elements and aspects of music that allowed her to better understand how music is a valuable resource and tool to be integrated into her coping skills repertoire. Developing this knowledge not only informed her about why music is helpful, but also empowered her to make informed decisions and choices about when music may be the appropriate means for coping.

Table 2

Music therapy methods in trauma informed care

Music therapy method utilized with Angie	**Description of the method**	**Need identified by assessment**	**Music**	**Trauma informed principle(s)**
Music relaxation	Music listening to foster a relaxation response to manage stress and anxiety	Need: Coping & emotion regulation To help Angie select and use music to manage her stress and anxiety, to refocus and distract from her ED thoughts and provide her with a resource she could use at home or on a break at work	Instrumental contemporary/ new age and improvised music (60-80 beats per minute) created by music therapist; music and vocal music Angie selected music from preferred artists and groups that allowed her to focus on the music rather than ED or anxious thoughts	Safety, trust

Entrainment	Listening to music in order to slow down the rhythms of the body (breathing, heart rate, etc.)	Need: Coping & emotion regulation To support Angie learning how she can use music to help slow down her body's response to stress and anxiety	Therapist created a guided deep breathing experience accompanied by improvised music created music (60-80 beats per minute) created by music therapist utilizing instruments selected by Angie	Safety, trust, choice
Directed music imaging	Client imaging to guiding provided by the therapist	To empower Angie to develop her skills in managing her stress and anxiety	Imagery co-created by Angie and music therapist with contemporary/new age music that supported the imagery and preferred by Angie	Safety, trust, transparency, collaboration, empowerment/ choice
Stimulative listening	Listening to music designed to elevate or shift mood (based on the iso principle)	Need: Coping & emotion regulation To actively engage Angie in creating a tool (playlists) she can use to manage mood states and develop the skills to create playlists that would be helpful in the future and have accessible tool to use in her everyday life	Co-created playlists with Angie to help manage and shift, mood, anxiety, and to empower and inspire her. Music selected based on Angie's preferences and the desired mood state or message	Trust, collaboration, empowerment/ choice
Toning	Using the voice to create vibration to resonate with client's body (in this case her heart and stomach/gut)	Need: Coping To help Angie develop a coping skill that could be implemented when other resources are not available, to discover how her voice is a valuable resource, and empower her to use her voice	Practiced toning along with recordings the music therapist created using improvised music accompanied by ocean waves to give her support until she felt comfortable toning unaccompanied	Safety, Empowerment/ choice/voice

Chanting	Vocalizing on an empowering word(s)	Need: Coping & emotion regulation To empower Angie in using her voice and integrate words that fostered a sense of calm support strength (Angie chose the following words to chant: breathe, peace, tranquility, and rest)	Practiced chanting with recordings the music therapist created using improvised music with a drone base to give her support until she felt comfortable toning unaccompanied	Empowerment/ choice/voice
Drawing (mandala) or journaling to music	Drawing or writing while listening to music	Need: Coping & emotion regulation To provide Angie a way to release and contain emotions that needed to be expressed	Engaged in drawing and journaling with music to provide structure, containment, and time limited process to be present with and practice tolerating uncomfortable emotions when they arose	Safety, empowerment/ choice/voice

(Bruscia, 2014; XXXX & XXXX, 2015)

This phase of Angie's therapeutic process included weekly 50 minute sessions over the course of a three month timeframe. In sessions, Angie worked collaboratively to co-create the music experiences, that were then practiced within the sessions with the music therapist facilitating. Angie would then practice using these techniques in her daily life. She would check in during subsequent sessions and report on her process and progress using these new coping skills. When she reported challenges, these would be addressed in the therapy session by practicing, making adjustments or adaptations as needed. Angie demonstrated very good follow through in the process and practiced these skills diligently. She encountered struggles when her urge to use symptoms (ED and SIBs)

were strong. She expressed feeling shame when she reported that she 'slipped up' and used symptoms rather than her new coping skills. It was important to validate her experiences in this process, recognizing that change is not always easy, and that it takes time, patience, and practice. By the end of three months, she had a strong command of these new coping skills and was able to respond more proactively, implementing these new skills when she noticed early signs of stress and anxiety.

Angie's therapeutic process was designed to meet her needs by drawing upon her strengths, considering her cultural context, utilizing her music preferences, and integrating the principles of trauma informed care. Engaging in the process of change within the context of the therapeutic relationship, fostered the development of trust and her sense of safety for Angie. She cultivated her resilience as she co-created, learned, and practiced these new coping skills (Ford & Russo, 2006; Kain & Terrell, 2018), which allowed her over time to relinquish her maladaptive skills (Badenoch, 2018). Changing her pattern of coping, helped her interrupt her cycle (illustrated in Figure 1), which helped alleviate the shame she experienced when using her ED symptoms and SIBs. This phase of her therapeutic process was critical, as it helped her develop the skills, she would need to manage emotions that would emerge during the course of her trauma work (Heiderscheit, 2015).

Training, Consultation & Supervision

Working from a trauma informed care perspective is not trauma work. Trauma work is complex and requires **significant** training and supervision and is beyond the scope of this article. A clinician must have the necessary training to be able to practice ethically and responsibly to work with clients that have experienced trauma. This

often entails advanced and specialized training to ensure a client is not re-traumatized in the therapeutic process (Behrens, 2019). Literature related to trauma and its impact on the brain and body have helped to further inform how to effectively approach therapeutic work from a trauma informed approach. As a result, it is critical for clinicians to understand neurobiology and its impact on trauma (Behrens, 2019; Evans & Coccoma, 2014; Porges, 2017; van der Kolk, 2014). This may often require clinicians to seek out additional training and workshops that focus on this specialized knowledge or advancing their training (Sokira, 2019) to work safely and appropriately with clients.

Clinicians **must** maintain a strong ethical and professional practice, responding to the client's evolving and changing needs, while also attending to one's own self-care (Briere & Scott, 2015). As professional music therapists, we are obligated to practice within the scope of practice our education and clinical training has prepared us to practice (AMTA, 2015). This requires the music therapist to understand their knowledge, skills, abilities and experience, and to employ these skills in a safe, effective and ethical manner, without risk or causing harm. Music therapists are also bound to their professional code of ethics and to abide by the core values of kindness, social responsibility, dignity & respect, equality, accountability, excellence, integrity, and courage (AMTA 2019).

Due to the complexity and the impact of trauma on clients it is helpful for a clinician to actively engage in consultation with other members of the treatment team or with colleagues when questions, issues, or concerns arise (Sokira, 2019). The complexities inherent in trauma work can also warrant a clinician engaging in professional supervision. Due to a variety of therapeutic issues such as transference and

countertransference that may surface in the process of trauma work it is vital for a clinician to seek the supervision, or consultation from more experienced professionals to process through these therapeutic issues. This is not only important for the care of the client, but also to receive support and guidance as a clinician to manage vicarious trauma.

Conclusion

In summary, working from a trauma-informed perspective means having an awareness that clients may have experienced many different types of trauma; even if that is not the primary reason they give for seeking treatment. Trauma can be insidious, subtle, or chronic; each person will respond in their own unique way, including developing coping mechanisms that may contribute to other mental health issues. A trauma-informed approach creates a partnership between the therapist and client needs (Bent-Goodley, 2019). It involves incorporating the principles of trauma informed care (SAMHSA, 2014), completing a trauma informed assessment that will inform the treatment plan. Music therapists working within their level of competence can offer clients multiple music therapy methods to address identified clinical needs. It is important to know and recognize the signs of trauma to minimize the risk of re-traumatization (Classen & Clark, 2017). Finally, supervision, consultation or referrals should be made to an advanced practice, trauma-trained music therapist if traumatic memories surface or the client is re-traumatized.

Conflicts of Interest: None declared.

References

A-Kim, S. (2020). Music as an acculturation strategy in culturally informed music therapy. In Belgrave, M. & A Kim, S. (Eds.), *Music therapy in multicultural context: A handbook for music therapy students and professionals.* Jessica Kingsley Publishers.

Afana, A. Tremblay, J. Ghannam, J. Ronsbo, H. & Veronese, G. (2020). Coping with trauma and adversity among Palestinians in Gaza Strip: A qualitative, culture-informed analysis. *Journal of Health Psychology, 25*(12), 2031-2048.

Alaggia, R., Michalski, J. H., & Vine, C. (1999). The use of peer support for parents and youth living with the trauma of child sexual abuse: An innovative approach. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *8*(2), 57–75. doi:10.1300/J070v08n02_04

Aldao, A. & Nolen-Hoeksema, S. (2012) When are adaptive strategies most predictive of psychopathology? *Journal of abnormal psychology*, *121*(1), 276-281. doi:10.1037/a0023598.

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review, 20*(2) 217-237. https://doi.org/10.1016/j.cpr.2009.11.004

American Music Therapy Association (2015). *Scope of Practice.* Author. Retrieved from https://www.musictherapy.org/about/scope_of_music_therapy_practice/

American Music Therapy Association (2019). *Code of Ethics*. Retrieved from https://www.musictherapy.org/about/ethics/

Amirkhan, J. & Marckwordt, M. (2017. Past trauma and current stress and coping: Toward a general model. *Journal of Loss and Trauma, 22*(1), 47-60.

Anderson, R. McKenny, M. Mitchell, A. Koky, L. & Stevenson, H. (2018). Embracing racial stress and trauma preliminary feasibility and coping responses of a racial socialization intervention. *Journal of Black Psychology, 44*(1), 25-46.

Badenoch, D. (2018). *The heart of trauma: Healing the embodied brain in the context of relationships.* W. W. Norton.

Baird, C. (2018). A trauma-informed approach to substance abuse treatment. *Journal of Addictions Nursing, 29*(4), 262–263

Beck, B. D., Messel, C., Meyer, S. L., Cordtz, T. O., Søgaard, U., Simonsen, E., & Moe, T. (2018). Feasibility of trauma-focused Guided Imagery and Music with adult refugees diagnosed with PTSD: A pilot study. *Nordic Journal of Music Therapy, 27*(1), 67-86. doi:10.1080/08098131.2017.1286368

Behrens, G. (2019). Challenges, benefits, and trends from a neurobiological approach to music therapy. *Music Therapy Today, 15*(1), 13-20.

Bent-Goodley, T. B. (2018). The necessity of trauma-informed practice in contemporary social work. *Social Work, 64*, 5-7. doi:10.1093/sw/swy056

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361–368.

Booker, J. Fivush, R. Graci, M. Heitz, H. Hudak, L. Jovanovic, T. Rothbaum, B & Stevens, J. (2020). Longitudinal changes in trauma narratives over the first year

and associations with coping and mental health. *Journal of Affective Disorders, 272,* 116-124.

Brave Heart, M. Y. H. (2003). The historical trauma response among natives and its relationship with substance abuse: a Lakota illustration. *Journal of Psychoactive Drugs*, *35*(1), 7–13. https://doi-org.10.1080/02791072.2003.10399988

Brewerton, T. D. (2019). An overview of trauma-informed care and practice for eating disorders. *Journal of Aggression, Maltreatment & Trauma*, *28*(4), 445–462.

Briere, J. & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Sage.

Brown, V., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs, 45*(5), 386-393.

Brown, V. B., & Melchior, L. A. (2008). Women with co-occurring disorders (COD): Treatment settings and service needs. *Journal of Psychoactive Drugs, Sarc Suppl 5*, 365–385. https://doi:10.1080/02791072.2008.10400664

Bruscia, K. (2014). *Defining music therapy.* Barcelona Publishers.

Bruscia, K. E. (2015). *Forms of reflexivity in music therapy: An anthology.* Barcelona Publishers.

Cattaneio, L. B., & Chapman, A. R. (2010). The process of empowerment: A model for use in research and practice. *American Psychologist, 65*(7), 646-659. doi.org/10.1037/a0018854

Clark, C., Classen, C., Fourt, A. & Shetty, M. (2015). *Treating the trauma survivor: An essential guide to trauma-informed care.* Routledge.

Classen, C. C., & Clark, C. S. (2017). Trauma-informed care. In S. N. Gold (Ed.), *APA handbook of trauma psychology,* Vol. 2. (pp. 515-541). American Psychological Association.

Cludius, B., Mennin, D., & Ehring, T. (2020). Emotional regulation as a transdiagnostic process. *Emotion, 20*(1), 37-42. doi.org/10.1037/emo0000646

Curran, L. (2013). *Trauma competency: A clinician's guide.* PESI, Inc.

Dalenberg, C. (2000). *Countertransference and the treatment of trauma*. dx.doi.org/10.1037/10380-000

Dass-Brailsford, P. (2007). *A practical approach to trauma: Empowering interventions.* Sage.

Davidson, L., Chinman, M/, Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 12*(3), 443-450. doi.10.1093/schbul/sbj043

Davis, K. M. (2010). Music and the expressive arts with children experiencing trauma. *Journal of Creativity and. Mental Health* 5, 125–133. doi: 10.1080/15401383.2010.485078

Eisenberg, N. (2004). Emotion-related regulation: An emerging construct. *Merrill-Palmer Quarterly, 50*(3), Special Issue: The maturing of the human developmental sciences: Appraising past, present and prospective agendas, 236-259.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477.

Evans, A. & Coccoma, P. (2014). *Trauma-informed care: How neuroscience influences practice.* Routledge.

Fallot, R. D., & Harris, M. (2008). Trauma-informed services. In G. Reyes, J. D. Elhai & J. D. Ford (Eds.) *Encyclopedia of psychological trauma* (pp. 660-662). Wiley.

Fancourt, D., Williamon, A., Carvalho, L. A., Steptoe, A., Dow, R., & Lewis, I. (2016). Singing modulates mood, stress, cortisol, cytokine and neuropeptide activity in cancer patients and carers. *Ecancermedicalscience*, *10*, 631.

Ford, J. & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy*, *60*(4): 335-355.

Frenzel, A. C., & Stephens, E. J. (2013) Emotions. In T. Goetz, & N. C. Hall (Eds.) *Emotion, motivation, and self-regulation: A handbook for teachers* (1-56). Emerald Group Publishing Limited.

Frijda, N.H. (1994). Varieties of affect: Emotions and episodes, moods, and sentiments. In P. Ekman & R.J. Davidson (Eds.), *The nature of emotion* (pp. 59–67). Oxford University Press.

Garrido, S. Baker, F. Davidson, J. Moore, G. & Wasserman, S. (2015) Music and trauma: The relationship between music, personality, and coping style. *Frontiers in Psychology*, *6*, doi: 10.3389/fpsyg.2015.00977.

Gobin, R. L., & Freyd, J. J. (2014). The impact of betrayal trauma on the tendency to trust. *Psychological Trauma: Theory, Research, Practice, and Policy, 6,* 505-511. doi.org/10.1037/a0032452

Goodman, R. (2017). Contemporary trauma theory and trauma-informed care in substance use disorders: A conceptual model of integrating coping and resilience. *Advances in Social Work, 18*(1), 186-201.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*. 271-299

Gutierrez, L. M., Parsons, R., & Cox, E. (1998). *Empowerment in social work practice: A sourcebook*. Brooks/Cole.

Hakvoort, L. Bogaerts, S. Thaut, M. & Spreen, M. (2015). Influence of music therapy on coping skills and anger management in forensic psychiatric patients: An exploratory study. *International Journal of Offender Therapy and Comparative Criminology*, *59*(8), 810-836.

Harvey, A. G., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment*. Oxford University Press.

XXXX, X. (2015). GIM in the therapeutic hour and case illustration of an adult client in eating disorder treatment. In Grocke, D. and Moe, T. (Eds.). *Guided imagery and music (GIM) and imagery methods for individual and group therapy,* (pp. 99-107). Jessica Kingsley Publishers.

XXXX, X. & XXXX, X. (2015). Use of the iso principle as a central method in mood management: A music psychotherapy clinical case study. *Music Therapy Perspectives*, *33*(1), 45-52.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror.* Basic Books.

Hopper, E. (2017). Trauma-informed psychological assessment of human trafficking survivors. *Women & Therapy, 40*(1-2), 12-30.

Hwang, E.-Y., & Oh, S.-H. (2013). A comparison of the effects of music therapy interventions on depression, anxiety, anger, and stress on alcohol-dependent clients: A pilot study. *Music and Medicine, 5*(3), 136–144. https://doi-org.10.1177/1943862113495894

Jenkins, J. M., & Oatley, K. (1996). Emotional episodes and emotionality through the lifespan. In S. H. McFadden & C. Magai (Eds.) *Handbook of emotion, adult development, and aging* (pp. 421-441). Academic Press.

Johnson, S. D., Cottler, L. B., Callahan O'Leary, C., & Abdsallah, A. (2010) The association of trauma and PTSD with the substance use profiles of alcohol-and cocaine-dependent out-of-treatment women. *The American Journal on Addictions, 19*(6), 490-495. doi: 10.1111/j.1521-0391.2010.00075.x

Kain, K. & Terrell, S. (2018). *Nurturing resilience: Helping clients move forward from developmental trauma and integrative somatic approach.* North Atlantic Books

Kerig, P.K. (2013). *Trauma-informed assessment and intervention*. National Center for Child Traumatic Stress.

Khoury, L., Tany, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. *Depression and Anxiety, 27,* 1077-1086. doi:10.1002/da.20751

Kuper, L., E., Gallop, R., & Greenfield, S. F. (2010). Changes in coping moderate substance abuse outcomes differentially across behavioral treatment modality. *The American Journal on Addictions, 19,* 543-549. doi: 10.1111/j.1521-0391.2010.00074s

Landis-Shack, N., Heinz, A. J., & Bonn-Miller, M. O. (2017). Music therapy for posttraumatic stress in adults: A theoretical review. *Psychomusicology: Music, Mind, & Brain, 27*(4), 335-342. doi:10.1037/pmu0000192

Las Hayas, C., Padierna, J. A., Muñoz, P., Aguirre, M., Gómez del Barrio, A., Beato-Fernández, L., & Calvete, E. (2016). Resilience in eating disorders: A qualitative study. *Women & Health*, *56*(5), 576–594. doi:10.1080/03630242.2015.1101744

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Legge, A. W. (2015). On the Neural Mechanisms of Music Therapy in Mental Health Care: Literature Review and Clinical Implications. *Music Therapy Perspectives*, *33*(2), 128–141.

Malchiodi, C. (2020). *Trauma and expressive arts therapy: Brain, body, & imagination in the healing process.* Guildford Press.

Manning, E. & Gagnon, M. (2017). The complex patient: A concept clarification. *Nursing Health Science, 19,* 13-21.

Marik, M., & Stegemann, T. (2016). Introducing a new model of emotional dysregulation with implications for everyday use of music and music therapy. *Musicae Scientiae, 20*(1), 53-67. doi:10.1177/1029864915622055

Mattson, E. James, L. & Engdahl, B. (2018). Personality factors and their impact on PTSD and post-traumatic growth is mediated by coping styles among OIF/OEF veterans. *Military Medicine, 183*, 475-480.

McCormack, L., & Katalinic, N. (2016). Learning to heal from those who know! The "lived" experience of a peer support program for adult survivors of childhood trauma. *Journal of Aggression, Maltreatment & Trauma, 25*(10), 1021–1042. doi:10.1080/10926771.2016.1223247

McFerran, K., & Teggelove, K. (2011). Music therapy with young people in schools: After the Black Saturday fires. *Voices* 11. doi: 10.15845/voices.v11i1.285.

Menon, V., & Levitin, D. J. (2005). The rewards of music listening: Response and physiological connectivity of the mesolimbic system. *NeuroImage, 28*, 175-184

Mourra, S., Sledge, W., Sells, D., Lawless, M., & Davidson, L. (2014). Pushing, patience, and persistence: Peer providers' perspectives on supportive relationships. *American Journal of Psychiatric Rehabilitation*, *17*(4), 307–328.

Najavits, L. (2019). *Finding your best self: Recovery from trauma, addiction, or both.* Guilford Press.

Pearce, E., Launay, J., & Dunbar, R. I. M. (2015). The ice-breaker effect: Singing mediates fast social bonding. *Royal Society Open Science*, *2*(10), 15022

Perlman, L. A. & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress, 18,* 449-459. dx.doi.org/10.1002/jts.20052

Perry BD. (2009). Examining child maltreatment through a neurodevelopmental lens: clinical applications of the neurosequential model of therapeutics. *Journal of Loss & Trauma*, *14*(4), 240–255. https://doi-org. 10.1080/15325020903004350

Porges, S. (2017). *The pocket guide to the Polyvagal Theory: The transformative power of feeling safe.* W.W. Norton.

Pothoulaki, M., MacDonald, R., & Flowers, P. (2012). An interpretative phenomenological analysis of an improvisational music therapy program for cancer patients. *Journal of Music Therapy*, *49*(1), 45–67. https://doi-org./10.1093/jmt/49.1.45

Purdon, C. (2006). Feminist music therapy with abused teen girls. In S. Hadley (Ed.) *Feminist perspectives in music therapy* (pp. 205-226). Barcelona Publishers.

Racine, S. E., & Wildes, J. E. (2015). Emotion dysregulation and anorexia nervosa: An exploration of the role of childhood abuse. International Journal of Eating Disorders, 48, 55–58. doi.org/10.1002/eat .22364

Rosado, A. (2019). Adolescents' Experiences of Music Therapy in an Inpatient Crisis Stabilization Unit. *Music Therapy Perspectives*, *37*(2), 133–140. https://doi-org. /10.1093/mtp/miz004

Roberts, A. C., Galassi, J. P., McDonald, K., & Sachs, S. (2002). Re-conceptualizing substance abuse treatment in therapeutic communities: Resiliency theory and the role of social work practitioners. *Journal of Social Work Practice in the Addictions, 2*(2), 53-68. Doi:10.1300/J160v02n02-06

Saarikallio, S. (2010). Music as emotional self-regulation throughout adulthood. *Psychology of Music*, *39*(3), 307–327. doi:10.1177/0305735610374894

Schäfer, I., & Najavits, L. M. (2007). Clinical challenges in the treatment of patients with posttraumatic stress disorder and substance abuse. *Current Opinion in Psychiatry*, *20*(6), 614–618.

Shiner, R. L., & Masten, A. S. (2012). Childhood personality as a harbinger of competence and resilience in adulthood. *Development and Psychopathology, 24*(2), 507-528. doi:10.1017/S0954579412000120

Silverman, M. (2011). Effects of music therapy on psychiatric patients proactive coping skills: Two pilot studies. *Arts in Psychotherapy, 38,* 125-129.

Silverman, M. (2019). Music therapy for coping self-efficacy in an acute mental health setting: A randomized pilot study. *Community Mental Health Journal, 55*(4), 615-623. https://doi-org.10.1007/s10597-018-0319-8

~~Silverman, M. J., Gooding, L. F., & Yinger, O. (2020). It's...Complicated: A Theoretical Model of Music-Induced Harm. *Journal of Music Therapy*, *57*(3), 251–281. https://doi-org.10.1093/jmt/thaa008~~

Sloan, E., Hall, K., Moulding, R., Bryce, S., Mildred, H., & Staiger, P. K. (2017). Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline personality disorders: A systematic review. *Clinical Psychology Review*, *57*, 141–163. doi:10.1016/j.cpr.2017.09.002

Sokira, J. (2019). Considerations for music therapy in long-term response to mass tragedy and trauma. *Music Therapy Today, 15*(1), 78-90.

Southwick, S. M., Pietrzak, R. H., Tsai, J., & Krystal, J. H. (2015). Resilience: An update. *PTSD Research Quarterly, 25*(4). 1-4. ISSN: 1050-1835

Substance Abuse and Mental Health Services Administration (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health.* (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Center for Behavioral Health and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Sullivan, C. M., Goodman, L. A., Virden, T., Strom, J., & Ramirez, R. (2018). Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents. *American Journal of Orthopsychiatry*, *88*(5), 563–570.

Taets, G. G. D. C., Jomar, R. T., Abreu, A. M. M., & Abreu, A. M. M. (2019). Effect of music therapy on stress in chemically dependent people: A quasi-experimental study. *Revista Latino-Americana de Enfermagem*, *27*.

Ungar, M., & Theron, L. (2020). Resilience and mental health: How multisystemic processes contribute to positive outcomes. *The Lancet Psychiatry, 7*(5), 441-448. doi:10.11016/S2215-0366(19)30434-1

van der Kolk, B. (2014). *The body keeps score: Brain, mind and body in the healing of trauma.* Viking Penguin.

Watt, B. D., Robin, G., Fleming, L., & Graf, E. (2013). Complex needs assessment panel and integrated support: Description and initial evaluation. *Advances in Mental Health*, *11*(2), 152–156.

West, M. (2013). Trauma and the transference-countertransference: Working with the bad object and the wounded self. *The Journal of Analytical Psychology, 38,* 73-98. doi:10.1111/j.1468*5922.20138.x

Winkelman, M. (2003). Complementary therapy for addiction: "Drumming out drugs." *American Journal of Public Health*, *93*(4), 647–651

Zweben, J. E., Moses, Y., Cohen, J. B., Price, G., Chapman, W., & Lamb, J. (2015). Enhancing family protective factors in residential treatment for substance use disorders. *Child Welfare*, *94*(5), 145–166.