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Can You Hear Me Now? The Potential of Trauma-Informed and Resilience-Oriented Music Therapy in the Context of Foster Care

Czy teraz mnie słyszysz? Muzykoterapia zorientowana na traumę i odporność psychiczną w kontekście opieki zastępczej

Abstract: The main reasons for placing a child in foster care system in Poland is neglect and abuse, experienced in their family environments. These conditions might result in trauma, which strongly influences functioning of these young people. Currently, concepts like trauma-informed and resilience-oriented practice receive more and more attention both in the practitioners and researchers, in search of the framework of care-services and therapies. The current paper explores these approaches and connects them to music therapy. It provides with rationale on potential of this form of therapy in the context of work within foster care system with young people. The case vignettes illustrate the theoretical considerations.

Keywords: trauma-informed approach; resilience; music therapy; foster care

Abstrakt: Głównymi powodami umieszczania dzieci w systemie pieczy zastępczej w Polsce są zaniedbania i nadużycia w środowiskach rodzinnych. Sytuacja taka może powodować traumę, mającą wpływ na sposób funkcjonowania młodych ludzi. Obecnie koncepcje takie jak praktyka zorientowana na traumę i odporność psychiczną zyskują coraz więcej uwagi praktyków i badaczy poszukujących ram teoretycznych dla oddziaływań opiekuńczo-wychowawczych i terapeutycznych. W niniejszym artykule dokonano analizy tych koncepcji i połączono je z obszarem muzykoterapii. Opracowanie dostarcza uzasadnienia dla potencjału muzykoterapii w kontekście pracy z młodymi ludźmi w systemie pieczy zastępczej. Opisy działań praktycznych ilustrują rozważania teoretyczne.

Słowa kluczowe: podejścia zorientowane na traumę; odporność psychiczna; muzykoterapia; piecza zastępcza

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INTRODUCTION

According to the newest available statistics, at the end of 2021, there was 72.3 thousand of children placed in foster care in Poland. Most of them, 56.4 thousand, stayed in foster families; the rest – 15.9 thousand were residents of foster care institutions. The biggest group in the family foster care were children from 7 to 13 years old; institutions became homes for older teenagers, aged 14–17 (GUS, 2022). The most common reason for locating a child in foster care was addiction (typically to alcohol) of a parent or both of them, connected with neglect and abuse of different types (physical, psychological, sexual), coexisting with risk factors such as violence and criminal activity in the family (Domański, 2015; Szymańczak, 2016).

The assumption of psychological trauma in the representatives of this group is therefore reasonable. Accordingly, trauma-informed perspective seems to be important in this context. Considering above mentioned factors, trauma exposure is common mainly in biological families of children placed in foster care, followed by the risks connected to the life in institutions. According to chosen research, psychological and physical abuse, caused by other residents, is not a rare occurrence in residential facilities of this type (Abramowicz et al., 2012; Lueger-Schuster et al., 2018).

Psychological trauma is multidimensional; it includes objective factors, such as adverse events, and subjective elements, such as individual responsiveness and vulnerability. It is physiopsychological experience which results in permanent damage and changes in neurobiological functioning of a person (Rothschild, 2000). The literature on this subject is increasingly available, ranging from neurobiological perspective (Akiki et al., 2018; McCrory et al., 2011; Opendak, Sullivan, 2019; Packard et al., 2021; Perry, 2009; Stark et al., 2015), through psychobiological (Fuchshuber et al., 2019; Lahousen et al., 2019), to practical, clinical approaches (Allen, 2013; Baylin, Hughes, 2016). Within the concept of psychological trauma there are different subtypes, specified on the basis of different aspects, such as acute versus chronic, complex trauma (depending on the number and frequency of potentially traumatizing events), interpersonal versus non-interpersonal trauma, or partially similar natural versus human-caused trauma (depending on the involvement of other people in the traumatic experience), direct versus indirect (from being abused to being an observer of an abuse) (Ross et al., 2021, Steuden, Janowski, 2016).

Complex, interpersonal trauma, precisely "attachment trauma", will be one of the key concepts in this paper. This term seems to fit the chosen perspective best. It will be understood accordingly to Allen's (2013) conceptualization, as a trauma which took place within closest relationships and results in profound mistrust towards others and the world around. It is related to different types of neglect and abuse experienced mostly, although not only during childhood. Neglect is the

reason of so-called omission trauma, and abuse leads to the commission trauma (Lahousen et al., 2019).

Children who experienced neglect and abuse instead of safety and protection in their early years might develop coping mechanisms that help them in functioning in threatening circumstances. However, these skills obtained and useful in potentially harmful environment are counterproductive in safe situations. The area that is mostly affected by interpersonal trauma is attachment; traumatized children might find it difficult to build strong, supportive relationships with carers, friends and partners. If attachment pattern of a person is insecure or disorganized it can cause further disappointments in interpersonal interactions (Lahousen et al., 2019). Regarding emotions, both identification and expression of them can be challenging for children who experienced trauma, therefore, their emotional reactions can be sudden and unexpected. Moreover, emotional regulation and management of feelings can be difficult for traumatized individuals. Due to learned and internalized perception of the world and people as dangerous, children who experienced trauma tend to be aroused, vigilant and alert all the time, being ready for the attack to happen, and also easily becoming overwhelmed by the surroundings. It also shows through aggressive, defensive, oppositional and extreme responses to events, which are not typically perceived as threatening. On the cognitive level, reasoning and problem solving are also affected by trauma. Finally, children who experienced extreme and prolonged stress from their parents frequently carry guilt, blame themselves for adverse events, feel worthless and have low self-esteem (NCTSN, 2023).

All of the described problems might occur in foster care institutions residents, as a results of traumatic experiences. The main goal of the current paper is to present music therapy in light of trauma-informed and resilience-oriented approaches as a valuable and potentially effective treatment option. Before integrating all of the key elements, trauma-informed approach, the concept of resilience, and music therapy itself will be introduced and explored.

TRAUMA-INFORMED PRACTICE

As different types of psychological trauma became recognized as public health problem, various concepts appeared in response. One of them – trauma-informed approach – focuses on in-depth understanding of trauma and belief that its results can be overcome. It also emphasizes cultural and contextual components of trauma perception and treatment. Regarding healing processes, the accent is placed on safety, physical and psychological, as a foundation of change. Another important notice in this approach is the one suggesting that therapeutic process should be

based in partnership between the client and the therapist instead of hierarchical relation. The clients should be empowered by gaining the impact on the course of work. Regarding children, it needs to be acknowledged that the traumatic events occur in some kind of context, and its perception relates on intrinsic and extrinsic factors in child's functioning. As mentioned above trauma does impact development on the neurobiological level and cause specific reactions and ways of responding to life situations, which might lead to further adversities. This should be well understood by the trauma-informed practitioner. Moreover, this perspective underlines the awareness, that trauma spreads out to the family and community members, and also does impact the care providers (Wilson et al., 2013).

Based on these insights, trauma-informed practice proponents, researchers and practitioners, formulated six key principles, fundamental to this approach:

- safety, understood accordingly to the needs of those being served,
- trustworthiness and transparency in all therapeutic actions,
- peer support, with "peer" meaning other trauma survivors,
- collaboration and mutuality with sharing the power and decision-making processes,
- empowerment, voice and choice of clients and care-providers,
- awareness of cultural, historical and gender issues (SAMSHA, 2014, p. 11).

RESILIENCE

Resilience is an important concept in considerations regarding trauma and the therapy related to it, to which trauma-informed practitioners refer in practical reflections (Goodman, 2017) and research approaches (Edelman, 2023). It can be defined in many ways. According to the American Psychological Association (2022), it "is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (para. 1). It covers, therefore, two separate phenomena: the process and the result of it.

In fact, there are different approaches to resilience; it is conceptualized as personality trait by some researchers, while others understand it as coping strategies or interactive processes, in which risk factors are negotiated by protective factors. For the sake of this paper, resilience will be understood as "an active and dynamic process through which a person adaptively overcomes a stressful or difficult situation" (Snijders et al., 2018). Considering the therapeutic context, this perspective provides a useful framework for theoretical considerations and clinical practice leading to better understanding of mechanisms that support resilience on both levels – individual and environmental.

There are two main types of both risk and protective factors in the resilience processes. First one includes individual, genetic, biological aspects, second – social and environmental ones. Risk factors range from very broad social circumstances, such as poverty or homelessness to more specific, such as abuse of different kinds, or violence, family breakdown, emotional loss, ADHD diagnosis or other individual mental and intellectual conditions, which can be connected, experienced simultaneously, or lead from one to another (Rutter, 1995; Richman, Fraser, 2001). They are typically strongly present in lives of foster care institution residents.

On the protective side there are five groups of experiences: a) involving reduction in the personal impact of risk experiences, b) reducing negative chain reactions, c) promoting self-esteem and self-efficacy in a person, d) opening up positive opportunities, e) allowing for cognitive processing of negative experiences (Rutter, 1995). Other researchers mention in this context individual features, such as certain personality traits, perseverance, determination, self-efficacy, creativity, coherence, self-awareness, and self-regulation ability. They also see the positive impact of family and school support, quality interactions with parents, positive appraisals, and good interpersonal relations (Dias, Cadime, 2017).

Some of these protective factors are not attainable or very hard to achieve in the context of institutionalized foster care (especially these related to family members), but other can be nurtured, protected and supported through adequate care and various treatments, including music therapy.

MUSIC THERAPY

Music therapy is treatment modality based on music as a therapeutic tool and core of interventions. The widely accepted definition of music therapy is the one given by Bruscia (2014). According to it, "music therapy is a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research" (p. 36). Two most important components of the definition on practical level that require emphasizing here are: music therapy experiences and relationships developed, and built upon them. Regarding the first one, it clarifies the musical element: is not just about music itself in music therapy, it needs to become an experience. There are many different forms of contacting with the music: listening to it, creating it, performing, dancing to it. They might leave the person indifferent, or lead to a change, producing meaningful experience

within a reflexive, therapeutic process. Considering the second component, the relationships, it suggests that the music experience should become relational, interactive, when placed within a therapeutic context and being the foundation of the therapeutic bond. It starts to be a realm not only ofexpression, but also communication.

Regarding therapeutic practice, there are four main methods of using music:

- re-creating (including performing and personalizing songs from the vast repertoire, covering all genres, based on the client preferences and suitability for the process),
- composing (on basic and advanced level, mostly through songwriting activities, or sometimes in purely instrumental form),
- improvising (free or structured, vocal, instrumental and combined, referential or non-referential),
- and listening experiences (based in all kinds of music, from pop songs to classical symphonies).

Each method offers myriads of variations and techniques, providing the therapist with rich and flexible material to work with. The concrete choices are always based on the goals of the work, established usually with the participant of the sessions, or their care givers, in reference to the needs and deficits, but mostly with respect to resources and potential of the person (Hiller, Gardstrom, 2018). Depending on the approach or model taken these goals might differ, however – in general – they are non-musical, aiming for improving and broadening the functioning possibilities in everyday life, not just within musical environment (Stachyra, 2012; Konieczna-Nowak, 2018). Trauma-informed approach to music therapy is currently getting more and more attention (Beer, Birnbaum, 2022; Heiderscheit, Murphy, 2021).

MUSIC THERAPY AS TRAUMA-INFORMED AND RESILIENCE-ORIENTED PRACTICE

Similarly to other care providing specialties, music therapy can be applied in respect to the principles of trauma-informed practice and as a support of resilience development and fostering. Table 1 shows how different experiences and competences that have protective influence on the resilience of an individual can be linked to, and nurtured through, music therapy activities.

Table 1. Protective experiences competences supporting resilience and examples of music therapy activities that can enhance them

Protective experiences and competences supporting resilience	Music therapy activities with a potential to build or strengthen the experiences and competences – examples
promoting self-esteem and self-efficacy	success-oriented composing, songwriting and performing
opening up positive opportunities	offering new, musical ways of expression, learning new musical skills (e.g. playing an instrument)
allowing for cognitive processing of negative experiences	free improvisation and songwriting processes, including non-verbal and verbal components
perseverance and determination	training and rehearsing musical pieces for concerts or performances of other types, gathering material for song and video clip
creativity	improvisation of different types, composing and songwriting
self-awareness and self-regulation	listening experiences providing stimulating insights, relaxation and visualization techniques
good relationships with care providers	all experiences built upon the music as a medium

Source: Author's own study.

Similar links can be done between the areas that might be affected by trauma and – again – music therapy interventions (Table 2).

Table 2. Areas affected by attachment trauma and music therapy activities with potential to work on them

Areas affected by attachment trauma	Music therapy activities with a potential to work on these areas
relationships	improvising music is interactive activity which makes possible to build relationships of different kinds, improves communication and allows for experiencing roles, such as leader/follower, being similar and being different, being close and distancing
identification and expression of emotions, emotional regulation	improvisation and songwriting stimulate emotional awareness, song lyrics discussion might also contribute to better understanding of own emotions and emotional responses of others
high arousal and vigilance	relaxation with music might help in decreasing tension, also improvisation can be a tool to achieve release
aggressive and defensive behaviors	aggression and defensiveness can be acknowledged and accepted in musical improvisation, they also might be processes musically

cognitive functions – reasoning and problem solving	songwriting and performing activities require training of these skills, with possibly highly rewarding goals – production and recording or public performance of the song
self-esteem	attaining musical competences: ability to play instrument, write a song, perform, can improve self-esteem and build self-worth around the musical skills

Source: Author's own study.

The content of the tables is very general, and only roughly illustrates the correspondence between protective experiences and resources that music therapy has to offer, as well as shows links between areas that might require support due to trauma and the specific interventions. The potential of music therapy seems especially significant when considering work with children and adolescents, for whom verbal therapies might be challenging. In the teenage years the meaning and role of music becomes very important (Miranda, 2013). As Miranda concludes, "research on music opens up a scientific window to the psychological, social, and cultural needs of contemporary adolescents" (p. 20). Young people themselves tend to depend on music to feel better (McFerran, Saarikallio, 2014), music can give them sense of agency (Saarikallio et al., 2020), and – in case of children in out-of-home care system – making music together with trusted adult can bring comfort, satisfaction and pleasure (McFerran et al., 2022).

CASE VIGNETTES WITH INTERPRETATIONS

The final part of the current paper includes case vignettes, from practical experiences of the author. In vignette research methodology, vignettes are defined as short scenarios, which elicit data from research participants or present clinical situations. They can be hypothetical or reflect the real lived experiences. In this approach, narratives might be sometimes pragmatically manipulated to achieve research goals (Jenkins, Noone, 2019; Payton, Gould, 2023). Their role in this particular manuscript will be to exemplify and integrate the previously provided information.

Music therapy with S.

S. is 10. She was strongly physically and psychologically abused by her parents before being placed in foster care. She has problems with connecting with other people, carers and peers. She is always vigilant, not trusting anyone. When under stress, which can be triggered in unexpected moments, she withdraws from any social interactions. Very rarely she shows any emotions.

S. comes for music therapy once a week – loves to sing, but never tries to improvise, it

seems too scary for her, and she says she cannot do it. But very fondly chooses songs from pop repertoire and sings them with pleasure and obvious musicality. She has her favorite songs and focuses only on them: they come from different pop genres, but typically talk about loneliness, loss and despair in the lyrics. S. wants to rehearse them but is not willing to talk about their verbal content. At the beginning of music therapy process she sings the songs during the sessions only. After few month she is asked to take part in the concert at the local concert hall. She agrees to do so. The day comes. The hall is full. S. is slightly nervous, but she bravely goes on stage with the accompaniment of the therapist and performs beautifully. The audiences applauds her with enthusiasm and the emotions are strongly in the air. S. is very proud, and happy. She starts to participate in all concerts and opens up in conversations. When asked why she likes the performances she says: because people are listening to me and they are moved, when I sing a sad song; I feel a little bit sad but also happy that they hear it. I think I sing well, don't I?

Through the process of making repertoire choices and presenting her interpretations of songs to others S. learns to understand and name her emotions, she probably processes them through music as well. While singing, she can also identify emotions of others. The intense moments on stage are shared with the therapist. Thanks to these experiences she builds connection and trust. Her self-esteem increases – she has something to be proud of, and she sees the impact of her expression on others. In music therapy, S. experiences self-efficacy, open up for new ways of expressing herself, she practices being determined in rehearsing the songs and performing them in the best way possible. As performing is artistic activity, she also learns how to be creative in music and certain life situations.

Music therapy with D.

D. is 17. He was neglected early by his father, and his mother was addicted to different substances, sometimes abusive on many levels. He is at foster care facility since being 13. He started weekly music therapy sessions few month after being placed at the facility, because he wanted to learn to play guitar. D. is bright and open, always smiling, very polite and helpful. He has serious troubles with sleep and high anxiety. He clearly needs appreciation very strongly. His self-esteem is low and he frustrates easily. During first few sessions he tries to play simple chords on guitar but when is not able to get them immediately D. gest very upset with himself, claiming to be dumb and lose the therapist's time. Finally, refuses to play anymore, as "he will never play well anyway".

He is offered to write songs and eagerly jumps into this new activity. The first songs written with the therapist are based on the conversations about his life experiences. All are very happy and appreciative towards social workers and other care providers. The idea behind is "I have nothing to complain about, I should be always grateful". The casual discussions on his own lyrics happen from time to time. He reacts with surprise and anxiety on questions regarding other emotions. Is he really always so cheerful? No worries at all? From session to session, the lyrics he brings are getting less and less optimistic. D.'s first song lyrics say: we complain all the time for being poor and bad, while in fact we do not need anything more to be happy. His fifth song chorus is: I am so tired of observing the evil in the world,

> the wars and tragedies, I am done with it, I am fed up. He is working on this one with the therapist and two peer teenage residents, they create a band that is supposed to record the song. D. is singing, his friends play percussion, the therapist is on guitar. Rehearsing of this song brings heavy atmosphere to the room, but also unites all the members of the group. There is a talk about how life can be difficult among all musicians. After the session they all have the feeling of sharing something important.
>
> Next session starts with D. saying to the therapist: so you will not be angry if I say everything sucks? Weren't you scared by my last piece? I know it is not true that everything is bad, but sometimes it feels like it, you know?

Writing songs worked for D. as a way to process experiences, starting from the very surface, and then going deeply into more real, in-depth insights, including negative, scary states and feelings, naming, confronting and expressing them. While working on lyrics he had to do a lot of work on cognitive level, choosing the themes, the words, the rhymes, organizing it all into songlike structure. It stimulated his problem solving skills as well as creativity. Playing his own song with the band, including peers, helped him in building relationships based in shared musical experiences. Although tiring, the sessions became a tool to release tension and acknowledge traumatic experiences and their results leading to decrease in anxiety and sleep problems.

CONCLUSIONS

In the current paper, I focused on music therapy as a form of treatment which meets the criteria of trauma-informed and resilience-oriented therapy. Two main components that constitute this form of therapy – music and relationships – are crucial in work with people who experienced attachment trauma. Music is not only highly accepted and well-received medium especially in teenagers, but can also be effective in supporting their resilience and healing processes. As music is so important at this stage of life it seems to be natural modality of exploring, processing and expressing difficulties is relatively safe environment.

Hopefully, the case vignettes illustrate the possible processes well enough to understand the practical aspects of trauma-informed, resilience-oriented music therapy. It should be remembered, however, that they only show chosen situations and provide with very vague descriptions. The music therapy processes vary tremendously; they are based on people and music, which come in never ending interactive possibilities. Thanks to music experiences young people who experienced trauma might receive a chance to speak or sing, be heard and understood.

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