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ARTICLE

Trusting the uncertainty: Music therapy with young people who have experienced attachment trauma

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ABSTRACT

Psychological trauma has recently received increased attention in music therapy, resulting in a dramatic increase in writings about this subject. However, the voice of clinicians and participants is not represented strongly in the literature. This paper is an attempt to begin to fill in this gap, providing examples from practice presented through narratives that illustrate music therapist's perspective on the work, the clients' expressions, and relationships. Following case vignettes taken from music therapy sessions, reflections on the work are integrated with relevant literature. The vignettes capture moments where key concepts of trauma-informed practice, such as trust and safety, are being challenged and questioned. They serve as a starting point for connecting theoretical knowledge with lived experiences and are intended to bring awareness to the reader in a way that is intuitive and emotional, as well as intellectual.

KEYWORDS

attachment trauma,
trauma-informed music therapy,
safety,
trust,
voice

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INTRODUCTION

A growing body of literature and research is available on psychological trauma and posttraumatic stress and its consequences. This includes neurobiological (Akiki et al., 2018; McCrory et al., 2011; Opendak & Sullivan, 2019; Packard et al., 2021; Perry, 2009; Stark et al., 2015), psychobiological (Fuchshuber et al., 2019; Lahousen et al., 2019), and clinical/therapeutic approaches (Allen, 2013a; Baylin & Hughes, 2016), as well as resources that integrate these perspectives (Rotschild, 2000; Schore, 2010; van der Kolk, 2015). There are different ways of understanding trauma. Some

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resources, including the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) focus on the traumatic events that define trauma, stating that the trauma requires "actual or threatened death, serious injury, or sexual violence" (p. 271). This criterion is therefore quite objective. The 4th edition of the DSM (4th ed.; DSM-4, American Psychiatric Association, 1994) also included the subjective criterion of personal response to the event (fear, horror, and helplessness), but that was removed from the current version; this remains a subject of professional debate (Pai et al., 2017). Other resources conceptualise trauma as a single or repeated threatening experience that leaves the person powerless, in emotional shock (Farina et al., 2019; Reyes et al., 2008), thus including both objective and subjective components. Finally, some authorities understand trauma not as a specific event (or events), but as stress or even an emotional response alone (Krupnik, 2020).

Available materials include varying perspectives that bring a great deal of information, which sometimes form a coherent whole but at other times suggest contradictory ideas. Neurobiological, psychological, and clinical readings provide fundamental knowledge for clinicians working with people who experienced psychological trauma and allow for improved understanding of the functioning of the clients (Cristobal et al., 2017; Dorrington et al., 2019; Scoglio et at., 2022). At the same time, however, due to the wide spectrum of issues related to this area, the vastness of the resources might lead the reader to a feeling of helplessness. Even in terms of terminology, different words are used. Although they may have slightly different meanings, they are frequently used to discuss the same or similar issues. Terms range from general, such as "psychological trauma" (Hogg et al., 2022), to more specific. They may focus on different aspects of the experience, such as developmental trauma (Cruz et al., 2022), childhood trauma (Vanderzee et al., 2018), relational trauma (Alexander, 2013), childhood maltreatment (Kim et al., 2022), or attachment trauma (Allen, 2013b).

Psychological trauma is receiving increased attention in music therapy and, as in other disciplines, uses a variety of terms and concepts. McFerran et al. (2020) conducted an interpretive synthesis with 36 studies: they identified clinical music methods used with people who experience different kinds of psychological trauma and assessed whether the theoretical and research bases were provided as justification for the work. Included studies were identified by searching "music" or different ways of utilising music (songwriting, drumming, songs, Guided Imagery and Music) and "trauma" or "Post-traumatic stress disorder" (PTSD), "abuse," and "foster care." Through this analysis, McFerran et al. constructed framework of different ways of using music with people who have had adverse life experiences. These were found to be for stabilising, entraining, expressing, and performing purposes. However, a limitation of the findings was that different trauma-related groups were considered together, including various types of acute and chronic traumas. A growing body of studies regarding different kinds of psychological trauma and music therapy have been done. These include different types of work with children, young people and families (Bolger, 2015; Choi, 2010; Christenbury, 2017; Faulkner, 2017; Felsenstein, 2013; Osborne, 2012; Strehlow, 2009; Wiess & Bensimon, 2020; Zanders, 2015), and adults (Beck et al., 2018; Bensimon et al., 2017; Rudstam et al., 2017).

In two qualitative studies, Bensimon (2020, 2022) used grounded theory and phenomenological approaches to explore the techniques that music therapists apply while working on relational needs

of people who have experienced trauma (2020) and when facilitating integration in trauma survivors (2022). Relational needs of the clients were identified as the need for recognition, acceptance, emotional witnessing, emotional responsiveness, safety, trust, and for someone to reach out to them. Regarding how the treatment of trauma was focused on integration, Bensimon (2022) constructed three categories that illustrate the levels at which music therapists work: body integration, event integration, and life story integration. His studies provide insights into clinical processes and music therapists' perspectives.

Several books (Beer & Birnbaum, 2022; Gravestock, 2021; Sutton, 2002) on trauma also focus on clinical work from music therapists' perspectives. Gravestock (2021) elaborates on the lived experiences of music therapy in adoption and trauma. Her publication contains vignettes describing people and situations that occur in this work. Beer and Birnbaum's book (2022) provides theoretical considerations regarding concepts such as resilience and cultural humility, and reflections on different areas of practice in which trauma is present, including adverse childhood events, race-based traumatic stress, natural disasters, cancer care, sexual violence, mental health, and in the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQAI+) community.

Trauma-informed clinical guidelines and principles for music therapists have recently been published (Heiderscheit & Murphy, 2021). They are based on a general trauma-informed practice approach and focus on key principles formulated by Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment (for staff and clients), voice and choice, cultural, historical, and gender issues. These aspects were conceptualised within a resilience framework, which provides a perspective on the therapeutic process (Sokira et al., 2022). Three important stages that were identified were establishing safety, remembrance and mourning, and reconnection.

Critical reflections regarding trauma-informed work in the field of music therapy are also available. Although the above-mentioned materials cover clinical aspects of music therapy work, it was noted in the recent scoping review regarding music therapy and adverse childhood experiences (Abrahams et al., 2023) that clear overview of the interventions in this area is difficult to perform. It is due to the fact that the existing materials are inconsistent with regards to the terminology used in the descriptions of interventions and goals.

Potentially controversial perspectives that challenge the dominant narrative of trauma-informed work were proposed by Scrine (2021), Scrine and Koike (2022), and Hillman et al. (2022). After analysing and interpreting available music therapy literature, Scrine (2021) concluded that the "dominant trauma paradigm has the potential to further perpetuate harm, and does so through assigning vulnerability, reinscribing colonial power dynamics, and reinforcing individual responsibility" (Conclusion, par. 1). Scrine (2021) also suggested that this paradigm can be challenged by music therapists by fostering resistance and collective consciousness-building with young people. Scrine and Koike (2022) reflected on the idea of safety and proposed to reconceptualise it as a complex, ongoing relational practice. Hillman et al. (2022) critically examined assumptions supporting research regarding music therapy and psychological trauma with adult populations. They found that the participant's voice was lacking in the current literature, with clinical discourse and psychiatric constructions of trauma recovery being represented the most.

THE CURRENT PAPER

Aims and structure

This reflective paper has two main aims. The first aim of this paper is to present my own voice as a clinician, and – indirectly – the clients' voices, within the case vignettes and the interpretations that follow. This aim comes from considering Hillman et al. (2022) and Scrine and Koike's (2022) points regarding the need for including participant's voices in the discourse. Participants of the music therapy process are understood here as both the music therapist and the clients. Also, this aim is derived from a key principle of SAMHSA (2014), of which empowerment for staff and clinicians are treated as a base. In this case, the staff will be represented by myself, a music therapist. The clients will be introduced in the narratives.

I will try to capture lived experiences of being in a music therapy process with young people who experienced attachment trauma, but attempt to avoid a traditional, hierarchical clinical discourse perspective and psychiatric constructions. I am aware that the line between clients' voices and my interpretation is unclear and blurry. However, in music therapy practice, these two elements seem to be intertwined and sometimes even inseparable. Therefore, in the vignettes below I will use direct verbal quotations from the conversations, together with my interpretations and observations from the sessions.

The second aim is to integrate chosen literature with everyday experiences of the music therapist. Translating and transferring knowledge from theory and research to the practice can be a challenge in this area. Nevertheless, combining research and clinical experience together with patients' unique experiences is the core of evidence-based practice (Straus et al., 2019). In this article, I hope to link selected research and knowledge on attachment trauma and music therapy with my clinical experience. I will present the vignettes, followed by relating them to the selected readings.

While psychological trauma is a broad and ambiguous term, the other terms mentioned before identify more concrete conditions. In the current paper, clients' ages, levels of development, or adverse events experienced are not central to what is reported. "Attachment trauma" will be used, as it seems to describe the clients' difficulties most accurately. It will be understood according to Allen's (2013b) conceptualisation, which relate to trauma that took place within attachment relationships and manifests through profound mistrust. This type of trauma is associated with childhood neglect and abuse. I believe that a naturalistic perspective and personal insights are important and that the language should reflect these aspects. Therefore, the vignettes will be presented in the forms that come from everyday expressions, even colloquialisms, rather than in an academic style of writing.

I consider these means of presenting the information worthwhile for at least three reasons. It will:

1) Allow for including the words of the clients in the original form, initially without interpretation;
2) Promote connecting theoretical and research knowledge with lived experiences; and
3) Inform and bring awareness to potential readers, including clinicians who might struggle

with similar situations, in a way that is intuitive and emotional rather than purely intellectual. The sense of something being revealed does not always easily translate to words, but it can be grasped intuitively, in the emotional realm. I hope to convey this sense to others through the style of the vignettes.

The context and the participants

All of the vignettes below are based on experiences I had during music therapy work in a foster care institution in Poland. The young people whose stories are shared were abused physically, psychologically, and/or sexually before they entered the institution, and sometimes also afterwards. They all meet the criteria of trauma understood as an event. Attachment trauma is implied, considering the history of their family relationships. They live in an environment that puts them at risk of re-traumatisation and does not always support resilience; child maltreatment in foster care settings is common and known to have negative effects on their adult mental health (Lueger-Schuster et al., 2018). The parents' rights of these young people are limited.

There are many studies reporting associations between childhood maltreatment and alterations in brain, regarding its structure, function, connectivity, and network architecture (Tomoda et al., 2024). These alterations can be observed in behaviours. Young people might struggle with many symptoms related to attachment trauma/developmental trauma disorder: emotion dysregulation, somatic dysregulation, hyper- or hypo-vigilance, reactive aggression, impaired psychological boundaries, and difficulties in building relationships and feeling close to others (van der Kolk et al., 2019). The clinical work was done with respect to van der Kolk (2003) suggesting that children who experienced trauma "must learn to know what they feel, put those feelings into words, or find some other symbolic expression (drawing, play acting) that can allow them to gain distance from the traumatic events and help them imagine alternative outcomes" (p. 310).

Ethical considerations

The vignettes that are presented below describe moments of music therapy from recent work. The young people who are portrayed provided written consent to share these vignettes in anonymised versions. The consent was designed to be user-friendly and understandable. Young people also had a chance to ask questions and discuss the content and its extent with me, as a music therapist and author.

Obtaining the consent was done retrospectively, following the therapy but before completing the paper. Consent was also obtained from the foster care institution. The Ethics Board of the academic institution was also consulted concerning content of the paper and how it was presented.

CASE VIGNETTES AND REFLECTIONS

Case vignette 1 – Peter's song. On trust

Peter is 16 years old, bright and very sensitive. He has never met his father, but from what his mother says, his father was addicted to alcohol and used to abuse the family physically. Peter has two older

brothers. One of them, David, having received a good education, is doing very well, has a well-paying job, and is in a stable relationship.

Peter is shy during music therapy. He is reluctant to improvise. He wants to learn how to play guitar. He strums basic chords with lots of hesitation. When I suggest writing a song, he seems to like the idea, but postpones it until the next session. When it comes, he brings the lyrics, almost complete, written on a piece of paper. They are deep, poetic, full of metaphors, with rhymes, and an interesting structure. Wonderful! He says he also had an idea for melody but angrily claims he forgot it. I try to facilitate recalling or just recreating the music, but whatever I do, Peter is not satisfied.

After the session, I find myself quite surprised. I have doubts as to whether the lyrics were written by the client himself. I Google the words, but nothing appears; he did not find them on the internet.

Peter brings his smartphone to the next session, with a voice recording of his brother, David, singing the song – the lyrics and melody – with intense personal involvement. According to Peter, he explained to the brother what the melody was supposed to be, "and he got it much better than me before," so they recorded it for the session. Peter is very tense, and there is some kind of new awkwardness during the part of the session based on the song. We work on the song for few more weeks, and then I suggest writing another song during the session. So we go through the process together, and it is fun. However, it becomes obvious that Peter would not have been able to write the words of the first song by himself. I start to think that the previous piece was composed by the brother, but do not confront Peter with this suspicion.

The weeks go by with an accelerated therapeutic process based on songwriting. New songs are written during the sessions, the relationship seems more and more stable and safe, there is high energy and spontaneous fun.

A few months later, before leaving the session room, Peter says: "I have one thing to say… I guess you know… or maybe not… but probably so… I did not write our first song." "'Yeah? But so what?", I answer. "So nothing", Peter laughs, relieved, and leaves the session.

Much later, with therapy having ended four years earlier, and living a successful, independent adult life, Peter meets me and says: "Music therapy made a huge change for me. Do you know what was the best part of our meetings? That you trusted me despite my lies."

Case vignette 2 - Vera's stories. On trust again

Vera is 10. She is doing great: no problems at school, good friends, and lots of interests. She wants to be a teacher. She has been in the institution since she was 4 years old. Because her parents were and are imprisoned, she lived with her grandmother prior to coming to the foster home. She likes music, plays instruments freely, sings songs loudly. Her favourite part of music therapy is musical story telling. From time to time, she comes to the room and says: "Let's do the story. I will tell you the story, and you will play. It is a real memory of mine from the times I lived with Grandma."

So that is what we do. She usually starts by making sure that I know exactly where she lived. Her grandmother's house with the full address, the real one. She describes the area in detail. She asks if I know this part of town. I do, her description fits the reality perfectly.

> One day, it was sunny and warm, I decided to go to the park close to the house. I went there and, you know, it is more of a forest. I went there, further and further. Do you know this park?

'Yes I do', I say, while accompanying her story with guitar. I truly do, I know the park. She continues:

> I was there for a long time, and it started to get dark. And suddenly…. [dramatic pause] the huge wolf jumped out from the trees, and started to run after me. Can you believe it? I was so scared, I ran so fast, the wolf was huge, and black, with white teeth, running so so fast. Do you believe me? I managed to escape. But I was soooo terrified.

Sometimes it is a wolf, sometimes a bear, sometimes both, or a ghost, or a dragon, or some other horrible creature. But always, in between every few sentences, she asks if I believe her. When the story is done and the music is over, she asks again, do I trust her?

There are no wild creatures in our city. She knows it and I know it. But for some reason it feels important for her to hear: Yes, I do believe you. I am so sorry it happened. I can only imagine how scary it was.

A reflection on trust in music therapy with young people who experienced attachment trauma

Although quite different, both vignettes have one common denominator: they question trust and its relation to deception within the therapeutic process. One can read that trust is one of the most important factors in the therapy of people who experienced trauma. "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" (Heiderscheit & Murphy, 2021, p. 2). And to be trusted by others, one could add. As Peter and Vera show, trusting someone is difficult, but being trusted – hard to believe. Trust should go both ways.

Working with Peter and Vera supports the importance of trust, but brings nuances and shades of meaning to this notion. It occurs to be very much context- and individual-dependent. Trust can manifest in myriads of ways in therapeutic relationships, and it needs to be treated carefully and flexibly.

Profound mistrust, which is core to attachment trauma, causes young people to choose paths of development and relationship building in ways that may be surprising and sometimes paradoxical. It causes the therapeutic process to be indirect and involves a high level of uncertainty. There is the possibility of misunderstandings and misinterpretations, alongside the risk of making wrong decisions. From my perspective, it is not possible to overcome it by finding a common rule that would apply or following universal guidelines, which are by nature depersonalised and general.

It was found that "a high percentage of clients (93%) reported lying, in one fashion or another, to their therapist and that, for the most part, this occurs across all types of clients across all types of psychotherapies" (Blanchard & Farber, 2016, p. 106). At the same time, the experience of being lied to has a deteriorating impact on trust (Gawn & Innes, 2017). When working with young people who experienced attachment issues, one should be aware that "it is not uncommon for children with a history of maltreatment to exhibit symptoms of aggression, defiance, stealing, lying … all of which

may be driven by stored, unprocessed traumatic memories" (Shapiro et al., 2017, p. 287). Therefore, it seems important to define what lying is and how to deal with it in a therapeutic relationship, with trust in mind.

In general, lying is simply a form of dishonesty, such as when someone intentionally communicates in a misleading way in order to achieve some kind of goal. However, going deeper into the subject, it becomes clear that lies have very different features. They may be protective or beneficial, serving the lying person or others, being connected to self-regulation and social norms (Cantarero et al., 2018).

There is also pathological lying. It can be a symptom of PTSD or the result of childhood trauma or neglect. It might stem from low self-esteem. This behaviour is neurobiologically linked to dysfunction in the prefrontal cortex and limbic system, which are involved in executive functioning, impulse control, and emotional regulation (Kainth & Gunturu, 2024).

So how should we think about lies in the situations mentioned? Are they pathological? How should we treat them as we try to build dual trust? Baylin and Hughes (2016) suggest that maltreated children might construct their own reality, hoping to get the attention and safety that are not possible in the real world. If that is the case, being invited to the constructed reality and accepting it may actually lead to getting closer, not being manipulated. For maltreated children, using lies might also be a coping mechanism and a strategy to build safety. From the neurobiological perspective some research (Rubinestein & Lahad, 2023) suggests, that the hippocampus and the default mode network play an important role in both creativity and PTSD. Creativity and playfulness are also perceived as significant predictors of resilience after traumatic experience.

Another question, what do we want to trust as therapists? Which truth are we searching for? The factual one? The subjective one? The emotional one? Maybe when Peter presented his brother's song as his own, he wanted to be seen as more able, so presenting the song was the act of offering the truth about his ideal self, the self he is trying to achieve. When Vera was telling her story, she was communicating very honestly about her emotional memories from the past, the terror she felt, even though the wild creatures were not the reason for this feeling. During the initial stage of work, the therapist's main task is "to establish trust and foster engagement in the music. Focus should be on providing experiences that allow the client to safely explore, experience, and connect with self and others through music while providing a sense of control" (Sokira et al., 2022, pp. 12-13). The vignettes above support these words, but at the same time show that the understanding of trust should not be treated rigidly and although in certain situations lies erode trust, in the context of a therapeutic process with a person with attachment trauma, lies might be tools to build trust and communicate deeper truth. Acknowledging these personal narratives and staying indifferent or accepting towards them can be beneficial for the therapeutic process.

Case vignette 3 – Maja's concert performance. On safety

Maja's mother is almost 30, and Maja is 11 years old. They like each other. They both have Facebook accounts. One day, mother posts a photo of herself and a photo of Maja with a question: Which one is prettier? Give likes for Maja and hearts for me. Both received a lot of reactions; the comments

were full of funny emojis.

Maja loves music and enjoys music therapy a lot. As she has been at the facility since she was five, she has had many good experiences with improvising, singing, and playing. She likes to perform and took part in many concerts, finding being on stage stressful but exciting.

Another concert is planned in the near future, this time in a fairly large concert hall at the local Academy of Music, with music therapy students participating. Maja chooses a song to be performed that had been presented just a week earlier on *Idol* or some other television show and received a huge emotional reaction. The song was written by a young man whose mother had passed away some time ago. The lyrics are in the form of a letter to the mom, expressing lots of pain. The music is delicate and intimate, the voice is accompanied only by the piano; it could easily be categorised as kitsch. I am not very fond of this choice, it is too emotional and direct, plus it triggers my emotions and makes me cry. But Maja is sure about her choice, and she seems untouched by the song's verbal content or musical character. During sessions, she is relaxed, funny, and giggly. She sings this song the same way she did previous songs, very musically, commenting on 'technical' aspects such as whether she is able to memorise it all, when to start, how long is the instrumental interlude between the verses, and so forth. One of the music therapy students offers to accompany her on the piano. She comes for rehearsals and establishes a friendly atmosphere; clearly Maja feels comfortable with her. Maja chews gum, moves to the music, looks completely chilled.

The day of the concert arrives. Maja wears a nice dress. There is tension in the group of performers, but it is perfectly natural as the audience is large. Maja's mother comes and the daughter has her sit in the first row.

It is Maja's turn. She goes on stage and sits at the piano bench with the music therapy student. She planned the performance this way. The spotlight is on them only. She starts singing and you can hear more and more emotion in her voice. It is trembling. Maja is short of breath. In the middle of the song, she stands up. She takes her mic and slowly starts to walk to the edge of the stage where the mother sits.

The lyrics are:

> I want you to read this letter that was being written for many nights.
> You gave me everything, I can see the sky thanks to you.
> Thanks to you I can live, I can dream, I can love and forgive,
> So I forgive you, that you are not here today.
> Mom, I miss you most of all.

Her voice weakens and finally she stops singing and starts crying, fighting her tears for a moment and then losing it all together, crying openly in the centre of the stage. People applaud. Maja sits on the lap of a caregiver from the institution, hides her face in her arms. Mother sits just a few chairs away.

The next day Maja says to me: "See, I was right to choose this song. I made such a show! Exactly as I wanted. I surprised you! I even made some people cry. Did you see my Mom crying?! I am so relieved now."

She seems happy, a bit proud, much closer to me than before.

A reflection on safety in music therapy with young people who experienced attachment trauma

One can read that:

> physical and emotional safety, being protected from both internal and external threats, is a key element of trauma-informed practice. Therefore, music therapists should strive to create a therapeutic environment in which the client feels physically and emotionally safe to minimize triggers. (Heiderscheit & Murphy, 2021, p. 2)

Thinking about Maja's performance, the question arises: Was this event emotionally safe for her? The triggers were there – the mother, the stressful situation, and emotional music. Was there any protection? To me, during the performance, it seemed very unsafe. Moreover, I felt guilty seeing her crying on the stage. But apparently Maja felt good about it. All of this artificiality – the stage, the lights, the audience, the borrowed music – may not be a trigger, but a 'bracket' for reality that Maja needed in order to formulate this very private, deeply emotional message, to connect with her deep feelings. The stage, unexpectedly, was safe, creating physical distance. Maybe the people around watching also brought both safety and validation, or made the experience matter more? Or possibly Maja knew that with the audience, on the stage, being committed to perform, she would be forced to do what she planned and found this force helpful. Mastery is very important in treating children who experienced trauma according to van der Kolk (2003). During the concert Maja had a chance to be in charge, be calm enough to focus and accomplish her goal: to communicate what she felt was important.

This situation had one more aspect: It gave her mother no opportunity to respond. Being there was safer for Maja than talking to her mother in private. Apparently, also not talking to me about how she felt about the song before the concert was safer than sharing the emotional content. The reasons might be very different, however. "It is an apparent paradox of human development that precisely insecurely attached people […] strongly activate their unconscious attachment system in situations of strong psychological or social stress" (Lahousen et al., 2019, p. 9). Maybe Maja felt that she needed this stress arising from being on stage to work on her attachment issues. Baylin and Hughes (2016) say that:

> reawakening the suppressed need for connection in maltreated children is one of the most moving experiences therapists and parents can have. Scenes in which children, closed off for years … start to feel the pain of their prolonged isolation rising up through their defensiveness and urging them to finally seek comfort from a caring adult, can be stunning to witness. (pp. 157-158)

In Maja's situation it was the scene, both as the stage, and a scene she made.

But if one's attachment system is activated by strong stress and reawakening the need for connection means pain, how can it be done safely? What is safety in these circumstances? Different psychotherapeutic approaches interpret safety in various ways. They agree, however, that the therapeutic safety should be sufficient, not perfect, to leave space for frustrations and insecurities promoting growth and resilience (e.g., the humanistic concept of safe emergency, or the

psychodynamic idea of necessary danger; Podolan, 2022). However, it would be assumed that the risks are assessed by the therapist. In Maja's case, she took the responsibility and transformed through stress and pain. Regarding the music therapy process, as proposed by Sokira et al. (2022), at some point its purpose is:

> the telling of the individual's story. This includes sharing and connecting to the lived experience of trauma …. The goal is to normalize the clients' responses, for the client to feel heard, and to help the client connect current struggles with their traumatic experiences. (p. 14)

Maja shared and possibly became connected to the trauma. She was also heard. It was done on her terms.

Case vignette 4 – Ludwika's work. On uncertainty

I am a middle-aged music therapist. I have been working with teenagers who experienced attachment trauma for about 15 years. When I come home from work in the evening, I tend to talk to my husband (thanks for his patience!) about what happened. I don't give him thorough information on the clients, I avoid the context, but I report on moments that revealed something. At the beginning of the conversation (mostly monologue), I am usually not sure what it is that will be revealed, this material becomes clear while telling the story. While I talk, the experiences start to come together and become whole, to make sense, sometimes on an intellectual level, sometimes on an emotional and intuitive level. It helps me to integrate what has occurred and to navigate the following sessions.

Where am I in this work? What do I experience? Processing it seems to be a difficult task and naming it, ordering it, even more so. I wonder about my own attachment issues, the possibility of vicarious trauma in my work, and other aspects of my life that impact me as a music therapist. Sometimes, when I hear my clients' stories, I cry, but wonder if I should cry. Other times I do not cry and wonder why I do not. I try to be aware of my own emotions and regulate them. Nevertheless, I am a mother and working with children whose stories are so painful makes me feel guilty from time to time. For what I do, for what I do not do, and for the whole world around that allows it to happen. At the same time, I feel inspired by being with my clients. I am amazed by their strength, sense of humour, ability to grow, and perceptions of the world. Often, I feel we go through changes together; they are working on their issues, and I am changing with or because of them.

I am uncertain of what is going on during some sessions. Sometimes I even feel lost. In my personal life, I tend to be organised and, some friends would say, controlling. Yet, surprisingly, I trust this uncertainty during the sessions. Uncertainty is a part of my job. Am I safe saying it out loud outside supervision? How much do we, as therapists, not say – to feel safe, trusted, and professional?

A reflection on the perspective of the therapist working with clients with attachment trauma

The acceptance of uncertainty seems to be a most important factor, which actually gives stability and confidence to the therapist. It transfers then to the young clients, who can – paradoxically again

– start feeling safe, trusted, and trusting in the environment, which allows for keeping part of the work between the lines or even within the lies.

The self awareness of the therapist is important. Considerable literature on attachment or attachment styles, and how attachment determines people's functioning or the way they form relationships is available (Santona et al., 2019; Sheinbaum et al., 2015; Simpson & Rholes, 2017). Typically, these findings are considered while reflecting on clients' issues. However, therapists have their own attachment styles, and some studies suggest that these might influence the therapeutic alliance (Bucci et al., 2016). Recent findings show a complicated picture, where the attachment style of the therapist would not necessarily affect the therapist's ability to build an adequate therapeutic relationship but could interact with their emotion regulation abilities (Petrowski et al, 2021; Ruiz-Aranda et al., 2021). This seems to be particularly important in work with people who experienced attachment trauma, where attachment issues play a crucial role in the therapeutic process. Therapists' personal ways of relating to others and their possible responses to behaviours related to different styles of client attachment should be carefully monitored through self-reflection and supervision.

Witnessing trauma that has occurred to others is one of the types of exposure criteria listed in DSM-5 (American Psychiatric Association, 2013). Studies suggest that, indeed, the impact of working with trauma can be profound and complex for therapists. This can include both being close to the tragedy and pain, and also observing clients' resilience (McNeillie & Rose, 2020). Therapists themselves might experience growth from accompanying people as they overcome their traumas (McNeillie & Rose). Similarly, researchers involved in studying trauma are at risk of vicarious negative trauma reactions and, simultaneously, have an opportunity for posttraumatic growth (Berger, 2021).

These findings received confirmation in the last vignette. On the subjective level, I try to be aware of my own attachment-related behaviours. I do not see them impacting the therapeutic process heavily, but they obviously might. Regarding the processing of clients' traumatic experiences and the risk of secondary traumatisation, the research results fit my perceptions well. Although the work touches the emotional aspects and can be exhausting, it also brings the potential for change, for both personal and professional growth.

FINAL REFLECTIONS AND QUESTIONS

Coming back to van der Kolk's (2003) suggestion, "traumatized children must be helped actively to overcome their habitual fight/ flight/freeze reactions by engaging their attention in actions that (1) are not related to trauma triggers and (2) provide them with a sense of mastery and pleasure" (p. 310).In the three cases above within the interventions suggested by therapist (songwriting, improvised storytelling, performing pop song) the triggers were not unavoidable. There was no directing the work towards relating to trauma. However, the young people decided to go this way. Maybe they felt stable enough to express their experiences in different ways and build the distance they needed. Was the sense of mastery and pleasure included? In some moments, probably so. In others, not so much. But like with the concept of trust and safety, how should we understand and evaluate pleasure? How did crying on the stage feel for Maja? I will never know, but questioning

basic concepts and reconceptualising them seems to be necessary when working with people who experienced attachment trauma.

Scrine and Koike (2022) proposed reconceptualising safety as a complex, ongoing relational practice. It should also be highly individualised. Similarly, trust should be viewed as a fluid category, rooted in personal circumstances, as something that is not stable and objective, but based in interpersonal dynamics. The vignettes presented suggest that both safety and trust go beyond the physical and emotional environment, protection from triggers, and keeping steady boundaries. In practice, they require a more subtle and flexible approach that needs to be highly personalised. As Scrine (2021) suggests, assigning vulnerability might cause further harm, and protecting from triggers might stop clients from doing what they need to do.

Perhaps sometimes, the more people who experienced trauma trust you, the more they lie to you, hoping that the trust is deeper than words, as in Peter's and Vera's situation. Or, like Maja did, they trust you enough to trick you into doing something that they need, like organising her performance. Maybe sometimes the distance created by not telling the literal truth makes it possible to build a relationship and have a shared experience. It is like a safety valve, a buffer that can cushion the fall - something for which young people with attachment trauma are always ready and which they anticipate while relating to others.

Trust can go with acceptance and send a powerful message. Relating to Peter's words, if you trust in someone's lies, you show acceptance in a way. But how does that go with safety? Can you feel safe with someone who trusts in all your lies? Does it mean this person trusts everyone?

Relational needs of clients who have experienced attachment trauma are typical goals for music therapists. Bensimon (2020) listed the relational needs of these people as: the need for recognition, acceptance, emotional witnessing, emotional responsiveness, safety, trust, and for someone to reach out to them. But what about when the need for recognition and acceptance leads the client to lie and to jeopardize trust, as in Peter's situation? What if emotional witnessing and emotional responsiveness are too heavy and not safe for a young person during the sessions, or so great that the therapeutic environment is not broad enough, and the client needs the whole concert audience to be the witness and responder, as in Maja's situation? Is there any hierarchy of the relational needs? Considering Bensimon's other study (2022), referring to integration, is it possible to integrate the events and life stories by narratives which, on a literal level, are not true?

One of the aims of the current paper is to present voices of young people who experienced trauma and my own, as a clinician working with them. "From a trauma-informed perspective, empowering clients means providing choices so that they can have a voice in their therapeutic process and the overall treatment" (Heiderscheit & Murphy, 2021, p. 2). On a practical level, offering a choice is simple. What would you like to do? Sing? Play? Offering a choice is, however, only the beginning. Then comes the voice. So what do the clients use their voices for? At times, for lying. Or crying, or singing. Hearing and understanding the voice is the next step - a big responsibility, and quite a challenge for a clinician. As Hillman et al. (2022) noted, participant perspectives have been underrepresented in research on music therapy and trauma. But what tools or measures can be used in such a delicate, sensitive context?

Vera used her voice while repeating the story of her adventure, mixing reality with additional elements, needing to feel that she could impact other peoples' emotions. Maybe she believed that,

without this enhancement, the pure true story would make no impression, and no one would care. Peter and Maja used 'voices' of other people. In quite an honest way, like Maja, who chose the song from the pop repertoire, or cheating and attributing to oneself someone else's property, like Peter, claiming his brother's song as his own.

In this article, I have used my voice to share the vignettes and reflect on them. You can read about Peter, Vera and Maja as they were filtered by my sensitivity. You can listen to me, mostly my questions, doubts, and tentative interpretations. The voices of young people were physically heard during our sessions, cited literally in the vignettes, but I am not sure if I understood them correctly. The expressions had to be interpreted on many levels. Interpretation on the intellectual level was not enough; empathy and intuition had a role to play.

While interpreting, was I giving them voice or simply using their voices? I will never know. Perhaps the only strategy to keep working and not getting drowned in doubts and questions is to trust the uncertainty.

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Ελληνική περίληψη | Greek abstract

Εμπιστεύοντας την αβεβαιότητα: Μουσικοθεραπεία με νέους που έχουν βιώσει τραύμα προσκόλλησης

Ludwika Konieczna-Nowak

ΠΕΡΙΛΗΨΗ

Το ψυχολογικό τραύμα έχει πρόσφατα λάβει αυξημένη προσοχή στη μουσικοθεραπεία, με αποτέλεσμα τη δραματική αύξηση των δημοσιεύσεων σχετικά με αυτό το θέμα. Ωστόσο, η φωνή των θεραπευτών και των συμμετεχόντων δεν αντιπροσωπεύεται επαρκώς στη βιβλιογραφία. Το παρόν άρθρο αποτελεί μια προσπάθεια να καλυφθεί αυτό το κενό, παρέχοντας παραδείγματα από την πρακτική μέσα από αφηγήσεις που απεικονίζουν την οπτική του μουσικοθεραπευτή για τη δουλειά, τις εκφράσεις των πελατών και τις σχέσεις. Μέσα από σύντομα περιστατικά από συνεδρίες μουσικοθεραπείας, οι αναστοχασμοί για το έργο ενσωματώνονται με σχετική βιβλιογραφία. Τα περιστατικά καταγράφουν στιγμές όπου βασικές έννοιες, όπως η εμπιστοσύνη και η ασφάλεια, της πρακτικής με επίγνωση του τραύματος, τίθενται υπό εξέταση και

συζήτηση. Λειτουργούν ως αφετηρία για τη σύνδεση θεωρητικής γνώσης με βιωμένες εμπειρίες και στοχεύουν στο να ευαισθητοποιήσουν τον αναγνώστη με τρόπο διαισθητικό και συναισθηματικό, αλλά και διανοητικό.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

τραύμα προσκόλλησης, μουσικοθεραπεία ενημερωμένη για το τραύμα, ασφάλεια, εμπιστοσύνη, φωνή