

Tuning Relationships with Music™: An intervention for parents with an interpersonal trauma history and their adolescents

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Introduction

Interpersonal trauma experiences can have a profound effect on future relationships, including parent-child relationships. Adolescence is a particularly challenging time for most parents (Kim, Conger, Lorenz, & Elder Jr., 2001), and parenting interventions have been found to be effective in promoting adaptive parenting skills (e.g., Havighurst, Kehoe, & Harley, 2015). However, the effects of interpersonal trauma experiences on the neurobiological, emotional, and behavioural aspects of parenting (Schore, 2001) are not well understood or effectively addressed in existing evidence-based interventions for traumatised parents and their children (Carr, 2014; Cloitre et al., 2005; Maliken & Katz, 2013). Tuning Relationships with Music™ (TRM) (Colegrove, Havighurst, Kehoe, & Jacobsen, 2018; Colegrove, unpublished) is a systemic therapy developed to address the unique challenges experienced by parents with an interpersonal trauma history who are experiencing high levels of conflict in their relationship with their adolescent. Parents' challenges are addressed directly in order to help the parent-adolescent dyad (referred to hereafter as "dyad") reduce conflict and improve communication. This paper gives a brief overview of the literature about the impact of trauma on parenting and recommendations for effective intervention, followed by a detailed description of TRM's key principles, core tasks, and session structure. Considerations for counsellors, psychotherapists and other clinicians who are interested in working with TRM, and future directions for research are also briefly discussed.

Parents with an interpersonal trauma history often experience difficulties that may be understood as having initially developed as adaptations to a hostile and unsafe environment (Herman, 1992; van der Kolk, 1994). Problems with regulating emotion, difficulties with attention and consciousness, distorted attributions and perceptions, and interpersonal problems can all create, maintain, and intensify maladaptive patterns of interaction in later relationships, including parent-child relationships (Dixon, Hamilton-Giachritsis, & Browne, 2005; Newcomb & Locke, 2001). Adolescents' developmentally normative behaviour, including heightened emotionality and strivings for independence and autonomy, can trigger memories of earlier abuse or neglect experiences for parents with a trauma history. This may drive negative escalating cycles that mean conflict remains heightened and unresolved (Moed et al., 2015), with detrimental implications not just for the parent-adolescent relationship, but for the adolescent's mental health and emotional wellbeing (Crowell et al., 2013).

Skills developed early in life in the context of a safe and secure caregiving environment, such as the ability to infer and effectively respond to others' intentions and emotions based on nonverbal as well as verbal information (also known as "mentalisation"), are vital to successful parenting and establishment of secure attachment relationships (Asen & Fonagy, 2017). Where parents have not developed these skills, they are more likely to resort to rejecting and aggressive parenting practices (Dixon et al., 2005; Newcomb & Locke, 2001). They may also experience higher levels of overall stress (as a parent), have difficulty establishing boundaries, and are more likely to parent permissively, use physical discipline, and verbally and physically abuse their own children (Riser, 2009).

Nonverbal communication (NVC) may be considered "musical" when vocal tone is used to express emotions (Stern, 2010; Stern et al., 1998; Trevarthen & Malloch, 2000). Parents modulate their voices and use music when playing with children in ways that may enhance attachment relationships (Nakata & Trehub, 2004; Pasiali, 2014). Music is used by adolescents in a range of ways to manage and express their emotions (Hallam, 2010). Music can enhance parents' ability to recognise and respond to their children's NVC (Jacobsen & Killen, 2015) and assist with emotion regulation (Beck et al., 2018; Fancourt, Ockelford, & Belai, 2014; Sandler et al., 2017). Music can amplify feelings that may be numbed after prolonged trauma exposure, support tolerance of negative emotions, and evoke emotions that encourage coping and a sense of control (Miranda, 2009; Swaminathan & Schellenberg, 2015; Thoma, Scholz, Ehlert, & Nater, 2012). Music therapy is used with families who have clinical and parenting issues (which may be

exacerbated by emotion regulation and NVC difficulties) in order to improve parenting and communication, and enhance relationships (Jacobsen, McKinney, & Holck, 2014; Thompson, McFerran, & Gold, 2014); however, these approaches have not been utilised for parents with an interpersonal trauma history and their adolescents.

Evidence-based therapies have not been developed to address the particular challenges faced by parents with a history of interpersonal trauma; instead, existing interventions have been modified to meet their needs (Carr, 2014). A review of the research on challenges and treatment for parents with a trauma history recommends systemic approaches that highlight the restoration of safety, re-establishment of secure attachment relationships, and regulation of arousal in response to trauma triggers evoked by parent-child interaction (van Ee, Kleber, & Jongmans, 2016). These recommendations are supported by expert consensus guidelines for the treatment of complex post-traumatic stress disorder, a condition related to early-in-life experiences of neglect or abuse (Brewin et al., 2017). The guidelines suggest that stabilisation—that is, establishing safety, reducing symptoms, and improving emotional, social, and psychological functioning—needs to occur before trauma memories can be processed and reintegration into relationships and community life can be addressed (Cloitre et al., 2012). Helping parents with a trauma history and their children to achieve safety and security in their relationship may require attention to parent emotion socialisation practices (i.e., how they respond to their children's emotions), which are known to shape children's emotion regulation. Dyads may also require assistance to manage nonverbal and autonomic (sensory and somatic) processes that may underpin negative escalating cycles (Colegrove & Havighurst, 2017).

TRM draws on principles and techniques used in attachment, emotion-focused, mentalising, and trauma-informed approaches to relationship and family therapy. These include direct attention to nonverbal components of interactions (using music) in order to assist parents to accurately link observed behaviours with inferences about their children's internal states (Asen & Fonagy, 2017). Parents are assisted to inhibit dysregulated responses (Nijssens, Luyten, & Bales, 2012; Skowron, Benjamin, Cipriano-Essel, Pincus, & Van Ryzin, 2013), and supported to respond sensitively to their children's emotions (Valentino, 2017). Dyads are helped to manage bidirectional triggering that may activate and maintain negative escalating cycles of communication (Figley & Figley, 2009; Jenks, 2012), and assisted to learn new interaction patterns that foster secure attachment and resilience (Diamond, Siqueland, & Diamond, 2003; Saltzman et al., 2011). TRM uses a combination of “top down” (i.e., psycho-education, skill development) and “bottom up” (i.e., the use of music to directly work with nonverbal and autonomic processes that affect emotion regulation) strategies in order to address cognitive, emotional, and sensory/somatic difficulties that affect parents' and adolescents' functioning during interactions that may cause conflict. This integrated approach may give both parent and adolescent tools that alter their experiences of, and cognitions about, their relationship. Parents and adolescents are taught skills in emotion regulation (including managing trauma triggers for the parent), then the parent is taught adaptive emotion socialisation skills (i.e., emotion coaching) so they can respond to their adolescent using skills such as “turn toward” (i.e., acknowledging), “sitting with” (i.e., responding empathically) and “softened start-up” (i.e., expressing feelings and needs without criticising or blaming) (Gottman, Katz, & Hooven, 1996; Havighurst, Harley, Kehoe, & Pizarro, 2012).

TRM has been evaluated in a pilot randomised controlled trial to establish efficacy (Colegrove et al., 2018; Colegrove, Havighurst, & Kehoe, 2019) with a sample of 26 parent-adolescent dyads (10-18 years) recruited from: (1) an adolescent clinical mental health service; (2) family support services; and, (3) a previous University of Melbourne research trial, where the parent had a trauma history as reported on the Childhood Trauma Questionnaire (Bernstein & Fink, 1998) and the dyad were experiencing high levels of conflict as reported by parent and adolescent on the Conflict Behaviour Questionnaire (Prinz, Foster, Kent, & O'Leary, 1979). Demographic information is reported in Colegrove et al., (2018). Results showed that dyads who attended TRM were significantly more likely to reduce conflict (parent/adolescent report $np2 = .177/.166$), to be more emotionally regulated ($np2 = .359$), consistent ($np2 = .268$), and predictable ($np2 = .194$) during conflict interaction, and that parents were more emotionally responsive ($np2 = .849$) and less reactive ($np2 = .852$) towards their adolescent compared with dyads who received “treatment as usual” (e.g., psychology, psychiatry, family therapy).

Tuning Relationships with Music™ (TRM): Intervention and Structure

TRM is a manualised brief systemic intervention (Colegrove, unpublished) designed to address parent-adolescent relational difficulties where a parent has a history of interpersonal trauma. TRM is to be used as a precursor to “family therapy as usual” where issues causing conflict may be further discussed and emotion coaching, communication, and conflict resolution skills can be consolidated. TRM fits within the stabilisation phase of complex post-traumatic stress disorder treatment consensus guidelines (Cloitre et al., 2012).

Key principles of TRM are drawn from empirically derived theories and evidence-based therapies relevant to working with parents and adolescents affected by interpersonal trauma, and can be summarised as follows:

1. Establishing interpersonal safety must occur before functioning can improve, and before issues causing parent-adolescent conflict can be addressed (i.e., assisting a parent to experience their adolescent as non-threatening allows them to then respond to their adolescent in a way the adolescent perceives as safe).
2. Assisting parents to experience and consequently provide a sense of safety in the parent-adolescent relationship requires attention to nonverbal and autonomic processes that affect their functioning.
3. Parents will need to learn skills, access sensory (i.e. auditory) and somatic resources, and receive support during parent-adolescent interaction so that they can be non-reactive and responsive to their adolescent's emotions that may underpin conflict interaction. Nonverbal "bottom up" strategies (that support autonomic regulation) are taught in combination with cognitive "top down" methods (e.g., skill development) in order to address each of these.

TRM has five goals which are taught sequentially: (1) emotion awareness (including awareness of sensory and somatic aspects of emotional states); (2) connecting to emotions; (3) responding to emotions; (4) communicating about emotions; and, (5) using emotional regulation and emotion coaching skills when problem solving, limit setting, and interacting around issues that may cause conflict. A summary of goals and tasks, which are completed over eight sessions, are presented in Table 1.

Tuning Relationships with Music™: Goals summary and tasks

Goals	Key tasks for parent	Key tasks for adolescent
1. Emotion awareness	• Awareness of own emotions – Awareness of internal body states – Awareness of body sensations connected with emotions	• Awareness of own emotions – Awareness of internal body states – Awareness of body sensations connected with emotions -Awareness of own emotional response to parent's emotions
	• Awareness of adolescent's emotions – Awareness of adolescent's differing emotions and expressions – Awareness of own emotional response to adolescent's emotions	
2. Connecting to emotions	• Understanding the purpose of emotions	• Understanding the purpose of emotions
	• Accepting emotions	• Accepting emotions
	• Understanding the role of emotional disconnection and/or dysregulation in childhood trauma experience	
	• "Turn toward" (TT) own emotions – TT internal body states – TT body sensations – Labelling emotions – Understanding internal negative escalating cycles (NECs)	• "Turn toward" (TT) own emotions – TT internal body states – TT body sensations – Labelling emotions – Understanding internal NECs
	• "Sitting with" (SW) own emotions – SW internal body states – SW anxiety, sadness, anger	• "Sitting with" (SW) own emotions – SW internal body states – SW anxiety, sadness, anger
	• Regulating own emotions (ER) – Able to identify and use ER strategies	• Regulating own emotions (ER) – Able to identify and use ER strategies

3. Responding to emotions	• Understanding adolescent emotional development	
	• “Turn toward” (TT) adolescent’s emotions – TT adolescent’s nonverbal emotional expressions – TT adolescent’s indirect verbal expressions of emotion – TT adolescent’s direct verbal expressions of emotion – Recognising /accepting adolescent’s TT – Understanding interpersonal NECs	• “Turn toward” (TT) parent’s emotions – TT parent’s emotionally regulated verbal emotional expressions – Recognising /accepting parent’s TT – Understanding interpersonal NECs
	• “Sitting with” (SW) adolescent’s emotions – SW adolescent’s anxiety – SW adolescent’s sadness – SW adolescent’s anger – SW own emotions that are activated in response to adolescent’s emotions – Knowing how to SW adolescent’s differing emotions in a way that the adolescent finds helpful – Accepting that at times adolescent may not find SW helpful	• Respond to parent’s “sitting with” (SW) emotions – Directly communicating to parent when SW is not helpful (e.g. need to be alone)
	• Co-regulating adolescent’s emotions – Able to identify and assist with additional strategies that help adolescent self-soothe	
	• Emotion Coaching skills	
4. Communicating emotions	• Softened start-up (SSU) – Using SSU to communicate emotions – Using SSU in addition to TT and SW to communicate understanding of adolescent’s emotions	• Softened start-up (SSU) – Using SSU to communicate emotions
	• Principles of safe communication – Assertive communication strategies – Respectful language and nonverbal communication – Direct verbal expression of emotions – Emotion coaching and active listening	• Principles of safe communication – Assertive communication strategies – Respectful language and nonverbal communication – Direct verbal expression of emotions
5. Problem solving with conflict and limit setting	• Blending emotion coaching skills with emotion regulation skills	
	• Softened start-up (SSU) – Using SSU to communicate and/or problem solve about an issue that may cause conflict – Using SSU to set limits in a way that acknowledges adolescent’s emotions about the limit	• Softened start-up (SSU) – Using SSU to communicate and/or problem solve – Using SSU in addition to TT to respond to parent’s emotionally regulated efforts to problem solve and set limits

• Principles of safe communication – Blending assertive communication strategies with emotion regulation and emotion coaching skills – Respectful language and nonverbal communication – Maintaining awareness of nonverbal communication skills – Active listening strategies – Accepting adolescent's influence and negotiating limits where appropriate	• Principles of safe communication – Assertive communication strategies – Respectful language and nonverbal communication – Maintaining awareness of nonverbal communication skills – Direct verbal expression of emotions – Accepting parent's influence and negotiating limits where parent deems this is appropriate
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Outline of Sessions

TRM comprises eight sessions of therapy that include individual parent, adolescent, and conjoint sessions. This allows gradual scaffolding of the skills and process. Individual sessions are used to engage parent and adolescent, clarify issues that may need particular focus in therapy, and to give the parent psychoeducation and teach skills that do not require the adolescent's presence.

Conjoint sessions are structured as follows: (1) check in, including feedback regarding completion of homework tasks; (2) warm-up exercises and consolidation of previously learned skills; (3) introduction and practise of new skills; (4) discussion of how to generalise skills; and, (5) setting homework tasks.

The therapist takes a selection of musical pitched and unpitched percussion instruments, psycho-education handouts, and a fidelity checklist into each session. Musical instruments should be of good quality, and be comfortably held or balanced on the lap. Pitched instruments should be within the frequency of the human voice range. Unpitched instruments may include bongos, small-medium djembes, shakers, and clapsticks.

Session 1: Parent engagement (task 1): Individual session.

Session 1 is an individual meeting with the parent, which comprises six steps. 1) *Engagement*: engagement is achieved by asking parents to identify what they would like to gain from attending TRM, to air any concerns they may have about the process or about their adolescent, followed by discussion about how participation in TRM may achieve the parent's goals and address concerns. 2) *Overview*: an overview of the eight sessions is provided. 3) *Psychoeducation*: psychoeducation is given about emotional intelligence and emotion coaching (Havighurst et al., 2012), and the effects of trauma on emotions, relationships, and parenting. 4) *Reflection*: parents are invited to reflect on their "meta-emotion philosophy", or, their beliefs about emotions (Gottman, Katz, & Hooven, 1997), and how emotions were expressed and responded to in their family of origin. Parents with a history of childhood abuse or neglect may have experienced abusive (punitive) or neglectful (dismissive) responses to their expression of emotions, and would therefore benefit from the opportunity to reflect on how this has shaped their attitude toward, and awareness of, their own and their adolescent's emotions (Gurtovenko & Katz, 2017).

5) *Working with musical instruments*: parents are then introduced to ways of using musical instruments that may allow them to become aware of their own emotional states and sensations in the body that accompany these, via exercises such as listening to an instrument being played and noticing how this makes them feel, and what body sensations may be evoked. Parents with a history of interpersonal trauma may face difficulties in either awareness of emotions, and/or becoming emotionally flooded in response to either environmental or internal cues (Berenbaum, 1996; Mead, Beauchaine, & Shannon, 2010). Conducting music-based emotional awareness exercises with a parent allows the therapist to assess the extent to which the parent may have difficulty with emotional awareness and/or emotional/autonomic regulation, and provides an opportunity to teach strategies that either amplify emotional awareness and/or regulate an intense emotional response without the adolescent present, which can then be reinforced in future sessions.

Strategies that regulate emotion are taught using musical instruments that utilise harmonic frequencies within the human voice range, as this is thought to deactivate defensive or dissociative states and activate restorative autonomic and emotional states via the muscles of the inner ear connected to the ventral vagal system, which is associated with social engagement and caregiving behaviour (Porges, 2009). Strategies are developed in

collaboration with the parent (i.e., the parent is invited to experiment with different musical instruments and/or body sounds in order to discover which sound may be most effective in assisting them to connect to, or regulate, emotion and/or autonomic states). These strategies are then embedded into interactive parent-adolescent sequences in later conjoint sessions. 6) *Home tasks*: the parent is then asked to think about how they may use these strategies at home (e.g., using recorded music, audible breathing technique, humming), and to practise these before the first conjoint session.

Session 2: Adolescent engagement (task 1): Individual session.

Session 2 is an individual meeting with the adolescent. The session is configured in a similar way to the parent session. 1) *Engagement*: this is achieved by asking adolescents to identify what they would like to gain from attending TRM, to air any concerns they may have about the process or about their parent, then discussing how participation in TRM may achieve the adolescent's goals and address concerns. A key aspect of engagement is conveying the belief that the adolescent is the "expert" about their own thoughts, feelings, and intentions, and that information about their perspectives is of vital importance so that the therapist can assist the parent to respond to their adolescent in ways that the adolescent experiences as emotionally and physiologically safe.

2) *Overview*: an overview of the eight sessions is provided. 3) *Psychoeducation*: psychoeducation is given about emotional intelligence. 4) *Reflection*: the adolescent is asked to conduct a brief self-assessment about their emotional intelligence (competence), identifying strengths as well as challenges. They are additionally asked to comment on whether they consider their parent to be aware of which skills they have, and which emotional competencies they find more difficult, in order to assess further aspects of parent-adolescent emotional communication difficulties that may warrant attention in later sessions. Adolescents who have experienced their parent's lack of responsiveness and/or heightened reactivity to their emotional expressions may be reluctant to allow their perspectives to be communicated to their parent (Diamond et al., 2003). Therefore, it is important to reassure adolescents that information they provide in this session will be kept confidential, and is gathered solely in order to assist the therapist in working effectively with the parent.

5) *Working with musical instruments*: adolescents are then introduced to using musical instruments to facilitate awareness of their own emotional states, and how these may be experienced in the body. Similar exercises are used as with the parent, and assistance is given to help the adolescent regulate their response if required. The therapist may use exercises to assess the adolescent's level of emotional awareness in order to inform pacing of further sessions, as with the parent session.

Musical exercises where the therapist plays instruments that may evoke different emotions are also conducted to explore the adolescent's experiences of their parent's emotions, and the adolescent's awareness of their own emotional response to their parent's emotions. While it is important to reassure adolescents that this information will be kept confidential, adolescents are also encouraged to consider whether they would be willing to share this in joint sessions. It is explained that the adolescent's information will assist their parent to learn more about their emotional experience so they can be supported to adjust their response. If the adolescent is not willing to consider this, the therapist then negotiates other ways s/he may introduce the adolescent's perspectives to the parent (e.g., role plays of hypothetical scenarios). The therapist should stress the importance of being able to find a way to use this essential information in a way that the adolescent will feel safe with, in order for therapy to be effective. Conversations such as these are deemed crucial steps toward giving the adolescent a sense of confidence that the process of therapy will be safe, and that their needs and perspectives will be taken seriously. Successfully engaging adolescents in psychotherapy is thought to require offering choice, working collaboratively, and being candid about the limits, scope, and content of therapy (Oetzel & Scherer, 2003).

Session 3: Conjoint session (task 1 and introduction to task 2).

Session 3 is the first conjoint session with parent and adolescent, and begins by inviting each of them to share elements of their experience and learnings from their individual sessions. Next, emotion awareness exercises are repeated again, but this time the parent or adolescent (rather than the therapist) each represent their expression of differing emotions on a musical instrument, while the other guesses which emotion they are representing. Frequently, the parent and adolescent will represent each emotion somewhat differently to the other (e.g., one may show their experience of anger as fast, loud and with an irregular rhythm; the other may represent anger as a slow and/or rhythmic state). The aims of this exercise are to introduce the idea that emotions may be experienced quite differently by various individuals, that there is not a "right" or "wrong" way to experience an emotion. and that when others experience emotions in a way that differs from our own experience we may miss or misinterpret how they are feeling (Rachman, 2001).

From there, the parent and adolescent are asked to reflect on the purpose of emotions (e.g., understanding fear as a source of information about a situation that may not be safe). They are encouraged to adopt a position of accepting emotions as an important source of information, which may be helpful when deciding how to understand and therefore respond to a situation, as an introduction to goal 2 (connecting to emotions). Then, the therapist asks parent and adolescent to alternate representing an emotion on a musical instrument, and plays another instrument in a way that represents “turn toward,” “turn away,” or “turn against” their music playing. This exercise aims to give the parent and adolescent an experience of how “difficult to manage” emotions may remain heightened or become more intense when they are turned away from or against, but may lessen in intensity when they are turned toward. Parent and adolescent are then asked to reflect on how they may “turn toward” rather than away or against their own “difficult to manage” emotions, and what strategies may enable them to do this. Where the parent and adolescent are not able to identify strategies, the therapist provides information about using emotion awareness and connection exercises (e.g., notice then label the feeling). The therapist may also use musical instruments to support teaching of emotional awareness and/or emotional regulation strategies such as playing a resonant instrument that may heighten awareness of body sensations connected with an emotion, or providing a rhythm to pace diaphragmatic breathing. Strategies identified in individual sessions may be reinforced and practiced again at this point, with care taken to ensure parents are supported to use strategies practised in their individual session to manage dysregulated responses that may be triggered by their adolescent’s emotional expressions. Parents are also assisted to become aware of, accept, and support their adolescent’s strategies for managing emotional dysregulation.

Parents and adolescents are then introduced to the concept of “sitting with” their own feelings as an extension of “turn toward,” and are encouraged to identify strategies that may allow them to sit with their feelings in a range of situations at home, school, work, etc. Music exercises are used to assist them to identify strategies that may be effective, for example, the therapist may play quietly, rhythmically, slowly, or alternate playing with periods of silence alongside a parent’s or adolescent’s representation of anger, and ask the parent or adolescent to comment on which response they find more helpful. They are then encouraged to reflect on ways they can respond to their own emotions using strategies that induce a sense of, for example, stillness or rhythmicity in a range of contexts. Parents are asked to observe and comment on the adolescent’s experience and identified strategies, to reflect on how they may become aware that their adolescent needs a quiet or rhythmically energetic space in order to self-regulate, and to discuss with their adolescent ways they may support them to utilise their identified strategies. “Turn toward your own feelings” and “sitting with your own feelings” handouts are given to both parent and adolescent at the end of this session. Both parent and adolescent are asked to notice opportunities where they may “turn toward” or “sit with” their feelings during the week, and to practise strategies discussed and worked on in the session.

Session 4: Conjoint session (tasks 2 and 3).

The first portion of Session 4 is used to check in with the parent and adolescent about their experience of the previous session, whether they have found opportunities to practise skills, and, if so, what their experience of practising skills was like. Where dyads have not practised skills at home, they are asked to consider situations where skills might have been used, and how they could have used the skills. Warm-up exercises are then used to consolidate skills learned in Session 3.

Next, musical exercises used previously are modified in order to teach parent and adolescent how to “turn toward” the other’s (rather than their own) expression of emotion, and to teach the parent how to “sit with” their adolescent’s expressions of sadness, anxiety, and anger. As in Session 3, time is spent encouraging parents and adolescents to give feedback to each other about ways the other may “turn toward” that are helpful or not helpful. The therapist may need to coach parents and adolescents about helpful ways they can “turn toward” the other, and remind them of what was identified as helpful in the previous session. Frequently, the parent or adolescent may identify differences in what was helpful from the therapist, and what is helpful from each other. The therapist should normalise this (e.g., by explaining that we may find ways of responding that were helpful at one time and less helpful at another time depending on how we are feeling, or that we may find that what one person does to “turn toward” or “sit with” our feelings is not helpful when someone else does the same thing, because the relationship is different). The therapist may then encourage them to both find ways of responding to each other that fit for their relationship, and to accept that these may vary. The parent is additionally supported to maintain an awareness of whether their responses are being perceived by their adolescent as helpful or unhelpful, to experiment with different responses if necessary, and to be guided by their adolescent’s feedback.

From there, the therapist coaches the parent in ways of “sitting with” their adolescent’s anger, anxiety, and sadness, using strategies that were identified by the adolescent as helpful in Session 3. As with the “turn toward” exercises, the adolescent’s feedback is used to guide the parent’s strategies. Adolescents are additionally supported to talk to their

parent about when they need to be left alone, rather than having the parent sit with their emotional expressions, and parents are encouraged to accept this and reflect on how they will regulate their own emotional responses if necessary.

Psychoeducation about negative escalating cycles (NEC) of attack/defend and pursue/withdrawal is then introduced (Moed et al., 2015), demonstrated by the therapist with either the parent or adolescent using musical instruments. Parent and adolescent are asked to identify which NEC best characterises their conflict interaction. Musical exercises are then used to help parent and adolescent reflect on how they may recognise when they are in a NEC (e.g., body sensations, posture, volume or tempo, lack of turn-taking), and to practise stopping the NEC. It is made clear that either parent or adolescent can stop the NEC, and that is important for the other to accept them doing this (i.e., when one stops during an attack/defend sequence, the other agrees to stop also).

From there, sequences of NEC (stop-self-regulate- “turn toward”) are practised on musical instruments. Both parent and adolescent are supported to initiate interrupting the NEC, to use their previously identified emotion regulation strategy, then to “turn toward” the other. Discussion then focuses on what may make these skills difficult to use during a conflict interaction (e.g., emotional flooding) and what may help parent and adolescent to use skills when they are discussing an issue that can cause conflict (e.g., an agreement to stop and use emotion regulation strategies as soon as either parent or adolescent identifies that a NEC is occurring). Finally, the parent is taught to add “sitting with” their adolescent’s emotional expression to the sequence outlined above.

Parents and adolescents are then asked to identify and stop NECs when they notice these at home, and to practise using emotion regulation strategies before using “turn toward” and “sitting with” either after the NEC or at other times (here it is explained that the NEC does not have to be the first item in this sequence, and that where sequences begin with a parent’s recognition of and “turn toward” their adolescent’s emotional expression this may avoid a NEC developing).

Session 5: Individual meetings with parent and adolescent (tasks 1-3).

The first portion of Session 5 (approximately 40 minutes) is with the parent alone. The aims of this part of the session are: (1) to check how a parent feels therapy is progressing without the adolescent present in order to identify areas of difficulty that may require further attention; (2) to give further psychoeducation specific to the parent rather than the adolescent (i.e., effects of parent’s childhood trauma experiences on parent-adolescent relationships, managing rejection); and, (3) to prepare the parent to respond to their adolescent’s verbal disclosure of feelings about issues causing conflict using the skills learned in previous sessions.

Frequently parents feel somewhat overwhelmed and frustrated with progress at this stage of therapy. It is important to reassure them that these feelings are normal because although skills have been learned and practised a little, they are not yet consolidated. They may also be informed that they will have many more opportunities to practise these skills and to apply them to real conflict situations, and that they will learn the verbal equivalents to nonverbal skills taught in previous sessions. For dyads where parents have a history of interpersonal trauma, reactive interaction patterns may have become habitual, embodied, and automatic (Moed et al., 2015; van Ee et al., 2016). Awareness of these automatic patterns in order to interrupt them and learn new interactive cycles is an important first step, but it may take many repetitions before new patterns of response are consolidated.

Next, the parent’s difficulties identified by the therapist as well as the parent during earlier sessions are now given more attention. The parent is given an opportunity in this session to work on these further, and to discuss factors that may make skills difficult to put into practise that may not be related to the parent-adolescent relationship (i.e., lack of support from the other parent, other stresses). Where necessary, additional strategies or referrals may be given. Further psychoeducation may address some of the difficulties raised by parents about the parent-adolescent relationship. For example, information about adolescent emotional development may assist the parent to understand why their adolescent finds it difficult to calm down quickly after a NEC, and to accept that they may need to either give the adolescent more time or additional support via emotion coaching strategies, which are also revisited in greater detail during this session.

Preparing parents for their adolescent’s verbal expressions of emotion about conflict issues is important at this point, as the parents now have enough skills to understand what responses are required, and can rehearse these with the therapist before trying them with their adolescent. The therapist will configure this part of the session based on adolescent feedback from Session 2. Where the adolescent has given permission to share information about their emotional experiences of parent-adolescent conflict interactions, this information can be shared directly; where permission was not received, this information can indirectly inform the way the therapist guides the parent. The

therapist may prepare the parent gently using questions that encourage the parent to reflect on their adolescent's emotional experience during conflict interaction (e.g., "I wonder how your adolescent feels when you raise this issue?"). The parent generally has some awareness of their adolescent's emotional experience by this stage of therapy, as the adolescent has been asked in previous sessions to comment on how the parent's musical representation of anger, anxiety, or sadness makes them feel. TRM first teaches parents and adolescents emotionally regulated ways to discuss emotions without reference to conflict issues, before teaching skills that enable emotionally regulated communication about conflict issues. It is hoped that sequencing skills in this way will create a sense of confidence for both parent and adolescent that issues may be safely raised and addressed constructively. This sequence is similar to the way managing conflict from an emotion coaching perspective is taught in the Tuning in to Teens parenting program (Havighurst et al., 2012). In this program, parents are encouraged to manage their own strong feelings, and to assist their adolescent to manage their emotions where conflict is at a heightened level, before addressing the conflict issue.

Finally, the therapist informs the parent that remaining sessions will provide further scaffolding and skill building. Parents and adolescents will use skills learned in nonverbal communication sequences to interact about an issue that may cause conflict before applying these skills to verbal conflict interactions.

The second portion of session 5 is an individual meeting with the adolescent (approximately 20 minutes). The aims of this meeting are to: (1) check with the adolescent without their parent present about how they feel therapy is progressing, in order to identify areas of difficulty that may require further attention, and (2) to consult with the adolescent about which conflict issues they may be willing to discuss with their parent in subsequent sessions.

At this point in therapy, adolescents frequently express frustration that things have not consistently improved at home. As with the parent, the therapist should reassure the adolescent that skills have yet to be consolidated, that this session is the opportunity to clearly identify skills that are harder to master in order to work on them further, and that there will be more opportunities to practise these and apply them to nonverbal and verbal interaction about conflict issues. This can lead into a discussion with the adolescent about what conflict issues they are willing to discuss with their parent in further sessions, and to nominate which issues may be most important to them. If the adolescent did not give permission in Session 2 for the therapist to let their parent know about their emotional experiences of parent-adolescent conflict interactions, then this should be checked again at this point. If the adolescent is still not comfortable to disclose their experiences to their parent, the therapist then negotiates other ways this material may be addressed (e.g., the therapist may role play being an adolescent during parent-adolescent interaction about an identified conflict issue, then ask the adolescent to comment on whether their experience is similar or different. By now the adolescent has had an experience of the therapist role-playing an adolescent or a parent during exercises teaching emotional response skills, so this suggestion is generally acceptable). The therapist may also need to explore the adolescent's concerns further, in order to ascertain what skills the parent may still need to acquire or consolidate, and/or to negotiate with the adolescent whether there is a feeling or issue that they deem to be of low or moderate intensity, and which they are willing to disclose.

Finally, the therapist then informs the adolescent about the content of the remaining sessions. These may be explained in a similar way as with the parent above.

Session 6: Conjoint session (tasks 3 and 4).

After checking in with parent and adolescent, the outline of sessions 6-8 is briefly explained as involving a change of focus from acquisition of discrete skills to applying these skills in flexible combinations to real issues, and discussing these verbally while maintaining an awareness of nonverbal skills previously taught. After warm-up exercises, parents and adolescents are asked to play sequences of NEC, stopping the NEC by ceasing to play on their musical instrument (either can do this), using emotional regulation strategies, "turn toward," and "sitting with" in different combinations (e.g., "turn toward," loud or non-response, NEC, stopping the NEC, emotional regulation strategy) in order to demonstrate that conversations may not start with a NEC, but where these develop they can be recognised and moved out of using the steps previously learned.

Next, "softened start-up" (Carrere & Gottman, 1999) is introduced as the last building block of "safe communication" skills. "Softened start-up" involves expressing feelings and needs about an issue without blaming, criticising, or judging. Musical exercises that teach nonverbal elements of "softened start-up" include using a quiet/slow-to-moderate volume/tempo on an instrument that makes a gentle rather than percussive sound. Musical exercises are then sequenced either as the first step of a discussion that does not lead to a NEC (e.g., "softened start-up", "turn toward," "sitting with"), or added on to a sequence that may have included a NEC (e.g., NEC, stop the NEC, emotion regulation strategy, "turn toward," "sitting with," "softened start-up").

Parents and adolescents are then invited to nominate low-intensity issues where they may use a “softened start-up,” and to represent these discussions nonverbally on musical instruments. Nonverbal discussions about real issues generate the need for parents and adolescents to creatively use the sequences they have been taught in varying combinations. This session focuses on giving them a number of issues on which to practise these, and to experience the need to move flexibly between different skills. For example, a parent may need to briefly stop and use their emotion/autonomic regulation skill when their adolescent plays loudly in response to their “softened start-up”. Or a parent may experiment with how soon they can move from “sitting with” their adolescent’s expression of emotion about an issue to a “softened start-up” to re-address the issue.

The therapist then facilitates a discussion with the parent and adolescent about how to use these skills when interacting about issues at home, and to reflect on what may facilitate the use of these skills or make their use more difficult. This discussion provides a way to introduce further verbal “safe communication” strategies where needed (e.g., , checking with the other about when to discuss an issue, preparing to talk about a conflict issue by using emotion regulation strategies). Similarly, verbal equivalents are also introduced for “softened start-up” (e.g., , using “I” instead of “you” statements), “turn toward” (e.g., acknowledging the other person), “sitting with” (e.g., reflective listening), and stopping NECs (e.g., “I just need a moment to calm down”).

Lastly, parents and adolescents are asked to practise verbal “softened start-up” and “turn toward” at home. They are additionally asked to remain mindful of their nonverbal communication as practised on musical instruments (e.g., volume, tempo, turn taking).

Session 7: Conjoint session (tasks 4 and 5).

Session 7 begins with further practise during warm-up and preliminary exercises of “softened start-up,” and the sequences described in Session 6. The primary goal of this session is to assist parents and adolescents to successfully make the transition from using skills they have mastered nonverbally into their verbal conflict discussions.

To achieve this, parents and adolescents are asked to identify a conflict issue of medium intensity that they are willing to focus on using the skills taught to date. Once they have chosen their issue, they are asked to represent it nonverbally on musical instruments using the sequences practised earlier, and are encouraged to move flexibly between the core components as previously outlined.

From there, parents and adolescents are reminded of the verbal components of “safe communication” and emotion coaching skills, and elaborated where necessary (e.g., the importance of listening without judgement and/or using respectful language may need to be emphasised). The role of the therapist is to coach verbal and nonverbal skills, and to encourage the parent and adolescent to maintain a dual awareness of the process as well as content of their conflict interaction (i.e., staying aware of techniques while focusing on the issue to be discussed). Where there is time, and the therapist deems that that parent-adolescent dyad has mastered skills sufficiently, this exercise may then be repeated with a higher intensity issue (determined by the dyad).

A further task for this session is to encourage parents and adolescents to consider how they will use these skills at home in situations that are less controlled than the therapy context (e.g., where other family members are present, where there are other pressing demands for attention and time). The therapist may then give further advice where needed (e.g., choose a place to have the conflict discussion that is private, and at a time where both parent and adolescent are able to give the discussion their full attention).

Frequently, by this stage of therapy parents and adolescents are skilled at their nonverbal communication and emotional/autonomic regulation strategies, but are struggling to find the right words to clearly express their emotions and needs (adolescent) or to use verbal emotion coaching strategies (parent). This process should be normalised as per previous sessions (e.g., by assuring the parent and adolescent that their verbal skills are new and therefore have yet to be consolidated, or by giving detailed feedback about what parent and adolescent are now doing well).

This session and the following session now begin to look much like “therapy as usual” in that the focus has shifted to assisting the parent and adolescent to improve their verbal conflict communication. Psychoeducation is given to the parent in this session about problem solving and setting limits, and the adolescent’s views about this material are actively sought and discussed.

Dyads are then informed that limit setting will be the focus of the final session, and this will be done collaboratively with the adolescent (i.e., the adolescent will be able to express their feelings and needs about the limit being set; the parent will be supported to respond sensitively to their adolescent's emotions and needs, and to negotiate the limit under discussion where they feel this is appropriate). Parents with a history of interpersonal trauma may either set limits in an arbitrary and/or inconsistent way (Dubowitz et al., 2001), or experience emotional dysregulation in response to their adolescent's resistance to limits (Pears & Capaldi, 2001), meaning that they may experience themselves as ineffective in establishing and maintaining a limit. In an attempt to then set limits effectively, parents may resort to punitive responses, or impose consequences in order to reinforce limits which may then escalate parent-adolescent conflict, rather than working through the limit via exploration of the adolescent's feelings and needs (Dix, 1991). Therefore, it is important to equip parents with assertive and flexible ways of setting limits that are effective as well as developmentally appropriate to adolescent needs for some autonomy in decision making processes that affect them (Beveridge & Berg, 2007).

Finally, parents and adolescents are asked to notice opportunities to discuss issues that may cause conflict during the week. They are additionally asked to apply the skills they have learned to their verbal discussions.

Session 8: Conjoint session (task 5).

After a check in regarding the homework task, parents and adolescents are invited to further discuss problem solving and limit setting, and key messages are reinforced (e.g., it is necessary for parents to set limits sometimes; it is important to give an adolescent some influence over how a limit may be imposed where possible; and, where this is not possible, the parent should respond sensitively to an adolescent's expression of emotion about the limit).

Warm up exercises with musical instruments comprise a game where nonverbal elements of limit setting are introduced to illustrate that skills already learned can be applied (e.g., using "softened start-up" to set a limit, the parent using "turn toward" when responding to their adolescent's expression of frustration about the limit, the adolescent using "turn toward" in response to their parent's "softened start-up"). Additional music exercises are then introduced that: (1) teach the parent to maintain a non-reactive but consistent (assertive) response to the adolescent's attempts to alter their instrument playing; and, (2) teach the parent to respond flexibly to their adolescent's attempts to influence their playing. A discussion is then facilitated where dyads are encouraged to think about where each response may be appropriate (i.e., where the parent should or should not respond flexibly to their adolescent's view about a limit).

Dyads are then asked to select an issue that the parent has already attempted to set a limit with, and which they are willing to work on in the session. Once the dyad has agreed on an issue, they are asked to verbally address it using the combination of nonverbal and verbal safe communication and emotion coaching strategies previously taught. The therapist's role is again to coach, and to assist parent and adolescent to maintain a dual awareness of their nonverbal process as well as the content of the issue that requires limit setting. Where appropriate, dyads are assisted to collaboratively negotiate limit setting using problem-solving strategies introduced in the previous session.

The final portion of Session 8 comprises a review of the therapy process, and gives parent and adolescent an opportunity to reflect on gains made and further work still to be done. If dyads consider that they require further support to consolidate skills, referrals are given.

Considerations for Therapists

Clinical skills.

TRM is a hybrid therapy, blending approaches and techniques from systemic therapy and music therapy within a complex trauma treatment framework. It has been designed to be delivered by counsellors, psychotherapists, and other mental health clinicians from a range of disciplines, rather than requiring specialised training in family therapy or music therapy. Like the families that attend TRM, therapists are not required to be "musical" or to have completed any musical training. Rather, therapists simply need to be willing to use musical instruments in a way that directly addresses nonverbal and implicit emotional, sensory, and somatic processes that underpin parent-adolescent conflict interaction, in a similar way that play may be used to repattern problematic interactions between parents and younger children.

Intervention delivery.

TRM is best offered as a centre-based approach, rather than in clients' homes. This enables parents to focus solely on the adolescent, and for dyads to be able to focus on the therapy process rather than contend with other distractions. It should ideally be delivered on a weekly basis (allowing for the inevitable cancellations and re-scheduling that may be required around the demands of family life). TRM is sequential and skill-based, with an emphasis on home practise and generalising skills. Weekly sessions enable the therapist to provide a sufficient level of holding and scaffolding families so they can receive the support they need to practise and apply skills. TRM requires therapists and clients to make noise—where possible the therapy room should be not too close to other therapy rooms, or walls should be sound-proofed.

Practice settings.

TRM may be helpful for parents and adolescents who require support in a range of settings, including family violence counselling, clinical adolescent and adult mental health, sexual assault and other trauma recovery services, family support, and drug and alcohol services. TRM is not suitable for families currently exposed to family violence or other interpersonal trauma (including in the context of ongoing custody disputes), or where interpersonal problems have a biological cause that are better addressed through evidence-based therapies that are helpful for mitigating social deficits that characterise that condition (e.g., autism spectrum disorder).

Conclusion

Tuning Relationships with Music™ (TRM) is a therapy in its infancy. A pilot randomised controlled trial showed it was effective for a small sample of parents with a trauma history and their adolescents, with 100% of families who took part in TRM completing all sessions. This may indicate that as well as assisting families to reduce conflict, the use of music may be perceived as a helpful and manageable approach by a client group who are frequently hard to engage and/or retain in clinical practice (Imel et al., 2013). However, due to the small sample size (n = 26 dyads), results should be interpreted with caution. TRM is offered as a four-day training for professionals from a range of disciplines. Subject to funding, further research will be conducted to evaluate the effectiveness of TRM with a larger sample size, when delivered by a range of therapists in various clinical settings. It is not yet known whether modifications to TRM may be effective for different client groups. Clinicians are currently adapting TRM to work with traumatised children and their kinship or foster carers, with traumatised parents and younger children, and with couples where one or both have experienced interpersonal trauma in childhood.

TRM is a new intervention that integrates “bottom up” sensory and somatic techniques with “top down” cognitive approaches within a systemic framework, taking a less verbally-oriented approach than existing evidence-based therapies. Having a creative method for engaging hard-to-reach families with a history of interpersonal trauma who are experiencing conflict is vital, as these are the families who all too often fall between the cracks.

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