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**A Proposed Music Therapy Protocol for Trauma-Informed, Culturally Aware Practice with
Migrants at the US-Mexico Border**

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I have no conflicts of interest to disclose.

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Abstract

This paper reviews current literature surrounding therapeutic work done with the migrant population and considers it through the lens of future music therapy interventions to be done at the United States (US)-Mexico border. The migration process across the US-Mexico border is often filled with danger and treachery, leading to trauma responses, such as depression, anxiety, and post traumatic stress disorder. These traumatic experiences are augmented even further if there is a detention period or separation of families. In work reported by psychotherapists, counselors, and expressive arts therapists, there is often a focus of building empowerment, resilience, and coping skills. Yet in this work, there is also a disparity of power, often situating the migrant participants as victims of their circumstances without giving voice to other unique labels that may lie within the population. Within the music therapy field, there is concern in the literature that cultural competency is not being met, with most music experiences often using improvisation still based in Western music as opposed to culturally specific music trends. Through the research, these gaps are identified and a loose framework for future music therapy interventions is introduced. The hope of this research is that clinicians will consider their work and their findings through a more culturally-sensitive lens, working to empower the participants through other facets than just the experienced trauma. With this in mind, the field can advance its culturally humble practices in ways that then help our future clients with more competency, grace, and understanding.

Keywords: migrant, refugee, music therapy, cultural competence, border, trauma-informed

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Introduction

When listening to the news, ‘border crisis’ and ‘immigration’ seem to make the headlines daily. It is no question that these topics are hot and pressing in not only the United States (US), but across the globe. The idea of nationalism is on the rise in several countries (Bieber, 2018) and the mistreatment of immigrants, migrants, and refugees is a growing concern with this trend. Regardless of political alignment, the numbers pour in, showcasing the influx of migration. For instance, one of the main points of entry at the US-Mexico border in Texas is El Paso. At this port of entry alone, they moved 5,718,032 pedestrians, 13,727,146 personal vehicle passengers, and 222,660 bus passengers in the year 2019 (Bureau of Transportation Statistics, 2019). Within these numbers were real people, with names, jobs, families, and goals. Though not everyone was fleeing a crisis, many were migrating for the betterment of their family and escaping harrowing situations in their home country (DeLuca et al., 2010). Those who decided to move faced significant stressors within the migration process, such as acculturation, resettlement needs, and feelings of isolation (Ellis et al., 2019, p. 15). Furthermore, if someone decided to cross the border undocumented, they were then faced with many more risks, including exposure to even more violence, abuse, and neglect, possible separation from family members, and natural dangers, like unsafe or dangerous terrain during migration (Ellis et al., 2019, p. 13).

These factors make the migration journey one that is full of trauma. Often, families are crossing the border together, including children and adolescents of all ages. One of the biggest concerns flooding the United States media is the policy of family separation at the US-Mexico border and the resources allocated to the detention centers holding detained immigrants. Seddio (2017) addressed the topic of the refugee crisis as it pertained to children coming to the US, summarizing her article to say that resources should be provided beyond just physical needs so displaced and refugee children can develop appropriately, promoting “...prosocial

and nonviolent, resilient behavior” (p. 1045). While most government protocols aimed to meet very basic physical needs, the psychological, social, and ecological factors were often ignored. This was a severe detriment to the overall wellbeing of children in any regard, but especially in the context of immigration and migration (MacLean et al., 2019). In considering the wellbeing of adults, there were several studies pointing to the increased psychological distress experienced by immigrants, including depression, anxiety, and post-traumatic stress disorder (PTSD) (Garcini et al., 2019; Robjant et al., 2009; Orth, 2005).

Music Therapy

Music therapy is defined by the American Music Therapy Association (AMTA) as “...the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (2020). This therapeutic modality, according to Comte (2016), is uniquely positioned to address the needs of refugee and immigrant population. In reviewing the literature, music therapy is already being used widely across the globe, though few studies have been published in the past five years. One popular idea, gracing music rooms across the globe, is that music is a universal language. If this is true, perhaps music therapy would be an appropriate fit for this population when addressing the possible language barrier. On the other hand, though, this idea could be detrimental when considering music therapy from a culturally responsible perspective, diminishing the importance of the nuances that music within culture can have.

While music is used globally, its significance differs from culture to culture. For instance, music can be used to bring a community together, such as the Live Aid concert in 1985. It can be used create a political statement, such as the album *Asylum* mentioned in the article from Back (2016). It enhances religious ceremonies and unites members of the faith, influencing bonds, rituals, and practices. Music invites people to dance, the hypnotizing rhythms entrancing the body to move freely. It serves as a means of communication. It can be a fine art, performed only by trained professionals for an audience of means. Music infiltrates cultures,

influencing how people come together, how they engage with each other, and how they communicate. If music therapy is to be used as a treatment modality, it is imperative to understand how music is used in the culture of the population served.

Cultural Competency

Working cross culturally requires attention and constant assessment of cultural humility and competence. Hook et al. (2013) defined cultural humility as "...having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience" (p. 353). This definition requires a clinician to turn away from self and instead situate themselves to be focused on the other person, removing any notions of power or superiority as it pertains to culture. This definition commands respect as the first rule of interaction, creating space for multiple cultures to exist within the same space. Sue and Sue (2016) defined cultural competence as "...the awareness, knowledge, and skills needed to function effectively with culturally diverse populations" (p. 747). Through this competence, it is the job of the clinician to ensure that the treatment options offered respect cultural differences, engaging the clinician in a journey of self-reflection and honesty about prejudices, biases, limitations, and awareness. In working with refugees and immigrants, cultural competence is a must if treatment is to truly invoke any substantial, helpful change in the clients seen.

Importance of Research

This beginning literature review and proposed framework is important because it addresses the topic of culturally competent and trauma-informed music therapy work with migrants venturing through the "border crisis." It provides a summary and critique of what is already being done and recommends options for music therapists seeking to treat this population. With so few people publishing research in this juxtaposition of music therapy and the border crisis, it serves as a beginning overview that highlights the importance of this research, both now and as the migration and border crisis continues to evolve and change in the upcoming years. As a white, cisgender, heterosexual female researcher currently living in

Southeast Texas, this research would inform both the researcher and other clinicians, helping develop a practice for future clients and addressing the unique needs of the immigrant population while advocating for systemic change wherever incompetence or lack of treatment is found.

Design

In order to identify themes, gaps, and crosses in the current literature, a literature review matrix was created. A literature review matrix is a basic chart that helps researchers organize a plethora of information in a concise way to help answer a research question. They can be organized in several different ways, depending on the information needed for research. In this case, the matrix was organized to compare several articles across a variety of topics, including historical context, music therapy, cultural competence, and trauma-informed practice. The researcher also kept a journal, reflecting on the process of reading through the available literature and identifying emotions, feelings, and biases that presented themselves throughout the research process.

Methods

The resources used in this review were found by systematically searching several online databases as made available by the Lesley University Library and EBSCO Host. Terms searched included “music therapy,” “trauma-informed,” “immigration,” “culturally-competent,” “social justice,” “US-Mexico,” “border,” “crisis,” “expressive arts,” “counseling,” and “arts-based,” all in a variety of combinations. Articles were chosen based on a variety of factors, including type of research, published language, nationality of participants, and pertinence to the topics. Of the initial 56 articles saved for further review, 17 were chosen for in-depth review because of the focus on immigration/migration and acculturation.

Keeping in mind that one of the goals of this research was to propose a music therapy protocol for future interventions and further research, the articles included supported the development of a working framework. To account for potential biases in the selection of articles

to support this goal, the researcher maintained a journal, recording potential biases, personal thoughts and feelings about the research, and reflections on the research being synthesized.

A literature review matrix was created for the chosen articles. Within the matrix, the information for each article was synthesized into different columns, comparing conclusions, limitations, methodology, populations, and results. Each article was then tagged according to subject matter in a new column. After tagging each article, each tagged category was then further analyzed, looking for repeated themes, phrases, and words. The themes were noted and grouped and then analyzed again, but this time from an intervention perspective. Research was categorized by type of intervention and results, again analyzed for cultural competence, theoretical orientation, limitations, type of therapy offered, and response to those interventions. Crosses, similarities, and conflicting data were noted. One last analysis was performed on the literature review matrix, using geographic location and nationalities represented within the population to decipher which articles addressed the populations unique to the US-Mexico border and which articles generalized their findings to immigrants as a whole.

Literature Review

Historical Context

The development of the word 'border' is a relatively new term within academia. Brady (2014) defined 'border' as a term that has been coined in research to describe a certain political and social climate associated with the instability of war torn borders like North and South Korea, East and West Germany, and Palestine and Israel. As the social and political climate has changed in the United States since 2014, it can be argued that perhaps the US-Mexico border can be added to that list, given the instability and hostile environment. The late philosopher Gloria Anzaldúa was one of the most prominent border theorists who brought attention to the violence and crimes happening as an act of anti-Mexican racism (Brady, 2014). These acts of violence and crimes have only continued to escalate into our recent political climate, warranting more research and treatment for those affected by these traumas, as well as advocacy for change to the current policies and procedures regarding immigration.

In looking at the history, it is also important to define some of the more recent findings pertinent to the population. MacLean et al. (2019) released a study that assessed the mental health of children who were detained for over two months in a detention center. Through this research, it was found that 32% of children had elevated scores for emotional difficulties, and that when separated from their mothers, that percentage increased to 49% (MacLean et al., 2019). Furthermore, in analyzing the demographics of this population, they found that most of the mothers were from Honduras, Guatemala, and El Salvador, which contradicted most general belief that detainees were usually of Mexican descent. While this cross-sectional study could not ultimately draw a causal relationship between the emotional difficulties and specific time period of US entry during the immigration journey (MacLean et al., 2019), it did shed light on the fact that children coming into the US (especially children ages 4-8) were experiencing emotional distress, leaving them vulnerable to future complications from post traumatic stress disorder (PTSD) and other stressors. This study validated previous studies' findings, including a study by Miller et al. (2018) that suggested family separation was a major source of distress, often correlated with higher instances of depression, anxiety, and PTSD.

The trend of initial therapeutic work with any refugees was to focus on the trauma narrative (Schwantes et al., 2011; Robjant et al., 2009; Weine et al., 2008; Orth, 2005; Rosseau et al., 2005). In trauma focused work, narrative therapy was often used to help clients discover a sense of ownership of their own story, empowering them to then further change their narrative to what they desire while acknowledging all they have overcome. With the trauma focus, though, narrative therapy then took one step further, weaving the knowledge and impact of trauma into each aspect of treatment. The Substance Abuse and Mental Health Services Administration clearly lists what this approach looks like in their definition of trauma-focused therapy: the trauma-informed organization 1) realizes the impact of trauma and how it may affect healing, 2) recognizes the signs of trauma in the client and their systems, 3) responds by informing practice, policies, and procedures with this knowledge about trauma, and 4) avoids re-traumatization (Center for Child Trauma Assessment, Services, and Interventions, 2020). In

many ways, this is a responsible, ethical way to practice therapy, as it actively seeks to respond to the trauma in a way that avoids further damage or re-traumatization.

Garcini et al. (2019) took the idea of trauma and researched it a bit more specifically, investigating the idea of migration-related loss as the trauma and how it related to psychological distress among undocumented Mexican immigrants. They asserted that migration loss could be separated into domains (loss of symbolic self, loss of interdependence, loss of home, loss of interpersonal, and loss of intrapersonal integrity) and that migration-related loss, regardless of domain, was associated with significant clinical distress. Furthermore, in assessing available resources, the researchers found a gap, indicating detrimental effects for this at-risk population. This research spoke to the different types of trauma only related to loss that a migrant client may feel, not even investigating other traumas that may have happened pre-migration or during transit.

Current Work and Theories

Within the most current literature, trauma-informed therapy is still widely used (Miller et al., 2018; Garcini et al., 2019; MacLean et al., 2019; Suárez-Orozco et al., 2018). Perhaps most widely known is Cathy Malchiodi's recent work regarding children detained at the US-Mexico border and their art (Malchiodi, 2019). Her work brought to life several children's interpretations of their detention and the conditions in which they were living at the time. The pictures sensationalized media reports and went viral, giving a staunch visual to the potential trauma experienced during detention. News reports and research both continued to focus on the trauma that was sustained throughout the migration process, emphasizing the challenges the refugees have overcome. For news reporters, the overcomer was a story that would sell. For researchers, it was an effort to empower and help a client find healing. Empowerment, though, can be a tricky, albeit necessary, part of the work with this population.

Comte (2016) presented an alternative viewpoint to trauma-informed therapy that should be considered when evaluating treatment options and effectiveness with this population. They suggested that there is an "overemphasis" of trauma narratives with clients

labeled as refugees. In this label, you give power to political system from which they were escaping, and compromise the other qualities that create that client's identity (Comte, 2016). Historically, therapists have been working to empower clients through their trauma, and yet it is in this juxtaposition of identity as a "traumatized refugee" that disempowerment is also found. The main point Comte seemed to make here is that research and interventions should aim to empower the client, but that the clinician should also seek to discover other markers that make up the client's identity. Empowerment can be found outside of the trauma the client has faced, and perhaps being constantly referred to as "a refugee who has overcome so many things" actually disables them from owning other parts of their story.

Another theme that emerged from the research is the idea of resilience. According to Weine et al. (2008), resilience was one of the main pillars in the treatment interventions. The Coffee and Family Education and Support (CAFES) model sought to improve access to mental health services by Bosnian refugees by impacting the family unit in a family and community-based framework. CAFES focused on family strengths and resilience as coping tools in addressing trauma, both pre- and post-migration (Weine et al., 2008).

Ellis et al. (2019) made a strong case for resiliency, noting that especially in the acculturation process, it was the clinician's role to hold conditions in which the client could explore possibilities, finding parts of themselves that feel most true and authentic to who they want to be. The researchers postulated that resiliency could be found in the community as clients explored acculturation (Ellis et al., 2019). For clients, this means connecting with their ethnic identity, including culture, religion, and community. Through this connection, they can decide for themselves which parts of their culture they want to keep and engage in with their new community and which pieces are able to be let go or changed. For clinicians, this means ensuring the therapeutic space is welcoming of diverse cultures and open to exploration. The client should feel welcome and comfortable in coming to the therapeutic space and safe enough to explore these cultural pieces as they mold their identity.

The points Ellis et al. (2019) made about clients exploring their own process and being actively involved in that process reflect what Comte (2016) was commenting on earlier about involving the client in the discussion of their labels and empowerment. The client should be involved in deciding who they are, meaning they are an active part of the conversation in rediscovering themselves and reinventing their identity (Comte, 2016). This gives a sense of empowerment without completely focusing on the trauma of migration and allows space for both cultural identities to exist in a single space.

Suárez-Orozco et al. (2018) proposed a new theoretical framework from which to develop treatments with resiliency at the core. This model (titled “Integrative Risk and Resilience Model”) was developed compiling several frameworks together to address the specific needs and tasks related to immigrant-origin children and youth and adaptation. It measured adaptation as related to developmental tasks, psychological adjustment, and acculturative tasks, viewing each of these things from four viewpoints: global, political and social, microsystems, and individual (Suárez-Orozco et al., 2018). This framework may be a guide in future research as interventions develop to address the complex and specific needs of immigrant-origin children and adolescents.

Current Treatment Options and Barriers

Currently, there are several clinicians treating immigrants, refugees, and migrants. Traditional mental health services are offered along with other modalities, like drama therapy (Rosseau et al., 2005), art therapy (Malchiodi, 2019; Linesch et al., 2014; Lee, 2013), and music therapy (Comte, 2016; Schwantes et al., 2011; Orth, 2005). Even with services available, there are several deterrents that make services inaccessible to the population.

The first barrier when accessing services was status. There were notable differences between the words ‘refugee,’ ‘asylum seeker,’ ‘unaccompanied child,’ ‘unaccompanied refugee minor,’ and ‘undocumented immigrant,’ (Ellis et al., 2019). These labels dictated the types of services and assistances an individual could receive from different centers, whether funded by the government, grants, private funds, or nonprofit. Aside from having to know which place will

offer services, undocumented immigrants especially may have an added fear of deportation if an agency reported them as undocumented. Status was perhaps one of the biggest factors in having access to services.

Another barrier was language. Most studies in this review used materials translated into the language of origin or hired translators in an effort to minimize this barrier (Garcini et al., 2019; MacLean et al., 2019; Miller et al., 2018; Linesch et al., 2014; Lee, 2013; Schwantes et al., 2011; DeLuca et al., 2010; Robjant et al., 2009; Weine et al., 2008). In the 2010 study by DeLuca et al., language was one of the main concerns discussed. The researchers noted that there was a lack of resources regarding border crossing in the undocumented immigrants' language of origin. This led to a shock to the crossers when they came across challenges that were not communicated or expected by peers and other crossers.

The other main barrier in access to services was the lack of culturally competent healthcare. Comte (2016) briefly touched on this topic, proposing that music therapy was uniquely positioned to address this barrier because of the emphasis in community music therapy on social and cultural factors as they pertained to holistic health. Western medicine follows very scientific approach to health, asserting that if you are disease free, then you are healthy. For many cultures, however, this idea of disease is not central to health. This could result in mistrust of health professionals and misunderstanding of treatments due to cultural differences (Comte, 2016). Ellis et al. (2019) and Comte (2016) both discussed the importance of culturally responsive healthcare, noting that providers could experience significant resistance in treatment if not aware of the effects of their patients' cultures. Garcini et al. (2019) also addressed the importance of culture in treatment, noting that "...providers attending to the needs of undocumented immigrants should work to understand the immigrant's context and culture...and be cognizant of the multiple systemic and institutional barriers that undocumented immigrants face" (p. 253). In order for services to be effective, clinicians must know where their clients are coming from and what cultural beliefs surround health. If ignorant

to these beliefs, treatment could be ineffective and any attempt at building a therapeutic relationship could be thwarted.

Music Therapy and Migrants

Music therapy has been used with the immigrant population as early as 2000 and possibly even earlier. In an effort to breach the language barrier, music improvisation was often used in these sessions as a way to help clients express emotions without the pressure of language and words (Orth, 2005). This could become problematic though, in that within the idea of “music is the universal language,” the clinician still assumes how music is defined. In the research analyzed, the music used in the improvisations was still very much Western, whether because of rhythmic structures, instrument choice, tonalities, or other musical nuances. There was no documented effort to learn about the musical characteristics of the client’s musical culture, resulting in an unintentional but detrimental missed opportunity to use the client’s music to evoke therapeutic change.

Music, if allowed, can provide a space for people to make bold claims about their sense of belonging and experienced racially inflected nationalism. This space becomes even more salient and effective when the music holding these claims is of the culture being represented. Back (2016) explored how music allows us to understand the relationship between place, migration, and community. The album, *Asylum*, was analyzed from several perspectives, but most notably from how social life can be revamped through music and how musical collaborations can then connect others, bridging divisions and alliances (Back, 2016). Back (2016) found that the album was well received in the community, even though it contained controversial material and strong political statements contrary to the majority’s beliefs. The music served as a container for exploration and self-expression, propelling the artist’s experience forward and giving space to address new ideas. Similarly, Comte (2016) urged the voice of the client and the client’s culture within the process opened opportunities to engage with uncomfortable realities juxtaposed with new identities, a trend that has been resisted in present music therapy research.

Current research seems to be more aware of culturally conscious interventions. Schwantes et al. (2011) focused on culturally conscious music therapy practices. The group of Mexican farmworkers had all come together due to the death of two friends while at work. The music therapist introduced the *corrido* as a song structure for their songwriting intervention. Through this intervention, the men were able to process their grief, tell their story, and connect more deeply with their cultural identity (Schwantes et al., 2011). This intervention was important on two accounts. First was the use of the *corrido*. The *corrido* is a song that tells a story, often of lasting legacies, heroes and villains, love and loss, and other life lessons. It was a culturally appropriate song structure because it was used to help pass stories along from one generation to another. By using this song format, the intervention allowed for a connection to cultural roots, while healthily expressing the workers' loss and grief through music. The final composition was intended to keep the friends' memory alive, celebrating their life, acknowledging the loss, and decreasing the sadness of grief as the song was repeated over and over. Secondly, the researchers considered how music was used in the Mexican culture, and acknowledged how community change was more culturally important than individual change. In recognizing these cultural nuances, the interventions planned were more effective in eliciting change and healing for not only the individuals, but the community of migrant workers as well.

Arts in Healing and Advocacy

The previous study was an excellent demonstration of how art can contain "mental agony," serving as both process and product. Ornstein (2006) discussed the importance of the arts in healing as they reflected on how the Holocaust was perceived through art. In their opinion, art served several functions: 1) as a process for emotional survival, 2) as a witness for unprecedented events, 3) as an internal resistance against slander and propaganda, and 4) as a memorial to the dead after the event passed (Ornstein, 2006). These processes were all important in the healing process, as well as the process to advocacy and finding one's voice. In O'Neill's study from 2011, they reflected on participatory methods and critical models

pertaining to migration. The arts, they wrote, can "...[create] space for dialogue, better understanding, and social change" (O'Neill, 2011, p. 20). This research was further explored in a later study by O'Neill and their colleagues (2019), this time exploring how the arts helped researchers understand women's experiences at a United Kingdom border as asylum seekers. In both of these instances, art was used as a participatory activity in which dialogue was sparked, igniting advocacy, narratives, and change through the process of in-depth, authentic presence and participation (O'Neill et al., 2019; O'Neill, 2011).

Comparison of Designs and Methods

Most studies included in this body of research relied on case studies and interviews as means of research (Garcini et al., 2019; O'Neill et al., 2019; Miller et al., 2018; Back, 2016; Linesch et al., 2014; Lee, 2013; O'Neill, 2011; DeLuca et al., 2010; Weine et al., 2008; Rousseau et al., 2005). Aside from interviews, standardized questionnaires were also frequently used when measuring psychological well-being (MacLean et al., 2019; Miller et al., 2018; Robjant et al., 2009; Weine et al., 2008). Most of the research was qualitative research, reflecting on themes of acculturation, trauma, resiliency, coping, cultural competency, and empowerment (O'Neill et al., 2019; Miller et al., 2018; Suárez-Orozco et al., 2018; Back, 2016; Comte, 2016; Linesch et al., 2014; Lee, 2013; O'Neill, 2011; Schwantes et al., 2011; DeLuca et al., 2010; Weine et al., 2008; Ornstein, 2006; Orth, 2005; Rousseau et al., 2005). Of the 17 articles used, only 3 were quantitative in nature (Garcini et al., 2019; MacLean et al., 2019; Robjant et al., 2009). There was a definite lack of quantitative research in this area, though this could be due to accessibility to the population and the obstacles in obtaining a sample population.

Success of Earlier Studies with Immigrants

It is hard to gauge what measure to take when assessing the success of earlier studies. These studies have all had success in some way or another, and yet, there were still obvious strides that needed to be made in future treatment protocols. A consideration could also be made for the ever-changing needs of the population. Immigrants at the US-Mexico border are

shifting in demographics, from Mexican origin to further south, including El Salvador, Guatemala, and Honduras (MacLean et al., 2019). The reasons for migration may shift, moving from economic reasons to political ones. The political and social climates are guaranteed to shift. All of these factors and nuances point to continued research to adapt and address the evolving needs for the most sound practice.

In earlier studies (from 2008 and before) there was a trend of researchers publishing articles with significant gaps as they raced to simply publish something for others to follow. In the study by Rousseau et al. (2005), for instance, there was no formula for how to duplicate this research design. While the study produced results and positive change, it was hard for other clinicians to duplicate and retest the results. After 2008, instead of focusing on providing services to immigrants, there was an attempt to better understand the why behind the clients and to hold space for the clients themselves to tell their story (Weine et al., 2008; DeLuca et al., 2010; O'Neill, 2011; Schwantes et al., 2011). From 2013 until 2016, the research then moved to a lens on acculturation and adjustment (Lee, 2013; Linesch et al., 2014; Back, 2016). In 2018, the focus of research shifted to the psychological detriments of detention, family separation, and migration trauma while also promoting resiliency as a coping skill for the aforementioned stressors (Miller et al., 2018; Suárez-Orozco et al., 2018; Garcini et al., 2019; MacLean et al., 2019). Perhaps the shift from 2016-2018 could be attributed to the changing political climate of not only the United States, but the world as a whole, with several countries returning to a soft sense of nationalism (Bieber, 2018). This shift led to policies that inflicted severe trauma (Miller et al., 2018; Suárez-Orozco et al., 2018; Garcini et al., 2019; MacLean et al., 2019) and backlash from some of the public. Regardless of where these trends venture, it was valuable to see where the research started and how it has developed over the years to become more successful at addressing the needs of an ever-changing population. In this sense, success was defined as revising current research practices to meet changing needs while also intentionally working towards better cultural humility and overall awareness. The timeline reflected how the research has matured from a quick article roughly outlining interventions to more detailed and

precise treatments with actual client work and feedback included as a part of the discussion. The move towards client involvement empowered both client and researcher, providing space for authentic stories to be shared and for research to begin analyzing and accounting for potential biases.

Discussion

Research in this field is growing more and more as borders across the world become centers for abuse, trauma, and hurt and as clinicians begin seeking these places out for services. The worry with this movement towards treating this population is that clinicians will move quickly to fill the gap for treatment without proper training or background to work with multiple cultures within a potentially heavily traumatized setting. More information is needed to ensure that music therapists specifically are treating migrant clients in a way that empowers, encourages, and heals without ignoring the importance culture has on the music and the therapeutic relationship.

Gaps

The trends regarding research questions have all served a purpose in informing clinicians of best practices and illuminating gaps in the research where treatment may be failing. While this can be counted as a success, it is also worth discussing those now illuminated gaps.

Cultural competence and cultural consciousness are two areas of research that need to be explored further in depth, and especially as it pertains to music therapy. In the basic undergraduate music therapy degree, not many universities include a specific course in cultural competency. It is not until clinicians pursue a post graduate degree that cultural competency becomes more thoroughly and specifically addressed. Cultural competence is, however, included in several codes and standards within the AMTA framework for standards and ethics of music therapy (AMTA, 2020; AMTA, 2019). In Comte's (2016) review of the literature, it became obvious that as a field, music therapy had done a disservice to world music. Instead of inviting participants to bring in their own music and challenging the clinician to learn their

client's cultural music, they were relying on their own ideas of music as defined by a Western ear to complete interventions. While these interventions were still considered successes, it was worth noting that perhaps there could have been more success if the music used was more culturally relevant. By initiating research that allows for world music to come front and center, that gap can slowly come to a close, demystifying the exoticism of ethnic music, and perhaps even one day considering world music just "music."

Another gap that should be addressed is the lack of arts-based research with this population. Arts-based research could be key in beginning to understand the how and why of these problems while also providing a framework for which the researchers can observe their own biases in their artwork and personal responses to the research. This could be monumental in addressing cultural competence and cultural humility as research confronts its Western focus and privileged biases through artistic reflection.

After a substantial review of the literature and in light of the gaps in the current research, a protocol began to loosely develop. This protocol addressed using music therapy with the migrant population in a way that was trauma-informed and culturally-conscious. This protocol also called for researchers to be responsible for creating art throughout the process as a way to document their own growth, resistances, and biases encountered through their research.

Proposed Framework

The biggest hurdle in doing research with this population would be gaining access to the population. This would require careful work with local resources who already have access and rapport built within the community. Specifically when working with migrants near the US-Mexico border, religious organizations seem to be the most trusted and most utilized. Doing any work specifically in detention centers may not be possible due to government restrictions, even if doing the work pro bono. By using this protocol in a transition center (a place of respite utilized shortly after detention, crossing, or processing), you can more safely address the trauma because of the physical distance that separates the clients from the place of stressors

and potential triggers. The transition centers also allow for trauma to be addressed more quickly rather than having clients come in years later to address complex acculturation trauma compacted with the migration trauma. In treating clients sooner rather than later, there is a possible cost saving measure that could impact future healthcare costs. Treating earlier can also help the clients adapt more easily to the acculturation process as they structure their new lives and identities post-migration. If access to a respite center was not possible, this protocol could be done in a church or community center. The biggest factors would be finding a physical space to host the groups that is easily accessible for the population. It should be a location that is trustworthy, safe, and secure.

After securing an access point, a treatment team would need to be assembled. From the research in this study, it is recommended that the team be comprised of interpreters at the bare minimum, but more preferred is if the clinician can fluently speak the same language as the participants. This allows for nuances from language to be noticed and accounted for as the work unfolds. Aside from a music therapist and an interpreter, it is recommended that there be at least one or two liaisons from community who can help establish safety and rapport. Ideally, this would look like someone who has also crossed the border from their same country and perhaps a representative from the center where you are working.

The music therapist (or therapists) would then begin some initial demographic research, looking for specific cultures that are represented at their center of choice. It should not be assumed that every Hispanic client listens to bachata or the artist, Selena. These two musical influences are more prominent in Mexican and Tex-Mex culture, but may not be appropriate for clients who are from Guatemala. Though both speak Spanish, there are cultural differences especially in music that should be noted and addressed. The music therapists should spend time understanding the musical nuances of their demographics, exploring how music is used within the cultural, which instruments are more native to the country, and what rhythms and tones comprise the music that would be familiar to this demographic. This practice would be

the best in providing culturally competent services, an ethical mandate according to the American Music Therapy Association Code of Ethics (AMTA, 2019).

The other step before planning interventions completely would be to receive International Review Board (IRB) approval. IRB approval is essential for this work because of the need for humane work. The possibility that someone could take advantage of this vulnerable population is present, so by involving the IRB, the chances of any harm being done are reduced significantly. The migrant voice must be represented when reporting on the work that is done with this population. Without representation, a bias from the researchers could present itself within reporting and skew the perception of the work and of the population. By allowing migrant voices to speak for themselves, empowerment is handed over to the people who need it most. The clinician, in this instance, is analyzing the efficacy of the work while also creating and holding space for these stories to emerge and shine without bias from the researcher.

After gathering the intervention team and doing research about the clientele, the next step is choosing interventions. According to the research (Ellis et al., 2019; Garcini et al., 2019; MacLean et al., 2019; Weine et al., 2008), the most appropriate goals for migrants who have recently crossed revolve around validation of losses, coping skills for stressors (both past and future), empowerment for self, and increased resiliency. If able, there should also be developmental support for any children being served. There are many possibilities of music therapy interventions that can address these goals areas, including songwriting, lyric discussion, music improvisation, and playlist making. At this point, the team would then decide which population to focus on, whether that's adults, children, or families. Research suggests that children are the most vulnerable in the migration process, so they may be the best group to start with, although teaching parents things like coping skills may allow for healing to happen cross generationally.

Once the population focus and interventions are set, the ideal session length would be twice a week for a month, with each session lasting approximately two hours. Assessment,

including cultural factors and full history, would happen within the first session as a part of the intake process and before actual rapport building begins. The session outline would look approximately as follows:

Table 1

Session Outline of Music Therapy Framework with Sample Interventions

Session Number	Goal Area	Music Therapy Intervention Ideas
Session 1	Assessment, Intake, Rapport Building and Gaining Trust	Music Improvisation, Lyric Discussion, Music and Art, Music Games
Session 2	Naming Losses and Stressors	Song Writing, Musical Storytelling
Session 3	Validation of Losses	Musical Storytelling, Music and Art, Music Improvisation, Receptive/Active Music Listening, Lyric Discussion
Session 4	Coping Skills	Lyric Discussion, Music and Art, Song Writing, Playlist Making
Session 5	Building Resiliency	Music and Art, Song Writing, Music Improvisation, Group Music Making
Session 6	Supportive Systems	Group Music Making, Musical Storytelling, Receptive/Active Music Listening
Session 7	Empowerment	Music Improvisation, Song Writing, Music and Art, Playlist Making, Lyric Discussion
Session 8	Termination and Connection	Presentation of Music and Projects, Group Music Making, Song Sharing

These intervention ideas are just the beginning of the possibilities but are chosen at this point to reflect a group process that allows for lingual, artistic, and musical processing. When considering a trauma-informed perspective, this is a great framework because it gives each participant a varied structure in which they can engage with their own personal traumas within their own strengths and preferences. This allows for an empowered choice on behalf of the client to choose to what extent they engage in their personal traumas and to the extent of how they engage with it. The other consideration when choosing these interventions is that they all can be adapted to fit a variety of developmental levels. Even with songwriting, children at ages 4 and 5 can offer suggestions to contribute to a group song. By choosing interventions that

can be adapted for a variety of ages, the clinician has the tools needed to engage all of the group members effectively, whether the members are children, teens, or adults.

After setting the structure, the researchers would then begin to interact with the population and offer services. Though artistic journaling is recommended throughout the entire process, it is at the point of beginning treatment that it would then be absolutely necessary. As mentioned before, this is an integral part of the process as accountability measures for confronting biases. Protocol would recommend journaling at least once a week, but more preferably twice a week to align with the session schedule.

When offering instruments for music making, it would be important to offer both Western instruments as well as cultural instruments. In building rapport, this would be a perfect time for exchanging songs and asking for suggestions from your clients. Both of these practices allow for cultural to influence the music making in a way that is authentic and not forced. The opportunity to connect with the culture of origin is presented, but the therapists aren't assuming the culture as their own.

The ritual of termination is one that should be carefully considered when working with the migrant population. Because of potential trauma that may have been experienced surrounding leaving and transition, care should be given to make this as much of a positive experience as possible. The inclusion of presenting work, reviewing favorite interventions, and sharing songs as a group allows for the group to come to terms of ending on their own while also reflecting on the upcoming changes they will experience. The supportive system that was created in this group can be acknowledged and thanked as a part of their journey. The coping skills learned through the group process can be practiced one more time before terminating and moving on. The healing that has begun can be celebrated and resources for future treatments can be distributed so that families can continue services wherever they may end up next.

Limitations

This research was mainly limited by the access to the population. The framework proposed here was not able to be tested, therefore its effectiveness is unknown. This researcher was also not a member of the Hispanic or migrant community, so possible nuances or subtleties may have been looked over. Furthermore, the literature review matrix used had no computer calculated component, so some thematic material or overarching ideas may have missed.

Conclusions

The migrant population have special needs when it comes to therapy. There is a precarious balance that has to be achieved in the intersection of culture, trauma, stress, and therapy. As clinicians, it is imperative that the services offered are constantly assessed for appropriateness, cultural sensitivity, and effectiveness. In order to provide effective services, services have to be first offered in a place where they will actually be accessed in a safe environment. Secondly, services need to be offered in the migrant language of origin. This lets conversation flow naturally where it needs to in order for healing to begin.

When focusing on empowerment, clinicians should be aware of their language choice, biases, and prejudices, being willing to confront these topics within themselves. In doing so, the clients are best served in an ethical way. Furthermore, clinicians can expect that they would experience personal growth through this process. Ultimately, the goal of empowerment is to have the clients be able to stand up for themselves, owning and sharing their stories as they see fit for them. Through empowerment, clients can be participants in their own lives, taking an equal seat at the table and giving a voice for what is shared and how it is done within research reporting.

Along the idea of language choice, it is also important to not re-traumatize migrants. While the social story is that each person has overcome tremendous challenges, it simply should not be generalized to every migrant that comes across the border. Though trauma-informed practice focuses on the trauma and how it affects the client's life, it is important to

keep in mind that there may be other ways of establishing resiliency and telling the client's story.

Overall, as clinicians serving the migrant population, there is a responsibility to question typical practices and to assess the interventions done to ensure that they are ethical, culturally sensitive, and of service to the population. In doing so, perhaps there is hope that the migrant narrative can change from one of trauma and risk to one of resilience, empowerment, and healing, especially for those who are most at-risk.

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THESIS APPROVAL FORM

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