Music Therapy with Sexually Abused Children

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ABSTRACT

Music is part of everyday life, and is generally regarded as therapeutic. There is increasing interdisciplinary interest in innate human musicality and the link between music and the emotions. Innate musicality is evident in the dynamic forms of emotional expression that both regulate and cultivate the foundations of meaning in human communication (intersubjectivity). This article discusses music therapy, drawing from interdisciplinary perspectives, and illustrated by case material of individual music therapy with a sexually abused child. Where the growth of mind and meaning is devastated at its core by early relational trauma, music, when used with clinical perception, may reach and work constructively with damaged children in an evolving, musically mediated therapeutic relationship.

KEYWORDS

affect regulation, childhood sexual abuse, musicality, music therapy, theory of change

MUSIC HAS BEEN recognized for its therapeutic powers since ancient times (Gouk, 2000; Hordern, 2000; Tyler, 2000). The universality of music in every culture has its roots in human musicality which appears to be innate and functions in our everyday existence as a basic emotional resonance. Music is part of our human identity: 'Many, if not all, of music's essential processes can be found in the constitution of the human body and its patterns of interaction with other bodies in society' (Blacking, 1973). Musicality, as ethnomusicologist John Blacking asserts, is part of our humanness, intrinsic to our emotional and social everyday living, and not dependent on acquired musical skills.

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Modern music therapy is based on the premise that we are all innately musical, and that this musicality is robustly rooted in our brain, surviving even significant neurological trauma and impairment (Darnley-Smith & Patey, 2003). It has been defined as 'a systematic process of intervention wherein the therapist helps the client(s) to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change' (Bruscia, 1998a, p. 47).

Our bodily movements show rhythmic features that arise directly from our emotional states and motivational impulses. There is tone in our voices, not only when we are singing, but in speaking, laughing, crying. Musical expression is isomorphic with human expression (Aldridge, 1996). Music's properties afford an *involuntary* sympathetic field of relatedness, before there is any conscious effort to 'play music' or to be 'musical'. The physical laws of music that generate this sympathetic field of emotional resonance manifest in our bodily responses to music's wavelength and pulse. These sonorous oscillations influence us at visceral and neuroaffective-motor levels, of which we are mostly unaware. Perhaps it is these levels of music's influence on us that are expressed in our everyday references to how we experience ourselves and others, how we evaluate qualities of empathy and relationship: 'Being on the same wavelength', 'being in tune', a 'harmonious meeting', 'feeling off key', or 'you don't sound quite yourself today' are not merely metaphorical turns of phrase, but have a musical, emotional, and physiological reality. The basic properties of music linked with our innate musicality thus provide the naturally occurring ground of music's therapeutic effect, a resource from which a music therapist draws to develop a therapeutic relationship, according to the client's needs. This natural, universal responsiveness to music was described by music therapist pioneers in their explorations of improvisation with variously disabled, autistic, and emotionally disturbed children (Alvin & Warwick, 1991; Nordoff & Robbins, 2004, in press). Innate musicality and how it functions in developing a sense of self in relationship has also been explained from psychobiological perspectives encompassing a theory of intersubjectivity (Trevarthen, 1999, 2002; Trevarthen & Malloch, 2000).

In this article I discuss the significance of music as a primary catalyst of the therapeutic relationship, and how it can assist a traumatized abused child, particularly in terms of self-regulation and the development of meaning, that is the *capacity* to mean, where this capacity has to be reconstructed, or developed for the first time. Music has a generative role to play in this regard. The use of musical improvisation is a central creative resource that evolves within the therapeutic relationship.

Meeting in music

In clinically oriented improvisation the music therapist is not using improvisation, for instance, as in musical performance, but is improvising music with clinical perception to 'meet' and respond to a client's responses as they evolve. This 'meeting' is a term signifying the total music therapy setting in which the therapist helps a client to experience acceptance and understanding, alongside the tacit or explicit invitation to explore through playing, or to help the client who initially does not or cannot play, just to *be* in music. A useful analogy may be drawn here with Daniel Stern's (1995) concept of an 'emergent moment' of interpersonal experience which he defines as 'a subjective chunk of experience that is constructed by the mind as it is being lived. One experiences oneself as being "in" a moment. It organizes the diverse simultaneous happenings that are registered during a motivated event. In this sense, the moment is an emergent property of mind . . .' (p. 96). In helping construct or reconstruct a traumatized abused child's healthy capacity for being and relating, imagining and playing, for thinking,

musical improvisation can be used in highly adaptive ways to create interpersonal experiences bringing organization and coherent moments of feeling and living in one's own body. Paradoxically, it can also offer experiences of freedom from structure, creating a sense of space and time in which to be alone, while in company. The sense of separateness and togetherness is confused in the early abused child, whose experiences of being and relating have been traumatized and derailed at their visceral core. In music these primary experiences of self and other can begin to be explored, from which a coherent sense of self, a sense of continuity of self-experience and physical and emotional body boundaries, may grow.

Meeting in the music therapy relationship has been described as the 'Creative Now' where integration of affective and cognitive capacities of self may take place (Nordoff & Robbins, in press; Robbins & Forinash, 1991), a concept that bears comparison with Stern's (1998) idea of 'Now' moments, where it is the implicit levels of relating that give rise to living experiences of change. A rich palette of natural expressive musicality may be augmented and enriched in music therapy, providing new emotional landscapes of meeting, such as creating a different mood, offering a temporal framework to help develop a client's playing, however fragmented. Sometimes the therapist's quality of listening itself creates the kind of space and stillness in which a child or adult may begin to hear themselves with a fresh awareness. These are some means of therapeutic change, albeit always occurring in highly individual ways. Within an improvisational musical relationship the therapist responds in free and structured forms that may serve to frame, enhance, adapt to and develop the child's emotional responses and behaviour. The music therapist works with the different manner in which the client presents in the moment and across time, fostering a musical-therapeutic relationship to meet the client's needs, and bringing change and growth. Each therapeutic relationship is unique. Yet, in their different ways, with different client groups and settings, music therapists' discernment and distillation of clinical phenomena inform their work, while also bearing the therapist's individual stamp of personality, culture, training and experience.

Coactive improvisation is a form of shared play, a musical interplay that is developed through the therapist musically listening to, exploring and working with the qualities and characteristics presented in the client's 'being' and 'being with', as well as in the client's '*not* being', and '*not* being with'. Attending, listening, and waiting form as much a part of music therapy as active reflecting, matching or mirroring, enhancing, and interpreting (musically and verbally, as the clinical situation demands). Music therapy works with the senses, the inner movements of the self that come into immediate expression, as well as the subtle levels of being that do not reveal themselves so readily. In playing a musical instrument, even tapping on a drum or woodblock, or plucking the strings of a guitar, one experiences an extension of oneself. Sensory and motivational roots of feeling are set in motion and augmented by their resonance by touching the musical instrument which immediately becomes a sounding board for experiences of 'I', 'me' here, now, in this moment. Within the music-therapeutic relationship, the musical and psychodynamic expressive structures of self, both intrapersonal and interpersonal, come into play. Music therapy can help sustain motivation, regulate emotions, work with self-protective 'defences', habitual patterns of behaviour, explore new ways of being, feeling and relating, experiences of self in relation to another, self-agency and self-control, development of trust in self and others, expressing feelings and personal stories, using music and words (Bruscia, 1998b; Pavlicevic, 1997, 1999; Robarts, 1994, 1998, 1999, 2000, 2003, in press; Tyler, 2002, 2003).

Psychodynamic concepts and ways of understanding the interpersonal and musical dynamics of music therapy illuminate clinical practice in this field, informing both the

preverbal and nonverbal realms from which music therapy processes arise. Music therapists report the closely linked musical and psychodynamic phenomena of transference and countertransference as central processes of therapeutic change (Brown, 2002; Bruscia, 1998b; Hadley, 2003; Montello, 1999; Robarts, 1994, 2003; Rogers, 1995, 2003; Streeter, 1999; Turry, 1998; Wheeler, 1981). These are among the all important unsounded, less outwardly observable, but inwardly *sense-able* phenomena of musical empathy and musical interpretation. Understanding the unconscious dynamics of the child–therapist relationship, including (in the case of children) the relationship with parents or carers, and the wider multidisciplinary team, is as crucial in music therapy as in other disciplines. Boundaries of time and place, as well as preparing for any breaks in therapy, are observed but, in work with children who tend to act out their feelings, boundaries of behaviour need to be set, in the interests of the child's (and sometimes the therapist's) actual physical safety, and the child's internalizing a sense of containment in ways that are consistent and trustworthy.

Issues to do with touch abound with children in all kinds of settings, and music therapy is no exception. While common sense is usually a reliable tool – that is, taking children's emotional-developmental age into account, alongside their history, the whole domain of sensory experience becomes much more complex and harder to 'read' with abused children. This means keeping alert to subtle shifts of intensity and changes in quality of the child's behaviour and play. Musical instruments are extensions of the player's feelings and gestures in the moment. Music animates a host of sensory experiences that brings all kinds of feelings and behaviour into the theatre of play. Beating a drum, blowing a slide whistle, bird call, or kazoo are physical and emotional experiences whereby children hear and *sense* themselves differently. They are also being heard in a sound world that they are actively creating with someone. This can offer enrichment and *reeducation* of this fundamental area of the child's natural experience through musical relationship and play. However, musical experience can just as readily be felt as threatening and intrusive, and this includes the child's feelings about the therapist. The music and the musical relationship may, in a split second, become too immediate for some children to tolerate. This needs to be modified or explored accordingly, and here – sometimes, but not always – the music may need to stop. Verbal interpretation and the therapist's use of her speaking voice are also vital resources in the music-therapeutic process.

Children (and adults) may use the instruments symbolically, such as using them to form a protective barrier or 'music house'. In work with abused children, musical instruments and, indeed, the therapist, frequently become the focus of eroticized feelings in play, triggering a range of feelings in both child and therapist that demand careful attention, clear boundary setting, and working through (Robarts, 2003; Rogers, 1995). To this end attending to the overt features of the child's playing and relating, while attuning to both the subtle characteristics of the child's feeling responses and the feelings being triggered in her (the therapist's) being requires a constant honing of clinical and artistic perception and action. Therapists' ability to differentiate between feelings that they recognize as their own and those that seem peculiar to the client–therapist relationship is one that is cultivated through therapists' own work on themselves (e.g., through psychoanalysis), clinical experience, supported by clinical supervision, and further study and training. Music therapists' self-monitoring of their internal state of mind and bodily feelings is a crucial means of getting in touch with the subtle ever-shifting qualities of interresponsiveness, helping the therapist 'read' and act on the unsounded aspects of the therapeutic relationship, and what is going on in the space between and within – where mind and meaning are formed. The use of countertransference and other aspects of working with unconscious dynamics are briefly mentioned here to emphasize their centrality in

psychodynamically informed music therapy. Even though I am not focusing on this dimension of work in this article, it is implicit in the case material.

'The dance of wellbeing' and the emergence of meaning

The biological roots of musicality intrinsically linked to the emergence of meaning are evident from the beginnings of life: From the first impulse and gesture that are by their very nature imbued with rhythmic, dynamic shaping of action in time (Dissanayake, 2000; Peretz, 2001; Trehub, 2001; Wallin, Merker, & Brown, 2000). Infancy research substantiates the robustness and sophistication of musicality in communication that continues throughout the lifespan, creating and shaping meaning in relationship: 'The universal features of human musicality, its timing, emotive expression and intersubjective sympathy, are clear signs of innate motives, and music functions everywhere as a primary motivating force in human life' (Trevarthen, 1999). This 'dance of wellbeing' (Trevarthen & Malloch, 2000) may be observed in the musical-dynamic forms intrinsic to all human expression. Animated 'conversations', with their eloquent gestures, body movements and vocal expressions, form a spontaneously orchestrated symphony of emotional/motor impulses in sound. Significantly, it is the *regulatory, organizational* function of emotional attunement that leads to the emergence of meaning in relationship and the infant's developing capacity to mean (symbol formation). 'The infant is a virtuoso performer in his attempts to regulate both the level of stimulation from the caregiver and the internal level of stimulation in himself. The mother is also a virtuoso in her moment-by-moment regulation of the interaction. Together they evolve some exquisite dyadic patterns' (Stern, 1985, p. 109). At the heart of empathy is the capacity to listen, to take in or assimilate, respond, initiate a new idea or feeling impulse in response to another, and so on. These felt, living experiences of relatedness are primarily aesthetic and construct the 'cradle of thought' (Hobson, 2002), a phrase that captures the containing, regulating, nurturing and transforming nature of these primitive, yet nonetheless sophisticated forms of relatedness.

The term 'communicative musicality' has also been used to refer to the cultural roots of meaning or intersubjectivity (Malloch, 1999). In his research on the musical and spontaneously improvisational features of pitching, timing, the timbre and inflections characterizing early infant–parent vocalizations, Malloch observed the intrinsic *organizing* principle of communicative musicality in normal infant–carer interactions. In its organizing function, communicative musicality can be viewed as an embodiment of emotional expression and feelings in relationship arising from our motor impulses. Moreover, these impulses take form in sympathetic interpersonal activity that assumes a natural time frame. This temporal frame is intrinsic to the development of reciprocity and is the defining feature of mutuality or the self in intersubjectivity (Beebe & Lachmann, 1988; Beebe et al., 2000; Stern, 1985, 1995, 2004; Trevarthen, 1979, 1993, 1999, 2002).

In addition the regulating, organizing function of music has been described as a central feature of music therapy:

> In a basic sense, *music therapy offers the individual the experiencing of events in certain ways* . . . Although the past experiences of the individual may serve as a basis (often a very important one) for organizing the therapeutic situation, that situation always begins in the present and goes into the future. No therapist can change the past experiences of the individual, but he can organize a present situation so that the effect of the past is altered for a more adequate future. It is in this sense – that of the present going into the future – that the word 'experience' has been selected for use. (Sears, 1968/1996, p. 34, original emphasis)

Sears's concept of music therapy as providing experiences that brought order and change was developed further by Nordoff and Robbins (2004, in press). They too recognized the integrative potential of music to help children who found relationship impossible or difficult, and set about exploring in individual and group music therapy the effects of improvising music as a form of communication and relationship. As music therapists and researchers they explored the dynamic features of the musical relationship as it evolved with a wide range of children, recording and analysing their data. Sharing the basic beat was one feature of the music-therapeutic relationship that Nordoff and Robbins considered crucial in developing a child's capacities for playing and relating. From a developmental perspective, the shared beat or pulse is noted as an *intuitive* feature of infant–carer communication that in its organizing function creates mutuality or empathy (Trevarthen, 1980, 1999). This fundamental organizing feature of empathy is almost invariably not established or highly idiosyncratic and unstable in the case of atypically developing and emotionally disturbed children (Condon & Ogston, 1966; Evans, 1986) and here music can do much to help.

The ways in which music can organize or regulate a child's emotions and assist interpersonal/intermusical relationship in music therapy are particularly relevant to work with all kinds of children who need special help to find meaning in relationship, to grow their minds – all part of the emotional process that includes self- and interregulatory experiences that create the time and space in which thought and ideas can come into play. Through the clinical creative use of improvisation, music can provide an interpersonal framework, a living experience of interpersonal connectedness. Such experiences cannot be prescriptively or didactically generated.

Living experiences in music where the client's spontaneous emotional expression is supported and developed by the music therapist may give rise to autobiographical narratives, either in song or in verbal associations. The most compelling narratives of self-experience or self-history are those where the client's emotional expression develops within the music (for example, Austin, 2001; Etkin, 1999; Robarts, 2003; Turry, 1999; Tyler, 2002, 2003). Within the aesthetic, organizing, formal experiences afforded by the properties of music, a clinically, creatively developed musical relationship can bring integrative experiences of being and being with (Ansdell, 1995; Bunt, 1994; Darnley-Smith & Patey, 2003; Pavlicevic, 1997, 1999; Robarts, 1994, 1998, 1999, 2000, 2003, in press; Wigram, 2003; Wigram & De Backer, 1999a, 1999b).

Assessment of change

A recent meta-analysis of the effects of music therapy for children and adolescents with psychopathology found that music therapy produces a clinically relevant effect of a considerable size, particularly with children with behavioural or developmental disorders (Gold, Voracek, & Wigram, 2004). However, given the varied clinical settings and applications of music therapy and the range of clients of all ages with whom music therapists work, it is perhaps not surprising that no standardized assessment exists, applicable to all client groups. The development of the client's individuality is key to the therapeutic process, and further compounds this dilemma. Assessment or evaluation criteria tend to reflect the therapist's clinical setting and clinical population(s), as well as the therapist's cultural or philosophical orientation (Bruscia, 1998a).

My own evaluation of change in music therapy is a model of clinical pathways focusing on early processes of relating: Not early interaction *per se* but the development of mind, of meaning. This has evolved in my work with children and adolescents who are hard to reach or have fragile foundations of self (Robarts, 1994, 1998, 2000, 2003, in press). It

indicates the development of interregulatory capacities and symbol formation in the music therapy process that I consider in the next section as 'poiesis', where musical form has an architectonic role to play that is inseparable from the therapeutic relationship itself in bringing change and growth. My thinking has been helped by Stern's (1994) clinical model of coherence of self (schemas of lived experience, representational experiences, and evoked/reenacted experiences), Trevarthen's (1993, 1999, 2002) theory of motive states, and child psychotherapists whose work illuminates normal and pathological sensory, temporal and spatial realms of experience in the growing of a mind (for example, Alvarez, 1992; Maiello, 1995; Tustin, 1986). Through independent study, supervision and discussion, I have found this cross-fertilization of apperception to enhance my clinical understanding and practice in a very natural way.

Poiesis: The construction of meaning as a central process of therapeutic change

In trying to capture the essence of therapy and the aesthetic imperative in therapeutic change, I sometimes liken music therapy processes to the construction of a poem. In Greek, *poiein* means to make or construct, and is obviously the root of our word, poem. In music therapy (as I conceive it) the 'poem' *is* the therapeutic relationship, encompassing the changes occurring within that relationship, within the client and within the therapist. This is not intended as an idealistic or fanciful notion, but in the sense of poem *making*, a process of crafting and honing one's senses, perceptions, and creative skills to forge new horizons of meaning. The dynamic forms of timing, intensity, colour of voice and rise and fall of intonation, pauses have been described as the 'musical edge of therapeutic dialogue' and operate at subtle levels of every therapeutic relationship (Knoblauch, 2000). These are aesthetic experiences that appear to bring about a state of stillness or spaciousness in which listening to the self is a 'felt' experience. For this reason, I emphasize the constructive, creative, or, literally, 'recreative' properties of music in music therapy by describing these clinical pathways as '*poietic* processes in music therapy' (Robarts, 2000, 2003).

In working with children who find relating and assimilating new experiences difficult, I became aware of a core of clinical pathway in the therapeutic process. Among my main teachers were the very disturbed children who had histories of familial sexual abuse, leading to posttraumatic stress disorder. Children with PTSD may present their emotional disturbance in chaotic behaviour, or in total emotional withdrawal, unable to find inner calmness or stable vitality. Their volatile emotions and complex reactions to the therapist and the therapy setting present many challenges and dilemmas in developing a therapeutic alliance, not the least in attending to the somatic levels at which trauma and stress may find expression (Reid, 1999; van der Kolk, 2003;Wickham & West, 2002). Using improvisation in music therapy, the therapist can work directly with a child's emotions and behaviour in order to develop experiences of self-regulation, healthy attachment, and a capacity for play (Bargiel, 2004; Robarts, 1998, 2003; Wheeler & Stultz, 2001). The form and order that can be experienced in music are not rigid, but dynamic forms that can grow or diminish in intensity and duration, temporal/spatial structures, while retaining salient aspects of constancy and predictability. Here the biological link between music and the emotions takes on a particular significance, requiring careful attention by the therapist to the child's responses, the musical dynamics and psychodynamics of relationship, and all that this entails. Elsewhere I have described the use of musical 'shapes' and motives (motifs) in relation to work with autistic children (Robarts, 1998) and with anorexic adolescents (Robarts, 1994;

Robarts & Sloboda, 1994). This shaping of small units of time can often help children who find 'taking in' experiences of relationship difficult, and who can only cope with clear, easy-to-assimilate structures.

My clinical pathways model of *poietic* processes in music therapy gradually assumed a recognizable hierarchical structure. They offered me an overview and an 'experience-near' way of evaluating therapeutic change that was consonant with my way of working to help the children, adolescents (and adults) that I saw, especially in terms of a child's developing capacities for relating/symbolizing. Symbol formation arises from the basic interregulatory field of emotional communication and relatedness; in music therapy I describe this phenomenon as the 'tonal-rhythmic field of sympathetic resonance' (Robarts, 2000, 2003). This field manifests due to the resonating properties of music and sound, through the voice, the playing of musical instruments which in turn augment experiences of self and relationship. From this musical ground of relationship, subsequent levels of symbol formation develop, until autobiographical narratives may present spontaneously.

The pathway of symbolization in music therapy is a dynamic trajectory from evoked levels (that is, preintentional, unconscious responses) to more self-directed, intentional modes of expression, where imagination comes more fully into play as autobiographical narratives. These processes are illuminated by Stern's (1994) model of the infant's representational world, where the building of meaning and self-coherence grows from the sensory-motor-affective schemas of 'lived' experience, that are evoked and enacted spontaneously leading to autobiographical narratives. Damasio (1999) has also referred to autobiographical narratives arising from felt, lived experiences at a sensory-motor level. In music therapy, rather than our conscious associations with music, imagining and remembering, musing on our past, I am dealing with much earlier levels of being and relating, where the abused child's sense of self has been 'dis-membered', and where 're-membering', putting together, is invariably an intolerably painful experience. 'All traumatized patients seem to have the evolution of their lives checked; they are attached to an unsurmountable object. Unable to integrate traumatic memories, they seem to have lost their capacity to assimilate new experiences as well' (Janet, 1889, cited in Schore, 2001). Where the child has no mental space to *be*, let alone imagine or reflect, his or her being and relating has first to be addressed. If used with care and clinical skill to avoid retraumatization of those children whose foundations of self have been traumatized by abuse, music can set in motion *new* self-experiences as an integrative, formative pathway from visceral and sensory experience to conscious expression. In this way a sounder sense of self must begin to be developed in the present: A self which can begin to withstand, to some extent work through, and then perhaps be helped to move on from the trauma of abuse. This is, of course, far from being an untrammelled process, and is dependent on many factors that at best support the therapy process, but, at worst, invade and sabotage the child's overall therapeutic programme and care.

In order to explore clinical pathways as a model of therapeutic change, I carried out a small descriptive study[1] focusing on individual music therapy with six children, aged between 4 and 12 years old, with histories of a traumatic early life. One of these case studies is reported here. The music therapy sessions were all recorded on audio and video tape (with informed signed parental consents, and ethical procedures followed and approved by my places of work). From preselected episodes, termed 'significant moments', the data were analysed. From different periods of my work, I identified salient features of therapeutic change as 'clinical pathways' common to all cases. Despite each child's individuality, I found that the central processes or 'fields of relatedness/symbolization' where music acted most significantly comprised three fields of emergent relatedness

and symbolization. The following fields were identifiable, although constantly overlapping and interweaving in each evolving clinical situation:

- *Field (i)*: Tonal-rhythmic field of sympathetic resonance forming the ground of relatedness and regulation underlying development of meaning;
- *Field (ii)*: Emergence of motive (motif) signalling and building more aware dynamic expressive forms of relatedness;
- *Field (iii)*: Autobiographical narratives, spontaneously arising in song or other symbolic expressive forms, indicating that the Fields (i) and (ii) have been assimilated, a sign of integration and symbol formation.

The three fields represent different levels of relating and playing (different strata of symbolizing) within the music-therapeutic relationship. Field (iii) may remain fragmentary and tenuous until Fields (i) and (ii) are consolidated. Sometimes Field (i) assumes prominence in the building of the musical-relational phenomena of Fields (ii) and (iii). There are some anomalies that I found in work with some children, where the child was more readily engaged at Field (iii) in a symbolic form of expression (a drawing, an image, a story) in order to broach more immediate emotional and relational contact of Fields (i) and (ii).

A second phase of this project seeks to validate these criteria to evaluate the clinical process and the development of the child's capacity for self-regulation and relationship. An interdisciplinary panel, trained in the use of the rating parameters, will rate the case study extracts as well as rating a control sample of case material of children who have different histories but comparable ages. This stage is not yet complete. But the study goes some way to identifying different levels of interregulation, self-regulation and symbolization as processes of therapeutic change in music therapy with sexually abused children.

How music therapy can bring change for sexually abused children

If we accept that music can elicit almost involuntary, preconscious responses from us, felt within and expressed from our bodies (revealed in our motor impulses and in multifarious emotions arising with those motor impulses), then the significance of music for children suffering from early trauma merits some serious attention. It also demands that music is used wisely, with as much understanding as possible of how music can and does affect us. The embodiment of feelings of self in relationship, the temporal frame of emotions that arise and are developed in relationship leading to a sense of self and other, thinking and meaning (symbolization) – all are disrupted at their core by early relational trauma. Sexual abuse in early childhood we know to be a trauma that has a global impact with lasting consequences for the developing child.

Used with clinical musical perception music may forge new experiences of being and being with that the child can begin to assimilate. In work with sexually abused children the immediacy of 'connectedness' that music therapy can bring has to be handled with extreme care. 'Connectedness' here denotes the most basic experiences of relatedness and integration where intrapersonal and interpersonal experiences need to be carefully regulated. Experiences of being, being with, and dissociative states characteristic of sexually abused children can be helped by music in particular ways within a musical-therapeutic relationship, which I hope that, even without the essential element of the music, the following case material will convey.

'Sally'[2]

'Sally' displayed all the major symptoms of posttraumatic stress disorder (American Psychiatric Association, 1994):

- dissociative states;
- persistent symptoms of increased arousal;
- poor capacity to self-regulate;
- a distorted development of sense of self;
- persistent avoidance of stimuli associated to the trauma;
- numbing of feelings and persistent reexperiencing of the event;

as well as

- alterations in perception of perpetrator;
- alterations in relations with others;
- alterations in systems of meaning (Herman, 1992, p. 121).

Born a 'floppy' baby, Sally was the third child in a family of four. The family lived on an inner-city council estate. Her mother lived on social support and already had a difficult life and a history of violent relationships, as well as alcoholism and prostitution. From the age of 2 1/2 to 7 years, Sally was sexually abused by two men in the household, one being her mother's partner. The assaults were persistent and violent. When the abuse was finally disclosed, the perpetrators were imprisoned, and all the children were placed on the Child Protection at Risk Register. A strong bond of affection sustained the family, despite the volatile and sometimes violent relationships between the adults. Furthermore, Sally's mother's new partner was someone with whom all the children were developing a good relationship.

Sally attended a school for children with severe learning disabilities. Although her language and comprehension indicated moderate learning disabilities, her behaviour was such that she could not function at that level. Sally was doubly incontinent, with poor motor control, severe problems of attention and limited expressive language, but showed she could understand normal, simple conversation. She had a squint, her gaze often swivelling towards to the ceiling, where it would linger as she stood limp, passive, and often wailing a terrible, hollow wail, followed by piercing screams and hysterical hollow laughter. At first, Sally's remote manner, her volatile behaviour, her marked difficulties in social interaction and her obsessive-compulsive habits suggested to some that she was autistic as well as severely emotionally disturbed. Only when the full extent of her early suffering was disclosed was she recognized as suffering from PTSD.

At school a behavioural programme was set up for her, involving clear boundaries, with strict routines. The program emphasized that Sally was always to be given clearly communicated choices to enable her to feel secure by sensing that she had some control over situations, building her sense of autonomy and trust. Sally was frequently so disturbed that she would seek to harm herself, often banging her head against a wall. It required two adults to hold her to prevent her from injuring herself. Inevitably, this was experienced by Sally as being overpowered by her abusers, increasing her own distress and that of her helpers. Sally's response to being given help often spiralled out of control, culminating in her taking all her clothes off, and running to put her head down the toilet, while flushing it. She was obsessive about washing her hands and the rest of her body until her skin bled. For Sally to remain in school, a one-to-one support was required at all times. She had great difficulty in trusting people, and was scared of men and of dogs, so that normal outings in public would often trigger screaming and panic.

Sally received individual psychotherapy from the age of 7 to 9 years old but this was curtailed when Sally's mother was unable to take her daughter there regularly. From the age of 7 until she was 14 years old, Sally received individual music therapy once weekly,

initially lasting 30 minutes and, from the 4th year of therapy, increasing to 40 minutes. Continuity of sessions was achieved only because Sally was brought by her learning mentor. I would have liked to see Sally for at least two sessions per week but this was not possible. Ongoing liaison work between Sally's teacher, her learning mentor and me was vital. Sally could not have used her weekly music therapy sessions with me in the ways that she did, had she not had a daily 15 minutes session with her learning mentor at the end of each school day. In this way Sally was supported, listened to, and given the experience of her feelings and emerging thoughts being 'held' throughout the week. Sally's mother was wary of meetings with professionals but, with the support of Sally's learning mentor, gradually became more trusting and met with me on several occasions.

Music therapy with Sally

In the first two years of music therapy Sally's sense of herself and her trust in the therapeutic relationship developed slowly. Sally's sense of her self was growing in terms of body sense and body boundaries, sense of self-agency and trust in me, but she showed only intermittent episodes of coherent action or thought. Much of the time, she seemed to be experiencing falling, dark holes, and her screams and kicking – often directed at me but in a 'cut-off', remote state. Often after throwing herself to the floor, she stared up at the ceiling, uttering a few words repeatedly in her hollow tone of voice: 'Stairs', 'light off', 'dark', 'break your neck', 'f***ing bastard', and a long, drawn out guttural 'da-a-a-a-a' (possibly her word for Daddy, but I was never sure; it could have been a more drawn out expression of 'dark'). Her trauma was 'replayed' in this fragmented way, with sudden shifts of mood, impulses and withdrawal into remoteness. I had to learn how to listen, yet be firm and intervene if she was harming herself, and whenever possible not waver or react, even when I knew she was experiencing me as one of her abusers. I had to accept and acknowledge to her how she felt, while trying to comfort her in her distress. I also had to explore ways of helping her move forward from her habitual, self-destructive states, and offer her new experiences to build a more ordinary, healthy sense of self.

At first unable to modulate/regulate her impulses and feelings, Sally gradually began to stroke rather than kick or hit the musical instruments. She would then look at her hand wonderingly, almost amazed, as if recognizing her hand as her own for the first time. The various musical instruments proved to be vital intermediaries of relationship, offering her sensory experiences of herself in sound, that helped her begin to develop a sense of herself. Her sensory explorations seemed to help her not only to recognize but to 'own' her bodily experiences as she began to trust the act of playing using her hands, fingers, mouth, feet, arms. The resonance of musical instruments extended her self-awareness and holding her interest in ways that created space and time for thought. By the end of the 2nd year of music therapy, she had begun to use some words which reflected her pleasure in music: 'Swimming', 'riding', she would say as she played. 'Safe' became a word she used, when she became more able to settle and engage in a shared experience of quiet play.

In her 3rd year of therapy, 10-year-old Sally's capacities for self-regulation and symbolizing began to be more firmly established. She seemed more stable, at home in her body, able to stay in the 'here and now' of the therapy room, without such frequent dissociating and psychotic states of mind. The case material of this time shows the tenuousness of her sustaining these capacities, how quickly they fragmented, or became diffuse.

Significant episodes from a session in Sally's third year of therapy

Five episodes are highlighted from one session in Sally's 3rd year of therapy which illustrate significant moments in the music therapy process. These episodes represent integrative 'poietic' processes of affect regulation and symbol formation in music therapy, traversing all three fields of poietic processes. A brief summary of each episode is given in bullet points before a more detailed description.

Episode 1: Beginning of session

- Sally running around room; Sally showing ambivalent feeling states: Anger, hysteria, hollow laughter, kicking out at JR;
- Sally's movements begin to be influenced by pulse of music, and her responses become more focused;
- Moments of cohesion;
- JR musically matching intensity and ambivalence of Sally's feelings;
- Introducing stability of pulse and harmonic tension/texture.

After a few seconds of running around the room in a distressingly chaotic state, with hollow, wavering laughter, Sally brushes against a cymbal, knocking it over. This does not appear to have hurt her but it brings her awareness into the moment, into the 'here and now' where she appears to stop and reflect, look around. Then she cries. The music is dissonant, but lightly textured, rhythmically working to slow the tempo of Sally's fast running around the room. My role is to support her, listen, and provide a safe framework in which she may find stillness. I remained seated at the piano, sometimes silent, sometimes playing according to my sensing if she needs quietness, or someone to accompany her. She sometimes looks over to me. Silence is also a form of acknowledgement and offers a space in which Sally hears herself. I hope that my stillness will reassure her. Very readily I am made to feel like one of her abusers. I have to steady myself, ground myself to counter this feeling yet accept it until she begins to trust me more. (This is an example of Field (i) in which music used to create tonal-rhythmic field of sympathetic resonance, to meet her mood, while working to regulate/stabilize her emotional state, her running and feeling out of control.)

Episode 2: Working with Sally's alternating stability and distress

- Sally's intermittent screaming and repose seem to belong to a dream state;
- She quietens and whispers something that sounds like 'cry it' or 'try it', as she sits on the floor;
- JR places a small woodblock near her and a clave, tapping the woodblock twice;
- Sally then plays sporadically, alternating her playing with screaming/vocalizing;
- Intermittent regulating influence of musical pulse on Sally's playing, providing a framework for recurring silences which she fills with screaming – listening to her screams.

Sally's crying intensifies into a hollow wail; she then lets out a piercing scream. She does not seem to be screaming at me, for she is now lying on the floor, her body still, and she is staring at the ceiling. She listens to her scream, and then screams again.

She whispers very quietly, 'cry it' (possibly, 'try it'). I echo this quietly but with a slight questioning intonation. She sits up, looks around her, as if waking from a dream. I sense that she is not screaming at me, so much as remembering her screaming, an experience or experiences from her past that she relives. I also have the sense that she is exploring this reexperiencing of her screaming, listening to it in the safety of the therapy room – rather like a baby listens to its own babbling. Sally's screams have a hollow, frighteningly sinister ring to them. I have the impression that she appreciates my listening to her and not moving either away or towards her. I listen, but every now and then, I play a three-note motive – a simple musical statement; I use it as a way of 'calling' out to her, without using my voice, yet letting her know I am there and listening to her. (Example of Field (ii): Offering a musical motive, as a way of providing emotional and communicative experiences that have clear form. Islands of 'connectedness' and basic self-regulation begin to form. Fragments of her traumatic memories seem to be replayed in her mind. While responding to these, I also work to build new experiences of relationship in a bearable reality of a boundaried

present, that is, temporally and spatially structured at micro and macro levels through the music and the music-therapeutic relationship.)

Sally begins to tap sporadically in tempo to my singing. Her beating is unsteady, but becoming more sustained in repetitions that last 10 to 15 seconds at a time. I go over to her, and hold out a small woodblock and place a clave near her. I begin singing softly a simple children's song that I then improvise without words, and in a minor key. I slightly increase my verve to engage her physical/emotional response. Here she is beginning to experience herself in relationship, responding with some alertness and self-control, achieving a self-regulation that is generally hard for her to sustain in socially intimate situations. I am very conscious of the effect this new coactive experience in music may have on her, as she tends to avoid any close contact. In any physical proximity her motor impulses tend to become chaotic. I am hoping that the way in which I am providing music will give her an experience of steadiness that she can assimilate, as she responds to the stability of its forms. I pause, allowing silence and space, stillness to add to her experience and sense of being in control, and not overwhelmed. (Here Field (i) is becoming more stabilized, shifting tenuously into more formed shared activity of Field (ii) that brings greater awareness, control and intentionality.)

Sally's emotionally steadier state continually falters, alternating with her 'remembered scream' which is then followed by hollow-sounding vocalizing and a gagging sound at the back of her throat. I listen, wait and occasionally respond to her, trying to reassure her by singing a two-note motive that responds to her sounds but at a lower vocal register. I let her know that I am listening. Her experiences of herself in the here and now as she plays alternate with her remembered screams, which seem to be half-way between her habitual dissociative states and her very disturbed emotions, which she can now allow herself to feel and communicate to me. I feel it is important that I stay still, some distance from her, and witness these alternating episodes of her screaming then playing. My steadiness and non-action seem to be all-important at this point. In these moments Sally is no longer dissociating from the reality of her feelings, her terror about her traumatic past. She can remain for longer episodes in a present which is not only sympathetic to her, but is providing a structure for her to feel safe and protected enough for her to begin to use her thinking capacities. I sense she is beginning to experience some peace when she is held in the present, albeit with her harrowing memories. (Fields (i) and (ii) now increasingly unstable and need to be continually reestablished from moment to moment.)

Episode 3: Beginning to express her feelings through musically supported activity without dissociating

- Sally stamps her feet, and then wildly kicks at the tambourine held out to her by JR;
- The intensity and form of JR's singing support Sally's kicking and the feelings of anger that accompany this;
- This leads to some vocalizing exchanges between us;
- Sally lies on floor, continues kicking strongly upwards to tambourine held for her by JR, at first wild and angry, then stabilizes and begins to kick like a small child – normal experiences of early play and enjoyment of her kicking develop;
- A sense of trust in JR and listening to the accented pulse of the rhythmic music supporting her kicking.

A few minutes have elapsed since the events described in Episode 1. Sally's emotions and behaviour have become volatile, erupting into wild running and hollow, almost guttural, laughing. I am concerned to find a musical way in which she can experience her feelings, while also self-regulating/experiencing self-control and self-soothing. She is stamping and wildly kicking. I hold a tambourine to her flailing feet, and encourage her to direct her kicks there. (Field (iii) is being touched on, built on Fields (i) and (ii) – still tenuous, but

she is hardly dissociating at all, although because this is less extreme, it is sometimes hard to determine. She is expressing anger, rage, pain, terror: The feelings she usually splits off into dissociative states and self-harming behaviour.)

Episode 4: Vocalizing exchanges; sense of agency developing; memories (autobiographical narratives) being experienced with anger and pain, but less extreme dissociating

- Sally's vocalizing and mood are supported by JR, initially from the piano, harmonizing her sounds;
- Her vocalizing begins to develop into a mixture of speech and song;
- The trauma of abuse is always present but there is less dissociation as she now repeatedly dwells on the experience;
- Sally half-sings, half-says: 'Light . . . careful', (shouts) 'f***ing bastard';
- Her kicking continues with increased intensity supported musically and by JR holding a tambourine to receive her kicks;
- As in Episode 3 Sally begins to show normal enjoyment of kicking and to delight in this experience;
- Sally's kicking continues with intensity and begins to become steady, focused and intentional; eventually there is a clear qualitative shift into normal enjoyment of herself kicking, then stamping on the floor like a little girl;
- Twice Sally initiates steady stamping; signs of her enjoying her developing autonomy, self-agency and control in musically interresponsive activity.

Sally gets up off the floor and runs off around the room. Again, from the piano, I accompany her movements to try to help her regulate her emotional state, using close-textured harmonies in short phrases followed by silences. I try to give her space yet engage her awareness, and eventually draw her back into a more grounded expression of her feelings. However, this does not happen. In silence, Sally returns to sit on the floor and begins to sing-speak again in her hollow-sounding voice. It is a voice, not of an innocent child, but the whispering, gasping utterance of a child in a state of grief, pain and terror. At no time does she indicate that she wants to leave the room; rather, she seems intent on using the music room and the time with me to vent her feelings and her memories of her torture. These memories she begins to express in a few words interspersed by her screams. She listens to the echo of each scream. From the piano I offer a slow, gentle pulse using warm harmonies with intermittent silences to create both a temporal framework that supported and gave her space in which to hear herself. I say this to her in words. My speaking voice is in many ways an important contrast within the music and the silence. I use my speaking voice as another facet of the music, as well as to acknowledge her feelings, when they need to be understood in words. Here I use words as a symbolic form of musical motive that can be held onto and taken in by Sally to help her feel understood. (In this Episode, Fields (i) and (ii) are stabilized, and she begins to express herself in words – Field (iii). Here the whole pathway of symbolization from Fields (i) to (iii) begins to hold together, and indicates a level of integration that she is achieving in that moment. This recurs in later sessions with increasing range of emotional expression, less habitual, less impulsive, alongside increasing use of words in complete phrases and eventually sentences. Here we see the habitual and fragmented memories or hallucinations of her trauma being contained while at the same time starting to give way to newly emerging experiences of herself and relationship in the present, that is, the creation of new, healthy pathways of self and self in relation.)

Episode 5: End of session – calmer, tired

- Sally sits limply on a chair at the piano close to JR;
- JR holds a hand-chime for Sally to play with (otherwise Sally would be likely to throw it away, as it is a fairly new experience for her);

- JR provides a gentle, flowing (left-hand only) accompaniment using a three-beat phrase, ending in a pause that invites her to play – gentle but clear structure which engages her, steadily;
- A few minutes later, Sally half-sings a few inaudible words, then in a resonant voice sings 'da–rk', sustaining the vowel sound over my changing harmonies; she does not split off into a scream;
- Sally then sings/whispers: 'Bye-bye . . . time to go . . . light shining' before suddenly coming to a different level of consciousness, saying in a quite ordinary voice, 'sweating!', while examining her hot, rather flushed hand.

At the end of this session after volatile, extremely disturbed feelings and play, Sally sits on a chair beside me at the piano. She sways her body to a gentle lulling song I am playing. I use a rocking motive with harmonies that are warm and solidly in a tonality to support her quiet vocal sounds. Her bodily response is steady enough for me to hope she might be able to play, extending her experiences of herself in relationship with the music and myself, and focusing her in reality, that is, real time and real space. While keeping the accompaniment in my left hand, I offer her a hand chime with my right, pausing briefly to show her how it is played. She quickly understands how to pull back and release the hoop of rubber-covered metal, so that it hits the metal chime with a singing tone. I offer her the chime at each phrase end, so that she has the experience of structure, rather than leaving her to explore freely, as this is something that she cannot yet do without losing the sense of the activity. Sally is momentarily calm, supported by the music and her playing. She sings fragments from her disturbed memories expressed earlier in the session: 'Da-a-a-rk', 'Bye-bye . . . time to go . . . light shining'. I accompany her long sustained vowel sounds with sonorous hymn-like harmonies that offer a strong tonal centre and soulful solemnity to her singing. Her sudden noticing of her hot hand and her comment 'Sweating!' is a lovely moment when she is able to be fully aware without this awareness and 'connectedness' triggering her habitual anxiety and dissociation. She leaves the room quietly and contented.

Without the music itself, this case material may seem a little dry, possibly lifeless on the page. In words I can only attempt to describe some of the ways in which music may be used creatively: Adaptive, responsive, yet framing and giving context to a very disturbed child's feelings. These episodes also illustrate how she is met in music, how her feelings are supported, but also changed by certain uses of music and through the different fields of relatedness in the music therapy relationship. All important was the growth of Sally's capacity for self-regulating within the musical-relational frame; and as this grew, so did her sense of reality, her trust in herself and others in the present.

Summary of change

In the course of the first three years of music therapy, Sally changed from being a very disturbed, easily retraumatized and dissociating child to a child who could allow herself to respond to and assimilate new experiences, particularly basic sensory experiences that formerly would easily overwhelm her. Her feelings of anger, despair and sadness were now expressed less impulsively and more coherently, both in her musical responses, which were now less fragmented, and in words. She was also beginning to be able to have fun in music, although this experience still required careful regulation by means of clear structures or phrasing, using harmonic textures that had some 'grit' to them. This served to sustain a measure of stability of responsiveness in Sally that could not be achieved with, for instance, bland, consonant musical accompaniment. Once persistently self-harming, screaming, or completely passive and remote, she was now beginning to be able to play and participate in group activities at school. Her expressive language was becoming more fluent and coherent, as was her drawing, reading, and writing.

In music therapy with Sally, I first of all aimed to provide a safe, boundaried space in which she could begin to experience and explore more safely the emotions that assailed her. Music was used to work directly with the feelings that she brought, but equally it was used to engender new experiences of her feelings and herself in relationship. These experiences began to enable her to play, to touch and explore sensations within a musical framework that helped define real time and real space in the here and now. She could begin to tolerate and trust, and then initiate shared play, showing her sense of fun and enjoyment in music. This was not easily sustained, but grew in the following 4 years that I saw her. Her songs expressed her feelings, and enabled exploration and some resolution of her feelings of shame and guilt, sulliedness and rage.

My account of music therapy with Sally describes how recreative processes were set in motion to help repair the damage done to this child during formative stages of her development; how the medium of music played a vital role in helping her recover – or rather *build* – a bodily, emotional and mental sense of self. I have emphasized the potency of music and musical engagement from psychobiological and developmental points of view; these are also intrinsic to my understanding of psychodynamic phenomena underpinning the growth of trust and meaning in relationship. This poietic, clinical model of change has developed from my experiences with children like Sally. Ultimately, my understanding of *poiesis* (creative-constructive change) in music therapy is that it is the art of listening at the root of clinical musical perception and action; being tuned into the right wavelengths or fields of working, from moment to moment, from session to session.

Aspects of therapeutic change

- Working through trauma towards normal sensory and play experiences that brought with them basic sense of body boundaries and physical safety;
- Developing capacity for relationship – developing trust through experiences of predictability and variation;
- Experiencing cause and effect of her actions, modifying her impulses by leading them into musical sensory experiences and structures, linking touch, hearing, sight, being and being with;
- Increasing self-regulation of emotions in shared and anticipatory play; motor co-ordination and hand–eye co-ordination improved;
- Sally's feelings of rage and anguish becoming more contained;
- Developing intentionality and sustained interresponsive play;
- Developing normal, ordinary experiences of play, sense of fun; a capacity to explore and feel safe in *new* experiences;
- Developing the capacity to sing and speak about herself in the present, without constant dissociation and flashbacks.

Aspects of educational development

Sally's progress at school was outlined in an individual educational profile (IEP) when she was 11 years old:

- Improved concentration and ability to sustain shared interactive play and turn taking;
- Emotionally more stable, less prone to impulsive shifts in mood;
- Motor skills maturing and eye contact much improved;
- Behaviour: now more co-operative, more emotionally stable – she can now think and reflect on her feelings and actions; she expresses her feelings and thoughts more coherently;
- Hand washing and other obsessive behaviour almost overcome;
- Enjoying cooking as well as horse riding and swimming;

- Verbal expression: Her words are clearer and used with meaning; communicating her needs/feelings in speech;
- Reading simple sentences; writing sentences; simple number skills;
- Play: Her play is developing more imagination, less repetitive, habitual patterns.

Conclusion

When music, musicality and emotional expression are understood as being biologically based and part of our human identity, then the clinical potential of music therapy can be more fully appreciated. I have considered how children's ways of playing and relating in music, as well as playing *with* musical instruments, offer insights and opportunities for change from sensory, preverbal levels to the more sophisticated levels of expression. In music there is a two-way channel, to and fro, between the sensory realm from which meaning (or symbolizing) emerges to the more fully fledged symbolic realm of imagination and play. I have examined how music can be used clinically within a music-therapeutic relationship to generate changes in a child's being and relating, where this has been traumatized at a core level by early sexual abuse. Because music can both reach and regulate the core of our beings, for the traumatized child it can work to support and transform the distorted and disrupted foundations of the bodily emotional self. As part of a multidisciplinary programme, music therapy with sexually abused children seeks to help the child to build new patterns of being and being with, as well as working through the trail of devastation left by early trauma. In so doing, a coherent sense of self begins to form. From this self-coherence or 'connectedness' children can then begin to find a safe space *within* as well as *between* themselves and others that can be felt as stable, yet flexible in its vitality. In music as in life there is a need for variation and repetition, a sense of continuity but not stagnation. Only then can children begin to play and take in new experiences. While the past cannot be changed, its hold over abused children can be modified, so that they can develop a sense of identity, including bodily boundaries, autonomy and resilience. Through being reached and understood through their inborn musicality within a music therapy relationship, sexually abused children may be helped to develop a sounder sense of self and join the dance of wellbeing to which every child has a right.

Notes

1. City University Research Fellowship project: 'Playing and relating through music: Evaluating the development of emotional communication in music therapy with vulnerable children'.
2. The child's name and any details that might identify her or her family have been changed or disguised to ensure anonymity, while retaining the salient features of the clinical material.

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