The sound of trauma: Music therapy in a post-war environment

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Abstract

This article investigates the rationale and implications for using music therapy with children who have been traumatised by war. An overview of trauma related issues is provided, focusing on the impact of war on children. The article moves from theorising on the relevance of music and music therapy for this population to a discussion of specific music therapy aims. It highlights the unique and valuable role of music therapy in helping to address the needs of children who have been traumatised by war.

After the horrific sounds of killing and shelling,
of rape and torture, comes the deafening silence of trauma
(The Mostar Music Centre, 2000)

Introduction

War can have a profound effect on a child’s life. After the war is technically over “comes the deafening silence of trauma”. From out of the silence, children begin the long process of reforming their shattered concept of self, others and the world. This article illustrates some of the complex issues involved in trauma and neglect in a post war environment. It explores how the needs of children who have been traumatised may be unravelled and addressed through music therapy. Informed from a wide variety of literature and case vignettes, this article is the author’s attempt to conceptualise and make sense of her experience as a music therapist at the Pavarotti Music Centre, Mostar, Bosnia-Herzegovina.

Trauma

The word “trauma” comes from the Greek “trauma, traumatos” meaning “wound”. The Oxford English Reference Dictionary defines psychological trauma as “an emotional shock following a stressful event, sometimes leading to long-term neurosis, or a distressing or emotionally disturbing experience” (Pearsall and Trumble, 1996, p. 1533). According to Carlson (1997), the defining features of trauma are that it is a sudden, uncontrollable, and negative experience. The degree to which an event is traumatising is influenced by an individual’s perception and understanding of the event (Carlson, 1997).

Different perspectives on trauma have implications for and inform the music therapy approach. To broaden one’s understanding of trauma related difficulties, consideration of current theoretical approaches such as the neurodevelopmental and psychoanalytical perspectives is warranted.

Trauma and Neurodevelopment

The neurodevelopmental perspective on trauma has received increasing support in recent years. Research has demonstrated that trauma may have a long-term effect on neurodevelopment, particularly in children (Diehl, 2000; Heim, Newport, Heit, Graham, Wilcox, Bonsall, Miller & Nemeroff, 2000; Perry, 1997a; Perry, 1997b; Perry, 1999; Perry, Pollard, Blackey, Daker &
Vigilante, 1996; Van der Kolk, 1994; Van der Kolk, Van der Hart & Burbridge, 1995). Trauma during childhood can permanently influence the organisation of the brain, resulting in changes in physiological, emotional, behavioural, cognitive and social functioning (Perry, 1999; Perry et al., 1996).

Janet (as cited in Van der Kolk & Fisler, 1995) postulated that traumatic memories are stored differently from other memories: more as dissociated imprints of emotions and senses, or "implicit memory", rather than as verbal, logical cognitions, or "explicit memory". Recent research has linked these changes in memory storage to abnormalities in the neuroendocrine and limbic systems (Van der Kolk & Fisler, 1995; Van der Kolk, Van der Hart & Burbridge, 1995). Individuals who have been traumatised need to integrate memory functions into their general experiential schemas. In this way they can begin to put the experience into perspective, find meaning, form a narrative, and lessen the overwhelming emotional and somatosensory responses (Diehl, 2000; Van der Kolk & Fisler, 1995; Van der Kolk, Van der Hart & Burbridge, 1995).

**Psychoanalytical Perspective**

The psychoanalytic perspective provides a different framework through which to view the same symptom pictures and goals for recovery. Trauma, as conceptualised from this perspective, occurs when the protective filtering processes one uses to feel safe in the world become overwhelmed and useless. Essentially, one's defence mechanisms fail (Garland, 1998; Van der Kolk & Fisler, 1995). How a person responds to trauma depends on their experiences as an infant – particularly their experiences of attachment (Van der Kolk, Van der Hart & Burbridge, 1995). The personal experience of a traumatic event becomes connected to our early pre-verbal experience (Garland, 1998). A review of the literature leaves little doubt that early survival experiences have a lasting impact on our later development (Bowlby, 1988; Garland, 1998, Klein, 1987; Stern, 1977).

Conceptualised from within an "object relations" framework, trauma is the loss of the good object and the dominance of the malevolent or shadow object. The world and all external objects are viewed as unsafe and unpredictable. Basic trust is destroyed, and feelings of hopelessness and helplessness reign. Consequently, one’s sense of self is lost (Garland, 1998).

Trauma has a shattering effect upon the ego, leading to a loss of capacity to process meaningful events and to symbolise. Assimilation and making sense of the traumatic event is necessary in order to begin to rebuild a more positive internal world and re-integrate aspects of the self (Garland, 1998). This has strong similarities to Bion's (1962) concepts of beta and alpha elements. The mind of the person who is traumatised is filled with undigested, chaotic and fragmented sensations, or beta elements, that can overwhelm the individual and result in the state of "nameless dread". The individual experiences confusing feelings of despair, sadness, rage and aggression (Kalmanowitz & Lloyd, 1997). These beta elements need to be contained and transformed into cognitive and mental experiences, i.e., alpha elements (Bion, 1962).

It is worth emphasising here that Van der Kolk (1994) arrived at a similar conclusion, conceptualising trauma from a psychobiological perspective. He provided evidence that traumatic memories are stored as disassociated imprints of emotions and senses rather than as verbal, logical cognitions. Furthermore, he postulated that if explicit memory fails, the individual is left in a state of speechless terror in which they lack the words or symbols to describe what has happened. The therapist needs to assist the individual to integrate memory functions into their general experiential schemas (Van der Kolk, 1994).

**The Effects of Traumatic Experiences on Children**

Young children may be at greatest risk from traumatic experiences as they have not
developed the mental capacities to cognitively process these events (Carlson, 1997; Jensen & Shaw, 1993; Van der Kolk & Fisler, 1995). Dyregrov (1997) stated that, “traumatic losses in childhood have the potential to influence all aspects of a child’s development, including both psychological and physical growth” (p. 4). Ford & Kidd (1998) concluded that trauma that occurs early in psychological development may seriously mar the survivor’s core sense of self, their capacity for attachment, and their ability to relate to others.

Some of the most typical symptoms seen in children exposed to trauma include withdrawal, numbing of responses, regressive behaviours, irritability, anxiousness, concentration and memory difficulties, episodic aggression against self or others, sleep disturbances, learning difficulties, relationship issues, lack of a sense of self-identity, and personality changes. Besides Post Traumatic Stress Disorder (PTSD), other diagnoses commonly made with children who have been severely traumatised include adjustment disorder, anxiety disorder, conduct disorder, major depression, and borderline personality disorder (Carlson, 1997; Jensen & Shaw, 1993; McCloskey & Southwick, 1996; Montello, 1999; Van der Kolk, 1994; Van der Kolk, Van der Hart & Burbridge, 1995; Van der Kolk, Pelcovitz, Roth, Mandel, Mc Farlane & Herman, 1996; Zivic, 1993). Nevertheless, it must be remembered that the effect of trauma varies widely between individuals and also across the lifespan. Discussions of the external stressor alone are insufficient to determine the impact of trauma (Carlson, 1997; Perry et al., 1996).

**War And Children**

Many of the studies conducted into childhood trauma and PTSD may not easily translate to a war situation. War is often a chronic ongoing condition that can radically alter one’s preconceived notions and schemes of the world, forcing one to fight for basic survival on a day to day basis, amidst human atrocities. Friends, neighbours and families can be wrenchen apart and divided (Goldstein, Wampler & Wise, 1997; Jensen & Shaw, 1993; Kalmanowitz & Lloyd 1999; Zivic, 1993). People in Mostar told stories of themselves or their relatives being warned by a neighbour, who was previously a close friend, with the message, “Go! ... If you come back we will kill you” (A. Begovic, personal communication, July 30, 2000).

The effects of direct exposure to war cannot be separated from other compounding, adverse and detrimental conditions: loss of parents, poverty, deprivation, high unemployment and other changes in socioeconomic conditions (Goldstein et al., 1997; Jensen & Shaw, 1993). Even after the fighting is over, psychological, social, economic, and cultural deprivation continue.

The roles of significant others in mediating the effect of war on a young person are particularly important. There is general agreement among writers that attachment to a close adult provides a strong protective buffer from the negative consequence of trauma (Dyregrov, 1997; Herman, 1992; Perry et al., 1996; Zivic, 1993). This can only occur, however, if the parents can cope themselves (Zivic, 1993).

The majority of the children referred to the Pavarotti Music Therapy Department for trauma related difficulties were children without parents, or children whose parents were unable to provide the support and care needed by their child. This client base illustrated both the buffering role of a significant carer and the concomitant and compounding effects of one’s environment. Case vignettes throughout this article demonstrate the complexities of these issues.

What did war mean to this group of children, who all presented with trauma related difficulties? One would imagine that given the nature of the lives of these children, war may have been yet another external confirmation of the seemingly unpredictable and untrustworthy reality of external and internal objects, and ultimately the world itself.

Many of the children referred to the Music Therapy Department presented with disabilities, in addition to their trauma related issues. It is difficult, if not impossible, to tell how much of their
presenting needs were due to the direct trauma of war or other factors such as environmental deprivation. Additionally, from my experience, it seems likely that children with special needs may have more difficulty processing and coming to terms with traumatic experiences.

Having described the impact of trauma on children, the role of music and music therapy as an appropriate treatment modality for these children is now considered.

Why Use Music With Children Who Have Been Traumatised?

Music may have a viable role in assisting the recovery from trauma, given that music is: (a) a juxtaposition of both sound and silence; (b) a non-verbal and symbolic means of self-expression; (c) play; (d) immediate and occurring in the present; (e) motivating and enjoyable and a normal part of human life; (f) able to effect physiology; (g) found in all cultures, but is unique to and influences identity, on both personal and cultural levels; and (h) offers a uniquely human experience, embodying aesthetic creativity as opposed to destruction (Gaston, 1968). Each of these points will be now addressed.

Silence

Silence seemed threatening to many people in Bosnia. In East Mostar shells had fallen at the rate of one every two seconds. Silence was the tension of waiting for the next sound; a sound that this time could mean death. After the war, people spoke of their need to drown out silence. This was evident by radios blaring at very loud volumes from cafes, spilling out onto the streets, stridently juxtaposed with other sound systems, effectively creating a wall of sound. (L. Lang, personal communication, August 20, 2000).

In the music therapy situation, silence also appeared to be threatening for many of the children. It seemed to heighten tension, agitation and anxiety, evident through their body language and music. Some children played constantly and extremely loudly. Others were unable to sit in silence after an improvisation and seemed to experience a pressing need to immediately chat about unrelated subjects or move quickly to another instrument. Through therapy, these children were progressively able to experience softer playing and/or learn to tolerate small silences, to pause, and simply to be present in the moment.

Music is a Non-Verbal and Symbolic Means of Self-Expression

A major goal of therapy is to help individual’s who have been traumatised to find their own feelings again (Schmookler, 2000). Words are often inadequate to describe the feelings and personal experience of trauma. This is particularly so if the trauma occurred before the child had a grasp of language (Montello, 1999). As discussed earlier, trauma may connect with early pre-verbal experience (Garland, 1998). This would lead one to propose that traumatic issues may be more readily accessed and expressed through non-verbal means.

It has already been discussed that traumatic memories may be stored as emotion and feeling states rather than in a thinking/linguistic form. As a non-verbal, symbolic and expressive medium, music serves as a channel of communication through which people can access, explore and process traumatic memories and feelings, in a symbolic form. Thus music can provide a means through which the child can put their inner world into an outer reality. They can begin to make sense of their inner experiences and form a personal narrative. Assimilation and making sense of what happened is necessary in order to begin to rebuild a more positive internal world and reintegrate aspects of self (Garland, 1998).

Music therapy can bypass the need for words, which can be an inadequate or more
threatening means through which to conceptualise feelings and experiences. Improvisation, however, can be a powerful and intense experience. The immediacy of the musical relationship can be initially overwhelming.

In working with people who do not understand English, the therapist can use music to directly and immediately relate, without having to communicate through the complicating dynamics of an interpreter. Similarly, children with a learning disability, who may struggle with semantics and verbal self-expression, may be able to use music to express themselves.

Individuals who have been traumatised often oscillate between hypervigilance and withdrawal. They can also experience conflicting emotions and ambivalence, particularly if the trauma is due to abuse and neglect (Herman 1992). Improvisation may be an ideal medium though which to begin to address this. Through music, children can externalise these polarised states and/or their ambivalence. From there, the therapist can lead the child into experiencing the middle ground and assist their discovery of alternate ways of being. In this way, splits in the self structure can potentially be resolved (Montello, 1999).

Additionally, Cattanach (1992) has found that as negative feelings are expressed by the child and accepted by the therapist, the feelings become less intense. The child may feel as if the therapist takes some of the negative feelings away (Stuvland, 1990).

Van der Kolk, Van der Hart & Burbridge (1995) believed that talking about trauma is not enough. Trauma survivors need to take some action that symbolises triumph over helplessness and despair. Studies into the effects of war on the children of Bosnia report a pervading loss of hope and belief in the future (The location, 2000). Music is a symbolic and versatile language capable of easily representing both triumph over, as well as the feelings of, helplessness and despair. Feelings of hope can emerge, reclaiming belief in self, the world and, especially, the future.

**Vignette One**

Danjel was eight years old. He had been raised for three years in a local hospital during the war and then transferred to a children’s home. It was reported that Danjel had never formed a close attachment to another person. His carers felt that there was no one to whom he expressed his feelings. Danjel had unsuccessful experiences with verbal psychotherapy in the past, his therapist reporting that he presented as hyperactive and uncooperative.

In his initial sessions Danjel oscillated between loud energetic playing and withdrawing, appearing to be bored. He rested his head on his arm, gazed distractedly into the distance, and played with seemingly little engagement.

Danjel almost never spoke during the music therapy sessions, communicating solely through body language and music. He would respond to verbal cues with minimal responses and, if I spoke, may have acted quickly on what he thought I may have been asking, before the interpreter could respond. At times he appeared to be startled and jumped when the interpreter spoke. Throughout his sessions, I was left with the impression that he seemed to welcome the safe, non-verbal space within the music therapy environment.

As therapy progressed, Danjel no longer seemed to need to retreat emotionally. His music was intense, expressive, and reflective. The therapeutic environment may have been experienced by Danjel as a space where he was not asked to explain or justify; where he could be understood and supported without the need for words. This provided a non-verbal environment in which he could more readily express himself and relate to me directly. Outside of the therapy session, while Danjel tended not to initiate conversation, he was happy to answer my questions.
In the final stages of therapy after a number of sessions of very intense music, Daniel began to explore other styles of music and ways of interacting, becoming free enough to "play" with the instruments.

**Music is Play**

Music is a form of play. This has particular therapeutic significance for children who have experienced a situation of chronic trauma. These children may have never experienced ordinary childhood activities (Jensen & Shaw, 1993) and may even need to be taught how to play (Cattanach, 1992). Writing on the role of play therapy for children who have been abused, Cattanach (1992) referred to the importance of offering the child a creative space in which to heal. Such a space can be readily established in music therapy.

Play is an important part of any child’s development and it is the medium through which they learn about and make sense of the world and self (Cattanach, 1992). Winnicott (1971) wrote extensively on the centrality of play in a child’s world, and suggested that, “It is by playing and only in playing that the individual child is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers self” (Winnicott, 1971, p. 54). Children who have been traumatised need to regain a sense of self (Garland, 1998).

In music therapy sessions it was observed that some children went through stages of regression. Cattanach (1992) reminds us that in order to move forward, it is sometimes necessary to return to earlier experiences. Children whose only experience have been a war and post war environment, may not have had the opportunity to work adequately through early stages of development. In therapy they may revisit these developmental stages and engage in behaviours typical of young infants (like crawling on the floor or playing peek-a-boo, reminiscent of mother/infant interactions). Role-play is another developmental stage occurring in children’s play. In therapy children may use role-play to re-enact their own lack of nurture and engage in repetitious play around their experiences (Cattanach, 1992). Alternatively, children may experiment with themselves and others. They may “become the good mother(s)” and “express through their own senses their physical need for love and nurture” (Cattanach, 1992, p. 77). The following case study offers an example of one child’s use of play within the music therapy setting. It illustrates movement through regression and role-play, to experimentation with nurture.

**Vignette Two**

Adelia was a nine-year-old girl with learning difficulties, living with an alcoholic father, an intellectually disabled mother, and in substandard conditions. Her parents seemed unable to provide her with the care and support she needed.

During her third session Adelia initiated peek-a-boo games, hiding herself or me (fully visible) behind a shaker or guitar. Over a number of sessions these games developed into hide and seek and, eventually, we could disappear “totally” behind the piano. This play initially formed the focus of sessions.

Adelia later began role-playing her experiences through “punishing and scolding” me. For example, she would label me as a “stupid, stupid person” who could never learn or do anything right. Adelia would send me “to her room and lock the door”, and I was “not allowed to come out and have dinner”. This role-play was enacted with driven focus and intensity. In some sessions the role-play became very personal and Adelia would slip in and out of the first person, e.g., “my mummy is pregnant, she is crazy, you are crazy, we don’t want you, Daddy is going to send you away”.

As Adelia’s therapy progressed she began to explore feeding and nurturing herself and me.
She tried alternate ways of being, such as taking care of us through making “special lunches and meals”.

Music Occurs in the Present

Children need to learn to be present in the here and now rather than fearing the future and dwelling on the past (Van der Kolk, Van der Hart & Burbridge, 1995). Music can play an important part in this process. Musical improvisation happens in the present, while continuously moving through time. It has the ability to focus on the past, present or future, both separately and simultaneously, assisting integration and assimilation of experiences, hopes and fears.

Music is Motivating, Enjoyable and a Normal Part of Human Life

Overcoming traumatic experiences is, in part, learning to reconnect with ordinary life and regain the ability to join in age-appropriate childhood activities. Children need to rejoin the world and integrate the trauma as one aspect of their life. Re-experiencing or avoiding trauma leaves little space for new and pleasurable experiences (Orth and Verburgt, 1998). Pleasurable and new experiences are necessary to provide the feelings of mastery and gratification from which reparation of past injuries to the self can begin and on which a new self-perception can be built. Van der Kolk et al. (1995) emphasised that individuals who have been traumatised need to actively expose themselves to pleasurable experiences that are uncontaminated by the trauma. It is vital to remain aware of this and not always focus on the mind-set of dealing with the trauma (Pavlicevic, 1990).

Music has an Effect on the Physiological Level

Music can directly access the limbic system of the brain without needing to be processed by the higher cortical functions (Montello, 1999). This has profound implications for individuals who have been traumatised, as trauma itself directly affects and changes the limbic system (Van der Kolk, 1994). Chronic anxiety and emotional numbing can interfere with a child’s ability to identify and express internal states.

Children who have experienced trauma are frequently unable to translate somatic sensations into emotions and then into basic words and symbols (Van der Kolk et al., 1995). Music has the power to entrain and synchronise sympathetic responses at the neurochemical and neuromuscular levels (Robarts, 1999). Music is kinetic energy (Montello, 1999) and thus musical improvisation may assist in the expression of somatized states, enabling them to be worked through as emotional experiences.

Additionally, Schmoookler (2000) wrote that bodily sensations can be used to ground individuals and help them return to and remain in the present time and place. Depending on the individual personality and the actual music used, music’s direct physiological impact can help dissociated or anxious children feel more grounded and centred in their bodies, enabling them to gain greater benefit from the therapeutic process (Montello, 1999).

Music is Found in all Cultures, but is Unique to and Influences Identity, on Both Personal and Cultural Levels

Music is found in all cultures however the individual’s cultural and personal perspective must be taken into account. In my opinion, the therapist cannot overlook the importance of humility, the need to listen, listen again, and have recognition for the individual and their culture. This includes the recognition that we can never truly understand what other people have been through, nor truly be a part of their culture. If we come from this space of humility we can bring to therapy the unique perspective of our own background, life experiences and culture. In therapy each person
is an individual and accepted as they are in the moment, and in relation to the therapist and the music. The therapist supports the individual in finding his or her own path to recovery.

*Music Offers a Uniquely Human Experience, Embodied Aesthetic Creativity as Opposed to Destruction*

Music is a creative outlet. For children who have been traumatised, learning to create is an essential part of the healing process. The need for aesthetic experiences is part of being human. Music can offer a uniquely human experience amidst the dehumanising effect of war and its aftermath. By its very definition, trauma destroys a sense of self. The individual is made to feel less than human. Music is part of individual and cultural identity, thus music can be used to help rebuild identity and restore humanity on both a personal and cultural level (Kalmanowitz & Lloyd, 1999).

**Why Use Music Therapy with Children Who Have Been Traumatised?**

Some of the specific benefits of using music as therapy with this particular population will now be addressed. Music therapy (a) is the exploration and formation of relationships with self and others, (b) is a poetic process, (c) offers boundaries and structure, and (d) provides a sense of personal control.

*Relationship with self and others*

Trauma impacts upon the very core of one’s identity. Trauma shakes the foundations of one’s belief about safety and shatters one’s basic sense of self and assumptions of trust (Cohen, 1992; Garland, 1998; Herman, 1992; McCann & Pearlman 1990; Van der Kolk, Van der Hart & Burbridge, 1995). Through music therapy a client can experience and explore a trusting and safe relationship with another. There is an extensive body of literature that leaves little doubt that this relationship is an integral part of the therapeutic process (Cattanach, 1992; Garland, 1998; Herman 1992; Schmoekler, 2000; Van der Kolk et al., 1995). The client is able to “learn about him/herself in relation to the therapist” (Cattanach, 1992, p. 40). Likewise, Garland (1998) reminds us that a long-term need of an individual who has been traumatised is “the repair of the survivor’s relations with his social world, both the actual people around him and the representations of those figures or aspects of figures... his internal objects” (p. 113).

In therapy the importance of being there to support the individual is often mentioned, including being with the individual at whatever stage of their journey (Van der Kolk, Van der Hart & Burbridge, 1995). Until the ego is strong enough, the therapist may focus on simply helping the child be with another, in a safe and trustworthy environment. Clients who have been traumatised and abused often crave attention and love (Cattanach, 1992). They can seem to never receive enough attention and love to fulfill their hunger for nurture. At the same time, however, they may be afraid and unsure, pushing the offering away or retreating into familiar responses, such as withdrawal (Cattanach, 1992; Herman, 1992; Kalmanowitz & Lloyd, 1999). In my own clinical work some were highly active and restless. Some shut me out by not leaving any space for me in their music. Some avoided all music, and thus, the intimacy of this contact. For example, one child asked me to stop playing and removed the bars from the xylophone. Other children, who were withdrawn, tended to retreat back into themselves as soon as contact was made. Music can provide a safe space for these children to begin to feel again, to experience being alive.

These children have a pressing need to feel heard and understood (Montello, 1999). They need to be accepted and respected for who they are. Using music, the therapist can reflect the children’s current feeling states, and through this medium, communicate understanding and
empathy. Some of the children used the sessions to create a safe, reliable and stable environment in which they could feel supported and nurtured. From there they began the process of regaining their sense of self.

Vignette Three

Lejla, a young adult, was referred to music therapy for trauma related difficulties. She had been brought up as her mother’s servant and then sold into another family. Lejla particularly liked using the gentle sound of the Tibetan singing bowls together with her voice. Lejla and I would sit on the floor with our eyes closed and hum inter-weaving melodies with the support of the scaffolding offered by the sound of the singing bowls. This musical holding seemed to provide a safe, protected space in which Lejla could experience peace in the present, whilst being released from the pressing demands and conflicts of the past and future. For some children who have experienced trauma this can be a very new experience. Music therapy provided Lejla with an environment in which she did not have to qualify herself, a space in which she could gain the confidence to find her authentic voice. It offered her the acceptance and nurturing support from which she could begin to explore and express her feelings. Lejla’s music was meditative, mesmerising and reflective. She often commented how “good it felt to do this” [improvise in sessions], “how freeing” and “how quickly the time went”.

Ford and Kidd (1998) concluded that trauma that occurs early in psychological development may seriously mar the survivor’s core sense of self, their capacity for attachment and ability to relate to others. In psychodynamic music therapy, it is the therapeutic relationship that is the focus of therapy. Through countertransference, the therapist picks up on the child’s “unknown thought” and mirrors it back to the client (Montello, 1999). The therapist’s function has also been described as a transformational object, an object that transforms the subject’s internal and external world (Montello, 1999). The nonverbal aspects of the musical relationship between the therapist and the child parallels the interactions between caregiver and child, where the infant comes to know his or her self through the mother. This interactive and fluid interplay between caregiver and child has been referred to as “inter subjectivity” and/or “affect attunement” (Pavlicevic, 1990).

Pavlicevic (1990) introduced the concept of “dynamic form”, which she uses to describe the amodal and abstract qualities of emotions, expressed through acts such as our movements, music, voice quality and facial expressions. She wrote that dynamic form is inseparable from the client/therapist relationship and that “dynamic form in clinical improvisation is an interface of music and direct human communication and enables the therapist through his or her distinctive listening skills to gain a sense of the client in relation to him or her” (p. 16). The therapist “reads” the client’s dynamic forms and “gives meaning to these” by responding musically in a way which the patient comprehends (Pavlicevic, 1990). This may assist the individual to integrate memory functions into their general experiential schemata and facilitate the emergence of personal meaning, which are both necessary steps in the recovery from trauma (Garland, 1998; Van der Kolk, Van der Hart & Burbridge, 1995).

Poetic Process

Robarts (2000) described the music therapy process as being essentially poietic, carrying living, creative power. Poises, she wrote, “is a creative process of coming into being, bringing or being brought into existence, giving rise to the creative act” (p. 9). “Within the semiology and symbolic forms of the music therapy relationship … constructive experiences of self and self in relation can arise, bypassing self protective or cognitive defences” (p. 3). Ruud (1995) likewise

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believed that “it is the poetic or aesthetic aspect of the musical communication ... which give them [music therapists] power to transform the improvisation into a therapeutic tool” (p. 94).

Roberts’ model has relevance to and broadens our understanding of music therapy with individuals who have been traumatised. As discussed previously, these individuals need to create, to experience self and self in relation, to come into being, and to regain the capacity to symbolise. Roberts (1999) stated that

Music has the potential to construct or reconstruct the symbolising capacity of ego function which seeks to build the foundations of self and self in relation, the sense of continuity of the self in time, developing trust, imagination and a healthy autonomy. A capacity to have fun! (p. 193)

Boundaries and Structure

Boundaries and structure play an important role in therapy with individuals who have been traumatised. Boundaries can offer an experience of freedom within limits. Children who have been traumatised may be experiencing internal (and often external) chaos. They may feel they are in a constant state of flux and fragmentation. The therapist needs to be able to provide boundaries that are capable of holding whatever arises during the musical process (Herman, 1992; Kalmanowitz & Lloyd, 1999; Sutton, 1999). Many of the children in my practice at the Pavarotti Music Centre initially required repeated reassurances and concrete expectations. This seemed to allow them to feel safe and in control through providing a structure to contain and direct their chaos. Depending on the needs of the child, this structure can be provided by the boundaries of the therapy itself, through structured activities within sessions and by the structure within the music itself.

During the therapy process it was also common for the children to challenge the established boundaries, testing the safety and reliability of the room and therapist. This was seen, for example, through children continually playing the gong very loudly, dismantling and throwing instruments, ignoring my music or suggestions, and defying established structures and routines. The children needed to experience that I would still be there for them, but equally that they could trust me to provide a safe and reliable environment.

Control

Lack of perceived control is a defining feature of trauma. As children are relatively powerless in comparison to adults, they may be especially susceptible to harm (Herman, 1992). Establishment of a sense of personal control is widely believed to be a central need in the recovery from trauma (Van der Kolk, Van der Hart & Burbridge, 1995). Music therapy can provide an individual with the opportunity to experience personal control over situations. The therapist can play the required role allowing clients to experience omnipotence and leadership. Additionally, the containment offered by the music therapist can assist the client to harness their chaos and experience a sense of personal control.

Music Techniques

In thinking about the sessions and the way in which the music therapy team at the Pavarotti Music Centre worked, there seemed to be qualitative differences in comparison to my previous work as a music therapist in other settings. There were differences in the strategies used to respond to clients’ needs and differences in the way sessions were conceptualised. The roles of holding, reflecting and containing the client through music were often emphasised in my practice. Perhaps they helped the children to feel safe, nurtured and supported, served to establish rapport and trust, and demonstrated an understanding, acceptance and willingness to be there with the client. It was
equally important, however, to offer appropriate challenges to the child, ensuring they did not become “stuck”.

A child who is traumatised loses the ability to internally contain and assimilate their feelings. Without this internal containment, the capacity to symbolise is lost and the defences overwhelmed (Garland, 1998). “A traumatic event is a breakdown in containment and vice versa” (Garland, 1998, p. 108).

In Bion’s (1967) concept of a “container” the therapist and the therapeutic relationship provide a container for the client’s feelings. The therapist accepts the unprocessed spilling of the client (Bion’s beta elements) to help hold these unassimilated feelings, process them, and reflect these back to the client in a more symbolic and meaningful oriented form (alpha elements) (Garland, 1998). The therapeutic time becomes a space for the “digestion” of feelings. Montello (1999) also wrote that music therapy “can provide a transformational holding environment for the processing and integration of painful memories” (p. 75). In therapy the individual needs to be “provided with an experience of being understood, of a good experience of containment”. In this way, a personal narrative of the trauma is developed and the therapist may help “to begin to re-establish internal good objects, necessary for healthy psychic functioning” (Garland, 1998, p. 64).

Intense passion is often associated with traumatic experiences. An appropriate experience of containment, offered through the music therapy relationship, can serve to emotionally hold this intensity, channelled it into a format that can be managed and processed. In the sessions held at the Pavarotti Music Centre, I was struck by the often raw intensity of clients’ music, along with the feeling that the children were far older than their years. A related issue is the therapist’s need to take and hold what the children have to offer without becoming traumatised oneself (Garland, 1998). Secondary traumaisation does occur, and as a therapist, it is important to recognise this potential and seek appropriate support as necessary. This is essential not only for oneself but also for a duty of care (West, 1997).

**Conclusion**

Trauma can have a profound effect on all aspects of a child’s being: mental, physical, emotional, and spiritual. It shatters the very core, destroying one’s fundamental assumptions about self, others and the world. Music therapy has a valuable and unique place in assisting children in a post-war environment with trauma-related difficulties. It can facilitate the safe release of feelings and emotions, and the recovery of personal mastery and control. It offers an opportunity to work through relationship issues, and establish a sense of self. Music therapy can address issues of self-esteem and self-worth, assisting individuals who are traumatised to place the past and future in perspective, and find hope, meaning and purpose in their life. In short, these children can learn to create and to be alive.

*And this I know:*
*all these things that now,*
*while we are still in the war,*
*sink down in us like a stone,*
*after the war shall waken again,*
*and then shall begin the disentanglement of life and death.*

(Remarque, as cited in Garland, 1998, p. ix)
References


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