The Role of Music Therapy in the Treatment of a Girl with Pervasive Refusal Syndrome: Exploring Approaches to Empowerment

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Abstract
Pervasive Refusal Syndrome (PRS) is a life threatening psychiatric disorder, which is characterized by a refusal to eat, drink, talk, walk or maintain any level of self-care. In this article, it is suggested that music therapy may provide a unique role that is supportive, validating and empowering for patients with PRS. The rare condition of PRS predominantly affects girls between 8 – 16 years of age who, if managed well, are expected to recover completely (Lask, 2004). Literature has linked PRS to the theory of learned helplessness and as such, has highlighted the need for patients to control the pace of recovery (Nunn & Thompson, 1996). The value of music therapy interventions to provide opportunities for choice and control, and thus empowerment, is well documented. Similarly, music therapy theory and practice supports the use of improvisation to provide affirmation, validation, and support. This article examines the role of music therapy in the treatment of an 11-year-old girl with PRS in an acute medical setting. It explores how choice provision and improvisation may foster empowerment through the promotion of opportunities for control, validation, and affirmation. Clinical vignettes illustrate how these interventions may establish a therapeutic relationship, provide acknowledgement, containment, and offer a nonverbal form of support for a patient with PRS.

Keywords: Pervasive Refusal Syndrome, empowerment, choice and control, supportive listening, vocal improvisation.

Introduction

The aim of this paper is to explore approaches to empowerment in music therapy through clinical work with an 11-year-old girl with Pervasive Refusal Syndrome (PRS). Treatment occurred during two separate admissions over a total period of nine months in an acute paediatric medical
setting. These admissions lasted approximately 5 and 2 months respectively. During both admissions Emma\(^1\) participated in an average of two to three music therapy sessions per week. Music therapy interventions initially concentrated on providing opportunities for choice and control in a supportive and affirming space. As Emma’s condition deteriorated, approaches to treatment shifted focus to offer affirmation, validation, and control through the use of silence, supportive listening, and vocal improvisation. Case material explores how music therapy may assist in the development of empowerment through choice and control and through facilitating experiences which support the emotional and often distressing reality of a child with PRS.

**Literature Review**

**Pervasive Refusal Syndrome**

Pervasive Refusal Syndrome (PRS) was first described by Lask, Britten, Kroll, Magagna, and Tranter in 1991. To date there are no validated diagnostic criteria for PRS. It is agreed that it may be described as a rare, potentially life threatening condition where patients present with varying degrees of refusal to eat, drink, talk, walk, or self-care (Lask, 2004; McGowan & Green, 1998; Nunn & Thompson, 1996; Thompson & Nunn, 1997). Onset of the illness is usually acute, precipitated by a viral illness or injury, and commonly accompanied by school refusal, social withdrawal, and strong resistance to treatment (Thompson & Nunn, 1997). PRS seems to predominantly affect girls between 8 – 16 years of age with a premorbid personality that is high achieving and anxious (Lask, 2004). A comprehensive assessment is recommended to rule out the possibility of an organic condition or other psychiatric illnesses (Thompson & Nunn, 1997). Despite similarities with eating disorders and refusal syndromes, PRS is considered to be a separate psychiatric illness (Lask, 2004).

In 1996, Nunn & Thompson proposed that PRS might be closely linked to Peterson, Maier, and Seligman’s (1993) theory of learned helplessness, suggesting that children with PRS develop a learned expectation that they cannot control their environment. This perceived uncontrollability of life events becomes generalised to a sense of uncontrollability in the future, both personally and externally, causing the child to give up (Nunn & Thompson, 1996; Nunn, Thompson, Moore, English, Burke, & Byrne, 1998). Children with PRS do not respond to standard behavioural interventions such as praise

\(^1\) Name has been changed to protect confidentiality. Consent was obtained from Emma’s parents to write this article.
or positive reinforcement, and typically regress when commended for any achievements or progress (Nunn et al., 1998). This hypothesis suggests that there is a critical need to provide opportunities for choice and control for these patients.

Treatment and management of PRS usually requires intensive inpatient psychiatric care, though it may be treated in a general hospital (Edwards & Done, 2004; Lask, 2004). Recovery is slow, ranging from a period of months up to three years, with a full recovery expected if well managed (Nunn et al., 1998). The literature for PRS (Anonymous, 2001; Edwards & Done, 2004; Lask et al., 1991; Lask, 1996; Lask, 2004; McGowan & Green, 1998; Nunn & Thompson, 1996; Nunn et al., 1998; Taylor, Dosseter, Kilham, & Bernard, 2000; Thompson & Nunn, 1997), recommends the following treatment and management approaches: a) a multidisciplinary team based approach that incorporates the medical, physical, psychological, and emotional needs of the child (Lask, 2004; Nunn et al., 1998); b) no medication as it has no effect in the early stages (Lask, 2004); c) a secure, predictable environment for the patient, where consistency, structure and flexibility are maintained by the treatment team (Lask, 2004; Nunn & Thompson, 1996; Nunn et al., 1998); d) a gentle approach where the pace of recovery is controlled by the patient (Lask, 2004; Nunn & Thompson, 1996).

In addition to supporting the child, there is a need to support staff working with children with PRS as the recovery period can be long, demanding, and confronting (Nunn et al., 1998). If not supported appropriately, demoralized staff may exacerbate the child’s feelings of helplessness and thus impede the child’s recovery (Lask, 2004; Nunn et al., 1998).

**Empowerment**

Recently, empowerment has been identified as implicit to music therapy theory and practice (Daveson, 2001a; Procter, 2001; Sheridan & McFerran, 2004). It has been described as an essential part of the therapeutic process, both as a pathway to control through patient choice, and as a process of self-authentication (Daveson, 2001a). Procter (2001) describes empowerment in a holistic sense, where the whole being is the focus, as opposed to concentrating on the “ill” aspects of the child. Pavlicevic (2001) emphasizes the need to witness and validate children, stating “the challenge for us is to ‘be with’ the child’s wounding and suffering which may (or may not) be the result of ‘pathology’ in the formal sense” (Pavlicevic, 2001, p. 20).
Thus empowerment involves an acknowledgement of “each person’s ability and potential” (Procter, 2001, p. 7). The process of empowerment “entails the restoration of power and choice so that people may act, or cognitively and emotionally respond, in ways that are authentic or true to themselves” (Daveson, 2001a, p. 29). When empowerment occurs through this process of self-authentication, the response may involve a change in perception or emotional response, and as such may not always produce action (Daveson, 2001a). The restoration of personal power may be provided through affirmation, opportunities for control, establishing connections between people and through validation (Brown, 1991, as cited in Daveson, 2001a, p. 31). These mechanisms of empowerment are often the outcome of music therapy.

**Music Therapy, Choice and Control**

Music therapy literature has long supported the value of providing clients with opportunities for choice and control (Bailey, 1984; Daveson, 1999, 2001b; O’Callaghan, 1997). More specifically, paediatric music therapy literature advocates a flexible, adaptable, diverse, and child-centred approach (Daveson, 2001b; Gold, Voracek, & Wigram, 2004) which supports and promotes opportunities for choice and control (Daveson, 2001b; Edwards, 1995, 1998, 1999; Sheridan & McFerran, 2004; Robb, 1999, 2000) and provides an environment where a child may express themselves in a safe and supported manner (Pavlicevic, 2001; Robb, 2000).

Within a paediatric medical setting, where the actual or perceived loss of control is widespread (Daveson, 2001b; Edwards, 1999), participating in decision making may help to: a) reduce anxiety and pain (Edwards, 1994, 1999); b) increase mastery of one’s environment (Abad, 2003; Edwards, 1999; Robb, 2000); c) enhance self expression, emotional release, and self esteem (Abad, 2003; Daveson, 2001b; McFerran-Skewes, 2000); d) foster improved coping mechanisms (Daveson, 2001b; Robb, 1999; 2000); e) maximise a child’s sense of control (Abad, 2003; Daveson, 1999; Edwards, 1994, 1995, 1998; McDonnell, 1983; Procter, 2001; Robb, 1999, 2000, 2003; Sheridan & McFerran, 2004).

Through the provision of such opportunities in music therapy, clients may have the option to participate in a session, participate in music making, determine the degree and type of participation, select songs or instruments, select live or recorded music, decide how instruments are played, and influence the progression of each activity (McDonnell, 1983; Robb, 1999,
2000; Sheridan & McFerran, 2004; Steele, 2005). All these examples facilitate active decision making, which may offset feelings of helplessness (Daveson, 1999; McDonnell, 1983), and thus enhance a patient’s sense of control. This is particularly relevant to patients with PRS, and suggests that music therapy may be a significant treatment modality for this condition.

**Holding and Containment**

Music may also create a therapeutic space where communicative and authentic interactions may develop (Arnason, 2002; Daveson, 2001a; Pavlicevic, 2001; Pedersen, 1999; Robb, 2000; Sheridan & McFerran, 2004). At the heart of this musical holding space lies “the musical mechanisms of nonverbal communication” (Pavlicevic, 2001, p. 282) and mother-infant communication (Trevarthen & Malloch, 2000). Winnicott (as quoted in Jensen, 1999) describes “the mother holding the child” (Jensen, 1999 p. 59) in a psychological and therapeutic sense, outlining the importance of being supportive without invading, and thereby assisting a child to attain an authentic sense of their feelings and needs.

It is this kind of supportive holding that a child with PRS requires for containment and support during acute stages of the condition (Lask, 2004). Lask (2004) advocates “allowing” and “supporting” the expression of negative feelings, explaining that through this expression, a child can move through to resolve these feelings and begin to demonstrate more age appropriate behaviours. Nonverbal music therapy methods such as supportive listening and improvisation have the capacity to provide a holding space, which reflects, affirms, and validates a child’s experience, allowing him / her to “be”.

**Supportive Listening**

Listening may assist to break isolation (Pedersen, 1999), and facilitate communication and understanding (Arnason, 2002). The application of silence when listening may be a powerful tool (Arnason, 2002; Pedersen, 1999), a form of acknowledgement (Daveson, 2001a), and a means of holding “something traumatic, rather than become something traumatic” (Sutton, 2005, p. 383). Indeed, listening in the true sense of the word may provide holding and support for a patient, and allow for a person’s experience to be heard sincerely. In discussing her approach to clinical listening with adult patients with schizophrenia, Pedersen (1999) describes a fullness of listening “where the human being is heard as he / she is, as an independent human
being with all his / her qualities, no matter which psychological problems are involved” (p. 32). She continues to explain that at times this may involve listening “to the patient just [by] being present in the room” (p. 33). This type of listening, termed supportive listening by the current authors, particularly describes the approach to listening in vignettes two and three. There is a sense of affirmation, acknowledgement, and time given to the patient as required. This approach corresponds with the suggested treatment protocols for PRS which recommend the child controls the pace of recovery (Lask, 2004; Thompson & Nunn, 1997). As supportive listening allows a child to be, this method may provide an increased chance of reducing isolation, establishing rapport, and acknowledging the experience of a child with PRS, which may enhance opportunities for self-authentication.

**Improvisation**

Clinical improvisation has been defined as “the use of musical improvisation in an environment of trust and support established to meet the needs of clients” (Wigram, 2004, p. 37) and described in terms of providing a holding space and containment (Austin, 2001; Bruscia, 1987; Pedersen, 1999; Robarts, 1994). For the current discussion, empathic improvisation, grounding, holding, and containment will be explored in relation to vocal improvisation (Wigram, 2004).

Like supportive listening, empathic improvisation offers support and containment to a patient. Wigram (2004) states that in practice, empathic improvisation means, “taking into account the client’s body posture, facial expression, attitude on this particular day, and previous knowledge of musical interpretation of their way of being at the moment” (p.89). It is not intended “to change the client’s feelings or behaviour, but simply to play them to the client without any hidden manipulation of their feelings” (p.89). In vocal improvisation this may involve a vocal reflection of their presentation or feelings.

**Vocal Improvisation**

The voice is intimately linked to one’s emotions and may provide a powerful measure of a person’s health (Newham, 1999; Wigram, 2004). Newham (1999) describes the voice as a “channel through which to express or ‘push out’ something from the inside” (p. 14). The voice therefore provides a powerful tool to communicate emotions that may otherwise be too difficult or traumatic to express. Vocal improvisation has been described as a
useful way of providing containment and validation for strong emotions especially through nonverbal expression when feelings are too intense (Austin, 2001). Wigram (2004) outlines the following improvisational techniques as an effective means of providing containment and validation within a supportive environment: “Grounding: creating a stable containing music that can act as an anchor to the client’s music” (p. 91), and “Holding: Providing a music anchor and container for the client’s music making, using rhythmic or tonal grounding techniques” (p. 97).

This approach to improvisation is similar to the vocal holding technique developed by Austin (1998, 1999, 2001), which uses the voice to create a consistent and stable musical environment. Austin employs the voice and piano to provide a steady, consistent harmonic support with rhythmic grounding and vocal companionship. This method is able to “provide a strong, yet flexible, musical environment that is experienced as very safe and containing” (Austin, 1999, p. 145).

Similarly, Loewy (2004) uses a tonal vocal holding technique with babies and regressed patients to encourage them to cry. Through the vocal exploration of the voice, sound and breath, Loewy uses grounding and mirroring “to assist the baby, toddler, or regressed patient to release a first sound, or to promote a crying sound” (Loewy, 2004, p. 7). Loewy considers the cry to be an important first stage of work with a child who has become mute due to trauma, stating that “…working first with the cry, a child can be encouraged to release tension and through supportive and reflective vocalising, may work the voice into a cry state” (Loewy, 2004, p. 8). According to this method, singing in a child’s tonality may assist in the resolution of a child’s distress and lead to the development of turn taking and in the case of a regressed child, more appropriate communicative interaction.

Providing an empathic form of intervention allows a client to experience meaningful interaction “without ... having the pressure of being obliged to play back or to give anything in the first place” (Pedersen, 1999, p. 34). Furthermore, a client may derive a sense of being heard for who they are (Pedersen, 1999). Vocal improvisation with a child who expresses his/herself through crying and the voice offers a response that reflects and validates that child. As Lask (2004) states “the therapy best focuses on whatever material the child offers, rather than pursuing a specific agenda or therapeutic technique” (p. 7).
Client Background

Emma, a high achieving 11-year-old girl living at home with her family, was first admitted to a paediatric hospital for mild dehydration, intermittent abdominal pain, dry retching, and belching. She was re-hydrated and returned home after 4 days in a withdrawn state. Emma was re-admitted 10 days later, having refused to eat or drink at home. She complained of pain on swallowing and there was a recurrence of abdominal pain and dry retching. Emma was again re-hydrated and was commenced on a nasogastric tube for feeding due to a 3 – 4 kg drop in weight. She had an episode of re-feeding syndrome during this admission, became depressed, had a fluctuating mood, and a reduction in speech and mobilisation was noted. Emma was discharged after 12 days and over the next month at home her condition gradually deteriorated, her speech regressed to the use of only a few select words, she became bed bound, and refused to mobilise.

At this point, Emma was admitted to the general surgical paediatric ward in a large hospital where she remained for the 6 months of her first intensive admission. Emma was treated by a multidisciplinary team, including child psychiatry and neurology consultants, nursing staff, physiotherapists, a dietitian, a social worker, a school teacher, a play therapist, and a music therapist (RMT). Emma had stopped eating, drinking, walking, and had ceased caring for herself in daily activities (eg. bathing, toileting etc). She was alert, used occasional words (eg. “go away”, “mummy” and “oily” for toilet), and did not engage in eye contact.

Emma was placed in a single bedroom on the ward. She was nursed in bed or in a chair with the door and curtains open, and was fed through a nasogastric tube. TV, DVDs and toys were restricted and monitored. Emma was referred to music therapy for psychosocial support 3 weeks after her admission. By this time, she had been diagnosed with PRS. In keeping with the diagnosis, Emma displayed a strong resistance to treatment (Lask, 2004; Nunn et al., 1998) and it was common for Emma to scream or moan when approached by staff. Emma participated in daily physiotherapy which she opposed with strong vocal and physical resistance. Doctors’ visits were met with similar hostility and opposition. Early music therapy goals were for Emma to establish rapport with the RMT and to experience opportunities for choice and control.

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¹ Re-feeding syndrome describes “a life-threatening shift of electrolytes and fluid that can occur when first reintroducing food to someone with malnutrition” (Wilson, Harry, Blaney, & Bruere, 2005, p. 74).
Vignette 1: Empowerment through control

Music therapy was scheduled for midday, three times a week. Initially, Emma resisted interaction with the RMT: she avoided eye contact (e.g., looked away or hid behind toys), was vocally aggressive, made loud gasping sounds, and repeated, “go away” when the RMT entered the room. Emma’s mother had given the RMT a detailed account of Emma’s music interests and tastes, and encouraged Emma to interact. At times Emma decreased her vocalizations when urged to stop by her mother. Emma’s mother was present for the first few sessions and was then only occasionally present during Emma’s music therapy sessions.

At this time a range of approaches were trialed – talking to or vocalising with Emma, playing familiar songs on the guitar, and exploring various percussion instruments – with the aim of engaging her in some way. To all approaches, Emma’s response was the same: an increase in resistance and opposition as demonstrated through avoiding eye contact, loud resistive vocalisations, covering ears (e.g., when playing music or singing), and rhythmic exclamations of “go away”. Emma often hid her face, cried or whimpered. The intensity of Emma’s reaction escalated the longer the RMT attempted to engage her, and often stopped abruptly when the RMT ended the intervention, or left the room.

Emma was actively expressing herself, and clearly needed to control the sessions. The RMT began to attend sessions without taking instruments or any other equipment: entering the room and leaving as soon as Emma said, “go away” or began to vocalise, only returning for the next scheduled session. Emma’s resistive behaviour and vocalisations gradually stopped and she began to show signs of trust: she began to show the RMT pictures and favourite toys. Furtive eye contact followed and finally by the third week, Emma began to communicate by spelling words with a magnetic alphabet, writing letters then words, verbally spelling letters, and finally through speech. The relationship between Emma and the RMT became interactive and communicative, and for the remaining months of the admission, opportunities for choice and control were offered by following Emma’s interests and encouraging her to make decisions.

Generally, sessions consisted of discussions within Emma’s interests, listening to and discussing recorded music, reading stories together, making art and craft, and creating and enacting make believe stories. Emma communicated her choices through gesture, speech, action, and refusal to engage. Other staff, including the play therapist,
school teacher, and some nurses, also developed positive interactive relationships with Emma. Emma slowly improved: she began to eat icy poles and push herself around in a chair on wheels. Due to ward closure over Christmas and Emma’s improved condition, Emma was discharged home after five months in hospital.

In this example, the RMT first approached Emma with a set of typical music therapy methods. However, there was a need to adapt methods according to Emma’s needs (Gold et al., 2004; Lask, 2004) and allow Emma to take control as shown through acknowledgement of her choices. There are many ways that a patient may indicate choice. Initially, Emma stated her choice through resistance and non participation. Steele (2005) highlights the need to “facilitate communication and subsequently increase patient control through the use of simple techniques” (p. 75) to include and encourage a client’s ability to participate in the therapeutic process. Thus as music therapists, we need to pay attention to atypical ways of interacting and participating, as well as be able to identify atypical responses in our clients. The therapist’s acknowledgement of Emma’s response empowered Emma to perceive a change in her capacity to control her environment (Daveson, 2001a) which led to the development of trust and an interactive relationship with the therapist.

**Background to Admission 2**

Over two months at home, Emma’s condition deteriorated. She used few words, resisted showering and dressing, slept little, and made a lot of noise at night. Emma was re-admitted to a different paediatric ward in the same hospital approximately two months after discharge in an extremely distressed state. On the ward, Emma lay in a fetal position on the floor whilst whimpering, crying and moaning more or less continuously, she was not eating, and her speech had regressed to the use of one or two words. Emma kept her face hidden, either facing the wall, hiding underneath her mattress or with her hands covering her face. Emma consistently presented in this state for the length of this two month admission. In addition, Emma was often aggressive and showed an increased resistance to nursing staff. Despite previous rapport, Emma did not engage or interact with the RMT. Music therapy goals were for Emma to re-establish rapport with the RMT, to feel supported and acknowledged, and to experience opportunities for choice and control.
Vignette 2: Empowerment Through Supportive Listening

The RMT first attempted to re-establish rapport with Emma by talking to her. Emma whimpered continuously for ten minutes and then said, “go away”. The RMT left the room and noted that unlike the previous admission, Emma’s vocalisations continued when the RMT left the room, suggesting that this was a reflection of Emma’s emotional state rather than a mechanism for control. Emma’s sobbing continued regardless of attempts to engage or soothe her, nor did the crying stop if Emma was given control. It seemed important to offer a space that could validate and witness Emma’s pain. Therefore it was decided to assist Emma through supportive listening, where the RMT sat in silence, aiming to provide a containing environment where Emma’s distress was allowed to be expressed and could be held and acknowledged.

As Emma’s face and eyes were always covered, it was necessary to continually advise Emma as to what was happening. Thus the RMT would greet Emma, state that she was going to sit quietly, and inform her where she was sitting, when she was leaving the room, and when it was necessary for the RMT to move around the room. This aimed to ensure that Emma was being treated with respect and was aware of what the RMT was doing throughout the session. For three sessions sitting in silence with Emma was the sole music therapy intervention. Each time, Emma cried, whimpered and moaned continuously for around 20 minutes. There was no change in Emma’s vocalizations, nor did she tell the RMT to “go away”.

Emma’s response of “go away” when the RMT spoke to her in the first session suggested that talking as an intervention was ineffective. The RMT felt that it was more appropriate to offer a holding space where Emma’s feelings could be acknowledged and contained. As Emma was able to communicate her objection by increasing the volume of her vocalisation or by saying, “go away”, the RMT assumed that Emma’s lack of protest indicated that it was acceptable for the RMT to remain in the room. Pedersen (1999) describes how listening “can invite the patient to be listened to and be met” (p. 31). The clinical reasoning for using supportive listening as an intervention was drawn from the belief that it provided validation and acknowledgement of Emma’s feelings and expression, as well as a holding space where Emma’s true expression could be released and heard with empathy (Daveson, 2001a; Pavlicevic, 2001; Pedersen, 1999; Sheridan &
McFerran, 2004), thereby facilitating a process of empowerment through self authentication (Daveson, 2001a).

Weekly meetings with the psychiatrist, play therapist and teacher were a useful form of support and helped to reduce the sense of isolation sometimes experienced by the RMT. Furthermore, multidisciplinary team meetings ensured that the care being provided for Emma was consistent. Peer supervision with an RMT offered support and validated the RMT’s music therapy treatment approach. This work was confronting and at times isolating for the RMT. Although Emma appeared to accept the RMT’s presence, after three sessions of supportive listening, the RMT decided to meet Emma in her distress by joining Emma in supportive vocal improvisation.

**Vignette 3: Empowerment Through Vocal Improvisation**

During the fourth session with Emma, after sitting in silence for around 20 minutes, the RMT sang a soothing and slow minor third pitched with Emma’s crying. After a short period of time, Emma indicated that she wanted the RMT to stop, by making a louder sharp vocalisation, which dropped away to the previous, quiet whimpering when the RMT stopped singing. Although Emma had indicated that she wanted the singing to stop, she seemed to have listened for a moment, and so the RMT decided to pursue vocal improvisation as a tool for communicating with Emma. Emma’s ability to communicate through this louder cry, confirmed that she could indicate a preference for supportive listening or vocal improvisation and therefore exert control over sessions. Thus the RMT decided to proceed with vocal improvisation and supportive listening to encourage decision making and as a form of support and validation.

In the following session, the RMT sang a low bass drone, pitched in the tonality of Emma’s crying to provide support and create a holding space. This singular tone seemed to be the least intrusive form of vocal intervention and allowed Emma to express herself without competition or expectation. Musically Emma’s sobbing could be described as rhythmic and repetitive, often recurring in a slow 4/4 time: “huh” “huh” “huh” rest. Her sounds moved between short guttural utterances, long high notes, and whimpering. Several times throughout the session, Emma’s crying changed to “sing” at pitch with the long note sustained by the RMT. Thus, the crying rhythm became “huh” “huh” “huh” “aaah”, with the sobs as grunts, and the “aaah” as a high note pitched with the drone of the RMT. Emma’s sung high note was sustained into the third beat of the next bar, so that the fourth beat was
a rest before the pattern began again. When Emma indicated for the RMT to stop, by increasing the volume of her crying, the RMT responded by changing to supportive listening, while Emma returned to whimpering. The RMT considered gaining permission to audio record these sessions. After consulting with the psychiatrist and the supervising RMT, it was decided that even seeking permission could jeopardize the therapeutic process, and so the idea was abandoned.

Over the following ten sessions, the RMT gave Emma opportunities for control, self-expression, and acknowledgement through a combined approach of vocal improvisation and supportive listening as dictated by Emma’s choices. Invariably Emma cried or moaned in a distressed and agitated manner throughout sessions. However, Emma continued to respond vocally to these interventions by moving between guttural sobs and a sustained high pitched cry in the manner described above, and by adjusting her cry to sing at a lower pitch closer to the drone of the RMT. Emma continued to communicate when the RMT was to stop, through a specific loud, sharp cry. At times there was no active response from Emma, which was taken to indicate that it was acceptable for the RMT to proceed with vocal improvisation until otherwise indicated.

Emma became aggressive towards nursing staff and she began to display extremely oppositional behaviour, including biting, scratching and refusing to wear clothes. She continued to cry or moan loudly throughout the day and night. For her own safety and that of the staff, Emma was sedated and was commenced on anti-depressants. Throughout this time Emma still allowed the RMT to be present and interact using the methods described. Emma’s vocal distress would increase as the RMT commenced a session and decrease by the end, or it would oscillate throughout with Emma becoming distressed and calm at different points. At such times, the RMT continued to hold the note, which aimed to convey an acceptance of Emma’s expression, and create a holding environment. Over sessions 11 to 14, Emma repeatedly indicated that she did not want the RMT to sing in this way, and vocal improvisation was ceased as an intervention. Shortly after, Emma was discharged. The severity of Emma’s condition required specialist psychiatric intervention and she was discharged to a psychiatric inpatient unit for children under 12 years of age. Within weeks of commencing her admission there, Emma began the process of moving home at her own request, and has since recovered.
The use of a simple vocal bass tone created a gentle, musical framework and support for Emma. In vocalising with Emma, the RMT was able to momentarily meet Emma in her expression without being too intrusive. With regard to her work with children with early onset anorexia nervosa, Robarts (1994) emphasizes that “sparseness” within music is “essential, in order not to overwhelm” (p. 239) children who are beginning to gain self awareness. Similarly, Wigram (2004) discusses the benefit of using simple accompaniments as a “holding tool where the use of sustained sounds without attempts at interactive or dynamic music making provides the containing frame” (p. 97). The RMT’s bass note was pitched in the key of Emma’s cry, offering validation and containment. It was in Emma’s response of sustaining her cry to this note that an interaction occurred. This was a significant development for Emma who, during these moments, was briefly able to engage with another person. These moments of connection were also crucial for the clinician to maintain faith in the music therapy method and process.

The very nature of listening, holding, and supporting forces the listener to hear and confront the truth and pain of another’s experience. Sutton (2005) describes the significant aspect of silences as a result of “the way in which the therapist listens and attunes to what is not sounded” (p. 4). She continues to outline that a therapist may need to reflect, “what is within the therapist, and in their human response to the client” (p. 4). At times, it was quite distressing to witness Emma’s state. The confronting nature of this work sometimes imposed feelings of helplessness on the RMT. Lask (2004) and Nunn et al. (1998) caution against the potential for staff to burnout and thus exacerbate a sense of helplessness in a child with PRS. Working with the team, peer supervision, and some external supervision were of critical importance in maintaining counter-transference issues for the clinician. There were a few occasions where sessions were shortened due to the intensity of Emma’s ongoing distress. The RMT felt that Emma was aware of her surroundings and others’ emotional responses to her, and did not want to compound Emma’s apparent feelings of helplessness or impose added anxiety on her. It was therefore decided that it may have been more damaging for Emma if the RMT had remained in the room in an emotional state whilst experiencing such a strong counter-transference that could not be processed.

Vocal improvisation and supportive listening offered Emma opportunities to act in ways that were authentic to her experience, and provided a sense of control and acknowledgement for her distress. These two interventions aimed to give Emma space, time, and support to determine how she would respond “without the pressure of being expected to explain or
defend [her] expression” (Pedersen, 1999, p. 34). This is critical for a child with PRS who has an overwhelming need to recover at their own pace (Lask, 2004; Nunn & Thompson, 1996). Access to two supportive music therapy interventions enabled the RMT to listen to and communicate with Emma “in a spontaneous and intuitive manner” (De Backer & Van Camp, 1999, p. 21), adapting with flexibility according to Emma’s needs as they arose within the moment (Gold et al., 2004). Furthermore, supportive listening and empathic vocal improvisation complemented each other and yet provided scope to accommodate Emma’s needs.

**Conclusion**

As music therapists, we are able to support, “be with” and witness a child’s experience through active and / or reflective methods. Both approaches to intervention may be verbal or nonverbal, and may be adapted to suit the needs of the child as they arise within the moment. With such a range of verbal and nonverbal methods, music therapy may offer a unique role in the treatment of children with PRS. In the initial admission of the current case study, music therapy offered opportunities for Emma to experience empowerment through choice and control; and as Emma’s condition deteriorated in the second admission, music therapy was a particularly valuable form of intervention as it was able to offer opportunities for nonverbal validation, containment, and support for Emma to express herself, and thus experience self-authentication.

Many, if not all, of the staff involved in Emma’s care adopted a child-centred approach, and endeavoured to offer opportunities for choice and control where possible. The main difference between music therapy and other allied health interventions was that the RMT was able to use nonverbal methods, in particular supportive listening and vocal improvisation, to support a mute, weeping child, as well as meet the child and interact with the child in her own expression: that of the voice. A full multidisciplinary team participated in Emma’s long treatment. This case study has outlined the role of music therapy in Emma’s recovery process. The authors would like to recognise the work of each member of this team and acknowledge Emma’s family and her own participation in this process.

Due to the complicated and challenging nature of this condition, the current authors strongly recommend clinical supervision when working with children with PRS.
References


