Creating a Safe Place in the Midst of Aggression: Music Therapy in Child Psychiatry

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Abstract

Working as a music therapist in a psychiatric unit for children with learning disabilities, one is often confronted with a lot of aggression. Most of these children have attachment disorders and severe behavioural problems. By which means can music exist in music therapy within this specific setting? Can we speak of a traumatic nature in music and body? This article will present a case study, where finding a safe place within music therapy is of major importance. Learning and listening to songs can be a necessary way to safeguard control for the client, gain some self-confidence, and create a place for regression. Going through this process in finding a safe and contained place within music therapy, the possibility of playing techniques arises, offering the freedom for exploration and a form of control and predictability. The case study concludes with the importance of playfulness whereby traumatic material can be digested through the music. Also, the role of singing songs in music therapy with this population is highlighted briefly.

Keywords: music therapy, child psychiatry, learning disability, aggression, trauma, playfulness

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Introduction

In 1949 Theodor Adorno writes in his *Philosophie der neuen Musik* about the music of Schönberg "Music, condensed to the moment, is true as a result of negative experience. It is real suffering" (Adorno 1949: 42). Adorno compares this, making a reference to a poem by Hölderlin: "As my happiness, is my song, gone is it, and the earth is cold" (Adorno 1949: 42). The reference to happiness as a song, reminds us on how music versed and well structured by melody and tonality, is of an essential different nature than the music of Schönberg. As Adorno later on in his analysis of Schönberg writes "How in the medium of music real bodily movements are being registered, shocks, and traumas" (Adorno 1949: 43). One can compare this with the kind of music I am mostly confronted with as a music therapist when working with clients at Fioretti.

Fioretti is a psychiatric unit only for children with a learning disability between the age of six and seventeen, which is unique in Belgium. Typical about Fioretti is that it is based on institutional psychiatry and that only individual therapy sessions are given, from different disciplines. Most of the children have attachment disorders and severe behavioural problems, mainly aggression, with a history of violence, neglect and abuse. They also have a mild learning disability, while we often notice that there is a discrepancy between the cognitive level on which they function and their emotional age, which is often much lower.

ISSN: 1791-9622

The aggression which we encounter at Fioretti is being interpreted according to the model of Anton Došen, a psychiatrist who is specialised in behavioural and psychiatric disorders with persons with learning disabilities. His model, mainly based on Mahler and Bowlby, sketches the early socio-emotional development, which consists of different phases. The primary phase is that of the adaptation, which means the integration of sensory stimuli, resulting in homeostasis. When this is interrupted, aggressive behaviour is seen as an emotional 'dysregulation', as it is affective, uncontrolled and without a purpose (Došen 2005). At a following emotional stage in the development, the 'socialization' phase, aggression is considered as a reaction on separation, fear and frustration in interaction with the attachment figure. However, it remains uncontrolled. Generally speaking most of the children at Fioretti are functioning mainly on these first two levels.

The traumatic nature of music and body

Taking into account the particularities of the population and setting at Fioretti, various questions may arise with regards to the nature and role of music in music therapy.

Contrary to the knowledge that music has the capacity of being a non-threatening and inviting medium, music for this specific population can be, like in reference to Adorno, "the registration of bodily movements, shocks and trauma" (Adorno 1949: 42).

It has been described by Streeck-Fischer, Bessel and Van der Kolk (2000), how traumatised children have problems controlling their emotional responses and modulating their behaviour, due to problems with self-regulation. Those children show "an inability to inhibit action when aroused with uncontrollable feelings of rage, anger or sadness" (Streeck-Fischer, Bessel & Van der Kolk 2000: 910). Normal play becomes a traumatic play when "affectively charged stimuli" are involved. (Streeck-Fischer, Bessel & Van der Kolk 2000: 912). They react to the present as if they were back in the traumatic situation.

The way in which these children present their music is very physical. Their whole body is involved in their musical play, which is marked by an intrusive nature; their breathing, the use of their voice, the rhythm and movement of the whole body.

Daniel Stern (2009), inspired by Henri Bergson, speaks about vitality, the basic principle of human life. It consists of five elements: movement, force, space, intention, and time. These elements are all present within music as a dynamic form. When there is an early damage to the child, the whole vitality becomes affected, which presents itself in the music they produce.

As music is direct and immediate, you cannot shut it off. The musical experience has a sensorial and somatic nature, which means that sounds unavoidably surround our body. The sound of the world and our hearing body stick together, like they almost converge into a quasi symbiotic fusion (Van Campenhout 1999).

Therefore, as music is situated on the level of the body and vitality, it becomes clear how improvising can be intrusive and overwhelming with this population. We could say that the music becomes traumatic as their own body reflects the threatening and intrusive character of the music. Music and body become like two broken mirrors, reflecting one another.

I have often noticed that at the beginning of the therapy process, improvising, although possible, generally occurs in this specific traumatic way. I will try to illustrate this by means of the following case study, and elaborate further on the different possibilities on how the musical sound grows within music therapy, as it develops its identity within the therapeutic process.

Case study

A suffocating symbiosis

Liesbeth[1] is a young adolescent, with mild learning problems. She has a history of sexual abuse for several years when she was a young child. She comes from an isolated family, signed by loss of relatives. Liesbeth was referred to the department for behavioural problems and withdrawal.

In the first weeks of her stay at Fioretti, Liesbeth stroke me as being withdrawn. She was hardly speaking a word, was nervous, anxious and was hiding in her baggy boyish looking clothes. Every week she was invited for an individual music therapy session.

In the first session, she was drawn to the instruments, but was afraid to play or touch them. However, when I turned away, and said "I won't look", she would try carefully. In the second session, Liesbeth was able to explore different instruments, in a playful way, without saying a word.

> *A free improvisation at the piano evolves, in which the movement of the hands seems more important than the sounds they produce. Liesbeth is following my hands, crosses them, and plays with distances and closeness. Moments of intimate musical contact originate, in which we literally play*

[1] The name has been changed for confidentiality purposes.

ISSN: 1791-9622

> *on the same keys. The boundaries between us seem to fade away in the symbiotic play at the piano. Liesbeth also explores physical boundaries and closeness. She touches me softly for a second, then suddenly grabs my throat, like she wants to strangle me, but somehow she never hurts me. Liesbeth does not seem to be aware of how intrusive and threatening this is. She does not realise she is doing something harmful.*

As sessions evolved, and a developing relationship arose, it was like her hands wanted to melt together with mine at the piano. Liesbeth wanted to coincide with the music I was creating. When this was not possible, and the music did not sound like she imagined, she got frustrated, overwhelmed, and pushed me away. After this, she begged to come closer again. A suffocating symbiosis. The intimate contact at the piano seemed too threatening, but Liesbeth repeatedly was seeking it, over and over again. Short musical moments usually ended in a dysregulation, towards the piano or towards me. The lack of, and insistence for control over her own body showed itself in her music.

Even outside the sessions, Liesbeth often appealed to me. When she saw me, she clinged to me and did not want to let me go. Physically she came very close, too close, as it felt like she would like to crawl inside of me. Fear for an upcoming separation changed in aggression. She did not want to hurt me, but somehow this seemed to be beyond her control.

The individual music therapy sessions became an important moment for Liesbeth, causing nervousness. The walk to the therapy room became a burden and challenge for both of us; Liesbeth clinged to me, simultaneously grabbed my throat or hit me. When I verbally tried to define my boundaries, it just seemed to get worse as she was afraid I would push her away. She could not control herself and seemed to lose all boundaries between herself and the outside world. Only holding her physically brought some rest into her uncontrolled movements. This process also showed with other therapists and nurses to whom she got attached to. In the music therapy room the atmosphere became unsafe and making music seemed to become almost impossible.

Margaret Mahler (1952) wrote about symbiotic infantile psychosis, in which the early mother-infant symbiotic relationship is marked, but does not progress to separation. The mental representation of the mother is not separated from the self and becomes fused.

When the child is confronted with a possibility of separation from the mother, severe panic reactions occur, as the "illusion of the symbiotic omnipotence is threatened" as Mahler (1952: 296) describes it. Separation anxiety overwhelms and the boundaries of the self and the non-self are blurred. Mahler further describes how, "[t]he manifestations of love and aggression [...] seem utterly confused. They crave body contact and seem to want to crawl into you [...]. On the other hand, their biting, kicking and squeezing the adult is the expression of their craving to incorporate, unite with, possess, devour and retain the 'beloved'" (Mahler 1952: 300).

These blurred boundaries of the self and non-self were also presented in Liesbeth's music. There was no musical form, and one could hardly hear the difference in the play of the therapist and that of Liesbeth. There was not even a clear boundary when there was music and when not. Liesbeth played piano on my back or on a chair. She played in a similar way on the piano as she reached for me, sometimes gentle, sometimes aggressive.

A first melody

After a few months in therapy, Liesbeth expressed the desire to learn something, to be able to play something on the piano, as in her own experience she was always playing the "wrong things".

She asked if I could teach her the melody of the song *My Heart Will Go On* by Celine Dion from the movie *Titanic*. Her longing for security is translated in a kind of mastering and trying to obtain control of the music. Nevertheless, it seemed a positive desire as the learning process could develop her confidence.

However, learning this melody, which she studied very eagerly, seemed to evoke more frustration, as the music never sounded like she wanted. Even if she played it perfectly, she kept on repeating it, as to be sure she still remembered it. For many sessions she, almost relentlessly, kept on playing this melody, after which she started to hit the piano in rage, as she could not control the music.

Learning music can be a certain point of discussion within music therapy. Teaching a melody can be seen for one as answering the resistance of the client to improvise freely, but also be perceived as a form of uncertainty from the therapist who wants to do the right thing, both of which lead to a form of pedagogy. On the other hand, working with children and adolescents, the aspects of learning has been described by other music therapists (e.g. Frisch 1990; Tervo 2005) as a way to strengthen ego-development, as learning some musical skills can provide new possibilities of self-expression, and the experience of self-control.

ISSN: 1791-9622

However, one must be very careful in teaching musical skills when the therapist takes the lead. The client thus may no longer be appealed to use his own creativity, having learned *how* to use the music as a means for self-expression. An important aspect in this discussion that has to be accounted for is the spontaneity of this whole process. If one replies to the desire of the client to learn a specific song or some musical skills, one should be aware of processes of transference and counter transference.

In the case of Liesbeth, I replied to her wish of making the piano controllable, which is not possible. Nevertheless, it seemed an important step in taking some distance to my own play as a therapist, as Liesbeth could then play something on her own, with or without my accompaniment. Perhaps the learned musical skills could be seen as an introductory guide in the exploration of her own boundaries.

Gradually, Liesbeth was able to let go of the melody, while short spontaneous musical games became possible, especially if it concerned imitation. During these musical games, various atonal improvisations evolved, where we used the piano as a percussion instrument. Like a point of rest to return to, Liesbeth often introduced the melody of *Titanic,* something known and controlled, from which a short fragile melody could evolve. This seemed a safe way to explore musical material. Liesbeth liked to imitate me, but also started to enjoy hearing how I imitated her, like an echo. Any form of spoken playing rule or form remained impossible, as Liesbeth was afraid she would fail to complete it. Producing her own sounds through music making, without being overwhelmed by it, was a challenge. Short moments of constructive rhythmic and melodic playing were alternated with uncontrolled aggression towards the instruments or towards me, in between distance and closeness.

The search for predictability and a safe container

In session sixteen, closing the session was again difficult and separation anxiety overwhelmed, which resulted in destruction towards the music therapy room. Liesbeth needed a clear boundary, where I, as an attachment figure, had to regulate her.

After this session, Liesbeth brought her music of High School Music. A part of her own world entered the therapy. Listening to her familiar songs, while Liesbeth was resting with her head on my shoulder, seemed to bring tranquillity and relief to her. Her own predictable songs functioned as a safe container, where Liesbeth and myself as a therapist could co-exist. They were more familiar and less problematic than improvising at that moment.

Just like learning songs, listening to songs can create a feeling of control and open up a feeling of predictability and therefore a safer atmosphere within music therapy. It is more passive and regressive than the musical skills and therefore even less threatening. A specific element about listening to one's own favourite songs is that they create a frame for regression. The use of these songs has often been described as functioning as transitional objects. It can prove to be a useful tool to safeguard control for the client, as not to lose oneself in the traumatic play. Nevertheless, again here, one has to be careful for the easiness of putting on some music during sessions, as it could signify a resistance to invest in the therapeutic relationship. Or, as we described with learning songs, it could also come from the therapist's uncertainty.

Listening to the same songs every session, as an extreme form of predictability and familiarity, seemed necessary for Liesbeth, as, in the meantime, she became more attached to carers in the ward and therapists, and more serious dysregulations occurred (running away, vandalism), whenever separation fear overwhelmed her, due to absences of certain people because of staff turnover and illness.

The following months Liesbeth seemed to need closeness and safety in the sessions. Listening to her favourite songs of High School Music, she experienced the outside world as chaotic and unpredictable, full of separation.

After about nine months in therapy, the once disruptive and threatening music therapy room had turned into a safe place. This was caused by the possibility for Liesbeth to regress to the stage of a baby, being held by a mother figure, while listening to her songs, finding a kind of homeostasis. Some sessions, she even enacted this, by taking a blanket, rolling into it, after which she asked me to hold her and sing her favourite music. She was able to stay close, without jumping up: making uncontrolled movements, hitting me or the instruments.

The blanket and physically being held provided her a clear boundary of her own body, while her familiar music sounded, which was recognisable, like the voice of the mother.

Mahler writes in her article about symbiotic infantile psychosis, how important it is to "let the child test reality very gradually at his own pace […]. It constantly needs support and […] separation as an individual entity can be promoted only very cautiously" (Mahler 1952: 304).

Liesbeth could now experience safety, without being overwhelmed by separation anxiety. Depending on how she felt, Liesbeth coped with her music in a more active or passive way. While listening to her songs, drawing and word games

ISSN: 1791-9622

found their way in the music therapy room. At other times we looked into the content of a song, and connected it with her feelings.

Liesbeth said she did not like to improvise any more. She just listened to her favourite songs. This may tend towards a form of resistance. Still though, at the beginning or the end of sessions, moments of a spontaneous musical dialogue evolved. This had an informal character as if the session had not started yet, or had already finished. Also outside the sessions, at the ward, it became possible for Liesbeth to play music with me, without being overwhelmed, like for instance playing percussion instruments with other children, or singing songs together. As long as the musical interaction stayed informal, Liesbeth seemed able to show musicality, had a stable rhythm, listened to my playing, and in the meantime brought in her own elements. We played imitation games, but on different instruments, so an exact imitation was no longer necessary. But still, whenever the session started, whenever the fear rose up of it being too meaningful, Liesbeth became nervous and could not control herself. As a way of regulation, she put on her music, and being held close - something that helped her to calm down.

Playfulness – Playing together – Playing rules

After almost a year in therapy, Liesbeth asked if we could play a game. In playing a game, reality seems to be of lesser meaning or importance as it is 'only a game'. Nevertheless, this creates a possibility for exploration in a non-threatening way and as Winnicott states “psychotherapy has to do with two people playing together” (Winnicott 1971: 44).

Liesbeth chose an 'emotion card game' which we once made together at the ward, months earlier. She was not able to talk about emotions, but when I suggested to portray the emotions musically, within the game, she reacted enthusiastically. She then seemed ready to explore different aspects within music therapy and became actively involved in a constructive way. Her boundaries became clearer and she could hold on to a clear and playful structure, in which some free improvisation became possible.

Liesbeth was eager to win each emotion, and carefully gave each emotion its place. In the improvisations that evolved from this, I was amazed at how Liesbeth took a lead in showing me how the emotion had to sound and presented herself as a different person than the therapist. For some emotions she chose an appropriate song, for others we chose either the piano, or percussion instruments. The improvisations were short and fragile. Within this play, it became possible to explore emotional vulnerable content in the music.

The use of playing rules, within a kind of playfulness can be a necessary means to keep on working in the therapeutic relationship. Playing-rules create structure and some kind of restriction and consequently a boundary. When the boundary between self and non-self is blurred, musical boundaries can help create these. It has been described how structure offers stability and predictability and provides a safe container for self-expression (Frisch 1990). For example: “when we hit on this drum, we stop playing or change instruments”. It can strengthen impulse control, which is mostly disturbed with this specific client group and can improve ego-strength and self-esteem.

Playing rules can be brought up by the therapist or the client. But similarly as with learning within music therapy, again, one has to be careful in establishing them and taking too much lead. It is important to know what to gain when introducing playing rules, and how strictly these are used. The balance between freedom and a limited setting is most important. It should be evolving from the relationship, and depending on the context and the needs of the client at that moment, and rather not be determined in advance. Nevertheless, the children we are working with generally will not accept a playing rule, unless it evolves spontaneously within the needs of the therapeutic relationship at that moment.

It seems important how control over these playing rules creates safety for the client (Mahns 1997). Children will often change the rules to maintain control.

Playing-rules also create a kind of informality, a certain lightness, which is most important when working with traumatised children. In this way playfulness can act as an antidote for painful and traumatic experiences (Lanyado 2006).

As for Liesbeth, a long process was necessary to be able to play music within the music therapy sessions, without becoming destructive. Still, a long therapeutic process is necessary, in the search to make the trauma bearable and foster a socio-emotional growth.

The importance of playfulness

In a similar way, we also recognise the importance of playfulness with another sixteen year old girl in music therapy. The introduction of playing rules within a jesting kind of playfulness turned out to be of the utter importance throughout the difficult process she and I experienced during a year and a half of therapy. For this girl the way to and back from the therapy room was too long and frightening, as she was always afraid she would run away. It happened once, at the beginning of the

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therapy process, when a close musical contact in a free improvisation evolved on the accordion, which was a completely new experience for her. This experience, however, seemed too overwhelming. When the session came to an end, she did not want to leave, she started dissociating, becoming very aggressive, resulting in running away.

As in the case with Liesbeth this young girl's whole body was involved in the music and the free improvisational play became a traumatic play whenever "affectively charged stimuli" were involved, as described before (Streeck-Fischer, Bessel & Van der Kolk 2000).

Months after this incident, the girl was still frightened this would happen again, but was eager to come to the music therapy sessions. She even asked for two music therapy sessions a week.

In her musical play she would often lose herself, especially when she wanted to play on the drums. Hitting with a mallet seemed to re-enact traumatic experiences, but each time she would go back to the mallet, wanted to play with it, but after a while would try to hit everything, including my head. Again here, boundaries between self and non-self, between music and body, seem blurred. Often the therapist literally becomes involved to feel how the body-image can be wounded.

Through spontaneous playfulness and even humour, and the arising of playing forms, making it bearable and contained, traumatic material could be digested through the music and the dysregulations were diminished.

Singing songs

Along these different aspects of musicality within music therapy, such as learning, listening to songs, and the use of playing rules, another aspect which was not explored yet within this case study, is the use of the voice through singing. It is a special form of interaction and expression, and more than any of the previous forms connected to the body. Singing is closely linked to the first forms of interaction between mother and infant.

For some children at Fioretti, singing children's songs or other kinds of well-known songs provides them with a safeguard similar to the way in which this applies to the receptive music. It is a controllable road into the vulnerable exploration of the personal voice, also closely linked to the own body.

Klausmeier (Mahns 1997) states that by singing songs, the verbal content is given emotional meaning. Singing also gets an emotional content otherwise not possible to say through speech.

This can be exemplified by the case of a fourteen year old boy who asked in therapy to help him write a song for one of the carers who was leaving. The boy chose an existing song, and with some help changed the text into something personal, hereby giving expression to what that carer meant to him. Later it turned out that the carer was not aware of the fact that his departure laid a heavy burden on the boy, as the boy was not talking to him about it. Nevertheless, during therapy, he could sing it. We recorded it, listened to it, and presented it to the carer as a farewell present.

On the other hand using the voice in therapy can often prove to be too difficult, as with Liesbeth. Often she said to me how she knew all the songs by heart, but never sung along during music therapy. Especially with the older children and adolescents using the voice for singing or improvising can become a frightening or threatening thing. From my experience, exceptions to this are often children with psychotic behaviour who have no fear at all to use their voice in a creative way.

All these examples may provide us with some material to suppose that in the adolescent world of this population who is marked by abuse and neglect, the use of the voice can be a specific form of mutual intrusion of music and body. Using the voice proves to be an important part within this specific work as a music therapist. It remains a topic to be further explored.

Conclusion

According to Streeck-Fischer, Bessel and Van Der Kolk (2000: 913) "once a child develops the elementary capacity to focus on pleasurable activities without becoming disorganised he or she has a chance to develop the capacity to play [...]". In the context of music therapy finding a safe place through different forms of musicality is often a challenge. Especially within music therapy with children with attachment disorders and behavioural difficulties it is important to know how free improvisation can be threatening and intrusive.

Through a case study and relevant literature I explored what the place of listening and learning songs can be within a therapeutic process. Through establishing a contained and safe place, with the possibility to regress, it may become possible to explore traumatic material within a safe form of playing rules.

Finding a harmony and balance between freedom for exploration, and at the same time offering structure and boundaries, within a kind of spontaneous playfulness, seems most important within the therapeutic context.

Learning music or playing games, singing or listening to music cannot be handled or taught in a methodical or systematic way. Between the bodily trauma that can be re-enacted in the free improvisation *and* the safety of boundaries and

ISSN: 1791-9622

rules, there dwells the spontaneous synthesis of playfulness. It is the 'smiling dissonant' of music therapy.

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To cite this text:

Degryse, M. (2010). Creating a safe place in the midst of aggression: Music therapy in child psychiatry. *Approaches: Music Therapy & Special Music Education*, *2*(2), 48-54. Retrieved from http://approaches.primarymusic.gr

ISSN: 1791-9622