

## **The contribution of Music Therapy to the emotional wellbeing of children in residential child care**

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Aby Vulliamy  
Music Therapist

### **Introduction**

I was recently surprised to discover that there is only a small handful of music therapists employed within Scottish residential child care. There also appears to be a significant gap in the international literature with regard to music therapy in residential child care. I believe that the use of music therapy in residential child care can enhance wellbeing. This paper will review seven issues that I find particularly pertinent to music therapy for children who are looked after away from home. I will use case study examples from two young people with whom I have worked, reinforced with theoretical references, in order to show how these issues influence music therapy in residential child care.

### **Defining Music Therapy**

...music links with our innermost emotional, spiritual and most private selves. Music helps us to feel more human. It brings us into very close and immediate contact with the people around us and at the same time connects us both with images from the past and predictions of the immediate future  
(Bunt, 1994, p.1).

As the above quote indicates, music is not simply an auditory process; it inspires and conveys feelings, often reaching the most deeply hidden parts of our psyche, as well as aiding connections and communication between people in various verbal and non-verbal ways. Music therapists have a minimum of Masters-level training from a validated Music Therapy training course and they are regulated by the Health Professions Council. The Association for Professional Music Therapists (2000) provides a definition of Music Therapy:

The ability to appreciate and respond to music is an inborn quality in human beings. This ability usually remains unimpaired by disability, injury or illness, and is not dependent on musical training. Music therapists usually use jointly improvised music to create, develop and sustain a purposeful working relationship between the therapist and client. By responding musically and supporting the client's exploration of sound, the therapist helps to develop

the individual's communication skills and encourages the process of growth and discovery.

### **Theoretical influences on music therapy provision at Fairdon**

I have provided music therapy at Fairdon\* (the name has been changed for confidentiality) for the past five years. Fairdon is a home for young people with learning disabilities, many of whom have additional emotional needs, stemming from a range of experiences such as bereavement, neglect and abuse. Many have been labelled as 'challenging' at some point in their lives. Brandon states that 'it is often difficult to 'hear' what people are saying. Communication can come even more eloquently through physical movements rather than words' (Brandon 1989, p. 8). Brandon's statement explains why some children might resort to 'challenging behaviour' in order to communicate, and highlights the significance of non-verbal communication. These non-verbal sounds, gestures, and facial expressions are the basic tools of music therapy.

The potential of music therapy to function on a non-verbal or pre-verbal level has led many music therapists to incorporate theories about attachment and child development into practice (Pavlicevic, 1997; Nocker-Ribaupierre, 1999; Sobey and Woodcock, 1999; Bunt and Hoskyns, 2002; Wigram et al., 2002; Walsh-Stewart and Stewart, 2002; Oldfield, 2006, Abad and Williams 2006). Research into how infants communicate intimately with their parents without using words, and the impact of these early relationships on a range of wellbeing indicators is well documented (Trevanthen, 1980; Bowlby, 1988; Papousek, 1996; Stern, 2003). This research is particularly relevant at Fairdon, as many of the young people have learning difficulties and associated problems with communication. They rely more heavily on non-verbal interactions, in order to communicate and be understood. In addition, many of these young people have experienced disrupted early relationships or significant losses (Barns-Graham, 2009). By understanding theories of child development, I can focus on the types of intimate non-verbal interaction the young person may have lacked in their early relationships, and try to build a therapeutic relationship that can contribute in a holistic way to their wellbeing by rebuilding their ability to trust, express themselves, and to respect and feel valued by others.

In addition, like many music therapists, I am influenced by psychodynamic principles developed by theorists such as Freud, Winnicott, Bion, and Klien amongst others. This means that I try to understand the individual's current behaviours and difficulties in the context of their previous relationships. Psychotherapist Valerie Sinason (1992) pioneered psychotherapeutic work with people with learning disabilities, and has had a significant influence on music therapy theory (Sobey and Woodcock, 1999; Salkeld, 2008). Sinason asserts that

regardless of limitations in cognitive skills, all human beings possess a basic need for communicative and emotional intimacy. It is clear that at times we need to be creative in our attempts to meet this basic need, in order to be accessible for those who find intimacy, relationships and verbal communication difficult.

## **Seven issues to consider in the provision of music therapy in residential child care**

### ***1. Separate therapeutic space***

The carers are respected as the authorities in their home, but are asked to let the therapist be in charge of the session, setting boundaries and directing activities as appropriate (Hasler, 2008, p.170).

The music therapy I provide takes place within the residential home, but is clearly separate, and young people generally develop a clear sense of this separateness. Many young people in care have been through very difficult experiences (Hasler, 2008), which affects their overall wellbeing and ability to form trusting relationships. I find these clients often use their music therapy space to test relational boundaries and release pent-up emotions, in ways that may not feel safe or appropriate outwith their music therapy session. For these clients to feel safe to bring their most frightening and challenging feelings to the therapy situation, it is important that I am not involved in providing for their daily care needs, and that it is clear the rules of 'acceptable behaviour' may be different within music therapy. Consequently they can use their therapy however they need to, without fear of rejection or loss of basic care. It is important to note that while the staff at Fairdon would never actually reject any of their residents, some of the young people have experienced rejection from the family in their past. This can create a fear of *potential* rejection. For example, in his new home at Fairdon, David clearly enjoyed making people laugh and staff described him as 'happy to act the clown' (Sinason, 1992). David thrived on this public image, whilst also making use of his private therapeutic space where he could express and explore his serious and sometimes quite disturbing side. In the early stages of David's music therapy, he spent a lot of time pretending to expel an array of bodily fluids. We used cluster chords and dramatic flourishes on the keyboard to emphasise the 'revoltingness' of his outpourings. David seemed to be ridding himself of many foul feelings that he had been carrying around with him, and seemed to feel refreshed and lighter after these outpourings. In this way, the separate space provided by music therapy became a 'container' (Wigram and De Backer, 1999) for David's painful and disgusting feelings, thoughts and experiences, which were difficult for him to communicate in other contexts. Over time, David moved on from this phase of his therapy. I would argue that if he had not had this safe space in which to explore these

feelings, they may have remained suppressed within him, or potentially found more damaging outlets.

## ***2. Reliable and predictable boundaries***

Boundaries provide environmental and psychic containment for the patient. They communicate that the room can 'cope' with the patient's communications and that the therapist can 'hold' the patient's mental and emotional experiences

(Walsh-Stewart and Stewart, 2002, p.133).

It is important that as far as possible, each individual's session happens in the same place at the same time each week. These reliable and predictable boundaries of time and space combine with the consistency of my therapeutic attitude, to provide a secure framework within which a trusting therapeutic relationship can develop. This contributes to their wellbeing because many of the young people have experienced chaotic, inconsistent or disrupted early relationships or separations from their loved ones. They have a stronger need to feel informed and prepared for any planned absences or endings in order to feel valued and secure (Heal, 1989; Walsh, 1997; Brown, 2002). Well-managed therapeutic endings can help people cope with future endings and changes in relationships more easily. 'I look towards Andy's ability to lose me [i.e. end the therapeutic relationship] without losing the experience of having me, and to be able to generalise this to other relationships and experiences' (Walsh, 1997, p.19). David would frequently conclude his sessions with a song about what fun we had together, which seemed far from the seriousness and intensity I had experienced. In this way, David requested reassurance that I was resilient and committed, and would return again each week, even when sessions were really tough.

## ***3. Person-centred attitude***

Therapy is a journey where you do not know where you are going until you arrive. New directions can be thought about and planned for but often lead into unexpected territory (Brown, 2002, p.85).

Many looked-after children have experienced a frightening or traumatic lack of control over their own lives. Additionally, many young people, especially those with learning disabilities can feel disempowered and patronised in various ways (Brandon 1989; Phillips 1993) and yet may be capable of much more than they have opportunities to prove. They may find that in most of their relationships they are the weaker and more vulnerable, which 'leads to a very imbalanced view, a poor self-image, which can stunt personal growth' (Brandon, 1989, pp. 9-10). The experience of a person-centred relationship where the young person feels empowered and valued in their uniqueness may be easier

for me to offer within music therapy than in many other contexts. The luxury of working one-to-one, in a dedicated space without interruptions is hard to achieve in educational or residential contexts where there are many individuals with complex needs. By working in a client-led, person-centred way, I try to give control back to the child, within a safe therapeutic environment (Rogers, 1967; Portner, 1996; Natiello, 2001; Keys, 2003).

For therapy to be most effective and to have longer-term effects on their relationships and wellbeing, the individual needs to feel ownership of any growth and development that takes place. This is best achieved by enabling the individual to dictate the direction, focus and pace of the work. Within a person-centred approach, each relationship is entirely unique. In my work with David I found myself being uncharacteristically theatrical and dramatic in response to David's love of drama and intense emotional interactions. This was an intuitive response to what David seemed to be demanding from me; it is not a technique or formulaic approach that I use with other clients. David began telling stories of great emotional intensity, initially using characters from *Eastenders*, but gradually incorporating others, including myself. There was a sense of constant danger, either through natural disasters, or the threat of incarceration which was often disproportionate to the crime; for example being locked up for just 'being silly'. These constant dangers could be seen to reflect David's perceptions of his actual experiences; David moved into the care system when his father, who was his primary carer, died suddenly in an accident. The entire family struggled to cope with this devastating loss and David was eventually put into care. In therapy, David seemed to explore the possibility that he was somehow to blame or had been punished for the loss of his dad. As a child with learning disabilities, death was a very difficult concept for David to understand (Worden, 1991). In his music therapy, David found ways to gain understanding of the concept of death and explored his notion of families, of relationships and of 'home'. Sharing the piano, we would improvise sound tracks that emphasised the feelings being experienced by each character, heightening the emotional impact and illustrating the changing moods of the stories. David became very adept at conveying feelings using the piano, and this medium seemed to be very accessible and effective for him. Over time, as David came to terms with the confusing and painful feelings around his father's death and his subsequent removal from the family home, the constant threat of danger and punishment was gradually replaced by calmer, more mature and co-operative negotiations between characters, as well as expressions of more complex feelings, conveyed in more measured ways. The progression of David's therapy now seems very neat, as if it may have been pre-planned. This is a tribute to David's courage, determination and instinct towards positive personal growth (Rogers, 1967), since the work was genuinely directed by David. My role was to stay with him, and maintain a non-directive, accepting and resilient attitude to support him on his therapeutic journey.

#### ***4. Musical interactions as non-verbal communication***

Music therapy can 'rekindle the primacy of the powerfully non-verbal, and pre-verbal ways of being' (Pavlicevic, 1997, p.101).

Music offers teenagers an age-appropriate medium to replay and reform early attachment patterns (Hasler, 2008, p.164).

Many of the young people at Fairdon have difficulties using words to express themselves. This affects their overall wellbeing because they sometimes struggle to contain or express their more painful and confusing emotions. Musical interactions can enable young people to feel heard and understood. The music therapy relationship can reflect the intimacy and attunement of the 'first relationship' (Stern, 1977) between mother and infant, which does not rely on shared verbal language, but on multi-sensory gestures (using primarily sound, movement, touch: all sensory experiences that are essential in music-making). These expressive multi-sensory gestures can sometimes communicate feelings more accurately than words (Stern, 2003). For children whose early relationships may have been disrupted, this return to the immediacy and intimacy of non-verbal interactions can feel liberating, and may be powerfully reparative (Bowlby, 1988; Stern, 2003). Fairdon staff have commented on how much David's emotional vocabulary, fluency and ability to ask for help when he needs it (before his feelings become overwhelming) has increased over the years. One staff member stated:

*I have seen a very noticeable improvement in [the young peoples'] communication and ability to express emotion and feeling. One of the young people has been able to assert himself far more and another has been able to converse with others much better than before. I feel that music therapy has given these young people more confidence.*

(Senior support worker, Fairdon, 2009)

#### ***5. Music enables safe expression of challenging feelings***

*[Music therapy] sessions provide a channel for release both physically and emotionally for the young people, who have complex needs and issues and limited communication'*

(House manager, Fairdon, 2009).

Musical interactions can be seen to provide an outlet for feelings that are too painful or damaging to be expressed in other ways (Pavlicevic, 1997). In this way, music can provide an alternative to the physically aggressive or self-harming behaviour that often arises within residential child care contexts. Walsh (1997) makes this link: 'When she overturned the instruments, Andrea seemed to be communicating how she felt internally: feelings banging around inside her, upside-down and in a mess' (Walsh, 1997, p.17). Many musical instruments are designed to be hit with considerable force, so can withstand aggressive attacks.

Drums and cymbals emphasise the power of the communication by emitting a loud sound on impact, which can release tension and lessen the need to hit others or self-harm. Simply supplying the young person with instruments on which to release tension independently is likely to be helpful but insufficient, because ‘the cathartic release of tension through music, without knowledge of what the feelings are about, gives temporary relief, but, without understanding, the tension will mount again...’ (Priestley, 1987, p.148).

For example, Nicola seemed to feel vulnerable and insecure whenever she experienced intimacy or enjoyment in relationships (these responses could be rooted in her early experiences with a mother who sometimes showed great love for Nicola but at other times was too inebriated to attend to Nicola’s needs). Consequently, she had an instinctive urge to attack or destroy things; both in terms of objects that she loved and in terms of relationships that were important to her. As Austin states, ‘The urge to resolve trauma through re-enactment is extremely compelling’ (Austin, 2002, p. 244). As with all Fairdon staff, Nicola often attempted to hit, kick or bite me. In Nicola’s sessions, I gently but firmly redirected her aggressive feelings towards the instruments, and she began to enjoy the feeling of hitting the drum. We began interacting playfully, and she was encouraged to use her voice expressively too, and her urge to hit me subsided gradually. Over time, Nicola discovered a wide range of ways of expressing herself through music that was loud, soft, high, low, fast or slow. This developed into exploration of different moods. In this way, Nicola’s complex feelings were safely channeled into music, where they were explored, accepted and understood differently. What seemed helpful for Nicola in her music therapy was the provision of a cathartic outlet for her violent urges alongside encouragement to explore vocally the feelings behind these urges, all within the boundaries of a safe and secure therapeutic relationship. Music therapy gradually provided containment of Nicola’s feelings, and this experience gradually enabled Nicola to see that she was capable of containing herself more independently (and that emotional intimacy could feel good), both in therapy and for her general wellbeing.

### ***6. Balance between confidentiality and communication with staff***

I believe Fairdon staff trust me to protect the confidentiality of the therapeutic relationship, whilst knowing how much information needs to be shared across the team in the best interests of each individual. Maintaining a trusting relationship between myself and staff members is crucial, since we share a desire to do the best we can for the young people with whom we work. For example, at the time of his father’s death, David had expressed his emotional pain (as well as visible physical pain) by a ‘squawking’ sound which was loud, harsh and disturbing. David’s ‘squawking’ subsided as he settled into his new home at Fairdon. During the period when David was using his music therapy to revisit

the complex and confusing events and feelings involved in this pivotal period of his life, he once again began 'squawking' around Fairdon. This isolated him from his housemates and caused concern for staff. We needed to respectfully and sensitively exchange enough information in order to give a context for the worrying regression, and David's 'squawking' gradually subsided again.

### *7. Supervision*

It is recognised that the supervisee will need to share work that is difficult for them. Therefore, the objectivity of the supervisor within this process is essential, in order to assist in the supervisee's development and understanding of a therapeutic relationship in which they are often deeply involved...particularly when working with the vulnerable, traumatized client group

(Lang et al., 2002, p.212).

In accordance with Health Professions Council requirements, I receive regular clinical supervision from an experienced therapist and supervisor, who helps me to understand my work and my responses to particular aspects of it (Casement, 1985; Brown, 1997; Sutton, 2002). The supervisor has an objective and analytical stance, having never met my clients in person. Through video-analysis and in-depth discussion about my own feelings as well as what the client presents, we share theoretical and practical observations that are challenging, enlightening and supportive. The separateness of my role as 'therapist' as opposed to 'support staff' at Fairdon enables me to receive and respond to communications behind a client's behaviours in slightly different ways. This sometimes involves staying with a client's overwhelming pain, anxiety or rage in ways that inevitably affect my own psychological state. Independent supervision helps to keep this process safe and manageable for myself and my clients. As such, supervision is 'an essential part of taking care of oneself in order to be able to function healthily at work.' (Lang et al., 2002, p.212). It is important that we look after our own health and wellbeing in order to provide support for the children and young people with whom we work.

### **Conclusion**

The seven issues I have discussed here are relevant to music therapists working in many different contexts, but I think they require special consideration within residential child care settings. I want to acknowledge that by choosing to ground the case studies in clinical theory, some of the two clients' unique, inspiring and endearing personal traits have been subsumed within a more objective stance.

Having recently finished work at Fairdon in order to start my own family, I realise that Fairdon felt like an unconventional but very welcoming and

supportive family within which an astonishingly complex web of relationships are facilitated. The young people are supported to maintain and cherish existing relationships with their families of origin at the same time as establishing alternative supportive relationships within Fairdon. Likewise there was a feeling of reciprocal support and mutual value between myself and Fairdon staff. After five years, leaving Fairdon really felt a bit like leaving home and venturing out into the big wide world. My warmest thanks and admiration go to the whole Fairdon family, who have had a huge impact on my development as a music therapist and as a person.

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