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The Introduction of Music Therapy for the Treatment of Toxic Stress in Young Palestinian Refugees of Lebanon

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General Index

Dedication

This study is dedicated to my Palestinian refugee community in Lebanon, which has suffered from marginalization and social exclusion for more than 70 years. I hope that my new professional profile as music therapist will help me to serve it better.

We Refugees

I come from a musical place
where they shoot me for my song
and my brother has been tortured
by my brother in my land.
...

We can all be refugees
Nobody is safe,
All it takes is a mad leader
Or no rain to bring forth food.

We can all be refugees
We can all be told to go,
We can be hated by someone
For being someone.
...

I am told I have no country now
I am told I am a lie
I am told that modern history books
May forget my name.

We can all be refugees
Sometimes it only takes a day,
Sometimes it only takes a handshake
Or a paper that is signed.

We all came from refugees
Nobody simply just appeared,
Nobody's here without a struggle,
And why should we live in fear
Of the weather or the troubles?
We all came here from somewhere.

(Zephaniah[1] 2016)

Pity the Nation

Pity the nation that is full of beliefs and empty of religion.

Pity the nation that wears a cloth it does not weave, eats a bread it does not harvest, and drinks a wine that flows not from its own wine-press.

Pity the nation that despises a passion in its dream, yet submits in its awakening.

Pity the nation that raises not its voice save when it walks in a funeral, boasts not except among its ruins, and will rebel not to save when its neck is laid between the sword and the block.

Pity the nation whose statesman is a fox, whose philosopher is a juggler, and whose art is the art of patching and mimicking.

Pity the nation that welcomes its new ruler with trumpeting, and farewells him with hootings, only to welcome another with trumpeting again.

Pity the nation whose sages are dumb with years and whose strong men are yet in the cradle.

Pity the nation divided into fragments, each fragment deeming itself a nation.

(Gibran[2] 1963)

[1] Benjamin Zephaniah (b. 1958), Jamaican poet who lives in London.
[2] Gibran Khalil Gibran (1883 – 1931), Lebanese writer, poet and artist.

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[3] National Institution of Social Care and Vocational Training: the popular name "Beit Atfal Assumoud" can be translated as "House of the Children of Resilience"

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Note to the Reader

The author, a native Arabic speaker, has written this thesis in English. The Italian version has been translated by Deborah Parker and corrected by Alberto Balducci, following the criterion of respecting the author's English linguistic style.

Similarly, the quotations not originally in English have been translated to remain as close as possible to the original text.

For reasons of privacy, the name of the child described in the clinical case study is invented, together with any other details which might lead to identification.

Details of references to publications con be found in the Bibliography a the end of the text.

Introduction

"The term "music therapy" means the research and use of various forms of relationship through the medium of sounding and rhythmic expression, in the fields of prevention, rehabilitation and therapy within "diversity".

The term "improvisation" refers not only to a technique, but also to a way of living a relationship musically. It represents a genuine perceptive capability, both in music and in relationship.

Music therapy is not about teaching clients music or how to use or play with musical instruments; it is qualified by the therapist's presence, how he supports the client in exploring these instruments and the opportunities they offer, by her/himself. The basic principle in the sessions is to encourage the client to engage in a musically expressive interaction.

The clinical environment and the therapeutic frame-work

The concept of framework is essential to good practice in all kinds of therapy, and informs many aspects, such as:

1. Space and time frames: consistency of place and regularity of sessions guarantees a vital rhythm to the work and contributes to the client feeling safe in the therapy setting. Regularity is discussed and agreed on with the client through the therapeutic contract before beginning the pathway, which establishes the nature (individual/group) and the frequency (weekly, etc). Time structuring not only creates a sense of psychological security, but also sets safe limits for the unfolding of free improvisations or other therapeutic activities, both for the client and the therapist.
2. Privacy: the constancy of the place of therapy must be complemented by the safe conditions of the room, which must be free from interruptions, without which it is impossible to build up the trust necessary for the therapeutic relationship to develop. Therapeutic work requires a great deal of concentration from both client and therapist, which must be protected from interruptions which can break trust irreparably. If interruptions do occur, the therapist invariably spends the remainder of the session feeling guilty at having failed to protect the therapy space from intrusion, or angry about the lack of respect for the therapy shown by the intruders. Such feelings provide further distraction from the central task of the session. It is important to mention that the establishing and maintenance of a safe setting is not a simple task, in particular with regard to the work environment focused on in this study.
3. Endings: if the points mentioned above refer particularly to starting a therapeutic pathway, endings are also of immense importance. Louis Zinkin writes that "*there is a great difference between bringing something to an end and just stopping*" (Zinkin 1994: p. 18.).

> Embedded in the process of therapy, as in life, is the fact that it will end. The end of treatment is not necessarily the moment at which the desired outcome is reached but, like the beginning and the middle, is an essential stage. Sometimes for various reasons, such as the unexpected travel or transfer of a client to another place, the therapy does just stop. It is sometimes possible for the therapist to repair this abrupt ending by a contact at distance with the client (written communication), especially if the latter has had no control over events, but it is also necessary for the therapist to elaborate this loss and frustration through supervision or intervision.

The music therapy approach addressed in this study uses clinical improvisation and is informed by psychodynamic theory which works on the principle that we repeat aspects of our earliest relationships, particularly those with our parents, throughout our adult life. It derives its rationale from Darwin's theory, quoted in Brown and Peddar (1991: pp. 63-4.) that humans, like all mammals, possess the capacity "*to pick up non-verbal cues about the emotional state of fellow beings so as to be able to know whether they are friend or foe*". Psychotherapy makes use of the concepts of transference and counter-transference. Transference refers to the projection of feelings from an earlier relationship into a present one. In music therapy, the therapist's experience of and response to the client's music may be considered as counter-transference.

In the music therapy approach adopted, the concept of attunement (Stern 1985) is of primary importance. We use the tactic of harmonic attunement, in which the analysers function in the same modality of alpha or beta, so that the therapist-patient relationship is experienced in as balanced and stable a way as

possible, setting the foundations for greater internal and external integration, which in turn supports more well-being. If, in a rehabilitative context (curing "from the outside"), it is more likely that exact attunement will be used, stimulating an imitative response in order to assimilate the proposal which will support the construction of self unity, in the therapeutic context (curing "from inside"), it is more probable that inexact attunement will be used, stimulating the patient to respond to the variation, thus developing the necessary flexibility for mental development (Postacchini 2014). The therapist's role is to receive and interpret the patient's communications and, by means of "inexact attunement" transform his/her response, with that minimal grade of difference which will stimulate the patient to react to something new, and therefore to employ new mental strategies.

Clinical improvisation as a method of music therapy offers a very flexible resource, affording infinite possibilities for both client and therapist. Conficoni defines improvisation in music therapy as "*a doorway, an entrance*". (Conficoni 2016).

The therapist's duty is to support the client during his/her free improvisation and to help to develop his/her music. This support is given musically through a variety of techniques, including mirroring, imitating, matching, empathetic reflecting, grounding and holding, and containing (Wigram 2004), so that unconscious elements from the client can be expressed symbolically. Verbal reflections, where appropriate, form part of the music therapy approach discussed in this study, allowing interaction between the therapist and the client to develop. During music therapy sessions, space for the patient is one of the important elements; often moments of the silence inside the session can function as powerful opportunities for the therapist to observe what happens when the music stops, and music therapists must refine their abilities to wait to see what will happen.

Furthermore, the therapist's silence supports his active listening, in comprehending and "mentalizing" meanings of the client's playing and silences.

The focus of our investigation is on improvisation as regulated by factors of primary importance, such as the musical personality of the therapist, his perceptive capacities regarding rhythm, melody and harmony, the work environment and the instruments available, the child in treatment and his/her pathology, and the close relationship which develops between these primary elements. The more the therapist is able to instil feelings of security and trust in the client, the more the reactions will be positive. And this factor is closely connected to the serenity with which the therapist manages his/her own relationship with self, with the work environment, and with the instruments on hand.

From experience I have learnt that, especially in traditional therapy, direct attention to sustained traumas can cause significant anxiety, resistance, and avoidance. In individual music therapy I find more possibilities to offer the client a safe environment, in which to express feelings related to a trauma and to tune in to the specific and culture-related needs of the client.

Non-verbal instrumental and vocal improvisation, accompanied in a respectful and appropriate way by the music therapist with close attention to the moods and needs of the client, seems to form a safe and inviting place for the expression of feelings. Because there is accompanying music, silences in playing become less tense, and intense emotional outbursts can be structured to be part of the music. The client feels supported by the music, which supports his/her mood, and new musical material and phrases reflect this flow freely and automatically.

The aims of this study

To date, no research has been conducted in the field of music therapy as a protection against toxic stress for children suffering from marginalization and social exclusion, due to severe life conditions, such as with the Palestinian refugees of Lebanon.

The aims of this thesis are to explore this topic in more detail and to include descriptions of my clinical work within the project "Music and Resilience"[4], which addresses not only music therapy, but also the broader aspects of making "Community Music" accessible to deprived and marginalised children and their families. The study focuses on the use of music therapy with children suffering from toxic stress and emotional problems, even from chronic traumatic events, as survivors in areas of post-conflict.

The thesis is divided to 5 chapters:

- Chapter 1 investigates the risk factors of marginalization and social exclusion, with particular reference to the Palestinian refugees in Lebanon;
- Chapter 2 reviews the scientific, medical and psychological aspects of the stress syndromes, as defined by the two main psychiatric diagnostic manuals (DSM and ICD) and discusses these syndromes in Palestinian refugee children in Lebanon;
- Chapter 3 provides a literature review of the publications relative to the themes of the thesis;
- Chapter 4 illustrates the application of music therapy in the Palestinian refugee community of Lebanon;

[4] For details of the project, visit: www.musicandresilience.wordpress.com

- Chapter 5 discusses the clinical case study and the analysis of data provided by clinical evaluation tools, supported by a detailed description of observations and interpretations of some specific music therapy sessions;
- The conclusions draw together these threads, together with my personal reflections.

1. The Context: social marginalization

1.1 Marginalization

Marginalization is the term used to define the situation of individuals, groups or populations living at the 'fringes' of society, segregated from the social groups at the centre of power, of cultural dominance and economic and social welfare. It is defined as:

> *"a process by which a group or individual is denied access to important positions and symbols of economic, religious, or political power within any society…a marginal group may actually constitute a numerical majority…and should perhaps be distinguished from a minority group, which may be small in numbers, but has access to political or economic power."*
>
> (Scott & Marshall 1998: p. 437.)

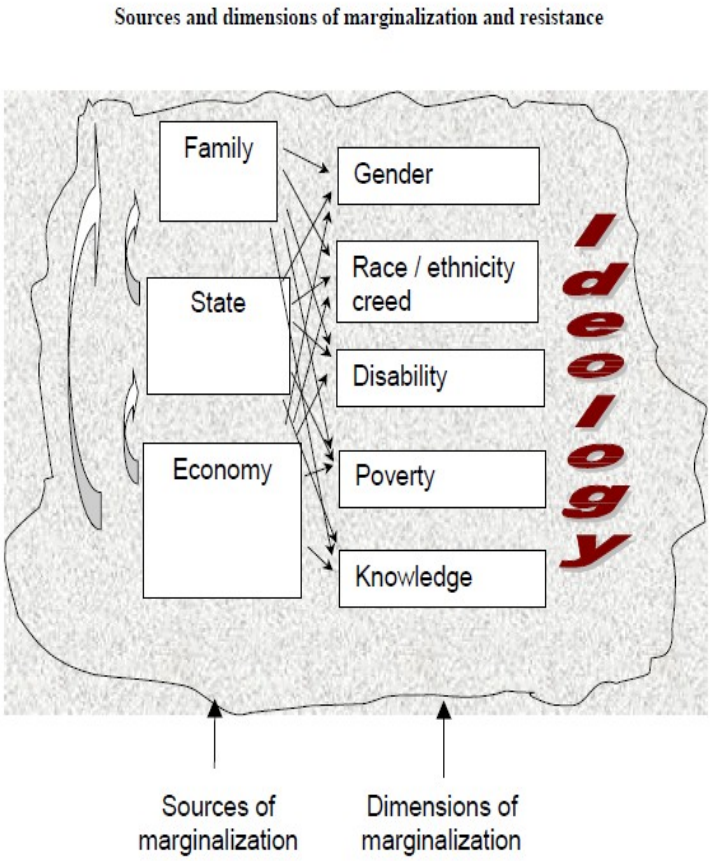
Social marginalization has become a major concern in many areas of the world during the last decades, due to the unprecedentedly negative consequences of globalization, and the world economic policies which drive this process, on millions of people's quality of life and social agency. The effects of neo-liberalism in world politics, with the resulting conflicts, famines and other disasters, have provoked mass migrations and vastly deepened the divide between the rich and the poor. Amongst the latter are millions of refugees, migrants, ethnic minorities, and other vulnerable populations. For these citizens of the world, marginalisation can mean statelessness, homelessness, lack of access to adequate education and healthcare, unemployment, deprived living conditions, and many other disadvantages. When these life conditions are protracted for long durations – in many cases over generations – the social fabric of the community and its members becomes characterised by stigma, loss of self-esteem and sense of agency, at its worst often leading to desperation manifested in inappropriate actions and, in any case, inevitably playing out its effects in individual suffering at psychological and social levels.

According to Peter Leonard, these individuals remain outside *"the major arena of capitalist productive and reproductive activity"* and are therefore victims of *"involuntary social marginality"* (1984: p. 181.). Abilities to develop resilience and coping strategies as protection against the threats of marginalization differ according to individual characteristics, such as personality and history, and are heavily influenced by the environment. Nevertheless, marginalization as a social phenomenon represents a significant

threat, both to psycho-social well-being and life quality at an individual level, and to social stability and civil development at a collective level.

1.2 Ideological Aspects of Marginalization: the culture of blame

Marginalized groups and individuals suffer not only the material, social and psychological consequences of living at the edges of the "communities in power"; they are also often negatively affected by the latter's attitude to them, which represents an attempt to delegate blame and guilt for their situation directly onto them, thus absolving the "communities in power" from any obligation to address the inequality. This attitude assigns the cause of marginalization not to external social, political or historical factors, but to biological or psychical characteristics inherent in the group itself. The group's or individual's problems are explained as inevitable, given the nature of their respective identities. This strategic stance of "*blaming the victim*" (Ryan 1976), well documented and researched in many disciplines, contributes to the phenomenon described as the "*culture of blame*" (Faber & Azar 1999), suggesting that, in the case of marginalized communities for example, the characteristic poverty is a result of inherent social behaviours which lead to a lack of adaptive capacities necessary for positive change.



Kagen et al. 2003: p. 19.

1.3 Psychological risk and protection factors of Marginalization

Marginalized groups and individuals, therefore, suffer not only from the internal life situation in which they are forced to live, but also from the stigma with which they are observed and described from the outside, often from the very groups which hold the possibility to promote improvements for them. This has devastating effects on their intimate existential being:

> *"... no matter what one has done occupationally ...[once marginalized] ... there is no way one can escape the experience of a social context that is like a stagnant pond in which we*

> *are the suffocating organisms. There is an absence of the social conditions that make optimism and hope a realistic life strategy".*
>
> (Charlesworth 2000, quoted in Kagen et al. 2003: p. 9.)

This lack of "optimism" and "hope of a realistic life strategy" lead to serious psychosocial damage, both at the collective and the individual level, affecting mental, affective and social functioning, which require attentive observation, monitoring and the development of appropriate contrasting, protection factors.

Community psychology and other community-based health interventions are of prime significance in creating protection factors against the risks of marginalization. Planning interventions in a community context avoids the danger of isolating the individual with his/her problem, and of addressing social and environmental issues with proactive strategies, encouraging members of the community to participate actively in finding the solution to the problems. "Community psychology" works with the logic of systems theory, considering the interdependence of the individual, relational and collective spheres and is thus well indicated as a tool for combating marginalization. The challenges for this discipline are to develop more refined methodologies for investigations and planning of interventions, and to develop robust networks for the sharing of best practices in a broader social context globally, in the interests of marginalized people everywhere.

1.4 The link between marginalization and health inequalities

There is a strong link, well illustrated by a large body of research from diverse disciplines, between the material and psycho-social deprivations caused by marginalization and health problems of many kinds. Health inequalities are closely related to socio-economic determinants which, in the case of marginalization, comprise low incomes, poor housing conditions, limited or no access to clean running water and/or electricity, below-standard hygiene conditions, both in the home and in the immediate surrounding environment, particularly with regard to "closed urban spaces", such as ghettoes and camps. To these must be added socio-economic determinants relating to the social sphere: lack of access to adequate education and health facilities, lack of recreational activities at all ages, lack of adequate care systems for the vulnerable members of the group (babies and children, women, especially in pregnancy and in young motherhood, the unemployed, the ill, the handicapped and the elderly). It is inevitable that these social determinants will lead to feelings of low self esteem, unworthiness, frustration, fear, anxiety and anger. Furthermore, in a world where money buys everything, poverty brings with it an immense feeling of impotence which will manifest itself in different ways along a psychological spectrum ranging from deep depression to enraged acting out. Poverty, defined as lack of both financial and psychosocial resources, is recognised as being the most significant determinant of ill health.

> *"...Human poverty is deprivation in multiple dimensions ... not just income and unemployment, but also lack of basic capabilities such as health and literacy, important factors in whether a person is included in or excluded from the life of a community".*
>
> (UNDP 1998, quoted in Schatz & Schiffer 2008: p. 7.)

The World Health Organization relates poverty to a range of risk factors affecting all areas of community and personal life, material, physical, emotional, relational and social:

> *"Living in poverty is correlated with higher rates of substance use (tobacco, alcohol and illegal drugs), depression, suicide, antisocial behavior and violence, an increased risk of food insecurity and a wide range of physical complaints. Large – and in fact increasing – numbers of people in European societies today are at risk of experiencing poverty sometime in their lives".*
>
> (WHO 1999, quoted in Schatz & Schiffer 2008: p. 7.)

The effects of marginalisation and poverty are also related to life expectancy:

> *"People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have, within their shorter lives, a higher prevalence of all kinds of health problems".*
>
> (Mackenbach 2005, quoted in Schatz & Schiffer 2008: p. 7.)

1.5 Social exclusion: the Effect of Marginalization on Palestinian Refugees in Lebanon

Social exclusion is the consequence of marginalisation. It is the situation that marginalized people have to tolerate; a situation not of their own making and one which they themselves are not in a good position to change. Social exclusion generally encompasses all life domains, economic, social, cultural, political, within the collective dimension, with profound repercussions at the personal level of psychological and physical health.

The story of the social exclusion of Palestinian refugees in Lebanon begins in 1948, year of the proclamation of the state of Israel which led to the partition of Palestine, creating hundreds of thousands of refugees, about l00,000 of whom fled over Palestine's Northern border to Lebanon.

The number of Palestinian refugees currently registered in Lebanon is given as 449,957 by the United Nations Relief and Works Agency (UNRWA) for Palestine Refugees in the East (UNRWA 2018). Lebanon's total population is given as 6,082 million (Google 2018), of which the Palestinian refugee population is therefore almost 7.4%. UNRWA also reports that the majority live in 1 of the 12 registered Palestinian refugee camps in Lebanon, all of which lack resources such as housing, education, and access to health care.

Refugee camp "Ein En Helweh" (Source: ImLebanon.org).

Many refugees also live in unofficial and non-registered settlements known as "gatherings", the living conditions of which are considerably worse than those in the official camps.

The Palestinian refugee population in Lebanon has had limited economic and social rights in the country for more than 70 years:

> *"for example, they cannot work in as many as 20 professions. Because they are not formally citizens of another state, Palestine refugees are unable to claim the same rights as other foreigners living and working in Lebanon. Among the five UNRWA fields, Lebanon has the highest percentage of Palestine refugees living in abject poverty".*
>
> (UNRWA 2018)

Lebanese laws that relegate this enduring Palestinian refugee community to second-class status may be inconsistent with international law.

UNRWA is responsible within the camp perimeters for the provision of education and health resources, and for some community services; a chronic and currently worsening lack of sufficient funding has resulted in these services being perennially inadequate and under-resourced. In addition to the exclusion from professional life cited above, exclusion also applies to the right to own property. The camps function therefore as forms of urban exclusion, intensifying the effects of discrimination at a legislative level.

Open Day in the camp of Ein El Helweh, 3rd September 2018 (Source: Tadamon 2018)

Some of the most common influences of this extreme and prolonged social exclusion on the community which forms the context for this study, and in particular on the children growing up in the camps (one of whose music therapy journey forms the focus of the case study presented on chapter 5), are clearly presented in the following table:

Origins of Social Exclusion: risk factors affecting young children

Child factors	Economic factors	Parent factors	School factors
Low birth weight Physical and mental instability	Poor living conditions	Low aspirations for child and lack of interest	Pre-school support poor or absent
Poor visual-motor skills	Rented social housing in economically rundown areas	Troubled relationships within family, especially between parents and between parents and children and family Break-up	Inadequate transition from pre-school to primary school
Poor early cognitive development	Overcrowding	Lack of adult role models for child	Home-school relations weak
Poor grasp of basic skills: reading and number work	Free school meals for children	Lack of social controls	Poor leadership
Temperamental difficulties - Hyperactivity, impulsiveness and attention (hai) disorder Agressivity, lack of attachment to adult role models	Low family income	Frequent changes of carer and parental absence	Low teacher commitment to child
Behavioral problems		Father long-term unemployed	Manual working class intake
Poor school attendance		Lone parent	Council estate intake
Low self-esteem		Parents with alcohol, drug or psychiatric problem	Poor monitoring of children's progress

(Bynner 1998: p. 22.)

All these features can be found in the Palestinian refugee communities in Lebanon and elsewhere; it is evident that for children born and growing up in such marginalised and under-resourced environments, with little or no prospects for future improvement, the risk factors for physical, mental, emotional and social development are alarming, and require well-timed and adequate responses from the care community.

2. Trauma and stress

2.1 Post-traumatic stress disorder

> *"For nearly 4,000 years, the emotional effects of exposure to extreme stressors have been recorded in historic accounts, clinical records, and in western literature".*
>
> (Figley, in Elliott 2012. p. 1.)

Descriptions of the emotional effects of life experiences which cause terror and feelings of total vulnerability, lack of any protection, and complete helplessness were first included under a variety of names in the two most authoritative medical manuals of Western medicine in 1948 (ICD-6) and 1952 (DSM-I). However, a specific and fully detailed medical definition of the physiological, affective, mental and social effects of trauma, did not appear until 1980, in the 3rd edition of the DSM, in the section of Anxiety Disorders. The motivation for this was the proposal by American psychiatrists treating war veterans on their

returning from the Vietnam war (1955-1975) for the definition of a specific disorder describing their trauma symptoms. The suggested name of "post-Vietnam syndrome" was not accepted, probably for political reasons, but also because the described clinical profile presenting in the soldiers was significantly similar to that seen in victims of other traumatic events, such as rape or natural disasters. Finally, the name of Post Traumatic Stress Syndrome was agreed upon. However, discussion about the definition and the symptoms it describes has continued, and continues to this day, provoked by the need to differentiate more accurately the many aspects of this over-generalized heading. In particular, and in relevance to the present study, the attribute "post" is not correct in situations of continued trauma, and, as will be illustrated in the discussion below, the necessity has emerged to name and describe a clearly ongoing trauma caused by the continuous existence, in cases such as that of the Palestinian refugee community in Lebanon over generations, of a state of vulnerability, without adequate protection, or the right to autonomous agency.

In 2013 the criteria for the diagnosis of PTSD were revised in the 5th edition of the DSM, which introduced for the first time a subgroup for preschool children (aged under 6), indicating that this client group is now present and necessitates attention in child health protection.

For the traditional client group (children over 6 years of age, adolescents and adults), diagnosis is indicated where there is evidence of the person having experienced a traumatic event, or "stressor" which caused signs and symptoms defined in 4 clusters: intrusion, avoidance, negative moods and cognitions, and arousal and reactive disturbances. Further criteria evaluate the duration of the presentation of

symptoms, impairment in social and/or occupational functioning, and the exclusion of other attributable causes, such as substance abuse or co-morbidity.[5]

2.2 Acute stress disorder

Acute stress disorder is caused by the experience of a number of traumatic events in succession. People suffering from this disorder take at least three days to recover from the clinical consequences which it provokes. An example would be for children exposed to many kinds of abuse or to a natural disaster.

The international classifications differentiate between acute stress disorder and stressful life events, depending on whether recovery after the stressful event or events takes only a few hours or some days. However, both daily stressors and acute stress disorder provoke symptoms similar to post traumatic stress disorder.

For a deeper discussion of this topic, we refer to the scientific resources of the DSM-5 and the ICD-11, to clarify the diagnostic symptoms, in order to focus specifically on the symptoms of acute stress disorder in relation to children, as a foundation for the clinical research presented in chapter 4.

The diagnostic criteria listed in the DSM-5 for Acute Stress Disorder (code 308.3) are divided into five sections which address: A. the traumatic event itself and how it is experienced (directly or indirectly) by the person in diagnosis; B. the categories of symptoms, divided into 5 distinct groups of "intrusion", "negative mood", "dissociation", "avoidance", and "arousal" symptoms; C. the duration of the disturbance; D. the effects of the disturbance on social, occupational or other functioning; E. the verification that the

[5] For full diagnostic details, see Prior 2015.

symptoms are not caused by other problems, such as substance abuse or additional medical problems. Specific reference is made to symptoms observable in children, such as "intrusion" symptoms of repetitive play in which elements of the traumatic event occur, or recurring nightmares, the traumatic source of which may not be apparent to the child. Furthermore, attention is drawn to children's playing which may contain trauma-specific re-enactment in a "dissociative" way (A.P.A. 2013).

The ICD-11 draft refers to this type of disease classification under the heading " Acute Stress Reaction" (code QA32.2), stating that the symptoms "*usually appear within hours to days of the impact of the stressful stimulus or event, and typically begin to subside within a week after the event or following removal from the threatening situation*" (W.H.O. 2014).

2.3 The difference between acute and chronic stress

The term "stress" is used, maybe over-used, in everyday language to refer to many different states ranging from normal tiredness to intense feelings of anxiety and even desperation. "Stress" becomes a medical, or more specifically a psychological issue when it takes on characteristics which interfere with a person's life quality, with his or her ability to function emotionally and socially in an adaptive and balanced way. In psychology, stress is defined in 2 different ways, depending on the length of time in which it affects people:

- short-term stress is defined as "acute";
- long-term stress is defined as "chronic".

In order to better understand these differences, we will consider some everyday examples.

"Acute stress" can occur often in daily life routines, caused by such events as a difficult relationship with one's boss at work, fears about taking examinations, delays in train journeys or long traffic jams for car and bus drivers and their passengers, or living in an unsafe neighbourhood where crime is prevalent. These "daily stressors" can become chronic in situations which extend for protracted lengths of time. The possibility to recover from short-term stress depends on the flexibility of mental health skills and resilience. Short-term stress affects blood pressure, heart rate, breathing rate and muscle tension, which, in resilient people return to normal levels after a short while. These positive adaptive skills are normally present in physically healthy people, especially in the young, living in good conditions. For example, the high quality living conditions of Europeans contribute to the possibility for them to find the resources the control their reactions to "daily stressors" using healthy brain functions to manage incidents of acute stress.

In less accommodating circumstances, short-term stress symptoms do not return within normal levels; the body is not able to cope with the pressure of the "daily stressors", resulting in continued "alarm rates" of heartbeat, blood pressure and breathing, which can lead to problems such as high blood pressure, heart disease, pain and depression. When the body's stress system is activated too frequently, or for a prolonged period of time, in response to persistent stimuli, this may have detrimental effects on the brain and behaviour. And when a child experiences strong, frequent, and/or prolonged adversity that overwhelms his/her skills or support, the result can create a "toxic stress" response (Shonkoff et al. 2012). Chronic stress exposure over-stimulates the body's stress system, which eventually leads to sustained

high concentrations of stress hormones even without any immediately accompanying threat, a situation that is presumed to have an adverse effect on the development of self-regulation in childhood and adolescence.

2.4 Toxic Stress

"Toxic stress" is a recently introduced term denoting the effects of chronic early childhood adversity which, in the absence of appropriate adult support, leads to less than optimal outcomes in learning capacities, behaviour and health. Responses to traumatizing and stressful events are particularly intense during the fetal period and early childhood, conditioning growth through continuous fear reactions which influence the nervous system's development. The "stressors" may be physical, emotional and/or environmental, and cause the body to prepare its stress response in one of the three recognised physiological states: fight, flight or freeze. In a growing child constantly exposed to events or circumstances which elicit fear, the prefrontal cortex becomes structurally damaged, causing the learned neural response to become generalised, even as a reaction to harmless stimuli. This has devastating effects on the child's emotional regulation and behaviour, on social interaction and learning styles. Children suffering from toxic stress will continue to show these extreme and non-adaptive coping responses even when removed from the stressful situation, unless appropriate rehabilitative care is provided.

Toxic stress in later childhood and adolescence can lead to difficulties in attention, emotional regulation and impulse control. In later adolescence and early adulthood, it can lead to hyper-arousal, particularly

of the fear response. In later years toxic stress has negative effects on ageing, and can affect emotional response, cognition and memory. Both the endocrine and the immune systems are negatively affected, with increases in the normal levels of the glucocorticoids (stress hormones).

Children with toxic stress who are not attended to medically are likely to grow up as vulnerable adults at increased risk for a high number of difficulties, disorders and illnesses affecting general and mental health, personal and social functioning and the ageing process. Shern et a.l (2014) cite studies suggesting that toxic stress may also have epigenetic consequences; if this is true, then societies living in conditions which provoke toxic stress, such as those endured by the Palestinian refugees of Lebanon, are at risk of generational transmission of this disorder. However it is also recognised that many of the adverse effects caused by toxic stress to the brain and other physiological systems can be reversed by appropriate med - ical and therapeutic treatment, thus making a very strong case for political, social and sanitary interven - tions for the prevention and treatment of this debilitating condition for human existence.

2.5 Palestinian refugee children in Lebanon and toxic stress

For more than 2 generations the Palestinian refugees of Lebanon have faced the consequences of toxic stress through not only severely deprived living conditions, but also frequent and continuous exposure to traumatic events. The fact that most camps are closed areas, the perimeters of which are permanently

controlled by the Lebanese army, evoking the effect of a large prison, represents a source of continuous and and extreme stress. The oldest members of the refugee community are the last surviving witnesses of the 1948 Israeli aggression in their homeland, causing them to flee to Lebanon and to mourn forever the loss of their homes and their state. The 2nd generation has lived through the atrocities of the Lebanese civil war (1975-90) with the terrible massacres of Tel-Zaatar refugee camp (1976), when almost 3.000 Palestinians were murdered, of Sabra and Chatila camps (1982) with nearly 4.000 deaths, nearly all Palestinian refugee women and children, and an intense period of attacks in many camps (1985-87), causing further widespread displacement.

The youngest generation has absorbed all this trauma from parents struggling to find their resilience and to protect their children from the dangers of their home environment, where no safe playing areas exist, and where schooling is overcrowded and insufficient with an average of more than 40 children in the UNRWA school classes.

An UNRWA school class (Source : Al-Quds News)

Despite a school psycho-social program introduced 4 years ago, of limited impact due to lack of specialized staff, frustration is hard to control in the classroom, bullying is common, and violent fights often break out between students.

My professional experience as a clinical psychologist in the Palestinian refugee community of Lebanon has led me to meet many parents with children who present with a lack of concentration, impulsiveness, hyperactivity and depression. In order to respond to these problems, our interdisciplinary mental health team considers the extremely hard life conditions in which the families are living, with the resulting absence of resources for the children to develop resilience. There is a high prevalence of traumatizing events, such as:

physical and emotional abuse;

- severe neglect;
- mental illness and/or substance abuse in the caregivers;
- family economic hardship, including living under the poverty line;
- exposure to a violent environment, including armed conflicts in the camps;
- families escaping from danger by leaving their homes, sometimes sleeping in the streets without shelter.

Our first consideration, therefore, is that in these cases, the "stressors" are "toxic", leaving the children overwhelmed, with no means to cope, and therefore in deep need of mental health support.

Clinical assessments of the children using the CBCL (child behavioural checklist) reveal a prevalence of the following symptoms: sleep disorders, nocturnal enuresis, sadness, fear, lack of concentration, violent

behaviour. Most of the children have witnessed at least two traumatic events in their lifetime.

The high risk factors and low protection factors for toxic stress in Palestinian refugee children living in the camps of Lebanon will be further discussed in chapter 4, with an account of how the NISCVT "Beit Atfal Assumoud" mental health team structures this support, and in particular, how it is declined in the music therapy treatment offered.

3. Literature Review: music therapy interventions for refugee children in marginalized communities

My research for literature discussing the specific subject of the use of music therapy in treating refugee children suffering from toxic stress yielded no results. It would appear that this study is the first of its kind to address this topic.

There is a very limited amount of literature addressing music therapy specifically with child refugees. An unpublished master dissertation (Oliver 2014) discusses the introduction of music therapy for refugee children in English primary schools. One chapter of a recent book (Guney et al. 2018) describes the use of music therapy with other art therapies for the rehabilitation of Syrian refugee children in Turkey. Two articles were found relevant to the specific criteria of refugee children and music therapy: one (Hunt 2005) discusses a group music therapy project for young refugees in an English school setting; the other, published in Italy (Parker 2013) illustrates the initial stages of the "Music and Resilience" music therapy interventions for Palestinian refugee children in Lebanon, which provides the backdrop for this present study.

Some literature discusses music therapy with children who are not refugees, but who live in war zones or post-conflict areas. This is the case of an article of twenty years ago (Lang & McInerney 1999), which discusses music therapy interventions for the rehabilitation of children in Mostar, Bosnia after the civil war in Yugoslavia. Similarly Diamond (2012) writes about music therapy with children in schools in Belfast, in the aftermath of the sectarian conflict in Ireland. Mercedes Pavlicevic wrote extensively on the subject, with two specific articles relating to music therapy with children in South Africa (1994, 2002). Bergmann's article (2002) discusses the use of music therapy with children who have experienced war events. Heidenreich (2005) researches music therapy in war areas, stating that most interventions target children and cites an unpublished doctoral thesis (Gupta 2000) showing evidence from Sierra Leone and Rwanda that music therapy decreases traumatization.

However, if the search is broadened out to include music interventions for refugee children or children in conflict or post-conflict areas, which are not specifically clinical, then many publications can be found. The founder of the Bosnia project, Nigel Osborne (2009) contextualizes his work within a bio-psycho-social model. Coombes (2011) writes about the training of educators and health workers in Bethlehem for the psycho-social use of music with Palestinian refugee children. Storsve et al. (2010) write about musical activity for Palestinian refugees children and youth in one of the Southern Lebanese camps, in order to preserve their identity and culture. March (2017) writes about projects promoting the well-being of immigrant and refugee children through musical activities in Australia, UK and USA.

Other publications address the use of music psycho-socially and culturally in general, or with adults,in populations suffering social deprivation and marginalization, without focusing specifically on children.

This wider field is outside the scope of this study.

The literature found shows that music and music therapy are being used to care for, support and rehabilitate children of populations affected by wars. However, there is a lack of specific studies and researches investigating the effectiveness of music therapy in the treatment of children suffering from the effects of chronic toxic stress due to their prolonged refugee status and the intolerable conditions in which they are forced to live. The Palestinian refugee population of Lebanon is sadly the record-holder in bearing these conditions, now for more than 70 years. It is hoped that more literature will be published about music therapy and toxic stress, in order to alleviate the suffering of their children and all refugee children everywhere in the world.

4. The application of music therapy in the Palestinian refugee community of Lebanon

4.1 The work context: the 4.1 National Institution for Social Care and Vocational Training and the Palestinian refugee camp dwellers

I have worked for 8 years as a clinical psychologist, and for 6 years as a music therapist, with the Palestinian NGO NISCVT "Beit Atfal Assumoud" (Assumoud), which offers services to Palestinian refugees and other poor people, without distinction of nationality, creed or political opinion. Assumoud offers Mental Health (MH) services through its Family Guidance Centres (FGC) situated in, or near to, the camps. The services are virtually free of charge; Assumoud recovers 90% of the costs from funds donated by state and private organizations from around the world, and only a symbolic 10% is requested from the families. The multidisciplinary MH team in the centre where I work consists of psychiatrist, psychologist, psychomotor and speech therapists, music therapist and social workers.

The work context is characterised by many difficult circumstances, in particular due to the client population of marginalized and suffering people, whose daily life conditions are in a state of constant tension because of their social isolation. The security situation of their immediate environment is at high risk, often leading to episodes in which children and their parents are confronted with shocking or traumatic events.

Most parents do not have a stable job, and, despite the fact that a number of them have good education to a high level, the majority can find employment only in unskilled labour, such as construction work. The resulting economic hardship means that, amongst other deprivations, the children have no possibility of having their own games. Furthermore, the refugee camp environments are totally lacking in safe places to play, without sports fields or recreational spaces for young children, leaving no choice but the dirty, narrow alleyways and streets as play spaces.

Children playing in one of the refugee camps: the swing is a temporary attraction during one of the Muslim festive periods (Source: Al-Quds News,2017)

Many of the children who attend the FGC mental health centre are suffering from the effects of having experienced traumatic shocks, due to armed conflicts which flare up inside the camp perimeters periodically. Not all of them will have seen the fighting directly – those that have bring with them the trauma of seeing wounds, blood and maybe death – but certainly all will have heard the sound of bombs and shooting.

Considering this environment, the most prominent signs and symptoms the children present are best understood as reactions to the chronic anxiety in which they live. They are suffering from sleep disturbance disorders with nightmares, agitation and lack of concentration at school, in addition to an underlying and pervasive anxiety separation.

4.2 The introduction of Music Therapy

Music therapy was introduced in 2012 with the aim of experimenting alternatives to the traditional therapy services, such as speech therapy or psychotherapy, in order to better support the children in the development of more resilient and adaptive coping strategies. This was made possible through a partnership established with an Italian No-profit organization, Ulaia ArteSud (Rome), and the setting up of the International Cooperation project "Band Without Border", and with an Italian community based organization, Prima Materia, from Montespertoli (province of Florence), and the setting up of the International Cooperation project "Music and Resilience". The project provided the professional expertise for the initial training of NISCVT staff and support in clinical start-up, and guarantees continuous supervision and further training. The supervisor and principle trainer is Deborah Parker, who obtained her first diploma in the Assisi school of music therapy, and subsequently a master in music therapy at Anglia Ruskin University,

Cambridge, UK. Parker's clinical model is psycho- dynamic and works through improvisation. In addition, other trainings were offered by visiting professionals from Europe:

- Davide Woods (Italy), improvisational music therapy informed by psycho-analysis;
- Herbert Walter (Germany), oriental music therapy;
- Dr. Mercedes Pavlicevic and Dr. Simon Procter (UK), Nordoff-Robbins music therapy model.

My training has continued through the 4-year study course at Assisi, leading to this thesis.

After an initial intensive training in Beirut, the start-up of clinical work in the centre where I work was structured for children referred by the psychiatrist, with weekly individual sessions for varying periods of time (from 6 months to 2 years). After 2 years of training, due to very long and increasing waiting lists, the MH and music therapy teams decided to experiment with short-term group music therapy for traumatized children, structured in 12 weekly sessions, and with the specific objective of reducing anxiety and reinforcing social competences. In preparation for this new articulation of music therapy, the team was trained specifically in the techniques of working in a therapeutic team of therapist and co-therapist. The short-term group music therapy proved to be effective in preparing children who needed to enter the more traditional therapies (speech, psychomotor) to be able to access with more success the benefits from these therapies, subsequent to their music therapy cycle.

This short-term therapy model is now applied to all cases, offering from 12 to 16 sessions of music therapy, after which each case is assessed by the MH team for subsequent treatment.

General objectives for music therapy interventions are defined as follows:

- Social objectives:
    1. the reintegration of isolated and withdrawn children into social relationships;
    2. the promotion of subjective experience of organization and structure;
    3. the establishment of a meaningful relationship between the internal body rhythms and the external rhythms of personal interaction, leading towards the broader patterns of cultural activity.
- Psychological objectives:
    1. mood improvement and stabilization;
    2. promotion of self expression;
    3. reduction of unhealthy stress;
    4. regulation of arousal status.
- Cognitive objectives:
    1. improvement of communication;
    2. improvement of spatial logic;
    3. improvement of memory;
    4. improvement of attention;
    5. improvement of executive functioning.
- Physical objectives:
    1. sensory stimulation;
    2. motor integration;
    3. mood-related physiologic response, such as heart rate, respiratory pattern, blood pressure;
    4. reduction of pain and other symptoms (e.g. vomiting).

4.3 The Assumoud MH referral system and referral to music therapy

Children arrive at the FGC with their parents who are concerned about some issue, or have been advised to come by school teachers, social workers or other community workers. The psychiatrist meets the family, takes the anamnesis and starts the first medical evaluations of the child; reports from school teachers are also collected by the social workers, where this is appropriate. This leads to a preliminary hypothesis of diagnosis, which is discussed with the MH team during the weekly meeting; information and evaluations are shared, and, if required, further specific tests are planned, depending on the child's needs with referral to the relative specialists. When evaluation is complete, the team meets again to verify the diagnosis and to structure the treatment action plan.

This process includes also referral for music therapy, during the MH team discussions, for those children who the team feels can benefit from this therapeutic pathway. In addition, however, children are sometimes referred to our centre by external health professionals – psychologists or psychiatrists, who have followed the NISCVT annual conferences on mental health – specifically for music therapy, given that the Assumoud FGC is the only centre offering this kind of therapy.

Referrals to music therapy are made for children who have been diagnosed with:

- Trauma or PTSD;
- Psychological problems, such as depression, anxiety, ...;
- emotional problems;
- Behavioural problems, such as conduct disorder, withdrawal, ...;
- Learning difficulties;

- speech delay;
- intellectual disabilities;
- Autism and Rett syndrome;
- physical handicaps.

4.4 The music therapy pathway at the FGC

The music therapy treatment pathway for a child begins with a meeting with his/her parents, to explain the potential benefits of this kind of therapy and to gain their consent for this referral. This is particularly important for a therapy which is little known in Lebanon, and which uses music, which in some interpretations of Muslim culture is regarded "negatively". During this meeting, the parents who give their consent are asked to give their full support to the child's attendance at every session.

They are also asked to sign a consent form permitting video recordings of the sessions for the exclusive scientific reasons of supervision, evaluation, study and research; the form states clearly that the child's privacy will be fully respected.[6] We consider that video recording is important as an excellent tool for the observation of the interaction between therapist and client. In particular, for the purposes of supervision, study and research, the video documentation supports detailed observation and reflection focused on the therapist, in order to investigate fully the counter-transference feelings.

As in all therapies effected in the FGC, before beginning treatment, careful consideration is given to the anamnesis, the diagnosis, the MH team's discussions and the parents' thoughts and statements. The first

[6] See Appendix 7.1 for music therapy video-recording consent form.

2 music therapy sessions are conducted, video-recording one of these for IMTAP evaluation[7], which helps to inform the therapist's observations and preliminary assessment, together with the protocol notes taken after each session.[8] In this way, the therapist is able to set the action plan for the remaining sessions.

Regular feedback about how the therapy is progressing is shared with the MH team in the weekly meetings; through discussion with the other specialists, the music therapist is supported in adjusting and regulating the goals and strategies, in order to serve the child's needs to the best of his capacity. Feedback is also requested from the parent who brings the child, before each session; has anything particular happened that week, which may have affected the child's physical or emotional state, that the therapist should know about? Has the parent noticed changes at home? Has anything been reported from school? Parents are often involved themselves in regular meetings for follow-up about the child in therapy. These are occasions in which the therapist can council the parents, and share feedback from his observations of the child in music therapy with them, in order to inform their picture of their child, offering them a new aspect which may positively influence family functioning.

In addition to the MH team support at the FGC, Assumoud's music therapists also meet regularly once a month, centrally in the Beirut FGC, for a day's intervision. These meetings are structured with time for warm-up exercises (breathing, listening, improvising, or other activities proposed by group members), monitoring of each centre's progress with music therapy, presentation of clinical cases for review and discussion, and organizational or administrative updating. The intervision pathway assures a supporting

[7] Individualized Music Therapy Assessment Profile. see chapter 5.4 for detailed discussion.

[8] See Appendix 7.2 for template of music therapy observation protocol

and caring process for the music therapists themselves, which is of fundamental importance for their own psychological and emotional health with regard to the patients they are treating.

As children finish the music therapy cycle, a final video-recording is made, for IMTAP analysis and comparison with the earlier assessment. A case closure report form is completed which remains in the child's medical folder.[9] The MH team then decides how care for the child should continue. For children who have left the clinical environment of music therapy, but who show a desire to continue with music, referral is made to the Centre's Community Music group. Here they can choose an instrument to play and participate in weekly group rehearsals, workshops, and eventually concerts and other community events. These children are followed carefully in their progress in the Community Music group by the FGC's social workers, who liaise with the music teachers and the music therapist/psychologist.

4.5 The Research Project

In 2016 the MH and music therapy teams of Assumoud decided to formulate a small research project for the period 2017-19, in order to investigate clinical evidence for a specific hypothesis: music therapy is an effective therapeutic method in lowering anxiety levels in children suffering from the effects of stress and trauma, and in strengthening their self-esteem and sense of agency, thus contributing to the development of their resilience and increasing their abilities to respond positively to subsequent treatment programs.

Inclusion and exclusion criteria were set to select Palestinian refugee children from Lebanon aged 7-11, with a preliminary diagnosis of depression and mood disorders. 23 children, between the three FGCs

[9] See Appendix 7.3 for music therapy closure protocol

offering music therapy, met these criteria. These children were given 16 weekly 30 minute individual music therapy sessions, which were monitored to measure the impact of music therapy on their emotional and social functioning, through the following data collection protocol:

- pre- and post- psychiatric evaluations:
    1. Children's Global Assessment Scale;
    2. DSM-V diagnosis;
    3. Visual Analogue Scale.
- pre- and post- evaluation of Child Behavioural Checklist (carried out by music therapist or social worker, with parents);
- IMTAP assessment of video-recorded session n°1 or 2 and n°15 or 16, in 3 domains:
    1. emotional functioning
    2. social functioning
    3. musical functioning;
- music therapists' clinical notes and observations;
- writing of 6 case studies, as examples of the experimental group.

Publication of the research is programmed for 2019, with a first presentation at the NISCVT Annual Conference on Mental Health in Beirut, October 2019.

The child whose case study is presented in chapter 5 is one of the children in the research experimental group.

4.6 The challenges

As therapists and mental health professionals working in this very particular context, it is necessary to bear in mind always a number of factors affecting the children and families who come to our centres asking for help:

1. Stigma: within the Arab communities in Lebanon in general, including the Palestinian refugee community, there is a very great sense of fear and shame in needing to ask for help from a MH centre. A large proportion of parents with children who may have psychiatric problems refuse to request or receive psychological treatment, despite the difficulties that this lack of support creates for them. Mental illness and psychological disorders evoke intense social stigmas, caused by the negative way in which persons who suffer from these problems, and their families, are considered as "different" to the rest of "normal" society, thus increasing their position of marginalisation and exclusion.
2. Religious culture: some interpretations of Islamic religion regard the practice of music as a potential danger to cultural identity and integrity. This leads some parents to express feelings of discomfort and fear regarding the use of music as a means of help for their children.
3. Safety and danger: the situation of the Palestinian refugee camps surrounded by Lebanese army guards represents an external risk factor which often affects the course of therapy. Moments of tension and unrest in the camps result in difficulties, maybe even the impossibility, for children

and their parents to move inside the camp, or to leave the camp area in order to access the Assumoud MH centre. The result is a disruption in the continuity of the therapeutic pathways.

4. Disruption due to family events: continuity of therapy is also often put at risk by family events such as illness or death of a family member; escape from Lebanon to other countries by one or more family members; circumstances obliging the family to transfer to another camp in the country, and so on.
5. Inflexibility of the UNRWA school system: the timetabling of therapy interventions is further complicated by the lack of flexibility from the UNRWA school system, which does not tolerate children being absent from lessons in order to attend therapy sessions.

4.7 Responding to the challenges

The MH teams have developed protective strategies in response to the difficulties of stigma and religious cultural fears. Much time is devoted to meetings and presentations with parent and community groups about mental health in general and in particular about the therapy pathways. Where music therapy is concerned, the Assumoud music therapists are very careful to respect the defensive attitudes about music and Islam, and to explain clearly to the parents and children that music in therapy is used primarily in its function as a means of non-verbal communication, and is therefore a clinical tool, similar to all other therapies. An attitude of tolerance is adopted for all external risk factors which disrupt the interventions, and as much support as possible is given for parents to try to follow the session timetable with their children as regularly as possible.

Over the years, feedback from parents about their children's progress in music therapy has been largely positive. The parents are happy with the information they have been given about this therapeutic discipline, and are able to see improvements in their children's self esteem, coping strategies and adaptive capacities. Most importantly, they report how much their children enjoy the music therapy sessions, and how this happiness remains after the session has finished, supporting a marked improvement in the children's mood, the repercussions of which clearly affect not only the families, but also the wider community.

5. Case Study

The child discussed in this case study lives with her family in one of Lebanon's "largest" refugee camps; the adjective "large" refers not so much to the size of the camp, just 1.7 km², but to the number of people living in this space, which is estimated at 85.000. This immense number includes the relatively recent influx of Syrian refugees and Palestinian "2-time" refugees from Syria.

Rim is an 11 year-old Palestinian refugee girl, whose family moved from Syria to Lebanon in 2011, at the beginning of the Syrian crisis. At that time her father disappeared and the family has never had any subsequent news about him; where he might be, or even if he is still alive. Rim is the third child in her family, she has two older sisters aged 16 and 14 and a youngest brother of 8 years old. After they moved to Lebanon, the family faced heavy economic difficulties, and no income was guaranteed. The mother tried to find work to support her family, but this is inevitably precarious, temporary, irregular and low paid. The family therefore depends in part on charity donations from NGOs.

When she came with her mother to our mental health centre she was in grade five at one of UNRWA schools in the area. Her brother was being followed by the psychologist at the centre for learning

difficulties and behavioural disorders. The main request of Rim's mother was for help in dealing with some aspects of her daughter's behaviours, mainly her rejection of rules at home and school, and her poor communication with her siblings and mother, her sadness, withdrawal and frustration. Rim was reported to be usually violent with her youngest brother.

Rim was assessed by the interdisciplinary MH team and was diagnosed by the psychiatrist at the centre with moderate depressive disorder, affecting her overall behaviour with impulsiveness traits. Her mother, also followed by the psychologist is diagnosed with depressive disorder. Rim's uncle is schizophrenic and periodically lives with the family in the same one room house. This creates another source of distress for Rim and all the family, and a much more complicated dynamic due to the uncle's behaviour.

Following her mother's consent, Rim was referred to music therapy with the main objectives of:

1. decreasing her depressive symptoms;
2. developing her resilience supporting recovery from her trauma;
3. improving her control of her behaviour at home and in school.

Rim followed 16 sessions in music therapy, showing from the first session the capacity and motivation to respect the space and time of the therapy. Her interaction during the first phase was limited, despite the positive and co-operative attitude with the therapist. She was not showing any kind of challenging behaviours or weakness of communication, but she was rather receptive, reluctant to take initiative or to improvise during the music therapy sessions. Within the sessions however, she showed a good capacity to

follow instructions and to react positively, but this behaviour was not seen outside the setting of music therapy.

In the first sessions Rim improvises on the piano, but her music is not interactive. She tends to repeat the same rhythm and the same musical lines. She is always using the guitar and the piano as her favourite instruments. Rim developed her improvisation capacities during the sessions and became more ready to interact with me as a therapist especially after the fourth session.

After each session Rim was given 10 minutes for verbal exchange to help her speak about things that caused her discomfort. The music therapy intervention with Rim helped her not only at a psychological level, but also helped to highlight her strengths and to develop her communication skills. Working through rhythm and improvisation increased her capacity to listen to others and to respect turn taking.

Despite the limited period of the intervention there was a positive impact on the child's personality. Music therapy in my opinion helped to alleviate some of the depressive symptoms and allowed a better adaptation on Rim's part to her environment and her situation.

Towards the end of the music therapy cycle, Rim's mother reported that her behaviour was much more adaptive and appropriate, both in the home and in school. She is now able to express her emotions verbally, and generally communicates with, and reacts better to, others. At school no educational problems are now reported, apart from some attention problems and lack of concentration. Rim is making friends and has even been elected as the class representative. In our opinion, the mother's involvement and cooperation was very important for the achievement of the objectives set for the music therapy intervention.

5.1 Analysis of the music therapy process with Rim.

Music in music therapy can inform the therapist about interaction and emotions, supporting the achievement of therapeutic goals. In this context, music is a modality of expression and communication. The focus is not on whether the client is playing "the right" note, but "how" s/he is playing, and how the improvisation is developing. The client reacts within the music medium, with rhythm and melody and with other musical elements, and the therapist reflects on what kind of needs these expressions evoke.

In order to illustrate the music therapy process with Rim, two sessions will be discussed in detail – the second and the fifteenth (penultimate), based on the therapist's protocols written after each session. Following this, the pre- and post-CBCL evaluations will be presented, and the 2 Individualized Music Therapy Assessment Profile (IMTAP: Baxter et al., 2009) evaluations of the second and fifteenth sessions will be discussed, thus providing both qualitative and quantitative evidence of Rim's music therapy journey.

5.1.1 The second session

The therapist's protocol records the date of the session and the length, which in this case was 30 minutes. The instruments made available, providing opportunities for both rhythmic and melodic improvisation, are: guitar, digital piano, drum, harmonica, hang-drum and glockenspiel. Details describing the child's reactions observable to the therapist are recorded in a table, as below:

Posture	Tense, body position looks uncomfortable
Changes in posture during session	Gradually becomes a little more relaxed, breathing better
Expression / communication *(vocal/verbal/non-verbal ...)*	Non-verbal, body language, virtually no verbal expression, only a few words at the end.
Sensations of therapist *(heaviness/lightness/warmth/cold ...)*	Heaviness, tension, confusion

A second table records the therapist's description of the music improvised:

Tempo and rhythm *(pulsed/free-flowing; fast/slow/moderate; steady/erratic; getting faster/slower ...)*	She plays with a frequently changing and unstable rhythm; her tempo is fast and erratic. Only at the end, a short phrase in moderate, stable tempo.
Pitch and melody *(high/medium/low register; tonal/modal /atonal ...)*	She was playing randomly, single notes, chords, clusters, glissandi. On glockenspiel, same way with beaters, also hits table top sometimes.
Intensity and dynamics *(loud/moderate/soft; getting louder/softer; accentuated/gentle ...)*	Unstable intensity, mostly loud, sometimes responds to my invitations to play more softly, but generally uses loud, uncontrolled dynamics.
Timbre and texture *(sound qualities: heavy/light/open/closed ...)*	Closed, heavy, dense, rough, hard.

The therapist sits at the piano and invites Rim to choose the instrument she would like to play on; she comes to join him. He is sitting on the left-hand side (low register) and Rim takes her place on the right-hand side (high register). The first improvisation is 15 minutes long. The therapist begins to play, offering a short phrase as an invitation to the child to join him; when he stops, she begins to explore and soon

finds a simple, rhythmic structure. The therapist listens, but soon Rim stops. The therapist offers another short phrase, and again, when he stops, Rim plays another short phrase. She is unable at this stage to sustain her music, so a kind of dialogue develops. It is very evident that Rim is unable to take initiate on her own. She needs the therapist's encouragement to take her first, cautious musical steps, stopping each time and waiting for him to "show the way". After three minutes, the therapist takes the risk to start playing with her and a duet develops. They play together, but Rim plays without initiative. She is dependent on the support from the therapist. The playing is not organised, with random material which has no fixed pulse or shape. There are no real points of meeting between the two players. There is no verbal communication or direct interaction; Rim's attention and gaze are focused on the piano. The therapist's playing is participatory, attempting to promote interaction with the child; at this stage, this behaviour is maybe too insistent, probably because he is, unconsciously and impulsively, trying to help her. For him, the chaotic sensation created by the music is associated with the sensory chaos when we need to release stress.

After 5 minutes this chaos begins slowly to subside and the music becomes more harmonious, despite continuing to vary in tempo between the therapist's attempts to slow down the tempo and create some space, and Rim's need to play fast and fill the space randomly. At minute 7 Rim's speed begins to slow down definitively, coming to a complete silence, which the therapist respects, and which lasts for 17 seconds.

At minute 8[10], after the silence, her style of playing changes, slowing down, with a softer texture. She appears more comfortable, maybe she begins to acknowledge the safe environment, and is more able to

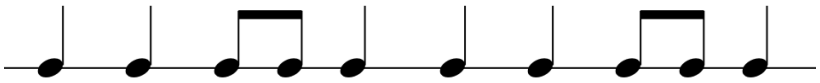
[10] Audio track 1 (see attached CD)

react to the therapist's improvisation, with more awareness regarding interaction, and more active listening, but this moment is very short.

At minute 9, again, she listens and tries to match his rhythm and melody. There are some moments of synchronicity, based on the therapist's slower tempi, but they last only for a few seconds each time; Rim always "escapes" by accelerating her tempo into her characteristic random and chaotic "rushing", experimenting now also with the palm of her hand on the keys, and even her fists. There is a sense of catharsis of anger and maybe this is the first time that she is able to experience liberty to play as she likes in the presence of a caring adult. At minute 10 there is a second silence, following which Rim's finger movements on the keys seem less tense. After 15 minutes, the therapist decides to bring the improvisation to a close; he moves to another area of the room, towards other instruments and Rim turns, following his movements with a slight smile. He invites her verbally to come to choose another instrument, and she follows.

The second improvisation takes place at the table, which is brought close to the piano.. Rim plays the glockenspiel and the music therapist, sitting at right angles to her to avoid the direct confrontation of being face to face, which at this stage he retains too threatening for the child, plays the hang-drum. Significantly, Rim begins this improvisation; her music is similar to the first improvisation, random and unstable rhythmically; the therapist supports Rim's explorations quietly, with a very light texture on the hang-drum. His choice of this instrument is strategic; it is in the same timbre group (metal), but the low resonating sounds of the hang drum provide a stable bass evoking space, in contrast to the brighter and more brilliant, higher-pitched sounds of the glockenspiel. Despite repeated attempts at slower, more stable accompaniments, he is unable to "ground" her. In this improvisation, which lasts 6 minutes, Rim

begins to look at the therapist, sometimes smiling. Towards the end, she puts down her right-hand beater, then swaps the left-hand beater to her right-hand, and with her left hand begins to play on the bass register of the piano at the same time as on the glockenspiel. It is as if she is experimenting with "taking in" some of the elements she has heard from the therapist (the father figure) in the first improvisation. The improvisation comes to a stop. After a brief silence, the therapist begins to play alone on the hang-drum. He plays for forty seconds, in a moderate tempo, using a stable symmetric rhythm in four quarter-notes with eighth-note divisions:



Hang-drum rhythm

For the entire time, Rim sits, looking directly at him, smiling and listening. After he stops, they sit in silence for ten seconds, and then Rim picks up one beater in her right hand and for the first time plays a stable, regular melody in scale form, first descending and then ascending on the white notes of the glockenspiel. The melody is organised and structured; it lasts only for 20 seconds, before she begins to resort to her more random playing, accelerating the tempo, and playing again with her left hand on the piano in the bass register. The therapist joins her for a final short sequence. They sit in silence looking at each other, and the therapist announces the end of the session. Rim is cooperative in helping to tidy up the instruments.

As the music therapist, reflecting after the session, it was hard to face this child, knowing her situation, and to work with her through the musical medium, without words. I was fearful about my capacity to

help her through music, since I do not have a formal music training. In addition, from fantasizing before the session about how it would be, my expectations were raised to hope that it would be joyful with a lot of interaction; but in fact the difficulties were disappointing to me and I felt perplexed about the psychodynamic approach in music therapy compared to that in my more usual psychological therapies, using words. But soon I started to focus on accepting the situation, and on respecting Rim's style of playing. I told myself that we had only just started, and I reminded myself about my role for supporting her; my duty was to find a place for myself in company with her.

I then recognised my own feelings of confusion when Rim came to sit beside me at the piano, so closely, without direct communication. My interpretation of this is that she was looking for a situation of safety, testing and trying out the relationship of trust between me and her. I wondered if she misses the father figure.

Through her music, Rim was able to express her anger openly, and to experience another person tolerating and sharing her emotion. This is very important in situations where she is unable to describe verbally her inner experiences. In the moments of silence, I perceived fear, maybe because silence increases Rim's anxiety and she tries to avoid this. Perhaps this explains how few pauses and silences there were in this session. In these early sessions, it seems that music offered a medium in which Rim could "keep moving" (avoiding silence), without having to use verbal communication, so that she could express her emotions in a less direct way, without being pushed.

So in this session I think I met my own anxiety at a level similar to hers, because I do not have the secret key to heal her psychological wounds. My confusion was induced by wondering whether what I was doing was right or wrong, whether I was leaving enough time, whether I should be doing something else,

and so on. It took time for me to realise that impulsiveness in my playing in this session was due to my deep desire to "play with" Rim all the time; this led me maybe to not give enough space to her, for the expression of her emotions through music. My attention was focused on taking her to a safe zone, but she was not yet ready for this; this was only the second session, with another 14 sessions to go. The professional framework and methodology of music therapy comes after a long time of practice and supervision.

As a psychologist in this situation, I would have behaved in a different way, since the therapeutic process depends on verbal communication and considers the symptoms in a direct way, whereas in music therapy the dynamic is different. We play music symbolically, without any verbal communication, and we try to find solutions to problems through the improvisation, providing help and support in an indirect way within the therapeutic relationship.

5.1.2 The penultimate session

The therapist's protocol records the date of the session and the length, which in this case was 31 minutes. The music therapy environment is coherent with that of the previous sessions; there are some small variations in the instruments that are made available: guitar, digital piano, tambourine, and log-drum. Rim plays the guitar; the therapist plays the digital piano. The child's reactions, observed by the therapist and recorded in the protocol table are as follows:

Posture	Comfortable, relaxed body
Changes in posture during session	Moving freely without tension
Expression / communication *(vocal/verbal/non-verbal ...)*	Verbal and Non-verbal, body language
Sensations of therapist *(heaviness/lightness/warmth/cold ...)*	Warmth, lightness

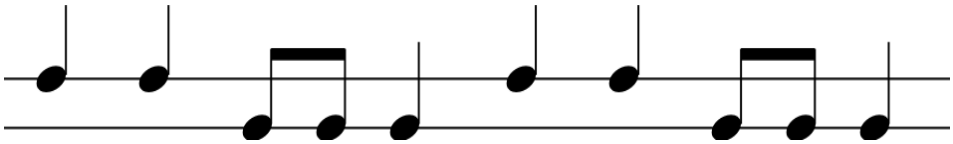
The therapist's description of the music improvised records the following characteristics for this session:

Tempo and rhythm *(pulsed/free-flowing; fast/slow/moderate; steady/erratic; getting faster/slower ...)*	Her tempo and rhythms are stable but flexible; her tempo is moderate and free-flowing
Pitch and melody *(high/medium/low register; tonal/modal /atonal ...)*	She was playing freely, often chords with one hand, alternating, sometimes clusters, and some glissandi up and down.
Intensity and dynamics *(loud/moderate/soft; getting louder/softer; accentuated/gentle ...)*	Stable intensity, mostly moderate, sometimes responds to my invitations to play more softly, and more dynamic.
Timbre and texture *(sound qualities: heavy/light/open/closed ...)*	Light, open

At the beginning of this session, the therapist promotes a verbal exchange with Rim to remind her that they are nearly at the end of their music therapy work together. This subject has already been introduced in the fourteenth session. The way the music begins in this penultimate session is of great significance with respect to how far Rim has moved during the cycle.[11] She is the first to sit down, on a chair at the table, picking up the guitar. She is smiling all the time and serene and she moves gently and flexibly.

[11] Audio track 2 (see attached CD)

The therapist then takes his place at the piano; their positions are still at right angles to one another. There is a silence of forty seconds, broken only by the therapist asking Rim: "jehzen?" ("ready?"). She responds with a small nod, but still remains in a reflective silence. After six seconds she intensifies her smile directly to him, and gently plucks one string of the guitar, as the beginning of the same rhythmic cell which the therapist used in his hang-drum solo of the second session[12]:



Guitar rhythm: the upper line represents the highest string of the guitar, the lower line the lower strings strummed together

Gently the therapist joins her, and they begin to improvise together, in synchrony. The tempo readjusts between them, becoming very slightly faster to reach a comfortable and light sensation. Rim's playing is organised, and she often responds to what the therapist is doing. The interaction is direct and attuned; Rim's attention is directed at her interaction with the therapist and she is focused on playing harmoniously. The improvisation, which lasts for twenty minutes, has a dreamy, floating quality. Many times the therapist stops to listen and to leave the child her space, which she is happy to take, glancing at him in a relaxed and secure way, smiling. She expresses no need to evacuate chaotic feelings, and is content to maintain her gentle accompanying figure, with small variations contextualised within the regular rhythmic framework. She can accept and support the therapist's occasional delicate, mirroring melodic phrases, which add colour and interest to the musical development. This is motivated by the therapist' strategy of deep listening to be able to match her style of improvisation, and to sustain Rim's

[12] Audio track 2

concentration on what she is playing so that she can develop this. Both the therapist's and the child's playing is participatory, supporting reciprocal interaction; this is an indication of how much the psycho-dynamic relationship has progressed by this stage.

The improvement in Rim's attention and concentration can be seen in the CBCL and IMTAP results. Her ability to concentrate is associated with reducing her impulsivity, and building a feeling of safety, which in turn reduces anxiety and helps to develop the therapeutic relationship. Taking the initiative in impro-visation indicates liberation from the idea of subordination to the therapist, and helps Rim to experiment with her leadership skills.

After 4 minutes a musical dialogue develops, in which Rim participates with awareness, sending and re-ceiving messages in an socially appropriate way. Both therapist and child are relaxed within the harmoni-ous flow of flexible tempo which varies from fast to slow.

At minute 6, she is able to respond to the therapist's rhythmic phrases by mirroring and imitating in a playful way. Her ability to tolerate the changes in the quality of music, moving between fast and slow tempi and between loud and soft intensities, indicates that she is more flexible in adapting to these changes; she no longer feels fear or frustration when things change and does not need to resort to de-fensive rigidity.

Within this session, her musical behaviour is characterised by interaction and curiosity, taking initiative, involvement and sharing, and leadership. She is focused on listening, waiting and respecting her role. Her capacity for adaptation, in order to harmonize the improvisation, indicates the building of a secure inter-action in the relationship with the therapist.

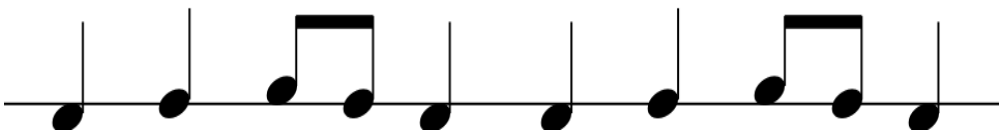
At minute 9:00 she begins to use both hands on the guitar, copying the therapist's rhythms with varied articulations, from single strings to strumming more stings together.

At minute 9:25 there is a short silence of 3 seconds, after which Rim develops a solo improvisation. She is able to play alone for two minutes, supported by the therapist's attentive and respectful listening. This solo is characterised by a moderate tempo, gentle intensities and solid structure.

At minute 12:00, playing again with the therapist, Rim is able to catch and match the therapist's tempo and rhythm, playing synchronically with him, with focused concentration. There is a feeling of space, in which she is able to express her emotions through the music. The ending of the improvisation is also very significant; child and therapist bring the music to an end together, with a final soft descending glissando from the therapist at the piano answered by a final single strumming of the guitar strings by Rim. Then follows a relaxed and reflective silence of sixteen seconds, with exchange of glances and smile between the two. The therapist breaks the silence, inviting Rim if she wants, to put down the guitar, which she does, slowly and gently.

She moves to join the therapist at the piano, sitting down to his right, at the higher register. The therapist proposes some melodic phrases of 3 and 4 notes, with varying rhythms, to which Rim responds, matching the changes of tempo and rhythm adaptively.

At minute 25:00 the therapist goes to pick up the guitar and returns to sit at the piano beside Rim, who continues at the high register of the piano. At this point, she begins to lead the improvisation, at first exploring to find the musical expression to her liking, and then, after 22 seconds, using again the familiar rhythmic cell, to play a melodic phrase using three consecutive tones:



Piano melody

The therapist follows her pulsation, strumming the strings of the guitar in support. For 5 minutes the improvisation develops, first with variations on the rhythmic and melodic material, a then rising to an exciting and jubilant finale with accelerated tempo and higher intensities, in a joyful ending. The loud and fast music is now structured and synchronous, very different from the chaotic, random quality of Rim's isolated and cathartic playing in the second session.

At the end of the session, the therapist initiates a goodbye song, to which Rim joins her voice in a reciprocal greeting. As in all the sessions, after finishing, the therapist gives an opportunity to Rim to talk, to express feelings or tell him anything she wants. Her newly developed ability to inhabit the musical-relational space in a relaxed and secure manner is also tangibly evident in her growing ability to talk about her experiences and reflect on them without tension. It is as if the musical improvisations have helped her to recollect her memories and her self-awareness.

As the music therapist, reflecting after this session, which formed part of the preparation for ending the therapy pathway, my attention was directed to the separation process, and in turn to my concerns about what would happen after the completion of this treatment, and which feelings would be carried forth from this relatively short experience. I imagined that for Rim this ending would create some confusion, but also that maybe the learning in coping with emotions would help her to overcome this and maybe some of the difficulties she faces in her daily life. I could imagine the interpersonal anxieties as matching and reflecting Rim's feelings; my awareness of the need for integration of interpersonal space, time and relationship supported the emergence of moments of attunement, creating the potential for greater

communication. It was clear to me that the musical parameters of attunement and harmony within the relationship supported the improvement of the therapeutic environment, through the adapting of goals; in Rim's case, this took the form of supporting her to become the leader in the improvisations. Her growing capacity to listen, follow and be actively musical indicated the increasing security she felt within our relationship, which supported the improvement of her leadership qualities which she was able to own and express. This was a source of comfort to me when thinking about the development of this music therapy pathway, in relation to her passivity at its beginning.

5.2 CBCL Assessment

The Child Behavioural Checklist (CBCL)is one of the most important evaluation methods permitting the collection of a clear and comprehensive picture of the child's behaviours. It is available in almost 100 languages, and is used by many psychologists and psychiatrists around the world, both for clinical practice and in research. The checklist comprises empirically based questions for caregivers (parents, school teachers, etc.) in 8 syndrome scales of behaviour concerning the child in question:

1. Anxiety / Depression
2. Withdrawal / Depression
3. Somatization
4. Social problems
5. Thinking problems
6. Attentional problems

7. Delinquency (non-compliance with the rules)
8. Aggressive behaviour

In addition there is a section for "other problems"

For partial scoring, some of these syndromes are combined into 2 broader scales of:

1. Internalizing problems: combining scores for I, II, and III;
2. Externalizing problems: combining scores for VII and VIII.

The total score expresses an overall global sum of all the section scores together.

5.3 Analysis of CBCL scores for Rim

CBCL assessment, Rim, before beginning music therapy		
Parent assessment	**Total**	**Score T**
I - Anxiety / Depression	12	72
II - Withdrawal / Depression	6	68
III - Somatization	5	66
IV - Social problems	8	67
V - Thinking problems	10	74
VI - Attentional problems	8	64
VII – Delinquency (non-compliance with the rules)	9	72
VIII - Aggressive behaviour	19	75
Other problems	7	
internalization	23	73
Externalization	28	72
Score total	**84**	**73**

CBCL assessment, Rim, after finishing music therapy		
Parent assessment	**Total**	**Score T**
I - Anxiety / Depression	12	76
II - Withdrawal / Depression	6	54
III - Somatization	5	74
IV - Social problems	8	70
V - Thinking problems	10	67
VI - Attentional problems	8	54
VII – Delinquency (non-compliance with the rules)	9	65
VIII - Aggressive behaviour	19	66
Other problems	7	
Internalizzazione	23	71
Externalization	28	67
Score total	**84**	**68**

In the CBCL results tables:

- T scores in red indicate high level of problematic symptoms, and the necessity to develop strategies for their reduction;
- T scores in yellow indicate a low level of problematic symptoms, suggesting family consultation and support;
- T score in white indicate no emergence of problematic symptoms.

These assessments were carried out by the music therapist with Rim's mother. The positive changes in Rim's behaviour, as reported by her mother in the second assessment are highlighted in green in the table.

Reflection on the results of the 2 CBCL evaluations takes into account the therapeutic objectives set for Rim in music therapy - decreasing depression, empowering resilience and improving behaviour regulation – with respect to the psychiatric diagnosis defined for her of 'moderate depressive disorder'. The progress

charted by the difference in the 2 CBCL evaluations represents an effective decrease in symptoms, but clearly no evidence of "healing" these symptoms. The changes in Rim's behaviour, as reported by her mother in the second evaluation, clearly show an improvement, despite the fact that her life conditions have not changed at all.

From a psychodynamic point of view, the therapeutic, relational process promoted positive emotional and psychological progress in the child, and a shift in coping mechanisms.

In the 2nd evaluation, the overall score has decreased, as have both scores for internalizing and externalising symptoms. Rim's withdrawal symptoms (scale II) have decreased, and her aggression and non-compliance with rules (scales VII and VIII) have improved, as have her thinking and attention (scales V and VI). However, some behaviours relating to the environment, anxiety (scale I), somatization (scale III) and social problems (scale IV) have increased. In our opinion, this could indicate a change in Rim's defensive resources available for responding to her very challenging surroundings; she appears more active in defending her identity, when she does not feel safe or supported and protected.

5.4 IMTAP assessment

The Individualized Music Therapy Assessment Profile (IMTAP: Baxter et al., 2007)) is an assessment protocol developed by a professional music therapy team specializing in the needs of at-risk, behaviourally and emotionally disturbed children and adolescents. It was designed for use in paediatric and adolescent clinical settings, where music therapy is offered.

The IMTAP can be used as a treatment plan, a tool to develop goals and objectives, a means to address and assess target skill sets, as an indicator of overall functioning to provide a baseline for the treatment, as a research method and as a communication tool for the parents and the healthcare professionals.
The IMTAP begins with intake and ends with a computer-based graphing and report system.

Dorit Berger comments that the IMTAP is *"one of the first most comprehensive approaches to discovering specific characteristics of behaviours through extensive cross-sections of observable characteristics. The IMTAP is an excellent across-the-board instrument addressing a variety of diagnoses, but is mainly applicable to children´s functions.*" (Berger 2009). She writes that the IMTAP is not suitable however for assessing certain adult diagnoses, such as dementia patients, psychiatric diagnosis or pain management.
The IMTAP includes 10 main domains presenting the relative fundamental functions, followed by a number of specified sub-domains to score. If all main domains and sub-domains are evaluated, the tool provides a a systematic profile of 374 skills. The main domains and sub-domains are the following:

1. Gross motor skills: fundamentals;
    I. *perceptual/visual/psycho motor.*
2. Fine motor skills: fundamentals;
    I. *strumming;*
    II. *autoharp/Q Chord;*
    III. *guitar/dulcimer;*

IV. *piano;*

V. *pitched percussive/mallet.*

3. Oral motor skills: fundamentals;

I. *air production.*

4. Sensory skills: fundamentals

I. *tactile;*

II. *proprioceptive;*

III. *vestibular;*

IV. *visual;*

V. *auditory.*

5. Receptive communication/auditory perception: fundamentals;

I. *direction following;*

II. *musical changes;*

III. *singing/vocalizing;*

IV. *rhythm.*

6. Expressive communication: fundamentals;

I. *non-vocal communication;*

II. *vocalizations;*

III. *spontaneous vocalizations;*

IV. *verbalizations;*

V. *relational communication;*

VI. *vocal idiosyncrasies.*

7. Cognitive skills: fundamentals;
    I. *decision making;*
    II. *direction following;*
    III. *short-term recall/sequencing;*
    IV. *long-term recall;*
    V. *academics.*
8. Emotional skills: fundamentals;
    I. *differentiation/expression;*
    II. *regulation;*
    III. *self-awareness.*
9. Social Skills: fundamentals;
    I. *participation;*
    II. *turn-taking;*
    III. *attention;*
    IV. *direction following;*
    V. *relationship skills.*
10. Musicality: fundamentals;
    I. *tempo;*
    II. *rhythm;*
    III. *dynamics;*
    IV. *vocal;*
    V. *perfect and relative pitch;*
    VI. *creativity and development of musical ideas;*

VII. music reading;

VIII. accompaniment.

IMTAP scoring analyses the occurrence of capacities in individual skills, sub-domains and domains in 4 categories:

1. never;
2. rarely (under 50%)
3. inconsistently (50-79%)
4. consistently (80-100%)

thus providing a profile of the client in the assessed areas of functioning.

5.5 Analysis of IMTAP evaluations for Rim

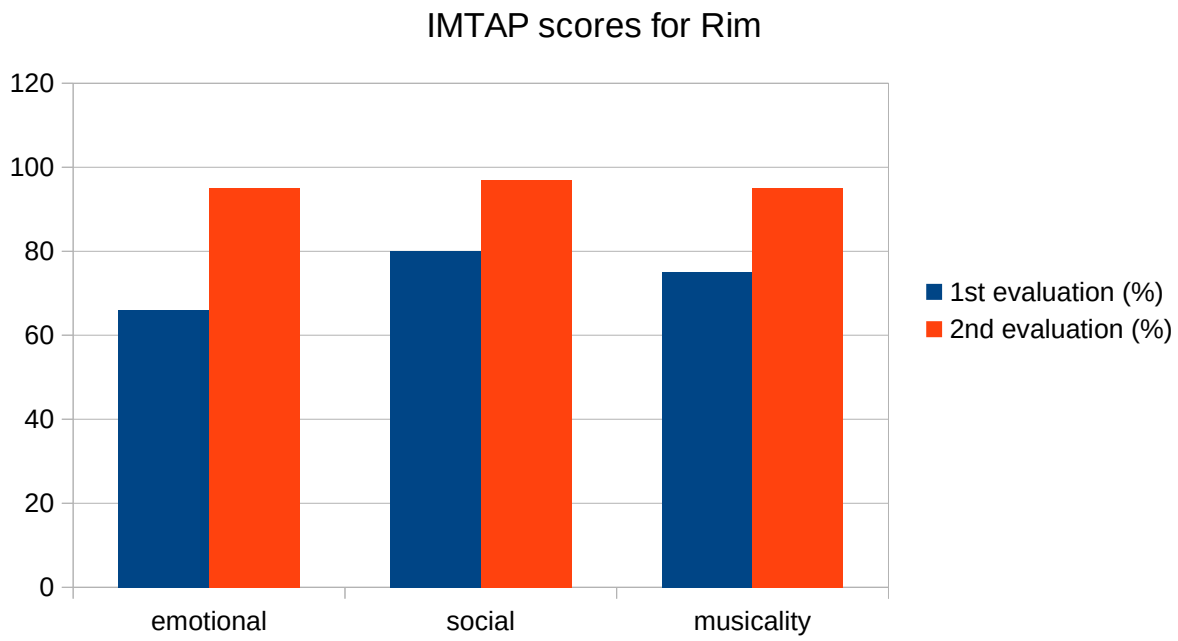
In accordance with the music therapy research protocol, IMTAP evaluation was made on 2 sessions within Rim's treatment – at the beginning (2nd session) and at the end (15th session) - in the three chosen domains of emotional, social and musical skills.

The emotional domain assesses the client's capacity to express different emotions appropriately, to be able to regulate and control emotional response within an acceptable range. The last sub-domain assesses awareness of, and ability to reflect on, one's personal emotional states.

The social domain assesses the client's ability to be in a relationship with an "other", to respond and interact appropriately, to be aware of the "other" and to be able to support forms of communication such as turn-taking and role changing.

The musicality domain is the only domain to be defined in the IMTAP manual as fundamental and obligatory for every assessment; all other domains can be included or excluded as is retained useful for each particular client. Assessment of musicality measures the client's response to the music environment offered in the setting, in terms of interest, curiosity and emotional response. The sub-domains assess precise musical skills, from basic areas such as tempo, rhythm and dynamics, to more sophisticated academic musical skills, such as music reading and accompaniment. As with each domain assessed, the therapist marks as "non assessed" the sub-domains and skills which are not relevant to the client. Musicality domain scoring supports the verification of the client's musical style, likes and dislikes, informing the therapist in decisions regarding the structuring of the sessions and the activities proposed.

In discussing the results of the IMTAP evaluations for Rim, we must bear in mind that some general factors will have influenced her behaviour in the early stages of therapy, regardless of her clinical profile: before coming to music therapy, she had never had the experience of being in a relationship alone with an adult and sharing an activity. For every client in relational therapy, understanding interaction within the therapeutic context - the possibilities and choices available, the potential consequences, and so on - needs time. When working with depressed clients, we should remember that depressed people usually need more time to show their capacities, due to an initial lack of interest in the initiative and low-level interaction with the therapist. The impact of the session will initially be less enthusiastic.



Summary of Emotional Domain Scores (%)		
	Session 2	Session 15
Fundamentals	63	100
Differentiation/Expression	55	90
Regulation	71	95
Self -awareness	70	97
Score range	55-71	90-100

The 1st assessment for Rim's emotional skills reveals an "inconsistency" in her responses in music therapy, with all 17 separate scores within the range of 50-79%. The child is not showing any consistent pattern in this area of functioning; she is unable to control her emotional responses and unable to benefit from the emotional support afforded by the interaction within the psychodynamic relationship. In this early stage of music therapy, she is closed in on herself, unable to open herself up to the surrounding environ-

ment. The music therapist's notes record, in fact, the sensation of her "closed" music played on the instruments of her choice, as described earlier, heard, for example, in a repetitive motive on the guitar strings.

In the final assessment, Rim's emotional functioning is consistent, with all scores exceeding 80%. The IMTAP evaluation of her emotional skills brings out her strengths. Our interpretation of this very pronounced change is that Rim has become familiar with the music therapy setting and feels secure and comfortable. In these circumstances, her emotional functioning is normal. She is able to be involved in the music making together with the therapist, sharing emotions and regulating her own depressive states through both non-verbal and verbal communication. Her body language and her facial expressions were changed, with more postural flexibility, eye-contact and smiling. During improvisations, she is able to accept and change roles, playing together with the therapist at the piano.

Summary of Social Domain Scores (%)		
	Session 2	**Session 15**
Fundamentals	**77**	**97**
Participation	**85**	**100**
Turn-taking	**70**	**90**
Attention	**92**	**92**
Direction following	**91**	**100**
Relationship skills	**78**	**98**
Score range	**70-92**	**92-100**

In the 1st evaluation (session 2), Rim's social skills are assessed as inconsistent for the fundamental items and for sub-domains of turn-taking and relational skills; her scores in the sub-domains of participation, attention and direction-following are within the consistent range. These results are consistent with the profile of her emotional skills, indicating her unease in the therapeutic relationship at this stage.

She is well focussed on, and involved in, the activity, and shows her acceptance of the therapist by complying with his directions. However, she has not yet developed trust in this situation, and her diffidence leads her to withdraw, and does not allow her to interact flexibly, for example in turn-taking; rather she plays by herself, without sharing.

In the 2nd assessment (session 15), all social skills are scored highly within the consistent range, showing her ability to modulate and control her social behaviour, and to enter into an interactive relationship fully, indicating good trust in the therapeutic relationship. Her participation is more open and she is able to accept not only the therapist's presence, but also his musical personality; she respects her role in the turn-taking improvisations, and is able to leave space and wait for the therapist's response.

Summary of Musicality Domain Scores (%)		
	Session 2	**Session 15**
Fundamentals	**78**	**95**
Tempo	**68**	**98**
Rhythm	**77**	**92**
Dynamic	**80**	**96**
Score range	**68-80**	**92-98**

The 1st evaluation of Rim's musical skills shows a generalised inconsistency in all the assessed items, which is partly explained by the fact that she had never before been exposed in any way to musical instruments or any kind of musical activity.

Her scores in the 2nd evaluation, which are all high in the 'consistent' range, clearly show how much and how quickly she is able to learn. Her good attention skills (which are shown already in the 1st evaluation of social skills) enabled her to concentrate well on rhythm and follow the tempo, so that she could develop her musical skills.

6. Conclusions

The supporting research for the writing of this thesis led me to search for academic papers, articles or books treating the subject of music therapy for toxic stress in refugees scientifically. I found there is a lack of information on this topic, and therefore also a lack of a clear framework for proceeding. The best solution seemed to be to rely on my professional training as a clinical psychologist and my experience of working psycho-dynamically with the use of clinical improvisation, as a basis for exploring this experimental therapeutic methodology employed with my clients in music therapy.

In 2012, when I started my pathway of training in, and practising of music therapy, this therapeutic discipline was as new a topic for me as it was for my community. I remembered that many years previously, during my first training for my degree in clinical psychology (2002), my internship had taken place in an adult psychiatric hospital, and I had proposed listening to classical music, in order to promote relaxation in patients with anxiety and depression. Occasionally, musical instruments had been offered, to sustain psychological discharge or catharsis. I had in effect experimented with the use of music in therapy, but not music therapy as a treatment in itself. I had no musical involvement with patients.

As a music therapy trainee, I was forced to face my anxiety and fears about using music as a therapy, especially with respect to the fact that whilst I do have a solid psychological training background, it was not possible for me to obtain a formal music education; what if I am not good enough? Should I always play music instruments during the sessions and nothing else? In my mother-tongue language of Arabic, there is no literature about contemporary music therapy, and there are no Arab specialists in this discipline. I wondered whether the people from my Palestinian refugee community environment, after seventy long years of chronic stress from social exclusion and marginalization, were ready for this new kind of therapy, which places music at the centre of the therapeutic work:

> *"[...] every case of music therapy practice represents the possibility that the music therapist encounters clients or participants who think differently. In other words; there may be a mismatch between the music therapist and the client participant in terms of how music therapy works. If music therapy works the way we think it works, this kind of mismatch may make it not work. Or our misconceptions, at least, may inhibit music therapy from working in the best ways."*
>
> (Stige & Kenny 2007)

My confused thoughts produced a kind of paranoia, a fear of putting my patients, and with them my community, at risk in this new style of therapy, after having served them as a psychologist for many years.

I was impressed when I read about Mercedes Pavlicevic's first experience as a professional music therapist; I was reassured that it would be possible for me to proceed through the training experience step by

step, in order to acquire the necessary knowledge.

> *"Mercedes Pavlicevic (1987) considered the first meeting between client and music therapist in the first session of music therapy. She reflected upon the challenges of meeting clients and their various expectations to what music therapy might be. In her experience, some clients were excited while others became anxious after being referred to music therapy.*
>
> *The client's past experiences with music, music therapy as something new or unfamiliar, and the client's present troubles were all factors that influenced the client's openness to music therapy, she argued. She stressed that the first pre-musical meeting should be focused on establishing a safe and trusting relationship and the client and therapist should come to a mutual agreement to whether they should try music therapy".*
>
> (Bjotveit,2017: p. 24.)

I feel that my working as a music therapist, supported by studying, reading and searching about music therapy, has made an important contribution to my own personal and professional development as a psychologist. Working as a music therapist has so far been a vital part of my journey of experience. It has helped me to develop awareness about why we make music in therapy and about what the meanings behind this kind of musical, improvisational activity are. I think working as music therapist has also helped me to develop keen listening and reflective skills. I believe the primary role of techniques in music

therapy in mental health care is to serve as a ritual through which clients can work out their troubles together with the music therapist. The effectiveness of the technique mainly depends on the client's and therapist's belief in its utility.

Music therapy, as a culturally respected "healing practice" presented and guided by a competent music therapist, can therefore offer possible explanations and solutions for the motivating symptoms and signs brought by the client.

I chose the clinical case of Rim in my study, since the characteristics of this child resemble many other cases with which I work, and certainly her life conditions are unfortunately only too representative of many children in her community. Her case satisfies all search elements: social marginalization, toxic stress (from, among other things, the shock of losing her father in war), problems of social exclusion, marginalization from society. In some sense, she could be described as a "light" case, compared to many of my clients, since she does not suffer from mental deficiencies. However, her social conditions, psychological pressures and constant stress affect her emotional functioning, her social life and her academic achievement. In addition to problems in social adjustment, which cause her anxiety and depression, Rim's story, of escape from the war in Syria and refuge in undignified living conditions in Lebanon, highlights the economic deprivation and lack of security typical of the community which contextualizes this study.

At the end of this thesis, my thoughts go to the importance of conducting field research specialized for this approach and technique to give treatment for these cases, in view of the fact that there is as yet no scientific evidence proving its effectiveness. To this end, our Assumoud music therapy and mental health teams decided to conduct the small research project, investigating whether music therapy can support the improvement of social and emotional functioning in Palestinian refugee children whom present

problems in these spheres. Despite the immense difficulties of conducting research in this intensely difficult environment, we hope this will be at least a first, humble contribution to the scientific community, regarding this topic.

Finally, it is also my hope that more Palestinian refugees will be able to train to become professional music therapists, in order to serve in the community where they share the same life conditions, culture, language and beliefs, given that work of this kind is very complicated, and maybe less effective, when conducted by foreign specialists.

7. Appendix

7.1 NISCVT consent form for video-recording in music therapy

The National Institution of Social Care
And Vocational Training
Lic No. 135/AD

المؤسسة الوطنية للرعاية الاجتماعية
والتأهيل المهني
عملا وخبرة رقم ١٣٥ / أد

I the undersigned .....

Parent of the child .....

Agree that parts of the audio and /or video recording taken during the music therapy sessions which my child has followed during the period between ..... and ..... with the therapist Mohamad Orabi at the Family Guidance Centre Saida, will be used for research purposes.

I am fully aware that the parts which will be used will solely serve scientific and research purposes which do not in any way harm my child and will fully protect his/her privacy.

When using the mentioned parts, the name of my child will be changed, as all the details that could disclose his /her identity.

Agreed upon reading

Signature .....

Date .....

تلفون: ٨٥٩٠٧٦(٠١) خليوي: ٢٣٣٠٧٣(٠٣) فاكس: ٠٠٩٦١-١-٨٥٩٠٧١ ص.ب: ١٣/٥٦٢١ شوران - بيروت ١١٠٢-٢٠٦٠ لبنان
Tel: (01)859076-Cell:(03)233073 - Fax: 00961-1-859071 - E-mail:NISCVT@socialcare.org - P.O.Box: 13/5621 Chouran - Beirut 1102-2060 - Lebanon

7.2 Music therapy observation protocol

Music Therapy Observation Protocol

Date of session:
Length of session:

Child's posture:
Does it change?

Expression / communication
Verbal / speech / singing / vocal sound
Non verbal
Body movement

Child's physical tension
Heaviness lightness
Warmth cold
Relaxation tension
Other

Description of music

Tempo and rhythm
(pulsed/free-flowing; fast/slow/moderate; steady/erratic; getting faster/slower; ...)

Pitch and melody
(High/ medium /low register; tonal / modal /atonal / free moving; ...)

Intensity and dynamics
(loud / moderate/soft; getting louder / softer; accentuated /gentle; ...)

Timbre and texture sound qualities
(heavy/ light open /closed; ...)

Therapist's reflections:

7.3 Music therapy closure protocol

MUSIC THERAPY

CASE CLOSURE – FINAL REPORT

MusicTherapist -

FGC -

Period of treatment -

Name/s of child/children	Age at closure	origin (Pal/ Syr/DPS/Leb)	Diagnosis

Objectives of therapy:

Objectives reached ☐ / partially reached ☐ / not reached ☐

reasons why:

Brief description of evolution of treatment and results achieved:

7.4 CD of audio tracks

Track 1: Rim, 2nd session, minute 8:00

Track 2: Rim, 15th session, minute 0:00

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