

*Full-Length Article***Weaving Words and Music: Healing from Trauma for People with Serious Mental Illness**Gillian Stephens Langdon¹, Faye Margolis², Kristina Muenzenmaier³¹New York University, United States of America²Private Practice, New York, United States of America³Albert Einstein College of Medicine, United States of America**Abstract**

This article presents the development of music-verbal therapy trauma groups for people with serious mental illness. The work grew out of the collaboration of an interdisciplinary trauma committee in an urban mental health center. Recognizing the high rates of childhood trauma in this population, members of the committee developed interventions targeting their specific needs. The collaboration of music and verbal therapies was found to be very valuable in the treatment of complex trauma. The article outlines the interdisciplinary collaboration and the structure of the groups. Elements of music as tools in trauma treatment are described along with using words to identify specific problems and solutions. Examples of the authors' clinical work are shared from this interweaving of words and music. Brief vignettes demonstrate survivors' journeys as they begin to identify and create safety, build healthy relationships, and maintain equilibrium while facing the challenges of their past traumatic experiences.

Keywords: *trauma, psychosis, music therapy, interdisciplinary group, complex PTSD*

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Vignette A:

Latoya has been in our music-verbal therapy trauma group for many months. The more we speak to Latoya today, the more the words gush out of her – her mother's visit, her recent fight, her childhood abuse, her wanting to die. The feeling of helplessness is contagious. After a few minutes I ask what she needs. She says, "Music. Play piano." I play wide open chords with major 7ths – a little gospely sounding with a descending bass line. Latoya is on the conga. Her rhythm is simple and steady. My co-leader, Faye, and the rest of the group are playing on hand drums, tambourine, and maracas. The piano appears to call forth a beautiful melody. After a while I ask for a word to put into the song. No one has one. I am feeling a kind of relief after this playing and I let the words sing out of me. "A storm was here and now has passed." Another group member picks up the song "A storm was here and now has passed us by and now the tears can fall." We all join her and sing together.

Background

In the last 4 decades there has been increased recognition of the impact of trauma on the mental and physical health of traumatized individuals. However, less attention has been paid to trauma and its impact on people diagnosed with serious mental illness (SMI). We conducted a research study that included assessing prevalence rates of stressful childhood experiences (SCE) in this population in the boroughs of Queens and the Bronx [1]. A large number of the study participants were recruited from the same public mental health facility in the Bronx in which the treatment program described below was piloted. All participants from the study had at least one psychiatric hospitalization in a state mental health facility and 70% were diagnosed with either schizophrenia or schizoaffective disorder. The prevalence rates of reported childhood abuse were high with physical abuse 82%, sexual abuse 26.2%, emotional abuse 51.4%. More than 1/3 of the sample reported to have witnessed violence in the family (36.6%), have an immediate family member arrested (36.4%), reported substance abuse (47%) and mental illness (29.3%) in primary care taker (ibid).

We created a composite score that included the seven abuse/family stress variables modeled after Felitti's Adverse Childhood Experiences (ACE) study [2]. We then examined four outcome variables: symptoms of PTSD, dissociation, risk of self-harm and revictimization experiences. We found that the higher the score the higher was the symptom severity.

The results support our clinical experience in this population with serious mental illness (SMI) that the majority

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are severely traumatized with high rates of individual childhood abuse/family stress variables including high rates of co-occurring stressful childhood experiences (SCE). 39.2% of the sample experienced between 4 and 7 different co-occurring types of SCE.

Complex Trauma Symptoms

Considering the extent of the traumatization, the people we serve have an array of complex symptomatology and trauma related disturbances. These include affect and behavioral dysregulation, relationship difficulties, severe dissociative symptoms, in addition to posttraumatic stress disorder, anxiety, eating disorders, and substance abuse [3, 4]. They also exhibit more severe and more treatment refractory symptomatology that can include psychosis [5, 6, 7]. While the relationship between psychotic symptoms and trauma is complicated psychosis can be co-morbid with trauma-related symptomatology [8, 9, 10] and/or psychosis can result from trauma [11, 12, 13]. In either case it is imperative to assess trauma histories and related symptomatology in people with psychosis [14, 15]. In addition, current psychiatric treatment needs to include a reconceptualization of diagnostic categories and trauma informed interventions that take complex trauma reactions into account for people with SMI [16, 17, 18].

The challenges and difficulties clinicians experience when working with this population can be overwhelming. In our endeavor to develop a program that targets trauma related issues we developed an interdisciplinary trauma committee in which we could raise difficult issues, find support among our colleagues and learn from our mistakes. Because of the multidisciplinary nature of the committee we were able to address isolation, withdrawal, hopelessness, rage, aggression, self-injurious and suicidal behaviors, reenactments, flashbacks as well as psychotic symptoms through different modalities (e.g., creative arts therapies and verbal therapies). We had the flexibility to adjust the treatment to the needs and abilities of each particular survivor. This facilitated a sense of safety and trust for survivors. The collaborative multidisciplinary nature of our work led to the development of unique interventions. In this paper we will describe our music-verbal therapy trauma groups and present examples of how we integrated a variety of modalities in the context of an in-patient setting.

As we began working together as a multidisciplinary committee focusing on issues related to trauma in people with SMI a new understanding started to emerge. We were able to view psychotic symptoms from a “trauma informed” lens. The primacy of “safety” as described in Judith Herman’s book *Trauma and Recovery* [19] became an underpinning of all our work. We learnt to recognize trauma related symptoms in people with psychosis and were able to reconceptualize behaviors, feelings and cognitions in the context of complex PTSD. A client becoming suddenly distressed and angry in a group was no longer a moment to suggest an increase in

medication. Instead, the music therapist could look around, review the previous moments, and ask directly, “What music could we play now that would make you feel safe? What is safe music for you right now?”

One advantage of this was that the clinician could experience a calmness that could be communicated to a distressed client. Instead of feeling the terror of things going out of control that the client may have been feeling the clinician could feel calm and communicate reassurance that there was a path to follow. We had a new way of looking and had new tools to use. The music provided a safe “container” through which difficulties in affect regulation could be worked with thereby shifting to a calmer affective state and an increased capacity for self regulation and tolerance of heightened affective states.

Vignette B

We are in the music therapy group. Adrian, who is known to be violent, suddenly stands up. She throws a small drum across the table. My heart is beating fast. The other clients shove their chairs back away from the table. I go to the door to call for help. My co-leader, Faye, moves right up to the client – right in her face – and says calmly, “Look at me. Look at me. This is Faye. Do you see me? It’s Faye. You’re safe here.” Adrian begins to focus on Faye. Gradually she calms down. “Can you sit with us?” Faye continues, “This is a safe place. No one is going to hurt you here.” Adrian is able to sit down again with us and join in the music

Music-Verbal Therapy Trauma Group

The group members were in-patients in a psychiatric hospital and were referred by their unit staff for trauma treatment. At times members of the group would suggest some of their peers to be invited to participate. Interestingly we decided to call this music-verbal therapy trauma group the “women’s empowerment group” in order to not stigmatize the women who attended. But the women decided to rename it and called it the “trauma group”. They would call out to the staff on the unit when we came to pick them up. “I’m in the trauma group. I need to go with them.” “The traumatized person is often relieved simply to learn the true name of her condition...She discovers that she is not alone; others have suffered in similar ways. She discovers further that she is not crazy....” [20]

We began to work together with the purpose of helping survivors come together in a “safe” place, experience emotions within a predictable structure, and to gain insights and tools for clients to take into their daily lives.

This was not easy. The group members had suffered severe abuse, often beginning in early childhood. Their coping strategies were largely fighting, self-harm, or withdrawal. Sometimes a client would come into the group mute and

apparently unreachable. At other times conflicts from the unit continued into the group. There could be shouting, crying, confusion. It was our task to create safety, encourage self-expression and try to make sense of what was happening. The hope was that the safety of the group would lead to an increased capacity of the members to self-regulate during heightened levels of arousal.

Discussions in the multidisciplinary Trauma Committee allowed us to see that a verbal approach alone was limited. Research by Bessel van der Kolk “demonstrated that when people are reminded of a personal trauma they activate brain regions that support intense emotions, while decreasing activity of brain structures involved in the inhibition of emotions and the translation of experience into communicable language.” [21]

We realized that survivors often preferred creative arts therapies, therefore we combined verbal and music therapy groups. We found that music was often a pathway to verbal discussions and music could at times expand the feeling-fullness of a verbal presentation. Music could also soothe or help to integrate aspects of a particularly intense verbal discussion. “...Treatment of trauma requires a new model distinct from the traditional psychotherapeutic strategies of face-to-face dialogue ...Music and music therapy strategies may provide this portal to the Social Engagement System and avoid the initial face-to-face interactions that may be misinterpreted as threat by a traumatized individual.” [22] The process of music making also helped to encourage the forming of relationships among group members and support group cohesion.

Vignette C

Clunk. Clunk. The sound of the mallet falling onto the xyimba. Maria's head is down; her shoulders slumped. She is barely able to lift the mallets; she lets them fall onto the xyimba. Clunk. Clunk. I begin to play chords on the guitar to mirror her sound. Strum. Strum. A simple harmony. The other group members and Faye, my co-leader, begin to play percussion instruments. Maria's sounds become louder now. She is playing with intention. I strum louder with a sparse rhythmic pattern. Maria begins to lift herself up and move to the music slightly. She begins to create a simple melody and I follow her with a steady rhythm. The music comes to an end. Maria looks around and laughs. “How are you doing?” Faye asks. “Not so good,” Maria answers. “I had a bad experience during my leave outside the hospital.” She shares an experience of both physical and sexual intimidation. She initially was hesitant to share her experience but other group members encourage her. One group member points out how important it was that she was able to stand up for herself and walk away.

Group format

In the beginning we adopted a very structured cognitive behavioral approach using topics such as dissociation, re-scripting nightmares, or self-care as foci for each of the group

sessions. As time went on and we became more confident the flow of the groups became more open and less rigid and we moved to a more process oriented approach. This allowed us to follow more immediately the clients' needs in the moment and the topics they brought up spontaneously while being able to use the tools as needed.

One of the important aspects of safety is the structure of the group. Music can be used to create this structure. Groups often begin with a check in song. How are you feeling? How are you doing? Members sing, mirroring back what they said. This allows each member to be acknowledged and gives us all an opportunity to take in how each client looks (body language, affect, etc.) and hear what might be important. This can set the stage for the themes of the group which can consist of music and discussion in what might be called a middle section. In this middle section the feelings that come up can become themes for the group, for example anger, helplessness, isolation, empowerment. These themes allow us to pursue the ways that members cope with difficult situations while providing us with opportunities to find new ways that are more adaptive. Sometimes we might improvise in the music. “In improvising with others we are also dealing in a fundamental way with our relatedness to other people. We experience ourselves dynamically in relation to others. There are moments of connection and disconnection in the improvisation.... Interpersonally, this becomes a ... rich area for exploration.” [23] At times we might role-play situations that they previously had withdrawn from or engaged in a fight or flight response (behaviors typical of traumatic experience). It was not uncommon for members to validate the feelings of other members and or provide responses to situations that were more adaptive. This allows group members to respond to each other forming more positive relationships.

Music is often used to create closure. The music can help to integrate an abstract verbal discussion with the feelings underlying the words. It could be a soothing element. Sometimes it is a way of ending the session with something that is uplifting and hopeful.

An important aspect to preserve safety in addition to confidentiality is the rule that clients would not speak of the specifics of their trauma in the group. They could discuss these in individual sessions. The reason for not sharing the trauma itself in group is that the recounting of traumatic events often would trigger traumatic memories in other clients in the group who would then begin to dissociate or leave the group. Instead, group members were encouraged to discuss the symptoms they were experiencing and explore tools to cope with these symptoms. They could discuss problems they were having in the present and identify maladaptive coping mechanisms. They could be encouraged to discover new tools to try out. “Thematic comments in this early phase do not encourage a deeper delving into the details of trauma memories, but instead assist the client in self-regulation and gradually tolerating self-awareness.” [24]

Interplay of musical and verbal elements

Other aspects of safety are created in music through the modality itself. Music provides phrasing or a chorus to provide predictability. “The predictable rhythms, phrases, and forms (e.g., verse and refrain) of music, in addition to a feeling of safety, help survivors modulate their emotions during hyperaroused states. The physicality of playing an instrument or singing helps with grounding and, with the support of the music therapist, assists the [survivor] in returning to the present from a dissociated state....” [25] No matter how strong the emotion expressed, the music can support a return to a regular rhythm or a chorus. Music can also help with the experience of affect modulation, encouraging the music to become louder and then return to a quieter place. Words can be sung to musical improvisation to provide context or reassurance such as “No one understands me...” or “It’s a long journey...”

Sometimes music can cut through what is merely a verbalization without any connection to affect. The therapist might say, “We’ve been talking a lot. Maybe we can play some music.” The seemingly organized verbalization might suddenly be followed by a loud burst of playing.

Music provides predictability, fosters community, and supports self-expression. “When we sing words, we can move beyond the shell of the words itself into the expression within it. We go to the essence of the word without needing to describe, explain, or justify its meaning... And most importantly, music can give voice to the unspeakable.” (26) Yet words allow for the specifics, for strategies for handling different situations, for validation of gains, and delineate tools for coping. For example, in one group two women came in saying, “There was a fight this morning.” “Yeah, I hit the psychiatrist,” said another. “I talked to my mother on the phone and I was so angry, I hit the psychiatrist!” One wouldn’t think anything positive could come from this but Faye said, “This is so important. You realized *why* you hit the psychiatrist.” The client quieted down for a moment, clearly taking in this reflection. After this initial chaos we were able to quiet down the group and began the check in song.

Co-leadership Collaboration

To conduct groups such as these it is important to have a two leaders. One would be able to follow a client who left the room to talk and reassure them while the other leader could stay and keep the group together, trying to process what had occurred. One of the things we did frequently was to talk to each other within the group. We modeled reflection and decision-making. For example, “I wonder what we need right now. Everyone seems really upset....”

This collaborative work can be challenging. It can be difficult to jump between verbal and musical elements. And co-leadership requires commitment and ongoing communication. For example after each group session we

shared our thoughts with each other. As group leaders, our relationship developed. We could have differences in front of the group. For example, one of us might say, “You didn’t respond to me.” And the other leader could say, “I’m sorry,” modeling communication versus fighting or dissociating. As we continued to work together we began to move in and out of verbal and musical modes freely, as my co-leader called it ‘dancing together without stepping on each others toes’. Sometimes it would be my co-leader who said, “I think there is a song here.” Or I would say, “Before we get into the music, can you tell us more about this?”

Support

The Trauma Committee which met once a week was a place where we were able to get our bearings and share difficulties. If anyone in the Committee was feeling overwhelmed, their experiences and feelings took precedence. There was a recognition that vicarious traumatization was a common phenomenon and having a place to recognize this and feel supported was essential and paralleled the safety we tried to create in our groups. As Andrea Frisch Hara states in *Caring for the Caregiver* “...true self-care mean[s] the ability to feel vulnerable, to honor [one’s] feelings and to use that awareness to get the important tasks done..” [27]

What kept us going and what we could marvel at was the strength of the clients in the face of such difficult experiences. We are grateful for what they taught us about resilience.

Vignette D

*Maria was a woman who was silent. She might smile, a kind of submissive, anxious smile. In her history we learned that she had been kept in a closet as a child. At times we would ask what song she might want to hear. Since she was Latina, one group member would jump in not waiting for her response and say “La Bamba.” One day, as I asked her to give Maria time, which I had often done, hesitatingly Maria said, “Sun...come out...” Two group members gleefully finished the line “tomorrow!” We all joined in. “The sun’ll come out tomorrow. Bet your bottom dollar that tomorrow, there’ll be sun” from the musical *Annie*. We made space for Maria to join in. She smiled and looked all around at the group and in a very quiet monotone sang “Sun come out tomorrow....”*

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