Worlds in Collision: Music and the Trauma of War

Friday 28 June 2013, The Mansion House

TRANSCRIPT

Music Therapy and the treatment of trauma related to conflict – Ann Sloboda

NIGEL OSBORNE: It is my great pleasure to introduce Ann Sloboda, one of the leading figures of music therapy in this country, but also active now as a psychoanalyst, covering so many fields that are relevant to our concerns today with her presentation 'Music Therapy for patients with treatment-resistant PTSD'.

ANN SLOBODA: Today I will talk about a clinical research trial that we undertook at the Guildhall School of Music & Drama, and the collaboration with a local health provider, the Institute of Psychotrauma, at that time based in the City of London. Part of it will be numbers, inevitably, as it is talking about a research trial, but I hope to move on as quickly as possible to talk about the human stories of the people involved in the research.

The literature on music therapy has shown a lot of interest, increasingly, in the application of music therapy in psychological trauma. Until this trial in 2008 there had been no randomised control trials. Little data had been gathered on the subjective experiences of patients. Most of the literature talked about the experience of the therapists. These were the two organisations collaborating: the Institute of Psychotrauma in East London, was very keen to explore arts therapies as an alternative treatment to the standard treatment that they offered, which was cognitive behavioural therapy; the Guildhall School of Music and Drama, located very nearby, provides training for music therapists, which is what my job is, I head the Masters programme there. We wished to conduct clinical research and also explore clinical practice, but as we were a college working with students it was very difficult for us to access any patients. So we collaborated together so that the Institute of Psychotrauma could come to the Guildhall, bring some of their patients, and we, who had the music therapists and the resources, could trial it. The purpose of this was to see if music therapy might have an effect on both the post-traumatic stress disorder symptoms of the patients and the depression, which often accompanied it.

The patients included in the trial all had a diagnosis of PTSD. They had all received trauma-focused recommended treatments, generally cognitive behavioural therapy, or had been offered it. They had all not responded to the treatment and had been discharged from the clinic still suffering severe symptoms. The design of the study, very briefly, was that one group of people had ten weeks of music therapy, in a group, once a week on a Friday afternoon at the Guildhall. A second group spent that period of time waiting for treatment. And then following the weeks they then also had ten weeks of music therapy. The treatment group were compared to the control group in terms of their symptoms. The control group's period of therapy wasn't evaluated, but it did provide additional treatment data, but it wasn't used in the research study.

How were the patients selected? This was done entirely by the clinical psychologists working at the Institute of Psychotrauma. They invited a large number of people to take part and eventually 17 men and women were randomly allocated to the two groups. They came from a range of different cultural and ethnic backgrounds, and their experiences were a range of trauma. Some had experienced torture, some had witnessed war atrocities, rape, had been victims of terrorism and some had grown up in this country but had trauma here such as childhood sexual abuse. For all of these people talking therapies had been refused or not properly used due to feeling shame, anger or fear of the past, which meant they couldn't, at that point, make proper use of them.

For all these people it was very difficult for them to take part in the research study. That involved getting themselves to the Guildhall every week at the same time to take part and to be evaluated before the group with a questionnaire. Many of them had a lot of practical problems facing eviction, deportation, bankruptcy, and many of them had serious mental health and physical health problems. None of them had any musical training before, so were pretty apprehensive about music therapy. They were very worried about getting around London, many of them, and that was a major symptom for a lot of the people. They felt frightened going out in public; they felt frightened using public transport; they felt frightened amongst crowds of strangers. However, they had become familiar and trusting of the clinical psychologists who worked at the clinic. It was agreed the best way to help them get to the Guildhall was meet them at the clinic and the researchers would bring them. They were prompted by telephone calls, texts and e-mails during the week to remind them to come, and to encourage them to come. Several of them were highly sceptical about the relevance or usefulness of music therapy, but they agreed to give it a go.

I just want to run through briefly the principles that inform music therapy in the UK. That wouldn't necessarily be true internationally but certainly these characterise the way it is taught here. There is a great emphasis on relationships either between the patient and the therapist as you heard in the previous presentation, and if it takes place in a group, on the relationships between the group members. It is very important that anyone having music therapy does not need to have any musical training or skill. Improvisation holds a very central role. It was important in this work as well that people have the freedom to play, talk or be silent. So participants to music therapy are not coerced into doing anything, and therapists offer support and exploration through their clinical musical techniques. So the therapist needs to have musical skill and training, but the clients don't.

As this was a funded research project and needed NHS ethical approval, before getting this we were required to produce a manual saying what our treatment was going to consist of. This is quite a challenge for music therapists who have a very improvisatory approach and would not want to lay down exactly what they were going to do before the session takes place. Nevertheless, we managed to produce something that was broadly manualised, but had built-in flexibility. So we said what we would do is the therapist would facilitate members in starting to improvise. We would listen closely to the participants music, and when I say music, I mean any sounds they might make, and accompany them. Of course in a group that is complicated because they may be making a great number of different types of music.

But nevertheless, that would be the task. The therapist may discuss, describe and draw out themes that become evident in the musical activity. They would encourage members to discuss their experiences, and highlight shared themes or connections between members, and when I say experience I mean the experiences they were having at the time in the group. Nobody would be pressurised to discuss their traumatic experiences because it is clear that with this group of people that was something they found very difficult. There would also be a group focus in that no one member would be singled out unless they wanted that.

That is a rather blurry photo here, but it is just to show people who may not know what a music therapy room looks like, the setting that they were working in. Out of view there were two pianos and there is a mixture of percussion. The thing you can see in the foreground with metal bars is a metallophone, which Julie Sutton spoke about. There is a range of drums and other percussion.

A large number of people were invited to take part in this study. The ones that were eventually enrolled, as I said earlier, were randomly allocated to two groups. One group had music therapy, with on-going assessment and they took part in a questionnaire every week. They had a follow-up interview and their data was analysed. And then the same thing happened with the group that had been waiting.

Before they had music therapy all the participants had high levels of post-traumatic stress symptoms, which were measured on the impact of events scale, revised. Their average score was 52. As I understand it, the point at which they would receive a diagnosis would be 35. They also had high levels of depression and their score on the depression inventory was 34. I don't want to dwell on numbers, but this table just shows that the score for people having music therapy, that is the bottom line, decreased significantly after ten weeks of music therapy. It was certainly a bigger change than we expected.

Exit interviews were conducted with all the participants, not by the therapists but by the assessors. We asked them what was helpful and what was unhelpful about the experience. The things they found helpful about it were that it was relaxing, and the fact that it was in a group and they were taking part in something with other people was very much valued. The other themes that came out from many people is the experience somehow gave them tools for managing their emotions. For example several people said when they were encountering difficult experiences going on public transport, feeling frightened, feeling overwhelmed, they imagined they were playing one of the instruments from the music therapy group. That was quite a surprise; we hadn't necessarily expected that. Things people found unhelpful: some felt the group was too noisy. Many people improvising on percussion, it could be noisy. One or two actually wished they could have discussed their traumatic histories more than the group norm enabled them to.

Of course research had its limitations, particularly in the small number. There was no masking or blinding in that everyone knew what treatment they were receiving. Some people might have said that the outcomes were due to just being in a group and it was encouraging and supportive to take part in a group therapy, so it might not necessarily be anything to do with the music. The therapists and musicians were unusually committed. I have never worked in a clinical environment anywhere in my 30-year

experience of working as a music therapist where there has been such a commitment to music therapy from clinical psychologists, it was amazing – so it might not be very typical. The environment and setting was unusual. Not many people get the opportunity to receive music therapy in a conservatoire; they found the environment quite invigorating and encouraging. The music therapists of course had the dual role of being researchers and clinicians.

It was very encouraging that the psychological scales quantified some sort of change, but what was much more important for me was to think about the clinical content and the experiences. It is very rare for music therapists to have the opportunity work with a homogeneous group of people with one diagnosis, particularly PTSD. Of course we encounter people with traumatic experiences all the time; people who work with children, as you heard this morning, and in the general psychiatric population. But it is very unusual that a music therapist would work with a group of people who only had PTSD and not psychosis as well, for example.

So I am going to give some case examples from the first, fifth and penultimate sessions of ten, to illustrate some of the themes. I'm going to tell you who was in the group. Another unusual thing, for me, was that I met these people all at once, without having assessed them first, or met them before, and the experience was quite overwhelming for me.

Jacob, aged 20, he came from Liberia, where he had witnessed the murder of his family, before being forced to commit atrocities as one of an army of child soldiers. He had asylum seeker status, having lived in sheltered accommodation since his arrival in the UK as a teenager. He was studying A levels at the time of doing the group, and he was intending to go to university. Ivan was 56, he was from Bosnia, he had suffered imprisonment and torture during the war. His English was the weakest of all the members of the group. Matteo was 20, a British born Italian, and he had been subject to numerous violent incidences of bullying within school. Osmana was 42, a political asylum seeker from Kurdistan who had been imprisoned and subjected to sexual assault and torture. Joanna was aged 37, an asylum seeker from Jamaica. She had been abducted, tortured and raped by members of an opposing political party who had set upon her when they had seen a sticker on her car supporting the party that she worked for. She had fled, leaving behind her children, and she was awaiting the outcome of an appeal to remain in the UK. Kerry was 30, she was British, she had been sexually abused by her father over many years. Her situation was complicated in that her father had then been murdered by someone else connected with the family, and she felt to blame for that. Alice was 21, she was from Uganda. She had witnessed the rape and murder of her mother before being raped herself. She had escaped the country and was currently an asylum seeker in the UK and she had a young child. Imane, aged 40, was originally a refugee from Iran. She had been a member of a persecuted ethnic group and suffered severe symptoms of PTSD, after traumatic memories of the death of a family member were triggered by the London bombings. Zina was 50, a political antigovernment activist, opposing the repressive regime in Afghanistan. She had been imprisoned and tortured and escaped to Britain as an asylum seeker.

So before I talk about the first session, I think I'll say something about my own enormous anxieties before I met this group of people, having read their case histories,

and felt increasingly anxious that they would have a terrible experience, it would be too frightening for them. I couldn't imagine what music therapy could offer them and felt extremely worried that the whole exercise would be a terrible failure. However, my anxiety paled into insignificance next to theirs. When the patients arrived, their anxiety was palpable. The psychologists met them and did the assessment measures with them. Each participant was also given a voucher for lunch at the Guildhall, and I thought about it earlier on, how important lunch is, but it certainly was an incentive for them to come. And they needed to have that first, before the group. They then came and sat in a circle in the room, and it seemed very important to help people get started with something very simple, so I led the session and my co-therapist, who was a recent graduate from the Guildhall, assisted.

So we started with very structural activity, which is passing an instrument around the circle and each person just saying their name. Everybody was encouraged to play something on the instrument, but it was their choice what they played. The therapist did it first, so people had something to copy, if they couldn't think of anything to do. This simple exercise allowed the therapist to introduce some very important ideas. One was that everybody was able to play in their own individual way, somebody might just play one note, somebody might do a roll on it, and individuality within the group was a very important principle. Also, the idea that people were going to be making up music, the concept of improvisation was a very important principle as well. This activity extended then to two instruments; so as a group, two people would play together, on two separate instruments, then pass them round. So that was a graded way of moving towards group improvisation, that people would play in pairs. They could talk about the experience of having a musical conversation, if you like, and the therapists were able to reflect on the concept of who was leading this pair, who was following? What did it feel like to listen to it? What did it feel like to be part of it?

We then moved into group improvisation, which would have been very difficult to do without those preliminary exercises. And the only instruction was: there are lots of instruments here, find one you like the look of, try and find a sound you like, and then once you've got used to your sound, see if you can fit in with someone else. People were able to do that, so we got to a point, about ten minutes into the session, where people were all improvising in a group. I played the piano, being very careful to provide a solid rhythmic and harmonic base, with very safe harmonies – C major, F major – and the flute, played by my co-therapist, provided a melodic structure on top, so it was a sort of percussion sandwich really, everybody else was playing percussion. Our aim was to provide some sort of musical coherence to help reduce the anxiety and confusion of the other members but without restricting or impeding in any way the freedom of what they might want to do. And we tried to imitate things that people were doing. So if someone was shaking a tambourine we might echo that on the piano, if they were playing a pulse, we might try and imitate that.

As a therapist, I tried not to speak too much but I would speak if the group was silent for a while, and seemed anxious. I tried to highlight statements that were significant for individual members or the whole group. In the early sessions the participants said very little, but they volunteered more as the sessions went on and by the end were talking lots amongst themselves.

I'm going to play a clip from session one, and I think when you see the people – it's a video, and they have all given consent for this – what's noticeable is how tense their posture is and how anxious they look. They're not making much eye contact. There's not much of a shared rhythmic pulse and I might say a little bit about that afterwards, why that might be. The clip you see is towards the end of the session, and at the end of it you begin to see more movement, some people begin to get out of their seats, to explore some other instruments, and they're beginning to notice aspects of each others' playing and imitate it, such as trills or tremolos, or moving to a higher or lower pitch.

[Video plays.]

You probably noticed that the therapists' music was very, very gentle, almost as if we were wrapping the group in cotton wool because they were so nervous. But you could probably also see that people were beginning to gain some confidence, and feeling that they might like to be a little bit more playful. Something that came up in the group as a theme was the idea of leadership, and in the first session, there was an almost pathological lack of pulse, nobody seemed to be able to deliver a strong pulse, and we wondered if that was possibly because people wanted to avoid being pushed into some sort of musical forced march, that people might feel compelled to join in with. In the session prior to this one, I began to comment on the fact that if I ever stopped playing, then the rest of the group would instantly stop as well, and I questioned that, and they said, well, it's because you're the leader. So, obviously, that's how I was experienced, but I began to suggest that we played around with that idea, and that other people took the lead, which some of them were prepared to experiment with, while others absolutely didn't want to. But it did introduce the idea that people could be a bit more dynamic, and have a bit more confidence in taking some of their ideas forward. So I think in this session, you'll see that that's beginning to happen, there is a stronger pulse, the therapists are able to play a bit more forcefully, there's still a lot of repetition and stiffness, but I think you'll see the members are less isolated and more able to follow each other.

[Video plays.]

I will say a bit about the session before the end of the group. What happened in this one was that members of the group were playing in pairs and sharing instruments. There is much more creative freedom and the improvisation ended in a very powerful shared synchronised pulse from all members. I will skip over the clip because I want there to be some time for questions. But after this improvisation I commented how energetic the group were and that I actually hadn't needed to play, I had stopped. It is a very different situation from earlier on where if I stopped playing everybody fell silent. What happened after this group, was that people began to talk about how satisfying it was to play and what a release they got from drumming. Jacob said "a drum can't hit you back" and they all laughed. The members were talking to each other and not just to the therapists. And people began to make reference very gently and subtly to their traumatic experiences. In contrast to the experience they were having in the group.

I'm just going to give a little account of the discussion that they had after this improvisation. Jacob said "I think when you are playing it gives you something to

focus on, you forget everything, you can shut the rest of the world out". I said "a refuge almost ". Joanna said "I look forward to Friday and sitting around with all of you, this is my safe place on Friday". Kerry said, "yeah, safe until you start again, you can be yourself here, it is like you are feeling not like somebody else." I said, "it sounds like you are saying that this group can help you feel in yourself, as in embodied rather than taking yourself out? That's really important." This is somebody who found it so difficult to articulate anything, it is the first statement she had made, really. She suffered a great deal from disassociation, of not feeling in her body. She said, "when I'm playing and I get an instrument and I'm playing it I feel me again, like I was before everything that happened. When I go out that door, out there, I feel as if I'm up there again in the clouds watching me." And this got a nodding agreement from several people in the group. I acknowledged that other people could relate to that.

I will very quickly say what we thought the changes were for people in, admittedly, a very short period of work, but it is the equivalent to what they might get offered in the NHS: people became more autonomous in the group; they collaborated and began to make individual choices and spoke about their preferences; there was increased group cohesion, through finding drumming satisfying and acknowledging what they were experiencing; and as I said, spontaneous verbal disclosure. Talking about both their experiences outside the group but in it as well. I think that is a good place to stop so there is time for questions.

NIGEL OSBORNE: Thank you, do we have any questions for Ann?

FLOOR: I just wanted to find out why the second group weren't also doing a group activity such as watching a film or doing knitting or origami, just to counter that question of whether it might have been the coming together and doing a group activity rather than not.

ANN SLOBODA: You mean why weren't they offered an alternative therapeutic group activity?

FLOOR: Yes.

ANN SLOBODA: I don't know; it is pretty difficult to get them together as a group at all. They agreed to come to be part of that research study. I wasn't involved in any other aspect of their treatment, so I can't really answer that.

FLOOR: One of the points you made was that there was no requirement to have musical qualification, or to be able to play an instrument or anything by the participants, and the importance of the therapist providing the therapy to be qualified. But was that something that you made the participants aware of, or that you actively held back?

ANN SLOBODA: We didn't verbally say that to them. I think they assumed it because of where it took place, it was at the Guildhall School of Music, and we were playing instruments in a way that looked like we knew how to play them.

FLOOR: I was trying to get to the leadership part of it. You said you didn't want particularly to be portrayed as "the leader", but that being qualified as the therapist was important, and not being qualified as the participant was also important. How do you kind of manage that?

ANN SLOBODA: I mean of course it is obvious that I was the leader. But I think what I was trying to say was that it doesn't necessarily mean I have to lead and control every aspect of the music making, and encouraging people to feel that they could take some agency in that. I think that's the point, that within particular improvisations they didn't actually have to be following me musically all the time. I might not even be playing the piano all the time; I might be doing something different like playing the drum, but even if I was doing that and I stopped, they would. It was trying to move on from that rather rigid and restricted dynamic on to something that was more confident and free.

FLOOR: Did you observe any lasting effect of this study, you know, follow-up treatment for instance or an observation after the fact? Did this confidence or increased ability continue to exist or were the people reverting to their old behavioural pattern as soon as they had left?

ANN SLOBODA: This isn't exact, but some of them decided they felt able to participate in verbal treatment and wanted to go on and have that, following this experience. So that was a quantifiable outcome. And some of them went on to get work and get jobs, not all of them. So there was some anecdotal evidence and some more quantifiable things, but certainly they were more able to engage in verbal treatment, which is easily available to them.

FLOOR: That was really informative. You made a comment about the National Health Service, and my question was working in that way as you are with demanding clients, how do you counteract what's happening in the NHS with staff getting burnt out and worn out by the pressures of work, which is what seems to be happening. Within music therapy, are there structures in place to maintain the morale of the therapists?

ANN SLOBODA: I guess as in any other psychological profession there are structures like supervision and support. But you are quite right, there are many music therapists who have either lost their jobs or had them reduced in hours, so it is a very difficult time.