



**HOW SONG-WRITING CONTRIBUTES TO
THE TREATMENT OF TRAUMA IN A CHILD
EXPOSED TO GENDER VIOLENCE AGAINST
HER MOTHER**

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Master thesis at the Master Program in Music Therapy. Department of Communication
and Psychology. Aalborg University

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Abstract

In this work the benefits of using song writing are explored, concretely in relation to post- traumatic stress symptoms in a child who has been exposed to gender violence against her mother. According to the literature, song writing is supposed to facilitate expressing emotions and thoughts and reducing symptomatology of stress (Baker, Wigram, Stott & McFerran, 2008). In this case, music therapy is included in a more extensive program of emotional intelligence and song writing is used for the treatment of traumatic memories. So, this work will be focused on analyzing how song-writing can help to the treatment of trauma improving emotional aims.

Physiological symptoms, aggressive conducts and avoidance and resistances to talk about traumatic situations are reduced at the end of the intervention.

However, there are some limitations before concluding that results are due exclusively to music therapy.

On the other hand, a new line for future studies has appeared. Using song writing, traumatic experiences never before mentioned have been verbalized without showing any symptom of anxiety. So, song writing could help to detect traumatic scenes and reduce the initial anxiety when an episode related to trauma is referred for the first time.

Key words: *Music-therapy, Song-writing, Trauma, Emotional Intelligence, Gender violence, Children exposed to violence*

Resumen

En este trabajo se exploran los beneficios de escribir canciones para el tratamiento de una niña con síntomas de estrés postraumático tras haber sido expuesta a violencia de género. Según la literatura, esta técnica facilitaría la expresión emocional y de pensamientos, además de reducir la sintomatología (Baker, Wigram, Stott & McFerran, 2008). En este caso, la musicoterapia se incluye dentro de un programa más amplio de entrenamiento de inteligencia emocional y la escritura de canciones se utilizar para trabajar los recuerdos traumáticos. Así pues, el trabajo irá encaminado a analizar cómo esta técnica puede contribuir a la consecución de objetivos emocionales relacionados con el trabajo del trauma.

Los síntomas fisiológicos, las conductas agresivas y los comportamientos de evitación y resistencias se reducen al final de la intervención.

No obstante, existen algunas limitaciones antes de concluir que los resultados pueden ser atribuidos por completo a la musicoterapia.

Por otro lado, surge una nueva línea de interés para estudios posteriores. El hecho de crear canciones ha facilitado la verbalización experiencias traumáticas que nunca antes se habían abordado y además, sin síntomas visibles de ansiedad. Así pues, esta técnica podría ayudar a detectar nuevas escenas traumáticas para su trabajo posterior y a reducir la ansiedad que se genera inicialmente al referir un episodio relativo al trauma.

Palabras clave: *Musicoterapia, escribir canciones, trauma, violencia de género, menores expuestos a violencia*

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Chapter 1: Introduction

1.1.- Description of the field of study

I have been working as a Psychologist for four years for the regional government in Madrid, dealing with children who have been exposed to violence against women. `Violence against women` or `gender violence` is a technical term, which is defined by The United Nations General Assembly (1993) as *"any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."* This public service consists on emergency centres, where women who have been abused or attacked by their husbands, boyfriends, ex- husbands or ex- boyfriends, get protection from them. Children from 0 to 18 years old usually live with their mothers there too. The nationality of families is varied in these centres and the maximum stay is 3 months.

Although the term `gender violence` refers to women as victims, they are not the only victims of that situation. Children exposed to violence against women, suffer many harmful effects (Groves, Zuckerman, Marans & Cohen, 1993). There are physiological effects as bad health (Jaffe, Wolfe & Wilson, 1990), nightmares and other dream disorders (Jaffe et. al.,1990) or enuresis (Abrahams, 1994). The most commonly observed behavioural effects are externalizing behaviour problems referring to aggressive and antisocial conducts (Graham-Bermann & Levendosky, 1998; Jouriles, Norwood, McDonald, Vincent & Mahoney, 1996) and internalizing behavior problems as phobias or inhibition conducts (Fantuzzo, DePaola, Lambert, Martino, Anderson & Sutton, 1991; Hughes, 1988; Hughes, Parkinson & Vargo, 1989). Cognitive problems of attention or concentration are described too in the literature (Moore & Pepler, 1998). Lots of investigations are about emotional problems in these children, showing traumatic effects such as anxiety or depression (Hughes, 1988; Maker, Kimmelmeier, & Peterson, 1998; Sternberg et al., 1993).

Bibliography about psychological treatment of these children is limited. Some interventions are lead to improve emotional expression, solving problems and facing strategies (Jaffe, Wolfe & Wilson, 1990; Kenning, Merchant & Tomkins, 1991).

Based on these premises and on my own experience, an Emotional Intelligence Program including music- therapy has been designed, in which music therapy is mainly used to raise traumatic scenes, concretely song-writing, which has shown to be a useful technique to apply in traumatized children (Davis, 2005; Coulter, 2000). Once the required approval from mothers are obtained, only after creating safety, and once established a confidence relationship, song-writing is offered as a tool and as an opportunity to express what children felt during traumatic experiences mentioned before by them in session. This will let them re- elaborate traumatic memories.

The emotional intelligence program

There are not too many publications about interventions with children exposed to gender violence. However, according to the literature, different kind of programs can be described:

- Those programs which are lead to work with mothers for improving mother-child relationship and offering them orientation about the way to talk about the problem with the children
- Programs for children
- Programs for both collectives (mothers and children)

In this case the last one has been chosen as the best form to attend to this problematic. So, apart from children therapy, there is a parallel intervention with mothers. Related to the process with children, some programs have been focussed on prevention; teaching to the child how to keep away from the fight or how to phone the police (Kolar & Davey, 2007). Programs from this frame are usually developed when children still live at home or mothers decide to go back with the aggressive partner. Other programs have been directed to improve resilient factors such as cognitive flexibility, self-concept or self-

regulation (Vaise, 2001). The last type of intervention is the one developed in order to reduce symptomatology derived from being exposed to gender violence at home. In this last group some of the aims are improving emotional management and emotional expression or dealing with traumatic memories (Jaffe, Wolfe y Wilson, 1990; Kenning, Merchant y Tomkins, 1991).

On the one hand, the designed program includes the aim of improving resilient factors as emotional intelligence (Sandel 2008). On the other hand, it is also expected to reduce symptomatology.

Regarding emotional intelligence, considered concepts are some of the ones suggested by Mayer and Salovey (1997): emotional perception, communicating emotions and understanding emotions which includes identifying them. Those objectives are useful and applicable for the treatment of trauma.

Music therapy and concretely song writing technique facilitates achieving these aims. Because of that, it is used for dealing with traumatic scenes.

Making children re- experience traumatic experiences could require an ethic explanation: on the one hand, as it has been said previously, the task of dealing with traumatic memories is only developed when they have verbalized those experiences before. In that moment, song-writing is offered as a way to express feelings about it. Apart from that, the base of this practice is that patients suffering post-traumatic stress reduce intrusive thoughts when they are capable of reviving traumatic experiences from a secure place (Richards, Lovell & Marks, 1999). That is why there are some sessions focused on establishing a good relationship therapist-client and creating a secure place for expressing emotions.

1.2.- Problem formulation

How can song writing contribute to achieve emotional aims related to trauma in a child who has been exposed to gender violence against her mother?

1.3.- Relevant theory

There are some protection factors that reduce damage in children who have been exposed to violence. The ability to recover from the problem and to come back to the previous emotional state is named `resilience` (Rutter, 1987). On the one hand, high emotional intelligence is one of these resilient factors (Sandel, 2008) and on the other hand, there is a piece of scientific evidence about music therapy and resilience ((Pasiali, 2011; Amatea, 2010). Besides, music therapy has shown improvements in emotional management (Hanser, 1985) or gender violence (Cassity & Theobold, 1990).

Non- verbal techniques, such as colouring or games, show good results with traumatized children (Corder, Haizlip & DeBoer, 1990; Schwarz & Penny, 1994), as well as music therapy particularly (Sutton, 2002), even in extreme cases of Post-Traumatic Stress Disorder (Else, 2007). Naitove (1982) exposes that the traditional methods of therapy could be perceived as threats when children have suffered abuses. Based on this premise, Volkman (1993) designed a musical intervention for the treatment of trauma with dissociated victims. However, Berry and Pennebaker (1993) emphasized the importance of complementing these techniques with verbal expression. Focussing on this point, Coulter (2000) pointed out that song writing is one of the best combinations of verbal and nonverbal information and applies it in physically or sexually abused children. Positive results were obtained.

Baker, Wigram, Stott & McFerran (2008) found that song-writing was a technique used all over the globe. *`It is the process of creating, notating and/or recording lyrics and music by the client or clients and therapist within a therapeutic relationship to address*

psychosocial, emotional, cognitive, and communication needs of the client (Wigram & Baker, 2005, p. 16).

Austin (2002) used it with traumatized adults: once provided stable musical environment, singing improvisations were facilitated. Aasgaard (2002) describes song-writing stories from hospitalised children and Zharinova- Sandenson (2002) used songs as a link to client's personal history and identity.

Other important concept on this treatment of trauma is empowerment. Following Rolvsjord (2004), therapist who advocated a resource- oriented music therapy approach, use it as a philosophical metaphor for therapy. Other trauma treatments using creativity and arts, also mention this concept of empowerment, apart from creating safety and re-experiencing (Kubany, McCaig & Laconsay, 2004). From this approach, music therapists are not 'professional helpers', but nurturers of human potential (Garred, 2006; Rolvsjord, 2004).

1.4.- Method

A qualitative method will be used mainly based on descriptive observations not only during the intervention, but also outside it. Special attention is put on those moments in which song writing is used. A clinical case of a child will be exposed to illustrate the way in which this technique is applied, how the child reacts to it and after it, which emotions related to traumatic memories she has and how she expresses them.

Systematic observation will be used, considering the following kinds of data:

- 1) A diary in which child reactions reflecting trauma and anxiety are written down after every session by the therapist

- 2) Reports created after every session with the mother of spontaneous feedback about the child and her post traumatic symptoms, derived from weekly sessions designed to improve mother- child relationship.
- 3) Written reports of observations from educators, which are noted in a daily control- document.

Recollected information will be organized initially in the following categories: externalized symptoms and internalized symptoms. In the first classification (externalized symptoms) there are:

- Physiological symptoms
- Aggressions towards others or oneself

Internalized behaviors considered have been:

- Resistances and avoidances to talk about what happened or on the contrary, verbalizations about it (including lyrics from song writing)

Taking into account all of these items, links and relations between them will be analyzed in order to clarify the way in which song writing contributes to improve the emotional conditions of this child.

Chapter 2: Theory

2.1.- Introduction

Gender violence is one of the most important problems of our society. It has been thought to affect only few percentages of people because it is hidden by the privacy of one's home. Because of that, it has been really hard to show the real nature of the problem. Luckily, nowadays, society is more and more concerned about it, and attitudes have started to change. Consequently, from different social frameworks different steps have been adopted.

For example, legal changes have been introduced for attending this necessity, and from an institutional context, the implication level in this problematic has been increased too, and new resources have been created in order to cover needing and demands.

In the County of Madrid concretely, there is a complete set of services offering solutions to this problem; telephonic services (012, 016), orientation and advice or psychological intervention (SAVD 24 hours), policies accompaniment or protection centers, where this work has been developed.

Recently, it has been shown that not only women suffering violence have dramatic consequences, but also children who live in this kind of families. So, this work will be focused on this area.

2.2.- Gender Violence

Gender violence definition is complex, and it varies depending on the approach adopted. From a sociological point of view, we should consider the history and analyze women's role in societies through the years. Few years ago, sex was thought to be determinant for differences between men and women, and, consequently, biology was said to be the

main cause of social discrimination. Even Plato assumed that women only participated partially and inappropriately of rationality and Aristotle pointed out that feminine sex was a natural malformation. So, this group (women) has been undervalued in a patriarchal society along the history.

Nowadays, because of the increasing researches about it, it is known that sexual identity is not only formed by biology or genetic. Differences between men and women are mainly due to a differential socialization process. In this context, violence against women is not an individual private form of violence; it is the effect resulting from the discrimination over the years.

From a social perspective, it is usual making mistakes talking about *Gender Violence* and *Domestic Violence*, and they are very different concepts. The first one is referred to any kind of violence against women in familiar, social or working area, while the second one describes any violence in the family, no matter who perpetrates it.

Maqueda (2006) remarks that terms confusion sometimes could be originated by the resistances that society has to recognize and visualize women maltreatment.

The United Nations General Assembly (1993) defines it as "*any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.*"

Introducing *Gender* term in the definition, cultural components of this kind of violence are remarked.

In the present work, although there is no doubt about the situations that the concept covers, the term *Gender Violence* will only be referred to the violence against women produced at home by sentimental partners or ex-partners.

2.3.- Prevalence of Gender Violence in Spain

It is really difficult getting exact statistical data about this problematic because of the character of privacy that it presents. Collecting data is only possible observing reports, which only represent a little part of the group of women being abused. Figure 1 shows victims during the time and the relationship of them with the aggressors.

| VICTIMS OF GENDER VIOLENCE | | | | | | | | | | | | | | | |
|---------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-----------|-----------|-----------|-----------|
| | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | 2007 | 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 | 1999 |
| 24-abr | | | | | | | | | | | | | | | |
| RELATIONSHIP | 16 | 49 | 61 | 73 | 86 | 76 | 71 | 69 | 57 | 72 | 71 | 54 | 50 | 63 | 54 |
| Partners | | | 31 | 26 | 27 | 23 | 31 | 31 | 20 | 34 | 31 | 24 | 25 | 31 | 30 |
| Ex partner | | | 3 | 3 | 3 | 6 | 4 | 4 | 2 | 5 | 4 | 2 | 2 | 4 | 2 |
| Sentimental partner | | | 17 | 25 | 13 | 20 | 16 | 15 | 16 | 14 | 24 | 19 | 16 | 13 | 13 |
| Ex sentimental partner | | | 7 | 8 | 3 | 11 | 10 | 14 | 7 | 6 | 9 | 3 | 1 | 3 | 3 |
| Boyfriend | | | 1 | 5 | 2 | 11 | 8 | 5 | 6 | 8 | 0 | 4 | 2 | 8 | 3 |
| Ex boyfriend | | | 2 | 6 | 3 | 5 | 2 | 0 | 6 | 5 | 3 | 2 | 4 | 4 | 3 |
| Ending a relationship | 7 | 12 | 26 | 28 | 25 | 32 | 26 | 30 | 17 | 28 | 28 | | | | |
| Partner | 9 | 37 | 35 | 45 | 31 | 44 | 45 | 39 | 40 | 44 | 43 | | | | |
| % Ex partner or breaking | 43,8 | 24,5 | 42,6 | 38,4 | 44,6 | 42,1 | 36,6 | 43,5 | 29,8 | 38,9 | 39,4 | | | | |
| % Partner | 56,3 | 75,5 | 57,4 | 61,6 | 55,4 | 57,9 | 63,4 | 56,5 | 70,2 | 61,1 | 60,6 | | | | |
| CONVIVENCE | | | | | | | | | | | | | | | |
| Yes | 9 | 36 | 39 | 46 | 35 | 40 | 47 | 45 | 36 | 48 | 55 | | | | |
| No | 7 | 13 | 22 | 27 | 21 | 36 | 24 | 24 | 21 | 24 | 16 | | | | |
| Not registered | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| % Yes | 56,3 | 73,5 | 63,9 | 63,0 | 62,5 | 52,6 | 66,2 | 65,2 | 63,2 | 66,7 | 77,5 | | | | |
| % No | 43,8 | 26,5 | 36,1 | 37,0 | 37,5 | 47,4 | 33,8 | 34,8 | 36,8 | 33,3 | 22,5 | | | | |
| % Not registered | 0,0 | | | | |

Data from: Delegación del Gobierno para la Violencia de Género

Figure 1: Victims of Gender Violence in Spain in the last years

In 1996, WHO (World Health Organization) declared Gender Violence as a priority of Public Health.

2.4.- Children exposed to Gender Violence against their mothers

Children suffering gender violence at home have been forgotten in this problematic although they are one of the most injured because of it. Tajima (2004) affirmed that gender violence is a very reliable predictor of violence in children, who could be direct or indirect witness of it. High rates of negligence have been found in parents (Beeman, Hagemester & Edleson, 2001). Negative cognitions about children are an important

factor in the effects of exposure to gender violence and abuse and negligence (McGuigan & Pratt, 2001; Huth-Boocks, Levendosky, Theran & Bogat, 2004).

The concurrence of women and children abused have been documented enough in literature (Appel & Holden, 1998; Edleson, 1999; McKay, 1994; O'Keefe, 1995, McGuigan & Pratt, 2001; Pulido & Gupta, 2002), being estimated that 40% or 60% of children exposed to gender violence have suffered direct physical abuses too.

On the other hand, children often suffer indirect violence; mothers battered while they were in her arms, children used as psychological weapons or thrown objects hitting them (Ganley & Schechter, 1996).

However, not only violent moments are hard, but also what happens after them: mothers crying and injured, policies interventions or being forced to live in protection centers (Syers-McNairy, 1990).

These children, often considered as `silent witness` of gender violence (Groves, Zuckerman, Marans & Cohen, 1993), suffer lots of effects as a consequence, which are worse, the harder violence is (Mullen, Martin, Anderson, Romans, Herbison, 1994). When they are directly abused, effects are quantity and quality worse (Edleson, 1999, Fantuzzo & Mohr, 1999; Margolin, 1998; Rossman, Hughes & Rosenberg, 2000; Chiodoa, Leschied, Whiteheada & Hurleya, 2008; Carpenter & Stacks, 2009).

2.5.- Effects of exposure to gender violence in children

Effects of being exposed to this kind of violence at home are emotional, behavioral, developmental and social (Hershorn & Rosenbaum, 1985; Holden & Ritchie, 1991; Hughes, 1988; Hughes, Parkinson & Vargo, 1989; Pfouts, Schopler, & Henley, 1982; Sudermann & Jaffe, 1997; Edleson, 1999; Owen, Thompson, Shaffer, Jackson & Kaslow, 2009). The most common effects observed will be described below.

2.5.1- Physiological effects

In spite of the most remarkable consequences of gender violence exposure in children are related to emotional and behavioral areas, it is important to point out that physical health is also damaged and they have more problems of health than other children (Jaffe, Wolfe & Wilson, 1990). They may experience sleeping difficulties too (Jaffe et al., 1990) such as enuresis (Abrahams, 1994).

2.5.2.- Behavioral effect

There are researches showing cognitive and behavioural problems of these children (Rossman, 2001; Litrownik, Newton, Hunter, English & Everson, 2003; Saunders, 2003). They exhibit more *`externalized behaviours`*, referring to aggressive and antisocial behaviours (Graham-Bermann & Levendosky, 1998; Jouriles, Norwood, McDonald, Vincent & Mahoney, 1996), and more *`internalized behaviours`*, referring to fears and emotional inhibition (Fantuzzo, DePaola, Lambert, Martino, Anderson & Sutton, 1991; Hughes, 1988; Hughes, Parkinson & Vargo., 1989).

Social adaptation in school has been also analysed, concluding that these children do not have the so much social competence as others who have not been exposed to this problem (McCloskey & Lichter, 2003; McCloskey & Stuweg, 2001; Adamson & Thompson, 1998; Fantuzzo et al., 1991, Parker & Asher, 1987). Apart from that, their capacity of solving problems is minor (Spaccarelli, Coatsworth & Bowden's, 1995), and they have more difficulties in interpersonal relationships (Logan & Graham-Bermann, 1999).

Based on Social Learning Theory, these children would be supposed to exhibit more aggressive conducts because of imitation. Despite of this fact, there is not a lineal progression; there are some protection factors avoiding these behaviors. In 1986, Wolfe, Zak, Wilson and Jaffe, suggested that children exposed to violence at home, tend to

justify the use of violence in interpersonal relationships. This has been contrasted reaching to the same conclusion later (Osofsky, 1999; Pfefferbaum & Allen, 1998).

2.5.3.- Cognitive Effects

Attention, memory and lecture capacity have been observed to be damaged by the exposure to violence (Moore & Pepler, 1998). Westra and Martin (1981) found that these children had lower punctuation in test about intellectual, motor and verbal abilities. However, this study had some limitations because the sample was taken from institutionalized children living with their mothers.

Some authors did not find significative variations in academic area (Cristopoulos, Cohn, Shaw, Sullivan- Hanson, Kraft & Emery, 1987), but others show differences in cognitive functions, lower in these children (Rossman, 1998; Mathias, Mertin and Murray, 1995). There are few studies with pre- scholar children, but results suggest than those exposed to violence have more difficulties in spatial, visual and verbal tasks (Huth-Bocks, Levendosky & Semel, 2001).

2.5.4- Emotional effects

Data in literature show that children exposed to gender violence against their mothers, show higher level of anxiety depression and traumatic symptoms comparing to other children (Hughes, 1988; Maker, Kemmelmeier, & Peterson, 1998; Sternberg et al., 1993). For example, these children suffer more distress when they see a simple verbal conflict (Dejonghe, Bogat, Levendosky, Van Eye & Davidson, 2005).

Frequently, children exposed to gender violence have attachment difficulties, causing a negative self-perception or low self-esteem (Doyle, 2001), which can originate future problems, such as eating disorders (Eggert, Levendosky & Klump, 2007) or personality disorders (Van Ijzendoorn & Bakermans- Kranenburg, 1996).

Related to emotional identification, children exposed to violence tend to associate neutral stimulus to negative emotions more than other children (Logan & Graham-Bermann, 1999).

Furthermore, these children are suitable to present Posttraumatic Stress Disorder (Sudemann & Jaffe, 1997), even in pre- scholar time (Levendosky, Huth-Bocks, Semel & Shapiro, 2002). Graham-Bermann (1998) evaluated the symptoms of this disorder in 64 children from 7 to 12 years old, who had been exposed to gender violence, and she found that 13% showed a complete symptomatology of posttraumatic stress, 52% had intrusive thoughts, 19% avoiding conducts and 42% traumatic acting symptoms. However, PTSD does not explain the variety of consequences found in children exposed to gender violence. Due to this fact, there are some studies (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996) considering a differential diagnosis: DESNOS (Disorder of Extreme Stress not Otherwise Specified). Even neurological effects in amygdala and hippocampi have been observed in organism exposed to traumatic situations (Van Der Kolk & Van Der Hart, 1989).

It is complex to develop longitudinal studies but there is evidence of meaningful association between violent behaviours in adolescents and having been exposed to violence in infancy (Spaccarelli et al., 1995).

2.5.5.- Protection factors

As it has been exposed before, effects in children derived from gender violence are numerous and they concern different areas. Nevertheless, it is important to remark that it does not affect to every child in the same way. Depending on the person, effects are higher or lower. Because of that, lots of authors have been interested in investigating which these factors are. The concept of *resistant personality* appeared for the first time in scientific publications in 1967, and it was related to the idea of that some people suffering intense stressors, mainly in professionals areas, did not show any symptoms of stress (Kobasa, 1979; Maddi y Kobasa, 1984). On the other hand, Rutter (1987)

introduced resilience concept referring to the ability of recovering faster from an emotional problem and going back to the previous state. Therefore, it can be assumed that the bigger capacity of resilience, the minor damage for children exposed to traumatic experiences. Later, there have been lots of authors who have been interested in this topic, and the studies have shown positive relations with physical and mental health (Florian, Mikulincer & Taubman, 1995). A good example is a study with adolescents who had suffered traumatic experiences in Israel, in which it can be seen a negative correlation between Post-traumatic Stress and resilience (Levine, Laufer, Stein, Hamaca- Raz & Solomon, 2009).

Some of the studies have pointed out the importance of familiar links as one of the most important factors of resilience (Lee et al., 2009). In other cases, the focus has been on emotional intelligence and social abilities shown at school (Bumphus, 2009).

Therefore, resilient factors should be detected in order to improve their development in the intervention and form part of the basis of the emotional intelligence program created. Some of them are related to intrapersonal factors, while there are other ones based on social processes.

When the attention is on gender violence and resilience, lots of studies are focused on those features inside each person. Some of the researches remark genetics as a protection factor (Jaffe, Moffitt, Caspi, Taylor & Arseneault, 2002; Koenen, Moffitt, Caspi, Taylor & Purcell, 2003). However, it is not possible to modify this, so this work will pay attention to psychological matters which can be trained in therapy.

There are some studies which establish relations between resilience and personality, even analyzing the big five personality factors (Furnham, Crump & Whelan, 1997). This relation was later confirmed (Friborg, Barlarg, Martinussen, Rosenvinge & Hjemdal, 2005).

Other researches were focused on emotional and cognitive abilities. Regarding the cognitive field, the interpretation that the child does about gender violence observed must be considered (Grych & Fincham, 1990; Kerig, 1998). On the other hand, locus of

control and attributional style has been analyzed concluding that children with an external- attributional style have more resilience (Wolfe, 1987).

Furthermore, resilience- intelligence relationship has been investigated: the higher the intelligence is the more capacity of solving problems and creativity the child has (Sternberg, 1998).

In spite of describing lots of resilient factors in literature, in this work the focus will be on those ones which are related to emotional intelligence or related to the training of some emotional abilities. Based on Fredrickson's (1998, 2001) and his model of positive emotions, it was found that there is a correlation between emotional intelligence, traumatic exposition effects and resilience (Sandel, 2008). As it has been previously exposed, the main reference for describing these abilities are according to the ones that Mayer and Salovey (1997) established: emotional perception, communicating emotions and understanding emotions which includes identifying them

Related to these abilities, there is a remarkable study showing that children who have not been offered a space to express emotions and feelings about traumatic experience (in this case the mother had been killed), show higher symptomatology than other children who had verbalized it (Spencer-Carver, 2008). Paolillo (2006) also points out the importance of verbalizations in these cases in order to understand and accept emotions.

2.6.- Non- verbal therapies in the treatment of trauma. Music Therapy

During traumatic experiences some non- verbal memories are recorded in the patient. These are related to emotional and sensorial components (Van Der Kolk, 2003). People suffering trauma dissociate implicit memories from explicit ones. It seems that traumatic experiences are fixed in the implicit memory (Rothschild, 2000).

Levine (1992) considered the left frontal cortex, in particular Broca's area, as the responsible of the language, is not active in neuro-images from traumatized patients. However, in the right hemisphere, the amygdala is acting (Rauch et al. 1994; Bremner et al., 1992).

After this, it can be concluded that trauma does not affect to verbal and analytic cerebral regions. Non- verbal regions and limbic system have the main role, but these structures are not very mobilized using thinking and cognition. Because of that, scientists have tried to find other ways, apart from verbal strategies, for dealing with trauma (Chapman, Morabito & Ladakakos, 2001; Brett & Ostroff, 1985; Howard, 1990; Klorer, 2000; Rakin & Taucher, 2003; Yates & Pawley, 1987).

One of these other strategies for working trauma, is art therapy, which includes both hemispheres (McNamee, 2003, 2004, 2005). Ziadet showed this relation in visual art. Chapman et al. (2001) found that symptoms of posttraumatic stress were reduced after applying art therapies. Besides, Bogousslovsky (2005) observed the link between changes in artistic style and brain damage. So, art therapy seems to be an effective tool in the treatment of trauma.

Other forms of art, such as literature, are also useful for collective memories when there have been a community disaster. A study from Zarowsky (1997) describes narratives about suffering and rhetorics of emotion as central elements for refugees. Corder et al. (1990) also presented the success of story-telling in abused children. On the other hand, poetry therapy constitutes another way of expressing emotions and feelings (Gladding & Hanna, 1982; Mazza, 1981a; Morrison, 1969). So, Langosch (1987) includes this therapy based on poetry in a therapeutic area. It is remarkable that Jones (1987) postulates that music and poetry in this context have lots of similarities.

This necessity of offering non- verbal ways of expressing is clearer in the work with children because sometimes they do not know how to express themselves, as they are still acquiring some abilities for the adult life. This is more notorious when there are problems of trauma or abused (Mazza, Magaz & Scaturro, 1987). In a study made with adolescents, it was shown that the 86% of them usually wrote poetry, songs or a diary as a way of expressing themselves (Roscoe, Krug & Schmidt, 1985). Adults should reinforce this practice because it could become a helpful strategy of facing and solving future problems (Roscoe et al., 1985).

There are some studies defending that painting and drawing are very useful in an initial phase for expressing feelings and emotions the first time (Mazza, Magaz, Scaturro, 1987).

Focusing now on music therapy, it is remarkable that music has had historically a main role in societies, particularly during emotionally charged events such as marriage ceremonies, funerary rites, preparing for the battle with drumming or during it (Beattie, 1963; Blades, 1970; Carrington, 1969; Gerson-Kiwi, 1950; Hanna, 1979; Moore, 1979). This fact is an example of musical influence in emotional world. Because of that, music therapy concretely is considered a very good method to apply in case of emotional problems comparing to other kind of therapies. This modality uses a tool (music), that presumably is intrinsically powerful to promote emotional changes.

Music and emotion are linked in some way and lots of scientists have tried to determine which kind of relationship they have (Storr, 1992; Volkman, 1993; Van Der Kolk & Fisler, 1995). The relationship between these two elements is so close that it has recently appeared a new expression: *musical emotion* (Krumhansl, 2002). However, this term presents lots of doubts from a conceptual point of view.

There are different opinions about the reasons and nature of the capacity that music has to generate emotions. On the one hand, this could be explained by simple associations of neutral stimuli (music) with situations, people or objects. On the other hand, there is other explanation considering music as the unique responsible of creating the emotion. This is the most interesting premise according to this work. However, adopting this last hypothesis some problems must be exposed.

Emotions are always related to the biological adaptation. For example, fear constitutes an adaptive reaction when danger is perceived and it prepares oneself for fighting or escaping, increasing oxygen in muscles when the heart sends blood to them. On the other hand, anger is a defensive reaction towards something perceived as threaten. So,

every emotion has a function for survival and adaptation. From this premise, which would be the function of music?

There are some theories which have tried to explain this phenomenon. Firstly, they assume that music is not only one of the most important canals of social communication, but also a way to respond to the emotional necessity of the society (North, Hargreaves & Hargreaves, 2004).

So, in this line, emotivist theories defend that music provokes emotions in a genuine way. By the contrary, according to cognitivist theories, the origin of emotions in music is in the cognitive conscious of the emotions that music is expressing. Physiological response in relation to music has been investigated, and changes in heart rate, skin conductance or facial muscle activity have been found (Van der Zwaang, Westerink & Van den Broek, 2011; Lundqvist, Carlsson, Hilmersson & Juslin, 2009; Witvliet, 2007; Krumhansl, 1997).

Apart from internal elements of music, external variables have been observed, such as age, personality or gender, concluding that these have influence in emotional reactions (Juslin & Liljeström, Laukka, Västfjäll & Lundqvist, 2011).

However, for this work and concern subject they are much more interesting emotivist theories. Sloboda (1991) analyzed the relation between some structural parts of music and corporal reactions, and he concluded that used musical structures determine those effects. Paying attention to musical elements, there is another theory proposed by Meyer (1956). He asserted that musically, expectative of future development in sounds is generated, and this let people anticipate or wait for concrete sounds. This expectative provokes emotional reactions depending on the appearance of expected sounds. In this way, tension or quietness can be generated using music. Pfordresher (2003) also continues noting the importance of this musical expectative.

Nevertheless, in this work, the hypothesis formulated by Juslin and Laukka (2004) is much more interesting. These authors defend that people choose music depending on their own needing in each moment. So, in this line Berlyne (1971) showed that each

piece of music creates a different activation level and preferred music varies depending on preferred activation level in that moment. This hypothesis is reinforced by Fischer (1981). He found that people having taken stimulating drugs, usually choose music of a major activation level.

There are other investigations standing out the importance of neural activity during musical experience, remarking that the power of sounds is due to the stimulation of diverse neuronal structure (Molnar-Szakacs, Overy, 2006). Peretz (2001) also assumes that there is a specific neuronal organization for some musical emotions, but he defends that this is not a simple system which justifies every emotional reactions in music.

From a philosophical framework, divergences go in this same line. Davies (2010) points out some doubts that appear when music and emotion are related. Firstly, he considers the same difficulties described previously by mentioned authors. Those are about the origin of emotion in music. He exposes some possibilities: music being associated with external emotional objects, or music as an element intrinsically emotional. He adopts a paradigm combining both possibilities. Secondly, he exposes some thoughts about the correspondence between emotions of the music and the emotion that each person experiences listening to it. Is the way of transmitting emotions universal? Does it have correspondence with universally considered basic emotions? (Ekman, 1980, 2003). This is a very important point when music is being analyzed as therapy.

On the other hand, there is an ideology based on arousal theories. They consider that music can be sad or happy depending on the activation elicited and its correlation with that emotion.

However, the relationship between music and emotion is more and more accepted. Some operative systems have been created for establishing multifactorial classifications. They have lots of labels and categories, so during musical experience, these emotions can be automatically recognized. This is still in an experimental phase. (Youngmoo et al., 2010).

Anyway, in spite of finding many conceptual difficulties from the term `musical emotion`, it cannot be denied the relationship between music and emotion. This idea makes music-therapy an attractive possibility although other non-verbal therapies have been shown to be effective too.

Music therapy has shown effects in soldiers suffering post- traumatic stress disorder (Bensimon, Amir & Wolf, 2012) and anxiety reduction and improvements in sleep quality in women who have been abused (Hernández-Ruíz, 2005). Roberts (2006) use music-therapy in children sexually abused.

Nonetheless, music- therapy encompasses lots of different techniques. In order to focus this work, attention will be on song- writing.

2.7.- Song-Writing

There are some few cultures that do not use musical instruments, but there are not cultures without songs (Myskja, 1999). According to this, song is something universal that has been used in different ways; from popular songs, directly connected with particular cultures, to songs written in funeral processes (Aasgard, 1993).

In Music Therapy, clinical practice describes the technique of song writing as a method to make patients express and share feelings (Castellano, 1969; Ficken, 1976). Crocker (1952) points out that, the employment of songs makes patients aware of their own emotional problems. From the same point of view, Glassman (1991) affirms that song writing facilitates emotional identification.

Wigram and Baker (2005, p.16) describe song- writing as:

`The process of creating, notating and/or recording lyrics and music by the client or clients and therapist within a therapeutic relationship to address psychosocial, emotional, cognitive, and communication needs of the client`.

Amir (1990) remarks that song-writing is not only a technique, but also a method, activity and tool. However, literature about song writing is usually referred to clinical examples more than describing the method (Wigram & Baker, 2005). Schmidt (1993) focuses on the creative aspect of it. Besides, memory is stimulated and patients can remember past situations (Aldridge, 1996). Song helps people to integrate their past, present and future, to contact unconscious, to face difficulties in interpersonal or intrapersonal experiences and to project new emotions through music (Wigram & Baker, 2005). When a person expresses feelings incorporating them to song lyrics is accepting and validating these emotions (Freed, 1987). Roberts (2006) agrees with this premise; the role of the therapist is encouraging people to *'tell their story'* and this facilitates exploring and expressing traumatic processes.

Songs are in every culture, so this technique could have a universal character. Baker, Wigram, Stott and McFerran (2008) interviewed 477 music therapists from 29 different countries about their use of song-writing. According to the results of the study, it is used frequently all over the globe.

In 2009, these same authors analyzed 21 questions answered by 419 therapists using song writing and they found some characteristics about the use of this technique. On the one hand, attending to the answers of these therapists, songs are often composed individually and not in group. However, song-writing can improve group cohesion (Edgerton, 1990) and depression symptoms (Goldstein, 1990).

On the other hand, song-writing has been used in different populations and with different aims and depending on this, the use varies. In most cases music is prioritized. It has been applied to traumatic brain injured young people (Amir, 1990; Hadley, 1996; Robb, 1996); Johnson (1981) used it in disadvantaged social groups; Freed (1987) in people with substance abuse; and Feller (1987) in groups with some cognitive difficulties.

The number of sessions used for composing songs varies, but there are many professionals, especially in oncology or palliative care, who explain that patients usually need only one session for that. In psychiatry it often takes them more than one session.

The main aims of using song writing have been discussed in different studies. Williamson (2006) defined as main objectives: Socialization, self-expression and communicative abilities, memory and trauma. Baker, Wigram, Stott & McFerran (2008) defined other objectives more focused in psycho-emotional context: sense of self, increase insight, express feelings, thoughts and fantasies, telling client's story and clarifying thoughts and feelings.

Baker, Wigram, Stott & McFerran (2008) defined the following aims related to:

- Development of auto- confidence and self- esteem.
- Selection and decision making
- Improvements of the sense of self
- Externalization of thoughts, fantasies and emotions
- Telling client's story
- Increasing insight and clarifying thought and feelings

Being a tool for expressing feelings, thoughts and stories, song writing can contribute increasing client's motivation for other therapies (Tamplin, 2006).

About the way in which it is applied there are some differences too. In many cases, therapist creates music and client lyrics. For stimulating lyrics creation some therapists promote expressing feelings and ideas related to a concrete theme. Other ones use a famous song changing words. Other times, they make clients finish sentences or fill in the blanks, edit familiar songs, vocal improvisation, compose new parts of a known song or use nature rhythm at the beginning (Ficken, 1976, Schmidt, 1983).

While Dalton & Krout (2005) applied song writing from a cognitive-behavioral framework in children from 6 to 11 years old obtaining good results, Ficken (1976) uses it applying an eclectic approach. So, there are different ways and approaches to apply

this technique. One form of using it is the one proposed by Ficken (1976) and which Tamplin (2006) describes as Song Collage Technique (SCT), consisting on extracting pieces of existing songs, words, phrases, expressions, to write own songs. In other cases, the therapist facilitates songs composition using improvisation, making questions that the client answers about musical style, instrumentation, or using known music (Wigram, 2005). Grief Song-writing Process is a method which was developed for interventions with bereaved adolescents following this line; they choose each aspect of music and freely create lyrics (Dalton & Krout, 2006).

Referring to the style of music, there are many musical forms that can be successfully used. However, Sears (1968) remarks the use of Blues form as the best way to combine harmonic components of the poetry that everyone has inside oneself and the freedom that music offers. According to this author, this kind of music affectively evokes ordered behavior. Moreno (1987) agrees with this premise and promotes the use of Blues music as an effective way of expressing feelings, because blues itself prepares the environment for this task. Blues form is usually in minor modes, promoting the expression of melancholic feelings. Nonetheless major mode can be also used in order to express positive affect such as happiness (Schmidt, 1983; Moreno, 1987).

Tonality and mode of the songs, tempo, the musical form and lyrics can be elements for the posterior analysis (Schmidt, 1983).

Song writing has shown to be especially effective in children and adolescents having problems in verbal expression (Davies, 2005). Sometimes, when they have been abused is difficult to express it in a verbal therapeutic context (Day, 2005). Aasgard (2002) applied it in hospitalized children with different health problems, and she collected 19 songs as analysis and interpretation material. Song-writing can contribute to work fears and anxiety in hospitalization contexts with children (Fagen, 1982; Loveszy, 1991) and improve self-esteem (Griessmayer, 1990; Glassman, 1991). It can promote coping skills and reduce helpness feelings (Edgerton, 1990; Goldstein, 1990; Robb, 1996).

Following Mayers (1995) children were said to write a song in order to help them to manage bad feelings even though the song was not about anxiety or distress. Song could talk about emotional security or facts or figures related to it (*mother and father will always be with you*). According to this author, this technique can be effective for the treatment of trauma and anxiety in children. The repetition of the message of the song is used as a ritual or even for hypnosis. Snyder (1930) had previously investigated about poetry and hypnosis.

However, the intervention does not finish in this point. Once written, sometimes, songs are shared with friends and family in order to communicate messages (O'Brien, 2005; O'Callaghan, 1996) or obtain reinforcement. (Aasgaard, 2001, 2005).

To sum up, song writing is a useful tool to work about emotional aims combining verbal and emotional communication.

Chapter 3: Empiri

3.1.- Introduction

The main aim of this study is analyzing how song writing contributes to the treatment of trauma in a case of a child who has been exposed to gender violence against her mother using a qualitative method (observations and case description).

3.2.- Case description

This intervention takes place in an emergency shelter for gender violence depending on Madrid city Council. In this kind of centers women who have suffered gender violence from their partner or ex-partner live with children for no more than three months. There is a psychological intervention with the mother, a social involvement, an educational work and a child psychological area from which this procedure will be developed. Music-therapy treatment forms part of a program of emotional intelligence and it is mainly used for the treatment of trauma.

This 8 years-old child, called in a fictitious way Andrea, arrived with her mother the 10th of December of 2012, when the police intervention at their home made them leave it because of the violence they were suffering.

An initial evaluation:

From an unknown father, the child has grown up with her mother in a little village of Valencia with a good socio-economics status. However, during her short life she has been exposed to different kind of problems:

- Mother abusing drugs and alcohol
- Lots of sentimental violent partners of mother (child has been exposed to sexual violence, physical and verbal abuses and environmental violence).

- Many neglect events (she spent some nights at home despite being a little child, anyone was responsible of taking care of her when her mother wanted to go out)
- Dysfunctional role in the family for the child (exceeding power and responsibility in the relationship with her mother)
- Lots of familiar secrets (her mother made her think that she was going to have a little brother, but as soon as the baby was born, she decided to give him in adoption in the hospital. The mother had not paid some bills and they had to stay at home using candles because the company of electricity had cut their supply and she was forbidden to talk about it with the rest of the family)

As a consequence of this, Andrea presents symptomatology according to Post-traumatic Stress Disorder (increased arousal and irritability observed in some behaviors as tantrums; sadness and fear, physically and verbally expressed; avoidance of thoughts and feelings related to trauma object and enuresis).

Mother exhibits infantile behaviors and attitudes, showing jealous feelings to the therapeutic relationship; she has alcoholic problems, and tries to hide relevant information for the process.

After seven sessions with Andrea (once a week) working aims as establishing a therapeutic relationship, identifying emotions, emotional management and detecting trauma scenes, song-writing is used for dealing with trauma during four sessions. There are two more sessions conforming *closing phase* before she suddenly leaved the shelter.

It is important to remark that during phase 1, the emphasis is in establishing a trusting and confident relationship and creating a secure place for the child and her emotional expression. From this space, the person's rhythm is respected; the therapist waits until the child tells an episode or story, never asks about that before she expresses it. Once referred something, it is contented in any form depending on the context. One of the used ways of collecting and detecting these moments to be worked later is drawing her

life in vignettes. Figure 2 is an example of this method in which there are three vignettes of her first years of life:

When she was born in the first cartoon, when she and her mother lived with a mother's boyfriend in the second one and when police came because this boy had marihuana at home. Andrea decides how to organize her life story, drawing every moment that she considers relevant no matter the reason. For example, In this case, it results significative that she chose the moment in which the police went to her mother's boyfriend's house.

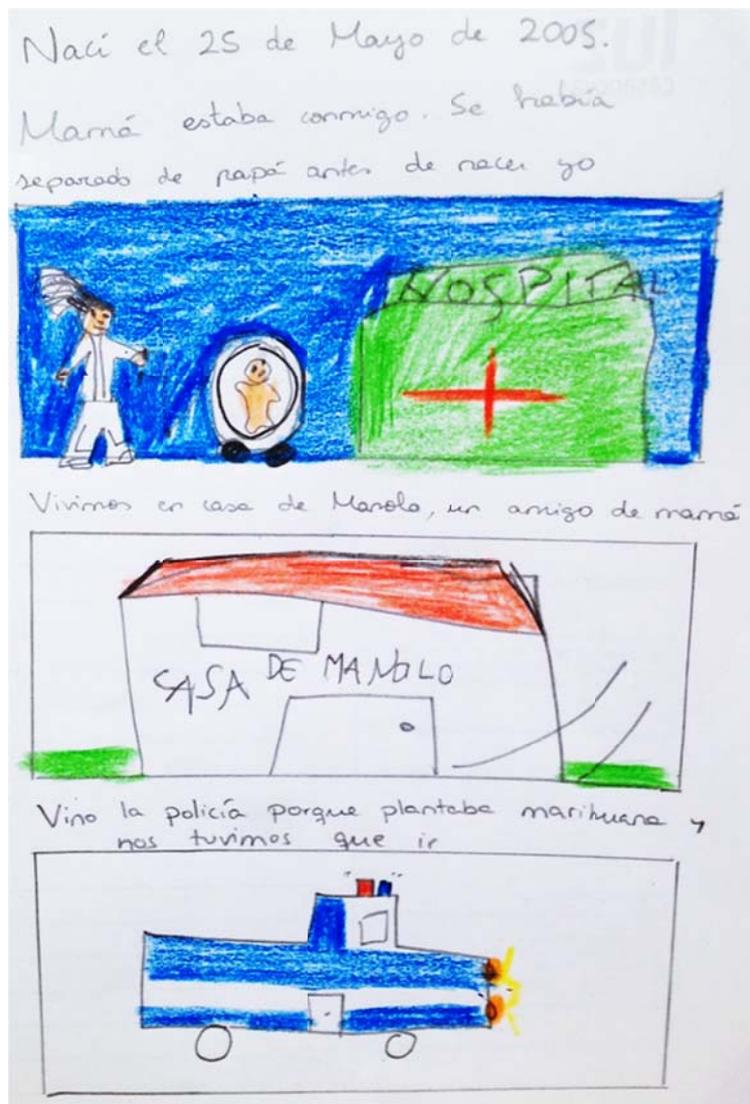


Figure 2: Picture drawn by Andrea showing a method of contenting emotions when she refers something about her life.

However, before this, the child has been trained in identifying emotions. Basic emotions (happiness, anger, sadness, fear and embarrassment) and its usefulness have been identified and described. So, this allows Andrea to accept her own emotions and identify what she felt in each vignette. On the other hand, it lets the therapist detect the most traumatic scenes and the moments more meaningful in the child's life.

So, the aims of each phase are very different:

| Linking and exploring (session 1-7) | Dealing with trauma (sessions 8-11) | Closing (sessions 12-13) |
|---|--|--|
| <ul style="list-style-type: none"> • Identifying emotions • Establishing relationship • Detecting traumatic scenes | <ul style="list-style-type: none"> • Traumatic scenes are tackled | <ul style="list-style-type: none"> • Closing and containing |

Figure 3: Aims in different phases of the intervention

Some of the activities used in the in the first phase are drawing, talking, playing games, using free improvisations and corporal movements, depending on Andrea's preferences. The structure of the session is not defined, but objectives are always present, no matter the kind of activity chosen.

In the phase of dealing with trauma song-writing is introduced. The child is told to sing about what happened. Sometimes the song is referred to a concrete vignette:

`Lets sing about this draw`

Other times, it is referred to an emotion.

`The most traumatic scene you have ever experienced`

And some other times she is told to sing freely about anything she wants.

During phase 3 drawing, corporal movement and free improvisations are used again; Andrea, who knows that she is about to leave the shelter, does not want to write songs again.

3.3.- Data collection

Data for analysis are extracted from:

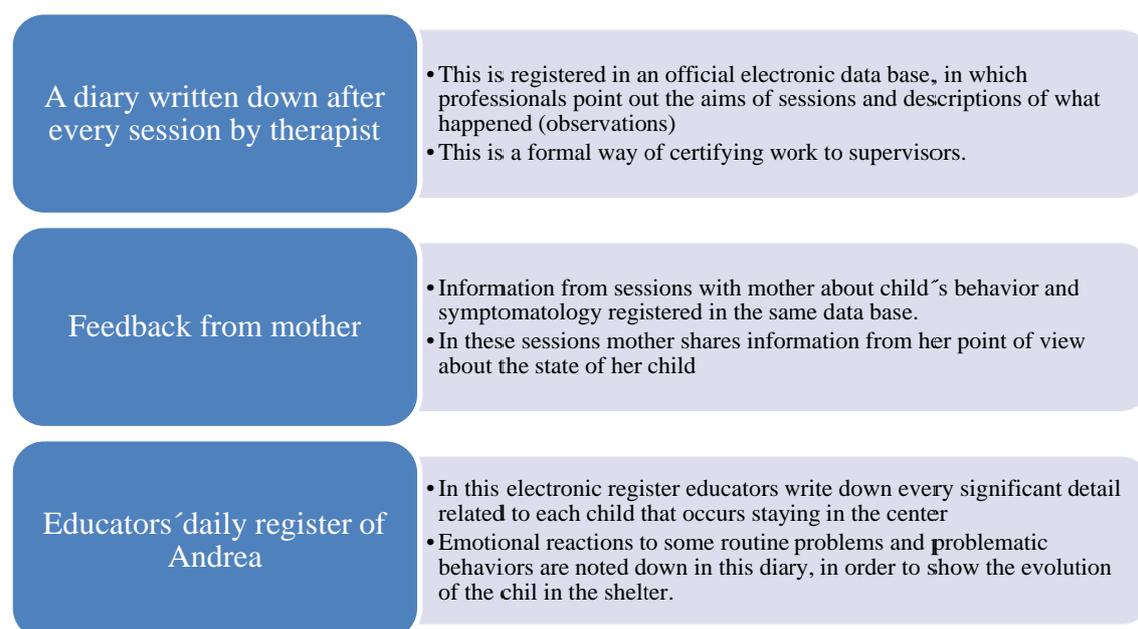


Figure 4: Registers of data

Data from this three registers (some of the behaviors are observed in therapeutic sessions by therapist and other ones are observed by the mother and the educators) will be classified in different categories, all of them related to the Post traumatic Stress Disorder symptomatology previously described in chapter 2. In this work observed conducts will be named as *externalized behaviors* -physiological symptoms, aggressive behavior (self-harms or being aggressive toward other children)-and *inhibitory behaviors*- resistances and avoiding talking about traumatic events.

Figure 5 shows all of the analyzed symptoms. In each session, therapist observes and writes down some symptoms which have been classified in order to make easier the analysis of physiological symptoms, aggressive behaviors toward oneself and symptoms

of resistances and avoidance. This classification has been done attending to criteria for the diagnosis of Post- traumatic Stress Disorder in DSM-IV:

A. *The person has been exposed to a traumatic event in which both of the following were present:*

- *The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others*
- *The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior*

In Andrea's case, both of them were present.

B. *The traumatic event is persistently re-experienced in one (or more) of the following ways:*

- *Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.*
- *Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.*
- *Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.*
- *Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event*
- *Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event*

In this case, physiological symptoms are referred to intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Andrea's behavior shows intense distress when appears memories and verbalizations about traumatic experiences. They have been divided according to a subjective evaluation of intensity done by therapist: low intensity (*Low voice, fast breathing, clenching her fists, quavering voice, legs trebling*) and high intensity (*crying and trembling*).

The mother and educators are asked about physiological symptoms as *enuresis* (subjectively considered a high- intensity symptom) and *emotional lability* (subjectively considered a low- intensity symptom).

C. *Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:*

- *Efforts to avoid thoughts, feelings, or conversations associated with the trauma*
- *Efforts to avoid activities, places, or people that arouse recollections of the trauma*
- *Inability to recall an important aspect of the trauma*
- *Markedly diminished interest or participation in significant activities*
- *Feeling of detachment or estrangement from others*
- *Restricted range of affect (e.g., unable to have loving feelings)*
- *Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)*

Related to this point, symptoms observed in Andrea have to see with *persistent avoidance of stimuli associated with trauma*. In the beginning, the child avoided talking about anything related to trauma, and when she did it she tried to hide herself (*covering with a blanket, covering face with hands, turning back to therapist or hiding under bed*) or *changed the subject* immediately. Sometimes, she *went out* the room (this has been considered high- intensity symptom and the rest of them low- intensity symptoms).

Apart from this, outside the session, these resistances were also observed. However, only the mother gave information of resistances and avoiding talking about traumatic situations: when she avoided it completely and there was not verbalizations about it (high- intensity symptom), when she mentioned something about it and changed the subject (low- intensity symptom) and when she talked freely about anything related to traumatic events (no symptomatology observed). Educators do not usually talk about traumatic stimuli because there is not a therapeutic space for it in their intervention.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- *Difficulty falling or staying asleep*
- *Irritability or outbursts of anger*
- *Difficulty concentrating*
- *Hypervigilance*
- *Exaggerated startle response*

Some observed conducts have been classified as aggressive behaviors toward oneself: High- intensity behaviors such as *scratching face* and low- intensity behaviors such as *hitting legs* or *cutting threads from the clothes* (intensity evaluation is subjective again). On the other hand there are aggressive conducts toward others such as outbursts of anger (*tantrums*) and *physical aggressions* (high intensity) or *jealous conducts* and *causing problems with other children* (low intensity).

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Although symptomatology is not considered enough to establish a diagnosis of Post-traumatic Stress and it was not the aim of this work, all of the behaviors that the child presents are clearly related to these ones described in DSM- IV.

The mother and the educators are asked about these symptoms, always referring to the previous week.

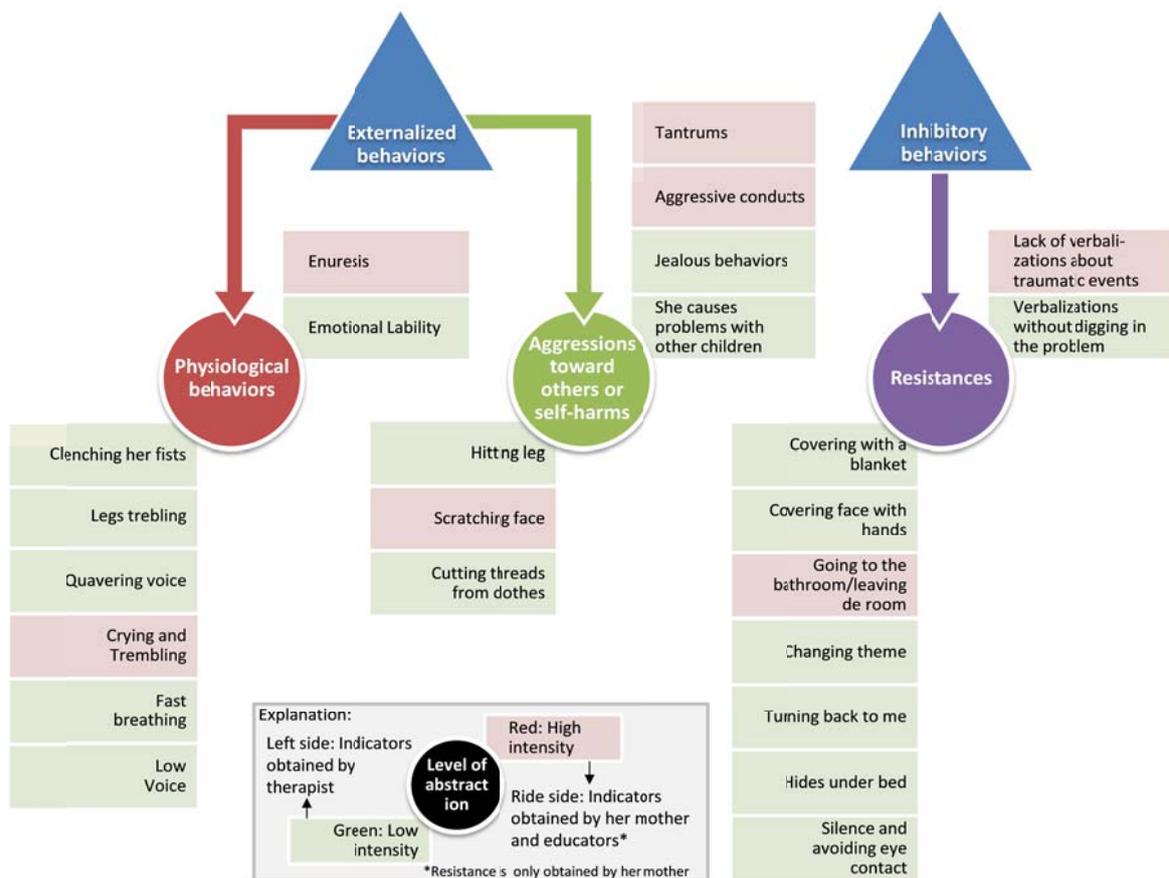


Figure 5: Observed behaviors

3.4.- Data exposition

Figure 6 shows registered symptomatology in each session and collected information from mother and educators.

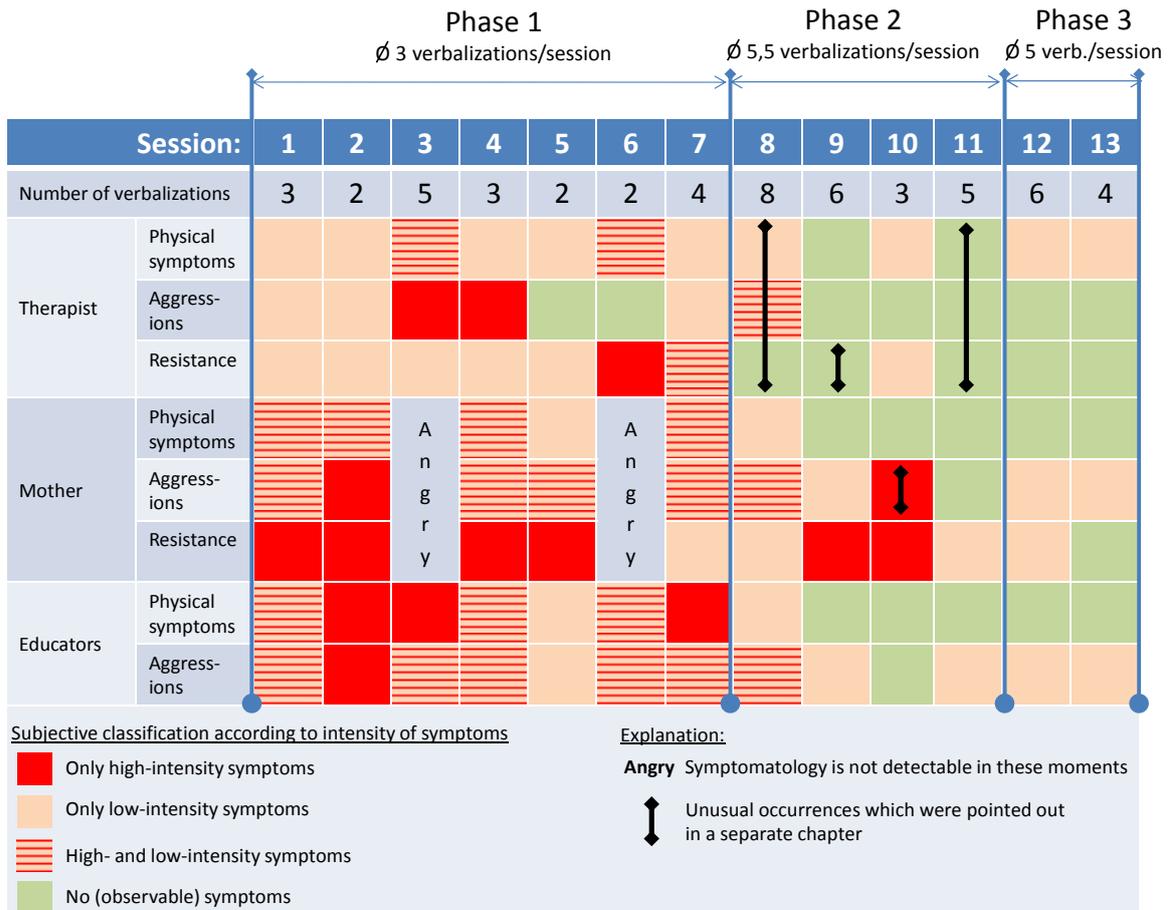


Figure 6: Evolution of symptomatology

Red squares represent sessions in which there are only high- intensity symptoms detailed in Figure 5, while pink squares are used for low- intensity symptoms. Lines in squares are used to indicate high and low- intensity symptoms and green squares show lack of symptoms. There are two sessions in which there is no information from the mother because she is angry with the professionals and she does not want to talk to anybody. An arrow represents unusual behaviors or remarkable things happening during those sessions.

Verbalizations are counted in each session and media is calculated. As it is shown in this figure, the media of verbalizations is a little bit increased ($X=5,5$) in phase 2, when song writing is used. In the first phase, the intensity of the physiological symptoms observed during sessions is higher than in the other phases. Self-harms disappear in session 5 and 6 after being very intense in session 3 and 4, but reappear in session 7 and 8. After that, the child stops hurting herself.

She shows resistances of talking about traumatic scenes, which get the most intensity in session 6, when Andrea leaves the room. No resistances are observed in phase 2 and 3.

Mother is angry with professionals in sessions 3 and 6, so there is no information from her in these periods of time. However, it can be appreciated that physiological symptoms observed by the mother such as enuresis decrease in phase 2 and 3. Aggressive behaviors get better in session 9 but high- intensity symptoms reappear in mother's feedback of session 10. After that it gets better again.

About the resistances to talk about themes worrying her, Andrea verbalizes to her mother something about traumatic situations shyly avoiding digging in the problem in session 7. The same occurs in session 8, 11 and 12. In the last session, the mother refers that Andrea has asked her lots of questions about traumatic events.

The educators usually agree with the mother's register excepting: In session 2 and 7 there are low-intensity physiological symptoms referred by mother that the educators do not observe, in session 5 the mother perceives high-intensity aggressive conducts, in session 10, very remarkable, the mother refers high- intensity symptoms but the educators do not observe any of them and in session 11 the educators write down low-intensity aggressive behaviors which are not pointed out by the mother.

Focusing on observed resistances, in session 7 and 8 there are some verbalizations to her mother about what happened. During the last session she talks to her mother freely about it.

According to the educators, physiological symptoms are reduced punctually in session 5 and progressively from session 8 until they are eliminated. About aggressions towards other children, they get better from session 9, although in session 5 again a punctual reduction is found.

3.5.- Descriptive information from significant sessions

Phase 1: Linking and exploring

In session 2 and 3 symptomatology is very intense. There are more verbalizations during session 3, and that is why this session has been selected to be described in depth.

As soon as Andrea comes back to the session, she expresses being very sad. Her mother is angry with the educators because they have tried to help her to recognize that she has a real problem with alcohol. Then, she has become violent to them, shouting and insulting them. This situation is very uncomfortable for Andrea, who has a good relation with professionals and she does not understand what is happening.

The child refers lots of incidents related to her mother's alcoholism problems and she seems to be confused. She asks about the normalcy of that fact and she is worried about the image of her mother in the shelter (*I don't want you to think that mum is not a good mother*). Once this theme is worked (drawing and using other psychological techniques) and Andrea is calmer, she tells me:

Now I will tell you why my mother drinks so much and what happened with her boyfriend.

The child talks about the violent behavior of mother's boyfriend. She confesses being scared and feeling impotent to protect her. Verbalizing this, she cries, scratches her face and hides under bed.

| Verbalizations | Physiological symptoms | Self- harms | Resistances and avoidances |
|--|------------------------------|-----------------|---|
| I am very sad today | | | `I don't want you to think that mum is not a good mother` |
| Now I'll tell you what happened with her boyfriend | Low Voice | | Silence after saying this and avoiding eye-contact |
| Joust hit Mum | Crying and trembling | | She hides under bed |
| I thought she was dead | Trembling Quavering voice | Scratching face | She turned her back to me |
| I wanted to help her but I couldn't | Crying | Scratching face | |

Figure 7: Behaviors registered during session 3

Feedback from mother: Mother is angry with all of the professionals and she does not want to talk any more. There is no information in this register.

Feedback from educators: In educators' diary it is registered that Andrea cries a lot during these two days without any triggering event, continues suffering enuresis and she stays alone in her bedroom.

Phase 2: Dealing with trauma

There are some remarkable points during sessions in which song-writing has been used.

| Session: | | 8 | 9 | 10 | 11 |
|--|-------------------|---------------|--|--|---|
| Therapy | | Telling story | Song-writing | Song writing | Song writing |
| Number of verbalizations | | 2 | 6 | 6 | 3 |
| Occurrences | | | More verbalizations and one scene never mentioned before | She had a verbalization never mentioned before | She told to their educators that her mother is drinking a lot and her mother was angry with her |
| Therapist | Physical symptoms | | | | |
| | Aggressions | | | | |
| | Resistance | | | | |
| <u>Subjective classification according to intensity of symptoms</u> Only high-intensity symptoms High- and low-intensity symptoms Only low-intensity symptoms No (observable) symptoms | | | | | |

Figure 8: Behaviors and occurrences during phase 2

In session 8 there are more verbalizations when song-writing is introduced. It is remarkable that physiological symptoms registered during this session appear while Andrea is talking and drawing, but not singing.

Apart from that, she verbalizes a traumatic situation never before mentioned: when they left the little village where she had lived and went with her mother’s boyfriend (she wanted to go back but mother did not take care of her).

Lyrics of the song 1

| | |
|---|---|
| <p>Yo vivía en un pueblo llamado “Aldea Nueva” Y luego me fui a un pueblo llamado “Torrevieja” Mi madre se quedó allí para vivir Ella pensaba eso, pero no era así</p> <p>Entonces, conoció a un niño, a un chico que se llamaba Joust Entonces Joust le dijo por Skype que fuera allí en semana santa. Entonces, mi madre dijo sí, yo dije también</p> <p>Pero yo pensaba que sólo era por semana santa me di cuenta de que ya pasaron 11 días, y vi que todavía estábamos allí</p> <p>Yo le dije a mi mamá que cuando nos íbamos, y ella ya ni sabía lo que decía. Entonces, dijo que sí, que nos íbamos. Entonces, eso no, no, no se realizó</p> | <p>I lived in a village named `Aldea Nueva` And later I went to live to a place named `Torrevieja` My mother stayed there to live That was what she thought but it wasn't like that</p> <p>Then, she met a boy, a man Named `Joust` Then Joust told her using Skype To go there in Easter Week Then, mother said `yes`, I said `yes`, too</p> <p>But I thought it would be only during Easter Week I realized that 11 days had passed And we were still there</p> <p>I told mum when we were leaving But she didn't know even what she said Then she told me we were leaving Then, it was not true, it was not true</p> |
|---|---|

Figure 9: Lyrics of song 1

The same happens in the song written in session 9. This session will be described as an example of phase 2.

In this session, Andrea is told to sing about the most traumatic experience she ever had after having drawn different traumatic scenes in previous sessions in cartoons. At the beginning she chooses the last aggression her mother suffered. However, singing about it, she describes how she felt being on holidays with her uncle and aunt in Andorra and her mother phoned her. The mother told her that she had to go back because Joust had battered her. Andrea had never mentioned this episode before. This had not been detected as a traumatic moment yet. She travelled alone by train from Andorra to Valencia, and during this time she was afraid of the situation she would find at home. Neither in this song nor during the session, physiological symptoms, self-harms or resistances was shown.

Lyrics of song 2

Yo estaba en Torrevieja, eja, eja
Estaba en Torrevieja

Yo no estaba en la casa
No estaba en ese pueblo
Yo estaba en Andorra
Con mi abuela
(¿Puedo decir mi abuelo? Para que no quede...)

Pero resulta que me fui
A Andorra a vivir
Luego un ratito con mi tía
Se quedó embarazada de una bebé
de una bebé, de rosita que tiene 2 meses

Al día siguiente ella se iba haciendo más mayor, más mayor
A medida que se hacía, a medida que se hacía mayor, yo
Yo me tuve que ir, y yo me tuve que ir
Y me fui, y me fui
Pero resulta que me fui

Yo me fui en tren de renfe,
No me fui con mi abuela
No me fui con mi madre
Yo me fui sola con una cuidadora

Que en verdad tenía un collar que ponía
mi nombre y apellido
me llevaba mis maletas
y yo iba muy solita,
no tenía a nadie acompañado
y por eso yo ya,
yo ya estaba, yo no estaba llorando

Pero ya resultó que había llegado
yo me había asustado porque Joust
porque tal, porque yo me había asustado

Porque mi madre, porque mi madre
me contó que se había peleado con Joust

Entonces, no quería
Yo tenía miedo de llegar a casita,
aquel día me contó mi mamá pienso yo que me quedé
sorprendida
porque por, porque no, porque sé

Entonces yo ...
Que yo llegué,

I was in Torrevieja, eja, eja
I was in Torrevieja

I was not at home
I was not in that village
I was in Andorra
With my grandmother
(Could I say `my grandfather`? It sounds better)

But I had to go
To Andorra to live
Then, a little time with my uncle
She got pregnant
She had a baby, pink, a two months-baby

The next day she became bigger and bigger
And in that moment, I had to go

And I went, I went
I went, I went
At the end, I went
I went by train
I didn't go with my grandmother
I didn't go with my mother
I went alone with a carer

She had a neckle in which
My name and surnames were written
She carried my package
And I felt very alone
I had nobody with me
And because of that
I was crying, no, I was not crying

But when I arrived
I was frightened because Joust
Because..I had scared

Because mother had told me
That she had fought with Joust

So, I didn't want
I was frightened of arriving home
That day, my mother told me...
I got surprised
Why not, because I know

Then, I...
I arrived
I didn't want to arrive home

| | |
|--|--|
| <p>yo no quería llegar a casa</p> <p>Pero mi madre me contó que no estaba allí Joust, yo me relajé entonces mi madre me contó que al día siguiente Joust volvería</p> <p>y un amigo vendría a por nosotros. Me contó y me fui a Moratalaz...</p> | <p>But my mother told me That Joust wasn't there Then I relaxed Then my mother told me that Joust would come back the next day</p> <p>And a friend would come for us That is what she told me And I went to Moratalaz...</p> |
|--|--|

Figure 10: Lyrics of song 2

| Verbalizations | Physiological symptoms | Self-harms | Resistances and avoidances |
|---|------------------------|------------|----------------------------|
| I went alone with a carer and I felt very alone | | | |
| I had nobody with me and because of that I was crying, not crying | | | |
| I was frightened, I had scared | | | |
| She had fought with Joust | | | |
| I didn't want to arrive home | | | |
| I was frightened of arriving home | | | |

Figure 11: Behaviors registered in session 9

Feedback from mother: Andrea behaves better. She says that they had only one argument which finished with a tantrum because of the clothes she wanted to wear to school.

Feedback from educators: In educators' diary it is written that Andrea is more calm and do not promote so many problems with children. She is having a positive relationship with another child who was previously the focus on her problems. They play together and she does not behave in an aggressive way as she did before.

The other subjects of the songs are: descriptions of the visualized violence against her mother (there are two songs about that), her own feelings about it (there is one song talking about this), fears and worries at the moment (two lyrics deal with this subject) and moments of happiness (there is only one song about it).

Phase 3: Closing (session 13)

Andrea is going to leave the shelter and she admits being sad because of this. This is the last session. She expresses being worried about mother's behavior. She talks freely about violence observed, mother's alcoholism problems and her own feelings.

| Verbalizations | Physiological symptoms | Self-harms | Resistances and avoidances |
|---|------------------------|------------|----------------------------|
| I don't want to leave | | | |
| What do I have to do if mother drinks again? | | | |
| I am sad because I want to go back to my village | | | |
| I will phone you if somebody treats my mother or me badly | | | |

Figure 12: Behaviors registered during session 13

Feedback from Mother: According to Andrea's mother, she has asked her lots of questions about what happened, about aggressions observed including sexual aggressions, about her intentions of going back or not to her boyfriend's house and about some familiar secrets concretely about the brother that she lost. Her mother was pregnant and she had prepared Andrea for having a little brother but suddenly she decided to give him in adoption. She arrived home telling her that her brother was with other family because she had thought it was better for him (this fact appeared in a song).

Feedback from educators: There is no enuresis or emotional lability observed. Andrea still exhibits jealous behaviors but there are no more aggressions towards other children or tantrums.

3.6.- Results

In the beginning of the intervention, Andrea showed different symptoms which could be associated to Posttraumatic Stress disorder. The intensity of all of them has been reduced at the end of the process according to the therapist, mother and educators.

Data are presented considering the best and the worst punctuation in each phase, so if there is a session with no symptoms and there is another one with high- intensity symptoms in the same phase, both of them will be reflected.

Physiological symptoms

Regarding symptoms development in phases, it is shown that the intensity of physiological symptoms in therapy has become lower at the end of the intervention. There are not high- intensity symptoms during phases 2 and 3. The mother and educators refer that these symptoms have disappeared.

| Phase | | 1 | 2 | 3 |
|-------------------|-----------|-------------------------|------------------------|--------------------------|
| Physical symptoms | Therapist | High-intensity symptoms | Low-intensity symptoms | No (observable) symptoms |
| | Mother | High-intensity symptoms | Low-intensity symptoms | No (observable) symptoms |
| | Educators | High-intensity symptoms | Low-intensity symptoms | No (observable) symptoms |

■ high-intensity symptoms
■ low-intensity symptoms
■ No (observable) symptoms

Figure 13: Evolution of physiological symptoms in phases

Aggressive behavior

In the first phase, aggressive behaviors were more intense (aggressions towards herself and others) than in the other phases, although they do not disappear completely according to the mother and educators; symptoms still appear with low- intensity in

phase 3. In therapy, the intensity of aggressive behaviors is lower in phase 2 and they disappear in phase 3.

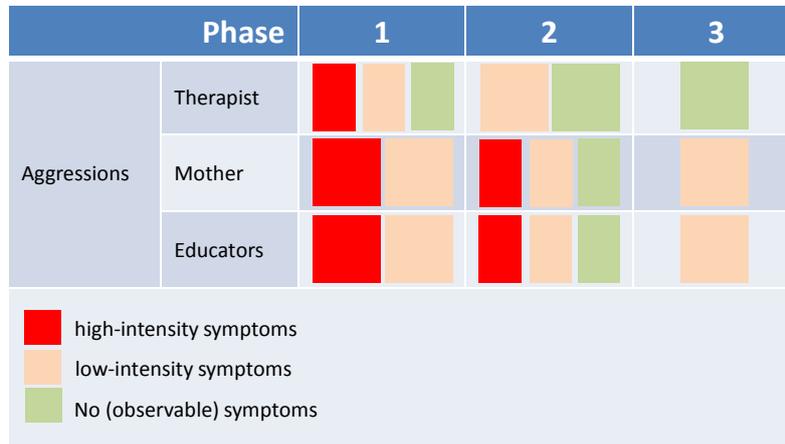


Figure 14: Evolution of aggressive behaviour in phases

Resistances

There is a visible evolution in this variable. In therapy there is not any resistance in the last sessions, and attending to mother's feedback, during the last phase Andrea verbalizes many traumatic events.

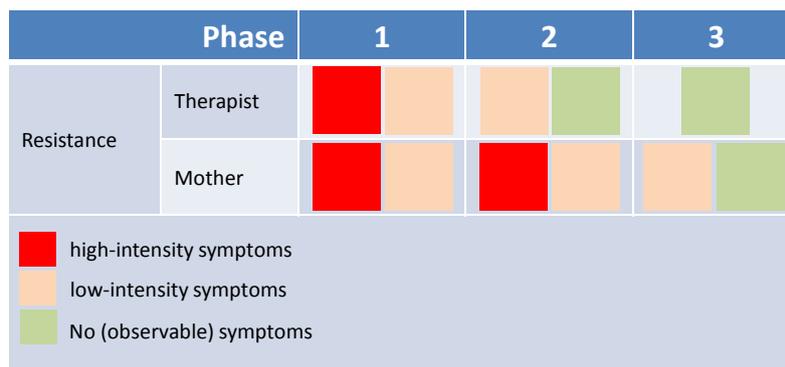


Figure 15: Evolution of resistances in phases

In resume, evolution in therapy is clearly observed: physiological symptoms still appear with low intensity in last sessions but the most interesting thing is that while songs are composed they are not observed; aggressions and resistances disappear at the end. It is

surprising that in session 8 there are more self-harm behaviors and more intense than in previous sessions. Anyhow, it could be explained because there are many verbalizations.

Chapter 4: Discussion

Once having exposed the results in the previous chapter they should be compared with other studies in order to determine if they are coherent with previous conclusions and researches or they are not.

Song-writing has been used for the treatment of trauma with a child and the focus of this work is analyzing in which way it has influence in emotional aims related to this problematic.

According to literature, song-writing would promote expressing and sharing feelings (Castellano, 1969; Ficken, 1976) and externalizing thoughts and emotions. This technique has showed to be effective for these aims in the case described; analyzing lyrics of created songs it can be concluded that the child has expressed how she felt during traumatic experiences and after them and she has described these moments without showing anxiety or resistances. For example, one of the physiological symptoms which had appeared at the beginning of the intervention and it has not been observed during the use of the technique is *`Fast breathing`*. It was supposed to occur like this in coherence with Mayers (1995) that defended that singing facilitates breathing regulation because of its own nature (respiration must be controlled). However, this is not the only symptom disappeared. Any of them is shown.

Therefore, related to this point, song-writing has contributed to eliminate resistances to talk about some themes without symptoms of anxiety, facilitating emotional expression and dealing with traumatic experiences.

Additionally, according to McFerran, Baker, Patton & Sawyer (2006) using song writing people mention episodes never before verbalized. This happened in this case: the child verbalized in songs some traumatic events which she had never talked about. This happens in a spontaneous way when she is asked to sing about an emotion or situation. This could be related to the study of Aldridge (1996) in which music has

shown to be helpful for remembering past situations. In the same line of thought the premise suggested by Turry (1999) is remarkable: song writing stimulates emotion and because of that lyrics are so significative. Apart from that and following the idea from this author, song provides a secure structure for contention.

A new hypothesis could appear referred to the technique of song-writing and its power for detecting traumatic objects, moments and scenes. As it was commented when session 9 was described, Andrea composed a song about a traumatic moment which she had never talked about. Although she had been asked about difficult situations and she had done lots of draws reflecting her life and the most difficult moments along the time, that one had never appeared. And what is more: it occurred two more times during the intervention.

Nevertheless, written songs are not so many and time is limited. So it results difficult to conclude that new information appears because of the use of this technique. It could be due to the development of the intervention and child's necessity of expressing more and more as the time goes on and she eliminates resistances (this occurs in a later phase). Anyway, trying to compare and control those variables and factors could be a future line for continuing this work.

The evolution exposed until this moment is referred to the facts observed exclusively inside the therapy, but can they be extrapolated to other areas? What does occur with symptomatology observed out of the sessions by the mother and the educators?

As it has been detailed in chapter 2, music therapy is supposed to be a useful tool in the treatment of trauma: improvements in sleep disorders had been found (Hernández-Ruíz, 2005) and it had been effective in the treatment of Post-traumatic stress disorder (Bensimon, Amir & Wolf, 2012). It should be reminded that not every symptom of post- traumatic stress disorder's symptomatology is considered; only some of them are observed. However, considered data are valued as positive: enuresis disappeared completely at the end of the intervention and also did emotional lability.

Aggressive conducts towards other children in the shelter are still observed but the intense of them has decreased.

Although there is an evolution in symptomatology from phase 1 to 3, some outstanding factors should be considered before concluding that changes are due exclusively to this intervention. One of these factors is mother's attitude; the child's behavior could be influenced by this in different ways indirectly. Because of the strong relationship between mother and child, mother's attitude could increase dysfunctional conducts or by the contrary, promote positive conducts. On the one hand, the hardest symptomatology is observed in the first phase, and it is during this phase that Andrea's mother has lots of problems with professionals. Attending to session 3 and 6, for example, symptomatology in therapy is very hard. It is remarkable the concurrence of this symptomatology and the mother's anger.

Something similar occurs in session 10. The mother registers high-intensity aggressive conducts but educators' reports are good. In the moment of the register, the mother was very angry with Andrea, which could have provoked this behavior. Another hypothesis could be that mother's testimony is biased because of her anger. Furthermore, the mother is working to solve her own problems and resistances to talk about traumatic events. Once been able to do this, it could make easier for the child talking about it. So, in phase 3, when Andrea starts mentioning some episodes to her mother, it could be not only this therapy, but also the mother's emotional state, which facilitates this. In an unconscious way, she could be more receptive to her daughter and to talk about what happened because it is no more a secret.

Apart from that, in this case, last phase is not defined by the development of the intervention; Andrea's mother suddenly decided to leave the shelter and to interrupt the child's treatment. This could have influence in Andrea's progress because the child was very nervous and worried about that. The mother was also nervous and irritable. After considering carefully the whole situation Andrea's reaction is absolutely adaptive: the child does not know where they are going, if mother wants to go back with her boyfriend and mother's abilities for protecting her from some risks are scant.

Information comes from three origins and they are connected in some way with each other:

Referring to physiological symptoms, three registers are very coherent in general; the register from the mother, the register from the educators, and the register written down in therapy, excepting that they are still observed in therapy despite of having disappeared according to mother and educators. However, it can be explained, as it has been exposed, because the child is worried about leaving the shelter and this could bring them real problems, so she would be worried in an adaptive way (low- intensity symptoms) and she would express it in therapy feeling the intervention as a free emotional space for it.

Attending to aggressive conducts in therapy, evolution is clearly observed; high-intensity behaviors disappeared in phase 2 when song writing is introduced. They could be supposed to have disappeared as a consequence of the intervention. However, if the lyrics were referred to previously mentioned episodes, it could be concluded that decreased emotional reaction was an effect of habituation to it (because of repeating the same story once and again). But some of the lyrics are referred to new episodes never before explained so this explanation is not completely acceptable.

Looking at Figure 4, during sessions 5 and 6 self-harms in therapy decrease, but this can be justified by the few verbalizations about traumatic scenes. During these session there is no many verbalizations comparing to other ones.

Aggressive conducts in mother's and educators' register are getting better from session 10 (except in this session according to the mother previously commented). The evolution could be expected to be higher in the last phase but it is not. It is important remembering that the child's fears about leaving the shelter during these two last sessions could be making her be more irritable. Nevertheless, this is just a hypothesis.

Related to the resistances, the evolution in therapy is more visible than the evolution according to mother's testimony. As it has been explained before, it could be due to mother's mood and psychological state.

In general, it can be concluded that there have been improvements. However, phases are very short; if phase 1 had been a little longer perhaps Andrea would have had time to refer more traumatic episodes and symptomatology could have decreased from that moment. At least this could have given more information about the relevance and clear effects of song-writing. On the other hand, it would have been interesting if phase 2 had been longer to clarify if positive changes are stable and to avoid the influence of their sudden exit. The same happens in phase 3 in which there are only two sessions; observing changes in the long-term would have been interesting in order to prove if they are perdurable or temporal.

In addition to this, there is one more limitation that must be mentioned. As the child and her mother are receiving an integral intervention from different areas, it cannot be concluded that these improvements in symptomatology are due exclusively to the music therapy intervention. Despite of that, what happened during sessions applying song writing is clear: the child expressed emotions and thoughts never before mentioned and she did it without showing any resistance, physiological symptom of stress or aggressive conduct. As a way of summing up the results of this work, an idea of Peter Etzkorn (1963) can be rescued from his studies about Mass Communication through popular music and exposed here: Who says What in Which canal to Whom with What effect. And the result is that Andrea told to the therapist about traumatic experiences singing without showing post-traumatic effects.

Conclusions

After analyzing carefully changes and relations between elements observed in the intervention related to song writing and some symptoms of post- traumatic stress disorder in the previous chapter of this work, conclusions are summed up:

- In this case, song writing allowed the child expressing emotions and thoughts about traumatic situations. The child used song as a way to communicating and expressing freely. She mentioned traumatic experiences.
- Some lyrics were spontaneously referred to traumatic moments no previously mentioned.
- There is not physiological symptomatology observed using song writing (no resistances or physical symptoms); symptomatology had previously been observed while the child verbalized traumatic experiences or anything related to the traumatic objects. However, when song writing is introduced, the child does not show any of these symptoms in spite of being dealing with traumatic objects.
- Aggressive conducts towards herself disappeared while song writing is in use. In the beginning of the intervention she used to show self-harm conducts while she referred anything about traumatic experiences. This is not observed at the end of the treatment: Andrea sings talking about every violent and difficult episode and there are no symptoms observed. On the other hand, aggressions towards other children living in the shelter are also reduced, according to the feedback of the mother and educators. Although some of these conducts are still observed, the intensity of them is lower than in the first phase.

- Physiological behaviors observed by the mother and educators (such as enuresis or emotional lability) disappeared completely at the end of the intervention. According to the literature revised, it was predictable.
- Physiological symptoms of anxiety were still detected in therapy during the last phase. Nevertheless, considering circumstances, this could be an adaptive reaction; the child and her mother were going to leave the shelter and the situation was not stable for the child. She did not know where they were going to live or where they were going to do.
- In spite of founding good results they may be influenced by the employment of other therapies: on the one hand it has to be considered that in the shelter there is an integral intervention with the family and on the other hand, because music therapy forms part of a more extensive program of emotional intelligence.
- There are some factors influencing on the results such as the mother's attitude towards professionals or towards the child. Sometimes she has argued with professionals or with Andrea, which has made the child being sad or worried about it.
- It is not known if changes are perdurable or not because of the sudden interruption of intervention. It has not been possible to continue evaluating effects along the time.

Despite of the limitations that this work presents, results are considered positive and it would be interesting to continue analysing some themes. It could have been stimulating to apply some techniques following some suggestions from literature such as sharing songs with the mother or with other people relevant for the intervention in order to promote more positive changes and reinforce development.

On the other hand, a new line of study has appeared. Song-writing has facilitated expressing feelings and thoughts, but it has also promoted referring episodes never before mentioned. Related to this, it could be suggested that song writing has helped therapist to detect more traumatic scenes in order to deal with them later. This fact could be explored in the future.

During the last phase of the treatment, Andrea does not want to use song-writing although she has enjoyed when it has been used. It could be relevant if it is considered as a sign of avoiding talking any more about trauma and avoid exposing new traumatic moments because she is leaving. And what is more, some of the traumatic episodes had been previously worked before start song writing but she did not show anxiety when she spontaneously mentioned other ones not worked before. So, could song writing facilitate expressing traumatic scenes? And could song writing reduce anxiety expressing traumatic experiences for the first time?

Unluckily this work is limited to value this point because there are no enough songs and there is only one case described.

Although the unique considered element in songs has been the meaning of lyrics, music could also have been analysed in a deeper work.

To sum up, despite of being some limitations, in this work song-writing has shown to be useful calming down physiological symptoms of posttraumatic stress, reducing aggressive conducts toward others and towards oneself and avoiding resistances to talk about traumatic experiences and new lines of interest have been created.

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