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The Boy With the Glass Flute

Journeying Through the Therapeutic Process With a Preadolescent Who Has Been Abused

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Abstract

This study describes music therapy sessions over 21 months with a preadolescent boy who had several diagnoses including Atypical Asperger Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), Reading Disability, and "probable" Conduct Disorder (CD). He had also been physically abused. John's initial rejection of music led me, as clinician, to question the appropriateness of a music therapy programme for him, the philosophical underpinnings of the work, and my skills as a clinician. However, by maintaining the humanistic existential framework that was familiar to me, and employing aspects of Paraverbal therapy, I was able to develop a relationship of trust with John and to facilitate his involvement in creative activities. Following an extremely tentative beginning he was able to communicate his love and fascination for music by creating the fantasy of owning a "glass flute", a symbolic object of beauty that can be enjoyed, but which was delicate and fragile. As his self awareness and identity became more established the image of the glass flute was replaced by the reality of recorder playing and he developed a new confidence in the mastery of music which allowed him to successfully perform for his peers and the general public.

Introduction

John was an 11-12 year old boy who had been removed from a home in which he experienced frequent violence and severe neglect.

The diagnoses of Atypical Asperger Syndrome, ADHD, reading disability and "probable" Conduct Disorder, are not mutually exclusive and neither do they alert the clinician to consider the impact of the abuse on his behavioural functioning. The behaviours that led to the diagnosis of Atypical Asperger Syndrome may have been symptomatic of ADHD or problems related to abuse or neglect. However, I knew that when I was working with John I should also consider the possibility that he did have an Autistic Spectrum Disorder. Brown reminds us of the pervasive impact of autism when she says "for the child with a disabling condition such as autism, trying to make life manageable often involves developing behaviour that seems even more dysfunctional, for example becoming obsessional, ritualistic and controlling" (Brown, 2002, p. 84). It was likely that John's complicated history would amplify and intensify these behavioural traits.

ADHD patients commonly have other diagnoses, most frequently Conduct Disorder, Oppositional Defiance Disorder, and Anxiety Disorder (August & Garfinkel, 1993; Rapoport & Ismond, 1996). The association between Learning Disorders and Conduct Disorders has also been demonstrated (Rapoport & Ismond, 1996). Attachment concepts and associated relationship difficulties are relevant to a wide range of psychopathological disorders, but perhaps especially conduct disorders (Rutter, 1995). And evidence also suggests that while

sexually abused victims are at risk of developing Post Traumatic Stress Disorder (PTSD), physically abused adolescents may be more at risk for behavioural and social difficulties than for PTSD (Pelcovitz et al., 1994).

Physically abused adolescents may 'enact' the results of their victimization rather than express their reactions to the abuse via the more trauma-specific avenue of PTSD. Kiser et.al (1991) found that higher levels of behaviour difficulties including delinquency, aggression, anxiety, and depression characterized a significant percentage of abuse victims without PTSD diagnosis. Trauma-induced reenactments; identification with the aggressor or victim; the use of denial, splitting, and dissociation; and an ambivalent attachment of the child to its mother may all be considered as defensive reactions to the trauma inherent in maltreatment (Green, 1998). Terr (1991) suggested that a "Type II trauma" is the result of repeated exposure to long-standing trauma and may be more likely to result in reliance on coping mechanisms such as denial and dissociation. The disorders commonly diagnosed in Type II trauma are conduct disorders, attention-deficit hyperactivity disorder, depression, and dissociative disorders.

Children who have been physically abused have no sense of identity and therefore poor self-concept (Kinard, 1980) and this is likely to be linked to aggressive behaviour. Kinard attempted to measure self-concept of children who were physically abused and presented with sad, withdrawn and depressed affect. The results of his study suggested that children of abuse are unable to evaluate themselves accurately on self-concept measures. A sense of self develops in the context of a child's most intimate relationships with crucial caretakers, notably the mother (Mahler, Pine & Bergman, 1975; Stern, 1985) and is formed through the sharing and modifying of feelings between parent and child. When abuse occurs at the hands of the solo mother, it is almost inevitable that the child's self identity will be disturbed. Rutter (1995), describes a form of attachment disorder associated with parental abuse or neglect that presents as a combination of strongly contradictory or ambivalent social responses. These may be most evident at times of partings and reunion; emotional disturbances evidenced as misery, lack of responsiveness, withdrawal or aggression; and fearfulness and hyper-vigilance. "The therapeutic relationship is similar to the mother-infant relationship within which the child experiences the mother as a container into whom a chaotic confusion of emotions and sensations can be put . . . Ultimately the (therapeutic) process enables the child to create a space in which to think" (Rogers, 1995, p. 25).

Therapeutic Approach

> "What makes music therapy different from every other form of therapy is its reliance on music. Thus at the core of every session is a music experience of some kind" (Bruscia, 1991).

My music therapy orientation is based on the humanistic philosophy, and I predominantly use the improvisational method of Creative Music Therapy (Nordoff & Robbins, 1977). I generally begin therapy by meeting the client musically thereby creating an accepting and responsive atmosphere. A connection is made and a relationship of trust develops *in the music.* My expertise is in using *music* to communicate my empathy with my clients, and once contact has been made I continue to use a variety of musical techniques to invite their participation in a non-threatening way, and to support their contribution to the music making experience. This in turn leads to their developing skills, which allow them more expressive freedom in music making.

Therefore, I felt unprepared for the strong rejection of sound and music that John portrayed. Experience has taught me that in order to respond to the unique experience, strengths and needs that each client brings to the music therapy process, I must be flexible, eclectic and open to new ways of working. However, one of my main philosophical understandings was that music is the primary healing agent in the therapy process and I use words sparingly. I agonized over whether I had the skills to communicate with John when my musical mode of communication had been taken away, and even wondered whether a music therapy programme was really the most appropriate therapy for him. My intention was to engage him in musical interaction for the purpose of self-expression and interpersonal skill development and to focus on the here-and-now. But I couldn't help but wonder on his strong projection of his psychic condition. If John were to eventually engage in the music therapy process, how long would it take for generalized behaviour changes to take place? What would the music therapy mean for him in the context of his life?

Through my limited knowledge of psychoanalysis I was able to identify in my therapy sessions

with John many interactions and feelings that could be explained in psychoanalytical terms as defense mechanisms. I was aware that through projective identification, John unconsciously attempted to arouse and incite my reactions to meet the response he historically anticipated from the mother figure. I valued the concept of the psychic container and knew that my work clearly depended on my ability to hold John's feelings when they were unbearable, to modulate them and present them to him in a more manageable form. However, I was not qualified to use a model of analytical music therapy and it would be irresponsible for me to attempt to do so. Further, some writers would argue that an integration of psychoanalytical and the creative models of music therapy might be inappropriate because the fundamental premise underlying the two models is conceptually incompatible (Hadley, 1999). However, I knew that John's past had had a significant impact on his present functioning, and when he rejected my music making so powerfully, I had to find a way of working with him that was new to me. I trusted my intuition and allowed John to take me with him on his journey. His path led me away from my Creative Music Therapy roots and into the realm of Paraverbal Therapy.

Paraverbal therapy is defined as an ongoing method of observation, assessment and treatment that uses various expressive media in unorthodox and nontraditional ways in order to address the expressive, communicative and therapeutic needs of the individual from moment to moment (Bruscia, 1987). The main goal of Paraverbal therapy is to open up lines of communication, and although musical or extra-musical experience may be used, music is not necessarily used all the time. This multi-sensory approach is particularly useful when a client does not have the affective tolerance to deal with what is communicated verbally or, as in John's case, even musically.

I accepted that the therapeutic process would be slow, at times painful, but believed that John would in time begin to trust that he was physically and psychologically safe in the music room. Rogers cautions that the therapist must be able to sustain powerful resistance and the massive projective identification accompanying it without abandonment of psychoanalytic techniques. "The therapist may have to endure long periods of sustained resistance, sometimes accompanied by contemptuous abuse and physical violence" (Rogers, 1995, p. 27). Rutter (1995) argues that an attention to real life experiences, cognitive models about such experiences, and the mental models of relationships, need to be a foci in working with children who have been abused. He asserts the importance of attention to interpersonal, as distinct from intrapersonal, defences and recognition of the importance of the factors involved in good relationships.

Rutter also introduced the 1985 work of Peter Lomas who suggested that good psychotherapy (when dealing with attachment issues) needs to be "based on mutual warmth, respect and trust and that an undue reliance on the uninvolved, dispassionate interpretation of defences may not constitute the best way forward" (Rutter, 1995, p. 564). While Rutter himself contends that attachment concepts should have implications for therapeutic interventions, he cautions that just how these concepts should shape treatment is still less clear. So I held fast to my humanistic experiential philosophy, believing we would gradually gain a mutual trust through my consistent "thereness" and "withness", and trusting in John's innate capacity for creativity and growth. And I regularly went to supervision-I thank my psychotherapist supervisor and music therapy colleagues for my survival.

Background Information

John was eleven years and eight months old when he was referred to music therapy. He was resident in a special education facility for adolescent boys who are failing academically and who have social and emotional difficulties, which cannot be addressed in their local communities. As noted, he had been given several diagnoses including Atypical Asperger Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), Reading Disability, and "probable" Conduct Disorder (CD). In addition, he had been removed from his single parent home in which he experienced frequent violence and severe neglect. His mother, who is partially deaf, is a drug and alcohol addict. John and his brother were both physically abused, and left alone for long periods, possibly up to several days, without food. John was prescribed Ritalin but was non-compliant with the medication.

John exhibited disturbed behaviour, engaged in extreme fantasy, and when sad or frustrated would curl himself into the foetal position. He was said to become aggressive if "cornered", had no self-confidence and was extremely mistrusting of adults. He engaged in obsessive-compulsive activities and his favourite occupation when he arrived at the special school was to spend hours cleaning the black marks from the gym floor while on his hands and knees. He

complained bitterly and frequently about a range of psychosomatic complaints, especially when asked to engage in a school activity. His teacher referred him to music therapy as she considered him to have "artistic talent" and felt that he would develop increased confidence if he were able to explore music in a therapeutic environment. He had shown an interest in playing the recorder at one of his previous schools, and was known to be able to keep a beat and to occasionally sing with a group.

Therapeutic Process

Full permission has been obtained for the writing and publishing of this study, and the clients name has been changed to maintain confidentiality.

As is usual in a study of this kind, initial sessions will be described in detail. However, as the therapy begins to take shape, I will illustrate John's progress by writing of quite distinct "periods" in the process.

Making Contact and Developing a Relationship

Session One:
I was looking forward to my first meeting with John. Here was a young man apparently very psychologically injured and mistrusting of adults, but with a reported interest in music activities. I felt optimistic that through music, we would develop a relationship of trust that would lead to his increasing involvement in music and subsequent increase in self-esteem and confidence. Perhaps more importantly, I was hopeful that in time he would be able to trust other adults, and to begin to feel safe enough to engage in more socially appropriate activities outside of the music room.

Another staff member brought John to his first session. He was clearly not eager to come but did not physically oppose the request to accompany her. Once we were alone, John was difficult to engage and generally defensive. My greeting song brought a tirade of verbal abuse, as I was not *ever* to sing his name. He refused to accept any of the instruments I offered him, and did not want to listen to live or recorded music of any kind. Although he made some attempt to look at the instruments in the room, he was highly critical of each one. For example, he was unable to play the "useless" drum kit because it did not have enough cymbals. He claimed to be able to play "Boyzone" music at the piano but was unable to strike a single note. He screamed when I made the simplest of sounds on guitar, piano, or any percussion instruments, claiming that they hurt his ears. I was of course concerned to monitor and accommodate any auditory sensitivity John may have, but the quality of his resistance was different to the responses I had noted in children who have hyperacusis. My attempts to reflect his distress were met with such fierce resistance I intuitively withdrew into silence.

Suddenly, John asked where my flute was. I explained that I did not have a flute, but perhaps we could play the recorder, as I knew he had done in the past. His response was that he didn't like the recorder, and he can't play it anyway. I worked hard to allow space and silence, to just "be" with him in the room, but wanted to also to balance my acceptance of his need for silence with invitation - *I* was desperate to make a musical connection with him. But no music was allowed. John was slightly hesitant when I suggested the session would close soon - and I wondered perhaps whether he felt it important that he be the one to renounce the session.

Session Two:
John brought his comforter, a fluffy rug, to the second session and when he complained of a sore foot, he was invited to curl in the corner to rest. He was there only briefly, screaming and jumping up when I attempted to make a musical sound. It was clear that he wanted to be in control, to call the shots and lead the session, and that his demonstration of being in control would involve opposing anything that I attempted to introduce. I felt I had "cooked my goose" by exposing my feeling of impotence when stripped of my communicative medium, music. I was desperate to hear sound, and was later able to recognize that may have been a feeling that John wanted me to uncover - how all encompassing was the silence when he was locked away?

Sandra Brown's account of her work with David is relevant, as she describes his need for control. She allowed him space to explore, to build up his trust that she wouldn't overwhelm him, and to bring him to awareness that she would keep the room safe in terms of personal and instrumental safety in order to allow him to explore creatively. Sandra felt strongly that until David felt safe enough that his world wouldn't go out of his control the moment his vigilance

wavered, he would not be able to explore what spontaneous interaction and the relationship could offer. She wrote "It felt vital clinically that I should not be drawn into exerting control for the sake of having it, and not feel rendered impotent by David - the very dynamic that he was caught in. Instead, I worked to step sideways into a separate position, where I could maintain free choice to allow David to control the situation or not, depending on the clinical needs of the moment. I did initiate playing, therefore, but stopped when told and accepted David's choice of instruments for me, waiting to see where his chosen route was taking us" (Brown, 2002, p. 90).

I allowed the silence for as long as I could bear it. However there were times when I believed it was important for me to increase John's tolerance for noise and I would introduce a sound. In the midst of one of his screaming protests at my musical initiation, John suddenly screamed "I am not like the others!" I understood that John's identity crisis had drawn him into exploring who he was in relation to other students at the school and believed he wanted reassurance that he was indeed *someone.* His insistence that I could never sing his name was also a sign of his self-identity and self-acceptance difficulties. "Show me who you are, John" I requested. In silence, John moved about the room, at times away from me, and at times approaching. He wanted me to examine his sore foot, seeming to need a reason to make a personal connection. I was silent - John would take control and I would accept his lead. Almost immediately, he seemed to sense my acknowledgment. He began to explore the instruments, not sustaining but occasionally making fleeting sounds. He asked if he would break the drums if he hit them hard. When reassured that it would be fine to hit it hard, he struck the drum solidly four times with long silences in between each beat. He then began to attempt to play sophisticated rhythms, similar to a rock beat, and became uncomfortable with his playing sighing heavily in frustration. I was able to begin an accompaniment without his conscious awareness. With the support of the piano he was able to establish a beat briefly before he became aware that he was playing "with" me. Although subsequently his beat was a little erratic, John allowed our shared music to restart several times and our musical closure was comfortable. John even seemed a little reluctant to leave the session and agreed to come back "if you want".

Session Three

In the early part of session three John again avoided any musical communication. He examined the recorder as if to play it, but declared it bigger than the one he used to have and he "couldn't remember his notes". He then invited me to his classroom to see the bean he was growing. However, on our return to the music room, he began to play absently on a tongue drum and although he spent considerable time putting the beater in the hole and trying to "straighten" a tongue on the drum, he allowed me to engage him in a call and response game with simple rhythmic patterns. We were later able to bring other percussion instruments into play and after a short rhythmic improvisation John allowed me to move to the piano to accompany his percussive play. John led two improvisations using contrasting rhythms (the first X X xx X, and the second a Calypso beat), and was also able to follow my lead as I moved to jig and ballad styles at the piano. John closed the session after 35 minutes, declaring himself "bored".

I thought of Rutter's caution that the attachment disorder may present as a strongly contradictory or ambivalent social response most evident at times of partings and reunion. It also seemed that he was perhaps beginning to feel emotional connections that were unfamiliar and therefore frightening for him. Walsh wrote that central to her thinking about her work with an adolescent who had learning difficulties and social and emotional problems was the notion of the client's struggle between wanting good feelings (but being unable to bear them), and not wanting bad feelings (but needing to hold onto them). "All good seemed to turn bad and out of her control. To feel in control meant holding on to excessive bad feelings. Bearing good feelings seemed to mean setting herself up for disappointment, emotional pain and physical damage" (Walsh, 1997, p. 18). John was unable to bear, let alone acknowledge, the good feelings associated with his music sessions.

Session Four

The fourth session again confirmed transitional difficulties and reinforced my suspicion that John may have been withdrawing from the emotions he experienced in making music. He advised me that he did not want to come to the session and would definitely not be playing. He also declared that if I were to play he would break the instruments. We were able to sit comfortably in silence for approximately ten minutes. Foolishly perhaps, I then began to ruminate on what we had achieved in session three, and felt concerned not to allow John to slip back into his passive/aggressive role. It is amazing to me now, writing up the study, how short a period of therapy we had undertaken to this point. The projected feelings were of a long unproductive programme with fleeting glimpses of connectedness, which gave hope that we may eventually engage in therapeutic activity.

Although cognitively aware of the brevity of the therapy to date in relation to the anticipated time frame for the process, and of the hopeful fleeting connections we had made, I continually fought my own frustration at what seemed to be lack of progress. In an effort to build on these tentative musical beginnings I began to play quietly at the piano. True to his word, John came to attack the piano, shouting, pushing, and kicking at the instrument. I matched his emotions with my improvised music, but was unable to contain him musically and the intensity of his fury reached damaging proportions. I resorted to a sharp verbal "Stop!" John responded immediately and again reiterated that he did not want music. I was able to concur that I did not want to play music now either, and we sat in silence for another 5 minutes.

John began to fiddle with the tongue drum, and I tapped my foot in response. His sound making increased in volume but remained erratic. When it seemed he was done, I told him that his music time was up but John was again reluctant to leave. He spent several minutes trying to retrieve an "object" from inside the tongue drum before leaving the music room.

Session Five

The fifth session followed a two-week holiday break during which John was with carers provided by the Children and Young Persons Service. He did not want to come to the music room. I worried over allowing him the choice/control that he demanded versus providing safe predictable boundaries for him to push against. I was thankful that I had already heard a musical connection between us. I was more convinced than ever, that John was calling "stop it - I like it!" as he began to experience a range of new and fear-provoking emotions through his music making with me. I insisted that he attend the session. He came independently, but screaming. In the music room he continued to shout, attempted to kick me and was able to make a significant bite mark on my upper arm. Importantly, I verbalized that his behaviour was unacceptable. However, I was as unresponsive to the violence as possible, wanting him to learn that there are alternative ways of being in the world.

John began to bite the musical instruments and the intensity of his aggression initially increased. As I sat, accepting but not acknowledging his fury, he gradually calmed and became verbally communicative. While sitting on the floor chewing a drumstick (which he was able to reduce to a mere heap of fibre) he told me of his flute. Using the synthesized sounds on the keyboard, I began to play the flute as he talked. His carer, Heather, liked his flute he said, and he was able to play it in his bedroom during the holidays. However, he was unable to bring his flute to school, as it is too valuable. His is a glass flute that he likes to take to his grandfather's farm. When he sits in the paddock playing his music, the animals gather around to listen. John was able to express in his seven-minute fantasy monologue about his flute, much about the pleasure he can experience in listening and playing music and I wanted to help him recapture and hold this joy. I was aware of the fragile nature of his fantasy object, the glass flute.

Conflict Resolution

In subsequent sessions John attended music therapy independently. He appeared cautious but calm and happy. After consulting the occupational therapist, I had offered to obtain a box of materials with various textures for John to chew. He asked for his box when he entered the room and continued to sit on the floor, talking to me as he gnawed on the rubber, metal, plastic and wooden samples. Occasionally I was allowed to play appropriate accompaniments with my synthesizer flute as I listened, and he occasionally repeated the story of his own glass flute.

Another recurring theme in John's story telling centred on three Pitbull Terrior dogs at his carers house. The pitbulls bite people regularly, even biting the legs off people who tease them. As the weeks passed John's stories became progressively more detailed, and the dogs behaviour increasingly more acceptable. He talked of how he had trained the dogs from puppies and had tried to teach them *not* to bite people. They were "naughty" when they jumped in his bag when he wasn't looking, and went to the shops where the shopkeeper gave them some lollies. They began to be clever the way they came when he called, and John loved to watch them play. Brown's work again offered insight into John's fantasy:

> "Tate (1958), talks of a little boy who brings his destructive self into the session in the form of a dangerous lion, who has to be locked in a cage in order to contain him.... I became aware of how this use of 'wild cats' to hold aggressive emotions for the child had occurred in my work before" (in Brown, 2002, p. 91).

John's pitbulls were able to hold the aggression for him, and the progression in the stories

seemed to be an indication that he had begun to glimpse a more positive side of himself. John continued to refuse invitations to play, and my use of music during this period was minimal. As the dogs became less aggressive I was able to ask John if he would allow me to play a song about a dog. I knew we had reached a turning point when he agreed, and he smiled as I played and sang "How Much is That Dog in the Window".

There was still much work to be done. John continued to acknowledge "our song" and I was allowed to play it frequently - in many keys and on many instruments. However, any attempt to introduce a new song brought about great resistance. Then John suggested that with the range of sounds I was able to produce on my keyboard, I would be able to go busking. My response that I would need more songs in order to be able to busk was the key to John allowing a wide range of music into his sessions. For several weeks he would come to the music room with a suggestion for a new busking song that I was to rehearse for him. John refused all invitations to join me in my playing and was highly critical of my work. I was delighted when he eventually began, spontaneously, to join me with his singing.

When he felt I was finally "ready to go busking" we discussed what people might pay to hear a song. John thought that most songs were worth one dollar, but "How Much is that Dog in the Window" would be worth one thousand dollars. We had a very strong connection in "Our Song"! I was able to ask him if he would like to learn to play our song, and he agreed to play the xylophone. He worked hard, reading the letter names on the xylophone as I called them out, but was quickly able, using his recall of the patterns as well as his ear for melody, to play independently.

Mastery and Internalization

I had been able to borrow two flutes, which were readily displayed in the room during John's sessions. His intrigue was immediate, but he had not attempted to play or request the instrument during the busking period. Once he felt I had achieved *my* goal with the busking work, he suggested that we could play the flutes. John demonstrated significant psychosomatic complaints during this and subsequent periods. Whenever he made a serious attempt to achieve a goal he was interrupted by pain, breathing problems or coughing which he used to explain why his music was not 'perfect'. Nevertheless we had several sessions during which we tried to play the flutes together, and John was noted to laugh on occasions when I was unable to produce a satisfactory note!

John agreed that it might be easier for us to play recorders, and so his music-learning period began. He was indeed a sensitive musician - his notes were clear and he was able to use a range of dynamics in his playing. He was pedantic about accuracy and was happy to rehearse repeatedly if he felt he made a mistake. He was less accepting of criticism from me, and resorted again to a range of health excuses when corrected. I was amazed when he asked if he could play his recorder in the school assembly. My response was cautious, as I did not want to set him up for failure. But he was insistent, and I knew he played well, so we organized a short programme for piano and recorder, which was very successfully presented before his peers.

John had reached a stage where he was accepting that music was an important and valuable medium in his life, and that he could share his love of music with others. He was able to express his emotions through and about his music, once declaring enthusiastically "I love that song!".

At the end of the first year of his therapy, I was able to take John to a flute concert. He agreed verbally that he was happy to go, but I did sense some anxiety around the trip. John refused to acknowledge his anxiety and insisted we go. However, no sooner had we entered the car than he became obsessively focused on food. He was hungry, he said, and although he had just finished dinner he needed to have more. He noted every fast food joint we passed, and talked compulsively about whether there would be supper at the concert. Clearly, John's early experiences when he was deprived of food had an ongoing impact on his ability to function in unfamiliar environments. However, he was completely won over by the music, and was able to relax to enjoy both the concert and the supper afterward.

Developing Autonomy - The Transformation

The special residential school that John attended invites the boys to participate in a biannual Operetta. In addition to my music therapy duties, I have assisted the school by writing a story and musical material that is appropriate to the boys' chronological ages but simple enough for their successful participation. The operetta has a theme that is relevant to the boys' situations

and provides opportunities for them to work towards therapeutic goals. Participation is voluntary. In his second year at the school, John auditioned and won the lead role in the operetta, playing the part of a boy who achieved his goals because he believed in himself. He was required to sing several songs solo.

The process of preparing for the operetta took over six months. John was just beginning to work in a group situation and several staff members at the school were skeptical that he would be able to last the distance. Before rehearsals began his behaviour had deteriorated, and he had begun scratching and spitting at classmates. He appeared to have no empathy, and would make cruel verbal comments to peers. During the process of the operetta, goals for John were to recognize the impact of his behaviour and actions on others and to consider and respond to their feelings. He was encouraged to formulate appropriate responses when feeling uncomfortable, by rehearsing "safety" phrases. Further, it was necessary for him to listen to and accept adult direction.

As lead player John had many opportunities to rehearse individually or in small groups, especially in the early stages of the process. He found working with peers extremely difficult, as he had an ongoing need for physical space and an intolerance of touch. It was especially difficult for him to wait respectfully for others, and to show appreciation for their efforts. I helped him to rehearse appropriate ways to express his discomfort such as "I don't like it when you do that". John was able to attend and remain at every rehearsal, and made definite gains in his tolerance for peer interaction in the controlled group situation.

We planned several opportunities to discuss his role as Fred, a young boy few believed in, who persisted in his attempts to become a member of the school rugby team and became a sporting hero. In this role, John had to endure peers putting him down, shouting at him and dismissing him as useless. Initially, John was reluctant to engage in discussion around how it felt to be in that position, albeit in a dramatic role. Even though eventually he was able to make connections between what he was exploring in the role and his interactions with peers, he continues to make choices and decisions based on his own desires with little consideration for how these may affect others.

John's slight build and sad presentation were perfect for the early part of role, and those who didn't know him thought him a superb actor. He sang the sorrowful songs beautifully with appropriate expression. Much more difficult for him, was the expression of joy required of him when he achieved his goal and became a hero. During the entire four months of rehearsals, staff working on the production were not able to help John express that emotion. However, during each of the three performances when he really was achieving his own personal goal of being the star in a dramatic performance, John was able to offer the audience a genuine smile of pleasure that grew increasingly as they applauded! And I received a warm, spontaneous hug from John at the end of his performance on closing night.

Summary

Music therapy always involves a client, a therapist, and music. In my practice to date the primary emphasis has been on addressing the needs of my client through music itself, a process Bruscia describes as "music as therapy"(Bruscia, 1989, p. 63). Bruscia would more readily explain the work illustrated in this study as "music in therapy", as the process of change relied heavily on my skills as a therapist and the relationship that I was able to develop with John. Further, the planned introduction of non-musical materials added another dimension, and along with John's use of storytelling the therapeutic process involved elements of Paraverbal therapy. The emphasis was on substituting pleasure for anxiety, allowing John choices, and giving him opportunities to follow his preferences. He became pleasurably engaged when he was offered a range of materials and encouraged to take opportunities for tactile and oral experience, felt accepted and cared for, and the therapeutic relationship was thus established.

John's diagnosis and history suggested a confusion of biological and environmental symptoms that were clearly evident but not untangled during the therapy process. He demonstrated a resistance to interaction, a need to control his environment, a resistance to change, poor self-awareness and the associated lack of confidence. While it was important and helpful to understand and acknowledge the pathology in John's presentation, the therapeutic process focused on trusting in the well aspects of his psyche, providing a safe environment, empathy and support, and allowing him time and space to grow.

Despite his initial rejection of music and sound, John *did* offer glimpses of positive interaction from early sessions of therapy. He has increasingly shown me that it is possible for him to accept good feelings, and to begin to trust that all that is good will not eventually turn into a painful experience. He has developed an awareness and appreciation for the beauty of the music he can create and thus is more aware of himself as an independent being, and as a being in relation to others. The recorder, a more robust instrument, has substituted the "glass flute" and his need to "play to the animals" has been replaced by opportunities to play music to his peers.

John has some long periods of settled behaviour in the classroom and residential staff report that he occupies his free time well. However, he clearly prefers lone activity, and spends much of his time developing his creativity with visual arts, clay modeling, or playing his recorder. He continues to have difficulty with peer interactions, and when he does not get his own way, he can become non-compliant, disruptive and sometimes abusive. Somatic complaints are ongoing. On the other hand, John now has good experiences that he can hold on to. It is difficult to determine what John's future holds, but "hope" is an emotion that is now acceptable.

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