Thesis for Master's degree

Group Music-Therapy with Unaccompanied Minor Migrants and Refugees

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ABSTRACT

Europe is experiencing a vast immigration crisis. People are fleeing from countries seeking a safer ground for themselves and/or their families. 50% of them are children and 25% of these children are entering without being escorted by any guardian. The term "unaccompanied minor migrants/refugees" describes those children who are totally alone in a new country without though taking into consideration the cause of leaving their country of origin. These children have suffered the loss of their home and/or family and they may have experienced violence either in the country of origin, on their actual journey and/or in the hosting country. This thesis proposes music therapy as the most appropriate solution when dealing with unaccompanied minors. Trauma is the term mostly used to describe their situation and although verbal psychotherapy has been applicable, in this thesis I demonstrate that music therapy is more appropriate mostly because of the differences in culture and language. Furthermore, I propose group music therapy as the most appropriate solution for unaccompanied migrants/refugees because, through groups, minors can develop the basic social skills that they will need in order to adapt to the new social environment. Lastly, I suggest that the best approach regarding the direction taken would be to combine elements from psychodynamic, creative and existential therapy. The literature regarding this issue has proven to be very poor so this thesis provides a necessary proposal on dealing with unaccompanied minor migrants/refugees which contributes to future researches that need to be done.

Keywords: unaccompanied minors, group music therapy, trauma, Irvin Yalom

ΠΕΡΙΛΗΨΗ

Η Ευρώπη βιώνει μια πελώρια μεταναστευτική κρίση. Άνθρωποι εγκαταλείπουν τις πατρίδες τους αναζητώντας πιο ασφαλείς χώρες για τον εαυτό τους και τις οικογένειες τους. Από εκείνους, το 50% είναι ανήλικοι από τους οποίους το 25% φτάνουν χωρίς κηδεμόνα. Ο όρος "ασυνόδευτα ανήλικα" περιγράφει εκείνα τα παιδιά που βρίσκονται εντελώς μόνα τους σε μία καινούργια χώρα χωρίς παρ'όλα αυτά να εξετάζεται ο λόγος που έφυγαν από τις χώρες καταγωγής τους. Αυτά τα παιδιά απέκτησαν την εμπειρία της απώλειας του σπιτιού, της πατρίδας, ίσως και της οικογένειας τους και ενδεχομένως να υπέστησαν βία στην χώρα καταγωγής τους, στο ταξίδι τους ή/και στην χώρα υποδοχής. Η παρούσα διατριβή προτείνει τη μουσικοθεραπεία ως την πλέον κατάλληλη λύση στην αντιμέτωπιση αυτών των παιδιών. Ο όρος "τραύμα" χρησιμοποιείται συχνά για να περιγράψει την κατάσταση τους και ενώ η λεκτική ψυχοθεραπεία μπορεί να εφαρμοστεί, παρουσιάζω τη μουσικοθεραπεία ως μία πιο κατάλληλη λύση κυρίως λόγω της διαφοράς παράδοσης, κουλτούρας και γλώσσας αυτών των παιδιών. Επιπλέον, προτείνω την ομαδική μουσικοθεραπεία, έναντι της ατομικής, διότι μέσα από την ομάδα, τα ασυνόδευτα παιδιά θα αποκτήσουν τις κοινωνικές επιδεξιότητες που θα χρειαστούν για να προσαρμοστούν στο νέο τους περιβάλλον. Τέλος, παρουσιάζω την άποψη πως η πιο κατάλληλη θεραπευτική κατεύθυνση για αυτή την περίπτωση είναι η συνδιαστική, χρησιμοποιώντας στοιχεία από την ψυχοδυναμική, δημιουργική και υπαρξιακή θεραπεία. Δυστυχώς η βιβλιογραφία πάνω σε αυτό το αντικείμενο είναι πολύ φτωχή ακόμα οπότε η παρούσα διατριβή παρέχει μία απαιραίτητη πρόταση στην αντιμετώπιση των ασυνόδευτων ανηλίκων συμβάλοντας στις επερχόμενες έρευνες που πρέπει να πραγματοποιηθούν.

Λέξεις κλειδιά: ασυνόδευτα ανήλικα, ομαδική μουσικοθεραπεία, τραύμα, Ίρβιν Γιάλομ

Nobody perhaps has ever described more successfully the goals of therapy than Sigmund Freud: *"To be able to love and work"* (1968).

1. Problem Formulation

Immigration and movement of people across borders is a process that has been continuous in human history. Throughout the centuries vast numbers of ethnic, tribal and other groups have immigrated to other regions and countries because of changes in climate or to escape adverse living conditions resulting from natural disasters, wars, oppressive regimes, political repression, extreme poverty, discrimination, and deprivation of rights. In recent years, the rapid geopolitical changes and associated wars have resulted in significant increases in immigration rates. However, the integration of immigrants in most host countries has proven to be a challenging process, mainly due to the hostility they receive in many western societies (Rebelo, 2018), the economic and social costs of their presence in the new country (UN, 1995) and the provision of medical care (Schilling, 2017). Globalization and the wide use of internet have brought this issue at the forefront of national and international agendas requiring social action and now everyone has knowledge of this continuously increasing phenomenon and its consequences for all those affected.

The urgency to effectively deal with immigration becomes even more prominent when children are involved; 50% of current immigrants are reported to be children, a quarter of which enter foreign countries without any parent or escort, seeking either a refugee visa or just a better quality of life (Duncan, 2016). Thus, the term 'unaccompanied minor' has been created to refer to children under 18 years old that arrive at a foreign country without the escort of a legal guardian. In Greece, these minors are usually considered as possible refugees, but until the settlement of their case most are hosted in special facilities of various organizations such as Medecins Du Monde (MDM) and Unicef (Unicef), or in state's hotspot facilities which are specially designed refugee camps at the entrance points of Greece, financed by European Union, where migrants and refugees are temporarily hosted. The terms "refugee", "political refugee", "war refugee", "migrant" and "economic migrant" are being used to describe different conditions about the main cause of the individual to leave his/her country. The main difference between a refugee and a migrant is that the former has been forced to leave his/her country, while the latter has chosen to (Eldridge). In this thesis, I chose not to distinguish these terms because the aim of the thesis is independent of the reason

these people left their country. Last year, I started doing some volunteer work in an accommodation facility of the Doctors of The World for unaccompanied male minors aged 12-18, in the centre of Athens, Greece. It was during this work that I came face-to-face with the situation, realizing the significance of the problem and the imperative need to find effective solutions. That experience constituted the springboard of this thesis and the realisation that each one of us carries the utmost responsibility to contribute to a peaceful and functional solution for all the parties involved.

Apart from the traumatic events that unaccompanied minors may have experienced in their home countries and/or during the immigration journey, I also witnessed significant problems being created by their placement in the same building or establishment with other unaccompanied minors from different ethnicities and tribes. Hostility, isolation and "ghettoing" in those facilities are few typical examples of their daily experience. Although nearly all children can speak basic-level English, and some of them even basic-level Greek, it is questionable whether verbal types of group interventions would be feasible to implement or even effective, although they do all usually receive personal help from psychologists and social workers with, however, the use of a translator. The reason for this is that usually in hosting facilities refugees and migrants arrive from different countries and/or different tribes, which makes finding a common language or dialect for communication a challenging task. Music, however, may provide the means for different non-verbal types of group interventions that could facilitate the social integration of unaccompanied minors. It has been argued that music is a universal language (Longfellow, 1835), which means it may be able to function as the medium for people speaking different language to connect with each other. Although I agree with the view that music has an adaptive role (Hogan, 2015) in the form of culture- and genre-specific organized sound, I disagree with the view that music genres can always be an effective modality in a therapeutic context. Considering the vast variation in the ways we approach harmony, rhythm and melody in different parts of the world, free improvisation seems to be the most enabling and inclusive modality for music therapy sessions and group interventions with people from different ethnic, cultural and social backgrounds. Such an approach could allow personalising and tailoring the musical language to individual characteristics within a group context, enabling participants/clients to have an individual voice while forming non-verbal interpersonal relationships and a group identity. Furthermore, this approach could enable strengthening the therapeutic relationship between the music therapist/facilitator and the clients, as – albeit in a different role - the therapist

would be part of the group, promoting the values of acceptance, respect and equality, while aiming to address specific therapeutic targets. Thus, using music as a 'third person' or medium a functional relationship could easier be established (Ansdell, 2014).

The aim of this thesis is to advance the hypothesis and provide supporting evidence for the claim that music therapy can facilitate the integration of unaccompanied minors, by (a) providing the means for emotional relief and the alleviation of negative feelings, such as loneliness, isolation and fear, and (b) enabling them to co-exist harmoniously in a group via the development of functional social relationships that overcome cultural and/or ethnic boundaries. Given the continuously increasing immigration rates, the challenges experienced by those affected, the dearth of primary studies on this topic, and the fact that music is one of the oldest (and very) effective forms of communication, this thesis may provide important insight into the potential benefits of music therapy for unaccompanied refugee minors, and promote further research that will facilitate changes in real-life practice during the provision of support. It is the author's hope that through this work, music therapy will be considered as a useful additional intervention, to improve the emotional and social well-being of unaccompanied refugee minors, and their sense of integration in the host countries. The objectives above appear to be of great significance as the well-being of unaccompanied refugee minors is currently under-investigated, while the social and mental health of the respective individuals is continuously at high risk. Living in Greece gives this thesis additional importance, since Greece (Euractiv, 2019), along with Italy (Adler, 2016), are the main entry countries for the high numbers of refugees in the Eastern Mediterranean region. As a result, and given the long waiting and transitional periods in the hotspots and ports (Tagaris, 2018), it is reasonable to consider the need for effective interventions in these countries as urgent.

The current thesis is divided into 5 chapters. The first chapter (Refugees) gives a brief description of the population this thesis is about, their background and the challenges they face. In the second chapter (Trauma), I explore these issues based in the context of the concept of trauma and how it relates to unaccompanied refugee minors. In the third chapter (Therapy), I consider the social care needs of these children and the rationale behind these needs. In the fourth chapter (Music Therapy), I examine the potential usefulness of music therapy as a therapeutic intervention, to meet the aforementioned needs of unaccompanied refugee minors. In the fifth and final chapter (Group Therapy), I place and discuss the music

therapy approach in the context of Irvin Yalom's theory of group therapy and why I chose this specific approach for unaccompanied refugee minors.

2. Introduction

Music-therapy is "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship" (AMTA). Music has been used therapeutically since the beginning of human history (Thaut, 2015). From ancient times when tribes (Densmore, 1927) would play music to meditate and heal, to Aristotle's use of music to stimulate the morality and intellectuality, and the use of music in hospitals to comfort patients in Great Britain in the late 19th century and in the USA during the World Wars (Grasida, 2018), music has followed human history in close proximity and often in a supportive therapeutic role. In the more contemporary times of our era, and despite the scarcity of primary studies on the subject, music therapy interventions have been suggested as an effective modality for the provision of socially inclusive activities for people with different ethnic and cultural background, partly because musical participation is possible without mastery of language (Stige, 2011). Given the scope and aims of this thesis, I reviewed the literature to explore whether music therapy has been used with unaccompanied refugee minors.

Previous studies on the consequences of immigration have shown that participants experience a strong sense of insecurity and injustice, challenges with relationships, profound changes in the view of self, and poor mental health. Depression, demoralization and anxiety were very commonly reported, while quantitative studies reported high rates of depression, anxiety, PTSD and low quality of life (Coffey, 2010). In a study conducted in Australia with new-comer students that have joined community music therapy, it was shown that "a major outcome for students is a feeling of belonging, both to communities of practice within the school and to the wider Australian community." (Marsh, 2012). Group music therapy sessions for refugee minors have also been suggested to elicit important benefits related with mental health and personal resources. According to a specialized organization based in Luxembourg: "Group music therapy sessions have the objective of reducing the stress and anxiety arising from difficulties experienced by the young people concerned, such as the dangers they were exposed to during their journey, the loss of their linguistic, cultural and material reference points and the estrangement from their family" (OEUVRE, 2017). At the

same time group music therapy can help ‘stimulate their personal resources, develop a form of resilience, thrive and develop and involve themselves in their new environment.’ (OEUVRE, 2017).

Of interest, musical activities and experiences are not viewed as separate from language and culture, but rather as embedded in culturally informed assumptions and values, to the degree that the notion of music is variable between cultural contexts and within any given cultural context over time. (Brynjulf, 2011). It is for this reason that Ditty Dokter (1998) emphasised the need for caution when working with refugees from different ethnic or cultural backgrounds, in order to promote both intercultural intra-cultural social relationships. As Dokter reported: ‘…playing together without the barrier of language, each brings a song that can connect to-set of example, people from the same tribe form a team and the rest either observe or become passive’ (Dokter, 1998). One of the commonly employed music therapy interventions for people with high levels of stress, anxiety, depression and PTSD, is that of drum circles, as these require no previous music knowledge or expertise (Bensimon, 2008). Additionally, drums lack the harmonic and melodic context that mainly differentiate cultures, which makes them a potentially appropriate technique for music therapy interventions with people from different ethnic and cultural backgrounds. Although not specifically with refugees, previous studies have investigated the effects of drum circles and reported reduced PTSD symptoms, increased sense of belonging, sharing, togetherness, openness, closeness, intimacy and connectedness, and achievement of ‘non-intimidating access to traumatic memories facilitating an outlet for rage and regaining a sense of self-control.’ (Bensimon, 2008).

While reviewing the literature for studies focusing on the use of music therapy for unaccompanied refugee minors, it became evident that there was a great scarcity of primary studies. However, while researching the views of scholars on refugees’ needs and the different approaches to care for refugees, I noticed a significance focus of experts on trauma and sustained negative emotional states, as well as on social isolation and relationships. As a result, I decided to focus on these key aspects of refugees’ experiences, to explore whether music therapy interventions could address the related needs of unaccompanied refugee minors during the provision of care. I came across three books that became the backbone of the present thesis. These books are Julie Sutton’s “Music, Music Therapy and Trauma” (2002), Renos Papadopoulos’ “Therapeutic Care for Refugees: No Place Like Home” (2002)

and Irvin Yalom's "The Theory and Practice of Group Psychotherapy" (2005). The aforementioned books led me to other articles and books that enabled me to develop a common thread connecting the different stages of the refugee minors' experience (i.e. from 'becoming a refugee' to 'being left alone as an unaccompanied minor in a strange country needing therapeutic care') with the potential capacity of group music therapy interventions to alleviate the negative psychological impact of this 'journey' and address their need for social integration in the host countries.

3. Aims and Objectives

The aims of the current thesis are to:

a. Explore the potential use and benefits of group music therapy interventions for unaccompanied refugee minors, via an interdisciplinary approach.
b. To contribute to a scarce body of knowledge on the given topic and promote further research that may facilitate evidence-based changes in real-life practice.

The objectives of the current thesis are:

a. To explore whether group music therapy could potentially provide the means:
    i. for the alleviation of negative psychological states resulting from traumatic experiences, for unaccompanied refugee minors
    ii. to facilitate the social integration of unaccompanied refugee minors in multi-cultural groups/societies by enabling the development of social relationships that overcome cultural and/or ethnic boundaries
b. To consider the potential capacity of music therapy to draw from different fields of expertise, such as Psychodynamic therapy, Creative therapy and Irvin Yalom's Existential theory on group therapy, to address the needs of unaccompanied refugee minors.

4. REFUGEES

Under Article 1A(2) of the Convention (UNHCR, 1951), a refugee is essentially a person who has "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion". "Unaccompanied minor

refugees" constitute a sensitive group of people for two reasons:(a) because they are minors and as such more fragile, exposed, inexperienced and in need of protection, and (b) because they are refugees, which means that they have left their land of origin due to fear of prosecution, lack of protection due to armed/war conflicts, or trespass of human rights. Furthermore, they could be victims of human trafficking, molested by their families, victims of discrimination and racism due to their sex, victims of child work exploitation, or generally be under the category of refugee as described by the Genève Convention for Refugees (UNHCR, 1951). "Unattended minor immigrants", on the other hand, have left their country because of poverty, low standard of living, or to pursue a better quality of life. Many of these children lack legal documents and need to remain at the country of entrance until the evaluation of the conditions on the country of origin and the child's best interest. (Braunschweig, 2017)

'The United Nations High Commissioner for Refugees (2015) estimated that at the end of 2012 there were 10.5 million refugees worldwide, of which approximately half were under the age of 18. The stressful experiences that many refugees and asylum-seekers are exposed to during forced migration, be that during persecution, flight and resettlement, or in the changes they experience in their family, community and society, make them vulnerable to a range of psychosocial problems (Fazel R. A., 2014). In a recent research study concerning asylum-seeking children in the UK, it was found that 'although there is a research base exploring the mental health of asylum-seeking children and adolescents who arrive with their families, there is in contrast very little focusing on the mental health needs of children and adolescents who arrive in the UK alone.' (Groark, 2011)

Although there is a difference between a migrant and a refugee, and each of these groups are divided into several subgroups, in the present thesis the word "refugee" will be used as a generic term in order to subsume all the subgroups mentioned above, to describe the asylum seeker.

4.1 Leaving Home

"*Home is the place where, when you have to go there, they have to take you in. I should have called it 'Something you somehow haven't to deserve'*." (Frost, 1955)

‘Home is where one is’, as written by Papadopoulos (2002). Home is more than the place, the house, the area or the country the individual is from. Home is connected with family, care, memories and a sense of protection and security. Refugees have lost their home. This creates a disorientation, while they are trying to adapt to a new reality. Papadopoulos has advanced the term “nostalgic disorientation” in order to describe the disorientation that is enwrapped in a nostalgic sense of deep ache (2002). For each individual, all that is included in the term “home” contributes to the establishment of a foundation to being human (Papadopoulos R. , 2002). This, basic as it may seem, often isn’t recognized or even perceived until a threat to this established reality occurs. Additionally, the stories of homes and families are inseparable entities. In Greek, ‘istoria’ (ιστορία) has a dual meaning, both history and story. So, the verb ‘istoro’ (ιστορώ) means basically to narrate, to tell what one has learnt or experienced. Regardless of the possible fact that these stories may be potentially related with deeply dysfunctional families full of violence and neglect, still an individual seeks for that sense of security which only home can provide, regardless of traumatic experiences connected to it. The theory of “secure base” (Bowlby, 1988) describes a principle that is pivotal to this concept. Bowlby’s theory investigates the benefits of a relationship between the child and a person who represents the figure of haven and security. “Home” is closely connected with this sense of security. In that matter, by providing a sense of home we also provide a sense of security, stability and warmth, a “secure base”.

The stressors to which refugees are exposed are described in three stages (Fazel, 2002):
(1) while in their country of origin; each refugee leaves home for different reasons. Most of the refugees though flee because of war and fear of persecution (UNHCR, 2015). Living in a country were war is on or you are being persecuted for your political views is an unnatural way of living, always hiding and always in fear.
(2) during their flight to safety; many refugees have travelled in dehumanized conditions, stacked on the back of a track, or on a small boat without food or water and with the peril of being detected, drawn or starved to death (Taylor, 2019)
(3) when having to settle in a country of refuge; the loneliness of a person arriving in different country, having nearly nothing with him/her, being treated like he/she is still at war (being forced to stay in refugee camps with poor conditions), and being alienated and threatened by society as a stranger, would be the third and crucial chapter to the journey full of angst but also, nevertheless, hope.

Ignacio Correa-Velez (2016) conducted a study with unaccompanied asylum-seeking minors and found that their journey, starting with the need to flee from a dangerous place, through travelling among people taking advantage of them (or among people they would meet but could not built a relationship with because they would move the next moment and never see them again), and ending on the arrival to a new country where their feelings of unsafety and mistrust have been magnified. As a natural consequence, Christina Groark (2011) revealed 5 pervasive psychological themes among the refugee minors at the arriving point, namely distrust, avoidance, feelings of loss, loneliness, and fear. The concept of "the isolated refugee" has been inducted by Papadopoulos (2002) describing the psychological condition of isolation and loneliness while a refugee is adapting to the constant changes though his whole journey mainly caused by the differences in culture; whether this is a difference in social class, difference in generation from infants to the elderly, difference in gender or difference in religion. This means that in order to acquire a better sense of who the refugee is and their position in dealing with their new situation, it is of great importance to have an informed picture of where they come from and what their background is, so that we can understand all the possible differences they experience in their new environment. To emphasize an early deficit is presumptuous in the face of the devastating events that many asylum seekers have endured in the months or years before their arrival in this country (Papadopoulos, 2002). It may feel an impossible task when the personality is damaged and disabled by traumatic events, and personal resources are at their lowest ebb (Garland, 1998). When the mourning process cannot be experienced or is impossible, melancholia (Freud, 1917), manic denial (Klein, 1928) or grievance (Gibb, 1998) can take over.

In addition to the above, the economic or material capital may be lost but the human and social capital of the refugees seldom are. Even if both economic and material stock are greatly reduced, or devalued by dramatic changes, in time refugees may reclaim them. It is, Papadopoulos argues, their characteristics as "social capitalists" which assist significantly in the issue of their longer-term adjustment and government policies which ignore or disrupt such processes inflict additional penalties upon them. (Loizos, 2000). It would be part of the objective of this thesis to explore whether and how group music therapy may be able to build on the social capital of the minor refugees, to facilitate their social integration in the host countries.

4.2 Social and Emotional Capital

Guidelines from the UK's Department of Health, such as "Working together to Safeguard Children" (2018) and the "Frame-work for the Assessment of Children in Need and their Families" (2000) highlight the necessity to increase awareness of the need for thoughtful sensitive interventions whilst at the same time being aware of the legal framework of England and Wales and what is acceptable. This emphasizes the fact that although there may be clear laws covering the issue of working with children to promote their physical, psychological, mental or social health, there are serious individual or country-specific factors that have to be taken into consideration like religion, traditions and customs. Additionally, to view all refugees as victims or as mental health patients would be equivalent to ignoring the resources implicit in the human capacity to survive (Papadopoulos, 2001, p. 45) and the substantial contribution and enrichment they have made to our culture over the years. Positive mental health flows from inner resources (Reading, 1999) and it is the way in which inner resources or emotional capital (Garland, 2002) can become undermined by the upheavals of seeking asylum that is worth exploring. Some have difficulties that predate their flight, but these difficulties have been considerably exacerbated by it. Thus, it is equally important to address any issues related with previous life stages of the refugee, before his/her life is dominated by a melancholic depression, by a defensive mania, or by an increasingly entrenched sense of grievance, all of which block the necessary process of mourning and recovery.

When it comes to personal resources, there are destructive forces, as well as creative and generous impulses, that appear in the individual, in the small group and in the large group (Papadopoulos, 2002). It is important to address and reduce the former and encourage and enable the emerge of the latter. By employing such an approach, it is the person that becomes the focus of treatment, rather than the trauma, as Papadopoulos mentions (2002). Moreover, the innate sociality of every human can be mobilized and working within a small group may be a good way to enable the emotional and psychological growth and integration, which may in time be exported to the context of the wider society. Of interest, Papadopoulos mentions the difficulty that members from the same country of origin had in connecting with each other, due to political differences and social difficulties linked with co-ethnicity (2002). It becomes evident that additional factors and difficulties need to be considered and overcome to enable the rebuilding of social capital.

4.3 Language and Adaptation

When working with families and children, we also have to consider the complexity of language, communicating through an interpreter, and culture. As characteristically stated by a Somali refugee in Britain: "It's important because we are temporary here, this is not our country, when we come to our country how can we speak to our parents or our family?" (Papadopoulos, 2002, p. 176). This claim of a refugee directs the issue of language and how complicated it is. It is not only the difficulty of learning a new language which is a serious burden, but also the guilt of the possible oblivion of the mother language. As Papadopoulos explains, in the last decades, social constructionism has had a significant influence upon systemic theory and practice in countries starting with Britain (2002). From a social constructionist perspective "because there can be no truth, all perspective must be equally valid" (Burr, 1995) and therefore to seek to privilege one explanation over another would be viewed as antithetical to working co-constructively with families. Practitioners need to adopt a "not-knowing approach" (Anderson, 1988) that is curious about the meanings that inform family members' beliefs about particular behaviours. On the other hand, Papadopoulos & Hildebrand (Hildebrand, 1997) have applied systemic thinking to their work with refugees and directed the dilemmas that emerged. What they found was that within refugee families some family members may hold on to a yearning for a return to the country of origin, while others are relieved to have found a place of safety. However, they argued that "these divisions in reality are much more complicated and less clear-cut than it first appears". (Hildebrand, 1997). Either way, refugees may be seen not as passive acted-upon victims but as "extraordinary resilient human beings" who are participants in clarifying the processes and meanings of human change (Muecke, 1992); overcoming the barrier of language is an essential part of the process for their social integration, as language plays an important role in adaptation and is the main mean a refugee can use to communicate his/her worries, problems, needs and wishes.

In western societies, the focus concerning the refugees' transition and adaptation problems tend to be on trauma. The most commonly used category to address mental health issues of refugees is Post-Traumatic Stress Disorder (PTSD) (Van Der Veer, 1998). Its emphasis on disorder and questionable applicability in different cultures has been a subject of concern (Marsella, 1994). Amongst alternative models of constructing the refugees experience, "cultural bereavement" (Eisenbrunch, 1990) and "nostalgic disorientation" (Papadopoulos,

1997) have been proposed. Although both proposals attempt to normalize the refugees' adverse and challenging experiences, "neither addresses the re-construction of identity that may be experienced by the refugee" (Papadopoulo, 2002, p. 192). Papadopoulos developed a classification of four main phases of the refugee experience (2002). The starting point of his argument is that when the main focus is on the "refugee trauma", it tends to influence not only the way the mental health professionals work with refugees, but also the very way the refugees perceive their own situation. In other words, professionals are more interested in what made those people refugees in the first place. This first phase is the phase "Devastating Events" according to Papadopoulos. He argues that by privileging "Devastating Events", professionals and refugees themselves tend to diminish or even not take into consideration the impact that other phases of the refugee experience have on those people's overall psychological state. Papadopoulos added three additional phases: "Anticipation" (when people sense the impending danger and try to decide how best to avoid it), "Survival" (when refugees are safe from danger but live in temporary accommodation and uncertainty) and "Adjustment" (when refugees try to adjust to new life in the host country). There is a direct link between these phases and the three stressors mentioned earlier in this thesis (see *4.1 Leaving Home*), as the former provoke the latter. It is therefore important to consider the whole of the refugee experience for each individual person, to promote their health recovery and social integration as appropriate to their needs.

Papadopoulos compared the stories of asylum seekers' refugees in the early phases in Greece and the UK respectively. The former seemed more eager to tell their stories than the latter. The narrations of the journey to Greece were realized with strong emotions, fast speech and hand gestures used to emphasize the words. By contrast their current difficulties - a deficiency of food, a lack of sanitation and no paid work - were described in a resigned, quiet manner. This manner was characteristically described in the following sentence by a refugee: "when you don't have a homeland, you have no place in the world, no homeland, so no identity, no passport" (Papadopoulos, 2002, p. 201). Sometimes the lack of "voice" may have reflected disappointed expectations in the new culture, claims Papadopoulos. One refugee despaired: "my wife hasn't spoken since we arrived", while another exclaimed in tears: "they should help us, we don't deserve this". According to Papadopoulos, most people in the camps in Greece appeared to be in a state of limbo where general activity, and communication channels with a wider world, were greatly reduced (2002, p. 201).

5. TRAUMA

The field of trauma has been a subject of intense – and sometime questionable - research for more than 30 years. Trauma has been defined as a "shock" (Hornby, 1974) or a "wound" (Wingate, 1972) that causes lasting effects and/or damage. These three facets - shock, wound and a lasting effect - are still in the core of our understanding of trauma in the literature (Sutton, 2002). According to DSM 4 (1994), trauma can be diagnosed when an individual has experienced an event that is outside the range of usual human experience and that would be significantly distressing to almost every human being, such as:

- a serious threat or harm to one's life or physical integrity,
- a serious threat or harm to one's children, spouse or other close relatives and friends,
- a sudden destruction of one's home or community,
- seeing another person who has recently been or is being injured or killed as a result of an accident or physical violence.

In the case of a traumatic event, "the person's response involves intense fear, helplessness, or horror. In children, this may be expressed instead by disorganized or agitated behaviour" (DSM-IV, 1994, p. 81). In 2013, DSM-5 was published and included two major revisions related with trauma. First, the disorder class for trauma moved from Anxiety Disorders to the new Trauma- and Stressor-Related Disorders, and second, the specific criteria apply only to people aged 6 years or older (DSM-5, 2013), which is also the population this thesis is aiming to help.

Historically, it was the thinking of Freud, Binet, Janet and Breuer that considered the psychological consequences and the idea of shock or wound to the mind (Leys, 2000). "When traumatic experiences and the following symptoms – especially the persistent re-experiencing of the trauma, the avoidance of any stimulus that reminds the trauma and a general overstimulation – have a deep and combined impact on a person, often the term 'entangled post-traumatic stress disorder (PTSD)' is used". This term captured the way in which traumatic events and the associated psychological responses may influence the personality of a person (Zanarin, 1998). The term PTSD was first used in 1980 (APA, Diagnostic and Statistical manual of Mental Disorders, 1994) and according to DSM-5 (APA, 2013), in order for a person to be diagnosed with PTSD he/she needs to meet all of the following criteria: a) The "stressor criterion", which specifies that a person has been exposed to a catastrophic event involving actual or threatened death or injury, or a threat to

the physical integrity of him/herself or others (such as sexual violence), b) The "intrusive recollection criterion", which involves daytime images of the event, traumatic nightmares, and vivid re-enactments known as PTSD flashbacks, c) The "avoidance criterion", which consists of behavioural strategies PTSD patients use in an attempt to reduce the likelihood that they will expose themselves to trauma-related stimuli, d) The "negative cognitions and mood criterion", which reflects persistent alterations in beliefs or mood that have developed after exposure to the traumatic event, e) The "alterations in arousal or reactivity criterion", which involves symptoms such as insomnia and cognitive impairment, anxiety, hypervigilance and startle, f) The "duration criterion", which specifies that symptoms must persist for at least one month before PTSD may be diagnosed, g) The "functional significance criterion", which specifies that the survivor must experience significant social, occupational, or other distress as a result of these symptoms and h) the "exclusion criterion", which specifies that the symptoms are not due to medication, substance use, or other illness. One of the main arguments when the term PTSD was first introduced in 1980 (APA, 1994), was that the revival of PTSD-associated trauma was mainly due to the aftermath of the Vietnam war, the increased awareness of the prevalence of child sexual abuse, and the concurrent attack on Freud's abandonment of the seduction theory (which associates hysterical and obsessional symptoms with the repressed memory of an early sexual abuse (Clark, 1980)). It was also argued that if there had been an awareness of PTSD during World War I, the lives of many soldiers who were executed or convicted of cowardice or desertion, would have been spared and, more than that, the soldiers would have received help to cope with their traumatic experiences. Thus, the development of the PTSD diagnostic category enabled the identification of a distinct syndrome which had been previously ignored. There have been many attempts to standardize the definition and diagnosis of PTSD ever since, mainly through the International Classification of Diseases (ICD) (World Health Organization, 2018) and the Diagnostic and Statistical Manual (DSM) (World Health Organization, 2018). Nevertheless, useful distinctions have been enabled, such as the differentiation between post-traumatic stress disorder (which is actually a direct consequence of a threatening external event) and panic attacks, on the fact that the latter are more likely to arise as a result of internal dysfunction, some features of it being an activation of the autonomic nervous system, rise in blood pressure, pulse rate, over-breathing, sweating, dizziness and a sense of foreboding. These physical manifestations of panic attacks are often accelerated by over-breathing and may be the reason for a conditioned response in the amygdala which will end in a resurgence of the post-traumatic experience (Sutton, 2002).

Regardless of the various approaches to understanding the meaning of the word 'trauma', psychoanalysis and psychology experts have highlighted three major components involved: a) an external stressor that comes suddenly and therefore cannot be prepared for, b) a stressor that is strong enough to break through the protective shield of skin and mind (Freud, 1920) which cannot be adequately mentally processed and affects the whole organism, and c) the interface with the individual's internal world including unconscious guilt and fantasy. Hartman (1985) and De Zuluette (1993) further highlighted how life-threatening physical illness and particularly sexual abuse fall under the category of traumatic events (Hartman, 1985), (De Zuluetta, 1993).

"The effect of psychological traumatization on individuals may be manifested in a range of well-documented effects", claims Sutton (Sutton, 2002, p. 74): a shattered belief system, disempowerment and deskilled, feelings of helplessness and dehumanization, loosened grasp of "reality", mind/body alienation, disturbed sleep, acute attacks of fear, inability to engage in pre-trauma relationships and lifestyle, inability to trust or to feel safe. Klein compared the sense of loss of safety and security to the early infant experience of the breast-feeding cessation (Klein, 1947). Of interest, it has been found that childhood attachment is a pre-requisite to safety. Spitz showed how children living in an orphanage that were physically taken care of, but had no attachment figures whatsoever, were much more vulnerable to dying (Spitz, 1945). Attachment to an adult figure protects children from danger whilst at the same time enables developing the necessary self-care skills while growing up. When a parent is unable to protect a child from danger or is part of a dangerous experience for the child, these factors may alter or even destroy a young child's perception of safety and adult protectiveness (Pynoos, 1995). It is widely recognized that explicit memories are more easily forgotten than implicit ones. Lazarus provided detailed information on coping styles and, particularly, "emotional coping" which depends on many variables, some of which are inbuilt (for example, personality traits), and some environmental (family support, related stresses and general health), also including treatment and management strategies (Lazarus, 1966). Emotional coping focuses on managing the emotions associated with a challenging situation and it may be a more appropriate starting point when dealing with minor refugees; the centre of attention involved in problem based coping may elicit a triggering effect at early stages of therapy and should therefore be addressed at a later stage when coping strategies for the negative emotions associated with

the situation have already been strengthened. As it is not possible to change what refugee minors have experienced, the focus should be on enabling them to cope, especially with the negative affective and cognitive states elicited by their traumatic experiences. (Field, 1985).

When coping with trauma, the person affected by traumatic experiences is considered to be struggling to regain an adaptive balance between two major forces: destruction and creativity. Destruction results from experiencing violence, both external and internal. A useful tool to understand the nature of trauma connected to destruction is The Tavistock model (Garland, 1998), which presents two axes: an event axis ranging from accidents to intentional acts, and an individual axis that ranges from acts which are sought out (as in high risk sports) and those not sought out (as in being in the wrong place at the wrong time). A characteristic example of external violence with acts not sought out can be found in South Africa where violence represents the expression of rage directed at one who represents "otherness" in the mind of the attacker (Sutton, 2002, p. 100). Of note, Edith Montgomery conducted a large study with refugee children from the Middle East and found that the most frequent specific types of violence-related events or circumstances were "lived in a refugee camp outside the home country" (92%) and the most important risk indicators for anxiety were "lived in a refugee camp outside home country" (Montgomery, 1998). A potential explanation of this is provided by Papadopoulos (2002, p. 31), who argues that repeated exposure to extreme violence may start to render violence frighteningly familiar to survivors, rather than overwhelmingly alien. This feeling of familiarity may result from unprocessed traumatic/violent experiences from the individual's earlier life, as well as from unconscious awareness of similar material in early-life fantasies, which may justify the use or reproduction of violence in the person's mind, either as a perpetrator or as a victim. For instance, it has been argued that trauma reactivates negative self-esteem and stirs up unconscious fantasy (Garland, 1998), while sights of death and dismemberment and possible experience of sadism and torture, represent enactments in the real world of an early aggressive fantasy, which, according to Melanie Klein (1975), is universal in human development. This is restrained, however, by the end of the first year of life. (Bragin, 2001). On the other hand, internal violence can be related with the inner conflicts of absence; through the mechanism of "splitting" the person affected by traumatic experiences related with their mother for instance, manages to "preserve" a good feeling about her by "splitting" off their "good" feelings – making "mum" wholly "good" and themselves "bad" (Maiello, 1992), thus ending up in self-blame and feelings of guilt and worthlessness. As part of mental

survival, a child cannot handle, or even comprehend, the idea of a "bad" mother so it is easier for it to take all the blame for her actions, although without being able to explain why, in order to keep the basic relationship between mother and child secure. It is noteworthy, that many refugees experience this kind of negative feelings as a result of traumatic experiences, which contribute to shaping negative maladaptive core beliefs (e.g. worthlessness) and undermine their capacity to cope with challenging life circumstances and adapt to new environments in a meaningful way.

Consistent with the above, the treatment approaches for people who have experienced traumatic events and extreme violence appears to be polarized: on one hand, there is the school of thought, in which PTSD belongs, according to which the trauma experienced by the individual is considered to be a response to external events and, second, the predominantly psychoanalytic approach, which places the emphasis on intrapsychic dynamics and early personal history of the individual, without having a coherent way of incorporating the external factors (e.g. the phases of the refugee experience: Anticipation, Devastating Events, Survival, Adjustment). It becomes evident, that a synthesizing approach is needed to incorporate all the aforementioned factors, in order to address the needs of the person that has experienced traumatic events or may be living with PTSD. This would further require to overcome the PTSD and trauma classification limitations in DSM 5 and ICD-10, especially during therapy (Yalom, 2005), and provide a more flexible and dynamic approach that goes beyond classification of the person, as this could hinder the therapeutic progress. In the core of the healing process should be the re-establishment and rediscovery of the creativity of the "victim". The term victimhood is associated with helplessness to reach active participation in one's own healing. Creativity is resistance to oppression or, in other words, the denial of victimhood and helplessness. As Sutton states: "Creating something new is an act of defiance in the face of destruction" (2002, p. 76). Survivors of devastating events often speak about recovering or finding their voice and power. Some of those who have successfully experienced such transitions describe arriving at new levels of understanding and insights by processing events through creative therapeutic activities. (Sutton, 2002, p. 76)

Although labelling all refugees as "traumatized" may not help to alleviate the symptoms of their experiences or help refugees to adapt to their new environment, the impact of their experiences should not be underestimated. The intensity and negativity of experiences, such

as forced immigration, can rarely leave refugees unaffected. The memories of flight, the nostalgia for home or any familiar place no longer accessible, and the justified sense of injustice resulting from involuntary exit will, in all likelihood, mark them psychologically for many years, probably for life. However, such memories and attitudes do not always lead to trauma or functional incapacity, and a stigmatizing approach rendering refugees as psychologically handicapped by definition should be avoided; it foregrounds an assumed disability, and undermines the capacities and abilities the individual refugee may possess (Papadopoulos, 1999b). Papadopoulos emphasized that supporting refugees is not simply a question of treating their trauma and that it requires an understanding of the complexity of their situation and of the adaptations they must make. "A conviction that mental illness, especially PTSD, is usually present in refugees is unhelpful". (Ritchman, 1998). A characteristic example of this is the largely misconceived symptom of frozenness, as a sign of PTSD. As Papadopoulos describes: "frozenness does not necessarily imply pathological traumatic dissociation, although certain functions, feelings and connections may temporarily be suspended as part of the emergency phase that requires concentration on the maintenance of a limited range of vital functions" (2002, p. 34). For more than one reasons, it is not possible to say what proportion of refugees have, or have not, been exposed to traumatic events. The main theoretical assumption is that: flight from danger does not in itself traumatize. It is the surrounding experiences, such as suffering and/or witnessing violence – which usually do the lasting damage (Papadopoulos, 2002, p. 45). If there is any room for doubt, it is better to keep an open mind than to assume "trauma". This seems to be a reasonable approach as classifying refugees and predefining their identity could have a negative impact and prevent them from redefining it in the new social context of the host country. Therefore, a positive empowering approach tailored to individual needs and experiences should be preferred.

An additional important aspect of providing support to refugees is the closed system of a 'victim-saviour' relationship that can easily be developed between refugees and therapists. Essentially, if the refugee is pathologized and views him/herself exclusively as a victim, undoubtedly the therapist will in most likelihood take the role of the saviour. However, this dyadic system can easily expand to the triangle of 'victim-saviour-violator', because saviours save victims by first attempting to protect them from their violators. This carries a risk of a perpetuating this triangle with the refugee carrying the disempowering 'victim's' identity and continuous alterations in the people occupying the other roles; this could hinder

the refugees' capacity to reclaim or redefine their identity in the new social context and develop growth and resilience via empowering support (Papadopoulos, 2002, p. 37).

One of the major challenges when providing support to refugees is the realization that a holistic approach needs to be employed, which will not exclusively focus on the "devastating events" or the atrocities they experienced, but will cover the entire time span from the anticipation of the devastation, the actual devastating events, and the uncertainty of survival, to the troubling destabilization involved in adapting in the host country (Papadopoulos, 2002, p. 157). Focusing on the devastating events alone, tends to underestimate the totality of the refugees' experiences and creates an unfair perception of them, their history and their life stories. Being a refugee is not a pathological condition, which raises certain issues regarding the position of therapists who need to be cautious during the therapeutic process. Papadopoulos claims that all systems have a dual need for both stability and change and if therapists were to only focus on changing everything that does not conform to their own theoretical/practice models or fields of expertise, they will likely contribute to the further destabilization of the system. He refers to a 'prescriptive' mistake often made by therapists early in their careers, who attempt to fit the needs of the client and the associated therapeutic approach in their field of expertise rather than adjust their practice to the needs of the individual client via a person-centred approach (Papadopoulos, 2002, p. 34).

6. THERAPY

6.1 The Anthropological Axis and Humanitarian Trainers

Bearing in mind the concept of "home", we should not undervalue the experience of losing home and everything that is connected to it. Home should be considered as "an important psychological and psychotherapeutic care for refugees" (Papadopoulos, 2002, p. 157). Refugee families endure fundamental changes and reversals in roles when they find themselves in a new social context. For example, as children are usually socially integrated faster than their parents, they take new responsibilities, often looking after their parents and grandparents. Mothers tend to obtain new authority due to their entanglement with their children (at school and in the neighbourhood) and fathers seem to become more detached as they lose their conventional position; they lose their role and authority of providing for their family as they usually lose their employment status (Papadopoulos, 2002). In addition,

Papadopoulos describes how most of men have "a strong sense of responsibility and shame for what has happened to their family" (2002, p. 287). Culturally, depending on the country, or even region, one has been raised in, opening up and expressing one's feelings can be an easy or extremely hard process, mostly because of reasons of acceptance. There are societies which are very closed in that regard, for example UK used to be very closed, but nowadays it is increasingly acceptable for children to communicate their feelings in front of their families (Papadopoulos, 2002). Still though, there are other societies, like Kosovars (as Papadopoulos (2002, p. 271) describes due to his experience with them) where families do not discuss children's psychological reactions to events freely and openly. Furthermore, there are cultural taboos which forbid talking about the dead in certain ways, making the current Eurocentric models of helping children very difficult to apply in populations with different ethnic background, as it is very challenging to comprehend what children have really witnessed and experienced. As Papadopoulos aptly observed: "Respect for cultural difference has been a cornerstone of the work, but this can be complex when some of the ideas that do not appear to fit are the very ideas we feel transcend cultural difference" (2002, p. 289). Children, however, can find themselves in a very difficult position when a parent loses their roles in the family and the relationship with them is disrupted. In the absence of a role model or due to disrupted family bonds, a young child or teenager can lose or try to redefine their sense of self and identity in maladaptive ways. Given the challenging experiences refugee minors have experienced and the often unstable – or even violent – social environment in the hosting facilities, this can be a high-risk process that can easily lead refugee minors in adopting social roles that prevent their social integration. Furthermore, after having witnessed unspeakable terrors like abuse, neglect and emotional and/or physical abandonment, and trying to exist in a threatening unsafe environment, refugee minors can become numb or deadened to life, without motivation or sense of purpose. When essential parts of the self-surface within such psychological conditions, they are not welcomed, processed, understood or valued by others or even the person they define. On the contrary, they are judged, shamed and rejected by negative labelling or perceptions of a "weak" person that is "too needy". This often results in hiding away these essential parts of self in an inner refuge (Papadopoulos, 2002) where unprocessed negative experiences remain buried; this poses a risk for the psychological, social and mental health of refugees. The same process seems to take place when an opposite positive attitude focused on potential, hope and dreams for self-fulfilment, is adapted by refugees, as the negative social norms that develop within the hosting facilities may result in envy, hatred and even violence

from other refugees who are finding it very difficult to cope with their experiences and adapt in the host countries. .

It is usually considered that refugee families struggle between two "oppositional discourses" with regard to their loyalty to tradition and overall orientation. On one hand, they have an inner responsibility to remain loyal to the home country's culture, language and traditions and to celebrate the past but, on the other hand, they need to get grip of the new opportunities presented to them in the host country and lay the ground for the best possible future in their new home (Papadopoulos, 2002, p. 36). This conflict is usually apparent between the different generations in the family were the elders tend to stay loyal to their home country's traditions, while the younger members of the family are eager to adapt to their new reality. These are all important factors that need to be taken into account when providing intergenerational support to refugees and their families as they could create confused perceptions of home and potentially delay or even prevent their social integration in the host country.

Going back to the importance of personal stories or narratives, it must be noted that these are used to "clothe" a chaotic reality in order to tame it, transform it and make a sense out of it. This, however does not occur on its own, as Feldman notes, "Narratives not only explain events; they are integral to how we decide what is an event and what is not" (Feldman, 1991). Papadopoulos uses the word ¨mythinformation" (2002, p. 229) which describes the way stories can be connected to objects, intentions, and events in a strong integration that appears genuine and credible due to its familiarity. The familiarity comes from the fact that it includes the fundamental triangle: aggressor-victim-rescuer. "Only if the humanitarian workers are able to have an awareness of their pre-selected role in this triangle (i.e. as Rescuers), can they offer other members of the constellation (such as the "Victim") solutions that are not repetitive and fatal" (Papadopoulos, 2002, p. 229). According to Enriquez (Enriquez, 1980), the humanitarian worker/trainer can be seen as a figure who aims to enable the refugees to regain control over their sense of self and their life, by constantly changing his/her role to:

a. Offer a good model/form (as a trainer)
b. Heal and restore (as a therapist)
c. Give light to, help emerge (as a midwife)
d. Interpret, make aware (as an interpreter)

e. Help act, change, move (as a militant)
f. Dedicate to something, take on problems (as a repairer)
g. Be a figure free of taboos, prohibitions (as a transgressor)
h. Act so as to render the other mad (as a destroyer)

6.2 Therapeutic Care for Refugees Rather than Psychotherapy

An important issue arises regarding what happens when we work with people whose damaging experiences are way beyond our own experience and understanding or their culture is way different than our own. How do we comprehend their needs and how sure can we be about what we comprehend? It is possible that this gap of understanding may be bridged if we place enough emphasis on the notions of "culture" and "cultural competence". Papadopoulos disagrees with that and thinks of it as a mistake, because "the problem of achieving therapeutic understanding under any circumstances might be framed as one of opaque world of the "other"" (2002, p. 244). He argues that cultural sameness cannot guarantee comprehension, and cultural difference should be reflected as a dimension added to the complication of the work rather than a special kind of barrier. Nevertheless, he recognises that "there are powerful obstacles in certain areas of psycho-social life to our capacity to extend therapeutic understanding beyond the terrain of the familiar" (2002, p. 252). Fear, to take one; the fear of the different, the stranger, the alien, the intruder, the outsider, the refugee with all their differences, needs, dependence (even 'parasitism' claimed by few) are still so enclosed in some cultures and societies, which makes it extremely difficult to really tune in to the experience of refugees (Papadopoulos, 2002). Giving emphasis to terms such as "stress" or "trauma" used extensively by international experts leads to attributing a reductive meaning or oversimplification by focusing exclusively on the experience of an individual rather than considering the social context of the community as well. New categories, new words and new ways of thinking need to emerge in order to interact between the "reductive tone of the translated psychosocial discourse and the local narratives" (Papadopoulos, 2002, p. 265). The latter have been obviously affected by the terms of stress and trauma mentioned above. Papadopoulos ends by emphasizing that as a result, professional therapists had to adapt their own roles in the context of these changes.

Sometimes, refugees may not have the proper motivation or symptomatology for traditional psychotherapy (Papadopoulos, 2002), which may not even be available or appropriate for

them due to language reasons or cultural disimilarities. Different therapeutic approaches beyond traditional psychotherapy also need to be considered and become available for the development of care plans tailored to the needs of refugees. This is why Papadopoulos uses the term "therapeutic care" rather than that of psychotherapy when referring to an appropriate approach for helping refugees (2002). By therapeutic care Papadopoulos means "the wider application of psychotherapeutic principles to any form of assistance to refugees" or, in other words, "elements of therapeutic care can be included in all types of work with refugees, be it with reference to their housing, educational, medical or financial needs" (2002, p. 4). Papadopoulos doesn't exclude proper psychotherapy, of course, but widens the field of therapeutic practice to suggest a more flexible and dynamic approach that can be tailored to the needs of the specific population.

7. MUSIC THERAPY

7.1 Music

"Music is the harmony of the universe in microcosm; for this harmony is life itself; and in man, who is himself a microcosm of the universe, chords and discords are to be found in his pulse, in his heart beat, his vibration, his rhythm and tone. His health and sickness, his joy or displeasure show whether his life has music or not." (from the Sufi Message of Nazrat Inayat Khan, quoted by Hamel 1976) (1976)

Music is, first and foremost, a communication tool (Cross, 2009) . Music "speaks" to us and the phrase "the language of music" is in everyday use, recalling the Deryck Cooke book of the same title (1959). The musical qualities of rhythm and pitch, which are important ingredients of "proto-conversation", as described by Trevarthen (1998), are progressively incorporated into the speech development. It is worth mentioning that these qualities are consequently localized mainly to the left side of the brain (the "language side"), which develops between two and four years of age (Sutton, 2002). The innate ability of brain to translate musical information suggests that the procedure has a value of biological survival (Blacking, 1976). According to Blacking this lies in the probability that music is meant for establishing social assimilation and personal relationships. Of all the elements of music, rhythm appears to be the most fundamental one, the beginning of order at prenatal and infant level and "the most primitive, yet complex, structure of the human mind" (Lehtonen, 1995).

The association of the rhythm of the body and the rhythm of music has been researched thoroughly by systematics musicologists (Bader, 2018) and shown how much they are connected. For example, Harrer and Harrer reported changes in pulse rate, respiration, galvanic skin responses and muscle activity in response to a variety of musical and non-musical stimuli (Harrer, 1977).

7.2 Music and Trauma

What could music therapy offer to children that have experienced or experience violence? Congreve (1697) argues that: "music hath charms to soothe a savage breast". By this quote he illustrates music as an antidote to violence. The very fact that this line is so often cited shows that it probably reflects some kind of truth for many people. According to Sutton (2002), music is often connected to love, kindness, tenderness and human warmth. This is probably because music, compared to language or pictures, is not a representational intermediate. It is contrary to the nature of music to symbolize or refer to anything specifically (Sutton, 2002, p. 123).

In this way, music in a spontaneous yet circumscribed environment can be very helpful to those experiencing trauma (Sutton, 2002). Music exists in time, is felt physically and as an emotion in the body, Sutton states. As such it is a powerful tool for finding a form within which to start adjusting to coping with extreme experiences – where the very existence itself is at threat.

7.3 Music Therapy and Trauma. Building the Environment

According to Winnicott's notion on infant ego development, needs which at first seem to be environmentally led can become associated with inner stimuli. In other words, we can consider how an infant is unable to be fed at will and is reliant on mother's interpretation of his or her need, after which the infant is actually fed. The vulnerable position leaves the infant dependent on mother's capacity to comprehend and react to what is required. When basic needs are not satisfied, the infant goes into a state of turbulent confusion that may feel as if it's very survival is at risk. This vulnerability follows the child to the rest of his/her life and the turbulence could lead to different reactions each time (Sutton, 2002, p. 30). For example, Almquist and Broberg (1997) have examined the mutual silencing that often occurs

between child and parent confronting an overwhelming trauma in families while exposed to war. The authors' term "family survival strategy" described the ways that parent and child "conspire" in order to avoid speaking about the trauma or experiencing fully its impact. This secrecy which remains an unresolved state is supported by each family member, affecting the child in particular. As Almquist and Broberg stated: "A traumatic event fills the inner life of the traumatized person… and because of this a pressure builds up in the child to verbalize his or her experience" (1997). Turner, McFarlane and van der Kolk (1996) indicate that traumatization may be connected to problems in dealing with intimacy, the instinct to bypass the anguish caused by the traumatic situation, along with shame and guilt, all of which are elements that may interfere with therapeutic engagement (Sparr, 1993). Feeling alienated and misunderstood results from traumatization and could become a further barrier to seeking help (Turner, 1996). As are cultural factors such as stoicism or those of denial and silence which dominated countries such as Northern Ireland (Smyth, 1998) until rather recently. Non-verbal methods, such as music therapy, art therapy (Malchiodi, 1999), interactive image work (Plummer, 1999), and other techniques such as hypnosis (Putnam, 1992), VK/D3 and EMDR (Jensen, 1994) have a role of importance to play in providing a diversity of directions to integration and potential resolution to people who have been traumatized. Their importance may well be due to their capacity to present a way to explore the traumatic experience without having to tolerate intimacy or other factors related to more traditional verbal therapies.

We could say that the music therapists find themselves in a powerful yet highly responsible position. They are in possession of a therapeutic tool which supplies them with forthright access to the emotions and the fundamental dangers of triggering unpleasant or threatening memories. However, if used with caution and responsibility, music also possesses the power to heal by helping people to comprehend and rationalize emotions (Sutton, 2002). Any process which restrains activity in the brain, or an exact area of the brain (in this case the amygdala nucleus) can, by creating a wall for anxiety, reduce the probability of re-living traumatic memories (Sutton, 2002, p. 50).

In the music therapy session, a relationship is offered which is based on what the child does as an act of emotional creativity. A child banging loudly on a drum, for example, and thus blocking out everyone else in the room, is not only expressing anger, erupting frustration or wanting to isolate him/herself from the world, as it might be experienced through the lenses

of countertransference (Sutton, 2002); such a child is also displaying a vast amount of energy, and the quality of which has a potential to be converted into creativity with the help of a therapist who is not disorientated by the "noise", who can endure the child's resentment, who doesn't have the need to direct the child to "play softly", and who can "find" the child where the child is, permit the vibrancy and potency of the "noise" to create a bond through music – with the condition, of course, that the child acknowledges the present of that other person (Sutton, 2002). Nevertheless, music therapists need to make sure that their intentions to provide a relationship are not damaged or diminished through their own fear and awkwardness towards the child's pain and loss, Sutton warns. She emphasizes that "our interactions not only conduct our social relations and our engagement with the world, but also help us to define and maintain our sense of self. When they are limited by trauma, severe consequences can follow" (2002, p. 130). Connecting with the core of a person's being is a lengthy process. However, even at the very beginning of the very first session, uncertain musical interactions can provide the first manifestation of a whole person traying to break through the traumatized exterior psychological dimensions of self.

Considering the sex factor, teen girls in various parts of the world have suffered repeatedly violence of sexual nature. Feminist music therapy (Purdon, 2006) analyzes in great extend these issues of sex and power which constitute some of the reasons behind molestation and comprehend this abuse as a phenomenon of patriarchic society. Under this aspect, we find the tendency to interpret molestation as a relationship problem or a matter of anger, justifying the acts of the perpetrator, silencing the victims or even an attempt to anthologize the methods of survival by the latter. (Μαυροδή, 2018)

Refugee minors often have suffered political violence, which is defined as organized physical and emotional violence committed by one group (political, ethnic or religious) against members of another group (Sutton, 2002). An essential part of therapy is understanding the origin and history of the child. Sutton provides with some additional insights related to music therapy and psychological trauma that have to be considered when the client has experienced war; the nature of the traumatic event, the developmental level of the client during the war, the family situation and other aspects of post-war life like having to try to adapt and accept a new life, not only in terms of the physical appearance, but also of the new place of living and the person that they had become as a consequence of their experiences. As a result, Sutton describes that traumatized clients often presented: a "wall

of sound" (i.e. continuous and very loud playing), extreme difficulty in tolerating quietness or silence, difficulty in staying in the room, dissociation and acting out the "invader" or invading army (Sutton, 2002, p. 223).

The four main characteristics a traumatized client may feature are (Sutton, 2002, p. 163):

1. Depression

It is expected from a patient to generalize the experienced gained in the music therapy sessions on other areas of his/her life, for instance, apprehending how interaction between two people works. Musical interactions with the therapist can occur in the form of conversation, with question and answer patterns, dialogue and pauses. The skill to apply this "musical conversation" outside the music room could significantly reinforce his/her verbal interaction with other people, providing him/her the confidence to take part in a most probably rewarding experience. Containing the pain the client has encountered in the process of the therapy while exploring the results of his/her physical and emotional traumas, is part of the work expected in a therapeutic setting. This brings in mind Klein's theory of the depressive position (1986) where the baby realizes that the good, idealized mother and the bad, hated mother can coexist.

2. Regression

In the last decades, a treatment connected to the idea of regression is viewed as one of the main paths through which deep changes can be achieved (Winnicott, 1984). Turry wrote: "working in a mixed gender team can create the possibility of corrective emotional experiences for the client within the traditional model of an intact family unit" (Turry, 1998). If trust and reliability, which are basic emotional conditions, are deprived in infancy then the therapeutic setting and the therapist's attitude can create an environment that provides both, adds Sutton. "The wish to listen to music can thus be apprehended as a deep longing within the individual to re-experience the primary object, as Bollas suggests in his discussion of the transformational object (1987)" (Sutton, 2002, p. 198). Sutton also strongly states that therapists must "be completely open to diverse sound phenomena that are not included in preconceived operational models". All sounds in the music therapy session matter. The words, the silence, the breathing, sighing etc., all matter and all derive from inner areas that have the need to present themselves. Through regression the music therapist's unconditioned

and attentive listening creates a safe path for hidden music to finds its way and emerge. “In the patient’s regression lies hope for a new relational experience”, Sutton writes.

3. Avoidance Behaviours

Existential questions arise together with the positioning of oneself in the world. Sutton writes that it would be fruitless to reject that negation makes itself appear on the initial ground of a relation of person to the world. “The world does not disclose its non-beings to one who has not first posited them as possibilities.” (Sartre, 1969). Having music in the session creates an experience and an expectation on a level where its absence would be notable and significant.

4. Aggression

There are two popular views on why aggression might be considered as a feature of trauma. One view is that “in order to regain a sense of control, the victim of aggression identifies with the aggressor and becomes aggressive him/herself (Srinath, 1998). A second view describes that “the need to relieve anxiety about one’s own vulnerability is so great that it causes a complete reversal of roles so that the victimized becomes the victimizer (Carlson, 1997).

Our suffering, aggression and destruction forces can turn into vehicles for creative transformation. Music therapy may be an efficient mean through which this potential could be achieved. The challenge is to integrate what music has to offer in the therapeutic dialogue without it resulting in “organized chaos” (Winnicott, 1971) and also “what may seem sometimes like the promotion of the music therapist’s own agenda”, adds Sutton. Sutton notes something very interesting following up this idea: “As a result of this approach, my attitude over the years has become increasingly non- intervening and the listening aspect of my role more prominent. I became more attentive to that sound aspect of the session that is non-musical (in the conventional sense), and have expanded the margins of music to include sound in all its manifestations, especially the wide range of vocal and body-sound productions that is regularly heard in the therapeutic dialogue” (Sutton, 2002, p. 197). The inner states of clients are often visible via body language and sound without even using any instrument, not even their voice. Additionally, a sense of tonality, a harmony of dissonance, stretto and counterpoint forms, dramatic pauses and changing tempi can be detected in the verbal dialogues between therapist and patient, Sutton mentions. All these elements can be

even found in breathing, sighing and coughing, as they echo in the session. More importantly, "silence in all its facets and colours, as a form of sound or non-sound, silence as absence and more often than not as presence, occurs regularly and has dramatic meaning in the therapeutic dialogue" (Sutton, 2002, p. 197). Music reflects the child's inner state. Learning to "read" the music of the child while playing will provide the therapist with the necessary tools to move forward in establishing a relationship and hence building the core of the therapeutic process. The child's music can reflect the child's anxiety because of the difficulties in interacting with other people and therefore trusting them. All these could also be detected in the child's body language, breathing, eye contact and most importantly in the presence of silence. Many things can be learned when the instruments are put aside when usually in the early sessions constant sound or talk follows, as Sutton mentions while elaborating on a therapy session with one of his patients. This is why Irvin Yalom, although representing a different direction in psychotherapy (existential rather than psychodynamic which is the main focus on this chapter), also suggests that therapists should encourage the patient to observe his/her body (2005). Often, he/she won't be able to experience the emotion but he/she will have awareness of the sentimental equivalents from the nervous system: stomach tightness, sweat, knot on the neck, blushing etc. In a group setting, the team can gradually help the member to translate those sentiments into their psychological meanings. The members could, for instance, point out the synchronization of the reactions of the client with an event happening in the group.

As mentioned in the beginning of this thesis, I believe that pure genres of music may not be the most suitable music modality in this application of music therapy. Different genres of music affect us differently. Depending on our experiences, culture and generation, a piece of music can have a completely different effect on two clients. When working with people from different ethnic backgrounds it may be best to look for that common ground that music can provide among the members of a therapy group, which overcomes cultural or ethnic constraints and enables focusing on the here and now, to facilitate the therapeutic process". The structure of music, however abstract it may seem at a music therapy session, is the most important aspect to rely on. The structure, like in a building, is a holding mechanism. The elements of motif and repetition, however, can also provide stability and security in the moments when the content becomes emotional and probably uncontained. "It is music's specific structure that makes it so closely related to the maternal process" as Sutton wrote (2002, p. 202). Winnicott suggested the idea of "therapy environment" acting as a medium

around the patient, holding him, without being too active or expecting anything from the client (Winnicott, 1984). Music can take the place of the environmental medium, especially in states of regression. The two main directions in current UK music therapy practice are the application of psychodynamic concepts together with those from the field of mother-infant interaction (Stewart, 2000). Similar to other psychodynamic therapies, what defines the essential frame for the work are clear boundaries (Stewart, 1996), for example:

1. "Consistency of time: per instance, weekly sessions of 30 minutes duration. If any breaks are anticipated they are prepared for, thereby giving the patient an opportunity to communicate something about missing, as well as having, sessions.
2. Consistence of setting: providing a range of robust, durable musical instruments in the same room each week.
3. Consistency of attitude: a commitment to being with the patient with no pre-set-agenda other than to receive his communications – conscious and unconscious – and to respond and give meaning to them."

These boundaries are creating an environmental and psychic containment necessary for the patient and therefore, the therapy. As Klein said: "As anyone knows who has glued things, the things to be stuck together need to be held firmly in a kind of frame until the glue holds. Then the frame is no longer needed" (1987). This is why making a circle, in music therapy, can benefit the therapeutic results. The symbol of the circle has become a common emblem of wholeness in many cultures throughout history. It is a symbol of mothering containment, as Sutton suggests, and as such can function as a containment vehicle in the therapy to provide the child the necessary safety and warmth to express itself in playing, recalling thus the bond the child has as an infant with his/her mother.

7.4 Playing and The Music Child

An indication of substantially good emotional health is the ability to play. Contrarily, being unable to play can reveal areas of poor well-being (Winnicott, 1971). Winnicott advocates that we "put a lot of store on a child's capacity to play". This sentence illustrates his strong belief in the principal connection between well-being and play. His suggestion is that whenever emotional adversities occur, the child's capability to play is characteristic of a

capability to create a solution (Winnicott, 1964). In his book, 'Playing and Reality', Donald Winnicott (1971) demonstrates the capacity for playing in the very early mother-infant relationship. He emphasizes that the highly important element of playing is in constituting and cultivating a sense of "self". He characteristically states: "it is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self".

Winnicott outlines that there are four main stages in the mother-infant relationship; mother as environment, separation and the discovery transitional play, alone in the presence of another and lastly, the playing relationship. Translating these stages into music therapy sessions we could describe a relationship that begins with the establishment of the environment. First the child presents itself and finds ways to be seen, heard and communicate musically via playing. Then the separation occurs and the child can segregate itself and identifies itself as a unit so that with the therapist as another unit searches for ways to interact; and the mean for this is, of course, playing together. Thus the relationship takes form via the two players. Or, in other words, in order to use the ability to play, defining the "self" and "other" is essential. This is a prerequisite for all creative living (Winnicott, 1971).

One applicable concept while thinking about music therapy with traumatized children is the respect for and focus on the child as a whole. Nordoff and Robbins write of the "Music Child" (1977); the Music Child is the part of one's internal world, which is alive, healthy and creative. Their concept was inspired by their work with heavily handicapped children who, although having profound disabilities, were in position to "play", to have a creative life and to engage in a full, dynamic, playful, absolutely committed musical-therapeutic event along with the therapists (Aigen, 1998). This concept of the Music Child also involves another significant aspect with regard to working with traumatized children. Sutton suggests that by concentrating our therapeutic work entirely on children's trauma we risk squeezing a multidimensional, complex child into a "small" box – called "the traumatized child". In her paper, Stephanie Grenadier (1995) questions professionals' profound need to provoke trauma, often encouraging patients to recall and reveal traumatic events. This, she suggests, encourages patients to claim themselves and remain in the "victims" or "survivors" of violence and abuse state. The concept of the Music Child assimilates all facets of the child in music therapy because it focuses on music and playing, which translates to creativity and relating. However, sometimes children remain unable to "play", unable to be integrated in

the group, unable to experience and establish a relationship. In this case, experienced trauma dominates a child's way of being. Sutton continues that such a child usually makes repetitive, less flexible and less transformative music, as they have difficulties to relate to other children in the group. Nevertheless, even a traumatised child can revitalize the part of self that remains creative and growthful. It is of clinical importance, to hold the Music Child in mind, rather than being preoccupied only with the part of the child that is traumatized (Grenadier, 1995). This "non-traumatized" part of the child – which reflects the Music Child – is potentially the beacon to the child's own healing process. It is the suppressed "wholeness" within children that should be addressed and "fed" during the music therapy sessions, helping children to gain what has been forgotten and silenced, their own healing and emotional capitals.

On the other hand, the playing of music may also become an issue of contest. Musical instruments may possess political associations and identities. For example, as Sutton explains (2002, p. 78), there are two kinds of pipes played in Northern Ireland – the Scottish bagpipes which is associated with Unionism and the Irish Uileann pipes which is associated with Irish traditional music and therefore identity. Likewise, the Lambeg drum is associated with Orangeism and Unionism and the Bodhran with Irish traditional music. Associations can also be found relating to musical forms, with gospel and certain forms of country music connected with protestant fundamentalism, and classical and orchestral music related to the ascendancy. However, as Winnicott has said, children's play is naturally exciting and precarious. He writes of therapy that it contains "the precariousness of magic itself, the magic that arises in intimacy, in a relationship that is being found to be reliable". (1971)

Contrary to using prepared music, improvisation music therapy (Bruscia, 1987) provides with an opportunity for "playing" – essentially, playing music – by producing spontaneous sounds on instruments available on their disposal or on sound objects (such as tables, glasses, the floor, parts of their own body etc.). This process of music-making is not an isolated one, but happens together with the music therapist who participates in the child's instant music-making. The therapist and child create a sharing bond via spontaneous music sounds, which can engage, stimulate and evoke the child's imagination, providing with a chance to "recreate" and "re-image" life. This musical relationship, which seldom needs words, can open the doors for the child to painful memories of events and convert them into a reality that the child could cope with. Everything in the "play" condition needs to stay open to

possibilities, because this is the only way that children can become masters of their world and their lives (Levine, 1998).

Going back to the analytical perspective, music playing can provide the framework to include all aspects of transference and countertransference in therapy. Parts of the self can be projected onto the voice, the music and the musical instruments (Austin, 1993). There are many cases involving children that don't talk (without lacking the ability though) in therapy, so there is a need for a specific therapeutic process in order to help them. Often, people's adversities can be viewed as being generated by unmanageable feelings which they keep deep inside themselves. If they could find a way to express these feelings, they could achieve a cathartic which could help them cope with the difficulties they experience. The intensity of silence is translated as the child is holding something inside. If children could express this intensity through music playing, they would step out of their shadowy, silent existence and back into the world. Musical interaction may be the solution for exploration of the new and profound self along with the therapist's self in relation to the child. This triangle of self, other and relationship is the most important part of musical engagement (Sutton, 2002). The fundamental operator of change within therapy is one of creative interaction. Although using words to describe experiences can be vastly therapeutic, there are times when "stability depends on silence, when memory cannot be restorative" (Frosh, 2002) There are also experiences too scary to put into words. Especially with children, nonverbal methods, like music, games and drawing, have been extremely useful, as Papadopoulos mentions. Papadopoulos continues with an example in practice: "Liridon, aged six, arrived at the centre quite frozen. He was present when his parents and five other family members were killed. He survived by hiding between his grandmother's legs, the blankets concealing him as she was beaten and punched by soldiers. His first drawings were blank pictures of houses burning: he used no colour, with the exception of little red to indicate blood and flames. As he began to feel understood, he was able to use more words to communicate, and his drawings gained greater colour and complexity" (Papadopoulos, 2002, p. 280). Using his experience in Kosovo Papadopoulos describes how the consequences of trauma may remain alive at a non-verbal and physiological level (Williams, 1999), so the counsellors often needed support between them. One way they achieved that was "by singing together at the end of each day, be they Kosovan songs, international pop, or opera" (Papadopoulos, 2002, p. 286).

Singing is therapeutic for a number of reasons. From the physiological side, singing includes deep breathing which is the core of living. Singing is also part of "neuromuscular activities" (Sutton, 2002, p. 235). In addition to that, muscular patterns are related to psychological patterns and emotional response (Newam, 1998). A song can provide a secure container for the patient to feel safe enough in order to express feelings and aspects of him/herself that were up to that point threatening. For this purpose, Sutton has developed and codified a method named "Vocal holding technique". "It involves the intentional use of two chords in combination with the therapist's voice in order to create a consistent and stable musical environment that facilitates improvised singing within the client-therapist relationship" (2002, p. 236). There are various ways in which Vocal holding techniques can be introduced into the music psychotherapy session. Taking an example of a patient who was extremely anxious about improvising, but willing to try, Sutton applied the technique of "Free associative singing". "Free associative singing", claims Sutton, "is the term I use to describe a technique that can be implemented when words enter the vocal holding process. It is similar to Freud's technique of free association (1938) in that the patient is encouraged to freely speak out whatever comes into his/her mind with the certainty that by doing so the patient brings forth unconscious memories, images and associated feelings".

Misunderstanding, loneliness and isolation is usually what trauma survivors feel (Sutton, 2002). Although singing can help to remove the walls of isolation, it demands courage from both the patient and therapist in the sense that the patient needs courage to deal with the shame and allow him/herself to be exposed as vulnerable and perhaps needy. On the other hand, the therapist needs courage to stay consistent, calm and available while escorting the patient on his/her painful journey through their "dark, empty corridors and into rooms filled with violent and painful memories" (Sutton, 2002, p. 257).

Musical interaction brings out the uniqueness of each individual, and simultaneously reveals the relations in our common humanity. "The way that music-making reaches and draws out the essential humanity of the most unreachable people places it in direct opposition to political violence, which denies the humanity and individuality of its victims." as beautifully put by Sutton (2002, p. 131). By this view, music-making is a foundation for human rights, a constant remembrance of each person's value and of humanity as an entity.

8. GROUP THERAPY

8.1 Why Yalom's model?

Given the background of minor refugees and their need for therapeutic care presented in the previous sections of this thesis, and the potential therapeutic usefulness of music therapy combining elements of psychodynamic and creative (Nordoff-Robbins) approaches, I will now proceed to propose a way to organize the therapy sessions of the actual music therapy intervention. I choose to follow Irvin Yalom's model for group therapy for that matter (2005). Irvin Yalom is considered as the founder of existential psychotherapy. He wasn't, of course, the first person to study the benefits of group psychotherapy and suggest a direction. He was, however, one of the most influential experts and his book on Group Psychotherapy (Yalom, 2005) is still considered one of the pinnacles of its kind along, of course, with his existential theory in psychotherapy. Existential psychotherapy wasn't the only one suggested for groups though. Social Therapy, Group Analysis, System-Centred, Emotionally Focused Therapy and others have been suggested and all of them have elements that could be very useful when planning a group therapy. However, the reason I base my thesis mainly on Yalom's work is that his theory and practice ideas are closer to what I consider suitable for the population I focus on. Refugees, especially unaccompanied minors, are in an existentially challenging situation, and Yalom's existential approach to therapy seems more appropriate. Additionally, refugee minors may have limited time for therapy (they are usually moved a lot among different locations) and there is a certain degree of specificity in the population in that they have all left home and they are all unattended. In that sense, there may be common therapeutic ground and goals to achieve among the members of the group. Lastly, Yalom managed to integrate elements from different theories to develop a more holistic approach, which I believe, is flexible enough to address the fundamental existential needs of this group; furthermore, the theoretical background and dynamics that Yalom's approach offers in organizing group therapy sessions seem to fit well with a therapeutic approach that combines elements of psychodynamic and creative music therapy.

8.2 Why group therapy?

According to Yalom there are 11 primary factors discerned during the therapeutic process in groups (2005, pp. 25-26):

1. Instillation of hope.

   Group therapy benefits from a unique source of hope found only between groups of people, especially if they belong to a specific group where they balance on a thin line between adjustment and collapse, like groups of cancer patients. (International Journal Of Group Psychotherapy , 1998)

2. Universality.

   In group therapy the sense of uniqueness is reduced and relief comes to take its place. Therapists must divert the cultural differences into cross-cultural cases turning all human conditions and afflictions into catholic reactions. In order to do so, the therapists must be able to distinguish all cultural aspects. (Schultz, 1988)

3. Imparting information.

   The unawareness of the source, the meaning and the weight of the symptoms could create fear and anxiety on the client making the whole therapeutic process harder. An advice provision, indirectly, could be beneficial in this matter, mostly due to the caring aspect involved rather than the actual content of the advice.

4. Altruism.

   Group therapy has the unique privilege of being the only kind of therapy where the clients can benefit from each other. This duality of roles finds itself when a client at some point receives help and another provides help (Kivlighan, 2000). In the eyes of the clients, the therapist is a paid professional but, on the other hand, the rest of the group represents real people and so they lay their trust on them; in this way, they learn that they have a responsibility towards the people they ask to take care of them. The new members of the group tend to underestimate the therapeutic influence of the team thinking that “how can a blind lead another blind?” while what they actually say is “I feel blind so I cannot be of any help to another person”.

5. Corrective recapitulation of the primary family experience.

   The vast majority of clients who enter a group, despite those who have experienced great stress due to environmental reasons (like work environment), do so because of an unsatisfactory experience from the first and most important group, family. What is important though is not to re-experience the first conflicts but to experience them in a repairing manner.

6. Development of socializing techniques.

These dexterities will be very useful and beneficial to the clients for their future social interactions and constitute the cornerstone of emotional intelligence. (Goleman, 1995)

7. Imitative behaviour.

   Mimetism can play an important role in the prime stages of group therapy when the new members identify themselves with the old members or even the therapist. Even if mimetism doesn't last long it can help a new client to open up in new manners something that will lead to adaptability. It is also common for mimetism to last for the whole duration of therapy while the client dresses up with manners from a different person each time and then abandons them. This could be very therapeutic on the basis that by "finding what we are not, we move towards to who we really are".

8. Interpersonal learning.

   Interpersonal learning in group therapy is the equivalent of self-awareness, therapeutic transference and corrective emotional experience. "Corrective emotional experience" is a term conceived by Franz Alexander in 1946 (1965). Alexander believed that if a patient is exposed to the same sentimental situation that he/she couldn't handle in the past, but in a more auspicious environment then the previously traumatic experience could be "corrected" by the new one. This works better in group therapy because individual therapy is more isolated so the client can easily dispute the spontaneity, range and authenticity of such relationship. For this to happen two things must comply; firstly, the client must feel safe and supported by the group in order for all the tensions to be resolved and secondly, there must sufficient participation and honest feedback in order to have a sufficient control of reality. Yalom continues that therapy is both an emotional and a corrective experience. This duality is very important. The experience must by intense. But through our logic we must also comprehend the importance of this emotional experience. Research has shown that the majority of group therapy clients consider the therapeutic interaction with the other members of the group more beneficial than the relationship with the therapist (Dies, 1998). Once a Yalom's client stated: "I once thought that a group is a natural environment for artificial experiences. It took me a while to understand that it is the complete opposite; an artificial environment for natural experiences" (Malat, 2001). It all comes to the core factor of relationship. Winnicott supported the child-mother relationship as the sole one (1978) and Mitchell said that a person is

understood through the tight web of relationships, old and present (1988). The American psychologist-philosopher Williams James wrote that we are not just social animals who just enjoy being among other people. We are also naturally inclined to seek other people's attention and more than that, their preferential treatment. James also commented that he could not imagine a more vicious punishment than putting a person to freely be in a social environment but completely ignored by the other members of the society (James, 1890). Social isolation has been found to be an element for early mortality like smoking and obesity (House, 1988) while social interaction and integration reacts positively in the course of serious illnesses like cancer and AIDS (Leserman, 2000). Sallivan said that if self-dynamism is constructed upon pejorative experiences it will encourage the hostile and devaluated appreciation of the person for the other people and then the person will receive naturally the selectively hostile and devaluated appreciation from the other people (Mullahy, 1970). This is called self-fulfilled prophecy. In his research on teenagers, Crunebaum and Solomon, stressed that the existence of satisfactory relationships between them and self-esteem are inseparable concepts (Leszcz, 1997). The therapeutic goals of the clients often change and the need for relief is substituted with the need of transpersonal character.

9. Cohesiveness.

   Cohesiveness is for group therapy what is relationship to individual therapy. An analysis conducted by the National Institute for Mental Health of the USA on different approaches on psychotherapy concluded that for the best possible results only a positive, supportive, reassuring and with good intentions person should take the role of authority (Jones, 2002). Cohesiveness is defined as the net force of all forces acting upon all members in a way that will keep them in the team (Zander, 1962) or, in simpler terms, the attractive quality of a team (Frank, 1957). What matters more is the sharing of our emotional world and the approval from the other people, especially in teenagers. Carl Rogers wrote a lot about the *actualizing tendency,* a tendency found in all organisms which drives them to extend and develop (Rodgers, 1951). The role of the therapist is to function as a facilitator and in favour of self-expansion. However, the primary work of a person is self-exploration, the research of the feelings and experiences, areas previously forbidden for consciousness. The goal of the therapist is not to provide the elements of maturity and self-fulfilment to the clients but rather to eliminate all the obstacles for this

natural tendency. It has been found that there are three variables which, although not affecting the course of therapy in a direct way, they significantly affect popularity. 1. Previous self-revelation, 2) Transpersonal compatibility and 3) Other factors like age, intelligence and educational status (Connelly, 1986). The members that are more popular tend to have more chances to change. They achieve this popularity by satisfying the previous factors. The person that follows the rules of the team not only gains in popularity in therapy but also gains a powerful tool for his social interactions outside therapy. Members of a cohesive group, comparatively with members of a non-cohesive group will try harder to influence other members (Goldstein, 1966), be more open to others' influence (Cartwright, 1968), be more willing to listen to other people (Back, 1951), be more acceptable (Zander, 1954), feel more safe and relieved inside the team (Seashore, 1954), come more willingly to the meetings (Rasmussen, 1954), reveal themselves more (Kirschner, 1978), protect the rules of the team and apply pressure to those who don't comply with those rules (Schachter, 1951), have less changes to break the team up after a member's departure (Goldstein, 1951) and feel that they own this endeavour of group therapy (Keys, 1988). In an environment, full of acceptance and understanding clients will be more willing to search into themselves. The definitive core of the therapeutic procedure in groups in an emotionally charged, intellectually processed transpersonal interaction in a frame of support and trust (Kivlighan, 2000).

10. Catharsis.

    The openly expressed emotion is of vital importance for the therapeutic procedure into a group. If it was missed, then the team would become a sterile academic exercise. However, this is only one part of the procedure. Yalom raises some very interesting questions though asking whether the pursuit for understanding ourselves lead to change or is it just an interesting, attractive, intellectual exercise for the clients to keep them tight together while something else is developed, the relationship (Yalom, 2005). It becomes evident that the relationship in the true force of the therapy.

11. Existential factors.

    Fromm, in his book «Escape from freedom» wrote that freedom frightens us much more than tyranny (Fromm, 1995). Sartre added that to be responsible of something means that you are the indisputable creator of it (Sartre J. , 1956). When someone discovers a meaning into a great adversity which troubles him/her, it can transform

him/her (Bower, 1998). Nietzsche once wrote: "whoever has a *why* to live can tolerate almost any *how*" (Nietzsche, 1968). Yalom, in his book "The Gift of Therapy" proposes the term *fellow traveller* as the most accurate and insightful description of the therapeutic relationship (Yalom, 2001). 200 years ago, Schopenhauer suggested that we all are *comrades to agony* (Schopenhauer, 1942).

8.3 Dynamics on Group Music Therapy

Group therapy's dynamics are based on the dynamics between the relationships of the group's members. Their escape from their isolation and their social exclusion is the basic therapeutic request. The connection between the members can be unified through musical structure (melody, rhythm, texture) and continuity (Κουκουράκης, 2011). Thus, the basic goals of creating trust, self-confidence, self-acceptance, felling of belonging, autonomy, constructive communication and interaction can be achieved through means of music.

8.4 Designing a Specialized Group and Goals

For the creation of a specialized therapeutic group Yalom suggests the following steps for the therapist (Yalom, 2005, p. 637):

First, an evaluation of the clinical context needs to be performed. The therapist has to locate and define the unchangeable clinical limitations. The department directors usually don't invest in a therapy program for which they know so little and have equally little faith in. Without a drastic and clear psychosocial therapeutic approach, the hosting organisms will avoid any attempt on therapeutic procedure.

Then comes the configuration of the goals. The therapist needs to develop goals which are appropriate and achievable inside the clinical limitations. Yalom provides with some examples of achievable goals for a group of hospitalized patients (2005, p. 638):
-To involve the client into the therapeutic procedure
-To show how discussion can help
-To locate the issues
-To reduce isolation
-To give the client the chance to help another person

-To bring relief from the stress if being hospitalized, or hosted on a refugee camp

Lastly, the therapist needs to modify any traditional techniques. Preserve the basic principles and the therapeutic factors of group therapy but modify the methods to achieve specific goals: therapists must adapt in clinical conditions and in the dynamics of the specialized clinical population. Results and vitality. The time frame of one session demands efficiency. Therapists don't have the time to structure the issues, to let things develop into the group and to process them slowly. There is no time to waste. There is only one time to involve the client and therapists cannot spend it senselessly. Support is the key. Emphasis must be given on the positive and not on the negative sides of a defensive position. Everybody can help by learning how if the receive more by relating to others. Yalom stresses that in group therapy we focus on relationships because this what group therapy does best.

When a clear opinion of the clinical data has been gained– the number of clients, the duration of the therapy, the duration and frequency of the group meetings, the kind and severity of the pathology and the availability of a co-therapist, the next step would be a realistic sum of clinical goals to be defined. In specialized groups of limited duration, the goals must be focused, achievable and adjusted on the capabilities and prospects of the group's members. It is important that the group becomes an experience of achievement; clients often enter therapy feeling defeated and with low morale. There is no better antidote to isolation from deep therapeutic bond with the group so the therapist must try the hardest in every meeting to create positive interactions in the here-an-now. Groups of mental trauma is likely to deal with a wider range of concerns (as shown before), perhaps in a series of different therapeutic group interventions. Security, trust and certainty are very important initially. Being between other people who have suffered a similar trauma and receiving psycho-education for the impact of the trauma in the psyche and body can help reduce emotional isolation and confusion. Later, these groups could use structured behavioural interventions to deal with specific symptoms deriving from the trauma. After that, groups can work with the way trauma has changed the basic ideas and the fundamental beliefs about the world. Ideally. Those groups should be homogenous for the initial stages but later a heterogeneous and mixed-sex configuration could be helpful in order to complete the process of re-instalment of the client in the post-traumatic world. (Schermer, 2000). Here are some goals of group therapy according to Yalom (2005):
-to receive and offer support and feedback

-to improve intrapersonal relationships and communication
-to experiment with new intrapersonal behaviours
-to speak directly and honestly about sentiments
-to acquire awareness and understanding of our own thoughts, emotions and behaviours by watching the relationships' patterns that develop both inside and outside the group.
-to learn and comprehend the thoughts, emotions and behaviours of other people.
-to improve confidence, self-image and self-esteem.
-to achieve a personal change inside the group with the expectation that it will transfer this knowledge in life outside the group.
-to gain confidence for therapists and all members of the group.

8.5 The Work of The Therapist in the Here-and-Now

Irvin Yalom declares that above all, the survival of the group as an entity is the backbone of group therapy (2005). The entity can be achieved by working on the here-and-now. In general, therapists who manage to maintain participation and have only but few conflicts have better clinical results (Kivlighan, 2001). A therapist doesn't want to avoid barriers but to cut through them. There is a paradox that Ormont emphasizes that while we strongly encourage clients to be involved in the here-and-now procedure we really expect them to fail satisfy their part of the contract. What we really wish is to, through the nature of the failing we will acknowledge and dissolve the special resistances of each client concerning intimacy, along with the texture of each resistance (for example apathy, distraction, hostility etc.) and the fears about intimacy that are underlying (such as impulsiveness, abandonment, indefensibility etc.) (Ormont, 1988). In order for the focus on the here-and-now to be affective two levels must be inseparably satisfied. The first level is the actual experience and the second is the pointing of the procedure. This means that the client has to consciously experience every phase of the therapy and then be able to comment on it giving reason to every action. The relationship an as environment is again crucial for this to happen, and communication (or even meta-communication) is the tool. The term "meta-communication" refers to the communication in relation to a communication which means, a message about the nature of the relationship between two people who interact (Stanford Encyclopedia of Philosophy, 2016). It is well known that one values the comments, opinions and intuitions that he/she reaches with his/her own efforts rather than those who are imposed by others, says Yalom (2005). The mature therapist resists to the temptation for clever and skilled

interpretations and contrary he/she seeks of ways which will allow the clients to gain self-awareness through their own effort. Foulkes and Anthony wrote that there are times were the therapist must restrain his/her wisdom, must tolerate the limited knowledge and wait patiently for the group to find answers by themselves (1965). So, what a therapist should mainly do is help clients remove all the barriers which suppress or limit the clients' will. However, interpreting the results of a session or a complete therapy could take under consideration three concepts which are interlocked with interpretation:

1. The use of the past. Using sessions to investigate the past isn't the best usage of clinical time. Such thing would show to the client that referring to the past is in the centre of the therapeutic procedure and as we've shown we are trying to focus on the person in the here-and-now and not on the trauma or the "devastating events".
2. The group-as-a-whole process commentary
3. Transference

Finally, the most important aspect of working in here-and-now is self-revelation. Self-revelation in here-and-now has much more effect in the coherence of the group than a revelation in there-and-then (Slavin, 1993). Self-revelation can lead to better understanding oneself which leads to better understanding the others as well. This will lead to relief of pain (understanding it), better relations with others (understanding them) and a more productive and full life (finding a meaning) which is, simply put, the prime aims of therapy.

8.6 Selecting Members for Group Therapy

Irvin Yalom provides clear directives on how to form a group with better chances of success (2005, p. 317). The basic principle is this: the clients will fail in the group therapy if they are not in position to participate in the primary work of the team due to either practical, intellectual, psychological or transpersonal reasons. The client must have the ability and will to examine their interactive attitude, to self-reveal, to offer and to accept feedback. Clients who are unsuitable for the group tend to fabricate a false interactive role which proves to damaging to both themselves and the team. According to Yalom, most therapists agree that when a client is at a crucial crisis in a field of his/her life they are not suitable for group therapy. These clients will be more suitable in an individual or family therapy (Melnick, 1979). Also, clients who are severely depressive and suicidal would be better not to join a

heterogeneous therapeutic group which focus on interaction. Tactical presence is also of a vast importance for cohesiveness so it would be wise not to include people who, for whatever reason are probably going to be absent a lot of times. Many therapists also mention the "wave effect", a phenomenon where a departure is followed by another one and so on. People that have the less dexterities and less innate features needed to work in a team – those who mainly have the need of what a team can offer – are those who are most likely to fail. This paradox has motivated some modifications on the group therapy experience. On the selection procedure, therefore, an unjustifiable focus on extrinsic stress should be taken as a negative clue for intensive group therapy, whether it represents a vast amount of stress or a manifestation of denial.

We also know, through the work of Sherif (1958) and Asch (1958) that a man can feel extremely unpleasant in the role of deviant (the member who is considered deviated by the rest of the team or have misunderstood the rules of the team) from the team and there are elements that suggest that these are the ones who will gradually demonstrate more stress and worry, if they are unable to speak about their position (Leiderman, 1971). Lieberman, Yalom and Miles studies shown that the deviated members didn't have much possibilities of gaining from the group and the chance that they would suffer negative consequences was high (1973). To sum up, there are indications that the deviated member, compared to the rest of the group, derive less satisfaction from the team, experience stress, has less value for the group, is less likely to benefit or affected by the team and, contrary, it is more likely that the team will hurt him and is much more likely to stop participating in the group. The clients who are bound to play the role of the deviant in a therapeutic group are easily identified from the initial selection interview. Their denial, the fact that they distance themselves from emphasizing the inner and transpersonal factors, their disinclination to be affected by the transpersonal interaction and their tendency to ascribe their dysphoria to physical and external environmental factors, will be apparent in a carefully carried out interview.

Many clients have left a therapeutic group due to some conflicts that had to do with closeness or intimacy which they came out with different ways: with schizoid withdrawal, with non-adaptive self-disclosures (endless disclosures or a pervasive way of revealing) and unrealistic demands for immediate intimacy. According to Yalom, most therapists agree that an important criteria for proposing a client to join a group therapy is whether he/she has obvious problems in his interactions, such as: loneliness, cowardice and social withdrawal,

inability to commit close encounters or to love, augmented competitiveness, hostility, preparedness for arguments, paranoia, issues with authority, narcissism, inability to share things, to empathy with others, to accept criticism, constant need for admiration, a feeling that his unable to be loved, fear to claim, submissiveness and dependence. Apart from these, of course, clients must be willing to acclaim part of the responsibility for those issues or, at the least, to acknowledge them and have a serious desire for change. A study by Lieberman, Yalom and Miles showed that in the trials before the grouping, they who were to be more benefited by the group, were those who thought of change as very important and desired it, whoever saw in himself/herself as insufficient, in both understanding their own feelings and his/her sensibility upon the others' feelings, whoever had high expectations from the team, waiting for them to supply him/ her with all appropriate chances for communication and help him/her correct their inadequacies (1973). The finding that a positive sum of expectations is a prediction factor of a fortunate outcome, has a strong research back-up: the more a client is expecting to be benefited by therapy – whether in group therapy or individual therapy - the more beneficial it will be (Frank, 1991).

The members are satisfied by their groups (they are attracted by the group and probably continue be part of them) if (Yalom, 2005): 1) they believe that the group satisfies their personal needs – that is their goals, 2) they drew satisfaction from the relation with the other members, 3) the drew satisfaction from participating in the team's work, 4) they drew satisfaction from participating in the group compared to the world outside. The whole procedure of composing the group and selecting its members is, therefore, relied upon the important assumption that we can, in an accurate degree to predict the interactive attitude of a member or his/her behaviour inside the group, by a careful selection prior to therapy. Two studies on master students of psychology of 12 sessions brought the following results (Semands, 2000): a. The members of the group that were distant and dodgy were more likely to view the other members as hostile; b. The members of the group that felt stressed about relations or were concerned about relations, viewed the other members as friendly; c. The most dominant members resisted connection with the group and devalued and underestimated the team. Other elements of measuring have the disadvantage of demanding from the client to participate in a semi-structured interview of 30-60 minutes. Many of the interview techniques of Harry Stack Sullivan can still be of great value (1954) though. According to Yalom, many writers propose that the therapist should try to achieve the maximum of heterogeneity concerning confrontational fields of the clients and ways of

dealing with situations, and at the same time to try and achieve homogeneity concerning the degree of indefensibility of the clients and their ability to deal with stress. Concerning the sex of the members of the group, some writers, drawing arguments from theory and clinical experience, are in favour of groups of the same sex. However, experience research doesn't support this idea. Men, in purely men teams tend to present less intimacy and more antagonism, while in mixed teams they self-reveal much more and they are less hostile (Rabinowitz, 2001).

In practice, two are the main theoretical approaches concerning group composition: the homogeneous and heterogeneous approach. In the foundation of the heterogeneous approach in the composition of groups there two theoretical rational bases which could be named theory of social microcosm and theory of disharmony. In the foundation of homogeneous approach for the composition of groups though there is the theory of cohesiveness of the group. The first priority must be given in the integrity of the team, so the therapists must select members with the minimum chance of early adjourning. The composition of the short-term therapies is usually homogeneous concerning a mutual issue, a syndrome of symptoms or a life experience. The focus more in transpersonal rather than intra-personals concerns (Klein, 1993).

8.7 Preparing the Group

The coordinators of the groups should achieve the following goals in the preparation stage (Yalom, 2005, p. 401):

1. to clarify the misconceptions and non-realistic fears and expectations.
2. to predict and lessen the appearance of problems while the group is growing.
3. to offer members a cognitive structure that will facilitate an effective participation in the group.
4. to create realistic and positive expectations for the group therapy.

An aim would be see candidate members at least twice before inducting them into a group. Yalom, in his book, finds very helpful to form a prepared interview with the following objective goals (2005, pp. 407-408):

- Turn clients into well-informed allies. Give them a theoretical frame about the interactive base of pathology and how therapy works. Describe to them in which way the therapeutic group can touch the transpersonal problems and how can it be beneficial to them. Inspire faith and trust in the group therapy. Increase their expectations about its effectiveness. Also, give directions on how it is the best way to participate in the team and maximize the utility of group therapy. A text could be given which the member can study prior to getting to the group. This text emphasizes several points, like the fact that the weight is put into the here-and-now, that the member should take his own personal responsibility, should avoid accusations, avoid advices and should forward dependence, learning from and listening to the other members, to acquire awareness of his feelings and thoughts, and to attempt to experiment with intimacy and new behaviours. Other preparation techniques involve watching recorded of videotaped meetings.

- Predict the frustration and disappointments in the group therapy, specially those happening in the first meetings. The first meetings are a period of significant stress for the clients, a stress so innate and unavoidable as extrinsic and unnecessary. Some usual problems that occur in groups are: a) the subjective perception of incompatibility of the group and individual goals of each member, b) the frequent substitution of members, c) group therapy, contrary to individual therapy, often doesn't offer immediate relief and d) the formation of sub-groups and social contacts of members outside the group. The concerns about the size of the group are also very often. The members are afraid that their unique individuality will be lost, while becoming one with the mass. This is why another important decision is whether the group will be open or closed. Open groups allow new members' entry at any point but closed groups do not.

- Give instructions on the duration of the therapy. Make a contract about the consistency of members' presence. Yalom advises to avoid sparsely meetings. Groups that meet less than once per week usually have serious difficulties to retain an interaction focus. If, between two sessions, much has happened to the lives of the members, the group tend to priorities those facts and the solution of a possible crises. Maybe it would be better to set a functional rather than a chronical definition: a short-term group is the shortest duration of a group's life in which a specific goal can be achieved – thus the well pointed term "time-efficient group therapy" (Gurman, 1988).

- Set the basic rules concerning the privacy and the formation of sub-groups. If, for example, the sessions are to be recorded or viewed by students from a one-way mirror there must have been given a license from the members first and plenty of time discussing the matter. If the recording is by a video camera then it is absolutely crucial to have written permission. Bureaucracy has its place in preparation too in the form of written consent (Beahrs, 2001).

In the preparation stage, decisions should be made about several issues, such as: (Yalom, 2005, p. 575)

- Individual therapies with clients before they enter a group therapy present a great variety. Some therapists, after they meet with the candidate members once or twice in the selection interviews don't see them again individually whether other therapists continue individual therapies until the client enters a group. If several weeks are needed in order for the therapist to gather a sufficient number of members it would be better to continue seeing periodically each member in order to avoid loss. Group therapy can complement personal therapy (concurrent therapy) or could be completely relied on itself. In the former case the matter of different therapists in questioned and Yalom doesn't take clear position between them. It is all a matter of balance. So, a client could have personal and group therapy with the same therapist (combined therapy) or with different (conjoint therapy). What is important is the compatibility of the directions of the forms of therapy. In the case of conjoint therapy, it may be best for the therapist to communicate to each other the directions they take.
- Having a co-therapist comes with some advantages and disadvantages.
  Advantages: Co-therapists add and support one another. Together they have at their disposal a greater field of knowledge and observation kai due to their dual view they can have more intuitions and capture more strategic moves. When, for example, one therapist relates intensely with one member, co-therapist can have a larger awareness of the other members' reactions in that trade and so be in a better position to enlarge the range of interaction and research. Most of the co-therapist pairs share roles between them either intentionally or, more often, without realizing it: one therapist adapts a provocative role – something like the horsefly of Socrates – while the other one is more tender and functions as the balancer of the group. When co-therapists are a man and a woman, usually (but not always) they adapt the same roles respectively. Many clinics agree that a pair of co-therapists who one is a man and the

other is a woman can have unique advantages: the recall of the image of the primordial family can take place more intensely. Many fantasies and misconceptions about the relations between the co-therapists emerge which can be analysed with a positive outcome. I believe that the context of co-therapy has special advantages for the beginner therapist.

Disadvantages: The disadvantages of co-therapy derive from the problems co-therapists may have with each other. The group will proceed the way the co-therapy will do (Haley, 1987). It is also important that the co-therapists talk the same professional language. The best thing is to choose a co-therapist with whom you feel close but with whom the personal characteristics are not common with yours. This complementary enriches the group experience. The pair man-woman has advantages but again it is best for you to coordinate a group with a person of the same sex that suits you than a colleague of the opposite sex with whom you do not work very well. Some groups are divided into two splinter groups. For this reason, it is better, during the stage of the members' selection that the interviews are contacted by both therapists, preferable at the same time.

- There are instances where a session is decided to take place without a coordinator. Yalom is against that idea for the following reasons: a. The group would wander from its main work. A party vibe would dominate. The members would avoid to talk about their problems, long silences would take place and the conversations would take more and more distance from the main matter. b. The group would lose control of their emotions. Anger would be uncontrollable and there would be no one to save the members who suffered damage or to help the aggressive members to maintain control. c. The group would be unable to collect their experiences and to take advantage of them creatively. The members see the coordinator like a time file keeper – like the historian of the team who sees all patterns of behaviour in depth of time and points out that what a member did today, last week and last month belong to a consistent pattern.

8.8 Development of the Group

A very well-known theory of group development by Bruce Tackman regards that there are 5 stages: Forming, Storming, Norming, Performing (1965) and Adjourning (Abudi, 2010).

First stage (Forming): this stage involves orientation, hesitated participation, searching for meaning and dependence. The clients direct to the therapist many comments and they seek for reward while they try to secure the approval of the master. The therapist's first comments go through a thorough control, for directional guides about which behaviour is accepted and which is not. The clients look and behave is such way like they expect salvation exclusively, or mainly, by the therapist, if only they could find out what he/she waits for them to do (Harwood, 2003). In young teams, specially among minors, the fantasies of the members are orchestrated and lead into something that Freud called "the need of the team of be governed by an infinite power, its extreme pathos for power, its thirst for obedience" (1955).

Second stage (Storming): This stage involves conflict, dominance and uprising. There is no better way for a trainee to value the tension of the group to elevate and also attack the therapist than taking part to an educational or therapeutic team and experience the power of these feelings first hand. Some theoreticians (Slater, 1966) take "Totem and Taboo" by Sigmund Freud (1953) literally and believe that the pattern of the relationship between the clients and the therapist is a recapitulation of patricide and primitive horde (Yalom, 2005, p. 429).

Third stage (Norming): This stage involves development of cohesiveness. In order to describe this stage, different formalities have been used at times with similar co-statements: in-group consciousness (Bennis, 1964), mutual aim and group supporting (Taylor, 1950), consensual group action, union of the "we" consciousness (Abrahams, 1949), support and freedom of communication (Smith, 1953) and foundation of intimacy and trust between the alike.

Fourth stage (Performing): This is the stage that proves that the group has done a successful work already towards their goals. Among the members there is confidence, motivation, agreement and familiarity with the personality of the group as entity.

Fifth stage (Adjourning): This is stage added later by Tackman which is also known as Mourning. It is the stage where group is coming to an end and each member is ready to take his/her own path. Separation brings sadness, of course, but also happiness exists because there is a common admission and pride for achieving their goals.

We should note that, it is Yalom's opinion (through experience) that the development of the therapeutic groups always depends on a great extent in luck, that is the specific, unique composition of the group. Often, the course of the group in defined by one member only, usually by that member which has the most intense interactive pathology (Yalom, 2005).

8.9 Protocol of a Group Therapy Session

Having prepared a clear structure is a helpful tool for both the therapist and clients. Here, the golden ratio theory can apply, as Yalom claims; either too much or too little provision of structure by the coordinator is destructive for development. Yalom provides the following form as a base example:

1. First minutes. In this period, the therapist provides the group with a clear structure and prepares them for therapy.
2. Definition of the work. The therapist, in this stage, attempts to define the most beneficial direction the group can take in the specific session. You can define the work you want to achieve in different ways. For example, you can just listen, to gain a sense of the emergency matters of that day, or you can provide a structured exercise which can allow you to consider what would the most useful direction be for the group that day. The team meeting program of Lieberman, Yalom and Miles studied closely the effect of structured exercises and came to the conclusion that coordinators who used many structured exercises were popular in their groups. However, the members' course was significantly lower than of those who used less exercises. (Lieberman, 1973). Some examples of structured exercises are the Mindfulness-based Stress Reduction (MBSR) (Kabat-Zinn, 1994) and the Gestalt Therapy (Perls, 1951), most specifically the "Hot Seat technique".
3. Fulfilment of the work. When you have a wide view of the fruitful matters of a session, attempt, on the main body of the meeting, to deal with those matters involving in the session as many members as possible.
4. The last minutes. Last minutes is the time to recapitulate. Indicate that the phase of the work has ended and dedicate the rest of the time in a retrospection and analysis of the meeting. This is the circle of cogitate in here-and-now, when you attempt to demystify, in the clearest possible language, the interaction that took

> place during the session. You can also do a final tidying up, if you wish so: you can ask if there is any open subject or upset emotions with whom clients may leave the session with, or ask the clients, both active and passive, how they experienced the meeting and how they evaluate it.

Nevertheless, there are times where problems occur and create an adversity to the functionality of the group.

8.10 Problems in the Group

Yalom remembers that Freud once compared psychotherapy with chess in the way that more things have been written about the beginning and the ending rather than the middle of the game; and most of the problems in therapy occur right there (Yalom, 2005, p. 464).

As shown before, the backbone of the group is its power as an entity, as a building block. If bricks of that building block move or are being replaced by other bricks or are missing for a long time, the building becomes flimsy. Most of the problems that occur in groups is an outcome of the lack of punctuality or members turnover, as Yalom suggests.

It is of a great importance that the therapists to be absolutely convinced of the value of the therapeutic team and the regular presences in it. The therapist who functions based in this conviction, will inspire it to the members of the group. Therefore, therapists owe to be consistence on their time, to give the team high priority in their schedule and, if they have to lose a meeting, to inform the group about their absence many weeks before. Often, we find out, Yalom warns that an absence of the therapist or a postpone of a meeting is followed by low attendance (2005). If one day many people are missing then it is crucial for the session to happen or else it would be a message to those who came which would reflect the possible shrink and isolation these clients suffer from in their lives and their possible feeling that they are not wanted. In times the therapist who receives all the excuses from the members – problems in keeping the child, vacations, transport difficulties, emergency at work, home guests – is submitted in the weakness of synchronizing the schedules of many busy people. Yalom also warns that delay and irregular presences often mean resistance in therapy and we deal with these as we would in individual therapy (2005). Like any event inside the group, absence or delay are forms of behaviour which reflect the characteristic

patterns with which humans interact with another. The therapist has to be sure that he/she has examined the personal message of the client's act. If the client apologized upon delayed arrival; if the client enters the room with an indifferent and ostentatious manner; If the client comes late because he/she feels that he/she is nothing and contribute to nothing in his/her life or in the group; If the client attends the meetings whenever he/she chooses because he/she believes that, in the end, nothing essential happens without him/her; Or even if the client, after arriving delayed, asks for a recapitulation of the meeting. It is often then to show how the secondary interests are taking priority against the prime therapeutic interests.

Another problem that may occur is dropouts. The extreme members – both extreme passive or extreme active – are more likely to dropout. A common reason for dropouts is when a member feels that he is not being understood by the group and so being alienated. Yalom advices to try to balance self-revelation (2005). The therapist may have to slow down the pace of one the clients who reveal deep personal details far too fast before connection is established. On the other hand, members who persist in silence during sessions might feel discouraged and increase the fear of self-revelation. There are times where a therapist might think it would be beneficial for the group if a member is taken out. There is no clever and skilful way to remove a member from a group. Often, it is best to handle such matter in a personal meeting rather than in a group session. This kind of a situation can create much anxiety to the other members so the therapists can expect very few from a constructive conversation with the group.

Adding new members may also cause some turbulence. Yalom advices that the most beneficial period for adding a member is during a phase of stagnation (2005). Many groups, usually the elder ones, having the need for new stimulations, encourage actively the therapist to add new members. In some situations, if a client is integrated much easier than another one, can bring an unexpected outcome and create much greater discomfort to the new member who may feel that is already far behind the others. Nevertheless, introducing new members in pairs has more benefits; the team saves energy and time by integrating two members at once. The pair of new members may also make an alliance together so they feel less estranged.

A serious issue that may fall into the problem category is the subgrouping creation. Yalom reminds us though that fractionalization is met in every social grouping (2005). The creation

of subgrouping can be a manifestation of an important degree of hostility which isn't released into the group, mainly towards the coordinator. Research on different ways of coordination shows that a group is more likely to develop divisive inter-group and outer-group factions when the coordination is limiting and domineering (Lippit, 1962). Members who are not in a position to express their anger and cancelation directly to the coordinator, are releasing these feelings indirectly by ganging up and mobbing, or by turning one or more other members into an escape goat. The therapist has to become cautious though when deciding to exclude a subgroup because it can create a clash.

While our immediate association of a conflict is negative – destruction, bitterness, war, violence -, if we thing a little bit deeper, some positive associations come in mind: action, stimulation, change and development. This is the way it evolves during therapy groups. Some teams become "too kind" and skilfully avoid confrontation and conflict, usually mirroring the therapist's avoidance of aggression. However, conflict is so unavoidable in the course of the group's development that the lack of it only implies some deficit in the development procedure. This is because often their desire for friendship overcomes their bond of examining their behaviour. (Hodson, 1997). Hostility inside the group can be perceived in the perspective of the development stages of the group. In the initial stage the team cultivates regression -during the storming phase- and the emergence of the irrational, uncivilized part of human. The young team suffers from stress (fear of exposure, shame, anxiety towards strangers, weakness) which will probably be expressed through hostility. Prejudice (which is a way to reduce stress via a false conviction that we know the other man) can appear early in the group and, of course, provoke mutual anger from the rest of the team. In the whole course of the therapy often narcissistic injuries occur (injuries in self-esteem which derive from the feedback or are due to fact that a member is being neglected, not appreciated, excluded or isn't being understood), which are many times expressed with angry counter-vengeance. All sides must continue to deal with each other no matter how angry this gets them. In addition, everybody must be dealt equally seriously. All attitudes demand an active interference by the therapist. When someone shares powerful emotions, this can increase the importance of the relationship. The group's coherence is increased when the members experience together strong emotional experiences, independently of the nature of the emotion. When therapists realize quite late that a promptly or a different interference could have more helpful, they must admit that – like Winnicott said – the difference between

good and bad parents is not the number of mistakes they made but what they did when they realized their mistakes. (Winnicott, 1965)

Finally, in his attempt to summarize the clinical types of the problematic members Yalom finds 8 categories (2005, p. 527): the client who monopolize (talking all the time, interrupting the others and wanting to be the centre of attention), the silent client (only listens, always cautious, never actively participating and never self-revealing anything), the dull client (doesn't provide any excitement to the others and so diminish the energy levels of the group), the client that first complain and then refuses help (attention seeking, the permanent client, never really wanting to be helped but rather his condition defines him), the psychotic or bipolar client, the schizoid client, the borderline client and the narcissistic client (all of which are creating a confusion and destabilization in the group).

8.11 Termination

When the final stage of Adjourning arrives, termination can become a powerful force in the procedure of changing, if it is understood and confronted properly. Yalom stresses in various moments that group therapy is in a great extent a personal process (Yalom, 2005). Each member will start, participate, use and experience group in a solely personal way. This also happens during the termination of therapy. Therapist must never ally with the denial of termination. Contrary, the therapist must help members to search into it as thorough as possible. Clients who complete a personal therapy can one day return but clients who leave a group cannot.

8.12 Therapist's Supervision and Personal Psychotherapy

Any therapist working thoroughly is using him – or herself together with music as an "instrument". This human instrument needs often "fine tuning" so personal psychotherapy and/or supervision is more than necessary in order to achieve the self-knowledge and self-awareness needed to recognize and deal effectively with transference, countertransference and other unconscious dynamics that come up in a therapeutic relationship. Guggenbuhl-Craig describe the "wounded healer" as a therapist who has been profoundly wounded and has undergone a healing process, but on the same time continues to recognize his or her own "wounded" part as the "healer" part: "Such an analyst recognizes time and again how the

patient's difficulties constellate his own problems, and vice versa, and he therefore openly works not only on the patient but on himself" (Guggenbuhl-Craig, 1971). In the complex interaction between the client and therapist, detecting who holds which psychic content and who is in a reactive state to whom or to what, particularly while working within the music; "is the therapist reacting to the client's unconscious as it resonates through the music, or is it the therapist's music activating the client's unconscious" (Austin, 1998). Levine points out that, "the urge to resolve trauma through re-enactment is extremely compelling" (Levine, 1997).

Julie Sutton provides with some main elements on the process of supervision (2002, p. 218):
- having a space to share some of the difficult personal feelings and reactions that arose in moving to a different culture, in a town that was physically devastated.
- discussing practical issues such as setting up the service, administrative support, documentation and work with translators.
- continuing to think about and work with very challenging clients
- maintaining an objective perspective on different issues.
- exploring theoretical frameworks in which to place the work.

More specifically, when working with a translator some issues have to be attended. If the therapy takes place in a foreign ground, local assistants may provide translation. Having a translator present in the therapy sessions is fundamental in order for any verbal channel from the therapist to the client or vice versa be instantly and accurately comprehended. However, cultural aspects for translators have to be under consideration, like religion and cultural behavioural habits. Sutton uses the term "music therapy assistant" (2002, p. 157) to describe the role of the translator and the many ways that his/her presence may affect the course of a session. Some examples are supporting the client physically, being a groups member, supporting a musical structure developed by the therapist and being a voice from one side of the room (when translating the client's or therapist's words).

Yalom also suggests that supervision is above all an educational process. Each program has its own special needs and its own means. There are four main elements that Yalom considers essential in order for a therapist to be educated and trained (2005, p. 725):

1. observation of experienced therapists in action. Watching the master on his craft has always been educational; knowledge through experience.

2. close clinical supervision of beginner groups of clients. An alliance with the supervisor transfers to the trainee the value of therapeutic alliance. Dileo has emphasized that in the supervisory relationship rely "therapy-like" qualities. The supervisor should have awareness of such qualities and make all the necessary arrangements to safeguard and retain the boundaries set between supervision and actual therapy (Dileo, 2001). On the same side, Wosket wrote that supervision could be compared to a procedure in which pressure can be relieved in an open, non-judgmental environment, and in this way support and safeguard the mental health of the supervisee (Wosket, 2000). Usage of Audiovisual Technology for recording the sessions is strongly suggested. Watching/Hearing the taped session with the supervisor and even alone is a powerful tool for self-improvement. The reason is that in the tape the therapist can see/listen to all the little details that didn't caught his/her attention during the session and even evaluate himself/herself for things said, done or even more for things never said and things never done.
3. personal experience in a group. The therapist learns how important it is to be accepted by the team, what self-revelation really means: how hard it is to reveal your hidden world, your fantasies, your feelings of indefensibility, hostility and tenderness.
4. work in personal psychotherapy. If the therapist doesn't have awareness of his/her own motives, there is a chance, per instance, to avoid conflict inside the group because he/she has a tendency to suppress his/her feelings or to encourage without reason the juxtaposition in search of liven up his/her interior world. Perhaps the therapist is too eager to prove his/her value or make a smart reading and by this way weakening the group. Maybe he/she is scared of intimacy and he/she is blocking open expression of emotions making premature readings, or the complete opposite: he/she emphasizes too much on emotion, providing with too little explaining remarks and he/she overstimulates clients so they leave the group very upset. Maybe he/she has too much need of acceptance that he/she cannot challenge the group and, like them, he/she is taken away but the dominant group stream. Maybe he/she feels too exhausted by an attack he/she received and too uncertain about his/her impression on the group that he/she cannot distinguish between the realistic and the countertransference sides of the attack.

Sutton is emphatic when writing that "in terms of clinical work with traumatized clients we consider regular clinical supervision to be not only strongly recommended, but also

essential" (2002, p. 229). A fine balance must be preserved between education and therapy. Alonso suggests that the supervisor must listen as a clinical and talk as a teacher (Wender, 1951).

9. Discussion and Conclusion

The current refugee crisis has brought Europe to a point where solutions have to be found on dealing with the vast number of migrants fleeing to find a safer ground. Among them, children, often unaccompanied, trapped between countries or established in a new country where they need to re-build their lives. But leaving home, even without war being the main cause, and finding themselves on a new country among strangers with probable different language, religion, habits and/or culture can bring up feelings of insecurity, isolation, fear and helplessness, feelings closely connected to infants' feelings when detached by their mother. Children, on the other hand, need to play. Not only because they are children but also because playing, as a creative medium, could be considered as the opposite of destruction. Playing is thus used to build interaction skills, self-confidence and a way to channel all sentiments making it an important tool when dealing with children. Taking into consideration what these children have experienced or even experiencing in a new country, trauma is the first thing that comes to mind and so psychotherapy is also the first solution that is proposed. Nevertheless, verbal psychotherapy has limitations because seldom all children arrive from the same area, so finding a common language is doubtful. Also, depending on the culture of the country of origin, verbal communication in order to express feelings may be a subject of taboo. Music, on the other hand, can be found in all cultures and always as the medium for expression, communication and even healing. Bearing that in mind, music therapy is proposed as an ideal solution for dealing with unaccompanied minors. On the matter of personal versus group therapy, I clearly stand in favour of group therapy. A great problem these minors are dealing with has to do with difficulties in adapting to a new environment. Group therapy in the best medium to help people socialize and through interaction learn how to best communicate with each other thus taking a first step towards facing the whole of society outside. So, it is this current thesis' confident position that group music therapy is the best solution when dealing with unaccompanied minors. Taking into consideration the feelings of insecurity and isolation minors are experiencing, together with their need and joy of playing, elements from both psychodynamic and creative music therapy have been suggested as appropriate. Irvin Yalom's model and method on

building a strong group for therapy has been taken thoroughly into account and his existential theories in therapy, based on experiencing the here-and-now has also been added as a suggested approach.

The first aim of this thesis was to explore the potential use and benefits of group music therapy interventions for unaccompanied refugee minors, via an interdisciplinary approach which, through the books, researches and theories of Renos Papadopoulos, Julie Sutton and Irvin Yalom -among others- and with the suggestion of combining psychodynamic, creative and existential elements on our approach, has been covered. The second aim was to contribute to a scarce body of knowledge on the given topic and promote further research that may facilitate evidence-based changes in real-life practice. Unfortunately, the current bibliography and studies on group music therapy with unaccompanied minors are insufficient. This thesis was based mainly on the research of Renos Papadopoulos and Julie Sutton on refugees and the application of music therapy in dealing with trauma respectfully. Therefore, since there is no book directing the specific issue of applying group music therapy on accompanied refugee minors, I strongly believe that this thesis will help in the direction of closing this gap and help any future researches.

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