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REPORT

Adapting practice during the Covid-19 pandemic: Experiences, learnings, and observations of a music therapist running virtual music therapy for trafficked women

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ABSTRACT

This report describes a 10-week, hybrid face-to-face/virtual pilot project that was run in a safehouse in the south of England for women who had been rescued from human trafficking. Due to the implementation of Covid-19 pandemic restrictions, the final three sessions of the pilot project were run online via video conferencing technology (Skype). Outcomes of the project suggested that, while there were challenges, running online sessions was beneficial and better than not offering any music therapy at all. Continued contact and the provision of a safe, therapeutic space was highly valued. This report explores the benefits and challenges of running music therapy in a virtual environment versus music therapy in a face-to-face environment.

KEYWORDS

virtual music therapy,
trafficked women,
covid-19,
therapeutic presence,
communication,
interaction,
language barriers,
containment,
musical holding

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Lorraine McIntyre graduated from a music therapy MA at the University of Roehampton, London in summer 2019. She has successfully completed a music therapy pilot at a London safehouse for women who have been trafficked and following this, has been developing an arts therapy service at the safehouse together with a dramatherapist. Lorraine additionally delivers music therapy for a national adult mental health charity alongside her other work in the area of adult mental health and is in the process of setting up further projects with a particular focus on trauma and addiction in adolescents and adults. [lorrainejmc1@outlook.com]

REHABILITATION OF SURVIVORS OF HUMAN TRAFFICKING

Rehabilitation for survivors of international human trafficking is a complex process. Having escaped their abusive situation, they face a myriad of new problems that come with being displaced, such as facing loss, adjusting to a new culture and language, and navigating the systems of the country in which they find themselves, as well as dealing with severe trauma. There is also uncertainty about the

future as they wait for the government to decide whether they can remain in the country. Building relationships and establishing themselves in the community is consequently very difficult. Minimal financial resources add to this challenge and restrict their ability to build social networks or to improve prospects through education or training. In the UK, the majority of asylum seekers do not have the right to work (Home Office, 2019). The ability to cope with day-to-day life and recovery may be slowed down due to re-traumatisation as they undergo police investigations, and the estimated rate of re-trafficking and exploitation is still high (Jobe, 2010). The lack of stability, uncertainty of the future and fragile physical and mental health means that there is a real need for therapeutic, trauma-informed intervention and aftercare (Hemmings et al., 2016).

THE PROJECT

The 10-week pilot project began in January 2020, as an open group in a safehouse for women who were recently rescued victims of human trafficking, primarily involving domestic servitude and sex trafficking. The project was designed to determine if music therapy could be an effective intervention, in a service in which there was a frequently changing cohort of clients and in which the women in residence had been severely traumatised.

Due to the transient nature of the setting, the decision was made to run the project as a non-compulsory open group. The main aims were: 1) To create a feeling of belonging and togetherness, 2) To allow residents to find their place within a group and to become confident to express themselves, 3) To build positive, mutually supportive relationships with others and finally, 4) To build inner resilience through shared musical experiences. Due to the Covid-19 pandemic the work was interrupted which meant that the project had to be completed virtually. Providing a positive experience of ending was crucial for the women who attended, since they would have experienced significant disruption to their lives as a result of their situation. Sessions consisted of an opening activity (playing an instrument that was passed round to say hello), a drumming section, an improvisation section, a relaxation, and deep breathing section leading to vocalising, and finally playing an instrument that was passed round to say goodbye. A significant portion of the group time was given to structured improvisation, as transferences of anxiety and vulnerability were felt when improvisations were left completely 'open', showing a need for the group to feel more 'held.' The improvisatory portion of the project was adapted once sessions were moved online.

THE CHALLENGES

When transitioning from face-to-face sessions to sessions conducted virtually, a number of challenges became apparent as follows:

1. Reliability of the audio

The group met in their usual therapy room using one laptop and the therapist ran the sessions via a laptop from a private space in a different location. Unfortunately, the sound was found to be unreliable meaning that the group had to strain to listen if the therapist moved too far from the screen.

2. Difficulty with multiple, simultaneous audio sources

The audio worked well when the therapist talked exclusively, but multiple layers of sound (e.g. group musical improvisations) did not work well as they did not produce the sound quality needed to provide an adequate musical holding due to breaks and delays. This paralleled observations from the pre-virtual portion of this pilot project that indicated that the women found it challenging 'to be with' each other musically and to listen and respond to each other's music.

Austin (2001) suggests that when working with recently traumatised clients, it is vital that the music is stable and consistent in order to provide safety where there is potential for repairing the connection between self and others. The same author writes specifically of vocal holding techniques, a method of vocal improvisation using two chords and the therapist's voice that provides a

> […] reliable, safe structure for the client who is afraid or unused to improvising; it [the vocal holding technique] supports a connection to self and other and promotes a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed and integrated (Austin, 2001, p. 7).

If musical holding is interrupted through poor sound relay, it sabotages the therapeutic process.

3. Needing to adapt to a virtual environment

During the face-to-face portion of the project, the free improvisations were often fragmented and chaotic with some moments of cohesion that increased in frequency as the therapy progressed. The music reflected the dynamics in the house where there was a sense of fragmentation and separation, with residents from varied cultural backgrounds and speaking different languages recovering from their unique story of trauma and navigating their own, personal pathway to recovery. When moving the project online, adapting the content to focus more on turn-taking had the benefit of encouraging the women to listen and respond to each other accordingly.

4. Therapeutic presence

When thinking about how to run the sessions virtually, I decided to ask a staff member to be present for the duration of the session (it was decided that the house manager would attend all remaining sessions as a consistent member of staff. Additionally, a second manager participated in the final session). It was hoped that as well as providing technical assistance if needed, a staff member who was a familiar and consistent presence in the house could assist in containing any difficult emotions that arose from the group as well as assist with any communication lost through the limits of technology. This helped clients feel safe which was of paramount importance as trauma causes a deep wounding that "renders useless the protective filtering processes through which we have come to feel safe in the world" (Sutton, 2002, pp. 23-24).

Some additional questions arose as well. To what extent is it possible to contain emotions when one is removed physically? Is an on-screen presence less nurturing than a physical presence and if so, how does that impact on the experience of the participants? Which aspects of the therapeutic

relationship are limited by therapy that is conducted virtually? Malchiodi (2020, p.100) writes "Establishing safety and providing strategies for self-regulation form the foundations of effective trauma-informed intervention, but the psychotherapeutic relationship remains the central factor in reparation."

5. Non-verbal responses to treatment

Running music therapy in a virtual environment, when compared to a face-to-face environment may, to a degree, hinder the therapeutic relationship. For example, containing emotions felt more difficult due to being restricted in being able to use the full range of communicative tools, as compared to what is possible when physically present (e.g. coming to sit beside the client to show empathy). Picking up on the subtle nuances of subconscious communication, such as body language and facial expression, and matching that to felt emotional content was also more challenging. Overall, I felt that there was less accurate 'material' to work with when viewing and listening through a computer screen. Research involving technologies such as Zoom and Skype, describes an "inability to read nonverbal cues as a result of inconsistent and delayed connectivity" (Archibald et al., 2019, p. 2) as an issue in virtual communication. The transition to virtual music therapy later on in the project necessitated more of a dependence on the staff member and her ability to communicate authentically with the participants. My role as the therapist became more about the simplicity of providing a continuous service and a way of being together. It became more about shaping the direction of the group, providing the structure and means to interact, relate, and communicate, while being less able to 'be with' the group in a way that was as effective as in face-to-face sessions. I felt a strong sense of separation and was acutely aware of the two-dimensional nature of virtual interaction. This was exaggerated by the language barriers where communication was already a challenge and the women relied more heavily on the wider, non-verbal aspects of communication.

ADAPTING GROUP STRUCTURE

Due to the music therapy protocol being largely improvisation-based, moving the sessions to a virtual environment meant having to re-think the structure of the sessions. As such, the content was adjusted accordingly. The changes were as follows:

a) Lengthening the relaxation/deep breathing section as deep breathing promotes relaxation by helping to slow the heart rate, calming the nervous system and therefore the mind and the body (Orth, 2005). This seemed valuable to reduce any anxiety that may be heightened due to the pandemic.
b) More use of visuals to help explain concepts.
c) Preparation of a home programme resource with some music therapy informed activities to improve clients' mental health, reduce anxiety and the impact of the trauma they had experienced.
d) Increasing the time spent on the drumming section with more focus on call-and-response rather than playing at the same time.

e) Creation of a "thank you" and "goodbye" song that was sung to each individual during the final session with time spent to affirm each participant. Participants were also offered an opportunity to respond and express how they felt about the music therapy ending.
f) A "thank you" card was given to each participant who had ever attended the project. The later addition of the "thank you" card (which was thought about in light of the project having to be completed virtually) acted as a transitional object to mark the ending of the therapy in the physical absence of the therapist. This may have further enhanced the participants' positive feelings towards the therapy as they felt thought about and valued beyond the end of the sessions.

EVALUATING THE PROJECT

Evaluations at the end of the project took place in the form of a survey for clients with a blend of open questions and rating scale questions. The same survey was given to the two members of staff who participated. While language barriers prevented in depth commentary from the majority of clients, feedback was all positive and revealed that the music therapy was both enjoyable and of therapeutic benefit to them. Clients did not distinguish between face-to-face and virtual music therapy but commented on the project as a whole. In hindsight, comparative surveys of the two distinct sections of the music therapy could have been useful. Staff feedback affirmed the value of running the final sessions via Skype so that provision could continue and that while running the group virtually was not ideal, it was better than no music therapy at all.

FINAL THOUGHTS

Communication and its multi-faceted nature, a central tenet of any music therapy work, was particularly highlighted during this pilot project, as the clients came from a range of cultural backgrounds and spoke languages with which the therapist was not familiar. Additionally, the severe trauma experienced by the women affected the way they interacted with their environment. Therefore, the provision of a safe and holding therapeutic environment was critical to the work. The experience of running the remaining three sessions virtually exaggerated these challenges and meant that it was necessary to adapt rapidly and creatively to meet the need in a way that was of most value to the participants, while avoiding a sudden termination of the therapeutic relationship. It also meant that the role of the therapist was altered, with more emphasis on facilitation. The philosophical and practical concept of the importance of a therapeutic presence was emphasised, particularly in a group context.

Further research on the effectiveness of prolonged virtual communication, versus face-to-face therapeutic interventions, is necessary to ensure that best practices are identified that are specific to the type of intervention that is being used (virtual or face-to-face) in order to refine future music therapy protocols. As this pilot project shows, there remains new areas of clinical need which can benefit from the practice of music therapy and push the music therapy profession to greater heights of innovation and adaptability, while increasing our understanding of the therapeutic process.

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Ελληνική περίληψη | Greek abstract

Προσαρμόζοντας τη θεραπευτική πρακτική εν μέσω της πανδημίας Covid-19: Εμπειρίες, μαθήματα και παρατηρήσεις μίας μουσικοθεραπεύτριας από την προσφορά διαδικτυακής μουσικοθεραπείας με γυναίκες θύματα εμπορίας ανθρώπων

Lorraine McIntyre

ΠΕΡΙΛΗΨΗ

Η παρούσα αναφορά περιγράφει ένα υβριδικό πρόγραμμα 10 εβδομάδων όπου πραγματοποιήθηκαν δια ζώσης και διαδικτυακές συνεδρίες σε ένα καταφύγιο στη νότια Αγγλία για γυναίκες που είχαν διασωθεί από κύκλωμα εμπορίας ανθρώπων. Λόγω των περιορισμών που εφαρμόστηκαν για την πανδημία Covid-19, οι τρεις τελευταίες συνεδρίες του πιλοτικού προγράμματος πραγματοποιήθηκαν μέσω διαδικτυακής τηλεδιάσκεψης (Skype). Από τα αποτελέσματα του προγράμματος προκύπτει ότι, παρ' όλες τις προκλήσεις, η διενέργεια διαδικτυακών συνεδριών ήταν ωφέλιμη και προτιμότερη από τη γενική παύση της μουσικοθεραπείας. Η συνεχιζόμενη επαφή και η παροχή ενός ασφαλούς θεραπευτικού χώρου εκτιμήθηκε ιδιαίτερα. Αυτή η αναφορά διερευνά τα οφέλη και τις προκλήσεις διεξαγωγής μουσικοθεραπευτικών συνεδριών μέσω ενός διαδικτυακού περιβάλλοντος σε αντιπαράθεση με τις δια ζώσης συνεδρίες.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

διαδικτυακή μουσικοθεραπεία, γυναίκες θύματα εμπορίας ανθρώπων, covid-19, θεραπευτική παρουσία, επικοινωνία, αλληλεπίδραση, γλωσσικά εμπόδια, περίεξη [containment], μουσικό κράτημα