Full-Length Article

Music Related Sensibilities in Trauma Treatment: *An interview with Janina Fisher*

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Abstract

Janina Fisher PhD has collaborated with many of the pillars in the field of trauma theory and treatment – including Judith Herman, Bessel van der Kolk, and Pat Ogden – and she is a pioneering force and innovator in her own right. A prominent clinician and consultant, Dr. Fisher is a licensed clinical psychologist and instructor at the Trauma Center, an outpatient clinic and research center founded by Bessel van der Kolk. The opportunity to interview Dr. Fisher stemmed from her participation in the conference *Trauma Theory & Treatment: Somatosensorial Implications of Resilience,* hosted by the Louis Armstrong Center for Music & Medicine at Mount Sinai Beth Israel Medical Center in New York City. The conference lectures included mental healthcare professionals ranging from a broad spectrum of disciplines, with a strong showing of music therapists with specialties in trauma treatment with diverse populations. As conference co-chair I took the opportunity to interview Dr. Fisher, who graciously agreed to sit down with me and answer some questions. As a music psychotherapist whose work centers on pre-emptive strategies in fragile hospital populations such as newly diagnosed cancer patients receiving radiation therapy, her in-depth and thoughtful responses to my probing questions offered unique insight. At various junctures, I provide some commentary to contextualize some of the salient themes. Her comments expand upon the growth and 'interdisciplinarization' of the evolving field of trauma. We are indeed fortunate to have her share her knowledge and expertise on its inner workings and perspectives within these pages. The following is a candid exchange in which Dr. Fisher provides insight not only on her ideas on the neurobiological nature of trauma, but also how musical concepts, and her own musical training in her youth informs her clinical approach in working with victims of emotional trauma. I am grateful to Marija Pranjic for transcribing the interview.

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Andrew Rossetti [AR]: Dr. Janina Fisher, as you are a clinical psychologist, expert in a treatment of trauma and author of the book "Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation," how you might describe trauma and how has the concept of emotional trauma changed in a recent years?

Janina Fisher [JF]: It has changed a lot since the early 90's when I first entered the field. The definition of trauma that I use is that trauma can be a single event, it can be a series of events, or it can be a set of the enduring conditions. Such as we would find in combat, in child abuse, domestic violence, where, day in - day out, there is a sense of impending danger. And the latter is often overlooked, we tend to define trauma as an event...

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Andrew Rossetti, E-mail: andrew.rossetti@mountsinai.org | COI statement: The authors declared that no financial support was given for the writing of this article. The authors have no conflict of interest to declare.

AR: Yes, as just one word. So, that's something that in the DSM has also changed?

JF: Well, the DSM doesn't have the enduring conditions clause. That comes from an expert on trauma, Karen Saakvitne, and I think it is crucial to a definition of trauma. I suppose you know the benefits and the limitations of DSM. Certainly DSM really was in a way, very innocent when, I think, DSM-III defined trauma as an event outside the realm of normal human experience. It's been progressively tightening up the definition. But the concept of enduring dangerous circumstances- this is important.

AR: How common do you think emotional trauma is in, and since you are a globe-trotter, let's say in Western society?

JF: Are we thinking just emotional trauma or are we also talking of the impact of the physical abuse, assault, or rape?

AR: Yes, including.

JF: So, the estimate is that 70% of us will experience trauma in our lifetimes.

And, of that 70% about half will develop long-term posttraumatic symptoms. But trauma is unfortunately all too normative.

AR: …incredibly wide spread.

JF: Yes. And in Great Britain we were just talking today about the history of terrorist attacks in the UK. The history of

bombings in the World War II. The English have been subjected to traumatic events and enduring conditions for a very long time. But, wherever I go around the world trauma is becoming a phenomenon.

AR: It is present, certainly.

AR: Well, one of the things that I am interested in, what much of my work is related to is what we are calling medically induced trauma. There is room for more clinical studies on this, though in some ways it raises delicate questions, such as how the idea of someone just receiving a diagnosis itself could be considered - traumatizing.

JF: And we have patients in this clinic where I am the clinical director in the UK,—we have a number of patients who as psychiatric inpatients witnessed suicides, one of our patient's witnessed a women setting herself on fire or they have been assaulted by staff and fellow patients. The stories of medical trauma of all kinds have been horrifying. I just did a consult too at a Hospital in Massachusetts to a patient who is restrained on average once a day. And, of course, each one of those incidents is traumatic.

JF: And I am so glad that you are taking up this area- so important.

Interviewer's note:

During this phone conversation Dr. Fisher and I spoke at length about the dearth of, and the difficulties in implementing system-wide mechanisms to address medically induced trauma in potentially highly fragile hospital patient populations. Here she was referring to a program initiated by the Louis Armstrong Center for Music & Medicine at Mount Sinai Medical Center in NYC which is one of the few extant dedicated music therapy programs in radiation oncology. As part of standard treatment in this multi-site program, cancer patients undergoing their first day of treatment on the unit receive specific music psychotherapy interventions as pre-emptive treatment for trauma that can result from the fear, physical restraint and procedural isolation experienced by so many, especially in patients with head & neck cancer.

AR: What is your approach to trauma and how did it develop?

JF: You know, I heard Judith Herman speak in 1989 and I always say that hearing her changed my whole professional trajectory, because what she said is still vivid in my mind. She said: "People do not develop symptoms as a result of their childhood fantasies, they develop symptoms because real things happened to them". And I remember, I was a pre-doctoral intern and I remember - Oh my god, she is right! And I just set my course from that day forward. And then I also had a privilege of doing a postdoctoral fellowship with Judith Herman in the early 90's. Then I was invited by Bessel van der Kolk, to be a supervisor at his Trauma Center, just as the neuroscience revolution began. So that profoundly impacted the way I practice and the direction that my thinking has taken. And that's, of course, how I met Stephen Porges.

Interviewer's Note:

Here Dr. Fisher provides telling insight on what goes into the development of a fully formed effective model for dealing with the complexities of trauma. Judith Herman's theories and seminal work "Trauma and Healing" are a quintessential stepping off point for a profound understanding of the experience of trauma. Bessel van der Kolk's "hard neuroscience" approach has inspired a shift in mainstream approaches to include phase oriented models and EMDR itself. Any approach to understanding traumas' neurophysiological basis would be lessened without a strong understanding of Stephen Porges' Polyvagal Theory.

AR: As a leading figure in the field of trauma theory and treatment, how is your approach to trauma unique?

JF: I hesitate to call it unique but perhaps it is. I call my approach a neurobiological approach to trauma. And I think I speak for a wing of the trauma treatment field, in which we don't - not all of us - work directly with the body. But we all think, when we are working with a patient, we are thinking about how the nervous system and the body, how the brain is participating and driving the symptoms. So we assume that trauma related symptoms are an expression of how the brain and body have adopted to abnormal circumstances and how they perpetuate the trauma responses, because the brain and body are biased to prioritize survival over pleasure. We assume that the brain and body have adapted to remain prepared for the next trauma. It's a bit like when Stephen Porges talks about biased neuroception, our physiology becomes biased to anticipate danger.

I just came from running a group at our clinic in which one of the topics was the patient saying: 'I do better for a few days or a few weeks, and them somehow it all gets sabotaged and I am back to ground zero'. We were talking about, just how often, their bodies and their brains associate feeling good or at peace, or experiencing pleasure and confidence, as dangerous states. And you know, my book, which is mainly about what we used to call splitting, which is also known as dissociation. How the fragmentation - that is, the splitting as a response to trauma- also continues to manifest and cause our patients to feel that they can heal safely in one moment, and conversely, in the next moment, feel ready to fight, ready to flee, and on and on.. The responses that once preserved their lives have now become their symptoms!

AR: You mentioned the word safety and I think that's probably a key word for most of us as clinicians. Would you say that maybe one of the most important goals of treating trauma is helping a client or patient to be able to feel safe again?

JF: Absolutely. Now, the problem is, it's a bit like selling refrigerators to eskimos, because we are trying to sell safety to people who never experienced it. And so, sometimes even the word itself can feel like a threat. Because many, many of our trauma patients were abused by people who said – "you are safe with me." So my goal is to create a sense of safety in the

therapeutic relationship, but I know, again in a given moment, that the danger signals are going to be present no matter how much safety I try to create.

So one of the things that is central to my work- is helping the clients to recognize when they are having those defensive responses. So that they start to notice: "Oh, when she said this, I started to feel skeptical, I started to pull back, I started to question should I believe this woman."

Because if they can notice the trauma responses, then they can start to notice when they are not having them. Rather than trying to have them feel something they've never felt…

AR: You are about to take part in what is partially a music therapy conference.

I am just curious, is this your first one?

JF: Music therapy conference?

AR: Yes, it's not exclusively a music therapy conference, the one that is going to be in New York. About half of the speakers will be music therapists.

JF: I am actually very excited about this because of one of the things I am interested in is how the therapist uses the social engagement system to create that sense of safety. And I believe that how we use the larynx is a very big part of the social engagement system and important in establishing that sense of safety. Once upon a time in my early twenties, I was a voice student at the New England Conservatory of Music. So, I can't say I come from a musical background, but I come from a time in my life when music was my...

AR: Was very important to you?

JF: Yes, and I feel this work on how I use the larynx to help create safety is just kind of the outgrowth of my youth so to speak. It feels perfectly wonderful to be able to speak at this conference. It's lovely.

Interview's note

Dr. Fisher is referring to Polyvagal Theory's pointing to the myelinated vagus' innervations in the larynx, and how vocalizations, including spoken prosody and singing, can enhance social engagement system behaviors and promote feelings of safety.

AR: That's really great to hear. We are really excited to be hosting you. What purpose do you think music might serve in treating trauma?

JF: Oh, many, many, many purposes. One of the things I think music, as you know music can help us tap into very deep emotions, even if they are painful emotions.

But somehow, there is something about music activating those emotions that soothes them while getting in touch with them. Many trauma patients find music especially soothing to their nervous systems. I have a client who sings herself to sleep every night. She is a woman in her 50's, she is a scientist, super high functioning person. And someone suggested that she sing to herself, because when she hears music she feels better. So she started to sing the song to fall asleep. The effect of the voice on our emotions and on our nervous systems is just, is really... I don't know, can anyone speak scientifically as to why music has that effect?

AR: Music is such a pervasive and complex phenomenon, and much research is taking place to discover the relationship between music and the human experience. There are many experts from different fields looking at how music affects the mind and body on a mechanistic level. For instance, there are numerous projects, where neuroscientists are using fMRIs to track metabolic activity in the brain while their subjects (some musicians and some not) are playing music, listening to music, thinking about music, improvising, and they have seen that they engage a full range of areas of the brain – it's quite literally a whole body experience, and the complexity of it is stunning. What can be said in the case of your patient is that likely that process involves the direct action of the music- its elements and syntax, its metaphoric content and associations – on that person's psyche and soma, and that, according to Polyvagal Theory, indicates that there is a direct influence on her autonomic nervous system via the vagus. That is to say, there is a likely process in which parasympathetic activity increases leading to physiological changes and a "felt somatic experience" that increases feelings of safety. Still, with all the research going on we are still in our infancy of fully understanding how and why music produces the effects it does in humans.

JF: My first job in the mental health field, 40 years ago, was working with autistic children. And we used to use-the group I worked with was children without language- and we used "singing speak." Because when we sang our directions, they were able to process much more easily. So there is a way also that bypasses all those verbal processing centers, which are such a problem for people on the spectrum….

AR: My understanding of the thinking behind that is that there are structures in the brain shared with other areas that process music and that might be why, for instance with people with aphasia are often able to sing much more functionally than they can speak. That has taken clinical form in what's called Neurologic Music Therapy, which is often an effective strategy to take advantage of neuroplasticity helping them "rewire neural pathways."

JF: Wonderful.

AR: I think it is safe to say that thoughts on trauma theory have changed radically in recent years.

In the past trauma was pretty much exclusively thought to manifest itself in a mind as a psychiatric condition, but current theory points to it being more somatosensory based, something that might be thought of as being "coded" in the body-something you've already mentioned. And that it activates certain defense responses that we share with other mammals. How do you think we came to discover this paradigm shift?

JF: Well, I have to say that Bessel van der Kolk deserves the lion's share of the credit. He had this insight that "**the body keeps the score**," -that what was different about trauma was

how it encoded in the body and activated the animal defense responses that we share with all mammals.* People thought he was nuts. I remember people coming up to me and saying, "Stay away from that guy. He's a nut case." But over the years, research has proven him to be accurate.

And the partnership between the neuroscientists and traumatologists has been a really remarkable and wonderful thing.

Interviewer's (AR) note:

Trauma theory pioneer Bessel van der Kolk's "The Body Keeps the Score" is a comprehensive resource on trauma. In it he presents a paradigm shift in approaching trauma, in not limiting treatment to talk therapy only, but involving sensate and mind/body strategies.

His research on traumatic stress, reveals how it literally rearranges the brain's "wiring"--specifically in areas dedicated to pleasure, engagement, control, and trust. According to van der Kolk, trauma treatment's critical issue is aimed at calming bodies down, focusing more on bodily state and helping people learn to be safely in their bodies, than having them articulate their inner experience of the point of trauma [1].

He identifies trauma as a "disorder of the limbic system, in which treat is experienced as a sensation and that threat turns into trauma when we can neither functionally fight nor flee, when we are trapped, and the stress is turned against the self, changing irrational, organic responses from the body, except by the sufferer becoming deeply involved in the self – being aware of their internal world[2]"

AR: So, in examining this idea of defense responses that are kicked up or become a permanent state for people that have experienced trauma - can you speak about your ideas on those defense responses and how they manifest in trauma?

JF: And also why they continue to be sensitive to activation for years or decades later. So, what I believe and what I believe is corroborated by neuroscience is that the human brain and body, like all mammals, is extremely sensitive to stimuli it has encountered before, and again it's like Porges's discussion on bias in neuroception.

Interviewer's note

The term 'neuroception' refers to how neural circuits determine whether situations or people are safe, dangerous, or life threatening, which influences corresponding states of social engagement, mobilization or immovilization[3].

We become biased to those cues which have been indicators of danger in the past. So that then those cues contribute to reactivating the stress response, the flight & flight, and freeze responses.

And also another response that I am very interested in is the 'cry for help' response. Because that's much less written about. We see clients who've been crying for help for years, but have terrible difficulty using the help that was offered. And they go to the next therapist crying for help- and that nobody else has been able to help them.

AR: Contrary to what we have been discussing, there was a time when therapists focused on desensitization, and catharsis was often a part of that. Could you share your perspectives on why that approach seemed less effective then current approaches?

JF: Well, this is actually one of my favorite topics. So thank you for asking. We, I think the trauma field or the mental health field, recognized trauma at a time when the primary modality in the field was the talking cure. So the assumption was, that they needed to talk about it, they need to talk about the event. And that process will catalyze the effects of those events, and people will resolve the trauma. Judith Herman and Bessel van der Kolk both recognized by 1991, that that approach wasn't working, wasn't working in a VA, wasn't working in the crisis centers, it wasn't working in long-term psychotherapy. And that's when they and other leaders in the field began to look for, well... if talking about the events doesn't work, what does work?

And I think it's such an important topic, because so many psychotherapists still make the assumption that clients need to talk about it, as opposed to needing to be able to talk about the effects of it, whatever they were. I always say, "how is that traumatic experience still with you, how does it still affect your life, rather than what was it." And you can see a very logical step from there to (working with) the body, because what do the clients say?

They say "I can't sleep, I feel this terrible shame that makes me unable to leave the house, I feel too afraid to leave the house. I leave the house and I get into the fights with people or I hurt my body or plan a suicide." So, as soon as we get away from treating the event, we are right there in impulsive responses, which have their origin in the body. And shame responses are acutely physiological, and obviously fight or flight responses are equally physiological.

So it's one of my, what I call my "soapbox" issues, that trauma is not an event, it is an effect of the event(s).

AR: Indeed, my understanding is that another topic that resonates with you is this idea of psycho-education in the context of treating trauma.

JF: Yes. That was an idea that came from Judith Herman. Because she was not only a psychiatrist, but a radical theorist, and she believed that especially victims needed to be educated, they needed the power of information. And that it exacerbated the natural power and differential between the therapist and the client. So she began teaching her trainees to educate the patient, explaining to them "This is why you and I are able to speak. This is why those angry responses are expressed even while you are saying 'I'm not gonna get mad' and they are already happening." So we helped people to normalize their responses as trauma responses, helped them to de-pathologize and we de-shamed victims.

AR: To continue....
JF: So I was saying that psycho-education helps the client to understand his or her responses – to recognize them not as crazy but as normal trauma responses…. and therefore to actually have more motivation to work with them.
AR: You were saying to de-pathologize...
JF: Yes, de-pathologize... In fact, this patient group I was just doing is what we call lecture group. And it's one of the favorite groups of our clients, and one of the staff comes in and does a psychoeducational lecture on some topic of some kind on our clients choice - and they love it. They love the education. And it's really interesting.
AR: That is indeed interesting, there are certainly implications there. Let's go back to the idea about you being trained in voice in the New England Conservatory. Do you think your training and fluency in music affect your methodology or some of the theoretical aspects of your work?
JF: Absolutely. In fact, I was just having a thought before you asked the question. I was having the thought, I think the psychoeducation also benefits from being communicated by the human voice. Because I can see before me a client who is agitated or preoccupied, or someone who is spaced out and in another world. And when I start to say "Oh, this is why you might be feeling this way". I can feel that they start to focus, they follow the sounds of my voice, they begin to focus. They can concentrate a little better.
AR: So you are saying that you are aware of your vocal prosody?
JF: Yes, absolutely. And I teach therapists to try to deliberately work with tone and pitch, and softness versus loudness, with rhythm. Is it softer and slower? Is it, what I call, rock and roll? Is it more of a playful tone, is it tone with more energy or tone that is kind of misty in its softness?
And if you watch closely you can see the patient's physical as well as emotional responses, you can see - Oh, this rock and roll tone is getting the patient's focus or that this soft tone seems to be soothing the anxiety.
AR: So, actual observable responses to variations in prosody?
JF: Absolutely.
AR: As a music therapist, that makes perfect sense to me.
JF: .....which is so nice! Because when I speak with a group of traditional psychotherapists and I talk about pitch and tone and prosody, I think they look at me slightly skeptically. But, of course, music therapists would get it in a moment.

Interviewer's (AR) note:
Many music therapists take stock in the idea that varying the manipulation or modulation of discreet music elements such as tempo, tessitura, volume as well as melodic contour and harmonic/rhythmic complexity can vary response[4]. Polyvagal Theory subscribes to the use of certain frequency ranges in pre-recorded music to recruit vagal response and promote social engagement, and specifically that exposure to acoustic stimulation within the frequency band of human voice is capable of stimulating and exercising the neural regulation of the middle ear muscles and other components of the Social Engagement System [5].

AR: How important do you consider the relationship between client and therapist to be as opposed to a specific technique or model that the therapist might use?
JF: I think the relationship is critically important, but not in a traditional transference sense, in the analysis of the transference. Because I think, what I see is the most important thing is being in a relationship, not just talking about it. Especially for trauma patients. Talking about the relationship actually tends to feel frightening, threatening. And so, this is what I love, the concept of the social engagement system and the therapist using the social engagement system rather than words to create a greater sense of safety.
AR: I can't say I disagree with you.
JF: Yes, I kind of had a feeling we are on the same page.
AR: What advice would you give to a less experienced mental health care professional concerning treating trauma survivors?
JF: Thank you for asking that question. What it would be is to go with the resistance. That would be a little more like playing in tune with somebody else. And you know, therapists have a moment of disjuncture with a client, and they go into analysis of why is the client resisting. Why is the client kind of committed to the shame...? And instead they should start to think just at the moment, that they need to be singing a duet. So teaching a young therapist that psychotherapy is a duet. You know, if the patient goes off pitch, the therapist has to go with him. And, I will say "you've gotten off pitch, you need to just to bring the harmonies into synchrony." Actually, believe it or not, I talk about the therapist as an instrument. So I say, "you know, in psychotherapy we are the instrument, and we need to learn how to play that instrument so that it works to soothe the client into the music and to feel the sense of safety in the way we are playing."
AR: Those are analogies that will resonate with many music therapists.
AR: There is a quote that is a part of your email signature that says**:** "Hope is an orientation in the spirit and orientation of the heart. It's not a conviction that something will turn out well, but the certainty that something makes sense regardless of how it turns out". - what is it about that phrase that speaks to you?
JF: Exactly, and that is really, if we think about what people mean when they say "I feel hopeless," what they are saying is "I've lost my certainty that it would turn out well." And rather than trying to convince them to be certain, I really like this idea of helping people to believe that however things turn out, they can create something good from them. It is about the orientation of the heart, and the spirit. And I find it true in me, because, occasionally I will start to feel hopeless about the client. And as soon as I feel that hopelessness in myself, I have

to do a little reorienting about the heart and the spirit. Because it isn't good for the therapist to be in that hopeless place either. We need to play our instruments.
AR: Is there something you would like to add, Janina?
JF: I cannot think of anything. Thank you, your questions have been wonderful.
AR: That's kind of you to say. Thank you for being so generous with your time and sharing your thoughts. They are golden.
JF: Thank you, I am looking forward to this.

*(AR footnote) Peter Levine was among the first to study animal's fight or flight response:"In response to threat and injury, animals, including humans, execute biologically based, non-conscious action patterns that prepare them to meet the threat and defend themselves. The very structure of trauma, including activation, dissociation and freezing are based on the evolution of survival behaviors. When threatened or injured, all animals draw from a "library" of possible responses. We orient, dodge, duck, stiffen, brace, retract, fight, flee, freeze, collapse, etc. All of these coordinated responses are somatically based- they are things that the body does to protect and defend itself. It is when these orienting and defending responses are overwhelmed that we see trauma.
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