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An Introduction to MER, a New Music Psychotherapy Approach for PTSD: Part 1—The Theoretical and Clinical Foundations

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Abstract

This article describes a new music psychotherapy approach for the clients with posttraumatic stress disorder (PTSD) and negative life events. Over 5 years ago, I developed music entrainment and reprocessing (MER). Part 1 of this article is about the history and the procedure of MER, and part 2 is about the outcome of MER and a vignette is also included to show MER procedure.

Keywords

MER, music psychotherapy, music therapy, procedural music therapy, PTSD, music and imagery, trauma

The History of Development of MER

Posttraumatic stress disorder (PTSD), as a diagnostic concept, is applicable to a large variety of population with trauma, such as rape survivors, abused/neglected children, refugees, and survivors of accidents, disasters, war, domestic violence, and so on.[1] PTSD symptoms fall into 3 main groupings:

1. experiencing the trauma via intrusive thoughts, images, dreams, and intense distress because of real or symbolic reminders of the trauma;
2. persistent avoidance of stimuli associated with trauma and emotional numbing; and
3. symptoms of increased arousal such as sleep disturbance, irritability, anger, and hypervigilance.[2]

A method for treatment of PTSD called *eye movement desensitization and reprocessing* (EMDR) was developed by Dr Francine Shapiro, in 1987. This PTSD treatment model has helped people in a range of clinical areas.[3] The EMDR method begins with guided eye movements, and other sources of bilateral brain stimulation such as hand taps and alternating lights of hand buzzers have also been used. The basic premise of this intervention is based on the recognition that traumatic information that is held in a separate neuro-network is able to bridge itself to more positive information stored in the individual's memory.[4] This method, which was developed more than 3 decades ago, is currently being used throughout the world[5] despite some questions about its efficacy within the field of psychotherapy.[6]

As a music therapist, I received 3 years of EMDR training through the organization of the European Human Help Planning, in Beijing, and eventually I became a certificated EMDR therapist in 2005. In my early practice experience, I found that EMDR was a useful method to treat clients with PTSD. I also believed that its therapeutic value could be extended by combining it with ideas of music entrainment and music imagery. The method, which I have since developed, is called "music entrainment and reprocessing" (MER). The purpose of this article is to describe MER practice. A description of my work, including case study illustrations, will be presented in a follow-up article (part 2).

MER is aimed at changing clients' state of pain and anxiety toward more positive states as the therapist guides the client through various relaxation, imagery, and cognitive-based techniques that are supported with therapist-selected music. The music entrainment process is structured through the use of music pieces arranged from negative emotions (such as fear, anger, or grief) to neutral moods (such as peace, sedateness, or softness) to eventually positive emotions (such as pleasure, joy, or happiness). MER uses music and verbal intervention skills to promote imagery by using the guided imagery and music (GIM) principle of being a "music-centered exploration of consciousness which uses specifically a sequence of

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classical music programs to stimulate and sustain a dynamic unfolding of inner experiences.[7]

During my MER practice in China, I observed that many clients found creative solutions to their problems and possible relief from disturbing experiences through creative and spontaneous imageries influenced by music. This self-healing process can occur in just 1 or 2 sessions and helps to resolve a particular, patient-identified disturbing experience.

Description of MER

The MER process includes 5 steps: (1) information collection; (2) stabilization; (3) assessment; (4) desensitization and reprocessing; and (5) peak experience.

Step 1: Information Collection

Gathering information includes identifying traumatic event/events, symptoms, mental functioning and emotional stability, medical history and development history, and social support system. It is important to assess the emotional stability of the client. Is the client's ego strength strong enough to confront his or her traumatic experience? If not, the treatment needs to move to the next step, that is, stabilization. However, if the client is stable and strong enough and wants to confront the traumatic experience/experiences, the process of treatment can move directly to step 3. Usually, however, the stabilization step is necessary.

Specific ways to assess the client's emotional stability include (a) observing the client's emotional expression and behaviors, (b) assessing how the client functions in his or her daily life and at work, and (c) using the Safe Place technique to see whether the client has an inner safe and comfortable place good enough to comfort himself or herself and the ability to adjust and balance himself or herself emotionally.

In the Safe Place technique, the therapist uses the progressive muscle relaxation technique to help a client become relaxed and then asks the client to imagine a place that is the most comfortable, safe, and appealing in his or her imagination, while beautiful and peaceful music is played (I usually use a piece of peaceful classical-styled music combined with natural sounds such as a bird twitter and the sound of a steam, which I have recorded on my own for session use). The therapist continues to communicate with the client to facilitate a safe and comforting imagery experience promoted by a verbal intervention. The therapist offers suggestions and guides the images in order to assist the client in approaching a positive mood state and to avoid negative experience/experiences as much as possible. If any negative image consistently emerges, the therapist stops the imagery and brings the client back to a waked reality state because this might indicate that the client is not stable or ready to confront his or her traumatic experience yet. The client is then offered step 2, that is, the stabilization treatment, which is meant to build up his or her ego strength.

Step 2: Stabilization

When the therapist considers that the client's ego is not strong enough or his or her emotion is not sufficiently stable enough to confront the memory of a past traumatic event, stabilization is an important process to be completed.

The Safe Place technique can also be a good tool to reinforce ego strength and emotional stability. When a client is able to imagine a beautiful and safe place with the music being played, it usually indicates that she or he has a stronger ego and is emotionally stable. Aigen[8] describes the importance of aesthetic expression as a focus for the client's emotional resistance. In MER, the degree of beautiful imagination is used not only to assess the client's ego strength and emotional stability (before the desensitization and reprocessing step) but also to indicate the degree of healing and recovery in the whole treatment process. For this reason, the therapist may repeat the technique of Safe Place several times until a safe and comfortable image forms in the client's imagination.

Another powerful tool to enhance ego strength and emotional stability is the positive resource reinforcement. This is a technique whereby the therapist asks the client about a positive memory with strong emotion/emotions, such as pride, joyfulness, and happiness. This memory is then used as a starting point for an imagery experience. The therapist asks the client to become relaxed for a short period (usually about 5 minutes) and then plays a stimulating classical music while the client images his or her good memory. The intervention skills that the researcher uses here are similar to that of Safe Place. The goal of the intervention is to develop positive experiences rather than exploring the negative ones. However, as soon as any negative image emerges, the therapist asks the client to stop the imagery immediately, to open his or her eyes, and to take a deep breath. After a very short break, the therapist repeats the process. This process keeps going until the negative image does not emerge for a long enough time (should be 15 minutes or more). At this point, the therapist knows that the client's ego is strong enough and his or her emotional grounding is stable enough to move to the next step.

In a group situation, especially following a major disaster such as an earthquake, the 9/11 attacks, a hurricane, and so on, various re-creative music activities are ideal techniques to be utilized. In the 2008 earthquake in China, I led 3 music therapy student teams in the earthquake regions to assist the survivors. We provided them with various music performances, music games, sing-alongs, music with dance or movement activities, and so on. The survivors enjoyed making music, and their emotions eventually shifted from depression, sadness, and mourning to happiness and positive mood states. A TV reporter excitedly told the researcher, "This is the first time I see people laugh!"[9]

Step 3: Assessment

This step includes 5 steps whereby the client (a) identifies a picture that could represent a traumatic event, (b) identifies the negative cognition (NC), (c) identifies the positive cognition

(PC), (d) identifies the Validity of Cognition (VOC) in the scale of 1 to 7, and (e) identifies and rates Subjective Units of Disturbance (SUD) in the scale of 0 to 10. Further explanations of these steps follow:

The client identifies a specific picture or scene that best represents the memory from a traumatic event, which is called the worst picture (WP).

Then he or she chooses a statement that expresses a negative self-belief associated with the event. These negative beliefs are actually verbalizations of the disturbing emotions that still exist. Common negative statements include "I am helpless," "I am worthless," "I am unlovable," "I am dirty," "I am bad," "I am a loser," "I am stupid," and so on.

The therapist helps the client establish a positive self-statement that he or she would rather believe, such as "I am worthwhile/lovable/a good person/in control," "I can succeed," or "I can be smarter after the event." Sometimes, when the primary emotion is fear, such as in the aftermath of a natural disaster, the negative and the PC can be "I am in danger" and "I am safe now," respectively. This step can be difficult for the client, because he or she is in the shadow of a bad mood and, thus, he or she cannot think of any PC. In this case, the therapist may help the client to choose a statement that is both realistic and positive. For example, a woman may believe that she is dirty after being raped; then the therapist suggests a positive statement such as "I am still innocent." The client, however, may not agree with this statement because her body has been violated.

The therapist asks the client to estimate how he or she feels in his or her positive belief using the 1-to-7 VOC scale: 1 represents "completely false" and 7 represents "completely true." Usually, a client will rate himself or herself a low VOC scale, which indicates that the therapist and the client have a goal to work on. If the client gives a high scale of VOC, it indicates that the statement selected could be off target. In this case, the therapist and the client have to discuss what PC the client would like to have if the treatment was to be successful.

The client identifies the negative emotions (fear, anger, sadness, etc) and physical sensations (tightness in the stomach, cold hands, etc) associated with the traumatic event. The client also rates the disturbance using the scale of 0 (ie, no disturbance) to10 (ie, the worst feeling I have ever had) on the SUD scale. Usually, the SUD and VOC scale is negatively correlated, with a higher SUD scale paired with a lower VOC scale.

Step 4: Desensitization and Reprocessing

This step includes 2 steps: (a) induction and (b) desensitization and reprocessing.

Induction. The therapist helps the client to focus on and magnify his or her negative emotions and body sensations. The therapist guides the client to close his or her eyes, to take deep breaths, and to pay attention carefully to his or her body sensation/sensations. Then the therapist asks the client whether there are any uncomfortable sensation/sensations in his or her body and what his or her emotion is like. The client may report his or her emotion, such as "I feel tension on my arms and hands and feel discomfort in my chest, and I feel very angry." Then the therapist, with the music being played, will say, "stay with your tension on your arms and hands, and discomfort in your chest, . . . , let your tension and discomfort get stronger, . . . go to your worst picture with your tense and anger, you see your father is beating you with a big stick in your backyard. . .".

Desensitization and Reprocessing. This is the core part of MER. The therapist chooses music that match the client's state of feelings and emotions related to the traumatic imagery. For example, if the WP is a painful and terrifying situation, such as the client being beaten by his or her father, the music could be strong and furious. Bach's Toccata and Fugue in D minor is an example of such music. Sometimes, the therapist may present several pieces of music briefly before this step and ask the client to select the piece that would match his or her feelings related to the WP better. Then, the therapist gets the idea as to which piece of music would be the most appropriate for the client. While the chosen music is played, the therapist introduces the memory or imagery of the WP that was identified by the client in step 3. The client then describes his or her imagery with the eyes closed. As the client verbally reports his or her imagery as it develops, the therapist presents different styles of music to guide and calm the client through grief to sorrow, to peacefulness, and then to sedateness.

The main idea of this step is to demonstrate the role of music in the treatment procedure: first as a follower, then as an accompanier and as an entrainer. The therapist chooses and changes the music according to the story and the images that the client reports by giving consideration to the specific therapeutic objective. As the music matches the client's story, and the client releases his or her emotions, the therapist changes the music to entrain the client's emotions from the negative to the neutral and, eventually, to the positive state. The therapist establishes a dialogue with the client to facilitate the imagery process, and the verbal interventional skills are similar to the verbal skills in a GIM session or nondirective music imagery techniques.

When the client's images changed from the negative to the natural or the positive state, and the music changed from painful, horrific, or angry to quiet and peaceful, the music is stopped. The therapist asks the client to open his or her eyes, to take a deep breath, and then to give a rating on the SUD scale. I call this process as "round" 1, and the entire treatment process will involve a number of rounds. Usually, the SUD scale will be 1 to 2 degrees lower after the completion of each round.

The therapist takes a brief break and repeats the same technique again. However, because the imagery process changes from the negative to the positive state more quickly over time,

the therapist uses a shorter music program when repeating the technique. Usually, the first round takes about 15 to 20 minutes, but the fourth or fifth round may take only 3 to 5 minutes. Sometimes, when the images change quickly, the therapist has to quickly change a music piece to another, before the actual piece of music ends. The goal of step 4 is to achieve an SUD scale of 0. The number of rounds may vary. In practice, a single traumatic event with an SUD scale of 10 would usually take 5 to 8 rounds to complete the treatment process (meaning that the SUD scale scores would reduce to 0, and the VOC scale scores increase to 6 or 7).

Step 5: Transpersonal Experience

The goal of step 5 is to help the client establish a higher self-esteem and a higher self-confidence and to assist the client in creating his or her own resolution of the traumatic event. A client achieves stronger beliefs through his or her own positive experience, such as peak experience that can increase trust in the self and enhance self-esteem.

When the SUD scale reaches 0, it indicates that the client is no longer disturbed by the past traumatic event. But the treatment process does not end at this point. The goal of this step is to enforce and magnify the client's strength of the positive experience and establish positive beliefs to replace the original negative beliefs.

Because a traumatic event usually damages the individual's self-esteem, there are often negative statements and low self-esteem expressed at the commencement of MER, such as "I am powerless" or "I am stupid." The positive beliefs we choose at step 3 usually relate to a higher self-esteem. Our treatment goal is not only to remove suffering from the past trauma but also to look for a higher self-esteem that was reduced by the trauma. A strong belief that I established from my years of clinic experience is that successful outcome is not only to help the client move from a negative state but also to help the client to develop a positive state. A higher self-esteem comes from the individual's increased ability not only to control the exterior world but also to source more positive experiences in his or her inner world. We encourage the client to find his or her own internal resources until his or her VOC scale score increases to 6 or 7.

Transpersonal psychologists believe that all clients have the potential to grow and develop independently by following a natural course of personal healing. The therapist does not solve the clients' problems but merely supports the clients as they gain knowledge through insights that occur during the therapy. Through the transpersonal therapy, clients are able to go beyond the limitations of awareness at the ego level and experience a more complete self-understanding through imagery and dreams.[10]

The therapist introduces the client to progressive muscle relaxation, then provides a similar technique to the previous step and asks the client to close his or her eyes and imagine the WP again but to now think of a positive statement that has been identified in the step 3, such as "I am able to be successful in my future." The therapist then presents music that could elicit a peak experience. One of the pieces I often use is Wagner's *Lohengrin* (Prelude to Act I). The verbal intervention skill here is to facilitate positive experience and even peak experience. Usually only one round is needed, which takes 5 to 10 minutes. The client can travel in his or her peak experience with the music and have increasing positive experiences during the peak experience and develop self-esteem. When the VOC scale reaches 6 or 7, step 5 is ended and the whole treatment process is completed.

The Choosing of Music

In MER, choosing music is a process where the *emotional entrainment is assessed*. The term of entrainment in music therapy is defined as "A synchronization of physiological rhythms of the body (heart frequency, pulse, brain waves) and external rhythmical stimuli created through live or recorded music that can be modified in tempo."[11] However, I use entrainment in the perspective of emotion rather than of physiology. The basic idea of this method assumes that the powerful influence of music is used with sensitivity to emotions, to change and restructure the experiences of the client who is having negative life experience/experiences and even severe traumatic event/events.

It is expected that clients come with negative mood states when they arrive at our offices because of some negative life events. What we are going to do is to use the power of music to "entrain" the mood and emotion toward some kind of positive mood and emotion and eventually change and restructure the experiences associated with negative life events. Tony Wigram in his book *Improvisation* suggested how to make *seductive transitions* in improvisation:

> It is important not to provoke change that is either dramatic or too fast through this type of transition. . . . moving from tragic to happy would be an incongruent and insensitive mood change. Instead, one has to work around the wheel, from tragic to melancholy, melancholy to sentimental, sentimental to lyrical, lyrical to whimsical, and finally form whimsical to happy.[12(p143)]

This is not unlike the idea I used in MER when choosing recorded music in order to entrain with the clients' emotions. Before starting to work with a traumatic experience, I have to identify the moods and emotions the client brings in, and these are identified when talking or recalling the traumatic experience. I ask the client to assign words to describe what he or she is feeling at the present moment. In the initial work of the trauma, that is, exposing (in the beginning of step 4), the client begins imagining the WP of the traumatic event, and the therapist chooses a piece of music which may express a mood or emotion that may match the moods and emotions of the client as much as possible. The goal here is to promote and help the client to release negative emotions.

The reaction to a piece of music is quite subjective, and there is no accurate or objective way to tell which piece of

music, in general, could match a specific mood or emotion. There are obviously differences in the ''feeling'' reaction, and there are a wide range of experiences people may have in reaction to the same piece of music. However, this has not been presented as a problem when working with MER. The music always seems to work well when I choose it according to my assumptions that are based on my observations of the client's response at the moment. There are several reasons that may explain this: (1) people have relatively similar experiences that they associate with music, despite their differences in cultural, age, education, and preference of music. It is because of this reason that music is called a ''universal language.'' (2) Even though there are some differences in reaction to a specific piece of music that naturally occur between the therapist and the client, if the therapist is empathic enough with the client and works to access the inner world of the client as much as possible, she or he can empathize with the client, which helps the therapist to choose the appropriate music in the moment. (3) The content of music is not concrete, as the verbal content is, and therefore, musical content and interpretation is quite flexible.

I use some pieces of music to induce the client to express and release negative mood states and resistant emotions, such as Vivaldi's Violin Concerto in A minor (Largo), which is used in a GIM program[13] titled ''Grieving'' to promote the client to release grief emotions for a time (usually not more than 15 minutes). I may then begin to use a piece of music that elicits less grief to entrain the client's reactions toward less negative emotion, eliciting calmness—peacefulness—brightness—liveliness—vivaciousness—happiness . . . until a positive state is achieved. This process of change is quite similar to the process as described by Dr Wigram earlier. During this process, the client's rich imagery appears to be more and more active, which in turn represents the positive change in the clinet's mind.

I have made a series of music recordings for the EMR work, which included 45 pieces that were all of the Western classical music style. Many of these selections are taken from GIM music (Bruscia's program's CD[13]) and the rest of them are collected according to my own knowledge of Western classical music. The series of music that I use in this work is still developing. I have found that Western classical music works very well in the Chinese culture, and even farmers who are in mountain areas react well to this music as well as well-educated people in modern cities. This phenomenon is quite interesting but beyond the scope of this article.

The Theoretical Orientations of MER

MER is an integrative approach, which is informed by several different psychotherapy orientations as follows: first, repeatedly exposing oneself to a memory of a traumatic event in order to be desensitized is similar to *the behavioral approach called flooding*.[14] Second, the idea of identifying an NC and establishing a PC relates to cognitive therapy.[15] Third, focusing on the past, especially childhood traumatic experience, relates to psychoanalysis.[16] Fourth, utilizing imagery as a primary therapeutic dynamic is related to the psychodynamic and humanistic orientation.[17] Fifth, the nondirective attitude of the therapist and the belief that the client has the potential for self-healing are humanistic perspectives. And sixth, utilizing peak experience to promote self-actualizing and self-esteem is informed by transpersonal psychotherapy.[18]

Music entrainment and reprocessing can alter and/or even remove the negative emotional and physiological experiences associated with traumatic life events in a brief process. The mechanism, in my understanding, is the conditioned reflex in human's brain. When a person encounters a traumatic event or a negative life event, the memory of the event/events is usually stored in the brain in a visualized form, such as images and pictures (sometimes it is stored in other sensory forms, such as auditory or tactual). These pictures of trauma or negative life event(s) are associated with a series of emotional and physiological reactions. As soon as the person recalls the pictures, all the negative emotional and body reactions are evoked immediately, and those conditioned reflexes can exist for a long time, even for a lifetime. However, these conditioned reflexes can also be changed or removed in some circumstances. When a person recalls a tragic memory but is surrounded by lyrical and beautiful music, it seems that he or she cannot react to the memory in his or her brain in the same way as before because the positive experiences evoked by the music reestablishes a new conditioned reflex with the memory in the brain in a new context. The power of music in human experience is very strong and often irresistible. For instance, when a movie presents a tragic or horrible scene but it is accompanied with vivid waltz music, people might immediately react with humor and the original meaning of the scene disappears. Music entrainment and reprocessing uses this power of music to alter a former conditioned reflex into a new, positive conditioned reflex in the brain. The change in imagery, which is entrained by music, is the basic dynamic of MER, because the imagery functions as the form of carrier or container of the new experiences.

Conclusion

Music entrainment and reprocessing is a newly developed psychotherapy method for PTSD and other psychological disorders and difficulties that are related to negative life experiences. It combines the framework of EMDR and the ideas of musical entrainment and musical imagination. It also provides multiple orientations built upon a plethora of psychological orientations including psychodynamic, behavioral, cognitive, humanism, and transpersonal psychology. When compared to other music therapy techniques, such as GIM,[7] and improvisational methods, MER features a standardized framework and is easy to practice and learn. Unlike other music therapy methods that require many years of training, MER requires less intensive training, but supervision is recommended. In my several years of clinic practice, MER has provided a basis for effective outcomes that I describe in part 2 of this article.

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