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## **The Future of Music Therapy in the Treatment of People with Personality Disorders**

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## *The Future of Music Therapy for Persons with Personality Disorders*

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**Niels Hannibal**

### **Introduction**

This article focuses on the use of music therapy with people who suffer from personality disorders (PD). This population has until recently been regarded as very difficult to treat or even resistant to psychotherapeutic treatment. Characteristics of PD include difficulties in establishing functional relationships and acquiring a stable sense of self; these may lead to self-destructive behaviors during treatment. Persons with PD have a pressing need for support from others, and their difficulty in getting this support can lead to a negative spiral of regressive behaviors, for example, an “I hate you – don't leave me” ambivalent state of mind.

Bateman & Fonagy (1999) have described a new and different approach to the treatment of people with PD which involves intensive therapy provided daily on an outpatient basis. This treatment integrates both traditional and new therapeutic theories and practices and is called *Mentalized-Based Treatment* (MBT) (Bateman & Fonagy 2005). This approach has caused a shift in psychiatric treatment with this population.

This article provides a short overview of qualitative and quantitative research on music therapy with people with PD, followed by a short presentation of the Mentalized-Based Treatment model (MBT) and some discursive remarks on how suitable MBT is as a theoretical and clinical framework for music therapy with this population. Finally, I give suggestions for how this could have an impact on music therapy in the future.

### **Research on Music Therapy and Personality Disorders**

#### **Qualitative research**

It appears from several case studies that persons with PD may benefit from music therapy. Several case reports are described below.

Pedersen (2003) describes a treatment process wherein a man with PD, through the intensive use of music improvisation, heals and integrates parts of his psyche that were hidden deep in his unconscious. The creative and explorative process helped him to reacquire a sense of self.

Hannibal (2003) details a case with a woman who was unable to verbalize her internal states. In music therapy, she developed the ability to dialogue about her internal states, develop better emotional regulation and achieve a more positive sense of self.

In a 2009 case with a sexually abused girl, Strehlow illustrated how music improvisation can activate and facilitate different processes. The author presents nine different ways that music provided a therapeutic space for the child, for example, music as a way out of silence; as a space for good and secure experiences; and as re-enactment of traumatic relationship patterns through musical interactions (p. 181). These three cases focus on the music as a means for interaction and communication outside of words and language. It is the activity and the actual process of playing that seems to provide the experience of new and different ways of being together, and this new togetherness functions as a reservoir for correctional experiences.

There are also other case studies that describe music therapy with this population (e.g., Dvorkin, 1991; Hannibal, 1999; Kupski, 2007; Odell-Miller, 2011 & in press; Schmidt 2002,).

Hannibal investigated the concept of pre-verbal transference in his Ph.D. dissertation from 2001. This thesis included two case studies of people diagnosed with PD. Transference patterns were analysed from a preverbal perspective as they unfolded before, during and after musical improvisation. The theoretical frame for the study was based on Daniel Stern's theory (2000) of preverbal relational dynamics concerning how real-world lived experiences are the basic elements of building the sense of the self and the sense of how to be with other people. The research revealed that clients repeated transference patterns in their music improvisations and that musical interaction could both activate conflict issues as well as change the context of intersubjectivity after playing.

Rolvsjords (2007, 2010) completed a case analysis of a woman with PD using a treatment approach she developed: *Resource-Oriented Music Therapy* (ROMT). In ROMT, the primary objective is to empower the client, so that the therapy enhances the client's sense of mastery, increases self-efficacy and self-esteem and provides a therapeutic setting where the client can develop a more positive sense of self. ROMT is a constructivist-based approach that changes the therapist's focus from the client's pathology to the client's resources. Thus, music therapy is not concerned with fixing what is not working, but instead with developing and nurturing the potential resources already there. The ROMT model has been tested in a randomized controlled trial involving clients with low motivation (Gold, et al., 2013), and also including a small sample of people with a PD diagnoses. ROMT was shown to be superior to treatment as usual (TAU) in reducing participants' symptoms and increasing their function.

Strehlow and Lindner (2015) conducted a study "to identify typical interaction patterns, arising from the relationship between patient and therapist and also from the significance of music" (p. 1). The study involved an analysis of 20 cases of music therapy with people with borderline personality disorder (BPD); 10 typical interaction patterns within music therapy were identified. The relational patterns reflected typical BPD themes, such as regulation of proximity

and distance, splitting phenomena, trauma genesis, aggression and mentalization. A mentalization-based treatment model was used, and this model has been used also in other recent studies (Hannibal, 2011; Hannibal, et al., 2012a; Hannibal, 2014; Odell-Miller, in press).

### **Quantitative research**

There is very little quantitative research examining the effects of music therapy treatment on clients with personality disorder. Hannibal, et al. (2011) used an existing data set from a larger sample to examine changes in clients with PD. Music therapy was provided along with other interventions, such as individual and group therapy, psychoeducation, body therapy, medical consultation and support from staff. The sample contained 53 clients. The result showed that the group had reduced symptoms and increased function similar to patients that received art therapy instead of music therapy, but there were also some noticeable findings in this study. When looking at individual groups, larger differences were evident. Some groups had high attendance, some the same attendance and some groups showed very low attendance compared to verbal therapy. This indicated that for some clients music therapy treatment was challenging.

Hannibal, et al. (2012b) published a small study looking at adherence to individual music therapy treatment in 27 clients with either schizophrenia or personality disorder diagnoses. Findings showed high adherence to treatment for both groups and a low dropout rate. The study also examined predictors for low adherence and dropout, but found none.

From 2012 to 2014, a pilot study (n = 4) looking at music therapy for clients with personality disorder was conducted in Aalborg. The findings haven't been published yet, but the following is a brief summary. Results indicate a change in participants' attachment patterns as measured by the Revised Adult Attachment Scale (RAAS), and these were considered positive results. But there are also many unanswered questions such as: did the treatment manual work and did the therapist adhere to the Process Oriented Music Therapy (PROMT) manual? Should a future research design include both expressive and receptive interventions or should only one intervention be included as it was done in the Finnish study on the effect of musical improvisation on clients with depression (Erkkilä, et al., 2011)? Is it possible to create a research design that can work in an international, multi-centre study? These questions need to be addressed before a larger study can take place.

### **Mentalization-Based Therapy**

The Mentalization Based Therapy (MBT) model is seen as a new treatment model in music therapy in Denmark, Germany and England. Mentalization refers to the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes. When mentalizing is compromised, subjective, internal experiences and the interpersonal world stop making sense (Daubney & Bateman, 2015, p. 132). This is actually the central problem for people with PD. The reason for this is that vulnerability to a frequent loss of mentalizing and slower recovery of

mentalization in the context of interpersonal relationships is the fundamental pathology (ibid, p. 132). So in a sense the client lives in an almost permanent non-mentalizing mood, where interpersonal relationships create a personal state where, for example, anxiety, emptiness, confusion, loneliness or a combination of these is the dominant experience. So the focus of treatment is to develop the client's ability to regain the capacity to mentalize when it is lost. For further information, the reader is referred to: Bateman & Fonagy (2012).

### **MBT and Music Therapy**

In 2007, Odell-Miller's research found that music therapists in three European music therapy centers were implementing an MBT approach. In Denmark, the MBT model is integrated in a treatment manual, Process-Oriented Music Therapy (PROMT) (2012a). This manual was used in a pilot study mentioned above for people with personality disorders. In Germany, Strehlow has published on MBT and music therapy from an MBT perspective (Strehlow, 2009, 2011, 2013, 2014 & 2015). She claims that music therapy is especially suitable for stimulating the capacity for mentalization (2014). In 2014, a music therapy annual publication, *Mentalization and Symbol Formation in Music Therapy Practice* contained 9 articles that examined mentalization in relation to music therapy practice.

Both Hannibal (2013, 2014) and Strehlow (2009, 2011, 2013, 2014, 2015) have discussed how music therapy can adapt MBT's theoretical framework regarding the therapeutic process as well as how the techniques and interventions of both approaches can be integrated. These authors have also discussed how MBT in music therapy is different from MBT done in a solely verbal context. Music adds something to the therapy that MBT theory has yet to formulate. Hannibal (2013 & 2014) argues that music enhances the implicit level of relational knowing, and makes it available for both implicit and explicit processing.

It is my opinion that the MBT model fits very well with music therapy practices as will be described below. But it is also important to state that there are new elements in MBT that music therapists need to learn. The MBT community states that MBT is actually not new in many ways (Bateman & Fonagy 2005). As this model integrates many different therapeutic models such as psychodynamic thinking, attachment theory, evolution theory, neuropsychology and systems theory and adapt these theories to each other. For example, the therapeutic process is always viewed from the here and now perspective; whatever happens between the client and the therapist is related to the ongoing interaction between them. Activating the attachment system increases arousal and too much or too little arousal decreases the mentalizing capacity. The therapist takes the role of not knowing, implying that the therapist facilitates the client's ability to mentalize and make sense of what is going on.

An important question to pose is: how are music therapy and MBT alike and different? The following elements are characteristic of music therapy: music therapy is unfolding in the moment (here and now); the creation of music happens in the therapy context (Rolvjord & Stige 2015); and it is an enterprise where both client and therapist contribute. Music evokes and enhances implicit procedural

doing (the “know how” level) and also explicit symbolic, narrative, episodic, verbal, symbolic knowing (the “to know” level) (Hannibal 2001, 2014). Music can activate the attachment system, and this can be both supportive and challenging. Music can both increase and decrease arousal.

There are also differences between MBT and analytically-oriented music therapy: in music therapy, it is necessary to mentalize the client in the session. This means that the therapist has to keep a focus on the client’s mental state and sense when the arousal level is optimal; if there is too much intensity, the neuro-cortex may lose the ability to mentalize. Therapists also have to learn the “not knowing” stance. They have to understand and be able to identify when the client exhibits a low level of mentalization, for example when the client appears to reflect but it does not change anything.

What does not exist in MBT is a theoretical understanding of how mentalization unfolds in music therapy. For example how can we monitor the mentalizing capacity in the music? Sometimes engagement is there, and the client uses the music to explore himself or the relationship. The client might be very insecure and shy, so the music might sound like the client is detached, but in reality the client is risking and daring to express himself in the music. The ability to tell the difference is important. Sometimes clients are very dependent in their relational style, so detaching from the therapist and playing more separately might be a sign of implicit mentalization in the music. Detachment is a sign of low mentalization, and in these situations the therapist has to change the way he or she perform in the music so we can get the client back in a mentalizing position.

## **Conclusion**

What are the implications for the future music therapy in the treatment of clients with personality disorder? First of all, there is a need for more research focusing on the effects of music therapy with this population. We need to know more about what changes as a result of therapy and how it changes; if there are client groups where certain music therapy methods are contraindicated; if music therapy develops the person’s ability to function in interpersonal relationships; if it helps the client to regulate his emotional state, and if music therapy can help clients to mentalize better.

Secondly I believe that MBT and music therapy seem to fit very well together. MBT provides a conceptual framework that is relevant, and music can help to develop both implicit and explicit mentalization. However, we need to investigate how music can help improve one’s capacity to mentalize both within and outside of music in much greater detail. Further questions are: is there a difference between improvisation, song writing and song performance and how does receptive music therapy help and so on? Finally, we need to train music therapists in the theory and practise of MBT. I expect that in the future, therapeutic skill in MBT is something that will be considered fundamental for all personnel working in health care.

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