

RESEARCH IN MUSIC THERAPY WITH PATIENTS WITH PERSONALITY DISORDERS

MUSIC THERAPY CLINIC AALBORG UNIVERSITY
HOSPITAL –PSYCHIATRY
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Unit for Psychiatric Research

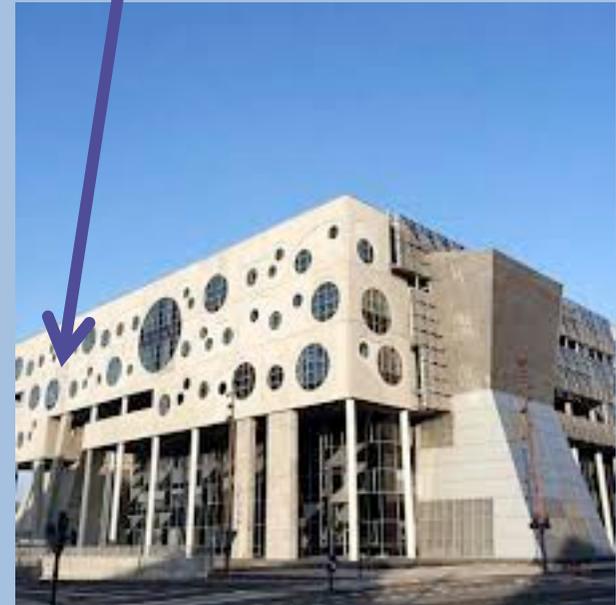


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The new Music House in Aalborg: Our new home



WE are here



Hoste:

- Aarhus Music Conservatory,
- Music Education Aalborg University,
- Music Therapy Education (from August 2015)



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Who am I?

- Born 1960
- Trained nurse 1984
- Trained music therapist 1994
- GIM level 1 and almost level 2
- Done clinical music therapy in psychiatry since 1995
- Ph.D. in 2001: Preverbal transference in musical improvisation
- Associate professor since 2005



Issues for this presentation

- The RCT and related issues
- The Conceptual framework
- A case
- MBT and music therapy
- A pilot-study for music therapy with people with personality disorder



THE RANDOMIZED CONTROLLED TRIAL



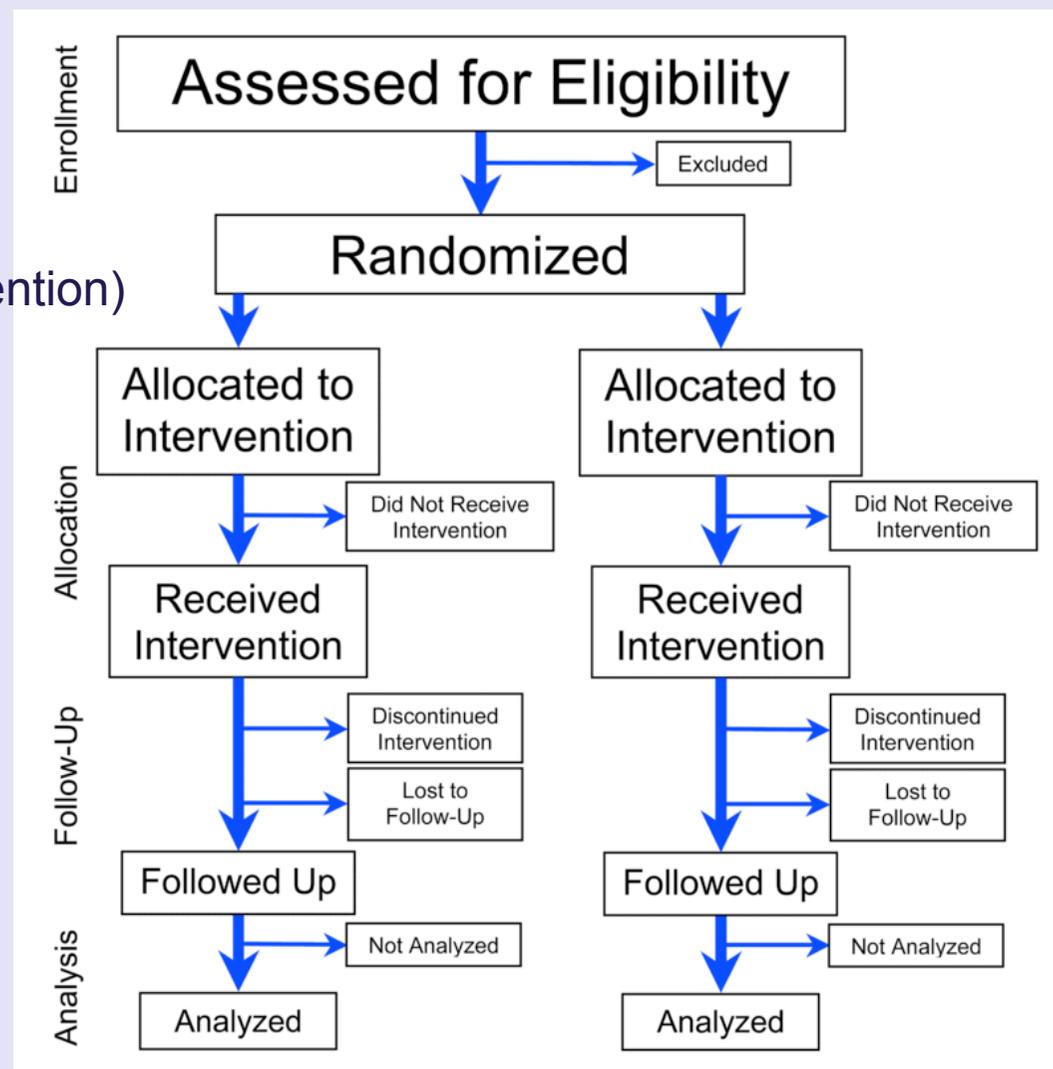
The RCT: Randomized controlled trial

- The RCT - the gold standard for a clinical trial.
- RCTs to test the efficacy experimental or effectiveness of various types of medical intervention in clinical settings
- Recognized as the standard method for "rational therapeutics" in medicine. As of 2004, more than 150,000 RCTs were in the Cochrane Library



RCT - normally

- Random allocation,
- Sample
- Control group,
- Independent variable (the intervention)
- Dependent variable (the effect)
- Blinding
- Ethical approval,
- Informed consent
- Data registration
- Statistical analysis



RCT's in music therapy: Challenges

- Complex intervention – naturalistic setting
 - The therapist adherence to treatment (manual) and competences (the level of skill) (Waltz et al. 1993)
- Many variables: Specific and non-specific
 - How can we know that music is the active ingredients
- Blinding difficult
 - Can blind assessors but normally not participants
 - The RCT with people with schizophrenia and effect on negative symptoms
- Recruitment problems
 - Population often not able to participate in trials (wont give consent)
 - The problem with referral and assessment
- Often MT is compared to TAU



RCT advantages and challenges

1. Eliminates **bias** in treatment assignment, specifically selection bias and confounding.
2. Facilitates **blinding** (masking) of the identity of treatments from investigators, participants, and assessors.
3. Permits the use of **probability theory** to express the likelihood that any difference in outcome between treatment groups merely indicates chance.
4. **Allocation bias** (or **confounding**). May occur when covariates, and the treatment effect is confounded with the effect of the covariates (i.e., an "accidental bias"
 1. Non-specific factors. For ex. Looking at treatment effect between **therapists** (Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., Vanhala, M. & Gold, C. 2011)



RCT- Music therapy and negative symptoms

Hypoteses: Music therapy can reduce negative symptoms compared to being together with a social worker (bostøtte)

Negative Symptoms scale (Panss)

- Blunted affect
- Emotional withdrawal
- Poor rapport
- Passive/apathetic social withdrawal
- Difficulty in abstract thinking
- Lack of spontaneity and flow of conversation
- Stereotyped thinking



The design

- Double-blind Randomized controlled study using three measurement points (baseline, after 15 sessions and at the end) .120 participants randomized 1:1 to either music therapy or time-compensated contact with social worker.
- Randomization is done in blocks with varying block size and stratified by whether the participant can meet up in a therapy room or need assistance in the home.
- All participants are offered 25 sessions of music therapy at 1 hour duration once weekly. The treatment period does not include holidays. Both participants and assessment personnel carrying out the experimental procedures are blind, while music therapists, the social worker and researchers carrying out qualitative analysis, unblinded (as blinding is not possible).



Music therapy RCT and Meta-analysis

- Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., Vanhala, M., & Gold, C. (2011). Individual music therapy for depression: randomised controlled trial. *The British journal of psychiatry*, 199(2), [132-139](#).
- Gold, C., Mössler, K., Grocke, D., Heldal, T. O., Tjemsland, L., Aarre, T., Aarø, L. E., Rittmannsberger, H., Stige, B., Assmus, J. & Rolvsjord, R. (2013) Individual Music Therapy for Mental Health Care Clients with Low Therapy Motivation: Multicentre Randomised Controlled Trial. *Psychotherapy and Psychosomatics*, vol. 82, s. [319-331](#), 2013.
- Gold, C., Solli, H. P., Krüger, V., & Lie, S. A. (2009). Dose–response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis. *Clinical psychology review*, 29(3), [193-207](#).



Questions and issues when wanting to do research in music therapy field.....actually in any complex field/natural setting?

- Can we standardise music therapy?
- Are the treatment the same in different settings and countries?
- Are our conceptual models for treatment identical?
- Is our understanding of the vehicle of treatment comparable?
- Is the context similar?
- Are our measurement tools valid and translated?
- How can we avoid treatment fidelity?
- How can we clime effect when we cant give blinded treatment /placebo?



PROMT or MBTMT
THE CONCEPTUAL FRAMEWORK



To Mentalize

- *Mentalizing is 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*
- *Vulnerability to frequent loss of mentalizing and slower recovery of mentalization in the context of interpersonal relationships is the fundamental pathology*

(Daubney & Bateman. 2015)

- And frequent loss of mentalization is what happens in for people with dysfunctional attachment systems and personality disorder



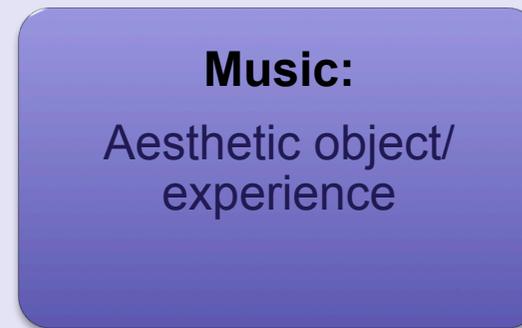


Mentalization in music

Explicit level: To know

- Words
- Narratives
- Images
- Symbols
- Artefacts
- Music
- Conscious

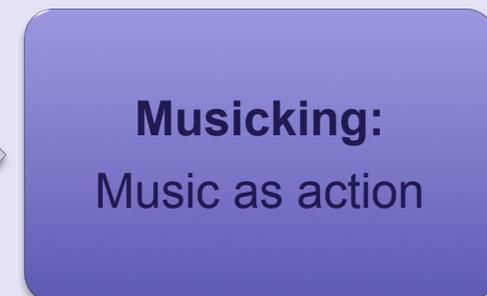
MBT community knows this



(Stige 2002)

Implicit level: To know how

- Procedural
- Knowledge of how to be with other
- Non-conscious
- Proto-musicality
- Musicking

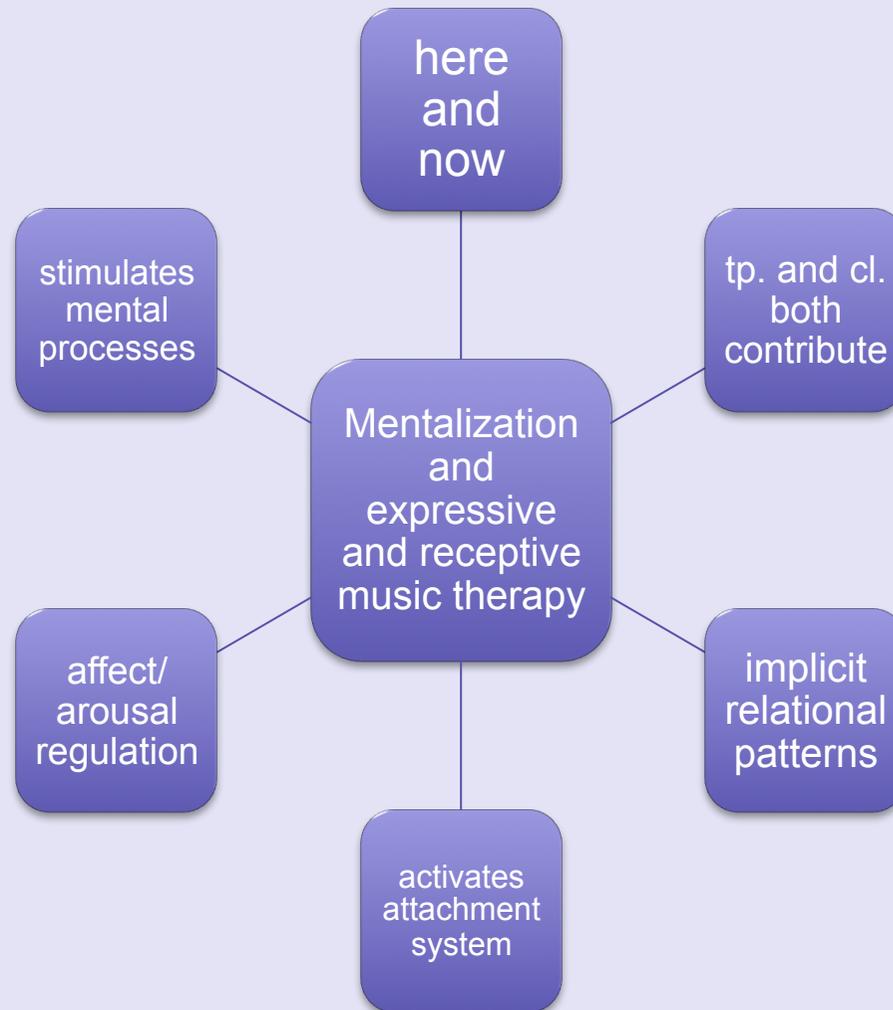


They don't know this – but we do!



Why does MBT model fit music therapy practice?

We have been doing
this all the time –
We just used different
theoretical frame



How does MBT change therapist role in analytical music therapy practice

Different therapeutic focus and understanding of process

- Has to be able to mentalize the client
- Not too “hot” and not too “cold”
- Always “here and now” focus - context focus
- The not knowing stance
- Only mirror marked emotions
- Use the past to understand the present
- Monitor mentalization capacity in self and other
- Intervene when client experiences a mentalization breakdown



The therapist don't

- Don't use free association
- Don't use of confrontation and frustration
- Don't mirror unmarked emotions



Testing the integrity of a psychotherapy protocol: assessment of adherence and competence.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. ([1993](#)).

How well do therapists adhere to the manual and how competent are they
How can we avoid treatment fidelity

Category 1: Unique and Essential Therapeutic Principles

Category 2: The Essential but not Unique Therapeutic principles

Category 3: Acceptable but not necessary Therapeutic principles

Category 4: Not acceptable – Proscribed Therapeutic Principles



Table 1
Examples of Four Types of Items for an Adherence Check Comparing Two Treatments

Psychodynamic therapy	Behavioral therapy
Unique and essential	
<ol style="list-style-type: none"> 1. Focus on unconscious determinants of behavior 2. Focus on internalized object relations as historical causes of current problems 3. Focus on defense mechanisms used to ward off pain of early trauma 4. Interpretation of resistance 	<ol style="list-style-type: none"> 1. Assigning homework 2. Practicing assertion in the session 3. Forming a contingency contract
Essential but not unique	
<ol style="list-style-type: none"> 1. Establish a therapeutic alliance 2. Setting treatment goals 3. Empathic listening 4. Planning for termination 5. Exploration of childhood 	<ol style="list-style-type: none"> 1. Establish a therapeutic alliance 2. Setting treatment goals 3. Empathic listening 4. Planning for termination 5. Providing treatment rationale
Acceptable but not necessary	
<ol style="list-style-type: none"> 1. Paraphrasing 2. Self-disclosure 3. Interpreting dreams 4. Providing treatment rationale 	<ol style="list-style-type: none"> 1. Paraphrasing 2. Self-disclosure 3. Exploration of childhood
Proscribed	
<ol style="list-style-type: none"> 1. Prescribing psychotropic medications 2. Assigning homework 3. Practicing assertion in the session 4. Forming contingency contracts 5. Prescribing the symptom 	<ol style="list-style-type: none"> 1. Prescribing psychotropic medications 2. Focus on unconscious determinants of behavior 3. Focus on internalized object relations as historical causes of current problems 4. Focus on defense mechanisms used to ward off pain of early trauma 5. Interpretation of resistance

Process Orientated Music Therapy (PROMT)

- now Mentalization Based Music Therapy (MTBMT)

Category 1: Unique and Essential Therapeutic Principles

The therapeutic process:

- is always the central focus of the music therapy work
- can focus on reduction of symptoms and/or development of skills/competencies and/or strengthening of resources
- **always takes place in a perspective of 'here and now' and the past is only involved from this perspective**
- **concerns both the implicit procedural level and the explicit and declarative level**
- is not bound by a certain music therapy method (improvisation, composition, reproduction or music listening)
- the focus of the therapeutic process are relational and communicative competences
- **The therapist has to know and be able to maintain "a not knowing stance" in the treatment.**
- The therapist should aim at preserving an attitude to the client in the verbal parts, in the musical parts and in the non-verbal communication, **which promotes mutual mentalization.**

Category 2: The Essential but not Unique Therapeutic principles

The therapeutic process:

- is identified in dynamic patterns such as defence, transference and countertransference
- necessary to creating, developing and maintaining the therapeutic alliance (cooperation on aims, methods, intimacy and leadership)
- has regulation of arousal as its focus
- can take place by verbal reflection or by musical actions

Category 3: Acceptable but not necessary Therapeutic principles

- Interventions, which curb negative processes and processes, which do not promote the on-going therapeutic process
- Advice and structuring interventions, when the patient cannot cope with the therapeutic process

Category 4: Not acceptable – Proscribed Therapeutic Principles

- Interventions based solely on methodological or theoretical reasons without involving the perspective of the patient
- Application of transference to examine unconscious repetitions of earlier behaviour
- Encouragement of fantasies and free associations about the therapist
- Application of frustrating and confronting interventions such as long silent breaks for example
- Mirroring of non-marked (explicitly) emotions



Integration of MBT into our PROMT manual

- here and now focus
 - implicit and explicit level of communication
 - **a not knowing stance**
 - strive to maintain a metallization enhancing attitude verbal and musical
 - identify dynamics patterns such as defence, transference and counter-transferences, and
 - only use them to enhance understanding of the on going unfolding interaction
-
- don't encourage the client to fantasise and use free association about the therapist
 - don't use confrontation and frustration-inducing interventions such as long periods of silences
 - don't mirror unmarked emotions

Name of department...



The Rational for using music in treatment with people with bpd

Discussing with Gitta

Music therapy can promote implicit and explicit mentalization

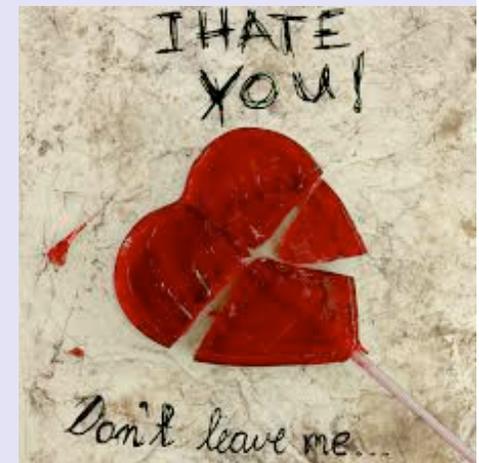
Music therapy can change dysfunctional and inflexible ways of being with other (WOBWO) persons to more integrated and flexible WOBWO

Our statement:

- Music provides an in vivo way to access the attachment system, affect regulation, and there by develops the ability to implicit and explicit mentalization
- Musical interaction is lived experience
- Music creates a relationship between people (affordance) where new attachment patterns can emerge
- Music can also stimulate the attachment system in a negative way:
 - Create high arousal and loos of mentalizing capacity



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A CASE: LAILA



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Laila

- Low self-esteem, feeling unmanageable, sadness and cries easily.
- Has been depressed for a long time since her first big love died accidentally some 20 years ago.
- She describes her husband as someone she married for safety more than love.
- Security is essential to her.
- Her father like to brag about his pretty daughter in front of friends and also same times made fun and humiliate her when she makes her self pretty.
- Mother is dominating and threatens to leave if her opinion is not respected.
- She depends on her mother because her husband is a sailor in the merchant fleet.
- It is difficult for her to engage with her children and relax at the same time.

- She has high demands to her self, and never seem to get a sensation of achievement and mastery.
- She is preoccupied with what other people think about her, or over involved in others.

- Diagnosed with
 - F60.0 Paranoid personality disorder;
 - F60.5 Compulsive PD and
 - F61.0 Disturbed personality mixed type

Name of department...



Possible triggers of mentalisations breakdown

- Her attachment style is ambivalent over involved
 - if she wants admiration - she fears humiliation and exposure
 - if she needs support and help - she won't have any room for her point of view
 - if she needs to process loss - she is afraid to be dined comfort in her grief

- 1. session



Experience loos of mentalization

- 40. session



Don't loos mentalization

Name of department...



At the end of treatment

- She reports experiences her self as more safe in relation to me. Annoyed to have to start all over aging in another setting.
- Is more open and honest.
- She is more aware about how she perceive others, and wished she was less suspicious
- Still occupied about what other people say about her. She feels bad but still sad deep down.
- She has begun working a few hours a week and manage this stress.
- She has begun to enjoy things and not only focus on if everything is perfect.



Questions

- What were the active ingredients in the treatment? Was it the relation, the expressive or the receptive music interventions
- Was it music therapy – or verbal therapy including music? There was a lot of talking, but the music played a significant role
- Was it analytical music therapy, MBT or something else? Non of the therapist had MBT training
- What had changed? Her mentalizing capacity had improved, the ability to respond and be more flexible in interaction, more autonomous, less dependent, higher life quality
- Was the effect lasting? We don't know



PILOT-PROJECT II

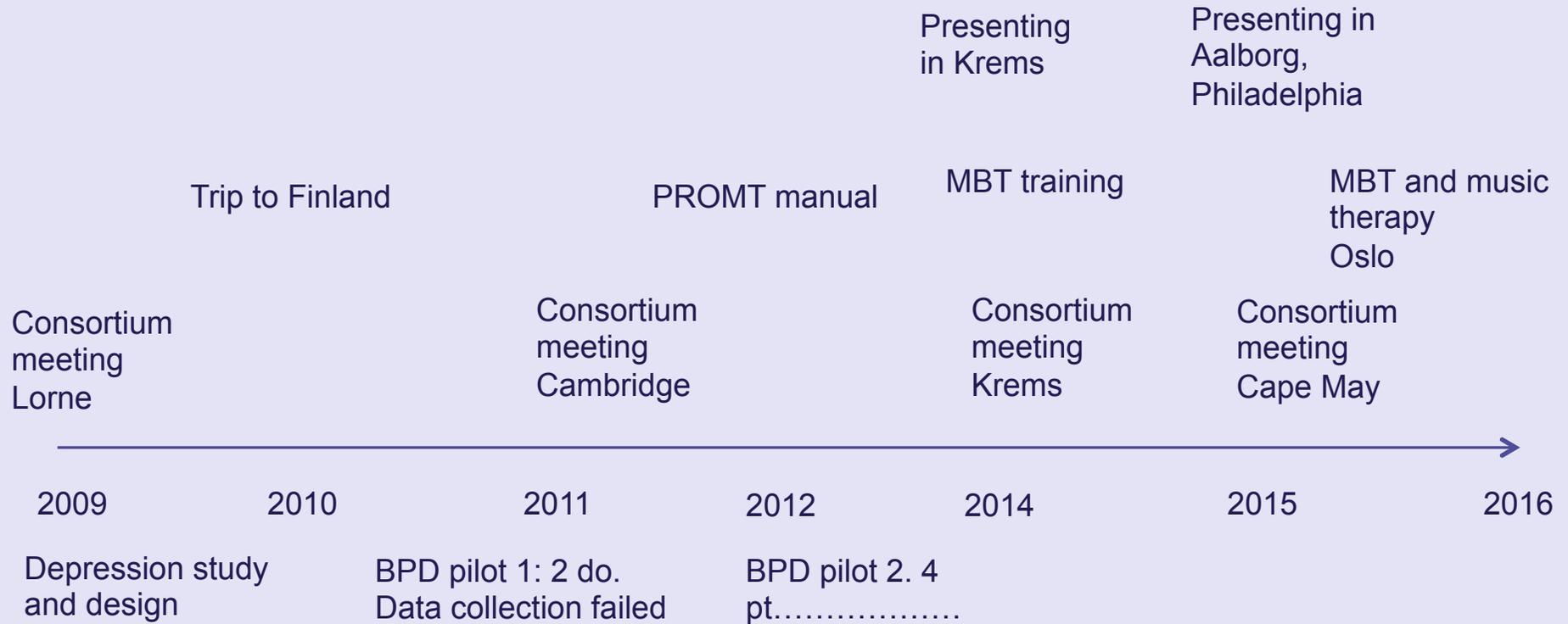


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Timeline

Not treatment

Writing-
publishing



Treatment



The second pilot:

- Data collection period: 2012-2014
- Pt. pre-post external assessment
- 40 sessions of treatment (2 session pr. week for 13 weeks, 1 session pr. week for 14 weeks)
- Both expressive (improvisation, songwriting, performing) and receptive technics (tp and/or cl chosen)
- 4 pt. participated (one male, tree women)



Research hypotheses

Music therapy can:

- Strengthen the clients ability to attachment and there by gradually reducing anxiety and change destructive thought and actions patterns
- Contribute to the development of pt's self confidence
- Develop pt's ability to communicate
- Improve personal integration
- Improve life quality
- Improve psychosocial function level



Variables – dependent

- Variables
 - RAAS: Attachment
 - WHO-QOL: Quality of life
 - SOC: Sense of coherence
 - HAQ-II: Alliance
 - SCL-90: Symptoms
 - HADS-anxiety: Symptom
 - IIP: Interpersonal function

- Measure point: Pre, 25 session!, follow up



Findings

Strength the clients ability to attachment and there by gradually reducing anxiety and change destructive thought and actions patterns	Yes better attachment, but no direct link to symptoms
Contribute to the development of pt's self confidence	Yes self-report
Develop pt's ability to communicate	Yes
Improve personal integration	Yes
Improve life quality	No
Improve psychosocial function level	No



Issues that needs to be solved

Meta/design

- Design
- Resources – applications – money/time
- Collaboration local and abroad
- Research questions

Theory/
hypothesis

- The rational for using music
- Conceptual framework
- Manual

Data/
practice

- Intervention
- Training of therapists – adherence to manual
- Variables
- Recruitment
- Intervention/control gr.
- Measure points



Current status

- The treatment manual: Does it work, adherence
- The theoretical framework: MBT?
- The uniqueness of the music: Why music
- The explanatory model: The why question
- The research design: RCT with one (improvisation) or several variables (expressive and receptive)
- The training of the therapist:



The future music therapy practice, research and theory in treatment of personality disorder

- We need some kind of effect study, to hopefully support the clinical impression that MT with this population in psychiatry is beneficial: PRE/POST, RCT, Mixed method
 - We are working on establishing a research group in collaboration between universities in Denmark, England, Finland and Belgium
 - We need to agree on the manual – how to conduct treatment to avoid treatment infidelity
 - We need to train therapist in MBT style
- Integration of the MBT model in practice and theory.
- Investigate how the mentalizing capacity develop in expressive music therapy (improvisation, song writing, music performing) and in receptive music therapy
 - Strehlow, G., & Lindner, R. (2015) Music therapy interaction patterns in relation to borderline personality disorder. Identified 10 relational patterns
 - Hannibal, N. (2014) Implicit and Explicit Mentalisation in Music Therapy in the Psychiatric Treatment of People with Borderline Personality Disorder



- Workshop August 6, 1.15-2.45 pm Oslo:
Strehlow and Hannibal: How to work with mentalization based treatment (MBT) perspective in improvisation based music therapy.



Future clinical recommendations

When working with clients who have personality disorder:

- Learn to mentalize your self and your clients
- Adapt you musical intervention to “what ever” enhances or re-establish the ability to mentalize
- Music therapy can improve attachment – implicit mentalization and explicit mentalization
- Some times even the unstable and difficult clients benefit form treatment



Music Therapy Clinic at Aalborg University Hospital – Psychiatry



Niels Hannibal
Associate Professor



Inge Nygaard Pedersen
Associate Professor, head of clinic



Lars Rye Bertelsen
Clinical Music therapist



Lars Ole Bonde
Professor

Thank you for your attention

enjoy the view



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Litteratur

- Hannibal, N., Petersen, B., & Windfeld, M. (2011). Gruppemusikterapi i Dagbehandlingsregi: Opsamling på perioden 2003 til 2010. *Musikterapi i Psykiatrien Online*, 6(1).
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