

Alliance building in music therapy for forensic psychiatric patients with schizophrenia. An exploratory case study research design

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ABSTRACT

Introduction: Forming therapeutic alliance with forensic psychiatric patients with schizophrenia is challenging, and there is a gap in knowledge about the dynamics in the initial phase of psychotherapy and how collaboration and trust is developed. Music therapy is described as a motivating approach enhancing the forensic psychiatric patient's ability to engage in a relationship. The purpose of the study was to explore and identify dynamics in the process of forming therapeutic alliance in music therapy for forensic psychiatric patients with schizophrenia.

Method: The study adopted an exploratory case study design with data from multiple perspectives providing thick descriptions. Four patients with schizophrenia from a medium secured unit at a forensic psychiatric hospital were offered weekly music therapy sessions for six months. An inductive process based on a hermeneutic phenomenological epistemology and a nine step procedure for the analysis led to a final abductive synthesis.

Findings: Each of the following themes formed a continuum of dynamic interactional processes within the development of therapeutic alliance with forensic psychiatric patients with schizophrenia in music therapy and were presented as a condensed continua model; 1) Control, 2) Closeness/distance, 3) Structure, 4) Process/product, 5) Focus of attention, 6) Interaction, and 7) Verbal dialogue. A case example is provided.

Discussion: The continua model may contribute to the clarification and conceptualization of the developmental dynamics in the initial phase of psychotherapy with forensic psychiatric patients with schizophrenia, and hereby contribute to a recognition of the importance of treatment efforts specifically concerned with relational and musical competencies.

KEYWORDS

Forensic psychiatric patients; schizophrenia; music therapy; psychotherapy; trust; therapeutic alliance

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Introduction

Forensic psychiatric patients

A person who has committed a crime and at the time of the criminal act was suffering from a major mental illness or a similar condition is assigned to forensic psychiatry. In the Scandinavian countries persons meeting such conditions are not punishable, and are, instead of ordinary penalty, sentenced to treatment at a forensic psychiatric facility (Grøndahl, 2005; Kramp, 2005; Langsted et al., 2010). Epidemiological studies show a correlation between major mental illness and a higher risk of committing a crime (Arseneault et al., 2000; Brennan et al., 2000; Räsänen et al., 1998), and in Denmark, 80 percent of forensic psychiatric patients are diagnosed within the schizophrenic spectrum (Brandt-Christensen et al., 2018; Kramp & Sestoft, 2008). These patients' ability to connect external sensory experiences with internal bodily and emotional reactions is reported to be seriously affected, resulting in psychotic symptoms with hallucinations, delusions and paranoia, and negative symptoms such as isolation and lassitude. As a consequence this leads to difficulties in building relationships (Simonsen et al., 2010). Further, forensic psychiatric patients (hereafter FPP) with schizophrenia are challenged by a high prevalence of personality disorder and/or antisocial behaviour (Blackburn et al. 2003; Pedersen et al., 2010; Simonsen & Newton-Howers, 2018), and are described as aggressive, projective and hostile, with an excessive need of control, and inability to regulate arousal (Hakvoort & Bogaerts, 2013; Smeijsters & Cleven, 2006).

In forensic psychiatry in Denmark, the traditional approach has been medical treatment of the patients' mental illness, expecting this to reduce the criminal and antisocial behaviour (Jacobsen & Johansen, 2011). This approach is challenged by a psychodynamic understanding, where the antisocial behaviours are understood as

reactions to protect oneself from anxiety and fear at a deep existential level, and to be caused by traumatizing childhood experiences with neglect, physical and/or sexual abuse (Afifi et al., 2011; Cohen et al., 2005). In this view, challenges such as antisocial behaviour, addiction and aggression should be addressed in psychotherapeutic treatment (Hougaard, 2006; Simonsen et al., 2010; Swanson et al., 2008).

Therapeutic alliance

The most predictive factor for a positive outcome of therapy is found to be the quality of the relationship between therapist and patient, also called the therapeutic alliance (Horvath et al., 2011; Hougaard, 2004; Martin et al., 2000). Polaschek and Ross (2010) found that therapeutic alliance significantly increased over time for what they labelled “high-risk, psychopathic violent prisoners”. In general, therapeutic alliance may consist of two phases; the first initial phase where collaboration and trust is established, and the second where the patient is open for being challenged by the therapist and for allowing new ways of acting and thinking (Horvath & Luborsky, 1993). It is described as vital for the development of therapeutic alliance that patients perceive their therapist as supportive, friendly, warm and emphatic (Najavits & Strupp, 1994). Thus, there is a need for research on the interaction patterns between patient and therapist in the therapeutic setting, in order to understand how this interaction affects the therapeutic alliance (Ross et al., 2008).

Therapeutic alliance with forensic psychiatric patients

A core conflict in psychotherapy for FPP with major mental illness and antisocial behaviour is the dilemma between the demand for treatment sentenced by court and the

patient's lack of recognition for the need of treatment. This conflict is central and complicates the development of a therapeutic alliance.

Research on therapeutic alliance has typically been conducted in “ideal” psychotherapeutic environments where the clients are able to engage in psychotherapy and building rapport with a therapist within few sessions (Horvath, 2001). Pribe and McCabe (2006) found that these results are not directly transferable to psychiatric settings, and that research and tools to assess the therapeutic alliance with patients with severe mental illness is needed. When it comes to general psychiatry, Svensson et al. (2000) confirmed that it is possible to build therapeutic alliance in psychotherapy with patients with major mental illness. Other studies found that patients' negative symptoms and neurocognitive disabilities were a major challenge to the therapeutic process (Davis et al., 2011; Jung et al., 2014). Therefore, enhancing the psychotherapist's ability to meet negative symptoms in patients with major mental illness in the initial phase of therapy has been suggested, and that such phase would need six months or more (Frederiksen & Ridder, 2020; Lysaker & Gumley, 2010; Sørensen, 2004).

In a review of the literature, we found no studies that confirmed the effect of psychotherapy or music therapy on therapeutic alliance building with patients with severe mental illness in forensic psychiatry (Frederiksen & Ridder, 2020). However, we identified four studies that explored how to support therapeutic alliance in forensic psychiatry (Krupinski et al., 1997; Lysaker & Daroyanni, 2006; Metzner, 2010; Vasic et al., 2015). Krupinski and colleagues (1997) suggested that the development of therapeutic alliance in itself should be considered an outcome of therapy in forensic psychiatry, and Vasic and colleagues (2015) found increased sensitivity in relation to power divide and punitive tendencies in the therapeutic alliance compared to general

psychiatry. Meeting and containing the patient's need for control and softening hostility was described as enhancing intersubjectivity and supporting the development of therapeutic alliance in psychotherapy (Lysaker & Daroyanni, 2006) and in music therapy (Metzner, 2010). Adding to this, research on rehabilitation of offenders with antisocial behaviour or personality disorders describe the development of therapeutic alliance as complicated (Ross et al., 2008). Further, a supportive setting with an empathic attitude using encouragement, reward and a directive approach is suggested (Ross et al., 2008) as well as an awareness of the patients responsiveness (Marshall & Serran, 2004). Forensic patients, whether suffering from major mental illness or not, have been described to "experience the therapist as dangerous and persecuting and therapeutic progression as a catastrophic risk of change and threat of losing control" (Temple, 1996, p. 35). This puts demands to the role of the therapist who has to contain the patient's extreme experiences of rejections and devaluation. Others consider arousal regulation and synchronization through non-verbal interactions as a prerequisite for patients with major mental illness to engage in therapeutic alliance (Beebe & Lachmann, 2005; Schore, 2001).

In summing up, the initial phase of psychotherapy is described as important for alliance building, and that it forms the basis for developing a relationship between patient and therapist. If psychotherapy should be a realistic intervention for FPP with schizophrenia, who may reject to participate and act with antisocial behaviour, there is a need for exploring the dynamics in the initial phase of psychotherapy.

Music therapy with forensic psychiatric patients

Music therapy is described to offer a unique contribution to treatment of persons in forensic psychiatric hospitals or prisons (Chen & Hannibal, 2019; Compton-Dickinson,

2014; Gold et al., 2014; Hakvoort et al., 2015; Hakvoort & Bogaerts, 2013; Leith, 2014), to increase self-esteem and social competencies and reduce anxiety and depression in offenders (Chen, 2014), and to increase the experience of self-perception in female patients (Leith, 2014). According to music therapy researchers (Frederiksen & Ridder, 2020; Hakvoort et al., 2015; Metzner, 2010), FPP with schizophrenia are offered an opportunity to express inner states in a creative and active way through music experiences and at the same time maintain a feeling of control. As stated by Jackson (2010), the music in music therapy allows for expressing anger in a safe and social acceptable manner, enhancing trust in the therapeutic relationship. For forensic patients in general, their relational competencies are described to increase in music therapy by reducing controlling, intrusive and possessive behaviours (Compton-Dickinson, 2014; Compton-Dickinson & Hakvoort, 2017), and their bodily grounded feeling of confidence to be supported through arousal regulation (Compton-Dickinson & Hakvoort, 2017; Hakvoort et al., 2015).

For patients with schizophrenia alone (and not in forensics), music therapy is described as a supportive, non-verbal and non-threatening approach that enhances emotional involvement without challenging the experience of losing control (Jensen, 1999; Pedersen, 1997). Based on a systematic review and meta-analysis of 18 studies, it is concluded that music therapy improves global and mental state, social functioning, and quality of life of people with schizophrenia or schizophrenia-like disorders (Geretsegger et al., 2017). For patients suffering from psychosis, music therapy is described to allow for meeting the patient's desire for interpersonal contact through synchronization and attunement (Metzner et al., 2018). Using musical improvisation, the therapist provides an unobtrusive musical space and supports with subtle rather than

structured accompaniment in order to prevent experiences of fusion anxiety, enhance self-object boundaries and nurture alliance (Metzner et al., 2018). In a study including patients with schizophrenia and borderline diagnoses, music therapy showed a low drop out and maintained the patient's motivation and engagement in the therapeutic relationship (Hannibal et al., 2012).

We found no studies on therapeutic alliance building in music therapy for FPP with schizophrenia. However, several studies reported positive results on overall social functioning with patients with either schizophrenia or in forensic psychiatry. This point at music therapy as a promising means for supporting therapeutic alliance also for FPP with schizophrenia.

Research aim

Therapeutic alliance is important for the outcome of psychotherapy, but difficult to establish in FPP with schizophrenia due to their symptoms of antisocial behaviour. Music therapy provides positive results on social functioning for forensic patients and for patients with schizophrenia, and we therefore aim to identify and explore the dynamics in the developmental process of forming a therapeutic alliance for FPP with schizophrenia in the initial phase of music therapy.

Methodology: Explorative case study research design

We applied an explorative case study research design in order to study the complex dynamics of clinical practice and reveal tacit clinical knowledge. The case design allowed us to generate knowledge by using multiple forms of data collected in the clinical context, and to systematically include multiple perspectives. Therefore rich and substantive data were included, with the purpose to investigate the phenomenon in

detail, situated in real-world-settings (Flyvbjerg, 2010; Ramian, 2012; Ridder & Fachner, 2016; Robson, 2011). This allowed for providing thick descriptions and understanding both subjective experiences, observations and numerical entities as part of the clinical context. It is possible to contextualize a phenomenon by “thickly describing occurrences of the phenomenon in the subject’s worlds of interaction” (Denzin, 2002, p. 360). The case study approach intersects with social and natural science as well as the humanities (Gerring, 2017). It is the bounding of the case in a context that identifies the design and allows for rich empirical inquiry of a person, several persons, a group or a situation (Aldridge, 2005). The explorative function of the case study research calls for a flexible method of data collection, whereby the principles of selection are successively revised and combined with inspection (Alvesson & Sköldbberg, 2018).

Exploring social interaction, and in this case processes of therapeutic alliance, calls for knowledge rooted in the experiences of the participants themselves. Hence, a hermeneutic phenomenological epistemology (Annells, 1996; Laverly, 2003) formed the core of the analysis, specifically drawing on knowledge from first-person experiences of the music therapist. The analysis followed the overall concept of the hermeneutic circle, integrating the researcher’s comprehensive clinical and theoretical knowledge in the process of interpreting data, and identifying meaningful connections and patterns (Kenny et al., 2005; Kvale, 1997). Phenomenology allows for revealing meaning of lived experiences in the process of data reduction. With the purposeful process of data selection and expansion, the most important and necessary knowledge is brought to a condensed meaning (Flyvbjerg, 2010; Ramian, 2012).

We describe the synthesis of going through the levels of structuring, reducing, meaning condensation and interpretation as *abduction*. Peirce was the first to describe abduction as a process that “must cover all the operations by which theories and conceptions are engendered” (Peirce, 1934, p. 414). The abductive synthesis is not strictly logical, but based on creativity in the process of interpretation (Brinkmann, 2013) and on the “researcher’s ability to immerse him/herself in the data and look for patterns, themes and relationships” (Wheeler & Kenny, 2005, p. 66). The immersive nature of the explorative case study research design allows for bridging the gap between research and clinical reality, providing in-depth insight not only in the phenomenon, but also in the co-construction of knowledge throughout the research process.

Method

Context of the study

The study was conducted at a Danish forensic psychiatric hospital with room for 60 inpatients who are hospitalized in a period of six months and up to four years. The hospital has medium secured units, and staff assesses psychopathology, evaluates diagnoses, and offers evidence-based treatment of mental disorder, violent behaviour, and alcohol and drug abuse. Treatment is performed by interdisciplinary teams, and apart from medical treatment includes in-patient milieu therapy, activities, sports, physiotherapy, psychotherapy, occupational therapy, activities using therapeutic music, and music therapy. On the weekly clinical conferences, patients are referred to appropriate treatment. Music therapy is regarded as a psychotherapeutic intervention and is carried out by a credentialed music therapist. The sessions take place at the unit

or in a music therapy room separated from the unit. The duration of a music therapy course varies, but on average lasts a year.

Recruitment criteria

Patients were enrolled in the study when they met the following inclusion criteria:

- Sentenced to psychiatric treatment or placement in a forensic psychiatric medium secured hospital unit in Denmark
- Diagnosed within the schizophrenic spectrum (F20, ICD 10)
- GAF¹ score between 10-40
- Hospitalized maximum a year at point of study inclusion
- Speaks and understands Danish language
- Referred to weekly individual music therapy sessions by the interdisciplinary team

Music therapy intervention

The patients were offered weekly individual music therapy sessions that lasted 30-60 minutes. The therapy was adjusted to the clinical reality of the patient, using a variety of receptive and active interventions in the therapeutic process, such as listening to the patients' preferred music; talking about music with a formal, symbolic or personal

¹ GAF (Global Assessment of Function, Jones et al., 1995) ranges from 1 (Persistent danger of severely hurting self or others) to 100 (No symptoms). The range between 10-40 consists of four categories that overall covers; *Some danger of hurting self or others* and/or *Some impairment in reality testing or communication*.

focus; forming a life story with pieces of music representing periods in the patient's life; singing composed songs with musical accompaniment and with awareness of the regulation of breathing, energy and dynamics; writing and performing song/rap texts; composing beats; playing composed pieces of music with an awareness of the regulation of dynamic elements and introducing small elements of improvisation; and finally, free improvisation on instruments either spontaneous or extemporaneous based on a musical or symbolic theme.

Music therapy approach

The sessions were carried out by the first author who is a registered nurse and a music therapist with a five-year approved university training in music therapy. She has worked as a music therapist in psychiatry for 20 years, and since 2006 in forensic psychiatry. With this extensive clinical experience as the background, the overall aim of the therapy was to facilitate trust and motivation creating moments of meeting. This aim corresponds with the goals for the initial phase of psychotherapy, but with the expectation that more than a few initial sessions are needed to build alliance with patients with schizophrenia in forensic psychiatry. Therefore, this initial phase was framed to last six months. The music therapist applied a supportive psychotherapeutic approach and focused on the patient's existing resources and on facilitating musical experiences with the objective to stimulate and/or support psychological adjustment or growth.

Ethical considerations

The music therapist performing the sessions for the study was also the researcher. This allowed for a first-person perspective, based on more than ten years of clinical music

therapeutic experience in the field, and was a prerequisite for combining clinical insight, reflectivity and meaningful interpretations, and enhancing trustworthiness (Kenny et al., 2005). However, this dual role requires an effort for securing transparency, transferability and accountability and to be open for divergent perspectives. Such situatedness concerns the researcher's position and involvement in the research process and is emphasised as *engagement* in an agenda for conducting qualitative research that guides the researcher to deal with and reflect on central dilemmas and ethical issues. Stige et al. (2009) used the acronym EPICURE in order to consider “the challenges of producing rich and substantive data material based on engagement, processing, interpretation and (self)-critique” as well as “the challenges of dealing with the researchers' preconditions and consequences of research focusing on (social) critique, usefulness, relevance and ethics” (Stige et al., 2009, p. 1504). The EPICURE agenda was applied as an ethical anchor throughout the research study.

The consent form, that each participant was asked to sign, included information on for example anonymization of data and the possibility to withdraw from the study at any time. The study was approved by the Humanistic Research Ethics Board at Aalborg University, reported to the Danish Data Protection Agency, and followed the Danish Code of Conduct for Research Integrity (Ministry of Higher Education and Science, 2014). The music therapist adhered to the Ethical Principles for Members of the Danish Music therapy Association (DMTF, 2016).

Data collection

With the aim to provide rich and substantive data, allowing for thick description, perspectives from both patients, staff and the music therapist were included. Patients were interviewed by a research assistant about their relation to the music therapist. In

addition, they were asked to rate their mood using the Mood adjective checklist (UMACL-TA) (Matthews et al., 1990) and the alliance with the music therapist using the Session Rating Scale (Duncan & Miller, 2000), before and after sessions. The research assistant was available to help the patients, still it was generally very difficult for the patients to carry out this type of self-observation. In order to explore the dynamics of alliance building, the core part of the data consisted of the music therapist's Immediate Therapy Notes (ITN) and Extended Therapy Notes (ETN). The ITN were descriptions of experiences and reflections on the dynamics in the interpersonal relationship, written by the music therapist right after each session. The Extended Therapy Notes (ETN) were written while listening to the audio recording of the session later on the same day, and systematically structured under the following headings: extended observations, subjective reflections and embodied experiences. Music therapy was already an integrated part of the treatment context, and data collected by staff were a part of the daily routines (assessing level of contact, observation, and violence, the latter with the Brøset violence checklist, Almvik & Woods, 1999). Table 1 provides an overview of data sources from these different perspectives. When data was collected just before or after a session, it is labelled with *pre- or post-session* in the table. The patient-interviews were carried out by the research assistant four weeks into the therapy process and four weeks after (*post*) the last session.

Patient perspective	Music therapist perspective	Staff perspective	Charts and records
Semi structured interviews (<i>Post</i>)	ITN: Impressions immediately after therapy (<i>post-sessions</i>)	Level of Contact scale (<i>post-sessions</i>)	Demographic data
Mood Adjective Checklist (UMACL-TA) (<i>pre/post-sessions</i>)	ETN: Extended notes (<i>post-sessions</i>)	Brøset violence checklist (<i>post-sessions</i>)	Transcripts of the audio recorded music therapy sessions
Session Rating Scale (<i>post-sessions</i>)	Empathy exercises (<i>post-sessions</i>)	Level of observation (<i>post-sessions</i>)	Medical charts, incl. information on use of rescue medicine (<i>post-sessions</i>)
	Assessment of relationship (<i>post-sessions</i>)		

Data collected *pre/post* each music therapy session and *Post* the course of therapy.
ITN: Immediate Therapy Notes. ETN: Extended Therapy Notes.

Table 1. Overview of data sources from different perspectives.

Analysis

Four patients were included in the main study. They attended music therapy for respectively 19, 16, 21 and 22 sessions during a period of six months. Data consisted of approximately 60 hours of audio recording which formed the basis of the 1) Extended Therapy Notes, 2) 400 written pages of the descriptive material of the Immediate and Extended Therapy Notes and 3) Eight semi-structured interviews, conducted by a research assistant pre and post therapy, which consisted of 120 minutes of recordings and 64 pages of transcripts. The analysis unfolded in nine steps as illustrated in Figure 1.

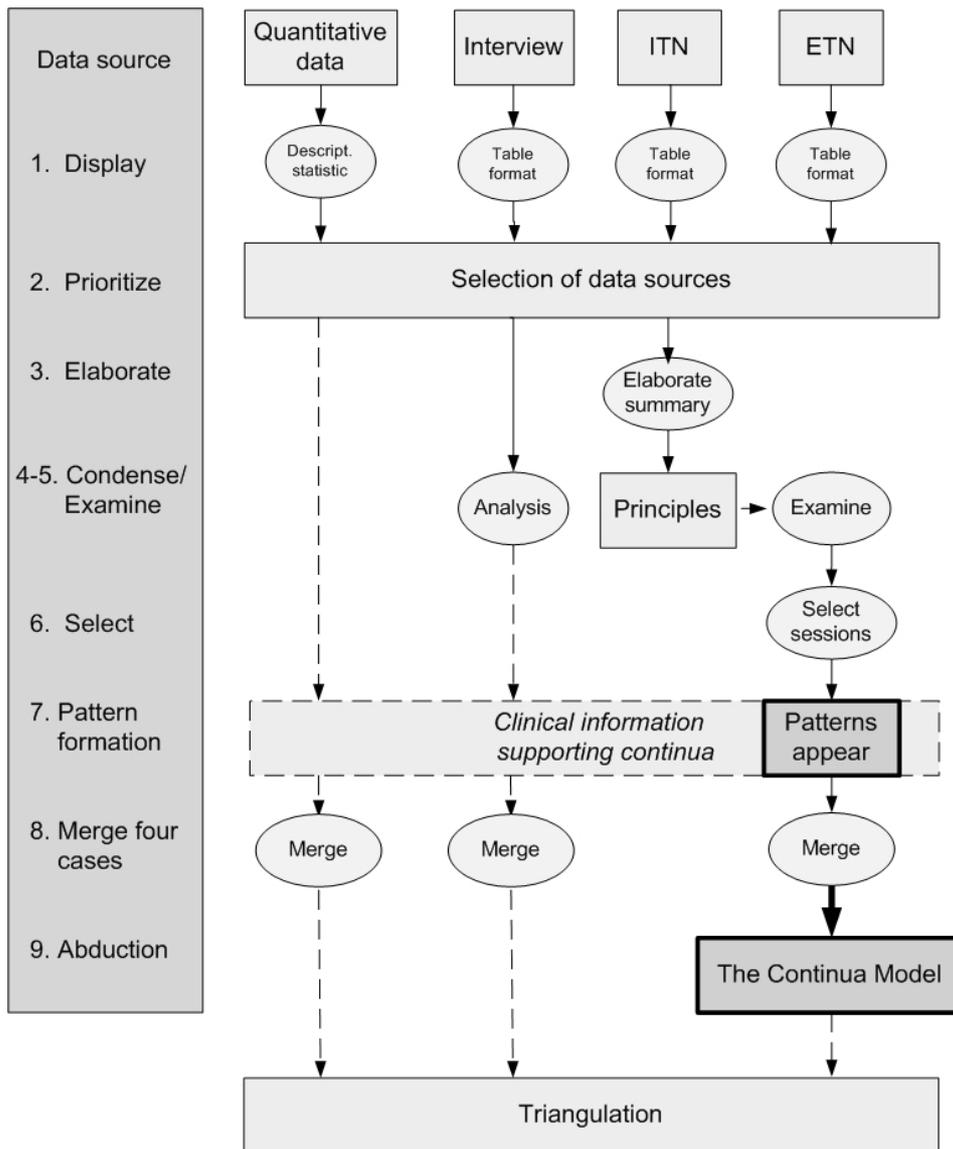


Figure 1. Illustration of analysis process.

Step 1 and 2 of the analysis illustrates the handling of all the collected data in order to get an overall picture. This led to the further elaboration represented by the steps 3-7. In the final part of the analysis, step 8-9, the four cases were merged with the aim of aggregating the parts to a meaningful synthesis. Each of the nine steps are described in the following.

(1) ***Summary and display***

In order to handle the large amount of data, it was necessary to create visual overviews using various summary and display techniques. All material was read, summarized, structured, and organized in spreadsheets and table formats with the headings; 1) Summary of data with keywords, 2) Evaluation of weaknesses and strengths of the data, 3) Focus points for the further analysis, 4) Status between data. The overall picture of the data at this point was that each of the four patients showed no aggravation of their clinical condition, but seemed to show a small tendency towards increased stability in the therapeutic relationship.

(2) ***Prioritization***

It was decided which data was important for providing a broad understanding and which to ‘dive into’ for gaining in-depth knowledge. The Immediate Therapy Notes (ITN) and Extended Therapy Notes (ETN), written by the music therapist, contributed with descriptions of verbal and non-verbal elements in the interaction as well as more implicit alliance revealing dynamics and experiences.

(3) ***Elaboration***

Elaborated summaries of ITN gave an overview and focus for how to analyse the ETN.

(4) ***Condensation***

Meaning condensation of the elaborated summaries of ITN led to the definition of principles for developing therapeutic alliance in the particular case.

(5) ***Examination***

ETN from all sessions were re-analysed in order to detect if and where the condensed principles were unfolded.

(6) ***Selection***

Based on in which sessions the principles were unfolded and represented the most, two sessions per case (all together eight sessions) were selected for further analysis.

(7) ***Pattern formation***

The selected sessions were re-read, summarised, and analysed by means of meaning condensation allowing for themes and patterns to take form.

(8) ***Merging***

The in-depth analyses of each case were brought together in order to find similarities and differences across cases.

(9) ***Abduction***

The systematic process of structuring, reducing, selecting, analysing and re-analysing the ETN from eight sessions, provided in-depth knowledge of the interactional dynamics to support the formation of therapeutic alliance with the four patients. This knowledge was structured, meaningful and manageable, and sensible meaning distilled through a process that facilitated relevant interpretations for a final abductive synthesis. The result was the formulation of seven continua to describe details of alliance building.

Selected case example

In order to bring transparency to the main part of the analysis and give an in-depth understanding of the music therapeutic process, we will illustrate the clinical data and the analysis process for steps 4-7 with one case example.

Background

A man in his 40ies – we will call him Fred – was sentenced to treatment at a forensic psychiatric unit due to serious criminal behaviour bringing other peoples' lives in danger. Fred was diagnosed within the schizophrenic spectrum and was admitted to psychiatric hospitals many times throughout his life. His childhood was characterized by sexual abuse, violence and rejections. He had no contact with his biological family from a developing country far from Denmark, but grew up in foster homes or with foster families. From a young age, he was involved in criminal activity and had a long history of alcohol abuse. He had no education or work experience.

Music therapy

Fred attended music therapy for 19 sessions. He explained that he wanted to attend this service because it was not psychotherapy carried out by a psychologist. Still, during the first months, he wanted to negotiate his attendance, and wanted to exchange it for the freedom to go for walks outside the unit. He told the music therapist that he was an experienced drummer and knew the style of traditional drumming from the country of his biological parents. In this tradition, holding on to a stable pulse for a long time, and at the same time varying the dynamics and intensity of the drumming, would according to Fred make it possible to reach an altered state of consciousness. He further explained that before he was sentenced, he played in a band and performed at concerts. He played a few pieces of this music at the piano, wanting the music therapist to be his audience. The music therapist noted that his music was simple, with no dynamics and repeating the same musical phrases. He talked incoherently, not listening to any remarks or suggestions, and seemed very tensed, both in his way of talking and his bodily expression. The following summary of a selected music therapy session (session

number eight) includes a *numbered coding*, which will be explained in the second paragraph of *Illustration of analysis step 4-7*.

Summary of extended therapy notes (ETN)

In the beginning of the session, I (the music therapist) suggest that Fred plays a Bodhrán drum (Irish drum). He replies that this was also his agenda, but then he starts to tell a story, which is highly imaginative and difficult to follow or interrupt. He is in control, *avoiding interference*¹. I am aware of this dynamic, knowing from earlier sessions that it makes no sense to try to grasp the meaning or ask clarifying questions. I *do neither confront nor confirm or interrupt his story*². I wait for the right timing to repeat and *invite Fred to interact by drumming with me and by that change focus*³.

While drumming, Fred *contains initiatives from me*⁴ and accepts that we are drumming simultaneously. I *hold on to a steady pulse and make small variations together with him*⁵. It strikes me that Fred has the impression that he is controlling the improvisation by lowering/rising tempo and dynamics. Actually, there is little variation and power in his playing. I sense a vulnerability in Fred when he is drumming, which is not as present when he is talking. This vulnerability in the music makes room for the possibility to soften his need for control; *he is being lead and supported*⁶. At the same time as he controls tempo and dynamics, I support his way of playing by matching, following and sometimes *introducing a little more accents and power in the way we are hitting the drums, still holding on to a steady pulse*⁷. There is a resonance in the way we are drumming. We are standing, facing each other, both with a drum, and both *swinging from side to side to the beat – we share control in the interaction*⁸. Still, I experience, that he is convinced that he is in charge and leading the music.

Intuitively, I sense that Fred can handle the introduction of a new element in the music. He seems relaxed and is smiling. *I try to take a little control – and starts using my voice*⁹. Instead of ignoring me, *Fred replies in a non-defensive way, and uses his voice too. He introduces his way of singing, fluctuating between “aij aij aij” and “oie oie oie”*¹⁰. I get the feeling that sometimes he actually follows me, without experiencing it as a threat. He is more relaxed than usual and breathing more freely. This musical way of interaction, fluctuating between accepting, inviting, sharing and taking control goes on for some minutes.

After the drumming he smiles and we *both breathe deeply*¹¹. Spontaneously, he says; “It was fantastic”. I am *smiling too, experiencing a small moment free of struggling*¹² about who is in charge of the power to control.

When starting to talk, he *controls again – repeating and emphasizing that he is teaching me*¹³ how to drum. The content of his talking again develops to a *fantastic and scary story, he accepts no interruption and is dominating the interaction*¹⁴.

Illustration of analysis step 4-7

After each session, the music therapist wrote immediate therapy notes (ITN). From elaborated summaries of these, the music therapist identified case-specific principles for developing therapeutic alliance (step 4). Concerning the therapist role, these included for example: a) Contain the chaos – not insisting on my agenda, b) Carefully disturb Fred’s stereotype play, c) Formulate my role in a way Fred can accept – not insist on being a therapist, d) Carefully facilitate ways of relating when drumming by sharing the same rhythmic and dynamical structures. By further examination of the extended therapy notes (ETN), all Fred’s sessions were re-analysed to see if and where condensed

principles emerged (step 5). Two sessions from Fred, and two from each of the other cases, were then selected for further analysis (step 6). For each of the sessions, patterns were formulated for both patient and music therapist (step 7). In the case of Fred, a pattern regarding *control* emerged. At this point, it became clear that these patterns could not be described as opposite ends (for example as *no control vs. full control*), but seemed to progressively develop step by step. Therefore, in order to understand control as part of alliance building, it was necessary to describe it on a continuum. Following this, *avoiding any form of interference* was placed at the left side of the continuum, with *being able to endure a certain level of interference from the therapist* at the right side, but with various degrees of control in-between. Control was therefore not understood as a dichotomy between patient-control and therapist-control, but in contrary, it was understood as a process of softening and finding ways to deal with control.

The numbered text parts in italics in the case example refer to the numbers in Figure 2, illustrating the therapist's perspective on the dynamics in the interaction. For the contributions or responses from Fred, see the white boxes in the upper row of Figure 2, and for those from the music therapist, see the grey boxes. That both patient and therapist are forming the continuum underlines the two-way, reciprocal process of interaction. This emphasises that the dynamics of developing therapeutic alliance is not a straight-forward chronological process, which is illustrated with the arrows.

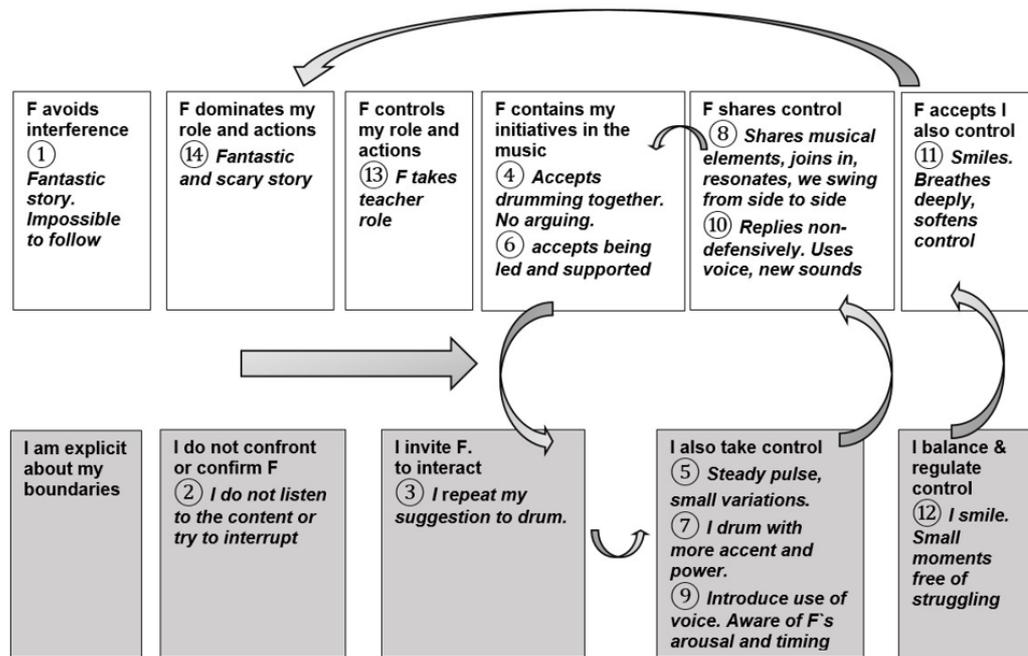


Figure 2. Dynamics of control between patient (F) and the music therapist (I) forming a continuum.

Figure 2 summarises how patterns of control are forming a continuum. Fred was dominating and controlling by talking and correcting the therapist (marked by (1) at the upper row, left side). The therapist accepted this role, but was constantly aware of the right timing for inviting to other ways of interaction without confronting (2). The musical interaction gave her a chance to regulate this power struggle or control issue in a way where he experienced still being in control (3, 4, 5); both were more equal and the therapist got momentarily the opportunity of leading. Fred engaged in the musical interaction, but did also reveal a vulnerability and insecurity. The dynamic is not only a process forward towards a balanced alliance, but with several detours or drawbacks as illustrated with the arrows (for example from 5 back to 6, 12 back to 13). After the improvisation, he acknowledged the interaction in a spontaneous and free manner, and in a short moment, the music therapist experienced an interaction free of control. After

this, Fred again became defensive, controlling and dominating (14). This pattern of interaction reappeared several times. Every time, allowing for short moments of trust and confidence, and for gaining new experiences of mutual interaction, but then returning to the left side of the continuum again. These moments of meeting seemed to strengthen the therapeutic alliance. For Fred, it seemed that implicit knowledge was activated together with new non-verbal experiences of affect regulation in the relationship. This would prepare Fred and the music therapist for entering the alliance differently and with more confidence for subsequent sessions.

In the two interviews, carried out by a research assistant four weeks after starting in therapy, and again after the full course of music therapy, Fred was asked to characterize the relationship to the music therapist. In the interview conducted after the full course of music therapy, Fred answered; “*there is a sense of empathy for each other*”. When asked about the music therapist’s role in the relationship, he answered; “*I know how the structure should be ... we help each other to guide which way to go ... it is me it is all about ... she asks what I want ... she suggests something and then I can say no*”. This example might illustrate Fred’s ambivalence in the relationship and a softening of his need of an omnipotent position, where he usually demands to be on top of the alliance. He seems to realize that he has a choice, which might be an entirely new experience for him.

Findings

We have now given an example of the steps 1-7 in the analysis. Similar patterns emerged across sessions and across the other three cases, and also included other experiences in the alliance building process. In the final part of the analysis, these evolved patterns from all four cases were merged (step 8). A process of abductive

synthesis (step 9) led to the formulation of a continua model consisting of seven continua describing the dynamic process of developing therapeutic alliance for FPP in music therapy. These seven continua were; 1) Control, 2) Closeness/distance, 3) Structure, 4) Process/product, 5) Focus of attention, 6) Interaction, and 7) Verbal dialogue.

Where the *Control* continuum was about structure, clear roles and containing chaos, the *Closeness/distance* continuum described a process of approaching each other from first avoiding contact to respond to challenges in a non-defensive way. The *Structure* continuum ranged from a restrictive to a supportive structure, and the *Product/process* continuum moved from a focus on the musical product, to a focus on interactional and therapeutic aspects of musical activity. The *Focus of attention* continuum described distracted or restricted attention, and how it evolved to inclusive and reciprocal attention. The two final continua included *Interaction*, starting from no interaction, gradually moving towards supportive engagement and mutuality, and finally, the *Verbal dialogue* continuum, ranging from chaotic talk to gradually more structured verbalization and interaction.

The details of the seven continua are presented in Figure 3 showing the patterns of the dynamics between patient and therapist. Various forms of data were collected from four patients and their music therapy session and informed the full analysis as each understanding and perspective added to the knowledge base and the abductive synthesis. The continua model suggests developmental processes of therapeutic alliance for FPP with schizophrenia. The alliance building process may be described by one or more continua for each patient-therapist dyad. It may describe the dynamics in a single session or in a long-lasting process consisting of many sessions. With the case example

of Fred, we have presented the detailed description of only the control continuum. For each of the other continua, a detailed description with case examples is provided in the doctoral dissertation of Frederiksen (2019).

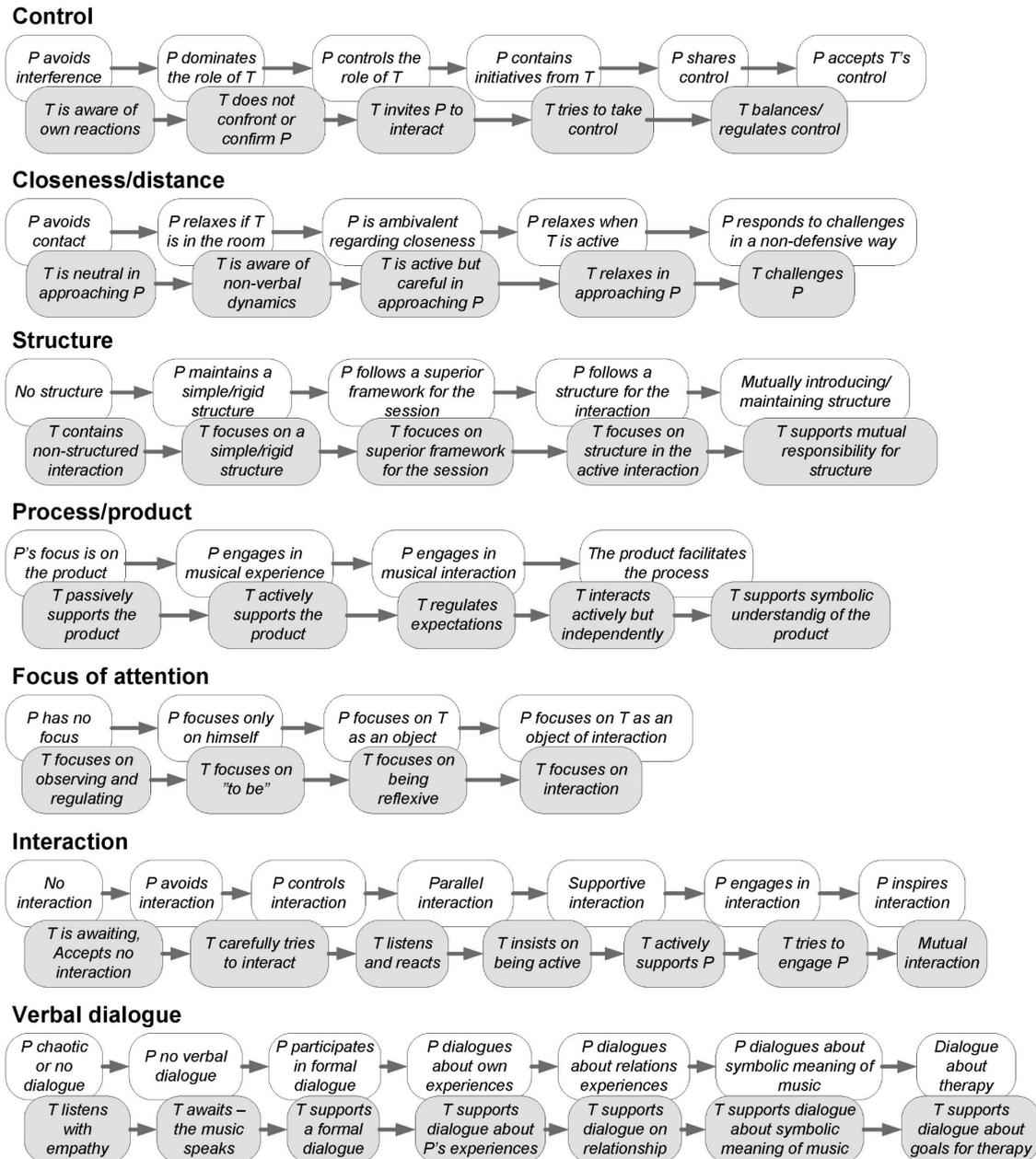


Figure 3. Seven continua illustrating the dynamic process of developing therapeutic alliance for FPP with schizophrenia in music therapy (White boxes: P = patient. Grey boxes: T = Therapist) (Frederiksen, 2019).

Discussion

The purpose of this case study research was to explore the dynamics in the process of forming therapeutic alliance for FPP with schizophrenia in music therapy. Forensic psychiatric patients often experience major challenges when it comes to social interaction, and we argue that there is a need to focus on these processes in the initial phase of a psychotherapeutic course in order to succeed in forming therapeutic alliance. Music therapy is suggested as a relevant approach as it is described to enhance engagement and relational competences through a non-threatening approach for psychiatric patients as well as for offenders. Through a nine-step analysis across four cases, we identified seven continua that give an understanding of the development of alliance building in music therapy for FPP with schizophrenia. We suggest that this understanding may support music therapists in containing forensic psychiatric patient's repeated retreat from contact, and how the patients may—over time—allow for increases in nurturing interactions, and with the detours permitting repairs, progressively leading to alliance building.

Clinical implications

We suggest that the continua model may be used to support clinical music therapeutic work in creating an overview of interactional dynamics in the process of alliance building. The model is grounded in the clinical reality and may be helpful by providing descriptions and concepts and by giving structure to actual observable interactions, reactions and reflections. It could be a tool for explicating non-verbal dynamics and implicit knowledge and for suggesting music therapeutic interventions. To meet the patient at his level of readiness requires flexibility from the music therapist, and the continua model may provide examples for how to adjust in a sensitive way without

threatening the patient's integrity. Likewise, focussing on the patients' interests and resources in the first contact in order to build rapport is emphasised in *The Clinicians guide to Forensic Music Therapy* by Compton-Dickinson and Hakvoort (2017). The wish to meet and adjust to the patient raises an important discussion about balancing between pleasing or challenging. According to Kim (2015), novice music therapists sometimes tend to choose activities where they avoid challenging clients in order to please them. Understanding detours with rejection from the patient as an expected part of the alliance building process may help novice therapists to adjust to the patients, but also to endure rejections and to see the therapy process in a larger perspective.

In the introduction, we have described synchronization and arousal regulation processes as important for alliance building. Beebe & Lachmann (2005) and Schore (2001) point at these processes as essential in a critical period in childhood for developing social competencies. If inner or outer circumstances have hindered the possibility for early attachment, which is often the case for FPP, social competencies are kept immature. According to Lysaker and Daroyanni (2006) it is possible to enhance intersubjectivity and support the development of therapeutic alliance with persons with psychotic symptoms in psychotherapy. The same is pronounced for music therapy (Metzner, 2010). Therefore, we do find indications that music therapy may be beneficial for alliance building for FPP with schizophrenia. The continua model may bring new perspectives on synchronization and regulation. This corresponds to the musical interactions described in music therapy with psychotic patients in order to prevent fusion anxiety (Metzner et al., 2018). For music therapists working for FPP, where alliance building may be complicated by controlling and possessive behaviours, the

continua model could be an inspiration in the way it empathises mutual interaction without the patient losing the sense of control.

Apart from suggesting a conceptual framework for dynamic interactional processes, the continua model may be used for clinically assessing the progression of alliance building. To reach a level of mutual and free interaction in a musical improvisation would indicate a stronger therapeutic alliance than if the patient is constantly dominating the relationship.

The music in alliance building

Forensic psychiatric patients with schizophrenia are sentenced to treatment and as it sometimes seems impossible to establish an alliance and carry out psychotherapeutic treatment, these patients will mostly receive only medical treatment. We have illustrated the data analysis with some excerpts from the case of Fred. He accepted to engage in music therapy and described the role of music as part of his identity and cultural background. Music offered him a way of interacting with the therapist where his symptoms of antisocial behaviour and psychotic anxiety were replaced with glimpses of mutual interaction. Music was used actively by drumming or singing, alone, together or in turns, or by listening to chosen music or talking about music experiences. Music gave the therapist various opportunities to be with the patient. In contrast to conventional verbal psychotherapy, the music therapist had a range of possibilities for engaging socially with the patient to create channels of communication. This was not only about making the patient feel comfortable, but also about building trust, seeing the patient in many different roles, supporting arousal regulation, giving opportunities to interact socially, and to use non-verbal forms of interaction that allowed for expressing his identity.

Limitations of the study

Describing alliance building processes is complicated as they consist of various reciprocal interactions with no possibilities to isolate cause and effect. The nature of an explorative study can only lend a theoretical understanding and conceptualization to alliance building, but it cannot be used to provide proofs of cause and effect. Even with these reservations, there are numerous limitations of the study. The work is based on only one music therapist's insight from her work with four patients. The study therefore provides a context-sensitive, idiographic perspective, however, with the therapist's long experience in the field, this also allows for extracting in-depth knowledge. The therapy notes were subjective descriptions based on clinical practice and collected through an inductive process. This is important to consider, when for example explaining why a term like "control" was chosen as heading for one of the continua, as control is often associated with coercion and non-tolerance. The way themes emerged reflects processes evolving from daily interactional experiences in forensic psychiatry, where the matter of control seems to be constantly present.

The various types of data were collected in order to draw a full picture of the context. In case study research, the context plays an important role for how to understand data and analysis. It is a limitation that we in this article were not able to include full descriptions and interpretations of context, interviews, observations, assessments and reflections.

It was difficult and sometimes impossible for the patients to assess their mood or therapeutic alliance due to dyslexia, inability to focus on the task, or resistance to adhere to such a tool. Their voice is important for the understanding of clinical practice,

and we find it necessary to look for ways of integrating the perspective of the patient that adheres to their current situation.

It is a strength of the case study design that it offers opportunities to investigate highly complex interactional processes and reveals dynamic interactional patterns between humans. We have provided examples of the therapist's experiences through therapy notes with included reflections, thoughts and reactions. These data were collected as a part of daily clinical practice, hereby revealing implicit knowledge about interactional dynamics. They were interpreted afterwards by the music therapist in the role of researcher. The double role as clinician and researcher assured prolonged engagement with data and subjective first-person knowledge, but also kept the knowledge and the interpretations situated in the unique context. Research knowledge from such an idiographic perspective cannot be generalized in a statistical sense, but may still provide input to cumulative knowledge creation if it makes sense to other clinicians and researchers working in similar contexts. The limitation of context specific data collection is important to stress, but in alignment with practice-based research as described by Smeijsters and colleagues in a study on young offenders (2011), we would also suggest that observations and interpretations carried out by clinicians can provide valuable data for research.

We have prioritized the perspective of the music therapist. It is a limitation that we did not include in-depth knowledge from the perspectives of patients and staff in addition to interviews, observations and assessments. It was important knowledge that the patients did not regress and show increased symptoms in our attempt to understand processes of alliance building, but knowledge from negative cases would also have informed the study.

This explorative study may offer an in-depth understanding of complex therapeutic dynamics, but it does not attempt to claim generalized truth. Instead, it aims to develop concepts for understanding mechanisms behind alliance building that may be validated in future studies. Further research should aim to apply the model by other clinicians and in other contexts. The next steps would be triangulation studies, feasibility studies and finally controlled studies with objective measures of patient experiences, symptoms and alliance building.

Conclusion

We have described the process of developing therapeutic alliance to consist of an initial phase with focus on establishing trust, and a second phase allowing for challenges that lead to change. Developing a safe and collaborative therapeutic alliance with forensic psychiatric patients (FPP) with schizophrenia is challenging and long lasting because of their difficulties in engaging in social interactions. Music therapy is described as a motivating and non-threatening approach enhancing the patient's abilities to engage in relationship and interaction. With the main objective to explore the dynamic interactions within this approach and how to support the development of therapeutic alliance, a case study research design was chosen with the aim of identifying and exploring the process of forming therapeutic alliance for FPP with schizophrenia in the first six months of a music therapy course. In the study, four patients with schizophrenia from a forensic psychiatric hospital in Denmark were included. Data covering multiple perspectives were collected and summarized, structured, reduced, condensed and synthesised through a nine step analysis. This led to a model consisting of seven continua describing dynamic interactional processes in the development of therapeutic alliance for FPP with schizophrenia in music therapy. A selected case example

illustrated the process of formulating one continuum, emphasizing the continuous repetition of repair of interactional processes. The continua model may contribute to a clarification and conceptualization of the developmental dynamics in the initial phase of alliance building in music therapy for FPP with schizophrenia, and how music therapy can meet treatment efforts concerned with relational competencies.

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