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– AN EXPLORATORY CASE STUDY RESEARCH DESIGN

BY
BRITTA VINKLER FREDERIKSEN

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AALBORG UNIVERSITY
DENMARK

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CV

Britta Frederiksen was born in 1965 in Denmark. She is a registered nurse and worked for some years as such in psychiatry. In 1997, she graduated from Aalborg University with a Masters degree in music therapy. Since then, she has worked as a clinical music therapist in psychiatry in closed wards, and in forensic psychiatry since 2007. She has worked in medium and high security units. Throughout the years, she has been a member of MIP (Music Therapists in Psychiatry) and through this she has been involved in work regarding the therapeutic relationship in music therapy with psychiatric patients. She worked part time as a clinical music therapist while working on this thesis, and part time as a PhD student. She has published several articles in Danish and in international professional journals.

ENGLISH SUMMARY

The number of forensic psychiatric patients in Denmark has increased markedly during the last 35 years, from 300 in 1980 to 4,500 in 2014. A majority of the forensic psychiatric population in Denmark suffer from schizophrenia and, in addition, comorbidity with personality pathology and personality disorders. The process of developing a therapeutic alliance is of paramount importance for establishing collaboration with the patient on treatment and recovery. Developing a therapeutic alliance with forensic psychiatric patients is a challenging and long-term task because of the patients' major difficulties in engaging in relationships and social interaction, which together with an excessive need of control and a hostile attitude, requires the utmost flexibility and attention of the therapist.

Music and music therapy, was described as being able to create a positive rapport based on the forensic psychiatric patients' interest, and to nurture the patient´s motivation and engagement in interaction. Music therapy was described as supporting the forensic psychiatric patients' ability to contribute and to express themselves, to regulate arousal, and to nurture attachment through non-verbal communication and a non-threatening approach.

A systematic review found no evidence of psychotherapy or music therapy developing a therapeutic alliance with forensic psychiatric patients in general psychiatry, however, an effect of psychotherapy with patients with schizophrenia was found. In the process of supporting the development of the therapeutic alliance, the initial phase was emphasized, where the focus is on nurturing the development of bond, trust and confidentiality, and where it may not be possible to formulate clear goals for the therapeutic process. The patients´ sensitivity to the power divide in the therapeutic alliance and challenges caused by negative symptoms and metacognitive disabilities were found to affect the development of the therapeutic alliance and, thus, were important to consider. In addition, not forcing the therapeutic process while giving attention to interactions at a non-verbal level and nurturing implicit knowledge and positive experiences of being seen and heard by the therapist were described as contributing to softening hostility, increasing intersubjectivity and enhancing relational abilities. Music therapy was described as making it possible to approach the forensic psychiatric patients and to enhance their emotional involvement without challenging them with the experience of losing control. Correspondingly, there is limited research on the therapeutic alliance with forensic psychiatric patients – in music therapy as well as psychotherapy – and especially on how to support the development of therapeutic alliance.

An explorative case study was conducted with the aim of investigating how an analysis of the dynamics of the interaction between music therapist and forensic psychiatric patients with schizophrenia can contribute to describing the developmental processes in the initial phase of developing therapeutic alliance, and, furthermore, how music therapists can contribute to supporting this development.

Four patients suffering with schizophreni and sentenced to placement at a medium secure unit at a forensic psychiatric hospital in Denmark were included in the study. They attended weekly individual music therapy sessions of 30-60 minutes. The clinical interventions included music listening, playing composed music, songwriting, singing and improvisation. The music therapy treatment was adjusted to the clinical reality of the patients and based on a psychodynamic and partly cognitive approach. The sessions were conducted by a registered music therapist.

Data was collected from the first six months of a course of music therapy treatment. Collecting data from various perspectives and sources generated thick descriptions. Through an inductive process based on hermeneutic phenomenology and a nine step procedure, it facilitated relevant interpretations for a final abductive synthesis.

The finding was the formulation of a continua model consisting of seven continua describing the dynamic interactional processes that support alliance building in detail. The continua model may support music therapists as well as psychotherapists working in forensic settings in creating an overview of interactional aspects to be aware of in nurturing alliance building with a specific forensic psychiatric patient with schizophrenia. Rather than a restrictive approach, a regulative approach focusing on synchronization is presented, suggesting that therapists be creative and flexible in the creation of their very first contact, and that they detect positive dynamic interactional patterns that support alliance building. Repeating, and being prepared for rupturing and repairing these dynamic interactional patterns, will lead to a strengthening of the therapeutic alliance.

The continua model contributes to clarification and conceptualization of the developmental dynamics in the initial phase of developing therapeutic alliance with forensic psychiatric patients with schizophrenia. If it is possible to identify and describe dynamic interactional processes in the therapeutic relationship with forensic psychiatric patients with schizophrenia, then this is the foundation for claiming that it *is* possible to develop therapeutic alliances with this patient group. The continua model was developed specifically within forensic psychiatric settings and may support assessment of the process of developing therapeutic alliance with the patients and may, furthermore, support a recognition of the importance of the treatment efforts in this phase of therapeutic relationship with patient with severe mental illness forensic patients.

DANSK RESUME

Antallet af retspsykiatriske patienter i Danmark er vokset markant over de sidste 35 år, fra 300 i 1980 til 4.500 i 2014. At udvikle en terapeutisk alliance er afgørende for at kunne etablere et samarbejde med patienten om behandling og recovery. Flertallet af retspsykiatriske patienter i Danmark har en skizofrenidiagnose og i tillæg har mange komorbiditet med personlighedspatologi og personlighedsforstyrrelser. At udvikle en terapeutisk alliance med retspsykiatriske patienter er en udfordrende og langvarig opgave pga. patienternes meget store vanskeligheder ved at involvere sig i relationer og social interaktion, hvad der – i kombination med et stort behov for kontrol og ofte fjendtlig holdning – kræver stor fleksibilitet og opmærksomhed af terapeuten.

Musik og musikterapi beskrives som værende i stand til at styrke patientens motivation for at engagere sig i samspil, ved at skabe den først positiv kontakt med udgangspunkt i den retspsykiatriske patients interesse. Musikterapi beskrives som støttende i forhold til patienternes´ evne til at bidrage og at udtrykke sig, regulere arousal og styrke tilknytning gennem nonverbal kommunikation og en ikke-truende tilgang.

En systematisk litteraturgennemgang fandt ingen evidens for effekten af psykoterapi eller musikterapi i forhold til at udvikle terapeutisk alliance med retspsykiatriske patienter. I den generelle psykiatri blev der dog fundet en effekt af psykoterapi i forhold til patienter med en skizofrenidiagnose. I processen med at støtte udviklingen af terapeutisk alliance med retspsykiatriske patienter blev der lagt vægt på den initiale fase, hvor der er fokus på at fremme tilknytning, tillid og fortrolighed, og hvor det ikke nødvendigvis er muligt at formulere klare mål for den terapeutiske proces. Patienternes følsomhed over for ulighed i magtforholdet i den terapeutiske alliance såvel som udfordringer, forårsaget af negative symptomer og manglende færdigheder i forhold til metakognition, viste sig at påvirke udviklingen af den terapeutiske alliance og være vigtig at tage hensyn til. Endvidere blev selve det ikke at forcere den terapeutiske proces og samtidig være opmærksom på interaktioner på et non-verbalt niveau samt at fremme implicit viden og positive erfaringer, beskrevet som fremmende ift. at styrke retspsykiatriske patienters evne til at involvere sig emotionelt uden at udfordre oplevelsen af kontroltab. Derudover foreligger der kun begrænset forskning i terapeutisk alliance med retspsykiatriske patienter – både m.h.t. musikterapi og psykoterapi – og i særlig grad manglende forskning i forhold til hvordan man kan støtte udviklingen af terapeutisk alliance.

Der blev gennemført et eksplorativ case-studie med det formål at undersøge, hvordan dynamikker i interaktionen mellem musikterapeut og retspsykiatriske patienter med skizofreni kan bidrage til at beskrive udviklingsprocesser i den initiale fase af

udviklingen af terapeutisk alliance, samt hvordan musikterapeuter kan bidrage til denne udvikling.

Fire patienter med skizofreni og dømt til anbringelse i en mellemsikret afdeling på et rets psykiatrisk hospital i Danmark blev inkluderet i studiet. De deltog i ugentlige, individuelle musikterapisessioner af 30-60 minutters varighed. De kliniske metoder omfattede at lytte til musik, at spille komponeret musik, sangskrivning, sang og improvisation. Musikterapibehandlingen blev tilpasset patienternes kliniske realitet og byggede på en psykodynamisk og delvist kognitiv tilgang. Sessionerne blev udført af en registreret musikterapeut.

Der blev indsamlet data fra de første seks måneder af et musikterapibehandlingsforløb. Indsamlingen af data fra forskellige perspektiver og kilder genererede "thick descriptions" – forstået som detaljemættede og erfaringsnære beskrivelser. Gennem en induktiv proces baseret på hermeneutisk fænomenologi og en ni-trins-procedure faciliteredes relevante fortolkninger som førte til en abduktiv syntese.

Det endelig fund var en kontinua-model bestående af syv kontinua, der detaljeret beskriver dynamiske interaktionsprocesser i opbygningen af alliance. Kontinua-modellen kan støtte både musikterapeuter og psykoterapeuter, der arbejder i retspsykiatriske sammenhænge, med at skabe overblik over interaktionelle aspekter, og særlige opmærksomhedspunkter i forhold til at fremme allianceopbygning med en specifik retspsykiatrisk patient med skizofreni. I stedet for en restriktiv tilgang beskrives en regulerende tilgang med fokus på synkronisering. Terapeuter bør være kreative og fleksible i forhold til at skabe den allerførste kontakt, samt opmærksomme på positive, dynamiske interaktionsmønstre, som kan støtte alliancebygning. Gentagelse af positive interaktionsmønster er vigtig samt at være forberedt på at disse kan, og ofte vil blive, afbrudt eller udfordret. Terapeuten bør i stedet være parat til at reparere dynamiske interaktionsmønstre, da det vil føre til styrkelse af den terapeutiske alliance.

Kontinua-modellen bidrager til at tydeliggøre og begrebsliggøre udviklingsmæssige dynamikkerne i den initiale fase af udviklingen af terapeutisk alliance med retspsykiatriske patienter med skizofreni. Hvis det er muligt at identificere og beskrive dynamiske interaktionsprocesser i den terapeutiske kontakt med retspsykiatriske patienter med skizofreni, er det grundlaget for at hævde, at det *er* muligt at udvikle terapeutiske alliancer med disse patienter. Kontinua-modellen er udviklet specifikt inden for retspsykiatriske sammenhænge og kan støtte en evaluering af processen med at udvikle terapeutisk alliance med patienterne med en skizofreni diagnose. Den kan endvidere medvirke til at fremme anerkendelse af behandlingsindsatsen i den initiale fase af den terapeutiske kontakt med alvorligt syge retspsykiatriske patienter.

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Thank you to my family – Jacob, Thomas and Louis for their fantastic support during the last “marathon” months; for their loving care, making food and outstanding help with computer problems. My kids did grow up during the period, and Jacob who was 10 years when I started told me that in the beginning he thought I was writing about toothpaste – among other things because, as he said, “P.H.D sounded very boring”. The process of writing this PhD might have been easier if I had been writing about toothpaste, but also more boring, I think.

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LIST OF PHD PUBLICATIONS

Article 1:

Frederiksen, B., Ridder, H. M. O., & Pedersen, L. (2015). Research in Music Therapy – Forensic Psychiatry [Approved translation of the Danish paper Forskning i musikterapi – retspsykiatri]. *Tidsskriftet Dansk Musikterapi [Danish Journal of Music Therapy],12*(1), 24–33.

Article 2:

Frederiksen, B. & Ridder, H. M. (2019). The therapeutic alliance with forensic psychiatric patients in music therapy and psychotherapy – a systematic literature review (Unpublished manuscript – submitted) Department of Communication and Psychology, Aalborg University.

Article 3:

Frederiksen, B., Ridder, H.M. & Pedersen, L. (2019). How to support and describe the developmental process of the therapeutic alliance in music therapy with forensic psychiatric patients (Unpublished manuscript). Department of Communication and Psychology, Aalborg University

STRUCTURE OF THE LINKING TEXT

In this PhD thesis, I want to present and describe the process of developing a model that can support clinicians in navigating the challenging process of developing a therapeutic alliance with forensic psychiatric patients with schizophrenia. This model consists of seven continua describing developmental processes in the initial phase of music therapy, where the aim is to nurture trust and confidentiality in the therapeutic relationship.

The thesis is article based, consisting of three articles and a linking text. In the following, the linking text, I aim to integrate the three articles into a cohesive whole and clarify the connection between them. In addition, I will add to the linking text aspects that do not fit into the article format. Four headlines structure the linking text: introduction, literature review, case study and discussion.

Introduction

In the introduction chapter, I will describe the three main concepts in the thesis, first the field of forensic psychiatry and characteristics of forensic psychiatric patients, followed by a description of the history and development of the concept of therapeutic alliance in general and in forensic psychiatry. I will present the history of music therapy in Denmark along with the background and development of music therapy practice. Lastly, I will describe music therapy in forensic psychiatry including a presentation of article 1. In order to situate myself within the field, I will describe my motivation and pre-understandings based on my personal, clinical and theoretical knowledge within the research field. Summing up these introductory chapters, I will describe the rationale for the thesis and formulate aims and research questions. Finally, I will explain the methodological, epistemological and axiological framework.

Literature review

In this chapter, I will present a summary of article 2: the systematic review aiming to reveal literature regarding therapeutic alliance with forensic psychiatric patients in music therapy and psychotherapy. Finally, I will discuss how the literature review formulates the background for the case study research in the thesis.

Case study

As article 3 presents the analysis process and findings of the case study, this chapter consists of a summary of article 3, adding and supplementing in order to secure a comprehensive understanding of the findings. Included in article 3 is a selected case study example describing in detail the complex process of analysing descriptive data. In the case study chapter, I have added a full analysis of all the multiple sources of

data from the three other cases. Finally, I will merge the findings from analysing the four cases in order to conduct triangulation and document how the overall findings of the case study emerged.

Discussion

The discussion section includes a synthesis of the main findings in the thesis and how these findings lead to answering the research questions and contribute to the research field. New perspectives, research and theory are included and discussed in relation to the focus of the thesis. Based on ethical dilemmas connected to my involvement in the research field as both the therapist and the researcher, I discuss the usefulness of the findings in clinical practice. The discussion chapter also includes a discussion of limitations and suggests implications for clinical practice and further research. Finally, a conclusion on the thesis as a whole is given.

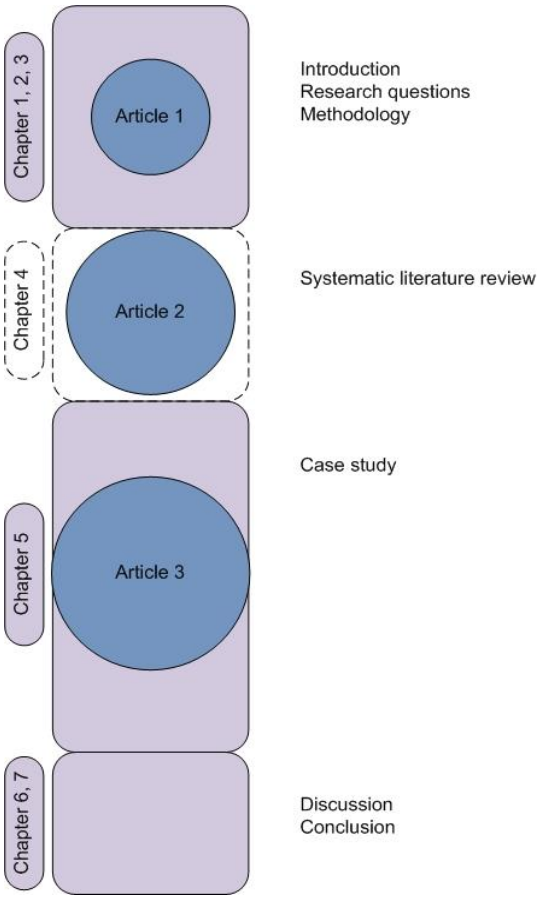

Figure 1-1 Connection between the three articles and the linking text

After the list of references, appendices A-F are added, providing information on the interview guide, rating scales forms and patient information.

The evaluation committee will receive, in addition, appendices 1-9 consisting of the three articles and appendices to illustrate the analysis process and document the full analysis of all sources of data.

CHAPTER 1. INTRODUCTION

Over the past 35 years, there has been a major increase in the number of forensic psychiatric patients in Denmark from around 300 patients in 1980 to around 4500 in 2014 (Kramp & Sestoft, 2008; Sundheds og Ældreministeriet, 2015).

In Denmark, there is a growing focus on empowering the patient as a partner in his own treatment (Region Sjælland, 2015). Addressing topics such as addiction, impulsivity and aggression, differentiated treatment of forensic psychiatric patients is emphasized (H. Hougaard, 2006; Jacobsen & Johansen, 2011). To succeed with effective treatment and rehabilitation of these patients, the development of a therapeutic alliance is of paramount importance in order to obtain an outcome of treatment which not only entails an immediate change in the patient´s behaviour, but a profound change including the patient´s understanding of himself and his problems.

1.1. MOTIVATION

I have been working as a clinical music therapist and, before that, as a nurse with patients with severe mental illness for 25 years. Most of my work as a music therapist has been in forensic psychiatric settings. I experienced how, in music therapy, it was possible to create a structure and a framework based on musical interactions and experiences, where the patients could relax and were motivated to attend and engage in a relationship. Through the musical interaction, I experienced how it was possible to "tune in" to the patient and support non-verbal elements of interaction and communication. For example, a psychotic and withdrawn patient who used to isolate himself in his room managed to attend an activity by just listening to music together with me. Another example was a patient with chaotic and latently aggressive behaviour, who joined in structured drumming, releasing energy, but also experiencing the ability to be part of a mutual interaction.

I experienced how music became a co-therapist in music therapy. The music and the musical experiences also affected me and calmed my agitation in the sometimes rather tense interactions with psychiatric patients. This effect was formulated in an article by Lindvang & Frederiksen (1999) as "increasing the capacity to be empathetic and create a room of resonance for the patient" (p. 57).

Throughout my career as a music therapist, I have been preoccupied with the process of approaching the most vulnerable and resistant psychiatric patients. I have been very interested in how music therapists could achieve a position where the patient would allow someone to help him. My experiences from music therapy groups in acute psychiatric units contributed to developing a music therapy approach within this setting. In addition, clinical experience gained from these groups was described as

being able to structure and regulate the patients' arousal and to nurture the experiences of connection and fellowship (Lindvang & Frederiksen, 2008).

Working in the psychiatric field as a clinical music therapist, I was often confronted with the question of the criteria for suitability of music therapy as a psychotherapeutic treatment in the psychiatric field. A colleague and I discussed these criteria (Lindvang & Frederiksen, 1999) and found that it is possible and relevant to work with certain areas in music psychotherapy that are not possible in verbal psychotherapy. We suggested considering the suitability for psychotherapeutic treatment of patients with severe mental illness in a broader and more dynamic manner based on the needs of the patients (Lindvang & Frederiksen, 1999).

During my career, I have also been part of the group "Music Therapists in Psychiatry" (MIP) in Denmark. The group collaborates on developing methods, assessment and research in music therapy in psychiatry. As a member of MIP, I participated in describing and documenting psychiatric music therapy in several reports and articles (I. N. Pedersen, Frederiksen, & Lindvang, 1998). One of the areas of focus for the MIP group is discussing how music therapy contributes to the development of relationships with psychiatric patients. A statement from a MIP seminar was "Music therapy can address non-verbal arousal regulation at the lowest functional levels and is a therapeutic goal for therapy. Music therapy can structure being together as human beings and validate even a peripheral participation from the patient". This PhD thesis has grown out of and was inspired by the discussions in MIP.

1.2. FORENSIC PSYCHIATRY

In Denmark, forensic psychiatry is part of general psychiatry. It is a subspecialty and concerns the assessment and treatment of offenders with mental illness. Underlying Danish legislation is a general philosophy that psychotic offenders should be treated and not punished (Kramp, 2005) as stated in the §16 of the Danish Penal Code.

> § 16 (1) "Persons who, at the time of the act, were not responsible for their actions on account of mental illness or similar conditions or a state of affairs comparable to mental illness, or who are severely mentally defective, are not punishable" (Langsted, Garde, & Greve, 2011, p. 67)

´Mental illness´ is the legal term for the psychiatric term ´psychotic´. When a person is found guilty of a crime, it is for the court to decide whether the person is responsible and thus punishable. If diminished responsibility due to mental illness is established, the court may decide to make use of other measures than punishment as stated in § 68 (1). "Where an accused person is acquitted in accordance with section 16 of this act, the court may decide on the use of other measures, which it considers to be expedient for the prevention of further offences" (Kramp, 2005, p. 156).

§ 68 (2) mentions other measures than punishment. The most commonly used measures are *treatment orders* or *placement orders*. In cases of criminal offences where an offender poses a danger to others, the placement orders are used. The offender is placed in a psychiatric facility and cannot be discharged without a new court order. Leave is restricted. The psychiatrist decides whether the patient should be placed in an open or closed ward within the facility (Kramp, 2005). Treatment orders mean that, by and large, the offender is to be treated like any other patient. Normally treatment orders have a time limit. Treatment orders can be on an in- or outpatient basis. On an inpatient basis, the psychiatrist makes all decisions concerning leave and the type of leave to be granted (Kramp, 2005).

In a survey from 2015, 55% of forensic psychiatric patients in Denmark were diagnosed within the schizophrenic spectrum (Sundheds og Ældreministeriet, 2015). In another survey this number was 80% (Brandt-Christensen, Balling, & Nitschke, 2018; Kramp & Sestoft, 2008) revealing differences in the examination of this field. It was stated, though, that the number of forensic psychiatric patients was increasing and especially among those patients with schizophrenia diagnoses (Jacobsen & Johansen, 2011). Epidemiological studies on cohort populations abroad and in Denmark found a positive correlation between a major mental illness (schizophrenia) and criminal violence (Arseneault, Moffitt, Caspi, Taylor, & Silva, 2000; Brennan, Mednick, & Hodgins, 2000; Räsänen et al., 1998). Patients with a diagnosis within the schizophrenic spectrum have a substantial disturbance in the ability to connect external sensory experiences and internal bodily and emotional reactions (Simonsen, Møhl, & Tom Havemann, 2010), causing considerable difficulties in their ability to interact in social life. The patients have psychotic symptoms such as hallucinations, delusions and paranoia, and negative symptoms such as isolation and lassitude.

In addition to the challenges caused by severe mental illness, forensic psychiatric patients also have challenges caused by their personality, characterized by antisocial behaviour and personality disorders. A systematic review found that the comorbidity rate of personality disorders among patients with psychotic disorders, including schizophrenia, was 39.5 per cent (Newton-Howes, Tyrer, North, & Yang, 2008). In a forensic psychiatric population, it was found that one third of men and three quarters of women had a personality disorder or a severe personality disorder (Blackburn, Logan, Donnelly, & Renwick, 2003). A research study conducted among a group of 83 men hospitalized in a Danish secure forensic hospital found that most had an early onset of anti-social behaviour before they developed schizophrenia (L. Pedersen, Rasmussen, Elsass, & Hougaard, 2010). Furthermore, it was found that patients with schizophrenia and antisocial behavior had an increased risk of committing violence (Swanson et al., 2008) and an increased risk of committing violence was present even before developing schizophrenia (L. Pedersen et al., 2010). Forensic psychiatric patients often struggle with alcohol and/or drug abuse (Sundheds og Ældreministeriet, 2015). Patients with schizophrenia and alcohol or drug abuse were found to have a

significantly increased risk of committing violent offences (Munkner, Haastrup, Kramp, & Jørgensen, 2002).

Forensic psychiatric patients with antisocial behaviour are described as lacking empathy and having difficulties regulating arousal when they experience discomfort and anxiety; either reacting with violence, impulsive behaviour or seeking isolation in order to avoid anxiety and the feeling of discomfort (Hakvoort & Bogaerts, 2013; Smeijsters & Cleven, 2006)

In the following, I will give an overview of the research on the often multiple causes of the problems and symptomology of forensic psychiatric patients.

In doing so, I will refer to Theodor Millon, an American psychologist who researched the development of personality and described how the strength of a person´s personality is a protection against psychosocial stress and developing mental illnesses such as schizophrenia (Millon, 1990). In the following, I will refer to the psychopathological development of personality in order to address and describe the causes of the problems and symptomology of forensic psychiatric patients.

Millon (1990) emphasized a developmental perspective and the importance of integrating different theories, He described four levels: cognitive-behavioral, psychodynamic, phenomenological and bio physiological, and he emphasized the combination and interaction of aspects from all four levels in order to explain the development of personality .The following overview is based on these four levels and addresses research in genetics, neuropsychology and developmental psychology.

Research on the effect of genetics has investigated the risk of psychopathological development among relatives of persons with schizophrenia. A study found a triple risk of developing a personality disorder among relatives of patients with these disorders (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988). In addition, research within this field has focused on identifying specific genes. The Norwegian psychologist Karterud et al. (2013) concluded that reactivity of emotional systems in the brain, temper, intelligence, attention and ability to show empathy was influenced by genetic factors and in addition, affected the development of personality. A study of Caspi and colleagues (2002) found a specific gene that code for an enzyme with an important role in cerebral processes, where signals from one cell are sent to another. Among children with poor levels of social functioning who had experienced neglect there was found a lower risk of developing antisocial behaviour if the children also had this specific gene variation (Caspi et al., 2002). In particular, the genetic background for symptoms such as impulsivity and aggression have been subject to investigation, including the effect of cerebral processes on activation and inhibition of these symptoms. In one study including patients with a borderline personality, affective instability and affective dysregulation was found to have a high correlation to the genetic background (Siever, Torgersen, Gunderson, Livesley, & Kendler, 2002)

and related to a higher activity in subcortical amygdala and lower activity in left interior frontal gyrus in cerebral cortex (Mathiesen & Thomsen, 2017). Still, although genetics affects the development of personality, it is as stated by Mathiesen & Thomsen (2017), interaction with others, for example attachment experiences and psychosocial factors, that is the most important factor in the development of personality.

Research in neuropsychology has focused on the effect of cognitive functions and the ability to regulate arousal. "Cognitive dysfunctions, such as impaired ability to plan, impaired mental flexibility, or repression of responses or visual memory, as well as impaired processing of negative emotional stimulus, were found among patients with an antisocial personality" (Mathiesen & Thomsen, 2017, p. 109) (my translation). At the same time, it was stressed that these cognitive disabilities were dependent on the person´s ability to be aware and concentrate, which again was dependent on the person´s ability to regulate arousal (Mathiesen & Thomsen, 2017). Therefore, it is difficult to reveal exact cause-effect relationships between organic reasons for cognitive dysfunctions and the development of personality disorders. However, studies of the brain structure, show diminished volume in different parts of the cerebral cortex among patients with an antisocial personality (Mathiesen & Thomsen, 2017). In addition, a connection between the neurobiological syndrome called minimal brain dysfunction (MBD) and developing a borderline personality was found. MBD described as causing a combination of cognitive deficits in language, episodic memory, attention and motor and perceptual abilities (Shaywitz, Cohen, & Shaywitz, 1978). The clinical symptoms of an MBD as emotional vulnerability, difficulties in controlling anger and impulses, and a weak sense of identity and low self-esteem were found corresponding with diagnostic criteria for borderline personality (Murray, 1979) .

Forensic psychiatric patients were described as extremely dysregulated (Sørensen, 2004), indicating a dysfunction in the regulatory processes at a neurobiological level. In particular, the regulation of arousal in the autonomic nervous system has been described as the basis for secure attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988; Hart, 2006; Schore, 1994), and development of a coherent self (Stern, 1991). The ability to regulate arousal has been described as founded in the infant´s first experiences of interaction with a primary caregiver, who becomes an external regulator of the neurochemistry in the infant´s brain and through this supports the development of regulatory processes in the brain (Stern, 1991). Bowlby (1988) described how infants express their needs through the arousal system by crying, for example, and the way the caregiver reacts to this may serve to regulate the state of arousal, facilitating communication, safety and reassurance. "Moderate levels of arousal cause a positive physical state and focused attention in the infant, while extreme levels of arousal (high or low) cause a negative physical state and distracted attention" (Schore, 2003, p. 26)**.** The interaction and communication between the infant and caregiver was described as primarily non-verbal and expressed through

bodily and sensory channels and the infant's first emotional experiences. These experiences were named vitality affects (Stern, 2001). These experiences of vitality affects were described as very important, forming an organizing principle throughout life and creating the basis for self-regulation (Schore, 2003; Stern, 1991) and interaction with other people.

Early relationship experiences are embedded as inner representations of interactions in the infant, and they nurture either a secure or an insecure attachment. A secure attachment was emphasized as one of the most important protecting factors in preventing psychopathological development. An insecure attachment was described as being either anxious-ambivalent, anxious-elusive (Ainsworth et al., 1978) or disorganized (Main & Solomon, 1990). The disorganized attachment style was found in particular among patients with a borderline personality, but also in general among patients with personality disorders (Bateman & Fornagy, 2004; Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010). In addition, studies have found that a childhood characterised by neglect, aversive parents, hostility in the family, lack of boundaries, as well as physical and sexual abuse, increases the risk of developing a personality disorder (Afifi et al., 2011; Cohen, Crawford, Johnson, & Kasen, 2005). Emotional neglect and sexual abuse were found to have the strongest influence on the risk of developing a personality disorders (Hernandez, Arntz, Gaviria, Labad, & Gutiérrez-Zotes, 2012). Another important research area for explaining the symptomatology of forensic psychiatric patients is the aspect of developing the ability to mentalize. Mentalizing is among others described by Allen, Fonagy and Bateman (2008) as "the ability to understand mental states in oneself as well as others" (p. 2) and the ability to be able to "connect behaviour and actions to mental activities as wishes, needs, fantasies, and intentions" (p. 4). "Patients with a borderline personality are described with a tendency to misunderstand and misinterpret actions, behaviour and intentions caused by a deficit in the ability to understand mental states in oneself as well as others" (Bo, 2017, p. 128) (my translation).

Swanson and colleagues (1997, 2008) emphasized that, in addition to treating the psychotic symptoms in forensic psychiatric patients with schizophrenia, there is also a need to address antisocial behaviour. I will add to this the need to supplement psychopharmacological treatment with treatments of psychosocial and psychotherapeutic nature. This emphasizes the importance of developing a therapeutic alliance with the forensic psychiatric patient.

1.3. THERAPEUTIC ALLIANCE

The concept of the therapeutic alliance has developed historically from an interest in the special relationship between the therapist and the patient, and the potential of this relationship. The effect of this specific relationship has been described within two areas. Either it facilitates collaboration regarding psychotherapeutic themes or the

character of the relationship is able to create a change in itself (E. Hougaard, 2004). Still, it was the emotional character of the relationship rather than the therapeutic techniques that were found to have an effect (E. Hougaard, 1986; Szasz, 1957). Freud (1913) emphasized conscious and positive transference as a precondition for success in psychoanalytical treatment. According to Hougaard (2004) is the work of Carl Rogers (1951) one of the most important influences on the description of the relationship between therapist and patient. Based on humanistic psychology, Rogers (1951) described what he called client-centred therapy. In addition, he formulated the necessary conditions for therapeutic change: empathic understanding, authenticity, unconditional positive regard (Rogers, 1957). The ability to create psychological change relying only on the facilitating conditions mentioned above has not been confirmed in research (Lambert, DeJulio, & Stein, 1978) it is, on the other hand, considered very important, as it gives the therapist the necessary influence to bring about change in the patient (Horvath & Luborsky, 1993; Strong, 1968). From this background, the concept of therapeutic alliance was developed, emphasizing as well the rational parts of the relationship and the therapist´s directive role in working towards therapeutic goals and change in the patient. The therapeutic alliance was referred to as a therapeutic relationship, a working alliance, a helping alliance or a treatment relationship (Bordin, 1979; Greenson, 2008; Horvath & Luborsky, 1993; Thorgaard, Haga, Hansen, & Rønnow, 2006). Moreover, in a number of studies, the character and quality of this therapeutic alliance was found to have a significant effect on the outcome of therapy (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Luborsky, 1993; E. Hougaard, 2004; Martin, Garske, & Davis, 2000; Nissen-Lie, Monsen, & Rønnestad, 2010). Bordin (1979) was one of the first to define three basic elements in the therapeutic alliance 1) the emotional bond, 2) agreement on goals, and 3) agreement on method. The therapeutic alliance and its effect has been one of the most researched areas in psychotherapy.

Based on a long career in psychotherapy research, Danish psychologist Esben Hougaard (1994) created a heuristic alliance model. Hougaard merged the many different contributions to the theory in order to describe and conceptualize the therapeutic alliance. Central to the model was Hougaard's description of how the therapist, patient and goal affect each other in a complex relationship. Hougaard (1994) described how the therapist as well as patient contributes to the therapeutic alliance within the personal as well as collaborative relationship. In the personal relationship, the patient contributes trust and kindness, as well as being accommodating and susceptible to empathy, while the therapist contributes authenticity, warmth, unconditional accept and empathy. Both contribute to an agreement on the level of intimacy and direction. In the collaborative relationship, the patient contributes motivation and positive expectations, while the therapist contributes expertise, engagement, and strengthening of the patient's expectations. Both contribute to the agreement on goals and tasks for the therapy. The model is presented (E. Hougaard, 2004, p. 281).

Basically, the therapeutic alliance is described as building on the feelings and attitudes that the patient and therapist have towards each other and the manner in which these are expressed (Horvath, 2001). The therapeutic alliance is the specific type of relationship between the patient and therapist, which takes place in a setting oriented towards the patient's change and development.

Most of the research on therapeutic alliance was conducted within a psychotherapeutic conceptual framework, with clients characterized by motivation and cognitive and emotional capacities to cooperate and involve themselves in psychotherapy. It was suggested that a rapport or bond should be established within 3-5 sessions (Horvath, 2001). The results of these studies were criticized as not directly transferrable to psychotherapy with patients with severe mental illness in psychiatric settings (Priebe & McCabe, 2006; Ross, Polaschek, & Ward, 2008). The task of establishing trust and security in the alliance with patients with severe mental illness is very challenging because of the patient´s avoidance of social interactions caused by paranoia, negative symptoms and fear of intimacy. Clinicians with many years of experience in the treatment of patients with schizophrenia stated that establishing a satisfactory level of trust and collaboration with these patients might take half a year (Sørensen, 2004; Thorgaard et al., 2006). Therefore, I find that patients with severe mental illness are not able to contribute to the therapeutic alliance as described in the model of Hougaard above. The aim must be on developing the therapeutic alliance by, first of all, working on establishing a bond with the patient where he feels safe, feels trust and is able to be receptive to empathy and help. Secondly, when the patient feels confident, it is possible to work on the patient's motivation to cooperate and make an agreement on the goals for the therapy.

The concept of the therapeutic alliance has also been influenced by object-relations theories (Winnicott, 2005) and attachment theories as described by Bowlby (1988). Generally, attachment was described as being of paramount importance in the process of nurturing the therapeutic alliance (Sauer, 2003). Moreover, the importance of this perspective is very important to consider when the effort to develop therapeutic alliance includes patients with severe mental illnesses, as these patients are described as having insecure attachment orientation. Attachment was described as facilitated by the non-verbal communication of synchronization and regulation of arousal (Schore, 2001). Repair of this attachment capacity through supporting the patient´s ability to self-regulate was suggested as a prerequisite for developing therapeutic alliance (Beebe & Lachmann, 2005; Schore, 2001). Facilitating self-regulation requires a balancing of the autonomic nervous system including the use of body language and was described as crucial in developing rapport and relationship with fragmented, psychotic patients and patients with severe mental illness (Sørensen, 2004; Thorgaard & Haga, 2006). Supporting the patient in regulation of arousal may make it possible to nurture small moments of connectedness and may become the first tiny steps in developing a treatment alliance with patients with severe mental illness patient (Thorgaard & Haga, 2006). McGlashan (1989), who researched early intervention

with patients suffering from schizophrenia, described eleven relational process levels (Thorgaard & Haga, 2006). The first of these levels was identified as indifference. This level described how the therapist does not exist for the patient and how the relationship is unpredictable. Gradually, the process develops and moves towards the levels of attachment, supportive working alliance and then psychoanalytical working alliance (Thorgaard & Haga, 2006, p. 132).

1.4. MUSIC THERAPY

Music therapy in Denmark was first developed in the field of special needs education, supporting development and learning in people with special needs. During the 1970s, music therapy was influenced by psychoanalytical and psychodynamic thinking and developed in the direction of psychotherapy (Bonde, 2014).

In 1982, a music therapy training course was established at Aalborg University, and the profession of music therapy developed from "an ideologically and experientially based approach towards a theory-based approach" (Bonde, 2014)(my translation). The music therapy training was organized in three areas, which remain the same today. These areas are 1) the training of *musical skills*, 2) the training of *therapeutic skills*, 3) *theoretical* courses. Today, 230 persons have completed music therapy training at Aalborg University. They are employed in various fields, such as special education institutions, hospices, somatic and psychiatric hospitals, nursing homes for elderly with dementia and homes for refugees.

1.4.1. BACKGROUND FOR THE THERAPEUTIC USE OF MUSIC

Why and how music affects us physiologically, psychologically, existentially and socially may be explained based on the theoretical framework offered by the field of music psychology (Bonde, 2009; Ruud, 2016).

Basically, music affects us through musical parameters such as rhythm, tempo, pitch, volume and timbre. Christensen (2014) gives an overview of neuroscientific research, describing "how music activates most of the brain and how the brain´s responses to music are integrated with bodily sensations and activity" (p. 24). Music is described as "having a direct effect on heartbeat, breathing and arousal" (Habibi & Damasio, 2014, p. 93). In addition, because of music´s activation of a large part of the brain, music was found to have an effect on attention, memory and expectation (Altenmüller & Schlaug, 2012).

Musical elements were described as either having a stimulating or calming effect (Wigram & Bonde, 2019). Among others, a tempo with 50-70 beats pr. min (Schou, 2007, p. 536), which correlates to the resting heartbeat in most people was described to have a calming effect. This calming effect was in part explained by entrainment, which is a tendency in bodily reactions to follow tempo and rhythm of music.

Music and emotion is an important focus for music psychology research, and an important contribution to this field is the work of Hevner (1936). She developed a systematic model categorizing the moods that music can create and that people can recognize, and through this she described general reactions to music (Hevner, 1936).

The American philosopher Susanne K Langer (1953) said "the tonal structure we call music bears a close logical similarity to the forms of human feeling" (p. 29) or expressed in a simpler way "music sounds the way emotions feel". Langer´s thoughts are explained by Pedersen & Bonde (2019) as "music expresses something in a sensory, dynamic way, which is similar to the way emotions arise, are expressed and die out" (p. 250).

This description forms the basis for the connection between music and affective attunement as described by Stern (1991) Early non-verbal interaction and communication between mother and infant are described through forms of vitality (Stern, 1991) using musical terms such as crescendo/decrescendo, timing, pulse. This early interaction was described as having a direct impact on the development of the brain and basic psychological structures forming a sense of self (Stern, 1991). Music´s effect on the autonomic nervous system and its potential in regulation of arousal and affective attunement has been described in literature and studies (Trondalen, 2016; Trondalen & Skårderud, 2007).

However, researchers also emphasized that the way in which music affects us has an important individual aspect, depending on the individual's preferences, memories and expectations regarding music (Wärja & Bonde, 2014). Music and how musical experiences affect the development of identity has been researched and described by (Ruud, 2013).

Bonde (2009) identify four basic levels in which music is perceived and affects us and how this influences the use of music therapeutically. These levels are physiological, syntactic, semantic and pragmatic and were identified based on works of Bruscia (1989, 1998, 2014) and Ruud (1990, 1998, 2001). Music and listening to music affect us …

> "physiologically in ways that are possible to measure and describe. At the syntactic level, music is considered a language that has a meaning within itself and with the ability to create experiences of structure and connectedness. At the semantic level, music is considered to have the ability to represent a symbolical meaning and message, and is able to create a connection between a person´s inner and outer experiences. Lastly, on a pragmatic level, music creates an opportunity for interaction and togetherness" (Bonde, 2009, p. 23).(my translation)

The above description of levels of understanding the therapeutic qualities of music is the basis for how music therapy practice and theory have developed. In the following

chapter, I will describe the roots and theories from which music therapy in Denmark has grown and is practiced today.

1.4.2. THE ROOTS AND PRACTICE OF MUSIC THERAPY

The explanation of how and why music is used therapeutically was explored by a number of music therapy researchers and pioneers (Alvin, 1975; Benenzon, 1997; Bonny & Savery, 1973; Bruscia, 1998; Nordoff & Robbins, 1977; Priestley, 1994; Ruud, 1990)). A full explanation of how and why the use of music can be therapeutic is not possible within the scope of this thesis.

Music therapy was defined by Bruscia (1998) as a systematic process of intervention using musical experiences in order to help a client promote health. The aim of music therapy was described as establishing a channel of communication and interaction (Benenzon, 1997), offering a new and different way of communication (Odell-Miller, 2007). The language of music and sound provides an accessible language, in particular with patients with communication difficulties (Odell-Miller, 2007), and I would add, a resistance to communicating verbally.

Music therapy can be either receptive or active. In receptive music therapy, the focus is on listening to pre-composed recordings of music or improvisations, performances or compositions by the patient and/or music therapist. In active music therapy, the patient and/or music therapist participate actively in the musical activity either in the reproduction of composed music, improvising vocally or using the instruments (World Federation of Music Therapy, 2011).

As mentioned above, during the 1970s, music therapy in Denmark moved towards a psychotherapy approach, where the therapeutic qualities of music refers to the semantic level (Ruud, 1990, 1998, 2001). Music is used **in** a therapeutic context and, as such, different from the use of music **as** therapy. The development of music therapy in Denmark was based on a classical psychoanalytical approach rooted in analytical music therapy (Priestley, 1994). Classical psychoanalytical concepts such as transference and countertransference were central in the analytical music therapy understanding of the therapeutic process and relationship (I. N. Pedersen, 2007). Among other things, free improvisation in music therapy was considered "similar to free association and free floating attention in psychoanalytic work" (Odell-Miller, 2007, p. 6). The analytical approach to music therapy differed from classical psychoanalysis in one aspect that is important to mention. Instead of observing and analysing the patient´s relational dynamics from a neutral position and trying not to interfere with the patient, the music therapist was described as actively interacting with the patient. In addition, the music therapist was observant of how she became a part of the patient's interpersonal dynamics. Relational patterns were considered as unfolding within the active interaction at a non-verbal and pre-verbal level and challenging the classical understanding of the therapist´s neutrality (Odell-Miller,

2007; I. N. Pedersen, 1997). According to Pedersen (2007), the music therapist while participating in the active interaction must at the same time be aware of countertransference reactions as intuitive reactions and bodily senses and use these reactions as important guidelines for the musical interaction. Pedersen (1997, 1999) described the music therapist´s balance between closeness and distance as disciplined subjectivity and developed this aspect further, describing a music therapist´s different listening attitudes. The primary method in analytical music therapy was clinical improvisation, based on the function of music as a "symbolic use of improvised music by the music therapist and client, used as a creative tool with which to explore the client´s inner life so as to provide the way forward for growth and greater self-knowledge" (Priestley, 1994, p. 3). Clinical improvisations were based on "play rules" emerging from the patient´s description of "inner images, connected to events, memories, emotions or moods that emerge in the moment" (I. N. Pedersen, 2019, p. 108). In classical analytical music therapy as described by Priestley, the patient and therapist would, after the improvisation, discuss and link the improvisation to the theme and the patient´s life and problems (Odell-Miller, 2007; Priestley, 1994).

Winnicot's (2005) object relations theory had an important influence in the movement towards a psychodynamic approach in music therapy. Clinical improvisations were described as transitional objects where the patient could try out aspects of inner experiences and feelings and be seen and heard, and thus develop secure object representations (Jensen, 1999; I. N. Pedersen, 1999). In recent years, theories of attachment (Bowlby, 1988) have grown out of object relations theory, and been described in a music therapeutic context also (Hannibal, 2013). The potential of the use of music in supporting regulation of affect and communication at a basic non-verbal and implicit level has been emphasized (Hannibal, 2013; Trondalen, 2016).

The psychotherapeutic approach to music therapy and its roots in analytical music therapy has been discussed, problematising among other things "the aspect of verbalizing with client groups who might not have the cognitive capacity to use music symbolically or the ability to communicate through words" (Odell-Miller, 2007, p. 15). The term analytically-oriented has been used by pioneers such as Pedersen (2002) and Odell-Miller (2007) to emphasize the development of a music therapy approach based on analytical music therapy. Odell-Miller (2007) points to modifying the practical music therapy methods with patients with severe mental illness. Among other things, clinical free improvisation is not always followed by reflection of the meaning of it through verbalization.

First and foremost, the music therapist combines professional knowledge about the effects of music as well as knowledge of the patient population in her music therapy practice, supporting and addressing individual treatment goals for the patient. As stated by Pedersen (2019), "music therapists in Denmark have many different approaches in music therapy, but they refer to the theoretical background and concepts of analytical music therapy" (p. 41); among others the understanding of the effect of

the music therapist on the clinical practice and technical rules for ways of being present (I. N. Pedersen, 2019).

Odell-Miller (2007) emphasized a focus on the musical relationship; not forcing verbalization in the therapeutic process, but recognizing the potential of direct intervention within the musical interaction. The very close interaction with the patient at a musical and non-verbal level was described by Bruscia (1998) as a basic and direct way to experience non-verbal reactions to music. In addition, musical interaction provides an opportunity to express difficult dynamics and emotions and experiences such as chaos or anger, without confronting them. As these reactions and dynamics become audible and clear, the possibility of containing and recognizing them arises, supported by the therapist´s musical interventions (Bruscia, 1998). Odell-Miller (2007) described a modification of Priestley´s (1994) definition of clinical improvisation. With a group of psychiatric patients, she described how improvisations might arise from the sounds and music expressed by the group members or grow out of pre-composed musical material. The therapist listened and interacted musically, being aware of the patient´s needs. To give a concrete example of a musical relationship, Odell-Miller (2007) described a patient …

> ”who previously had shown withdrawn, frightened behaviour beginning to beat in a triplet type rhythm quietly on a metallophone, the music therapist sees this as something that could be encouraged musically and perhaps could lead to the patient feeling more able to communicate in others ways. The musical intervention by the therapist was to support from the piano with soft but firm melodic improvised phrases in the right hand, and octaves in the bass in the left, providing a harmonic structure” (p. 8).

I find that the above description of music therapy is parallel to supportive music therapy as described by (2014) as “the therapist uses musical experiences to stimulate or support psychological adjustment or growth, relying largely on the client´s existing resources” (p. 234). Verbal interventions and/or therapeutic challenges can be integrated in the process “at the appropriate time, that is, when the client is ready to work on them, and when the client has discovered the resources needed to accomplish them” (Bruscia, 2014). Music therapy within a psychodynamic framework may serve as the initial therapeutic phase to prepare the patient for approaching challenging therapeutic themes moving towards psychological development and change.

1.4.3. MUSIC THERAPY IN FORENSIC PSYCHIATRY

Article 1

Frederiksen, B., Ridder, H. M. O., & Pedersen, L. (2015). Research in Music Therapy – Forensic Psychiatry [Approved translation of the Danish paper Forskning i musikterapi – retspsykiatri]. *Tidsskriftet Dansk Musikterapi [Danish Journal of Music Therapy],12*(1), 24–33.

The aim of article 1 is to introduce to and create an overview of the literature within the field of music therapy and forensic psychiatry, and as such reflect the state of the art in the area. I was invited to write this article to the Danish Journal of Music Therapy as a part of a series of eleven peer-reviewed articles with the aim of communicating research based knowledge about music therapy in specific areas to other professions. This series of articles was in addition included at the internet portal for the Danish Center for Documentation and research in Music Therapy (CEDOMUS), which is a center connected to the music therapy teaching and research milieu at the Department of Communication and Psychology at Aalborg University (Cedomus, 2018).

There are many types of literature reviews, and the scope of a review will always "depend on its purpose" (Abbott, 2016, p. 56). Literature reviews are research syntheses that provide "critical evaluations of material that has already been published" (American Psychological Association., 2010, p 10). A review may include meta-analyses where quantitative procedures are used, or may be regarded as tutorials where authors clarify a problem and summarize previous research (American Psychological Association., 2010). According to Abbott (2016) "a quality literature review is delimited, comprehensive, coherent, synthesized, and well referenced" (p. 56). The review presented in article 1 is aimed to provide information about the state of music therapy research in forensic psychiatry. In the article, the systematic search for scholarly literature is not described, in contrast to the systematic literature review described in article 2 and where focus is narrowed down to therapeutic alliance with forensic psychiatric patients in music therapy and psychotherapy. Article 1 was adapted to a fixed structure defined by the journal following their suggestions for headings such as "Documented effect" and "Reasons for the effect of music therapy". The article was co-authored with my supervisors and based on a systematic search conducted in 2012. The article was published in 2015, and before publication, the literature were revisited and relevant literature added. It was published in Danish language, however I translated into English, with the English version approved by the editorial board. I will like to stress that the intention of this article was to provide an overview of the literature, in order to not confuse it with a systematic review.

In this review of the literature on a population of forensic psychiatric patients, we found a number of studies pointing towards a positive effect of music therapy on the following outcomes; mood, thought and insight, social competencies, development of coping strategies, and regulation of arousal. However, the number and quality of the controlled studies was, at the time of the search, not sufficient to affirm a significant effect of music therapy on any of the outcomes.
In the article, we described the problems of defining the group of forensic psychiatric patients and transferring results from international research to a Danish context. This is due to differences in legislation and practices in examination and treatment of psychiatric offenders (Frederiksen, Ridder, & Pedersen, 2015).

In Denmark many forensic psychiatric patients are diagnosed within the schizophrenic disorder spectrum and because the focus in forensic psychiatry is on treating the patient´s psychiatric problems, we also included research regarding patients diagnosed within the schizophrenia spectrum disorder. In 2011 a Cochrane review including a meta-analysis on the effect on music therapy on schizophrenia was published, conducted by an international team of researchers. The results showed that music therapy has an effect on global state, especially on improving negative symptoms for patients with schizophrenia (Mossler, Chen, Heldal, & Gold, 2011). We found that this effect was important to emphasize in order to point to an effect of music therapy in forensic psychiatric settings also.

Apart from the psychiatric symptoms of forensic psychiatric patients, we pointed to an increasing number of literature focused on treating the patient´s antisocial and criminal behaviour, which was also reflected in the music therapy research literature. This included ways of expressing anger in music without hurting anyone, and using this as a starting point to develop coping strategies.
Although, we found no significant effect of music therapy in forensic psychiatry, we presented literature explaining and describing how music therapy may create changes in forensic psychiatric patients. This literature described that music therapy can be helpful in motivating forensic psychiatric patients to engage in a relationship, offering an opportunity to express, experience, explore and contain feelings and regulate arousal. The patients may express anger and aggressiveness in a situation where it is socially acceptable. In the literature, it is described how music therapy provides a setting where it is possible to support the forensic patients´ needs for secure attachment bonds and their ability to engage in social relationships through a non-verbal and non-threatening medium. The mechanisms behind these effects are in article 1 referred to as to the communication and interaction in music therapy happening through sound and motion that makes it possible for the music therapist to take an active part in the patient´s expressions. The effect of the music on the autonomic nervous system provides the music therapist with the opportunity to support regulation of bodily arousal directly and through this stimulate comfortable and positive experiences in the reward system of the brain, thus softening negative thoughts and hostility.

Finally, we found that music therapy was described as helpful in engaging and motivating forensic psychiatric patients to cooperate with the treatment (Frederiksen et al., 2015, p.1).

In addition to article 1

The literature included in article 1 was revealed through literature searches in bibliometric databases of scholarly research articles. This meant that books and clinical based literature from non-refereed journals were not included. Studies

including patients with other diagnoses such as borderline personalities were not presented in article 1, as the focus was on presenting literature and research to describe and document music therapy with forensic psychiatric patients with a schizophrenic diagnose. Therefore, in the following section, I find it important to include some additional publications that were not revealed in this first search, but are central to the introduction to the field music therapy and forensic psychiatry.

Music therapy has been applied in general psychiatry in Denmark for about twenty-five years, offering music psychotherapeutic treatment as well as recreational music therapy. Music therapy in forensic psychiatry is a new area, and from a preliminary search in 2012, when I started my doctoral studies, I found that the literature was sparse. Tina Mejsner was one of the pioneers working as a music therapist in forensic psychiatry in Denmark. In a case story, Mejsner (2009) emphasized the use of a regulatory music therapeutic approach, characterized by repetition and predictability, with a forensic psychiatric inpatient in a severe psychotic phase.

In an international context music therapists has contributed with additional literature relevant to mention here. Considering the difficulties in defining the forensic psychiatric patient population and the different music therapeutic approaches Leith (2014) contributed with a comprehensive overview of this area. In her literature review, Leith (2014) revealed conceptual frameworks for music therapist´s working in a forensic setting and found music therapists "situated their work primarily within cognitive behavioural or a process-oriented psychodynamic paradigms" (p. 30). She found that a smaller portion of music therapists applied a psychosocial approach. In addition, Leith (2014) found a "tendency to favour cognitive behavioural or psychodynamic frameworks in the work with offenders with mental illness placed in correctional/forensic psychiatric settings and with a psychosocial approach with prison populations" (p. 30)

The anthology "Forensic Music Therapy. A treatment for Men and Women in Secure Hospital Settings" edited by Compton-Dickinson, Odell-Miller & Adlam (2012) presents a rich material about the variety of aspects that a music therapist meets in secure hospital settings with patients with mental illness and with this illustrates the complexity of this work (Frederiksen, 2014 book review in the NJMT). The book is structured into three sections describing; 1) the institutional setting of secured forensic hospitals including supervision and management 2) the clinical music therapy through cases, and 3) research in music therapy. The research section of the book describes a pilot study investigating the effectiveness of Group Cognitive Analytical Music therapy (G-CAMT) in a group of women with a borderline personality disorder. The aim of G-CAMT was described as creating musical dialogues and through that support the patient´s development of mindful listening and self-reflection on their impact on others (Frederiksen, 2014). In this pilot study the patient´s ability to relate to others was, among others things, measured with the tool `Persons Relating to Others Questionnaire` (Birtchnell & Evans, 2004) developed from the attachment theory of

Bowlby (1988). The results of these questionnaires found "significant improvement through less fear of separation and being alone, less suspicious, uncommunicative and self-reliant behaviour …suggesting that the women developed their abilities to relate to others" (Lawday & Compton-Dickinson, 2013p. 2010).

1.5. PRE-UNDERSTANDINGS

This thesis is based on a qualitative methodology where the researcher´s knowledge and contact with the empirical data is considered a resource (Kenny, Jahn-Langenberg, & Loewy, 2005). This requires a description of the researcher´s pre-understandings in order to enhance transferability and so that others can judge the influence of these pre-understandings on the findings.

In the following, I will describe my pre-understandings based on my background, educational and work experiences, and I will discuss how they may influence the research. Further, I will give an account of a RepGrid analysis I made in order to describe my pre-understanding of the concept therapeutic alliance with forensic psychiatric patients.

Personal values

I grew up in a society based on humanistic and democratic values, and I think this background has supported my belief in the dynamic potential in every individual and in interactions between human beings. I endeavour to show respect for human beings in the sense of believing in their good intentions. This may have given me an approach where I do not always recognize that other persons may have bad intentions or, more specifically in the context of forensic psychiatry, that sometimes the most potent motivation for change is based in the patient´s fear that his sentence to treatment and hospitalization will be extended. This positive view of others may have affected my interpretations of the potentials of facilitating trust and self-reflection in the forensic psychiatric patients.

View of research

In addition to being a music therapist, I am also a trained nurse, and I have worked in hospital settings for many years. The bulk of my prior experience with research was within the concept of natural science, where the aim is to confirm and prove cause-effect relationships. This may have influenced my focus in investigating interpersonal processes, assuming that it was possible to confirm the existence of this phenomenon.

On the other hand, as a nurse, one of the main focus areas is interaction and communication between humans – supporting the patients in their recovery while respecting their knowledge and view of life. As a nurse as well as a music therapist, interaction and communication are in focus when supporting change and helping

people recover. This has given me a grounded understanding of the importance of communication and interaction and of the need for different approaches in order to investigate this phenomenon. I was attracted to psychotherapy because I found it was an ultimate communicative approach in supporting people to enhance psychological growth. This focus on psychotherapy and the power of verbal communication as the gold standard in psychotherapy may have influenced my assessment and appraisal of the psychotherapeutic aspects of non-verbal communication.

Clinical experiences

I have worked in forensic psychiatry for many years and I am influenced by the values and understandings of patients and treatment within this field and within a Scandinavian culture. The use of coercion, control and boundaries is part of the daily interaction with the patients in order to prevent violence and aggression. I do understand why coercion is necessary in some situations and may be a caring action in the treatment of a patient who acts violently because of psychotic experiences and anxiety. These practical experiences of coercion have helped me balance my understanding of the need of coercion and be clear about my own limits. It may have supported me in grounding my research in a real world clinical setting where interactions sometimes are characterized by a power struggle. The experiences of aggression and rejection in an interaction with patients is extreme and may cause defensive reactions and create some pre-assumptions that may have disturbed my understanding of the reasons behind the forensic psychiatric patient´s behavior. On the other hand, it has also prepared me to regulate and contain these experiences and maintain a professional approach.

In my working life, I have experienced how psychotherapy is not offered to all patients and how assessment regarding this often is based primarily on the patient's abilities or disabilities to become involved in a relationship. It has been and is still an important issue for me to change this way of understanding the patient, and include a consideration of the fact that the way one meets and interacts with the patient also affects the patient's ability to involve. This issue may have influenced my observations and interpretations because I want to prove that it is possible to adjust the psychotherapeutic approach in such a way that patients with severe mental illness can benefit from it. To balance the influence of this issue on my research I did a repertory grid to investigate my preunderstanding of the therapeutic alliance.

Repertory grid

The repertory grid (RepGrid) is a method to investigate deep and structural aspects of how a person understands a phenomenon, which would not appear if only parts of the phenomenon were described. The RepGrid method is based on George Kelly´s "Personal construct theory" (Kelly, 1977). Kelly wanted to describe and identify basic connections in the concepts behind a person´s understanding and experiences of a phenomenon. Besides being a researcher, Kelly was also a therapist. He had

experienced how clients divide experiences into implicit opposites, and from this observation he developed the RepGrid method.

In a Danish article, I described in detail the process of working with the RepGrid method and how it clarified my thinking and preunderstandings of the therapeutic alliance with forensic psychiatric patients, and made me aware of biases that could influence my research (Frederiksen, 2015).

I carried out a RepGrid analysis with the help of professor Lars Ole Bonde. Bonde interviewed me in a session that lasted about one hour. For this, I prepared a list of ten cases from my clinical practice as a music therapist in forensic psychiatry. I was then asked to name these cases, based on what I found was characteristic for each of them, for example: "Armour" or "Doll". Through a computer program, the ten cases were combined in different sets of three cases. I was asked to name how I found the dynamics in my relationship with two of the cases compared with the third one, and thus a pair of implicit opposites was created. This procedure was repeated ten times creating ten pairs of opposites or – as Kelly would put it: ten constructs.

The next step was to rate the ten cases on a Likert scale from one to five, evaluating my relationship with the various patients within each of the constructs. A computer program matched my evaluations, created a display of the connections between constructs and cases, and gave a structured and complex picture of my pre-understanding of the elements that define therapeutic relationship in music therapy with forensic psychiatric patients.

Two overall concepts of my understanding of connections were revealed: 1) tension, involvement and the level of reciprocity 2) expressivity and the therapist´s ability to empathize with the patient. The opposites within these concepts are illustrated in *Table 1-1*.

1.Tension, involvement and the level of reciprocity **The patient is indifferent, hostile and has a great need of control, making it difficult to establish an interaction with the patient.** **The patient does not listen, and I sense unreleased tension.** **The roles are unclear and cannot be talked about. The music is often rhythmic, signaling a need for structure.**	**2. Expressivity and the therapist´s ability to empathize with the patient** **The interactions are dynamic and without restrictions.** **There is mutuality in who takes the initiative in musical as well as non-musical interactions.** **The tension is dynamic and positive and it is possible to challenge the patient. We agree on the roles as patients and therapist.** **The patient is motivated, engaged and accommodating.**
2. Expressivity and the therapist´s ability to empathize with the patient **It is very difficult to empathize with the patient. Often I feel/sense nothing in the interaction and must be very aware of tiny attempts to express emotions.** **The expression of the patient is restricted, short and without dynamics, it may be experienced as mechanical. Verbalizing disturbs the relationship and may create resistance in the patient.** **The act of agreeing is not possible – just small suggestions from the therapist are perceived as being offensive.**	**1.Tension, involvement and the level of reciprocity** It is easy to empathize with the patient, among other things because he is expressive, and open to receiving empathy. The music is organic – developing and expressing feelings and emotions. The relationship is not disturbed by verbalizing or interventions – they rather support and strengthen the relationship. It is possible to agree on the roles and the patient can contain disagreements.

Table 1-1 Overall concepts in my preunderstanding of therapeutic alliance

My preunderstanding of the dynamics in the interaction with forensic psychiatric patients in music therapy is closely related to my experiences of being able to act or being restricted. My understanding of the therapeutic relationship is based on the experience of being a part of a mutual interaction and able to contribute to the interaction and empathize with the patient. My ability to act in the relationship is dependent on the expressivity of the patient. The experience of tension in the personal and musical interaction is an important guide for me in order to judge whether the quality of the relationship is either dynamic or rigid and mechanical. The forensic psychiatric patient's ability to contain challenges and the ability to recognize different roles indicates a strengthening of the patient's trust and security in the relationship and are considered an important component in the alliance building process.

The dynamics in the relationship with forensic psychiatric patients as revealed through the repertory grid are not restricted to the non-musical aspects of the relationship. On the contrary, these intrapersonal dynamics also reflect my preunderstanding of the dynamics in the musical relationship with forensic psychiatric patients. When I, for example, experience the dynamics in the interaction as mechanical, it is also a characteristic of the musical relationship. Actually, in the specific relationship, this feeling of a mechanical dynamic was expressed even more clearly in the musical

interaction meaning the musical expression followed a very fixed structure in relation to rhythm, volume and with no tonal adaptation and it helped me to realize that it was also underlying in the non-musical relationship. This also means that I consider that there is a parallel between the dynamics revealed in the musical relationship and in the non-musical relationship.

Definition of therapeutic alliance

The therapeutic alliance is difficult to define because it is both a description of the ideal components in a therapeutic relationship but it is also a developing relationship between a specific therapist and specific patient.

I do understand the therapeutic alliance as consisting of a personal relationship and collaborative relationship as described in the model of Hougaard (1994). He did not, however, describe the quality of the components in the therapeutic alliance. As there are many levels of interaction, the patient´s ability to engage may only be seen in short glimpses.
On the other hand, it seems impossible to characterize the relationship as a therapeutic alliance if the therapist and patient are merely in the same room and there is no interaction or agreement regarding the content of the meeting whatsoever. There has to be a minimum of safety and agreement in the relationship about working with therapeutic issues.

Therefore, in this study I will explore the development of the therapeutic relationship – musical as well as non-musical - between therapist and patient and how the components in this relationship support the process of developing the therapeutic alliance.

CHAPTER 2. RESEARCH QUESTIONS

2.1. RATIONALE FOR THE STUDY

Forensic psychiatric patients are described as having severe problems in their ability to form personal relationships, and to be part of and engage in social interactions, because of their severe mental illness. Small moments of emotional connectedness with another person may be the limit of what the patient can handle. In addition, forensic psychiatric patients often exhibit antisocial behaviour with an inability to empathize as well as being controlling and hostile. Combined with a lack of recognition of their psychiatric illness and need for help, the task of establishing collaboration with forensic psychiatric patients is very challenging. It may be questioned whether patients with severe mental illness in forensic psychiatry are able to form a therapeutic alliance. A majority of forensic psychiatric patients are in a Danish context diagnosed within the schizophrenic spectrum.

Achieving a position where the forensic psychiatric patient will allow the psychotherapist to support and help him to recover requires a focus on nurturing and developing the therapeutic alliance. In the initial phase of psychotherapy, there is a need to investigate and explore how to establish a satisfactory level of trust and confidentiality in the therapeutic relationship with forensic psychiatric patients. As will be explained later, the duration of six months for this initial phase was considered relevant.

Music therapy is described as an active experiential approach supporting engagement and motivation. In music therapy, it is possible to `tune in` to the patient, regulate non-verbal reactions and nurture moments of connection and communication and, through this, help the patient to relax in the interaction. Music therapy may be a relevant approach to nurturing the first steps in developing trust and confidence in the therapeutic alliance with forensic psychiatric patients. Investigating these moments of connection and contact between the music therapist and forensic psychiatric patient in the initial phase of a music therapy treatment may contribute to exploring how to nurture and support the developmental processes of therapeutic alliance.

2.2. AIM AND RESEARCH QUESTION

The overall purpose of this research is to **investigate whether it is possible to develop therapeutic alliance with forensic psychiatric patients with schizophrenia in music therapy,** summarized in the following research questions.

Research questions

1. What is the evidence base for therapeutic alliance building in music therapy or psychotherapy with forensic psychiatric patients?
2. What is emphasized in the literature regarding *how* it is possible to develop and establish a therapeutic alliance in music therapy or psychotherapy with forensic psychiatric patients?
3. How may the dynamics in the developmental process of forming a therapeutic alliance between music therapist and forensic psychiatric patient with schizophrenia in the initial phase of music therapy be described?

Aims

In order to answer the research questions, the following aims were formulated:

To conduct a systematic literature review on therapeutic alliance with patients with severe mentally illness in forensic and general psychiatry and evaluate the benefits of music therapy and psychotherapy in supporting the development of therapeutic alliance. (Article 2)

To conduct a case study exploring the dynamics of the interaction between music therapist and forensic psychiatric patients with schizophrenia in the first six months of a course of music therapy, in order understand and to describe the developmental processes of the therapeutic alliance. (Article 3 and Linking text)

CHAPTER 3. METHODOLOGY

In the following, I will describe the methodology that I applied in order to answer the research questions. This includes describing the epistemology and theory that was relevant for understanding the collected data. In addition, I will outline the principles according to which the case study was conducted and I will present the axiology describing the ethical principles related to planning and conducting the study and ensuring the quality of the research.

As the aim of chapter 3 is to provide a meta-reflective perspective on the research study, I will come back to the more detailed and specific methods and procedures used for data collection and analysis in chapter 5.

3.1. CASE STUDY RESEARCH

The aim of the research is to study the complex dynamics between patient and music therapist, and therefore I have applied a case study research design. “The case study research design is particularly useful for investigating knowledge of clinical practice” (Ridder & Bonde, 2019, p. 168). This type of research design is described as the investigation of a phenomenon in detail and in depth within a system and in a real life context (Flyvbjerg, 2010; Ramian, 2011; Ridder & Fachner, 2016; Robson, 2011), with the aim of “finding overall meaning and patterns and understanding outcome” (Ridder & Fachner, 2016, p. 602). What is special about the case design is that it opens for the possibility to include “multifaceted data from various sources and perspectives, among others to make the context in which the phenomenon occurs as clear as possible” (Ridder & Fachner, 2016, p. 600). This means that quantitative as well as qualitative data types can be included and combined. Depending on the aim of the case study, the emphasis may be on qualitative data and an explorative approach, or quantitative data and an explanatory approach. I aim to investigate a highly human and complex field of social interactions, in order to understand why and how the interactional dynamic between music therapist and forensic psychiatric patients takes place and contributes to the development of therapeutic alliance. Therefore, I found that an emphasis on an explorative approach was required, which means to be open for new aspects and understandings within the field of investigation (Ridder & Bonde, 2014; Robson, 2011). In order to investigate the character and quality of the therapeutic alliance in depth, I found that data in the case study had to be rooted in the experiences of the participants and therefore I emphasized a first-person perspective. The aim of first-person research is to describe “experiences as experienced by the participants which acquires first-hand personal accounts of subjective experience with the phenomenon of interest as directly experienced by self” (Hunt, 2016, p. 907). Data from self-descriptions and self-reflections of the participants involved were included as important sources of data in the study and added to the researcher’s engagement and situatedness in the field. In particular, descriptions from the music therapist who

was also the researcher of the study meant that highly subjective data were included. In order to balance the influence of the researcher's subjectivity, the perspectives of the patients and staff were also included in the data collection; some of these collected with quantitative measures, some by means of qualitative methods. Mixing quantitative and qualitative data added both objective and subjective dimensions to the study. I will discuss this way of mixing quantitative and qualitative data related to paradigms in the following chapter about epistemology.

3.2. EPISTEMOLOGY

Epistemology is the study of what is possible to know and therefore determines how to perform research (Steup, 2018). Traditionally, a study might refer to a quantitative or a qualitative paradigm (Robson, 2011) or an objectivistic or interpretative paradigm (Murphy & Wheeler, 2016). The objectivistic paradigm assumes that there is a single reality that exists independent of human experience of it, and that it is possible to get to know and study this reality through the senses (Murphy & Wheeler, 2016), whereas the interpretative paradigm assumes that reality and truth are multiple human constructions, without one reality of truth but many. Regardless which paradigm we adhere to, knowledge is grounded in our unique experiences (Murphy & Wheeler, 2016). Traditionally, these two paradigms were found to create different points of focus in research and required different research designs and methods to investigate the phenomena studied. According to Robson (2011), some researchers claim that, because "the two paradigms do not study the same phenomenon, quantitative and qualitative methods are incompatible" (p.162). Realism and real world research challenge this division, claiming that the investigation of complex processes in a complex field requires a focus on how it is possible and meaningful to investigate open and uncontrolled situations in a real world setting" (Robson, 2011, p. 30). In real world research the combination of quantitative and qualitative methods are not contradictory but might be the most relevant in order to study a certain phenomenon. Real world research is rooted in a pragmatic approach and refers, to a philosophical position founded by Peirce (1934). Fundamental to Peirce´s pragmatic approach is his understanding of how to obtain clarity about the content of concepts and propositions, and the fact that for any statement to be meaningful it must have practical bearings (Peirce, 1934). According to Peirce, a scientist must be creative in his analogical reasoning and construct reasonable hypotheses, which is beyond the traditional process of deduction and induction (Peirce in Anderson, 2013, p. 8).

Rather than assuming that a paradigm determines the research methods, a real world approach emphasizes a "two way relationship between research methods and paradigms, where paradigms are evaluated in terms of how well they square with the demands of research practice" (Robson, 2011, p. 162). In this study, the research methods arose from the research questions, which were based on what is meaningful in studying the development of therapeutic alliance. Therefore, I chose an exploratory case study design including multiple research strategies. The main part of the study

was based on a hermeneutic phenomenological epistemology and supplemented with a section referring to the inclusion of quantitative data. The purpose of applying a multi-strategy design in this case study research is to provide a multifaceted perspective on the investigated phenomenon and to allow for an open exploration. The numerical data may be a means of reducing information in a systematized way, and the inclusion of standardized scales may offer a way of balancing the subjectivity of the researcher in the collection and interpretation of data.

In hermeneutic phenomenological epistemology, descriptions and interpretations are the main methods. Thick descriptions, including not only objective facts but also embodied experiences and reflections of the participants, are a pre-requisite for grounded interpretations and for a phenomenological approach. Added to this is a hermeneutic approach where "the researcher constantly moves from part to whole reanalysing and reinterpreting the data until the consciousness of a phenomenon has been revealed" (Kenny, Jahn-Langenberg, & Loewy, 2005, p.342). Kvale (1997) describes the hermeneutic approach as "Based on an unclear but intuitive understanding of the phenomenon as a whole, the researcher interprets the parts, and based on these interpretations the parts are connected to the whole in a new way" (Kvale, 1997, p. 58) (my translation). This process of circling between knowledge and interpretations towards enhancing knowledge is referred to as the hermeneutic circle, and the researcher's relationship to the empirical knowledge, theoretical as well as clinical, is crucial in order to collect data and make trustworthy interpretations (Kenny et al., 2005). An important part of this research is the music therapist´s highly subjective clinical notes and self-reflections and the double role as researcher and clinician. This is described by Kenny and colleagues (2005) as an ultimate example of the researcher´s relationship to the empirical data and considered an advantage important for the quality of the findings of the study.

The research process in a hermeneutic phenomenological epistemology is a systematic process, requiring a process of structuring data and creating an overview and general meaning of the material (Kvale, 1997; Ramian, 2011). The process is based on the subjectivity of the researcher and must include multiple data sources and perspectives in order to support the integrity of the research. Kenny (2005), states "The researcher must establish asset of checks and balances that provides diverse perspectives through which to view the phenomenon under study" (p. 341).

3.3. METHOD OF ANALYSIS

The method of analysing the data material in this study followed the principles of handling and analysing data within a case study research design (Ridder & Fachner, 2016). The first step was to create an overview of the vast amount of data, including multiple data sources, quantitative as well as qualitative, in order to prioritize and find where to focus in the data. The aim of the first step of the analysis was also to decide how to use and analyse the different data sources requiring different methods of

analysis. The specific procedures for how the analyses were carried out, are described in chapter 5.

The main part of the analysis follows the overall concept of the hermeneutic circle described as moving deeper and deeper into the material circling between part and whole (Kvale, 1997) and between the empirical material and my clinical and theoretical knowledge. Kenny (2005) described the hermeneutic circle as a way of gaining insight; "it is as much a way of working through our own translations as it is the insight that is uncovered and renamed" (p. 341). Moving into the hermeneutic circle was important and started with an unclear and intuitive understanding of the whole in the first readings of the data material. In practice, this process of getting to know the data continued with reading, reviewing and structuring the material and by creating an overview (Kenny et al., 2005; Kvale, 1997; Ramian, 2011). The next steps in going through the data included interpretation and meaning condensation. The latter was defined as revealing the essence of meaning by reformulating data in a shorter form (Kvale & Brinkmann, 2014). In the synthesis, I went through these levels of data analysis, refering to the process of abduction (see article 2, Frederiksen, Ridder, & Pedersen, 2019).

In order to include the perspective of the patients, semi-structured interviews of the patients were included and analysed through a hermeneutic phenomenological analysis following the principles of meaning condensation and interpretation described by Kvale and Brinkmann (2014).

Other data sources were based on structured self-reports or outcome measures, and these clinical data were analysed by translating the data to numerical entities, making it possible to present them by means of descriptive statistics and to some degree compare the results. These perspectives were not meant to prove a causal effect of the music therapy process, but to add multiple perspectives on the analysis of the therapy notes, presenting a counterpoint to the perspective of the therapist. These highly diverse perspectives on the therapeutic relationship led into the final triangulation process.

Triangulation is defined as "the process of merging results from multiple methods of data collection, sources and perspectives" (Ramian, 2011, p. 181). It is described as a strategy to "enhance the rigour of research" (Robson, 2011, p. 158). To the extent that convergence of results is generated in different ways and by different individuals, the results become more credible through the process of triangulation (Aigen, 2005, p. 359). The detailed procedures in the triangulation process are described in chapter 5.

3.4. AXIOLOGY

As the thesis applies an explorative and qualitative methodology, and interpretations are based on the subjectivity of the researcher, different aspects must be included in

order to balance this subjectivity and to ensure that the process of generating the results is logical and compelling.

Stige and colleagues (2009) developed an agenda named EPICURE to guide the researcher in dealing with and reflecting on central dilemmas and ethical issues when conducting qualitative research. Gold (2010) recommends this agenda for evaluating quality of qualitative research. EPICURE addresses issues to consider throughout the research process, in order to secure the trustworthiness of a study. The name EPICURE consists of two dimensions. The first dimension refers to the first letters - EPIC – and "concerns the challenges of producing rich and substantive data material based on engagement, processing, interpretation and (self)-critique" (Stige et al., 2009, p. 1504). The second dimension refers to the letters CURE and "concerns 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).

Engagement – concerns the researcher´s position and involvement in the inquiry. The researcher must describe his situatedness within the field in order to "prevent an impression that the researcher's pre-conceptions confuse the findings" (Stige et al., 2009, p. 1508).

Processing – refers to the presentation of processes related to producing, ordering, analysing and preserving the data material (Stige et al., 2009), in a way that secures transferability in data collection as well as in the analysis process.

Interpretation refers to the process of creating meaning from the data material. In qualitative research, the researcher's interpretations are part of every step of the research process. As stated by Stige and colleagues (2009), it requires the researcher to reflect upon, describe and consider his preconceptions and use of theoretical frame of reference.

Critique – is described as a careful examination of whether the researcher demonstrates reflexivity in relation to engagement, processing and interpretations (Stige et al., 2009).

Usefulness – refers to the researcher's effort to describe how the research process and products are useful for clinicians, practice and understanding of real world problems and situations (Stige et al., 2009).

Relevance – refers to the researcher's reflections and discussion of how the study contributes to the "development of involved disciplines or within an interdisciplinary field" (Stige et al., 2009, p. 1511).

Ethics – "refers to reflections on how values and moral principles are integrated in the actions and reflections of the research" (Stige et al., 2009, p. 1512). How issues of confidentiality and informed consent are handled. In addition, the researcher's awareness of the consequences of the research, diversity of interest and how perspectives are integrated in the research (Stige et al., 2009).

I used this agenda as a support in the entire process of conducting the study, and will return to this in the final discussion.

CHAPTER 4. LITERATURE REVIEW

4.1. ARTICLE 2. THERAPEUTIC ALLIANCE WITH FORENSIC PSYCHIATRIC PATIENTS IN MUSIC THERAPY AND PSYCHOTHERAPY - A SYSTEMATIC LITERATURE REVIEW

In order to answer the research questions 1 and 2;

What is the evidence base for therapeutic alliance building in music therapy or psychotherapy with forensic psychiatric patients?

and

What is emphasized in the literature regarding how it is possible to develop and establish a therapeutic alliance in music therapy or psychotherapy with forensic psychiatric patients?

I conducted a systematic literature review presented in article 2:

Frederiksen, B. & Ridder, H. M. (2019). The therapeutic alliance with forensic psychiatric patients in music therapy and psychotherapy – a systematic literature review (Unpublished manuscript – submitted)

The article describes the process of planning and conducting the systematic literature review on music therapy with forensic psychiatric patients and presents the results. A preliminary review revealed only few studies on therapeutic alliance with forensic psychiatric patients in music therapy as well as in psychotherapy.

The article concludes:

> "Seventeen studies were included. No studies confirmed the effect of psychotherapy or music therapy on developing therapeutic alliance with patients with severe mental illness in forensic psychiatry, however in general psychiatry an effect of psychotherapy was confirmed. Four studies explored how to support the development of therapeutic alliance with forensic psychiatric patients. The aspect of power divide was highlighted for patients with severe mental illness in forensic psychiatry, further, in general psychiatry negative symptoms and metacognitive disabilities were found to affect the process. Music therapy was described as making it possible to approach the forensic psychiatric patient, thereby enhancing emotional involvement without challenging the experience of losing

> control. A supportive approach and a focus on the initial alliance building phase was suggested to soften hostility and enhance the patient´s intersubjectivity" (Frederiksen & Ridder, 2019, p. 1)

In general, the review revealed a lack of descriptions of how to intervene in the concrete interaction in psychotherapy in order to support the development of therapeutic alliance. As an example; how should the therapist intervene in order to nurture a perception of the therapist as being friendly and supportive or how should the therapist meet the patient´s negative symptoms?

4.2. DISCUSSION OF LITERATURE REVIEW

The review did not confirm an effect of psychotherapy on developing therapeutic alliance with forensic psychiatric patients, however it confirmed an effect on patients with with schizophrenia in general psychiatry. The majority of forensic psychiatric patients in a Danish context were described to be diagnosed with severe mental illness within the schizophrenic spectrum and with challenges in developing therapeutic alliance. Among other aspects, the sensitivity of forensic psychiatric patients to the power divide in the relationship was emphasized as well as the challenge of how negative symptoms and metacognitive disabilities caused by severe mental illness make it a very complicated and long lasting task to nurture trust and confidence in the therapeutic alliance was emphasized. A focus on the initial phase of a psychotherapeutic process was suggested, not forcing the therapeutic process, but softening hostility and thus enhancing intersubjectivity. Music therapy was described as being able to offer an approach that enhances the forensic psychiatric patient´s emotional involvement in the therapeutic process without challenging the experience of losing control.

This I find indicates that music therapy is a relevant approach in the initial phase of therapy, supporting the forensic psychiatric patient to engage and stay in a contact. Then it is possible for the music therapist to support and nurture trust and safety at a non-verbal level, and thus support the development of the therapeutic alliance.

In order to understand interactional dynamics leading to a strengthening of the therapeutic alliance in the initial phase of a psychotherapeutic process, it is relevant to study and describe in detail these processes in music therapy with forensic psychiatric patients. With a focus on how to nurture the development of therapeutic alliance in particular with forensic psychiatric patients with schizophrenia, an explorative case study research was planned and conducted.

CHAPTER 5. CASE STUDY

In order to provide an adequate presentation of the case study and clarify the data processing, the following chapters will summarize the planning process of the study and the handling and analysis of data. Finally, a full analysis of all four cases and all multiple data sources will be included.

5.1. METHODS AND PROCEDURES OF THE CASE STUDY

Recruitment

Patients were recruited from a Danish forensic psychiatric hospital organized with medium and high secure units and approximately 90 inpatients. Data were collected in the period 1 March 2015 till 1 September 2016.

Criteria for inclusion of the patients:

- Referred to weekly individual music therapy sessions
- Sentenced to psychiatric treatment or placement in a medium secured unit
- Diagnosed within the schizophrenic spectrum (F20, ICD 10)
- GAF score between 10-40 (Global Assessment of Function) (Jones, Thornicroft, Coffey, & Dunn, 1995)
- Hospitalized maximum a year at point of inclusion in the study
- Speaks and understands Danish language
- Signed consent to participate in the study

Demographic data of the patients' GAF scores were used as one of the inclusion criteria. GAF is an abbreviation of Global Assessment of Functioning and is a quick and simple measure of a patient's level of psychological, social and occupational functioning (Jones et al., 1995). GAF is a numerical scale from 1-100, where 1 is the lowest score and 100 is the highest. The levels range from positive mental health to severe psychopathology. The GAF scores were determined by the staff in charge at the unit.

Treatment

The patients were offered individual music therapy sessions once a week and I was the clinical music therapist conducting the therapy. At the onset of research, I had worked at the hospital 15 hours a week for 10 years. The music therapy approach and methods were adjusted to the clinical reality and the needs of the patients, and based on a psychodynamic approach. The music therapy methods included music listening,

playing composed music together, writing songs or rap lyrics, performing, singing and improvising. These methods are described in further detail in the specific descriptions of the case studies and in article 3 (Frederiksen et al., 2019). The sessions were performed in a specially adapted music therapy room situated in the hospital but outside of the unit. The room contains several pianos, a drum set and several different drums, metallophone and xylophone, electric and acoustic guitars, a cello, several percussion instruments and a stereo player with microphones. It is a bright room with big windows and has an exit to a closed yard that is only occasionally used by patients and staff.

I accompanied the patients from the unit to the music therapy room. Before the sessions, I sought information from the staff about the patient´s condition, and in connection with the daily routine assessments of risk of violence it was decided whether I could sit alone with the patient during the music therapy session without a protecting guard.

Data collection

Data was collected from the first six months of a music therapy treatment, which I considered the initial phase of psychotherapy with the aim of developing trust and confidence in the therapeutic alliance (Frederiksen et al., 2019). The sessions were audio recorded. Data from multiple sources and perspectives were collected and listed in *Table 5-1*. A description of the data collection procedures and the reason for this is explained in the following text.

Patient perspective (with research assistant if relevant)	**Music therapist** perspective	**Staff** perspective	Charts and records
Semi structured interviews *(Post)* Mood Adjective Checklist UMACL-TA *(pre/post-sessions)* SRS – Session Rating Scale *(post-sessions)*	ITN: Impressions immediately after therapy *(post-sessions)* ETN: Extended notes *(post-sessions)* Empathy exercises *(post-sessions)* Assessment of relationship *(post-sessions)*	Level of Contact scale *(post-sessions)* BVC profiles *(post-sessions)* Level of observation *(post-sessions)*	Demographic data Transcripts of the audio recorded music therapy sessions Medical charts, incl. information on use of rescue medicine *(post-sessions)*

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

Table 5-1 Overview of data sources from different perspectives

The patient´s perspective

The patients perspective was included through *semi-structured interviews* and *Session Rating Scale (SRS)*(Duncan & Miller, 2000), as well as a modified version of the *Mood adjective Checklist* (Matthews, Jones, & Chamberlain, 1990) (appendix A, B & C).

Semi-structured interviews: Based on literature on the therapeutic alliance (Horvath & Luborsky, 1993; E. Hougaard, 1994; Thorgaard et al., 2006), a first interview guide was developed. The interview guide was adjusted based on the results of 1) Pilot interviews with forensic psychiatric patients attending music therapy, and 2) discussion about the interview guide with psychologist colleagues at the forensic psychiatric hospital. A psychologist with no relation to the patients conducted the interviews after one month and after six months of treatment. The interviews were audio recorded and transcribed after end of data collection.
The Session Rating Scale (SRS) is a short four-item form where the patient was asked to score his alliance with the therapist in a specific session referring to therapeutic bond, goal, method and general impression of the therapy process on a 10 centimeter visual analogue scale. The SRS scale was tested and developed to facilitate the patient's feedback on the therapeutic alliance (Duncan & Miller, 2000). The SRS scale is easy to fill out after each session and the questions asked are not complex, which increases the chance that the patient will actually participate. My translated version of the SRS scale was used in the case study. The patients filled out the SRS immediately after every session assisted by staff.
The Mood Adjective Checklist is an approved self-reporting form addressing the patient's experience of mood ((Matthews et al., 1990). A modified and shortened version of the form was used in the case study addressing the patient's bodily experiences of arousal and tension, and is relevant for addressing non-verbal aspects. In addition, I have experienced that forensic psychiatric patients are often better at describing these immediate experiences than reflecting on their reactions. The patients were asked to evaluate the experience of being calm, relaxed, tense and nervous by circling the one of four words that fits the best:

- absolutely
- almost
- almost not
- absolutely not

The patients were asked to fill out this form before and after every session assisted by staff.

The therapist´s perspective

The therapist´s perspective was represented through therapy notes consisting of *Immediate therapy notes (ITN) and Extended therapy notes (ETN).* In addition, *empathy exercises* and *assessment of alliance* were used. (appendix 4 for committee)

Immediate therapy notes (ITN) consist of the therapist´s immediate and spontaneous impressions from the therapy, without limitations on what comes to her mind in associated with the session.
Extended therapy notes (ETN) consist of notes the therapist wrote down while listening to audiotape of the session on the same day as the session was conducted. These notes were guided by the following headings:

- Description of incident/sequence: Objective/observable (musical and verbal)
- Description of tension/arousal in the patient (in dialogue, music and body language)
- Description of dynamics in verbal, non-verbal and musical interaction
- Description of therapist reactions (bodily, emotional, thoughts, images and associations).

Therapy notes were included in order to generate thorough descriptions of the sessions, including the therapist´s considerations and non-verbal reactions revealing implicit knowledge about dynamics of the interpersonal relationship and countertransference reactions. As forensic psychiatric patients can be vulnerable, mistrustful and give very little information about inner experiences and reactions, this data may reveal important dynamics in the patient and the interaction.

Empathy exercises: The music therapist followed the procedure of empathy exercises developed by Thorgaard and colleagues (2006) in order to support structuring bodily aspects of the empathic reactions and interaction with the patient. These exercises were included in order to enhance the focus on interpersonal dynamics and implicit knowledge.
The music therapist considered the following four experiences:

- feel nothing
- feel the patient and how it really is to be him
- feel how the patient has been treated by another person, has experienced being treated or is experiencing being treated by another person – and feel how the patient treats himself
- feel how almost everyone experiences or has experienced being together with the patient (Hansen, 2009 p. 73) (my translation)

The therapist performed empathy exercises immediately after every session and wrote down reflections on these considerations.

Assessment of alliance: Immediately after each session, the therapist assessed the alliance using McGlashans 11 relational levels (Hansen et al., 2009; McGlashan & Keats, 1989). These levels were developed from case studies with patients suffering from schizophrenia and include descriptions of the first steps in developing alliance with patients with severe mental illness, among other things the micro non-verbal contribution of the patients. This assessment of alliance was included in the study in order to structure the subjective experiences of the music therapist. The eleven relational levels are described as:

1. No engagement (Indifference in the patient)
2. Engagement (Patient shows a wish for contact)
3. Attachment (Therapist becomes a unique and special person for the patient)
4. Working alliance – supportive (Wish for treatment and clear roles between therapist and patient)
5. Communication (relationship used to build common language and meaning)
6. Problem solving (explore and solve problems together)
7. Fortification (patient uses the relationship more actively and independently among others to fortify against the disease – the therapist is active in this process)
8. Working alliance – analytical (the relationship is in focus - patient is able to step back from participating to objectify the self and to observe the self in interaction.
9. Integration (patient demonstrates ability for self-analysis, taking the "meta" position and differentiating self from others to see the therapist as real)
10. Internalisation (patient capacity to function self-therapeutically and ability to mourn and feel impotence instead of omnipotence)
11. Termination (therapist is seen more clearly and objectively as someone real, different, and imperfect in empathy)

(Hansen et al., 2009; McGlashan & Keats, 1989) (my translation)

The staff´s perspective

The staff's perspective was included through *staff scoring of contact and tension* in the interaction with the patients and from staff´s routine risk assessments according to *Brøset Violence checklist (BVC*(Almvik & Woods, 1999) and *Level of observation.* (appendix D & E)

Staff scoring was conducted through a self-reporting form developed for the case study. Before every session the daily contact person was asked to score on a 10 centimeters visual analogue scale his/her experience of contact and tension in the interaction with the patient ***Brøset Violence checklist (BVC)*** is an easy to use and accurate instrument for systematic short-term prediction of violent attacks in acute psychiatric wards, scoring the presence (1) or absence (0) of six behaviours:

- confusion

- irritability
- loud behaviour
- verbal threats
- physical threats
- attacking things or objects (Almvik & Woods, 1999) (my translation)

The scorings are summed and support decisions of interventions to prevent violence.

Level of observation is based on observations of the patient and his interactions with other patients as well as with the staff. It is an internal guide for procedures at the forensic psychiatric hospital where the data in this study was collected. The observational levels are defined as:

- general
- extended
- heightened
- shielding
- constant guard (my translation)

BVC scores and Level of observation were collected from night-, day- and evening shifts on the day that sessions were performed.
Data from BVC and Observation levels are included to present the staff´s perspective and, in addition, to assess the patient's level of arousal as an indicator of the patient´s clinical state and ability to be attentive and able to interact with another person.

Data from charts and records

Demographic data from each patient were collected, as important background information in the case study.
Objective clinical data from the patient´s medical files on the use of rescue medicine and medical prescription were collected. Data from the use of rescue medicine were collected from the day-, evening- and night shift on the day that sessions were performed. The use of medicine may reveal aspects of the patient's general state of being.

Ethical procedures

The patients were informed verbally and in writing (appendix E), and they signed a statement of consent (appendix F). Ethical procedures were followed and approved (Frederiksen et al., 2019). The participants were informed that data were anonymized and that they could withdraw from the study at any time. The study was approved by the Humanistic Research Ethics Board (HREB) at Aalborg University, reported to the Danish Data Protection Agency, and follows the Danish Code of Conduct for Research Integrity (Ministry of Higher Education and Science, 2014). The music therapist adheres to the Ethical Principles for Members of the Danish Music therapy

Association (DFMT, 2016). The anonymized and names and personal information is changed so the person is not identifiable, see also article 3 (Frederiksen et al., 2019)

5.2. ARTICLE 3. ALLIANCE BUILDING BETWEEN FORENSIC PSYCHIATRIC PATIENT AND MUSIC THERAPIST. A CASE STUDY RESEARCH DESIGN

To answer the research question 3: *How may the dynamics in the developmental process of forming therapeutic alliance between music therapist and forensic psychiatric patient with schizophrenia in the initial phase of music therapy be described ?*, I planned and conducted a case study. The aim of the case study was to explore in depth the dynamics of the interaction between music therapist and forensic psychiatric patients with schizophrenia in the first six months of a course of music therapy. The planning and implementation of this case study is presented in article 3 along with a description of the analysis and the findings:

Frederiksen, B., Ridder, H. M. & Pedersen, L. (2019). Alliance building between forensic psychiatric patient and music therapist. A case study research design (Unpublished manuscript).

I planned and conducted a case study. The aim of the case study was to explore in depth the dynamics of the interaction between music therapist and forensic psychiatric patients with severe mental illness in the first six months of a course of music therapy. The planning and implementation of this case study is presented in article 3 along with a description of the analysis and the findings:

Summing up the conclusion of the article:

> "Forming a therapeutic alliance with forensic psychiatric patients is challenging and prolonged, with a gap in knowledge about the dynamics in the initial phase of psychotherapy and how trust and collaboration 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 with forensic psychiatric patients with schizophrenia A case study was conducted including multiple perspectives and sources of data. The analysis of the clinical notes from the therapist followed a nine step procedure and led to an abductive synthesis based on a hermeneutic phenomenological analysis. Four patients with schizophrenia from a medium secure unit at a forensic psychiatric hospital in Denmark were included in the study. The analysis process revealed seven continua describing dynamic interactional processes within the development of therapeutic alliance with forensic psychiatric patients with

> schizophrenia in music therapy. These processes unfolded within seven themes: 1) Control, 2) Closeness/distance3) Structure, 4) Process/product, 5) Focus of attention, 6) Interaction, and 7) Verbal dialogue. The continua may contribute to a 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 competencies" (Frederiksen et al., 2019).

5.3. ANALYSIS

In article 3, a selected case study example is presented in detail. In the following, I include a full analysis of three other cases and all the multiple data sources.

Six forensic psychiatric patients with schizophrenia and sentenced to placement in a medium secure unit at a forensic psychiatric hospital in Denmark were included in the study. From these, two patients dropped out after 3-4 session of music therapy. The reason for dropout was for both a rejection to continue music therapy. The four patients are presented with pseudonyms in order to ensure anonymity. The included patients' GAF scores were: Frederic: 25, Brian: 27, Sami: 22 , Pete: 39. They attended music therapy sessions 19 times (Frederic), 15 times (Brian), 21 times (Sami) and 22 times (Pete) respectively, each during a period of six months.

5.3.1. BACKGROUND INFORMATION

The case of Frederic is presented in article 3 (Frederiksen et al., 2019)

Brian

Brian was in his early twenties and sentenced to placement in a forensic psychiatric unit because of numerous violent and dangerous attacks on other people. Brian was diagnosed within the schizophrenic spectrum and had, in addition, an ADHD diagnosis. When he attended music therapy, he had been hospitalized for 4 years.

During his childhood, he had been placed in various foster families and homes. He had contact with his family, and all of them had problems with substance abuse and criminal activities. Brian also had substance abuse from a very young age, and had been involved in criminal activities in relation to drugs during his teenage years. When he attended music therapy his drug abuse had been remarkably reduced. Gradually he had gained the understanding that cannabis made him psychotic. Brian was very impulsive, and if his needs were not met at once he became angry and verbally aggressive.

Brian was very interested in music, spending hours listening to music in his room, especially rap music, and he wrote rap lyrics. Sometimes he invited people into his room to listen to his songs or to pieces of rap music he had found on the internet. At the same time, you could sense a shyness related to performing his lyrics because of low self-esteem and because these lyrics meant a lot to him. Over the 6 months of music therapy, he did not bring any of his lyrics nor did he want to perform them.

Brian refused to fill in the self-report sheets, because he was not able to read or write and felt very embarrassed about it. Even offering him the assistance from his daily contact person could not persuade him. After three months, Brian refused to have the sessions audio recorded. Therefore, I had to adjust writing the thorough therapy notes, relying on my memory of the session instead.

Sami

Sami was a man in his thirties. He was sentenced to treatment at a forensic psychiatric unit because of serious criminal and violent behaviour towards other people. Sami was diagnosed within the schizophrenic spectrum and had severely paranoid thoughts about other people. He had spent many years in psychiatric hospitals or institutions.

Sami was a refugee due to war and persecution in his home country and had fled with his family in his preadolescence. He was in contact with his family.

Sami was very vulnerable and anxious, wandering around the unit seeking contact with others in order to avoid being alone. Sami was able to describe bodily psychotic experiences. Sometimes he managed to calm down by lying in his bed listening to music from his home country or melodic Danish love songs. He was very interested in attending music therapy, but his vulnerable way of being also became very present in the music therapy room. He would talk a lot without listening; he often got up from his chair and would wander around. He was polite and smiled a lot, and he watched the music therapist very intensely and in an intimidating way.

Pete

Pete was a young man in his twenties, sentenced to placement at a psychiatric unit, and it was his first contact with forensic psychiatry. When he attended music therapy he had been hospitalized for one year. Pete was placed in forensic psychiatry because he had been extremely violent to staff in a unit in general psychiatry. He had a diagnosis within the schizophrenic spectrum.

Pete was placed in foster families after his mother died in his first years of school. He had an especially good relationship with the father of one foster family and with another boy placed with this family. Sometimes, the three of them played music together, and Pete remembered this as a very positive experience.

Before entering psychiatry, Pete had an extremely chaotic life with heavy misuse of various kinds of drugs. Under the influence of amphetamine, he would become very violent. He tried to reduce his use of cannabis but did not want to stop completely because he found that it helped him concentrate and gave him energy. Pete found it very boring to be hospitalised. Pete wrote lyrics and recorded rap lyrics with some of the other patients.

5.3.2. OVERVIEW ANALYSIS PROCESS

The process of handling and analysing the data of the case study is described in a nine-step procedure and explained in detail in article 3 (Frederiksen et al., 2019). This nine-step procedure is illustrated in *Figure 5-1*.

In the following, I will present an overview and add a full analysis of all four cases included in the study.

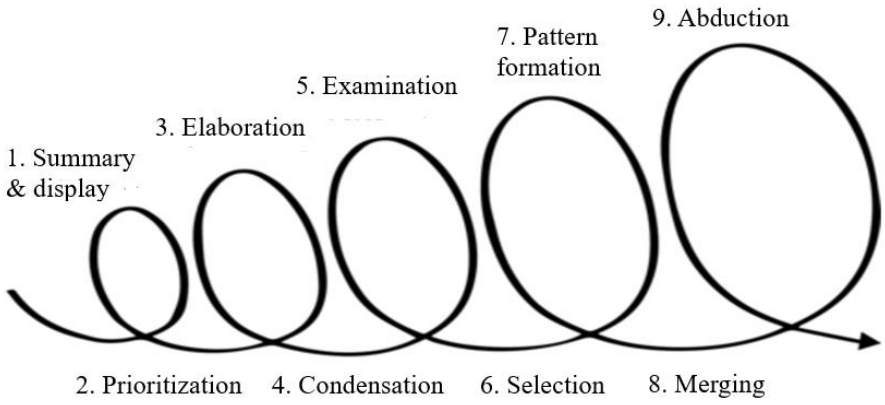

Figure 5-1 The nine-step hermeneutic phenomenological analysis process

The data collection revealed an immense amount of data. In order to provide transparency and outline all data, *Table 5-2* displays types and amount of data and gives an overview of step 1 and 2 in the nine-step procedure, including how data was prioritised.

	1. DATA SOURCE	2. AMOUNT of data	3. CREATING AND OVERVIEW OF DATA	4. PRIORITIZATION
Qualitative	Immediate therapy notes (ITN)	Frederic : 10 pages Brian : 8 pages Sami :10 pages Pete : 12 pages	First summary and important points organized in table format	High status: create overview, focus on non-verbal interactional dynamics
	Extended therapy notes (ETN)	F: 100 pages B: 50 pages S: 98 pages P: 120 pages	Important sections highlighted by reading and re-reading and organized in table format	High status: nuanced description of the interaction including non-verbal and countertransference reactions
	Semi-structured interview	F: 19 pages B: 8 pages S: 17 pages P: 20 pages	First summary and important points organized in table format	Medium status: Patients difficulties reflecting the relationship. Help to hold on to the patient`s focus and formulations about music
	Empathy exercises		Integrated in ITN and Translated to numerical entities, presented in descriptive statistic	Low status: Clinical data to inform about the patient`s condition during music therapy course. Not sensitive enough to reveal nuances in the interactional dynamics
Quantitative	Assessment of relationship		Numbers structured, summarized and presented in descriptive statistic.	Low status: (as above).
	SRS (Session Rating Scale)	F: 17 forms B: 0 S: 21 forms P: 15 forms	Translated to numerical entities, structured, summarized and presented in descriptive statistic	Low status: (as above).
	Modified Mood adjective checklist	F: 36 forms B: 0 S: 36 scales P: 44 scales	Translated to numerical entities,structured, summarized and presented in descriptive statistic	Low status: (as above).
	Staff`s likert scale	F: 15 forms B: 12 forms S: 10 forms P: 17 forms	Translated to numerical entities, structured, summarized and presented in descriptive statistic	Low status: Clinical data from another perspective to inform about the patient`s condition during the music therapy.(as above)
	BVC, level of observation Medical charts and rescue medicine		Translated to numerical entity, structured, summarized and presented in descriptive statistics or table format	Low status: (as above).

Table 5-2 Overview of full study data and first step of analysis process

Explanation to Table 5-2:
The first column in *Table 5-2* describes the different data sources, and the second summarises the amount of data. The third column describes the process of creating an overview of the various data sources, and the fourth lists a short explanation of how and why data was prioritised.

Explanation to Figure 5-2:
The analysis process, going through all nine steps, and how the different data sources contributed to the findings are illustrated in *Figure 5-2*. The left red column lists abbreviations of the nine-step in the analysis process.

The abbreviations in the blue squares:

- Interview: Semi-structured interview
- ITN: Immediate Therapy notes
- ETN: Extended Therapy notes
- Quantitative data: Session Rating Scale, Mood adjective checklist, Empathy exercise, assessment of alliance, staff scorings for contact with the patient, Brøset Violence Checklist, Level of observation, Medical record and rescue medicine

Broken and dotted arrows illustrate the flow of the analysis. The unbroken arrows illustrate an active analysis of the data source, whereas the dotted arrows illustrate how the data contributed with important clinical data to support the findings and informed the final result of the qualitative analysis of therapy notes in a triangulation of data.

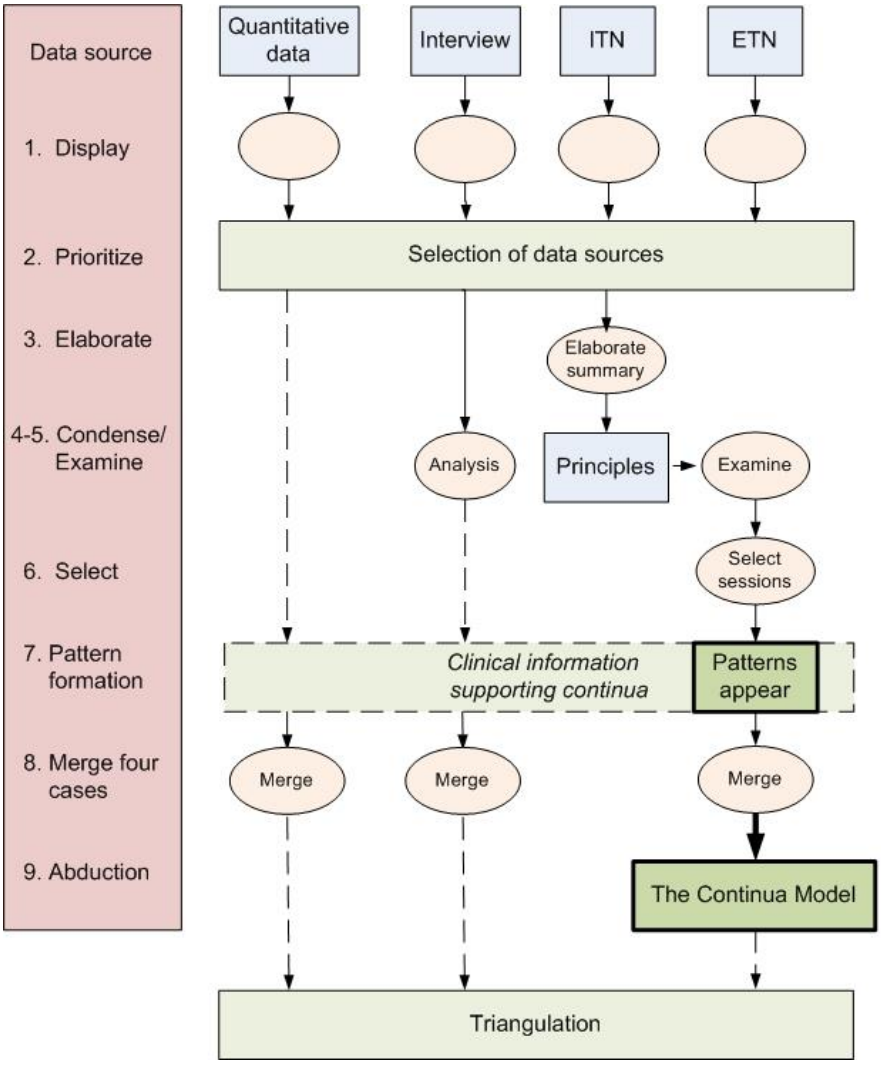

Figure 5-2 Illustration of analysis process

5.3.3. SUMMARY AND DATA DISPLAY

In order to create an overview of data, various summary and displaying techniques were used. Therapy notes and transcriptions of the interview were read and summarized. The quantitative data were structured, summarized and displayed in descriptive statistics.

All data, qualitative as well as quantitative data were structured and organized within the following headings:

- Summary of the different data sources with keywords
- Evaluation of weakness and strengths of data
- Focus points for the further analysis process
- Status between data (Appendix 5 for committee)

Below is a description of the structuring and summarizing process of the quantitative data from the case of Frederic, displayed with descriptive statistics. This adds to the analysis process presented in article 3 which primarily included analysis of the qualitative data (Frederiksen et al., 2019) .

Empathy scorings

The four categories of the empathy exercises were given a numerical value as in the following:
1 = to feel nothing
2 = to feel the patient and how it really is to be him
3 = to feel how the patient has been treated by another person, has experienced being treated or is experiencing being treated by another person – and feel how the patient treats himself
4 = to feel how almost everyone experiences or has experienced being together with the patient
The music therapist's scoring of the empathy exercises after 19 sessions are illustrated in a bar chart in *Figure 5-3.* This shows that predominantly the scores 2 and 4 were noted. In the course of the first 4½ months of music therapy, number 2 was noted 10 times and the last month number 4 was noted 4 times.

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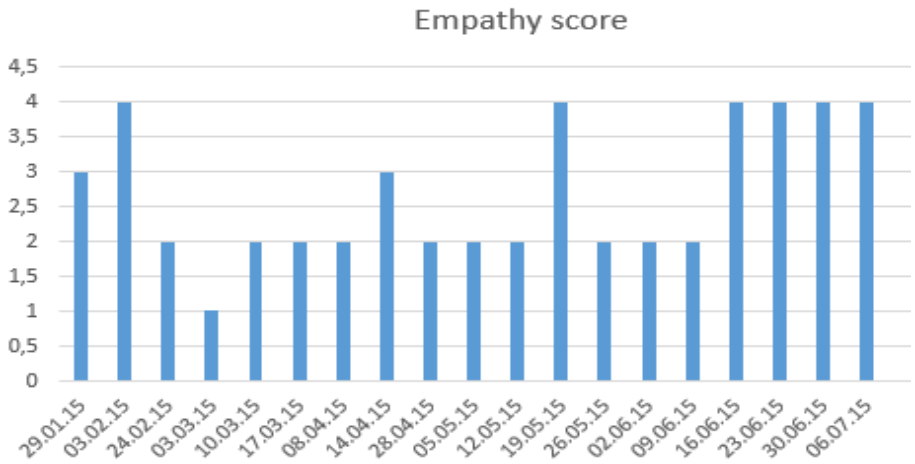


Figure 5-3 Empathy scores - Frederic

Assesment of alliance

The result of the music therapist´s assessment of alliance after 18 sessions shows a score of 2 in the first 10 sessions (with one session scoring 2,5) and then the scores of 2,5 in the following 8 sessions. The scores are illustrated in a bar chart in *Figure 5-4*.

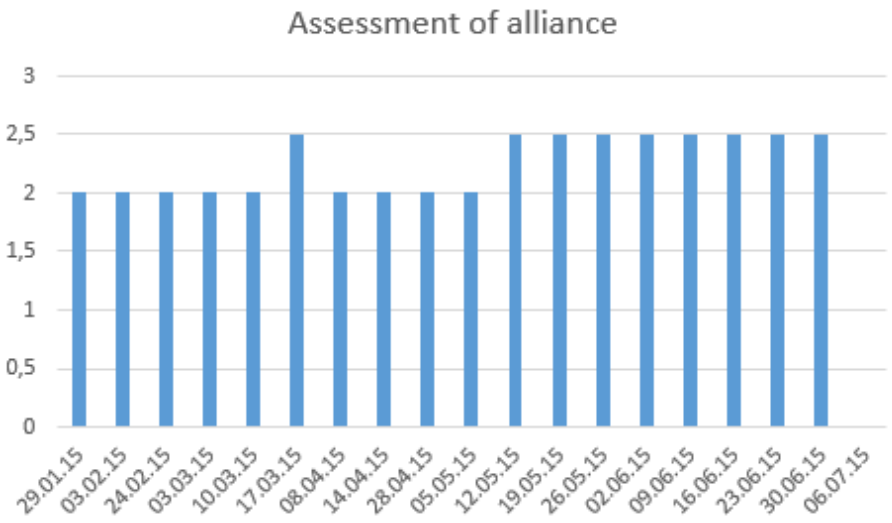


Figure 5-4 Assessment of alliance - Frederic

Session rating scale

Frederic´s scoring in 17 self-reporting forms using the session rating scales was illustrated in a bar chart in *Figure 5-5*. This shows that within all four items and during the whole period of music therapy treatment, the patient scored 10.

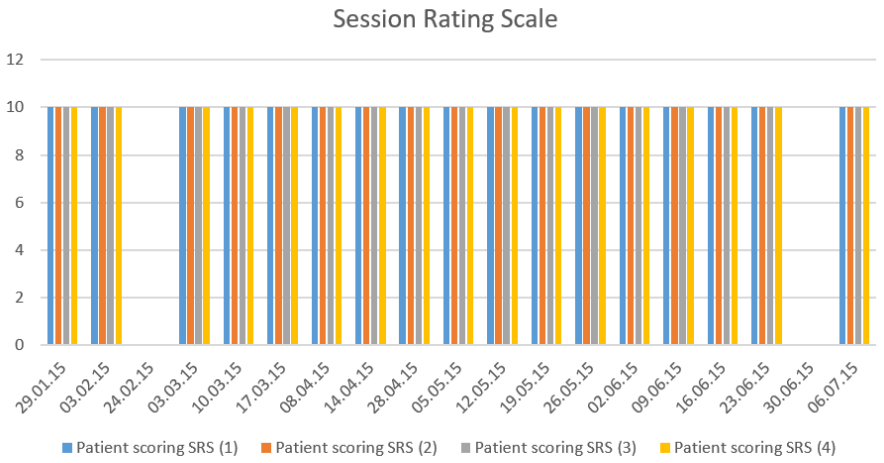


Figure 5-5 Session Rating Scale scorings - Frederic

Mood adjective Checklist

The categories of the modified Mood adjective checklist were given a numerical value as in the following:

Level of feeling relaxed and calm:
4 *=absolutely,* ***3*** *= almost,* ***2*** *= almost not,* ***1*** *= absolutely not*

Level of feeling tense and nervous scored:
4 *= absolutely not,* ***3*** *= almost not,* ***2*** *= almost,* ***1*** *=absolutely*

Frederic´s scoring of Mood adjective checklist from 36 self-reporting forms are illustrated in a bar chart in *Figure 5-6*. This shows the score 4 (absolutely) in feeling relaxed and calm and the score of 4 (absolutely not) in feeling tense and nervous in all forms.

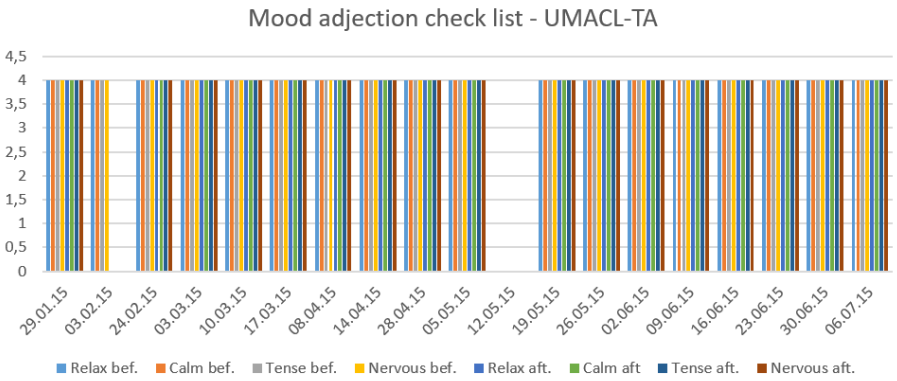


Figure 5-6 Mood adjective checklist - Frederic

Staff scorings of contact

The staff´s scoring of contact with the patient are illustrated in a bar chart in *Figure 5-7*.

Contact: 0 = contact with the patient has been poor
10 = contact with the patient has been good
Tension: 0 = patient has been tense in the contact
10 = patient has been relaxed in the contact

The staff´s score of the contact scale from 16 forms had a mean score of 7.36. All scores were higher than 7.50 except twice, where there was a score below 3 and three times where there was a score of 5.

The staff´s score of the tension scale from 15 forms had a mean score of 6,8. The scores fluctuated from session to session between 1.8 and 10.
The amount of missing data was 15 per cent.

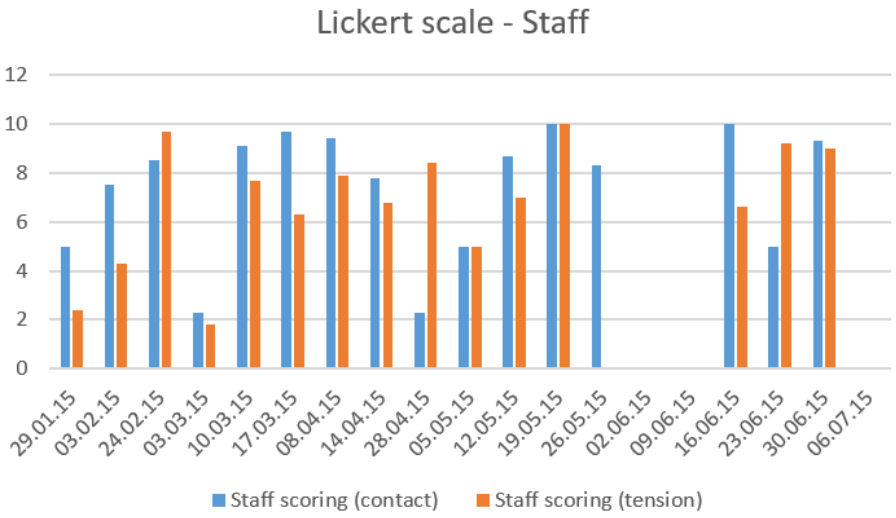


Figure 5-7 Staff´s scoring of contact and tension - Frederic

BVC, Observational level, Rescue medicine and status of medical prescriptions

Data from clinical records were given numerical values as in the following:

Rescue medicine:
0 = No rescue medicine issued in the day, evening or night shifts
1 = Rescue medicine issued in day, evening or night shifts

BVC scores:
0 = the risk of violent behaviour is minimal
1-2 = the risk of violent behaviour is moderate
>2 = the risk of violent behaviour is high

Level of observation:
0 = general
1 = extended
2 = heightened
3 = shielding
4 = constant watch

Status of medical prescriptions:
0 = no changes
1 = increase in analgesic, neuroleptic or sedative medicine
-1 = reduction in analgesic, neuroleptic or sedative medicine

BVC scores:
0 = the risk of violent behaviour is minimal
1-2 = the risk of violent behaviour is moderate
>2 = the risk of violent behaviour is high

Level of observation:
0 = general
1 = extended
2 = heightened
3 = shielding
4 = constant watch

The results of BVC and observational level revealed the scores 0 throughout the period.
With rescue medicine, there was the score of 1 six times in dayshifts during the period. With the medical record, the score 1 was noted three times, as there was an increase in the dosage of Pinex (analgetica), Lyrica (antiepileptics) were added, and there was a change in time for issuing Gemadol (analgetica).

The data is structured in *Table 5-3*, as I found that an illustration in descriptive statistics would not sufficiently illustrate the numbers.

Date	Rescue medicine	BVC score	OBS level	Change in med. record
29.01.15 D	1	0	0	0
29.01.15 E	0	0	0	
29.01.15 N	0	0	0	
03.02.15 D	0	0	0	1
03.02.15 E	0	0	0	
03.02.15 N	0	0	0	
24.02.15 D	1	0	0	1
24.02.15 E	0	0	0	
24.02.15 N	0	0	0	
03.03.15 D	1	0	0	0
03.03.15 E	0	0	0	
03.03.15 N	0	0	0	
10.03.15 D	0	0	0	0
10.03.15 E	0	0	0	
10.03.15 N	0	0	0	
17.03.15 D	0	0	0	0
17.03.15 E	0	0	0	
17.03.15 N	0	0	0	
08.04.15 D	1	0	0	1
08.04.15 E	0	0	0	
08.04.15 N	0	0	0	
14.04.15 D	1	0	0	0

14.04.15 E	0	0	0	
14.04.15 N	0	0	0	
28.04.15 D	0	0	0	0
28.04.15 E	0	0	0	
28.04.15 N	0	0	0	
05.05.15 D	0	0	0	0
05.05.15 E	0	0	0	
05.05.15 N	0	0	0	
12.05.15 D	0	0	0	0
12.05.15 E	0	0	0	
12.05.15 N	0	0	0	
19.05.15 D	0	0	0	0
19.05.15 E	0	0	0	
19.05.15 N	0	0	0	
26.05.15 D	1	0	0	0
26.05.15 E	0	0	0	
26.05.15 N	0	0	0	
02.06.15 D	0		0	0
02.06.15 E	0	0	0	
02.06.15 N	0		0	
09.06.15 D	0	0	0	0
09.06.15 E	0	0	0	
09.06.15 N	0	0	0	
16.06.15 D	0		0	0
16.06.15 E	0		0	
16.06.15 N	0	0	0	
23.06.15 D	0	0	0	0
23.06.15 E	0	0	0	
23.06.15 N	0	0	0	
30.06.15 D	0	0	0	0
30.06.15 E	0	0	0	
30.06.15 N	0	0	0	
06.07.15 D	0	0	0	0
06.07.15 E	0	0	0	
06.07.15 N	0	0	0	

Table 5-3 BVC, Observation level, rescue medicine, medical records - Frederic

The quantitative data from the three other cases in the study were collected and structured as illustrated above in the case of Frederic (appendix 6 for committee).

5.3.4. PRIORITIZATION OF DATA

Data was evaluated in order to decide and prioritise which data could best answer the research question and which data I should continue with in an in-depth analysis. I found that the therapy notes had the highest status because they include a variety of elements of the interaction, including non-verbal dynamics between the music

therapist and the patient. The Immediate Therapy Notes (ITN) were shorter than the Extended Therapy Notes (ETN) and therefore initially useful for creating an overview of the vast amount of Extended Therapy Notes. I selected the therapy notes for a further in-depth hermeneutic phenomenological analysis. In chapters 5.3.5, 5.3.4 and 5.3.5 I will describe this in-depth analysis.

The semi-structured interview was given a medium status. These data represented the patient´s perspective and helped me validate my interpretation. I chose to conduct a further hermeneutic phenomenological analysis of the interview even though the patients had difficulties in reflecting nuances and dynamics of the relationship and interaction with others. Chapter 5.3.7 is a description of this analysis. The results of the semi-structured interviews are integrated in the triangulation of findings.

In order to prioritize, I made a final evaluation of the summarizing and displaying of quantitative data.

Evaluation of quantitative data – Frederic

Empathy exercises indicated that it was easy to empathize with Frederic. The scores indicated a stability in Frederic´s behaviour reflected in the music therapist´s reactions to the patient. Assessment of alliance showed a very small tendency towards a strengthening of the alliance over the period, emerging from a wish for contact and engagement towards small glimpses of attachment and bonding in the alliance.

Session Rating Scale showed the highest score possible throughout the period of music therapy treatment, indicating that Frederic evaluated his relationship with the therapist as stable and satisfying during the period. The results of the Mood adjective checklist showed that Frederic scored the highest possible score for all items throughout the music therapy treatment, indicating that he experienced stability in his condition and that the music therapy sessions did not affect this stability.

The Staff´s scores were quite different from day to day, especially the score of tension, and it was not possible to identify any pattern or correspondence between low scores in contact and low scores in tension. These scores may reflect that the patient triggered very different reactions among staff and may reflect less stability in the contact than reflected from Frederic´s perspective.

BVC and Observation of level indicated stability in the patient's condition during the music therapy treatment, with no increase in risk of violence. The use of rescue medicine and changes in medical records showed very little fluctuation, indicating stability in Frederic´s condition during the period of time that he received music therapy.

The evaluation from the process of structuring and summarising the quantitative data from the three cases I will present below:

Evaluation of quantitative data – Brian

The empathy exercises indicated a stability in Brian´s behaviour reflected in the music therapist´s reactions to him, and she experienced clearly how others experienced being together with him. Assessment of alliance was very stable through the period and did not develop, there was engagement and a small wish for contact but the alliance did not develop towards attachment.

The staff´s scores concerning their impression of the contact with the Brian were stable, but must be interpreted with caution as there were 40% missing data.

BVC and Observation of level indicated stability in the patient's condition during the music therapy treatment, with no increase in risk of violence. Brian received rescue medicine analgesics and neuroleptics 10 times during the six-month period. The changes in medical records showed very little fluctuation, and indicated stability in the patient´s condition during the period of time that he received music therapy.

Evaluation of quantitative data – Sami

The empathy exercises indicated that the therapist had very different reactions to the patient from session to session. The score 2 which is "to feel the patient and how it really is to be him" appeared after 1½ month which might indicate a small change in the dynamics in the relationship between Sami and the therapist. Sami was anxious and nervous in all situations, not only in music therapy, and had great difficulty calming down, the score 2 might indicate a deeper level of empathising, where it was possible for the therapist to stay calm and perceive the dynamics behind Sami´s symptoms. Assessment of alliance showed a very small tendency towards a strengthening of the alliance over the period, as the assessment of alliance was stabilized at the level of "attachment".

Session Rating Scale showed a high average score, and in particular the results of SRS 4 fluctuated rather much and had the lowest average score. A low score in answering one of the questions did not reflect a low score in one of the others, and it is difficult to identify a pattern in the scores. Still, there was a tendency that the scores became more equal and did not fluctuate as much in the last 2 months of music therapy, which might indicate a small tendency towards an increase in the patient's feeling of safety. The staff who assisted Sami in filling out this form did tell me that it was difficult for Sami to understand the questions, and he did fill it out rather randomly, and it therefore has to be interpreted with caution.

The results of the Mood adjective checklist showed instability in Sami in the first period of music therapy, where he scored lower after the sessions. This might reflect Sami´s high vulnerability and anxiety when he experienced anything new such as music therapy. Tension and feeling nervous had particularly low scores, but in the last 3 months of music therapy his scores on feeling nervous were clearly improved after each session and the other parameters (relaxed, calm and tense) had a small tendency towards scores that were higher after than before the session. This might indicate a small tendency of moving towards Sami feeling more safety in music therapy and being able to receive comfort.

The scores from the staff fluctuated and considering that there was 25% missing data it is difficult to identify any pattern in the staff´s experiences of the patient. There may be a slight tendency that the scores reflect that contact with the patient was experienced as being tense.

The BVC scored 1 once and the observational level scored 0 throughout the period indicating stability in Sami´s condition in relation to the risk of violence. Sami, however, received rescue medicine many times during the period – mostly Pinex+Ibumetin (analgetica) and Truxal (neuroleptica), which does reflect his vulnerability in relation to physical symptoms. It is important to add that Sami had an infection in his tooth over a period of 1-2 months, which was very painful and caused anxiety and worsening of his symptoms, and therefore increased the use of rescue medicine. Changes in his medical record were primarily concerning this pain in relation to the infection. These data do not reflect Sami´s reactions to music therapy, but do emphasize that he was in a vulnerable situation caused by pain during the period of music therapy.

Evaluation of quantitative data – Pete

The empathy exercises indicated that it was easy to empathize with Pete, but there was no pattern. Assessment of alliance showed stability on the level of “attachment” , and a tendency towards developing the alliance towards the level of “engaging in supportive working alliance” indicating a small strengthening of the therapeutic alliance.

The interpretation of the SRS scores must be considered with caution because of missing data. The SRS question 1 is the most stable, whereas scores from the other three questions fluctuate in the first 2½ months. In the last 3 months, SRS questions 1, 2 and 3 are more stable, whereas SRS 4 still fluctuates, with a large drop in one session. This might indicate a small tendency towards Pete becoming more comfortable with the interaction and feeling safe at the end of the period, and secure in his opinion on how to evaluate the music therapy. The mood adjective checklist is very stable and most scores are 3 and 4. This indicates that Pete experienced stability in his condition and that the music therapy sessions did not affect this stability.

The staff´s scores concerning their impression of the contact with Pete were rather stable and scored mostly high. There seems to be instability in the staff´s scores the last months of therapy, with a couple of very low scores in tension as well as contact. These data must, however, be interpreted with caution as there were 38% missing data.

In BVC and Observation of level there was only one score of 1 in BVC during the period, indicating no increase in risk of violence and stability in the patient's condition during the music therapy treatment. The use of rescue medicine and changes in medical records showed very little fluctuation, also indicating stability in the patient´s condition during the period of time that he received music therapy.

Prioritization of quantitative data

The quantitative data were given a low status in part because they were not sensitive enough to reveal the nuances of the interaction and relationship between the music therapist and forensic psychiatric patient and to answer the research questions. Therefore, I did not analyse these data in-depth, but integrated them as important clinical information about the patient´s condition during the course of music therapy. In addition, however I integrated the results of the quantitative data in the triangulation of findings.

In the cases of Frederic, Brian and Pete, these quantitative data showed that the music therapy process happened at a pace and in a way where they were able to participate without an aggravation of their condition. In the case of Sami, the data reflected his general symptoms of being vulnerable and anxious and were worse than his usual condition because of a painful tooth infection. However, the data showed a small tendency towards Sami feeling more comfortable and safe in music therapy, and participating in music therapy did not lead to an aggravation of his condition.

5.3.5. ELABORATION, CONDENSATION, EXAMINATION, SELECTION

I did an **elaborated** summary of ITN, which made me able to conduct a meaning **condensation** of short principles for developing therapeutic alliance in the various cases. These principles are listed in *Table 5-4*.

Frederic	*Contain chaos*	*Disturb carefully*	*Formulate your own role in a way acceptable to Frederic*	*Facilitate structuring of musical activities based on Frederic's interests*	*Careful use of rhythmic dialogue and resonance when drumming*

Brian	*Neutral but aware*	*Music at the centre of the interaction and dialogue*	*Create a structure – formulate a personal meaning*	*Use humour and spon-taneity*	*Maintain the framework – contain his reactions – be open for togetherness*
Sami	*Concrete, clear structure – to be repeated*	*Experiences instead of understanding*	*Respect his need of distance – careful support reassuring*	*Simple musical interactions*	
Pete	*Meet in the music*	*Contain indolence – invite to interaction*	*Balance stability – in-stability*	*Gradually approaching Pete*	

Table 5-4 Short sentences for principles for developing therapeutic alliance

I used the condensed principles listed in *Table 5-4*, as the basis for **examining** all sessions for each case, one at a time. By reading and re-reading all the Extended Therapy Notes (ETN) from all sessions, I noted in a table where the principles were represented the most (example in appendix 7 for committee). Based on these tables, I **selected** two sessions for each case for further examination and pattern formation.

5.3.6. PATTERN FORMATION

Pattern formation is step 7 in the analysis process as illustrated in *Figure 5-2*. In this step of the analysis process, I re-read, summarised and meaning condensed the two selected sessions from each case. Patterns began appearing to me as described in detail in the case with Frederic (Frederiksen et al., 2019). In order to give a comprehensive and full presentation of the case study, I shall here add a summary of the analysis of selected sessions in the cases of Brian, Sami and Pete. These summaries are based on a similar and detailed analysis of therapy notes as described in the case of Frederic (Frederiksen et al., 2019) and with the detailed outline of the pattern formation process of all four cases, consisting of 54 pages, included in Appendix 8 (for the committee).

Brian

Brian´s interest in music was the focus point in music therapy, with the music therapist listening and accepting his music with a non-judgmental but interested attitude.

Brian´s generally unstructured way of being also became very clear in music therapy where he impulsively and abruptly insisted on changing to another activity or song. He either did not respond or he cut off an activity in a rather devaluating and controlling way. If the music therapist suggested any kind of structure or recognized the music they were listening to, he easily felt that there were expectations of him and it seemed as if his arousal increased.

In a few situations, the music therapist had to tell him clearly to stop what he was doing. She also sensed a great vulnerability and insecurity in Brian, and a few times, she had to be very clear in restricting him. Most often, instead of confronting Brian, the music therapist actively joined in his activities or invited him to interact. The music therapist understood Brian´s behaviour as his cognitive inability to stay focused, but also his way of keeping a distance, protecting himself and his way of regulating tension.

The music therapist was very aware of her bodily reactions and countertransference reactions. She was aware of her role in regulating arousal through acting rather than verbally. As an example, she would sit side by side next to Brian and not face to face, she would avoid looking at him and be neutral in her approach. She refrained from commenting on his at times rather provoking songs and she thought of it as a source for Brian to express strong and aggressive energy in a socially acceptable way where no one was hurt. In addition, not all of the music they listened to had an aggressive mood; the music also revealed important experiences from his childhood and youth.

Small musical active interactions could appear where Brian suddenly grabbed an instrument and started to play in an improvising way. In these situations, the music therapist joined in supporting Brian´s musical expression – for example by establishing a pulse and structure. In these small improvisations and musical interactions between the music therapist and Brian, there were short moments of mutuality and dynamics where power struggles were softened. In addition, in these moments Brian was receptive to being supported, and it was easier for the music therapist to support Brian´s engagement and nurture moments of meeting. Actually, Brian became calmer and more focused when playing music actively with the music therapist than when they were talking. When Brian was talking, his uncertainty and low self-esteem were easily ignited.

Moments of meeting quickly disappeared again. The music therapist had to be very conscious in her approach to Brian, and she always had to be careful and observant of his non-verbal dynamics, of whether he became unpleasant or he felt pressure to perform or relate. On the other hand, the music therapist also used music to attract Brian´s attention with musical experiences and to maintain their connection.

Gradually, Brian revealed a good sense of humour where the music therapist observed an empathic awareness of what she also found was funny. Humour became an

important part of the interaction between the music therapist and Brian, loosening up tension and facilitating a positive and mutual interaction.

Sami

Sami was very vulnerable and easily disturbed by inner as well as outer experiences. He changed focus abruptly by either saying or doing something completely different, thus interrupting small interactions or approaches between him and the music therapist. The music therapist had to regulate her irritation and contain this extreme vulnerability, which she sensed reflected a strong bodily vulnerability and anxiety in Sami. This vulnerability controlled the interaction between the music therapist and Sami and challenged the development of contact and confidence in the relationship.

The music therapist experienced that Sami would constantly approach the music therapist and then shortly after create a distance by his disturbed and chaotic way of being. The music therapist found that this behaviour reflected Sami´s ambivalence in relationships in general, and that Sami´s behaviour was also a way of protecting himself. This understanding helped her to contain Sami´s chaotic way of being.

The music therapist took the lead and created a rather rigid structure for the session, among other reasons because she sensed that there was a need for regulating the arousal and tension created by Sami´s vulnerability, in order for her to be able to nurture the contact between them. The music therapist chose to use listening to songs as a regulative source to support reassurance and calming down in Sami. She chose a song based on her knowledge about musical parameters considered to have a calming and relaxing effect on the body, for example with a slow pulse and a simple melodic and rhythmic structure. At the same time, she chose a song based on her knowledge about Sami´s preferences, and she insisted on listening to this song as a start for every session while Sami was sitting in a comfortable chair. The music therapist did not talk or answer if Sami had an impulse to say something. She tried to be very neutral, not watching Sami, but focused on listening. The music therapist used the music as a neutral co-therapist that did not expect anything from Sami. In addition, the music therapist chose this structure because she found that the repetition would create safety as to Sami´s expectations of what would happen and, through this, support regulation of arousal and reassurance. This structure and the music also helped her to regulate her own arousal and she found that it also helped Sami to calm down.

The music therapist noticed that Sami did accept this way of starting the session and she noticed that he became a little more focused, aware and in present in the relationship. This way of listening to the same song every session prepared Sami to be able to engage in active interactions with the music therapist, where short moments of closeness and dynamic interplay and approaching each other appeared. After listening to this song, suddenly an interaction appeared. Sami continued singing words/phrases from the song, and the music therapist joined in singing together with

him and invited him to interact. Sami did not reject this interaction, instead they continued singing in turns and finally they took a deep breath together. The music therapist had an image of a bird sitting on her shoulder, and she wrote in her notes – "I can´t control it but hopefully if I stay calm it will not fly away". The music therapist had to be very aware and catch every small attempt from the patient to approach her. The music therapist experienced a short moment of meeting in the music and hopefully this was also what Sami experienced.

The music therapist suggested playing the drum, which is an instrument where elements such as rhythm and volume are central, and where it is possible to feel the pulse of the rhythm in the body. While Sami was sitting in a comfortable chair he played a drum and the music therapist also played a drum. At first, he played in an unstructured way and was releasing energy with his drumming. In brief moments, it was possible for Sami to be receptive to support from the music therapist and engage in a common sharing of tempo and pulse in the musical interaction. The music therapist sensed that Sami also became aware of this interactional experience and the fact that he was able to contribute to it. Being able to establish this active interaction made it possible for the music therapist to support regulation of arousal in Sami on a very basic level. At first the music therapist matched Sami´s energy and tension in his way of playing the drum and in his body language and by that she established a first connection. On a non-verbal level, the music therapist supported the experience of a little more inner stability and grounding in Sami and supported his experience of sharing the same rhythm.

Pete

The music therapist noticed that Pete entered the room focused on drumming on the congas with a high level of energy. The music therapist sensed that Pete, in his body language and way of playing, signalled that he did not want to talk. Pete was very affected by negative symptoms and the music therapist sensed a need in Pete for increasing his level of energy. This way of entering the room supported him in this and, in addition, supported his ability to be aware and concentrated. Therefore, the music therapist decided not to disturb him in his playing.

After this start of the session, Pete played the instruments in a rather free manner as if he were trying to find the right song or melody he had in his mind. Pete invited the music therapist to play with him, but at the same time, the music therapist found that it was not possible to establish any interaction because he played in a sporadic manner, with no direction; chaotic and confusing. The music therapist tried to support Pete in his musical expression by structuring his complex rhythms, but then he would stop playing and the music therapist sensed it was as if she was disturbing him. The musical interaction became a field for projecting the interpersonal dynamics between Pete and the music therapist. The music therapist experienced a tension because of contradictory signals from Pete, but she also realized that this way of acting was

caused by a resistance in Pete against closeness at a very basic level and it was a way of protecting his integrity.

The music therapist also realized that she had to approach Pete in a way where she could relax in her effort to try to establish contact, and she had to contain his ambivalent way of approaching her. With a non-judgmental approach, the music therapist allowed Pete to play out what he wanted, without interfering, only helping him to solve practical issues such as a strap for the guitar.

Gradually and cautiously, the music therapist dared to interrupt Pete adding a new element to his musical expression; for example, she started to sing to his music. She sensed that Pete responded with curiosity. In her musical response, the music therapist was aware of connecting to what Pete was playing.

It was difficult for the music therapist to introduce free clinical improvisations and a symbolical understanding of musical expressions in music therapy with Pete. He said rather directly that the goal for music therapy was to improve his skills and focus on the musical product. Instead, the music therapist facilitated improvisation with Pete in a modified form, creating room for small improvisations and ways of more free expression. The music therapist introduced composed songs that she knew were rather simple and easy to approach in improvisation. She invited Pete to play with her, she at the piano and he at the drum set, where he had some skills from his former life and therefore felt safe. The musical interaction based on these composed songs created a structure for expression within the musical framework and supported accumulation of energy and positive expectations in Pete. In addition, this became a structure for small improvisations, where both could contribute with small variations in turn. It was also possible for the music therapist to support Brian´s musical expression by adapting to his rhythms, which at times became a little unstable and fluctuated and, through this, support his experience of success. The music therapist found that the musical interaction became a transitional object, where their ability to listen and adjust their playing to each other in a more sensitive way than if they had played the songs strictly as noted. The musical interaction became a symbolic room for trying out ways of interacting and for the music therapist to support Pete in his musical expression without verbalizing this dynamic. The musical improvisations within this framework gradually developed towards a mutual and energizing interaction where the music therapist noticed a freedom in her playing.

A repertoire of musical interactions was established, and the music therapist found that Pete´s focus on himself and his ability to perform was loosened. From being very critical of himself and his skills, the music therapist found that Pete now recognized he could have fun when playing music. The songs Pete and the music therapist played also facilitated expression of emotional experiences related to important issues in Pete´s life. These emotional qualities were not present in the verbal dialogue about

these same issues, and the musical expression became the first step for Pete in approaching these difficult themes from his life and talking about them.

The patterns

Through this in-depth analysis of the therapy notes, patterns of control, closeness/distance, structure, product/process, focus of attention, interaction and verbal dialogue emerged.

5.3.7. ANALYSIS OF SEMI-STRUCTURED INTERVIEW

The eight semi-structured interviews, conducted by the research assistant, consisted of a total of 120 minutes of recordings and 64 pages of transcripts.

I analysed the semi-structured interviews following the process described below:

- Reviewing the transcription of both interviews in each case, identifying meaning units and choice of meaningful headings
- Organizing the meaning unit from the transcribed interview text under headings
- Meaning condensing and interpretations of meaning units

For the full analysis (Appendix 9 for committee)

The following text is a summary of the analysis of the interviews with each of the patients. The text bites from the transcription of the interview are written in italics. In the abbreviations, information is added in order to enhance the understanding of the text bites from the transcripts.

Frederic

Frederic emphasizes the concrete musical activities and products and how the music therapist supports him in performing musically *"I have music in my head all the time and I make new pieces of music …the music teacher gives me inspiration and helps the music to come forward".* Indirectly, he acknowledges that the music therapist supports his motivation. He consequently emphasizes the music therapist as a music teacher and it is very clear that he will not acknowledge her role as a therapist.

Asked directly about his personal relationship to the music therapist, he replies only briefly and sometimes refuses to answer *"I think she does a good job, but the thing about if she likes me is difficult for me to answer"* on the other hand he also

characterizes the relationship as *"there is a good empathy for each other"*. If the questions are about the musical product and do not imply his participation in music therapy as therapy he describes the music therapist as *"she is very patient and that is good because she really has to listen to be able to understand it…because I am kind of an artist…"*. Simultaneously, he is also ambivalent in his personal relationship with the therapist, talking about her in third person saying: *"as long as it (music therapist) is someone skilful, positive and that makes you feel good"* – and, immediately afterwards, asked directly if he finds the music therapist has these characteristics he replies "*yes"*.

Frederic will not acknowledge music therapy as part of his overall treatment or that the music therapist has a special role in this sense, as the following sentence illustrates *"I am a musician .....I use (music therapy) for my future work as a musician….I do not use it to process memories"*. It is important for him to highlight his sovereignty in the alliance and that the music therapist is not someone special – *"she inspires me but my girlfriend also inspires me, maybe more"*. He denies that the music therapist has a special role in creating structure for music therapy – he says *"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 yes or no"*.

Still, he describes music and the music therapy this way *"I feel very calm and it helps me to forget the spasms in my face – my ability to concentrate improves"* emphasizing how music and the music therapy support him to relax and concentrate. In addition, *"I can feel how the music is; if it is happy or if the music is sad",* indicating perhaps that music helps him to be able to feel and experience emotions and name them. Shortly after, he describes that music mostly creates positive feelings in him. After analyzing the interviews with Frederic I identified the following themes: 1) role of the music therapist 2) perception of the music therapist 3) experience of receiving help 4) experience of the role of the music and 5) experience of the importance of structure.

Conclusion:

The interview informed me of how the therapeutic process happened in a tempo and way where Frederic was able to participate without increasing anxiety or psychotic symptoms. In addition, it supported my impression of how Frederic experienced music therapy, as a medium to support him in expressing himself and improving skills. His alliance with the music therapist was ambivalent – recognizing her influence and at the same time devaluating it. His need of an omnipotent position and being on top of the alliance became very clear. I found that Frederic would not recognize music therapy as a treatment because of his overall impression that he did not need any treatment. Frederic´s experience of the role of the music revealed some important therapeutic effects besides just making a product, and he formulated that music made him feel calm and forget spasms in his face, and that it increased concentration and revealed positive feelings in him.

Brian

Brian only wanted to participate in the first interview after a month.

Brian´s formulates the goal for music therapy as *"I would like to learn how to play Lake of Fire of Nirvana – it would give me more self-confidence"*. He adds that it is a project that will have to wait until after the planned relocation of the hospital, happening within a month. He emphasizes the role of music: *"I can relax totally"*. Brian implies briefly that the music and music therapy might support expressing central aspects *"...we tell each other afterwards why we wanted to listen to a song. For example, there was a song with a line `my eyes they have to see, see what they would like to see` ...and when you come out from here you will have to concentrate on what you would like to see and what you want"*.

He formulates interpersonal dynamics in the alliance with the music therapist and downplays the importance of it *"I do not mind meeting new people"*. Asked directly if it is important that the music therapist knows what she is doing he replies *"yes"*. He does not experience the music therapist as someone special or important and he replies to the question about what he thinks the music therapist thinks about him *"she may think what she wants"*. Still, he notices a dynamic in the interaction: *"When I have a CD I cannot always remember the name of the song I would like to hear, then I let her listen to a piece of it and ask her to go to the next in order to hear which one I want to hear ...she does not understand that I cannot remember the title of the songs"*. It bothers Brian that the music therapist does not recognize or understand that this situation is not about that he wants to lead or control but is caused by personal difficulties in remembering.

Analyzing the interview with Brian after the end of the therapy, I identified the following themes: 1) experience of feeling safe and having space, 2) experience of the role of the music therapist and the music and 3) goal for music therapy.

Conclusion:

The interview informed me that Brian was ambivalent about the music therapy sessions, but that the therapeutic process still progressed in a tempo and way where he was able to participate. On the one hand, music made Brian relax and therefore supported his participation; on the other hand, he downplayed the importance of the alliance with the music therapist. In glimpses, I found that he expressed awareness of dynamics and wishes for the alliance, among other things that the music therapist would understand his difficulties and support developing self-confidence. I found that this could indicate an opportunity and openness in Brian to a dialogue instead of power struggles in developing the alliance.

Sami

Sami repeats many times how music in general helps and supports him - he says "*I become calm and relaxed when I listen to music...it is lovely - I like music……".* He does recognize the importance of music therapy when he says "*(the feeling of calmness)remains for 2-3 hours (after the session)… it is important to me and that is why I attend (music therapy) every Monday".*

First of all, Sami replies to the questions very briefly and sometimes it is difficult to know whether he understands the question. He does not reflect on how music therapy or the music therapist contribute to his overall treatment. However, he expresses how the interaction with the music therapist affects him and helps him to become reassured as he says *"she is very nice and knows something about music…I find comfort and I become calm"*. He mentions actions of the music therapist that helps him *"we play music on a dabuka… She tells me how to breathe in through the nose and breathe out through the mouth…I become relaxed – the muscles and so"*. Knowing how confused Sami can be and the fact that he remembers this exercise and concrete actions he performs with the music therapist, this expresses, in an indirect way, Sami´s recognition of the role of the music therapist. On the other hand, when he is asked how important it is that the therapist lead the actions he replies "I also lead".

When the interviewer asks about the importance of the verbal dialogue in music therapy it reveals Sami´s very private way of thinking "*I become relaxed when I talk (to the music therapist) about my former colleague´s daughter …I communicate with her (colleague´s daughter) telepathically".* It does, however, show that Sami experiences a little safety, which allows him to share difficult kinds of thoughts. On the other hand, his paranoia and ambivalence is also revealed "*I am careful in what I say when I talk to others – also the music therapist"*.

When asked if he thinks the music therapist likes and understands him he replies: *"she likes me – she just smiles when I look at her",* underlining his vulnerability and need for reassurance and regulation at a very basic and bodily level.

After analyzing the interviews with Sami I identified the following themes: 1) role of music, 2) importance of the therapist in relation to feeling safe, 3) role of verbal dialogue, 4) experience of what the music therapist thinks about him and 4) experience of receiving help.

Conclusion:

The interview confirmed me in my impression of Sami as extremely vulnerable, but his condition did not worsen in the period of time he received music therapy. Moreover, Sami experienced music and music therapy as contributing to stabilize and regulate his vulnerability and arousal. As I knew how extremely impulsive and

confused Sami could be, his experiences of music therapy emphasized my impression of the importance of this approach in supporting and strengthening the relationship with Sami.

Pete

Pete is more explicit and concrete in his way of talking about music therapy in the second interview, which might indicate that he has become more engaged and aware of the significance of music therapy and how it affects him.

Pete does not relate directly to therapeutic goals for music therapy, as the main focus for Pete is the musical product and improving musical skills – as he says *"I have played music for many years, it is a great hobby….I come from a musical family where we had two drum sets, a guitar and a piano… Playing brings me rest and energy …it is like I feel I have done something good and something that is important to me*". In addition*, "I think it (music therapy) is important uhh ….when people, being locked up in a place like this, are allowed to do something else in a boring everyday life"*

Even though Pete does not formulate therapeutic goals, he does recognize and describe many therapeutic effects of music therapy: *"There was this day where (my mood) was totally black and depressed, then we played bongo drums or something and it started to swing. Then you do not think about the everyday problems …and I walked away smiling"*. In addition, he said *"Often I come with no energy and then when I get started I gain more energy …I take it with me …and it can last the rest of the afternoon"*. Fundamentally, he describes how music therapy helps him to experience being more integrated, focused and able to contain his worries. In the musical interaction, there is a focus on empowerment and on his resources. Pete has gained positive expectations to music therapy, which support his engagement and motivation.

Pete recognizes that it is possible to express himself about important issues in music therapy, among others how he feels inside "*Normally I am not someone who shows feelings, I don´t feel good about it, but when it is just a little bit, like it has been (in music therapy) it doesn´t matter"*. A little later, when he is asked to give an example, he also expresses an ambivalence about talking about these issues *"…among other things (we talked) about my mother´s suicide…I don´t mind talking about it….but it is difficult"*. The important thing, though, is that he feels comfortable about talking about this issue. When Pete is asked to name a piece of music from music therapy which was particularly important to him, he describes a connection between music and how it facilitates the verbal dialogue *"House of the Rising Sun …I learned to play this when I was 13- 14 years….we play this song together, she (music therapist) at the piano and I playing the drums…it sounds very good together"* He continues *"…it is about a house called the rising sun and the story behind this song is: the mother should not let her child come here because something is wrong …it is about drugs…and I*

have been into that a lot…it is something I can relate to…the lyrics mean something to me. We have talked about this issue; that I want to smoke hash - I like smoking hash, because I feel good afterwards. That is perhaps why it pursues me …we process it in another way than in the unit". The combination of active musical interaction and a certain melody creates a relationship to and a verbal dialogue about an important theme. The music and melody supports talking about non-musical themes, but without the music therapist getting too close.

In relation to how the music therapist facilitates expressing difficult issues in the music, he says, "*sometimes she asked me to put it into words on the drums ….actually I found it interesting but it is not something you just do…but it was okay"*. He expresses openness to new ways of interacting in music, which is challenging, but on the other hand does not create anxiety and resistance in him. In another situation, he describes a more structured way of improvising that makes more sense to him "*House of rising sun…. sometimes she plays differently than what it says in the notes, and then I play the drums and it sounds good*".

He perceives the music therapist as positive, understanding and non-judgmental, and she makes him feel confident, despite his low level of energy, as he says "*She is very positive and skilful…I am not afraid of trying something new (in music), because I will not be judged"*. He is capable of mentalizing about the specific alliance to the music therapist and the importance of it *"I think she likes me….it means a lot, we all want to be respected and appreciated…it gives peace*". In addition*, "...it is important she is understanding….if I do not have the energy one day, then we just listen to music"*. He expresses that the musical interaction, where he receives support in expressing himself and succeeding in musical interaction, also supports his perception of not being judged, but appreciated.

Indirectly, he does acknowledge that some kind of structure is important, but on the other hand he also doesn't want structure "….*when we enter the music therapy room I can´t resist taking one of the instruments either drums, guitar and then we play together….I don´t really like it when it is too much of the same…in my life predictability is not that important"*. He expresses that too much structure also might inhibit his motivation and ability to express himself because he wishes to and is used to doing what comes to his mind.

After analyzing the interviews with Pete I identified the following themes: 1) being in music therapy, 2) receiving help, 3) being supported in order to express himself and the importance of this, 4) structure and the importance of this. Lastly, 5) the goal of music therapy.

Conclusion:

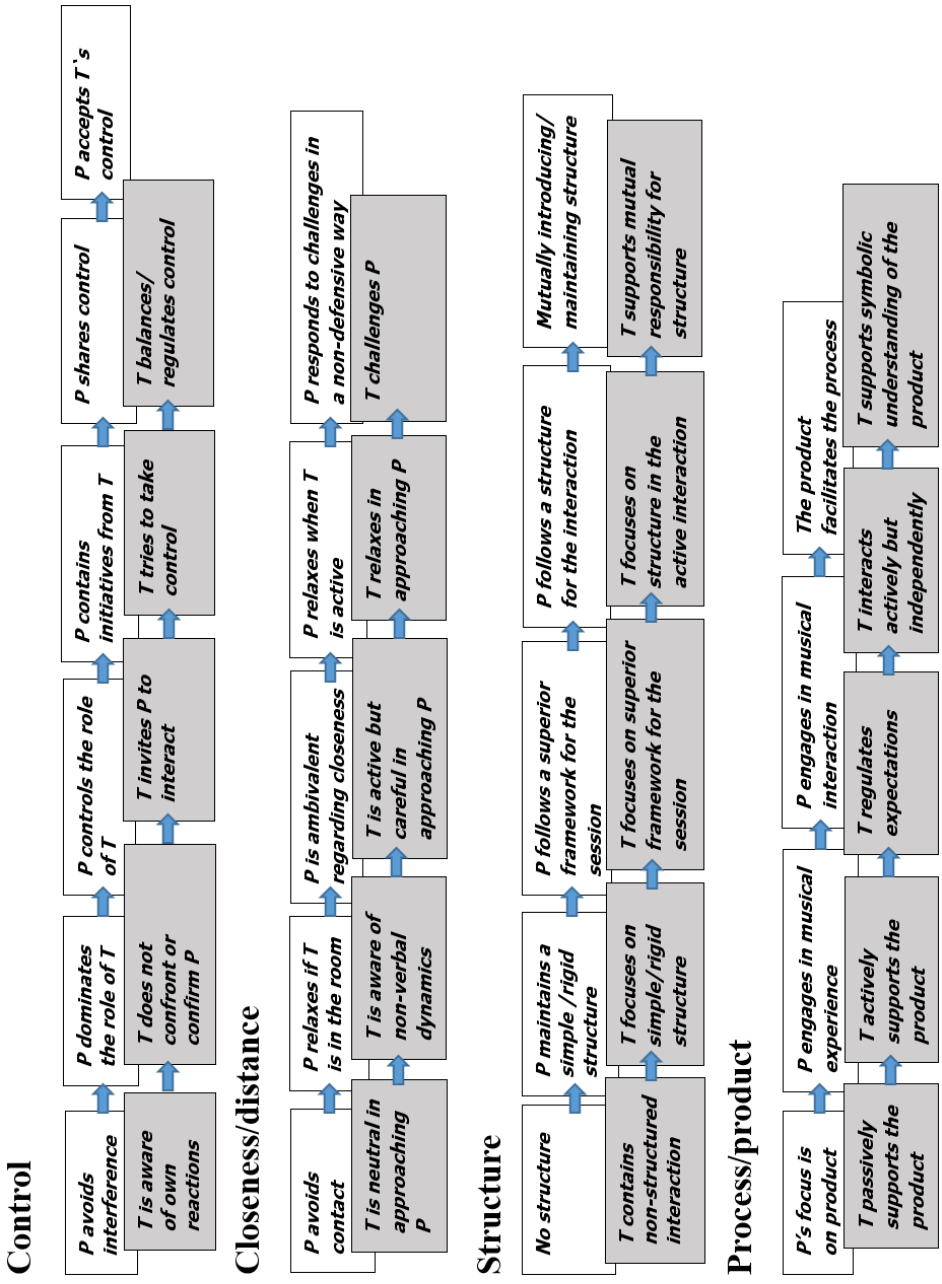
The interview confirmed to me the impression that music therapy with Pete happened in a way and progressed in a tempo where Pete was able to participate. It also reflected themes regarding what Pete found important in music therapy and the therapeutic alliance. He emphasized a focus on the musical product and improving skills in music therapy and therefore the skills of the music therapist were highlighted. On the other hand, he also described important therapeutic effects of the music therapy in dealing with negative symptoms and gaining access to energy, inner resources, concentration and a feeling of success. In addition, Pete formulated that this effect of music facilitated positive experiences and reassurance, affecting the perception of the music therapist as accepting, supportive and non-judgmental and affecting his motivation and willingness to engage, also in challenging musical interactions or verbal dialogues.

5.4. FINDINGS

According to the analysis model illustrated in *Figure 5-2*, the final part of the analysis consists of step 8, where I merged the evolved patterns from the four cases. Finally, I conducted an abductive synthesis (step 9) which led to the formulation of the continua model (Frederiksen et al., 2019).

5.4.1. THE CONTINUA MODEL

The continua model consist of seven continua and are illustrated in *Figure 5-8* below.


Control
P avoids interference
T is aware of own reactions
P dominates the role of T
T does not confront or confirm P
P controls the role of T
T invites P to interact
P contains initiatives from T
T tries to take control
P shares control
T balances/ regulates control
P accepts T`s control
Closeness/distance
P avoids contact
T is neutral in approaching P
P relaxes if T is in the room
T is aware of non-verbal dynamics
P is ambivalent regarding closeness
T is active but careful in approaching P
P relaxes when T is active
T relaxes in approaching P
P responds to challenges in a non-defensive way
T challenges P
Structure
No structure
T contains non-structured interaction
P maintains a simple /rigid structure
T focuses on simple/rigid structure
P follows a superior framework for the session
T focuses on superior framework for the session
P follows a structure for the interaction
T focuses on structure in the active interaction
Mutually introducing/ maintaining structure
T supports mutual responsibility for structure
Process/product
P's focus is on product
T passively supports the product
P engages in musical experience
T actively supports the product
P engages in musical interaction
T regulates expectations
The product facilitates the process
T interacts actively but independently
T supports symbolic understanding of the product

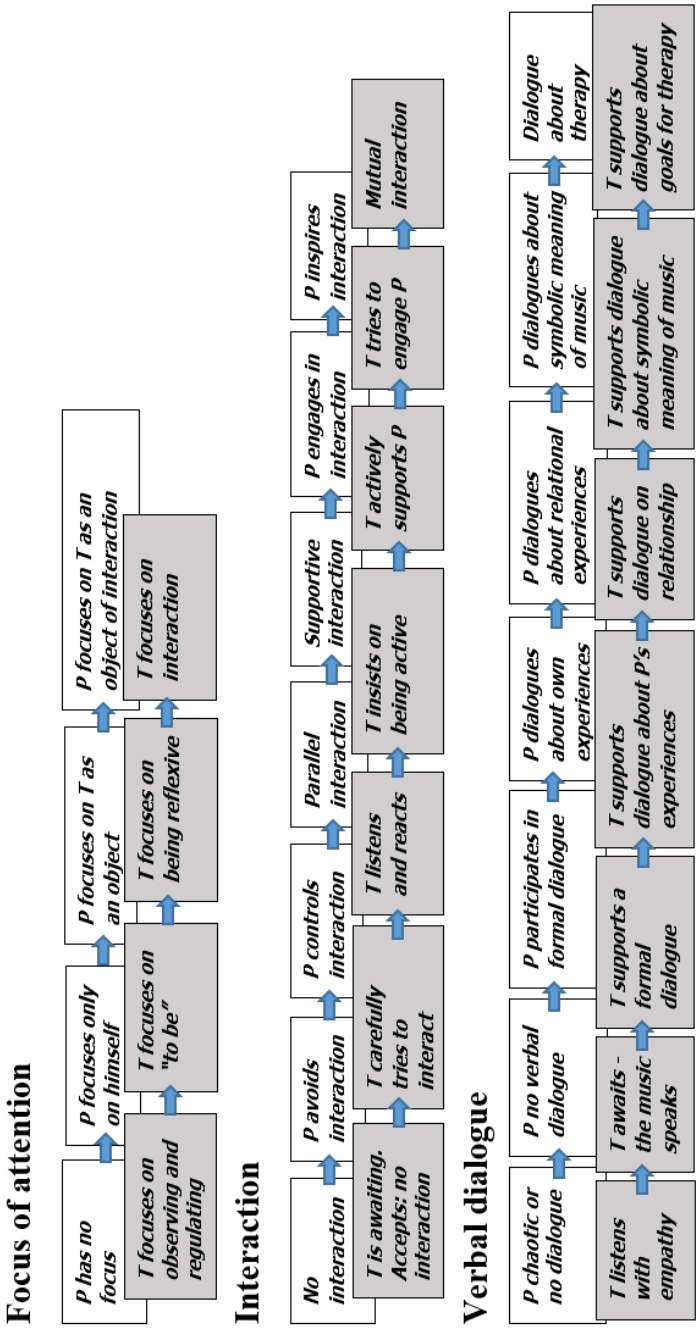


Figure 5-8 Seven continua illustrating the dynamic process of developing therapeutic alliance with forensic psychiatric patients in music therapy

(White boxes: P: Patient. Grey boxes: T: Therapist)

Control continuum

An extended explanation of the control continuum is presented in article 3 (Frederiksen et al., 2019)

The numbered text parts in italics in the case example refer to the numbers in the figures just below the text part, illustrating the dynamics in the interaction important for the development of therapeutic alliance.

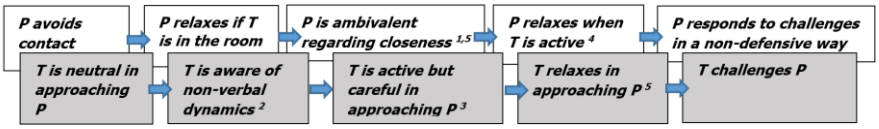
Closeness/distance continuum

The closeness/distance continuum starts with the patient signalling sensitivity and avoiding contact because of anxiety. The music therapist is neutral in her approach as a way of regulating arousal – she is not too enthusiastic, nor does she signal expectations as to a response from the patient. In this continuum, the therapist is very aware of her own arousal in order to identify small non-verbal dynamics and wishes for contact in the patient, for example if the patient relaxes being in the room with her or engages in a formal dialoguing. An increase in the patient's approach to the music therapist may result in ambivalence in the patient, for example as he invites the music therapist to participate and then rejects her. Gradually, the patient may relax when the music therapist is also active and may show an interest in her contribution. At the right end of the continuum, the patient does not react defensively when the music therapist challenges him; rather he shows positive expectations towards the interaction and an ability to receive empathy. The music therapist feels more and more free to express herself in music and speech, and it is possible for her to use humour and warmth and to show empathy, which indicates points of meeting between music therapist and the patient.

Vignette from the case with Pete:

> *Pete is ambivalent about closeness/distance to the music therapist [1]*. He plays sporadically on the guitar and asks the music therapist if she will play the bongo drums. At the same time, he makes so many changes to his way of playing that *it is not possible for her to accompany or follow him [2]*. The music therapist takes the initiative to *improvise with her voice - matching Pete´s way of playing [3]*. Pete stops playing, listens carefully, and then joins in singing, and the music therapist senses that Pete is approaching her. Pete´s body is less tense than at the beginning of the session and he *relaxes in active interaction [4,]* nurturing "a point of meeting".
>
> At the end of the session, Pete suddenly goes to the conga, playing in a very structured way. The music therapist joins in playing the djembe (African drum). They drum at the same time but there is no

interaction. *Pete returns to an ambivalent way of approaching the music therapist but he does relax in the room with her and the therapist relaxes in approaching Pete*[5].



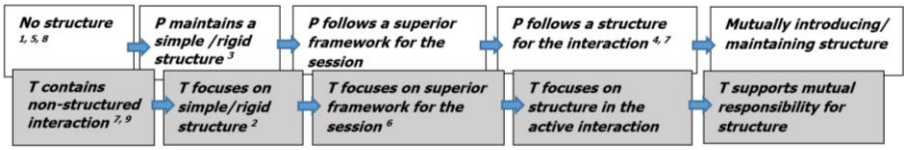
Structure continuum

The structure continuum starts with no structure – the patient is making many variations and shifts in music as well as talk, and it is not possible to interact. The music therapist is aware that this behaviour is a way of keeping a distance in the interaction, but also signals a need for structure in order to regulate arousal. The music therapist is aware of validating small structuring elements appearing in the patient's way of acting, not being too directive which may cause resistance in the patient. A rigid structure may be the first step, for example holding on to the agreement of when to take a small break. The next step in structuring may be a general structure for the common activity, for example following a list of music, without the patient rejecting it in a passive way. The next structuring elements may occur in the direct interaction, for example sharing a common rhythmic pulse. The therapist is always aware that the aim of the structuring elements is to nurture a dynamic mutual interaction and therefore she prioritizes simplicity. At the last step of the continuum, both patient and music therapist contribute to maintaining a structure in order to secure a dynamic interaction.

Vignette from the case with Sami:

It is a challenge to maintain a structure in the session with Sami – because he is very vulnerable and impulsive, and *the session easily develops into a situation with no structure*[1]. The music therapist *creates a recognizable structure to start every session*[2] and rigidly holds on to it. Based on the music Sami likes, with no talking and Sami sitting in a "relaxing chair", they listen to "Engel" by Rasmus Seebach. Sami *maintains this structure even though he finds it a little funny*[3], and it supports him in feeling reassured and calming down. After the song, they continue singing the song, first singing single words from the song in turns and then in a very sensitive and quiet way singing the last lines of the song together. They end up taking a deep breath together and laugh. *The song and the structure for starting the session have created a structure for a positive and active interaction*[4]. Abruptly and very surprisingly, Sami asks what the music therapist had for lunch, and at the same time he gets up the chair, and suddenly there is *no structure again*[5]. The music therapist notices this, and gets a *little irritated, but keeps focusing on a general*

framework for the session[6,] remembering that Sami becomes overwhelmed by his impulses from time to time and there is no structure in the interaction again. The music therapist suggests listening to a piece of Turkish music and she takes a drum showing Sami how to play to the music. The recorded music *helps to initiate a structure for active interaction*[7]. Sami also takes a drum and follows the pulse, and they play quietly and intensely, creating small rhythms along with the pulse. The tension in the music rises and falls without developing into chaotic, unstructured rhythms, which it often does. Sami follows a structure in the interaction, and afterwards he says "thank you"– which the music therapist interprets as an acknowledgement from Sami that he was able to participate in an active interaction. Sometimes *the music therapist allows Sami´s unstructured way*[8,9] of being instead of holding on to a structure, especially towards the end of a session, because she senses it is his way of avoiding interaction and closeness.



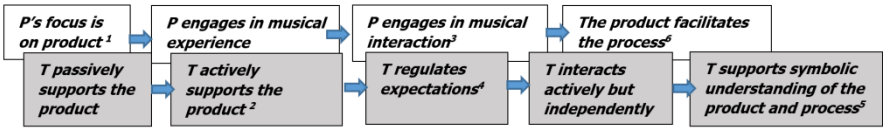
Process/product continuum

Within this continuum, the patient starts with high expectations of learning or performing music, or he is interested in the music in itself and has no interest in connecting the musical experience with any symbolic or personal meaning. The music therapist tries to regulate the high expectations and through interaction to facilitate a focus on the process and other aspects in relation to musical experiences, for example identifying activities that accumulate energy and create positive experiences and expectations. Gradually, the musical interaction develops with a focus on the common unique musical product and on listening to each other. The patient allows the music therapist to use her musical expertise and she actively takes the lead, for example by suggesting ways of playing. At the last step of the continuum, the patient is motivated to also explore non-musical aspects in relation to the musical experiences – and the music therapist supports exploring and talking about personal processes related to the music.

Vignette from the case with Pete

Pete has very high expectations and is *critical about his own musical skills and the musical product*[1], and he wants to practice intensely to reach the level of musical skills he had before he became ill. He does not want to talk about non-musical aspects of playing music. It is important for the music therapist to *accept Pete´s focus on the*

product[2] and to help create situations where he can experience success without her becoming involved in or stressed by his high expectations. The use of composed songs to create a structure for expression and improvisation within a musical framework *supports Pete´s engagement in musical interaction*[3], *accumulates energy and creates positive expectations*[4] in Pete. Gradually, Pete becomes *receptive to* comments on *having fun*[5] in the process of playing music, and the music therapy changes from being a one-man project to an opportunity of *creating a musical product in interaction with another person*[6]. This pattern is repeated in almost all sessions.



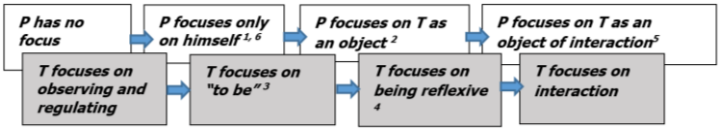
Focus of attention continuum

This continuum starts at a level where the patient has no focus, getting distracted and confused by anything. At the next step, the patient has an extreme focus on himself and his own project and does not include or integrate the music therapist. The music therapist accepts this and is aware of regulating her own arousal, just being present and passive, but at the same time, she is available if the patient´s focus of attention changes. Gradually, the patient integrates the music therapist into his focus, but still he follows his own agenda. At the right end of the continuum, the patient is focused on and aware of mutual interaction and he may ask for the therapist´s expertise. All the way, the music therapist is aware of the right timing and the patient´s readiness for her reactions and active contributions.

Vignette from the case with Frederic:

At the beginning of treatment, Frederic is not interested in the music therapist´s opinion. He is *focused on himself* [1] *and the matter of affecting the music therapist as an object*[2] or a pupil he can teach about his musical experiences/stories. The music therapist *accepts being taught*[3] and she makes the technical equipment work. Frederic is tense, confused and not in a contact. The music therapist tries to *regulate this tension by keeping the focus on the music* [4]. The music therapist suggests listening to music without talking, and *actively playing the drums*[5]. The music therapist has experienced an increased focus in Frederic on her as a person to interact with when they are in musical interactions. Even though Frederic will not admit verbally that the music therapist is an object for active interaction, where she also contributes to the music, *it is possible to engage Frederic in this active musical interaction where the focus is on our common*

"product" [5]. Frederic engages in active interaction with her, thus changing his focus to interacting with a person outside himself. Afterwards, however, he *returns to focus on himself* [6] – but with an important implicit experience of being able to focus and be present in the musical interaction and common "product". This experience and knowledge is very important for the music therapist to remember when suggesting a focus for new musical interactions.



Interaction continuum

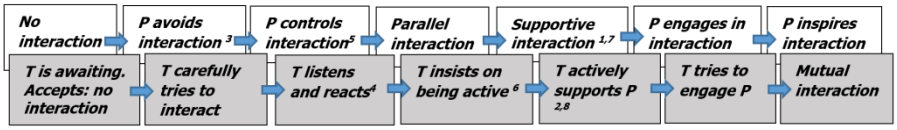
The interaction continuum starts with no interaction, and the music therapist accepts and supports this by being neutral. Carefully, the intensity of the interaction increases, in part facilitated by the music therapist carefully insisting on being active. The patient may soften his resistance and, at first, accept that the music therapist plays music at all. The next step in the continuum is when the patient is receptive to simple support and engagement, for example when the patient imitates the music therapist. In the last step of the continuum, the patient participates actively in facilitating mutual interaction. Gradually, the music therapist is able to give more space for her own musical expressions, and finally she can express herself freely. The last step signals that the patient has obtained a confidence in expressing himself.

Vignette from the case with Brian:

For 2-3 minutes, there is *a dynamic interaction in drumming, sharing the rhythmic pulse, and Brian allows the music therapist to accompany and support him*[1,2]in the music. Suddenly he changes his way of playing – becoming more unstructured and no longer following the rhythmic pulse – as if he is trying to *divert from and avoid the interaction*[3]. The music therapist senses some anxiety in Brian in performing and she *tries to put it into words* [4]. Brian answers in short sentences such as "What the hell do I know". By that, he signals that he does not really want to talk about this theme or that he is not capable of doing so. In this way, he *controls the interaction*[5].

Insisting on being active, the music therapist asks Brian to take the "sound bowl"[6], and the music therapist starts playing softly, with a slow pulse. Brian takes a sound bowl and the music therapist senses that he listens to the sounds and he becomes more relaxed. Quietly he says, "It sounds like church bells". H*e accepts a supportive*

interaction[7] *where the music therapist plays the cymbals in half time* [8].



Verbal dialogue continuum

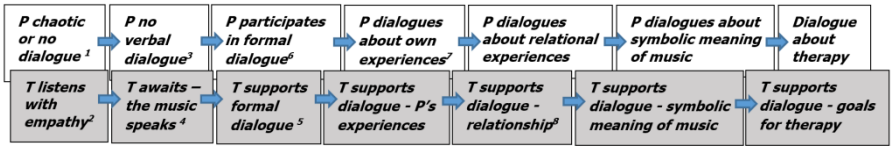
The verbal dialogue continuum starts at a level where there is no dialogue, and the patient´s verbal contributions are chaotic. Gradually, the music becomes a channel for informing about important issues and implicit knowledge. The music may fill out the silence when none of the participants knows what to say or respond. Actually, the music therapist is aware that the patient may experience talking as pressure. Verbal dialogue about formal themes may support verbal dialoguing in general and should be encouraged by the therapist. Gradually and carefully, the music therapist supports and integrates the patient's individual experiences, memories and relational experiences in the verbal dialogue. The music therapist may verbalize her own experiences in order to nurture a verbal dialogue at this level and thus support the patient in expressing himself verbally. When the patient is ready, the symbolic meaning of music in relation to the patient´s personal feelings and individual problems are supported and validated by the music therapist. Perhaps the patient will allow the music therapist to support him by borrowing the therapist´s verbal phrases. The last step in the continuum is a verbal dialogue about goals for therapy connected to the overall goal for the patient´s treatment.

Vignette from the case with Sami:

The verbal dialogue with Sami is often *unstructured and chaotic*[1], reflecting his psychotic and chaotic thoughts. It is very difficult for him to express himself clearly, and the music therapist formulates basic short sentences for *what she senses are his experiences and needs*[2].

The music therapist finds that *no dialogue*[3]*and letting the music speak*[4], are very positive for Sami because it helps him to become reassured and relaxed. Therefore, the music therapist directs the activities in the direction of only musical experiences to prevent a chaotic and confusing verbal dialogue, which is not constructive. The music therapy supports *formal dialogue about the instruments or other neutral themes*[5] which also supports Sami in calming down and increases his ability to *engage in a verbal dialogue at all* [6]. A subject on which Sami is very good at commenting – even though it is only with few words – is about *how music affects his arousal in the here-*

and-now[7]. The music therapist *supports and validates this kind of verbal expressions about individual experiences in relation to the music*[8].



5.4.2. SEMI STRUCTURED INTERVIEW

I merged the findings from the interviews from four cases, which made me able to formulate the following key points:

- The interviews confirmed that the music therapy happened in a way and progressed in a tempo where the patients were able to participate.
- The patients emphasized the musical activity and a focus on the musical product as the main goal for music therapy and interaction.
- The patients all emphasized how the use of music supported their ability to relax and thus deal with negative symptoms. They expressed that music increased their ability to concentrate, gain energy and take initiatives. Through the interview, the patients described, although indirectly, how the music therapy experience created positive feelings and a positive experience of being met and respected.
- The patients recognized the music therapist as a helper – but they all expressed ambivalence in recognizing her role, especially in relation to treatment. Frederic even refused to recognize the music therapist´s role as a therapist. All of them expressed the need of being equal in the alliance and Frederic and Brian expressed being the ones who led the activity.
- The patients perceived the music therapist as positive, understanding, supportive and non-judgmental, except Brian, who was more neutral in his judgment.
- The patients more or less described how music and music therapy could support personal expression. Only Pete reflected how musical expression could facilitate a verbal dialogue about important issues, however with no connection to an overall therapeutic goal for treatment.
- All patients, except Sami, expressed difficulties with the music therapist´s efforts to structure the sessions, as they experienced it as a way to restrict or inhibit their expression.

5.4.3. QUANTITATIVE DATA

I merged the evaluations of quantitative data, described in chapter 5.3.4, from the four cases, and was able to formulate the following overall conclusions:

In the cases of Frederic, Brian and Pete, the analysis of quantitative data showed that the music therapy process took place at a pace and in a way where they were able to participate **without an aggravation of their condition**. In the case of Sami, the data reflected his general symptoms of being vulnerable and anxious. The data showed, however, a small tendency towards Sami gaining a feeling of confidence and safety in the music therapy.

I find that the assessment of alliance reflected a small tendency towards a strengthening or stability in the therapeutic relationship in all cases. In the cases of Frederic and Sami, the therapeutic relationship developed from engagement and a wish for contact towards small glimpses of attachment. Whereas in the case of Brian, the therapeutic relationship stayed stable at the level of engagement, reflecting only a wish for contact. The therapeutic relationship with Pete showed stability on the level of attachment developing towards engaging in a supportive working alliance.

The SRS scores were either the highest possible scores in all sessions (Frederic) or very fluctuating (Sami and Pete), which I find indicates either an idealization of the alliance or that it was difficult to identify any pattern. In the cases of Sami and Pete, the scores stabilized during the period, which may indicate an increase in the patients' feeling of safety in music therapy. It could also indicate that the patients had gained more confidence in filling out the scales.

Mood adjective checklist also showed the highest possible scores in all sessions in the case of Frederic, which again I find indicates an idealization of music therapy. In the case of Pete, I find that the scores indicate that he experienced stability in his condition, and was not clearly affected by music therapy. Sami´s scores indicated a small tendency towards feeling more safe and able to receive comfort.

The staff´s scorings should be interpreted with great caution, because of missing data, and perhaps therefore it is difficult to identify any patterns. I found that there was a tendency towards the staff experiencing contact with Sami as tense, which I think also reflects his great vulnerability. In the case of Frederic, I find that the scorings indicated that staff had very different reactions and that he triggered very different reactions in them.

5.4.4. TRIANGULATION OF FINDINGS

In order to balance the results, in which the main finding is the continua model, I will apply a triangulation method to validate the model with findings from the semi-

structured interview and the quantitative data. The continua model is based on an in-depth analysis of the therapist´s notes, and the triangulation serves as a way to integrate the findings based on other perspectives and sources of data and as a counterpoint to the perspective of the therapist.

The findings of the interview and quantitative data lead me to the conclusion that the patients participated in music therapy with no aggravation of their clinical condition. The patients expressed being positive and motivated for music therapy, which indicates that they experienced the process and interaction as taking place at a tempo where they were able to participate. Moreover, I find that this conclusion supports the continua model, which illustrates the importance of regulation on a very basic level in order to support the patient´s engagement.

The assessment of alliance in three cases revealed alliance building at the level of engagement with small glimpses of development towards attachment or a supportive working alliance. This, I find, emphasizes the importance of maintaining contact and interaction with the patient despite the very weak signs of a therapeutic alliance. The therapist must be sensitive in identifying and validating the patient´s efforts to approach her in order to nurture the development of therapeutic alliance.

Brian, however, was more negative in his judgment of music therapy, among other things expressing a neutral or indifferent opinion of the interpersonal dynamic with the therapist. He was also the only patient for whom the assessment of alliance did not change during the period.

The theme "control" is the focus of the first continuum; it is central in the interaction with the patients and indirectly represented in all continua in the model. This may as well reflect the forensic psychiatric setting and an overall system of control. In the interviews, the patients reflected their need of being in control when with others, in their expression of resistance to being led and in the matter of who was in charge of structuring the session. In addition, I think the patients' ambivalence in recognizing the significant role of the music therapist as a therapist became clear in the interviews and, along with their emphasis on the musical product as the only goal for therapy, I find this reveals the patient´s need for control on a very basic level. The self-report forms that the patients filled out pointed toward an idealization of the alliance or their own clinical condition expressing "nothing is wrong" – or "I am in control and need no treatment". This requires of the therapist to remember that the forensic psychiatric patient´s need of control and his focus on himself is caused by his anxiety of losing control. Verbalizing or being restrictive regarding control may threaten the patient's feeling of integrity and create resistance and power struggles. The control continuum illustrates how to support the patient's experience of reassurance through regulation of his need for control in a way where he does not feel threatened and fear losing his sense of integrity. Assessing that the patient's need for control is decreasing and that

his ability to share control is increasing, reflects a strengthening of the alliance as illustrated in the control continuum.

All patients aside from Brian were inconsistent in their descriptions of their alliance with the music therapist; in one way perceiving her as a positive, understanding, respectful, supportive and nonjudgmental person and in another way not being able to or not wanting to recognize the importance of her presence. This, I think, emphasizes the patient´s ambivalence in the alliance, and underlines the necessity of approaching the patients in a non-threatening way, respecting their need for distance.

On the other hand, this need for distance and control does not mean that the therapist is not active. On the contrary, she is constantly trying to create a space for herself, perhaps just being in the room with the patient; waiting, listening and containing the lack of interaction as described in the interaction continuum. Or, as also described in the interaction continuum, she "insists on being active", balanced with sensitivity to the patients need of control and she possibly asks the patient to decide how the therapist should act. Even Sami emphasized that he also directed the session; despite the fact that the music therapist almost took over and decided how the structure for the session should be, and ignored his impulses to come with his own suggestions. She did this with great sensitivity in order to support Sami in calming down and being present in the relationship and eventually experiencing a sense of control. In the self-report form, where Sami was asked to assess his experience of calmness before and after music therapy, there was a very small tendency towards an increase in his feeling of calmness after music therapy sessions compared to before.

The continua model illustrates how interpersonal dynamics can be expressed, experienced and intervened with directly through the musical activity and interaction. I find that the relevance of focusing on the musical product as a start is supported by the patient´s emphasis on the musical activity or interaction as the main goal for music therapy. The music and musical interaction make it possible to support and validate the patient´s joy, interest and affection for music. The music therapist must be observant and creative in her awareness and use of the patient´s musical initiatives; in this way making dynamic musical interaction possible and thus nurturing confidence and safety in the patient.

In the interview, all of the patients described how music made them relax, which emphasizes the role of music and musical interaction as an important co-therapist for the music therapist in the process of regulating arousal and supporting reassurance in the patient. The musical interaction or activity facilitates the music therapist´s ability to support this process of reassurance, keeping a distance at the same time. Pete and Frederic both described the effect of music and musical interaction as enhancing their ability to concentrate, and Pete added that it enhanced his ability to contain worries and be energized. All patients described positive experiences of participating in musical activity and interactions. Therefore, I find that despite the patients' need for

distance and their tendency at times to push others away, these descriptions emphasize the importance of remembering that the patients have a need and desire to be able to participate and contribute to the interaction. In addition, I find that the patients' positive experiences of musical activity indirectly suggest an increased receptiveness to receiving support.

The patients did mention the therapeutic effects of music therapy as described above, but did not recognize the importance of this in relation to their overall treatment or need for treatment. As illustrated in the continua model, the musical interaction or activity is the starting point for cautiously working on and modifying the patients understanding of the interaction as something more than just a musical product, but also as something that reflects aspects of their own process. In the interview, the patients formulated how their personal needs were met through the musical activity and interaction, which I find is the first step towards an emerging understanding and accept of their problems. Sami expressed the need for rest, Frederic the need of expressing himself in a way that others could understand, and Brian the need of gaining self-confidence. Pete clearly saw how the musical expression facilitated symbolically a talk about his relation to drugs and his mother´s suicide. The musical interaction facilitated these experiences, making it possible for the patients to verbalize these needs. As illustrated in the verbal dialogue continuum, the therapist helps the patients to verbally express important dynamics or relations in the music and, as this becomes clearer and more tangible, she facilitates an understanding of how this relates to general problems and treatment. The therapist may facilitate this verbal dialogue on a symbolic level in order to ensure the patient's feeling of safety by not becoming too close and personal.

CHAPTER 6. DISCUSSION

The aim of this thesis was to investigate whether it is possible to develop therapeutic alliance in music therapy with forensic psychiatric patients with schizophrenia by exploring the following three research questions.

1: *What is the evidence base for therapeutic alliance building in music therapy or psychotherapy with forensic psychiatric?*
2: *What is emphasized in the literature regarding how it is possible to develop and establish a therapeutic alliance in music therapy or psychotherapy with forensic psychiatric patients?*
3: *How may the dynamics in the developmental process of forming a therapeutic alliance between music therapist and forensic psychiatric patient with schizophrenia in the initial phase of music therapy be described?*

6.1. MAIN FINDINGS

In order to answer research question 1, I conducted a systematic literature review presented in article 2 and concluded that no evidence was found to confirm an effect of psychotherapy or music therapy on developing therapeutic alliance with patients with severe mental illness in forensic psychiatry (Article 2, Frederiksen & Ridder, 2019). The systematic literature review did reveal a study confirming an effect of psychotherapy on developing therapeutic alliance with patients with schizophrenia in a general psychiatric setting (Svensson & Hansson, 1999). Combined with the fact that a majority of forensic psychiatric patients in Denmark are diagnosed within the schizophrenic spectrum, I find it is relevant to assume that the same elements supporting alliance building in general psychiatric settings are applicable to forensic psychiatric patients with schizophrenia and that there is a basis for investigating this field further.

In answering research question 2, the literature review emphasized that an increased focus on the initial phase of psychotherapy with forensic psychiatric patients is required in order to support the development of trust and confidentiality in the therapeutic relationship , and it is a prerequisite for the patient in allowing the therapist to help him recover (Article 2, Frederiksen & Ridder, 2019) .

In the systematic literature review presented in article 2, forensic psychiatric patients were found to be sensitive to the power divide inherent in the therapeutic alliance (Vasic et al., 2015), emphasizing these patients' need of control caused by threats to their self-esteem and loss of status. The patients' difficulties with social interactions caused by severe mental illness and, in addition, antisocial behaviour were found to make the process of developing therapeutic alliance very challenging, demanding the

utmost flexibility of the therapist. Music therapy was described in a case study as being able to offer a forensic psychiatric patient with severe mental illness the opportunity to involve himself in the relationship at an emotional level without losing control (Metzner, 2010), and we found that it pointed to the potential of music therapy as a supportive approach in the alliance building phase, balancing the tasks of softening hostility, supporting motivation and engagement in maintaining interaction and increasing the patients´ intersubjectivity (Article 2, Frederiksen & Ridder, 2019). In the article we found that negative symptoms and metacognitive disabilities in general among patients with schizophrenia affected the process of developing therapeutic alliance (Article 2, Frederiksen & Ridder, 2019), and one study emphasized the need of improving the therapist´s ability to address negative symptoms (Jung, Wiesjahn, & Lincoln, 2014). A meta-analysis (Geretsegger et al., 2017) on the effect of music therapy with people with schizophrenia or schizophrenia-like disorders found a beneficial effect on negative symptoms. Overall, I found that the systematic literature review emphasized the relevance of investigating how music therapy may contribute to the development of therapeutic alliance in the initial phase of psychotherapy treatment with forensic psychiatric patients and revealed a gap in the literature. In addition, it led to the formulation of the third research question, where I chose to focus on the group of forensic psychiatric patients with diagnoses in the schizophrenic spectrum.

In order to answer research question 3, an explorative case study, collecting multifaceted data and providing thick descriptions of clinical music therapy sessions with four forensic psychiatric patients with schizophrenia and from the first six months of therapy, led to a model consisting of seven continua. The continua model suggests a conceptual framework for describing dynamic interactional processes in the relationship between the music therapist and forensic psychiatric patients with schizophrenia, toward a strengthening of the therapeutic alliance in the initial phase of a course of music therapy treatment (Article 3, Frederiksen et al., 2019). The cases included in the thesis describe several of these dynamic developmental processes, emphasizing the potential of music therapy to engage the forensic psychiatric patient with schizophrenia in musical and non-verbal interaction and, through regulation and synchronization directly in the musical activity, to support the alliance building process.

The findings of this thesis raise some questions about the understanding and concept of the therapeutic alliance, the music therapist and psychotherapist´s contribution to the therapeutic alliance, and the special needs of forensic psychiatric patients regarding engagement in music therapy and therapeutic alliance.

6.2. CONCEPTUALIZING THERAPEUTIC ALLIANCE

The overall aim of this study was to investigate if it is possible to develop therapeutic alliance with forensic psychiatric patients with schizophrenia in music therapy. As the

continua model provides insight into the dynamics and development of therapeutic alliance, this leads to my suggestion that it is possible to develop and nurture essential elements leading towards establishing a therapeutic alliance with this group of patients. Such a process takes time, and rather than determining the forensic psychiatric patient´s ability to meet and fulfil a fixed definition of therapeutic alliance, determining *if* it is possible to meet the patient, this process shows *how*, which is essential. Moreover, it is relevant to ask if it is possible to describe patterns of dynamic interactional processes that indicate a development of trust and confidentiality in the therapeutic relationship. I find that the continua model emphasizes the importance of repeating and repairing these patterns of interaction, in order to support the alliance building process, because the contact between patient and therapist is often challenged by the patient's retreat and devaluation of the relationship (Article 3, Frederiksen et al., 2019). The need for conceptual work in research on therapeutic alliance that is specific to psychiatric settings has been highlighted (Priebe & McCabe, 2006), and the model of McGlashan and Keats (1989), describing eleven relational levels, is an important contribution to this. These relational levels were developed from case studies of psychotherapy with patients suffering from schizophrenia (McGlashan & Keats, 1989). The continua model has clear parallels to this model, in particular the first three levels starting from no engagement towards the patient's very slight wishes for contact and attachment. The continua model contributes to a detailed description of interactional dynamics with forensic psychiatric patients with schizophrenia in the first steps of the alliance building process, in particular pointing to how to meet the patient´s need of control.

The focus of the thesis is on the initial phase of developing the therapeutic alliance. In the case study, the first six months of music therapy treatment with forensic psychiatric patients with schizophrenia was defined as an appropriate length in order to succeed in establishing a satisfactory level of trust and collaboration. It may be debatable whether the length of the initial phase is relevant. The appropriateness of six months with severely mental ill forensic patients was based on literature (Sørensen, 2004; Thorgaard et al., 2006) as well as my own clinical experience. I find that the findings of the thesis confirm the need for a long initial phase in order to sufficiently establish the fundamental basis for developing therapeutic alliance. The focus in the continua model is on supporting and enhancing the forensic psychiatric patient's relational abilities and regulation of arousal, which reflects a parallel to what McGlashan and Keath (1989) named "building the relationship", representing the first phase of his model. Haga and Thorgaard (2006), who also refer to McGlashan and Keats, emphasized the patient's need of protection, support and structure in this first phase.

The next and what I call the second phase in developing therapeutic alliance is described as "using the relationship", when the patient has a clear wish for treatment (McGlashan & Keats, 1989; Thorgaard & Haga, 2006). Hougaard (1994, 2004) described in his model the agreement between therapist and patient on working on

specific problematic issues as an important element in the therapeutic alliance. In the case study, the therapeutic relationships did not develop to a level where it was possible to establish an agreement on clear therapeutic goals for the therapy. Several therapeutic issues were implied but not recognized by the patients as needs for treatment or important issues to work with in a therapeutic setting. This also reflects forensic psychiatric patient's resistance to treatment and lack of insight regarding their own problems.

In the thesis, I suggest that the way of dealing with power struggles and the patient´s need of equality and control is an essential element in nurturing the development of therapeutic alliance. Through musical expression and interaction in music therapy, the forensic psychiatric patient experiences new ways of acting and dealing with problematic issues without being forced from the start to recognize and agree on central therapeutic problems. I find that the psychosocial and resource-oriented perspective in music therapy contributes important aspects to consider in this initial phase of alliance building with forensic psychiatric patients. The process of empowering the patients by supporting their strengths and creative resources is emphasized in resource-oriented music therapy along with collaboration and equality in the relationship (Rolvsjord, 2016). The quality of this approach was supported in a study where patients with psychosis were interviewed about their experiences of participating in music therapy (Solli & Rolvsjord, 2015). In these interviews, the patients emphasized experiences of freedom, relationship, well-being and reduction of symptoms (2015). Tuastad & O´Grady (2013) write about a psychosocial approach in music therapy with prisoners with mental problems and how central therapeutic issues in relation to motivation and alliance building are affected, such as, for example, the mastery of being musicians rather than criminals. Despite the fact that the patients included in my thesis are psychiatric patients sentenced to treatment, not prisoners, I find that the forensic psychiatric patients are very preoccupied with their identity of being criminal and punished.

I find that the interactional dynamics described in the continua model have clear parallels to a resource-oriented perspective in music therapy, emphasizing how positive experiences in musical activity and interaction support the patient´s motivation and engagement in the therapeutic relationship. In addition, I find that the patients in the case study confirmed the importance of positive experiences in music therapy in the interviews. However, in contrast to a resource-oriented approach in music therapy, I find that music therapists also should consider the possibility of introducing a more confrontational approach regarding problematic themes such as addiction and aggression. This will challenge the equality in the therapeutic relationship and establish clear roles and the music therapist´s authority. The fact that forensic psychiatric patients have been sentenced to treatment increases the requirement of the music therapist to facilitate a change in the patient´s behaviour. I find that the formulation of Horvath and colleagues (2011) is helpful in the process of balancing support and confrontation in the therapeutic alliance,

> "… bridging the client´s expectations and personal resources and what the therapist believes to be the most appropriate intervention is an important and delicate task. Alliance emerges, in part, as a result of the smooth coordination of these elements" (Horvath et al., 2011, p. 15).

The continua model is a description of essential elements in the alliance building process and my answer to research question 3. Similar to what music therapy pioneers such as Benenzon (1997) and Bruscia (2014) describe as the first aim of music therapy, I emphasize the establishment of contact and channels of communication from the start, illustrated by the descriptions of interactional dynamics at the left end of the continua model. Establishing these short moments of contact or interaction is described by Bruscia (2014) as the starting point and prerequisite for being able to support the development of the therapeutic alliance which, again, is the prerequisite for supporting growth in the patient and preparing the introduction of therapeutic progression and challenges. Similarly, the continua model illustrates and describes the dynamic interactions supporting the alliance building process, moving from the left end of the continuum to the right. The continua model provides a detailed description of how, gradually and with the right timing, a common understanding of therapeutic challenges are prepared. In addition, and as illustrated in article 3 (Frederiksen et al., 2019), the continua model illustrates how, in the fluctuating here-and-now dynamic interaction, a pattern of moving back and forth within the specific continuum may still describe a positive alliance building process.

Research on therapeutic alliance has mostly focused on other patient populations, and the measurement tools developed may not be relevant when identifying and measuring therapeutic alliance with patients with severe mental illness in psychiatric settings (Article 2, Frederiksen & Ridder, 2019). Among other reasons, because these measurement tools are focused on detecting collaboration rather than emotional processing in the therapeutic alliance (Jung et al., 2014). The continua model is specifically developed within the forensic psychiatric setting and may contribute to enhancing the focus on emotional processing at a bodily level of synchronization and arousal regulation. Among other things, I suggest that a patient´s improved ability to focus on, follow and synchronize with a common structured rhythm is an element that indicates a strengthening of the therapeutic relationship. I want to emphasize that a development of the interactional dynamics described through the continua model could also serve as an overall assessment of the quality of the therapeutic relationship and alliance building process.

6.3. THERAPIST CONTRIBUTIONS

Research question 3 could indicate that I assume that elements in music therapy are specifically useful in the alliance building process with forensic psychiatric patients with schizophrenia.

Therapists' and patients' differences and the non-specific factors such as the therapist´s personal contributions and abilities have been emphasized as the most important aspects in developing the therapeutic relationship, rather than the specific therapy methods applied (Ackerman & Hilsenroth, 2003; E. Hougaard, 1994; Sloane, Staples, Whipple, & Cristol, 1977). Among other things, the way in which the therapist is able to enhance the patient´s perception of her as empathic, accepting, respectful, helpful, friendly and supportive (Coursey, Keller, & Farrell, 1995) has been found to be important factor in developing therapeutic alliance, also in forensic settings (Marshall & Serran, 2004). Ross and colleagues (Ross et al., 2008), who have described and researched the development of therapeutic alliance among patients in forensic settings, found that "how the social interaction between a specific therapist and a specific patient affects the therapeutic alliance is intuitively perceived as important but poorly understood and the literature on the subject small" (p. 470). In this thesis, the focus is not on whether music therapy as a specific type of therapy and method is better in supporting the development of therapeutic alliance than other therapeutic methods. Rather, the aim is to investigate how the use of a non-verbal medium such as music in a psychotherapeutic setting contributes to supporting the therapist in her personal abilities and resources towards enhancing the patient's positive perception of her. Hence, the continua model aims to describe the non-specific contributions in the alliance building process that are also relevant for other psychotherapists working with forensic psychiatric patients with schizophrenia.

In general, Ross and colleagues (Ross et al., 2008) and Marshall & Serran (2004) emphasized the efforts of the psychotherapist in forensic psychiatry to create a supportive setting and with an empathic attitude use encouragement, rewards and a directive approach. They also emphasized that being too confrontational may result in a reverse effect in the therapeutic relationship (Marshall & Serran, 2004). The continua model, I find, emphasizes that the music therapist should be particularly sensitive as to how she is directive with forensic psychiatric patients with schizophrenia, as this very easily can lead to the patient's experience of losing control. However, the continua model also points at the importance of stressing the professional skills of a music therapist in the way music plays an important role for mediating contact and meeting the forensic psychiatric patients´ need of control.

In order to contribute to an understanding of how to succeed in developing a good therapeutic alliance, I suggest an idiosyncratic focus on patterns of interaction between the therapist and the patient. In addition, I find this focus particularly important in the first phase of nurturing the therapeutic alliance, as it includes very complex therapeutic dynamics and the utmost flexibility of the therapist. Inge Nygaard Pedersens (I. N. Pedersen, 1997) described different listening perspectives that support the music therapist in being aware of interactional dynamics, including implicit and non-verbal dynamics, in music therapy with psychiatric patients with schizophrenia. Similar to what I describe in the continua model, Pedersen (I. N. Pedersen, 1997, 2007) described the necessity that the therapist is extremely sensitive,

so as to perceive nuances in the dynamics and to balance closeness/distance in the therapeutic relationship. As illustrated in the selected case story in article 3 (Frederiksen et al., 2019), an interactional pattern arose where the patient experienced a mutual, free and positive interaction without a struggle for control. This short moment of meeting strengthened the patient´s belief and trust in the alliance and the experience of being able to contribute in a mutual interaction. I find that this moment of meeting happened in a specific relationship, as a result of a complex interaction between the therapist's and the patient's reactions to and perceptions of each other, including the therapist´s intuitive perception of the patient´s perception of her in the here-and-now.

The therapeutic dynamics described in the selected case example in article 3 and the continua model have clear parallels to the descriptions of "now moments" and "moments of meeting" in psychotherapy (Stern et al., 1998). The "now moments" are described as the emergence of unpredictable interpersonal processes that prepare the appearance of a "moment of meeting". In the continua model, I describe the acute attention of the music therapist on small signs of the patient approaching her, and I emphasize the therapist´s creative contributions to enhancing synchronization processes, improvisation and resonance at a basic and sensory level towards strengthening the therapeutic alliance. This is similar to how Trondalen & Skåderud (2007) describe "facilitating "now moments" in music therapy by matching qualities such as form, intensity and timing" (p. 105).

In the case study, I describe in detail the musical relationship and the therapist´s efforts to regulate and reassure the patient in the musical interactions, and I find these descriptions help to illuminate and enhance the understanding of regulating processes on an implicit and non-verbal level. I also find that the continua model illustrates that it might be easier to support these regulating processes through the musical interaction. Discussing whether music therapy contributes specifically to enhancing the therapeutic alliance with forensic psychiatric patients, a case study suggested that "music therapy can sometimes provide a context for safe exploration of aggression and deep feelings…. enable the individual to sublimate negative emotions" (Pool & Odell-Miller, 2011, p. 1). I find that this way of offering a safe channel for expressing difficult emotions in music therapy may enhance the patient´s experience of receiving help and support their willingness to engage in the therapeutic relationship. Leith (2014) pointed to music therapy as an "entry point" for women prisoners with a borderline diagnosis, increasing their engagement in prison programmes and resettlement. Although this assumption is not directly transferable to forensic psychiatric patients with schizophrenia, it may point to a similar effect.

Research has pointed to the importance of identifying attachment style (Rubino, Barker, Roth, & Fearon, 2000; Sauer, 2003) and interpersonal schema of ways of interacting in relationships (Safran, Murran, & Rotman, 2006), in order to match the therapist and patient and create the best conditions for the development of therapeutic

alliance. This aspect requires an evaluation of the participant´s contributions at a deep and personal level. The aim of this thesis was not to draw any conclusions in the sense of the patient's or therapist´s different attachment styles. The continua model, however, may support an assessment of the ways the patient and therapist interact, react and perceive each other, thus supporting a description of attachment style and interpersonal schema.

6.4. PSYCHOTERAPEUTIC TREATMENT OF FORENSIC PSYCHIATRIC PATIENTS

A marked increase in the number of forensic psychiatric patients in combination with a gap in literature on therapeutic alliance with this patient population (Article 3, Frederiksen & Ridder, 2019) emphasizes the need for research within this field. The treatment of forensic psychiatric patients should not just support the patient in being discharged from hospital, but also aim to secure treatment that prevents readmission, because the patient has gained new knowledge and understandings about himself. This requires development of a therapeutic alliance based on mutual communication, contributions and sufficient collaboration beyond the aim of compliance and the patient´s passive acceptance of treatment.

There is an increased recognition of the comorbidity of forensic psychiatric patients in relation to personality pathology and personality disorder (Blackburn et al., 2003; L. Pedersen et al., 2010). In addition, treatment of problems caused by personality disorders can be overlooked because they are seen as part of a psychotic syndrome (Simonsen & Newton-Howes, 2018). This dilemma further emphasizes the need for psychotherapeutic treatment and development of therapeutic alliance in forensic psychiatry in order to support the treatment of problems caused by antisocial behaviour. A systematic review on the effect of music therapy in correctional settings pointed to the fact that most studies of treatment with offenders have a focus on reduction of recidivism and, in addition, that music therapy may offer treatment that addresses mental health problems in this population (Chen, Leith, Aarø, Manger, & Gold, 2016, p. 1). The review found that music therapy may support increase in self-esteem and social functioning (Chen et al., 2016). Combined with descriptions of how music therapy may offer a channel for expression of aggression and difficult emotions (Metzner, 2010; Pool & Odell-Miller, 2011), I think this emphasizes the potential of music therapy to promote recognition of a psychotherapeutic approach in the treatment of forensic psychiatric patients.

Through my clinical experience, I find there is a tendency to favour activity-based interactions in forensic psychiatric settings. In the continuum product/process, I emphasize an activity-based perspective as the starting point for developing therapeutic alliance, but, in the continuum, the effort to include and gradually integrate a more process-oriented perspective is emphasized. In addition, Odell-Miller (2007) points to "the risk of increased rigidity and something to hide behind if the focus is

solely on activity-based music therapy with patients with personality disorders" (p. 387).

This thesis contributes to an understanding of how to meet antisocial, hostile and possibly dominating attitudes of forensic psychiatric patients in a regulative rather than restrictive way. Thus, it supports the patient´s experience of being able to contribute to a relationship without harming others and, in addition, enhances the perception of the therapist as sincerely interested in trying to understand, help and relate to him. Developing trust and empathy in forensic psychiatric patients has been the focus of the research of music therapist Compton-Dickinson (2015; 2013). In a group of forensic psychiatric patients with a borderline diagnosis attending music therapy, improvements were found in the patients' ability to relate to others, including less fear of separation and less suspicious, uncommunicative and self-reliant behaviour (2013). For her approach, Group-Cognitive Analytical Music Therapy, she created a manual for clinical music therapists that described in detail four treatment stages facilitating mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness (Compton-Dickinson & Hakvoort, 2017). For the music therapist to facilitate mindfulness in the patients, she suggests techniques such as: being present in the moment, being supportive of reflective choices, using breathing/ground techniques and enhancing awareness of the environment through the senses (Compton-Dickinson & Hakvoort, 2017), which has clear similarities to some of the approaches described in the continua model. The continua model, I find, provides detailed descriptions of the interactions in situations where the forensic psychiatric patient may be defensive. An example of this from the case study was a situation where engaging Frederic in an activity aimed to strengthen grounding demanded the utmost creativity of the therapist in order to avoid increasing the patient's resistance.

My clinical experience in the forensic psychiatric setting has shown that the matter of what motivates the patients to change their behaviour is an important issue not agreed upon among clinicians, and the relevance of supporting therapeutic alliance is questioned. The aspect of motivation or readiness to change has been highlighted as more important than the therapeutic alliance, because offenders tend to experience relationships as a matter of power and control and they are more motivated by "what's in it for me" than by a bond within the therapeutic alliance (Kozar & Day, 2012). Moreover, the matter of creating a change may be dealt with more efficiently by improving motivation through negotiating goals and cooperation among others, because offenders do not have the ability to create a bond (Kozar & Day, 2012). These arguments were raised primarily in relation to offenders, but the comorbidity of forensic psychiatric patients with antisocial behaviour, as well as the fact they also are sentenced to treatment, creates the basis for similar arguments in the treatment of forensic psychiatric patients. On the other hand, I find the continua model presents how it is possible to support the forensic psychiatric patient´s ability to create a bond. I want to emphasize that the patient´s motivation for change is an integral part and

aim of developing a therapeutic alliance, and I agree with Polaschek and Ross (2010) when they describe the therapeutic alliance as " a motivationally supportive way to engender progress" (p. 108). To support these arguments, in a study investigating the relationship between the therapeutic alliance and treatment outcome in 70 violent offenders, Ross (Ross, 2008) found a small but significant association between alliance and outcome.

The ability to mentalize is defined as the ability to understand another person's behaviour in terms of their likely thoughts, feelings, wishes and desires (Fonagy & Bateman, 2008). Mentalization based treatment of personality disorders is a growing psychotherapeutic approach within forensic psychiatric treatment, especially with patients with borderline diagnoses, but also with patients with antisocial personality disorders (Bateman & Fornagy, 2016). The MBT approach is focused on verbalization techniques but is described as grounded in early attachment relationships and early experiences of regulation of arousal and synchronization with another person on a non-verbal level. Enhancing forensic psychiatric patients' capacity to mentalize has been described as ameliorating problems caused by personality disorders (Bateman & Fornagy, 2016). The continua model describes the process of supporting the patient´s ability to access implicit knowledge about relating, by experiencing synchronization and regulation of arousal directly in the musical interaction. Music therapists have described this connection between music, music therapy and mentalization; among other things describing how musical activities engage the patients in the therapeutic relationship on the implicit level and offer an opportunity to experience interaction with other people in a non-verbal medium (Hannibal & Schwantes, 2017). As such, music therapy could support the first steps towards enhancing the forensic psychiatric patient's ability to mentalize.

6.5. CONSIDERING ETHICAL ISSUES

Throughout this research, I was the therapist as well as the researcher, which created some ethical dilemmas and required considerations regarding my engagement and involvement in the research field. I chose to deal with these dilemmas and other ethical issues related to the case study using the agenda of EPICURE (Stige et al., 2009).

Engagement

In real-world research, the matter of interpreting personal meanings and experiences constructed by the participants can only be achieved by participating in their social world (Robson, 2011), and my involvement and engagement in the study along with my clinical and theoretical background was essential in order to secure trustworthy and useful data. My self-descriptions, including descriptions of subjective experiences such as thoughts and sensory reactions in the interaction with the patient, revealed important data on interactional dynamics and made it possible to gain "access to the phenomenon" being studied. As forensic psychiatric patients can be vulnerable,

mistrustful and give very little information about inner experiences and reactions, this engagement in the field was even more important. This does, however, require a thorough description of my situatedness within the research field. I am a registered nurse and music therapist with extensive clinical experience in psychiatry and, as described by Thomson et al. (2017), this influences reflexivity in how one approaches all aspects of research from planning the study to collecting and interpreting data.

Processing

The study involved a vast amount of data and required a thorough description of data collection procedures and, not least, a description of the process of reducing and selecting data, as well as the analysing process. I used a number of display sheets and figures to illustrate this process and to enhance the transparency and understanding of the process of making meaning out of data, towards a synthesis and formulation of findings. The full data sources and analysis sheets were added in appendix for the committee.

Interpretation

Highly subjective data such as therapy notes, and the fact that I was the therapist as well as the researcher, required reflexivity and flexibility in interpreting data and in the effort to create transparency. I described my preunderstanding and clinical experience thoroughly, in part through a RepGrid analysis aiming to enhance and describe my understanding of the concept of therapeutic alliance with forensic psychiatric patients. This I did in order for others to be able to judge the influence of my pre-understandings on the interpretations of the data.

I described my methodology based on a case study design and real world research, explaining and discussing the use of and integration of qualitative as well as quantitative data in a real world context.

In order to stay clear about my different roles, I consciously separated the process of data collection from the process of interpreting data. In writing the therapy notes, I tried to hold on to an authentic description of what happened and what I experienced, using words that were said and describing experiences as they occurred. Throughout the period of conducting the music therapy sessions, I received clinical supervision by a highly experienced expert music therapist in order to enhance my awareness and focus on relevant clinical issues of the treatment.

The strength and quality of the therapeutic alliance relies on the patient´s honesty and willingness to reveal difficult issues, which may challenge the forensic psychiatric patient’s feeling of safety and hope for the future. In the thesis, I was very sensitive to the patient’s signals and collected data that included not only what was said, but also embodied experiences of the patient´s condition and the dynamic in the

interpersonal interaction. These experiences support my ability to empathize with the patients in the therapeutic situation and, as the researcher, hold on to the complexity of the therapeutic relationship in the interpretation of qualitative data.

In the analysis process, I described my considerations in judging the status and sensitivity of the multiple data sources in order to answer the research question. In addition, I considered and described the risk of over interpretations, but also how these data could act as important data regarding clinical conditions and could reflect other perspectives**.**

Critique

To balance my engagement and the highly subjective descriptions, which form the main part of the data and are the basis for the continua model, I planned the inclusion of the patient´s as well as the staff´s perspectives. The semi-structured interviews with the patients were included with the aim of revealing their reflections on what they found helpful in the interaction.

On the one hand, I found that the patients did not and were not able to reflect on how they experienced the developmental elements in the therapeutic relationship, and therefore I found these data were not sensitive enough to answer research question 3. On the other hand, the interviews revealed how the patients conceptualized the relationship with the music therapist and the purpose of the interaction. Actually, the interviews in the thesis revealed the patient´s perception of what is important in music therapy, namely the focus on music and musical interaction rather than the specific dynamics in the relationship with the music therapist. Both the results of summarizing and presenting the quantitative data and the analysis of interviews were included in a triangulation of the main finding as a counterpoint to the perspective of the therapist.

Usefulness

Throughout the study process, I checked my interpretations on the meta-level with their relationship to the concrete and clinical reality. I presented elements of the ongoing analyses for peer colleagues and peer researchers, and asked for feedback on the usefulness of my concepts, findings and their dissemination. My aim for this was to improve the continua model and make it recognizable and understandable for other clinicians working in forensic psychiatric settings.

Relevance

Forming therapeutic alliance and cooperation with forensic psychiatric patients is an everyday challenge for clinicians working within the field of forensic psychiatry. Research emphasizing the importance of forming therapeutic alliances combined with, at the same time, a lack of research on this subject in forensic psychiatric field,

points to the relevance of the thesis. In addition, as there is only little research on therapeutic processes and case study research in forensic psychiatry, I see a need to further contribute to this research. My situatedness as a clinician feeds into my reflections as a researcher and brings in an understanding of the interdisciplinary field.

If I succeed integrating this in the research, the continua model will be relevant and contribute to clarification and conceptualization of the interactional dynamics in psychotherapy as well as music therapy, and may support general recognition of the importance of the treatment efforts in the initial phases of therapeutic relationships with forensic psychiatric patients with severe mental illness (Article 3, Frederiksen & Ridder, 2019). In the field of music therapy, this thesis contributes to the growing research in music therapy in forensic settings and increases the focus on patients with a major mental illness in this setting.

Ethics

The case study was conducted in forensic psychiatry, where there are specific ethical dilemmas in treatment as well as research. The fact that forensic psychiatric patients are sentenced to treatment by court, creates some fundamental questions on whether a patient´s participation in treatment and research is optional.

This dilemma should not automatically exclude forensic psychiatric patients from participating in research, as it would question the patient´s capability to judge consequences of participating and be a stigmatization of the patients. It does, however, increase the obligation of the researcher to consider and act in relation to ethical dilemmas, both in order to obtain the patient´s consent to participate and throughout the study. The forensic psychiatric patients' vulnerability and the fact that they are sentenced to treatment are two aspects of the ethical dilemmas.

Ethical aspects can be either normative or individual claims. The normative claims, among others things, refer to receiving an informed consent from the patient. The individual claims refer to judging and making sure that the patient understands information and gives an informed consent based on a grounded and true understanding of the research and the consequences for him as a patient and as a person. Among other things, this involves being clear about the confidentiality of the researcher in relation to the clinical practice, to make sure that the patient understands how being involved in the research might interfere with his overall treatment and legal situation. This demands thoroughness of the researcher and, at the same time, a respect for the patient´s mental capacity to process the information and make an informed and honest decision based on this. A research study by Carpenter and colleagues (Carpenter, Gold, & Lahti, 2000) concluded that a patient with a schizophrenic diagnosis is capable of understanding information about research trials if the researcher respects the patient and gives him/her sufficient time.

In order to provide the patients with sufficient information that could support a reliable consent, I formulated a written information sheet, carefully considering the language and length of it. This written information was repeated in an interview, where I also emphasized the aspect of confidentiality and the patient´s option of withdrawing from the study at any time. Two of the six enrolled patients did withdraw from the study after about a month of music therapy and one patient withdrew from parts of the data collection. In the latter case, the patient did not want to fill out the self-report forms, explaining that he could not read or write. His decision to deviate from the data collection procedure was fully accepted, and he was still included in the study with the data he was willing to provide.

The final judgement of the patient's suitability to participate in the research and ability to give consent was based on the enrolment interview situation and dialogue with the interdisciplinary time.

The patient´s expectations of participating in research may be the object of a risk/benefit judgement in the patient. The forensic psychiatric patient´s motivation for participating in treatment may be confused by contradictory aspects, for example the fact that being sentenced to treatment is supposed to be a help to the patient, but is experienced as a punishment. The length of this punishment might become longer than it would be if they were sentenced to prison, and can depend, among other things, on a judgement of their ability to collaborate with treatment. The patient may think that participation in research enhances the impression of his willingness to collaborate. In the enrolment interview, I emphasized that participation in the music therapy research would not affect his overall situation more than normal participation in music therapy treatment would. Sufficient treatment of forensic psychiatric patients is based on a true and informed impression of the patient´s condition, and requires an open and honest interaction and dialogue that depends on the patient´s feeling of safety. Forensic psychiatric patients may experience being honest as a threat to a positive impression of their recovery, because honesty may reveal information about their thoughts, symptoms, problems and state of being. I did consider this aspect in the interpretation of data in the thesis.

In addition, considering forensic psychiatric patients' vulnerability demands thorough efforts to ensure respect and mutuality and to prevent increased suspicion and anxiety in the patients. Asking the patients to reflect on the relationship with the music therapist, as I did in the study, may challenge their cognitive abilities and willingness to be honest. On the other hand, asking about the patient's opinion may also support an experience of mutuality and respect of what they find important that affects their situation and future. Both aspects were considered in interpreting the data of self-reports as well as the semi-structured interview.

6.6. LIMITATIONS

A limitation when using a case study research design is its specific ideographic nature, which means that findings from this study cannot be generalized to a wider population of forensic psychiatric patients or to therapeutic approaches in other contexts and with other therapeutic approaches. Therefore, the findings must be understood within these limitations.

The data collecting procedures regarding the quantitative data and interview data were to a certain degree structured, but did not live up to the expectations of a controlled study. This lead to limitations of the quality of data and how they support answering research question 3.

To enhance the interviewee's ability to reflect in an interview situation requires a feeling of safety in general, and to facilitate this feeling of safety in forensic psychiatric patients is an even more challenging task. If I had conducted these interviews instead of the research assistant, who was unknown to the patients, it may have revealed data that were more sensitive and with more in-depth descriptions.

In the thesis, I integrated data from patients' self-reporting forms such as SRS and Mood Adjective Checklist in a triangulation of data. I want to stress that the results of these data has to be balanced with the knowledge of a large amount of missing data and, in addition, the insecurity concerning the patient's cognitive ability to understand and reflect on their answers. The use of SRS and the Mood Adjective Checklist in an evaluation of the therapeutic relationship in the patient´s everyday clinical praxis might have revealed more nuanced data as the patients would have been more familiar with these.

Staff scorings revealed very fluctuating scores and may reflect the fact that the various staff members marked scores based on their own individual understandings of contact and tension. With 15% of data missing, it was difficult to make clear conclusions

6.7. IMPLICATIONS

The thesis may suggest some implications in relation to clinical practice as well as future research.

The fact that I have investigated the specific and complex interactional musical as well as non-musical dynamics with four forensic psychiatric patients with schizophrenia has enabled me to suggest some general aspects and clinical implications. The continua model may support music therapists or psychotherapists in becoming aware of the non-specific elements in the therapeutic relationship with a specific forensic psychiatric patient by providing an overview of interactional patterns to be aware of and to give attention to in their attempt to nurture safety and

confidentiality. As such, the continua model may be the first step working in a goal-oriented way with alliance building with forensic psychiatric patients with schizophrenia.

Psychotherapists can experience strong emotions such as rejection, devaluation and power struggles in the interaction with forensic psychiatric patients. The continua model supports the therapist in containing these feelings by slowing down the pace and noticing these small signs and dynamics in the interaction that may result in a strengthening of the therapeutic alliance. In this process, it is of paramount importance to remember that forensic psychiatric patients have a desire to be able to participate and contribute to interaction, but they are not always capable of recognizing positive relational experiences.

Through the continua model, I describe these in-depth and complex interactional dynamics in the first phase of a relationship with forensic psychiatric patients, where the possibility of an interaction is only vaguely suggested. I suggest that balancing the forensic psychiatric patient´s sensitivity and possibly hostile rejection of contact with his ambivalent wish for contact, requires the utmost flexibility but also friendly and respectful insistence from the therapist on contact and interaction. Resistance in the patient towards structure may reflect the patient´s ambivalence in relation to closeness and his way of protecting himself. In the continua model, I suggest that the therapist is observant of her own boundaries and reactions, and regulates her own arousal in order to regulate the patient´s. In addition, to support this regulation I suggest approaches such as being neutral, possibly not listening to the content of what the patient says, avoiding talk and using music to regulate.

If the patient is less rejecting, I suggest that the therapist focuses on supporting the positive experiences of musical activities in order to create a channel of communication. This is done by supporting and validating the patient´s joy, interest, affection for music and his focus on the musical product, and the music therapist should be creative in using this affection for music as a way to nurture dynamic interaction and regulate arousal.

I find that the continua model emphasizes that the music therapist should be extra sensitive in her way of being directive with forensic psychiatric patients with schizophrenia, remembering that the patient´s need for control and focus on himself is caused by a deep anxiety of losing control. I suggest that the music therapist uses musical interactions or activities to support a structure in a non-threatening way, which can reassure the patient about not losing control and, at the same time enhance his ability to become involved in and experience an ability to contribute to a dynamic interaction. The therapist may recognize the patient´s effort to structure and approach the patient and use this knowledge to propose structures the patient understands and accepts. In addition, the therapist should build a repertoire of these structured interactions where closeness is enhanced, and repeat these, rather than facilitate new

activities. I find that verbalizing may threaten the patient´s feeling of integrity and could create resistance and power struggles. Instead of confronting the patient in this situation, I suggest inviting the patient to another way of interacting.

The continua model, which is the main finding of this thesis, is a contribution to research in psychotherapy processes, of which there is only a small amount. I find that the continua model represents the first step in investigating the development of therapeutic alliance with forensic psychiatric patients with schizophrenia.

A patient´s enhanced ability to focus on, follow and synchronize with a common structured rhythm is an element that indicates a strengthening of the therapeutic relationship and could serve as an assessment of the quality of the therapeutic relationship and alliance building process.

Exploring the clinical applicability of the model, however, would require further feasibility studies including a larger number of patients and other music therapists or psychotherapists. In addition, research in the use of the continua model in comparable contexts such as prison or other correctional settings would be relevant in improving the generalizability of the model.

As techniques of detecting biofeedback reactions develop and gradually become less intrusive, it may be possible to measure forensic psychiatric patient's regulation of arousal directly in the interactional process, and contribute to finding a connection between what happens in the interaction and strengthening of the therapeutic relationship. This could be integrated in a future research study and support the development of the continua model.

The hermeneutic phenomenological analysis model described in the thesis may be relevant and inspiring for others when dealing with vast amount of descriptive data and may provide guidance as to where to dive into the data for further in-depth analysis.

CHAPTER 7. CONCLUSION

In this case study research, I explored the dynamics of therapeutic alliance building in music therapy with forensic psychiatric patients.

I found no evidence in the literature to confirm an effect of psychotherapy or music therapy on developing therapeutic alliance with patients with severe mental illness in forensic psychiatry. However, I found studies pointing to the relevance of assuming that some of the same elements supporting alliance building with patients with schizophrenia in general psychiatry are applicable to forensic psychiatric patients with schizophrenia.

The initial phase can be very challenging, characterized by chaos, devaluation, and power struggles, and in the literature an enhanced focus on this phase was emphasized, nurturing therapeutic alliance without forcing the therapeutic process, but enhancing non-verbal communication, synchronization and arousal regulation to support the forensic psychiatric patient´s relational abilities, soften hostility and nurture the special relationship between the psychotherapist and the forensic psychiatric patient.

The findings of the explorative case study, which included four forensic psychiatric patients with schizophrenia who participated in music therapy for six months, was the formulation of a model consisting of seven continua describing dynamic interactional processes within the development of therapeutic alliance. The continua describe processes unfolding within seven themes: Control, Closeness/distance, Structure, Product/process, Focus of attention, Interaction and Verbal dialogue.

The continua model revealed the importance of nurturing the patient´s interests and resources in music therapy in order to establish the first contact, thus creating an opportunity for the music therapist to interact and gradually support therapeutic alliance building with the right timing, and facilitate motivation for working towards a change in behaviour. The continua model suggests a focus on a regulative rather than restrictive approach with an awareness of the non-verbal aspects of the interaction. It describes how music therapy is a way of participating actively in expressive communication, facilitating synchronization and the regulation of aggressive communication at a non-verbal level without confronting.

The continua model may support the structuring of actual observable interactions, countertransference reactions and clinical reflections and, thus, help detect non-verbal dynamics, implicit knowledge and suggest interventions.

The continua model may contribute to clarification and conceptualization of how to nurture the development of therapeutic alliance in music therapy with forensic psychiatric patients with schizophrenia.

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APPENDICES

Appendix A. Interview guide

Spørgsmål til semistruktureret interview-revideret den 13.05.2013

Indledning:

Dette interview er en del af det musikterapi projekt du deltager i ifbm. Britta Frederiksen´s ph-d projekt. Interviewet bliver en samtale mellem dig og mig, med udgangspunkt i nogle overskrifter.

Samtalen vil blive optaget på bånd, men det er kun Britta Frederiksen, der kommer til at høre båndet, og det opbevares et sikkert sted, så uvedkommende ikke har mulighed for at høre det. Det der bliver skrevet ned fra interviewet vil blive anonymiseret, så der ikke er nogen der kan genkende, at det er dig der deltager.

Overordnet om indholdet:

Samtalen vil handle om **din** oplevelse:

- af hvordan du har haft det sammen (samværet) med musikterapeuten under musikterapi
  - dels når I var stille sammen eller lyttede til musik
  - dels når I talte eller spillede på instrumenter sammen.
- af hvad der har påvirket din oplevelse af tiden sammen med musikterapeuten i positiv/negativ retning
- hvilken betydning havde det for tiden sammen med musikterapeuten, at der blev anvendt musik

Det er vigtig at understrege:

- der findes ingen rigtige eller forkerte svar – det er din oplevelse, der er det vigtigste
- det du siger er meget vigtig ifht. at hjælpe terapeuten til at blive bedre til sit arbejde. At sige noget negativt om kontakten er kun godt, for det er der hun kan blive bedre

Spørgsmålene:

Måske er der nogle af spørgsmålene du synes der er svære at svare på, og så er det helt ok at sige at du ikke kan svare.

1. *Dette interview handler om dels kontakt- når man bare sidder sammen og ikke taler og dels samspil – når man foretager sig noget sammen enten at samtale eller spille sammen på instrumenter. Hvad forstår du ved kontakt og samspil?*
2. Hvad er din oplevelse af:
    a. at have følt dig tilpas (rolig/urolig) i musikterapien?
        i. Hvad betyder det for dig, at musik er en del af terapien ifht. at føle dig rolig/urolig ? Hvordan oplevede du det i musikterapien ?
        ii. Hvor vigtig er det for dig hvem der er terapeuten ifht. at føle dig rolig/urolig i terapien ? Hvordan har du oplevet det i musikterapien ?

    b. at det I lavede/talte om var vigtig/ikke vigtig for dig?
        i. Kan du evt. give et eksempel fra musikterapien ?

    c. at musikterapeuten forstod/ikke forstod det du synes er vigtig ifht. din behandling
        i. Var der nogen gange, hvor du var i tvivl om musikterapeuten forstod og anerkendte det du syntes er vigtig ifht. din behandling ?

    d. at du kunne sige/gøre hvad du ville eller at du begrænsede dig ifht. hvad du gjorde/sagde
        i. Var du nogen gange i tvivl om hvad musikterapeuten syntes om dig? Kan du give et eksempel?
        ii. I hvilken grad oplevede du at musikterapeuten var tålmodig/utålmodig ? Kan du give et eksempel fra forløbet?

    e. forudsigelighed i processen
        i. Hvor vigtig er forudsigelighed i et terapi forløb for dig ? Hvordan har du oplevet det i musikterapien ?

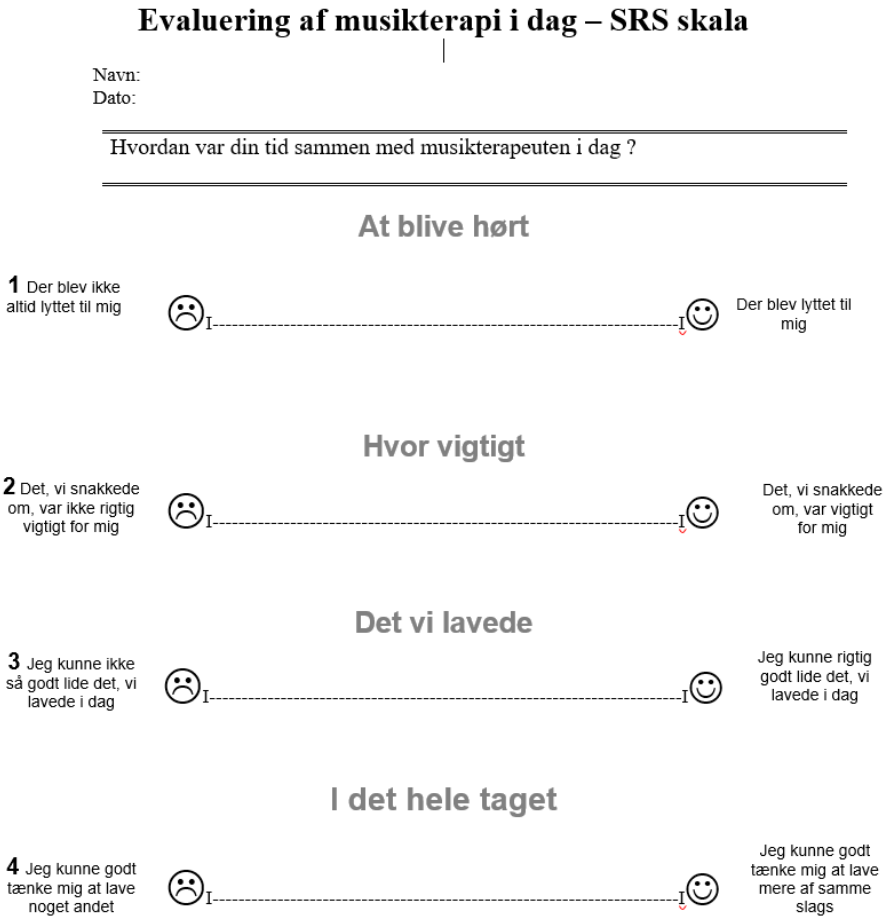
    f. hvem der styrer terapi sessionerne
        i. Hvor vigtig er det for dig at terapeuten styrer terapi sessionen? Hvordan oplevede du det i musikterapi sessionerne?

3. Hvor vigtig er det for dig at du oplever musikterapeuten kan hjælpe dig?
    a. Kan du give et eksempel fra musikterapi forløbet?
    b. I hvor høj grad er det I arbejdede med i musikterapi forløbet anvendelig /uden betydning i din dagligdag?

4. Hvor vigtig er musikken i musikterapi ifht. at du har kunnet udtrykke dig omkring:
    a. følelser eller stemninger?
        i. Kan du evt. give et eksempel fra musikterapi forløbet?
    b. problemer?
        i. Kan du evt. give et eksempel fra musikterapi forløbet?

5. Er der et stykke musik fra musikterapi forløbet, som du synes var særlig vigtig?
    a. Kan du sige lidt om, hvorfor det musikstykke var vigtigt?

Appendix B. Session Rating Scale



(Duncan et al, 2002)

Appendix C. Modified Mood adjective Checklist

Hvordan føler du dig lige nu? (Mood adjective checklist)

Navn: Dato og tidspunkt:

	Absolut	Næsten	Næsten ikke	Absolut ikke
Afslappet				
Anspændt				
Rolig				
Nervøs				

(Modified from Matthews el. al.1990)

Appendix D. Staff´s likerts scale

Spørgsmål til dagens kontaktperson inden musikterapi

Hvordan har du oplevet patienten i den tid du har været sammen med ham/hende i dag?

A:

Hvordan har kontakten til patienten været målt i forhold til den kontakt du vanligvis har til patienten?

God _____ Dårlig

Skriv evt. hvilke observationer der får dig til at krydse af som du gør:

_____

B:

Hvordan har kontakten til patienten været i forhold til den grad af anspændthed du vanligvis oplever hos patienten?

afslappet _____ anspændt

Skriv evt. hvilke observationer der får dig til at krydse af som du gør:

_____

Appendix E. Patient information

Information til deltager i ph.d.-projektet:

"Musikterapi med retspsykiatriske patienter med en skizofreni diagnose – opbygning af den terapeutiske relation"

Med dette projekt undersøges det, hvilken betydning brugen af musik har i forhold til at opbygge kontakt mellem patient og musikterapeut.

Som deltager siger du sige ja til:

- at deltage i et musikterapi forløb i 6 måneder
- udfylde 3 korte skemaer, der spørger til hvordan du har oplevet at deltage i sessionen. En anden person end musikterapeuten vil hjælpe dig med at udfylde disse skemaer. Det vil højst tage 5-7 minutter hver gang
- at deltage i et interview efter 1 måned og 6 måneder. Interviewet udføres af en anden end musikterapeuten. I interviewet vil du blive spurgt om, hvad du synes var vigtig i musikken i forhold til at slappe af og være tilstede
- terapierne må optages.

Såvel skriftlig data som optagelser af musikterapierne opbevares fortroligt og efter Datatilsynets regler.

Alle data vil blive anonymiseret, når jeg skal formidle resultater af projektet, så det ikke er muligt at genkende dig.

Deltagelse i projektet er frivilligt, og du kan trække dig ud af projektet igen, og tilbagekalde ubehandlede data.

Projektet er godkendt af det Humanistisk Fakultet´s Etik udvalg ved, Aalborg Universitet HREB

Britta Frederiksen
Musikterapeut, Ph.d.-studerende

Appendix F. Statement of consent

Samtykkeerklæring

Jeg giver hermed samtykke til at deltage i projektet i forbindelse med ph.d.-projektet "Musikterapi med indlagte retspsykiatriske patienter – etablering af den terapeutiske relation".

Projektet undersøger, kontakten og hvordan musikken indgår i musikterapien.

Jeg giver samtykke til at musikterapisessionerne og interviews fra projektet må optages. Optagelser og noter opbevares efter Datatilsynets regler, fortroligt og aflåst. Data og optagelser slettes efter ph.d. projektet er afsluttet.

Deltagelse i projektet er frivilligt og jeg kan til hver en tid trække mig ud af projektet.

I formidling af projektets resultater vil materialet blive anonymiseret, så det ikke bliver muligt at genkende mig for udenforstående.

Projektet udføres af Ph.d.-studerende ved Aalborg Universitet Britta Frederiksen og sker i et samarbejde med Psykiatrisk Forskningsenhed, Region Sjælland. Projektet vejledes af Musikterapeut, Hanne Mette Ochsner Ridder og Seniorforsker, Cand. psych. Liselotte Pedersen, Psykiatrisk forskningsenhed, Region Sjælland.

dato	projektdeltager	dato	primærforsker

Samtykkeerklæring vil blive opbevaret af primærforsker – kopi udleveres til deltager

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