



Theoretical foundations and workable assumptions for cognitive behavioral music therapy in forensic psychiatry^{☆,☆☆}

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ABSTRACT

This article offers a theoretical foundation for cognitive behavioral music therapy in forensic psychiatry. First, two cases are presented to give an insight into music therapy in forensic psychiatry. Secondly some background information on forensic psychiatry is provided. The Risk-Need-Responsivity model is explained as a starting point and the role of music therapy in this treatment is explained. The third part offers a cognitive behavioral music therapy model and explains the (neurological) role of music and the music therapist in the treatment of forensic psychiatric problems. The article ends with a few final remarks.

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Introduction

Although a relatively small number of music therapists work in forensic psychiatry (approximately 150 worldwide; Coddington, 2002), they have produced quite a substantial number of articles on their work in this specific context (Compton Dickinson, Odell-Miller, & Adlam, 2012; Crimmins, 2010; Daveson & Edwards, 2001; Davis & Thaut, 1989; Drieschner, 1997; Fulford, 2002; Gallagher & Steele, 2002; Hakvoort & Smeijsters, 2006; Hakvoort, 2002, 2007a, 2007b; Hakvoort, Bogaerts, & Spreen, 2012; Hakvoort, Bogaerts, & Spreen, submitted for publication; Hoskyns, 1995; Meekums & Daniel, 2011; Reed, 2002; Rickson & Watkins, 2003; Rio & Tenney, 2002; Santos, 1996; Sloboda & Bolton, 2002; Smeijsters & Cleven, 2004; Thaut, 1989a, 1989b, 1992; Watson, 2002; Wyatt, 2002; Zeuch, 2001, 2003; Zeuch & Hillecke, 2004), until now no publication has provided an explicit theoretical foundation for the effectiveness of music therapy in the treatment of forensic offenders. This article aims to provide such a theoretical basis by focusing on the role of music, the music therapist and their influence on patients' development during music therapy in forensic psychiatry.

The article consists of three main parts. The first part describes how music therapy is used in forensic settings, with two cases using treatment excerpts of the music therapy. One illustrates the music therapy treatment of a group of forensic psychiatric patients and the other an individual case. The cases show how the music therapist affects and trains forensic patients by creating a specific music therapeutic process and therapeutic alliance. The second part provides a brief description of the overall treatment of forensic psychiatric patients. This part includes a discussion of the specific character of forensic treatment. Forensic psychiatry is characterized by the importance of "Risk-Need-Responsivity" factors (Bonta & Andrews, 2007) and a cognitive behavioral approach. The third part of this article presents the theoretical foundations for the use of music therapy in forensic psychiatry. It discusses the functions of music in forensic psychiatry and how these functions can be utilized within a cognitive behavioral approach. Implications of the theoretical foundations are further illustrated using the cases as examples.

Case 1: group music therapy to enhance social interaction and coping skills

"... Blue Suede Shoes!..." screams Ron into his microphone. Jim hits all the tom-toms and the cymbals one after the other, while wildly hitting the bass-drum with his foot-pedal. Pete plays the A power-chord as fast as his hand can move up and down and Ben plucks the A-string on the bass guitar as strongly as he can. The noise is overwhelming, but as soon as the music therapist lifts her hands off the keyboard, they all four end at exactly the

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same moment. The last chord of 'Blue Suede Shoes' still vibrates in the music therapy room. Ben opens his eyes and looks around with a big smile. Not one of them speaks, but they all beam with delight. The therapist smiles and says: "Gentlemen, you have completed your musical goal very well! Each of you stuck to his assignments and used his acquired skills."

These four men have been participating in music therapy together for ten weeks. Ten weeks before the four of them were assigned to music therapy to work on their social and coping skills, such as listening to others, taking other considerations into account and learning to cooperate. The four men have quite a mixed background. Pete and Ben both suffer from psychotic episodes and are unmotivated for treatment. They are not allowed to move independently through the clinic. Ron is mentally retarded, has an antisocial personality disorder, and is prone to aggressive outbursts. He is on medication and quite motivated to participate in treatment. Jim suffers from an antisocial personality disorder and brain-damage due to severe alcohol abuse. During the intake he has stated that he needs no treatment, he is doing well in the unit. He doesn't understand why he is assigned to music therapy by the head of treatment. After a thorough intake, Jim agrees to come because he loves to play drums and the only drum-set available in the clinic is in the music therapy room.

During the first session Ben, Pete and Ron listen to Vertigo by U2, because it is one of the few songs they all appreciate. This will make the wait for Jim (who is late) less problematic and with its upbeat tempo might activate the three patients present. The first active musical assignment that was given is playing drums while the therapist plays Vertigo on the piano. Of the patients, only Ron is able to keep the beat steady. When the therapist stops playing, Pete also stops while the other two continue. Ron just does not listen and Ben is staring at him. The therapist prompts them to stop and judges that the assignment of playing drums and simultaneously listening to the others is too difficult for them.

The therapist decides to start on a lower entrance level and changes the assignment to all playing the djembe. For the next 30 min they practice tuning-in to one another. They start with exercises in following rhythms of just one person at a time. All kinds of drum assignments are played: looking at the person who has to stop, looking at one another, with eyes closed (except for the therapist). Ben is amazed that if he closes his eyes he can concentrate better on the music and the people around him. He realizes that he is always focused on visual stimuli (suffer as he does from mainly visual hallucinations). The music, and especially the clear structure of the drum assignment, makes it possible to keep repeating the tasks.

Jim enters the session 30 min before it finishes. He immediately dismisses the whole assignment as 'boring' and the next as 'too simple'. Jim refuses to play percussion, congas or djembe. He clearly states he is not a child and that these assignments are for 'sissies'. He only wants to play the drum-set. Suddenly no-one wants to continue the exercises they were practicing. The therapist doesn't want to raise the tension in the music room but also ignores Jim's negative attitude.

The therapist asks each one to join in with 'Blue Suede Shoes' (a song with an easier structure than "Vertigo"). The therapist returns to the keyboard and asks Jim to play the drum-set. Ron, Ben and Pete keep their djembes. The latter three are very alert as to what happens musically and are very much focused on how Jim acts. Jim plays the drum-set very loudly; he does not play a fill, nor reacts to any break. As soon as the song ends he starts complaining. He fusses about the quality of the drum-set, he mocks that he misses an e-guitar and a bass-guitar in the song, and he comments the lack of good musicianship in this group.

The therapist decides not to risk counter-transference and so asks them all to each tell one person what he would like him to change in the next run-through. Jim complains that a million changes are needed before this music can ever sound as it should. Because there is a tangible tension, the therapist asks Ben if he would be willing to play the three bass-notes on either keyboard or e-bass. Even before Ben can reply, Jim asks Ron to sing. Ron agrees. The therapist asks Ron what he would ask another person to change in his music. He asks Jim to play less loudly. It takes Ben and Pete far more time to formulate any request to another person. After a number of suggestions by the therapist, Pete hesitantly asks if he can play the e-guitar. Ben wants to move over, so he can play the bass on the music therapist's keyboard.

The next run-through of 'Blue Suede Shoes' is very tentative. Ron is singing softly keeping up with Jim's high pace drumming, which Pete cannot match on the e-guitar. Jim does not stick to his assignment and plays loudly, not listening to anyone else. Ben is completely focused on the therapist. He has lost the connection with the other three 'musicians', but is beaming. He successfully plays the A(4x)-D-A-E-A. The therapist paces the chords on the keyboard to Jim's tempo and Ron's singing but the latter only seems to hear Jim. After the first verse and refrain, the therapist decides to synchronize with Pete to support his efforts to play the correct chords. He smiles a blink of a second (recognizing that he has heard her), but has difficulties changing to the D chord, so the connection is lost again. After the second verse and refrain, the therapist stops, immediately followed by Ben. It takes a while before the others stop too.

Each one of them is asked to repeat his assignment verbally for this run-through and to state what are the most useful new skills they have learned today. Pete, Ben and Ron mention a skill from the attuning assignments. The therapist gives them the homework to apply that skill at least once a day. Jim announces that he should practice his drumming skills. The therapist suggests that he can try using pencils on his pillows and bed and try to play fills and breaks after each 7 bars. The therapist tells the group that they will continue the next session with attuning exercises to meet their treatment goals, necessary to perfect 'Blue Suede Shoes'.

One has to realize, that practicing 30 min does not change patterns of inattention that have grown for years. These men have, however, been developing new paths in listening to one another, taking others into consideration and actively asking others to make changes, which after 10 weeks results in a mutual performance of this song, that meets the treatment goals.

Case 2: individual music therapy to enhance anger management skills

Ralph has been referred to music therapy due to his violent outbursts. He is convicted for double homicide, multiple violent outbursts and knife-fights. He is highly intelligent, suffers from anti-social personality disorder and has been severely addicted to cocaine and speed. In an extreme rage, Ralph can destroy things in his direct surroundings without any inner warning (according to himself). In the living-unit, group-workers and fellow-patients are very cautious towards him. Because music is probably less direct in triggering aggression and might help to gain insight into and control his anger, he was referred to music therapy anger management.

During the first four sessions, Ralph listens to his favorite music (rock, blues, romantic and avant-garde classical music). Ralph likes to talk about what happens in the living-unit and what caused his offences. He states that he does not understand why people fear him or where his violent outbursts come from. Besides talking, he is also easily persuaded to make music and to play together. The therapist never requires him to do anything too difficult and always praises him for all his efforts; a therapeutic alliance of trust is built.

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