



Conference report

25th Annual Conference of the International Association for Forensic Psychotherapy (IAFP)

Forensic Music Therapy Symposium *'European music therapy research perspectives on recovery in forensic families'*

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25th Annual Conference of the International Association for Forensic Psychotherapy (IAFP)

Forensic Music Therapy Symposium:

'European music therapy research perspectives on recovery in forensic families'

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Inspired by their Honorary Life President Dr Estela Welldon, the International Association for Forensic Psychotherapy (IAFP) has supported the development of music therapy and art therapy in forensic psychiatric hospitals and prison settings for many years. United Kingdom (UK) music therapists, Alex Maguire (Broadmoor Hospital) and Stella Compton Dickinson (Rampton Hospital) have both independently presented on several occasions at IAFP conferences.

The overall title of the conference was: *'Families: How to survive them – or not... An analysis of the dangerous family and societal*

response'. Presentations began with a plenary on working with mothers and babies when unresolved maternal trauma threatens a baby's safe development (Amanda Jones, UK) followed by a choice of parallel sessions from forensic psychotherapeutic work which included *'Catathymic rage, dissociation and domestic violence: Psychotherapeutic and neuroscientific aspects of domestic violence'* (Leslie Lothstein, USA). Cognitive analytic therapy for patients within forensic settings led by Phyllis Annesley, including three presentations: *'Traumatic attachments and re-enactments'* (Phyllis Annesley, UK); *'Cognitive*

analytic therapy contribution to understanding anti-social personality disorder in a forensic setting' (Andrea Daykin, UK); *'Re-forming the family: Group cognitive analytic music therapy (G-CAMT) with patients suffering with schizophrenia'* (Stella Compton Dickinson, UK). Other parallel sessions covered five settings; homicide, female offenders in treatment; therapeutic approaches in detention; families, sex offenders and offence mirroring.

The present report features parallel session 5 *'European music therapy research perspectives on recovery in forensic families'*. This was held in the main conference hall. After which there was lively discussion by delegates in a large group analytic session regarding the value of the context specific models of forensic music therapy presented.

Four European perspectives of mixed methods forensic music therapy research were presented. This included two clinically tested, manualised models of forensic music therapy. Stella Compton Dickinson (UK) and Laurien Hakvoort, Clare Macfarlane and Gerben Roefs (Netherlands) all demonstrated how they have approached specific aspects of forensic psychiatric treatment.

The term 'forensic music therapy' refers to the model and context of treatment for psychiatric patients who have been sentenced for committing offences. Maguire and Merrick (2013) and Lawday and Compton Dickinson (2013) describe two interdisciplinary music therapy approaches from high secure hospital treatment in the UK. The aim of forensic music therapy treatment (as opposed to punishment) is to contribute towards the overall multi-disciplinary approach in the reduction of recidivism.

Recidivism is defined in Webster's dictionary (2010) as "a tendency to slip back into a previous condition or mode of behaviour, particularly criminal behaviour". The multi-disciplinary treatment approach includes offence-related psychology treatments, occupational therapy and educational needs as well as arts and speech and language therapies. The index offence is that which resulted in the patient being sentenced through the criminal justice system to a secure treatment setting or penitentiary.

By creating robust models of music therapy that meet specific multi-disciplinary treatment needs, music therapy is becoming acceptable not only for selected patients or those who may be considered difficult to treat but for any patient who is incarcerated.

The purposes of the symposium were as follows:

1. To draw together music therapy themes in common.
2. To consider the differences in each of the approaches.
3. To disseminate the unique aspects of each of the research projects.
4. To consider how to move forward towards a larger trial in forensic music therapy models of treatment.
5. To learn from and share with our expert colleagues, forensic clinicians and delegates of other disciplines.

Hakvoort and Compton Dickinson began together by describing the overall treatment models in the UK and Netherlands.

In the UK the overall treatment approach is called The Recovery Model. This represents a movement away from pathology, illness and symptoms towards strengths and wellness. Anthony (1993) describes it as growing beyond the catastrophic effects of mental illness towards social inclusion. Shepherd, Boardman and Slade (2008) state that recovery involves building new meaning and a satisfying life as defined by the patients themselves. McAffrey, Edwards and Fannon, (2011) focus on the meaning of the therapeutic relationship and the potential for growth and change.

The overall treatment goals are towards the reduction of risks of violent behaviour, the development of victim empathy, remorse, and through restorative justice the desire to make amends.

The overall model of treatment in the Netherlands is called the Risk-Need-Responsivity Model (Andrews & Bonta 2010)

The aims of forensic music therapy within this approach are:

1. To assess needs and risk behaviour.
2. To meet the needs of patients through their responsivity to music.
3. To enhance functional skills towards risk minimisation (anger management, social skills, relational abilities, and to reduce impulsivity).

Cognitive Analytic Music Therapy (Compton Dickinson 2006, 2013, 2015) and Cognitive Behavioural Music Therapy (CBMT) (Hakvoort & Bogaerts 2013) are models that are both based within robust evidence-based psychotherapy models. Over many years of clinically based developments, Hakvoort and Compton Dickinson – during their doctoral studies – have independently

modelled music therapy interventions which are 'context specific' because they take into account the impact of the index offence on how risks of violence can be managed.

Hakvoort began the individual presentations by describing the results of a mixed methods multi-centred trial of her manualised cognitive behavioural music therapy model called Music Therapy Anger Management (MTAM) (Hakvoort et al. 2013). She recruited individual participants from multiple sites and implemented a pre-post test design. Nine individuals in the treatment arm received one hour a week of the treatment intervention (MTAM) compared with five individuals in the control arm who received a group-work aggression management training. Participants who received the treatment intervention showed statistically significant improvements across time in their positive coping skills and in the self-management of their psychiatric symptoms. Hakvoort conducted a detailed qualitative analysis of aspects in music therapy that can contribute to risk assessment.

Macfarlane, doctoral candidate at Vrije Universiteit Amsterdam and music therapist at PPC Vught, then described a short-term music therapy programme (n=16) for prisoners with post-traumatic stress syndrome (PTSD). She explained how neural networks in the brain can be changed, quoting MacKinnon (2012) who states that patterned, repetitive inputs can reach poorly organised neural networks that are involved in the stress response; the neural network is activated and changed through this process of repetition. Macfarlane's doctoral studies are in progress and this pilot was designed to provide an alternative effective treatment for those who were unable to participate in treatment by Eye Movement Desensitization Reprogramming (EMDR).

Roefs (University of Applied Sciences, Utrecht, and music therapist at FPC de Kijvelanden, Poortugaal) then described Musical Attention Control Training (MACT) (Thaut & Hoemberg 2014); an evidence-based Neurologic Music Therapy intervention in rehabilitation for improving cognitive functioning – i.e. attention control for forensic patients suffering from schizophrenia. Gerben referred to the model of treatment for schizophrenia by Millan et al. (2014) that is a compatible 'top-down' cognitive control approach. He is exploring whether music therapy research results from previous studies for patients with schizophrenia, using structured improvisation techniques and songs, can be generalised to the Dutch forensic population.

Finally, Compton Dickinson (Anglia Ruskin University, Cambridge and Institute of Psychiatry, Psychology and Neuroscience, King's College London) summarised results of a single-site feasibility mixed methods, patient preference trial into the clinical effectiveness of manualised Group Cognitive Analytic Music Therapy (G-CAMT) in secure hospital settings. Statistically significant improvements in favour of the treatment group compared to control were found in domains of relatedness to others. The external observational measure demonstrated statistically significant improvements in sociability and hostility at the eight-week follow-up. Treatment effect was greatest in treatment resistant patients above the median age. The qualitative analysis of the music therapists' observations and experiences was triangulated with the statistical results of the primary and secondary outcome measures.

All the researchers agreed that more research is needed on a much larger sample in which the different models could be tested. Compton Dickinson and Hakvoort are now collaborating in writing and publishing *The Clinicians' Guide to Forensic Music Therapy* (to be published by Jessica Kingsley Publishers). This is intended to help clinicians who are new to forensic treatment and it will ensure that the two manualised models are available for wider use.

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