Music Therapy with Patients with Personality Disorder:

Advantages and Challenges

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Abstract

This clinically oriented article reflects on music therapy with patients with a personality disorder diagnosis, focusing on music improvisation and the advantages and challenges it may provide for both patient and therapist. The method used is reflexive and based on a combination of many years of clinical experience and theoretical reflection. The article has four parts. The first part describes our approach to music therapy. The second part presents our view on challenges in music therapy with patients with a personality disorder (PD) and specifically borderline personality disorder (BPD) issues. The third part presents our view on the advantages of music therapy with this client group and the fourth part is a discussion. The discussion has three topics: 1. Does this article present a more nuanced picture of music therapy with a more diverse understanding of challenges and advantages? 2. What is the relationship between challenges/advantages and rupture/repair? 3. How does music therapy relate to common factor theory?

Keywords: music therapy; psychotherapy; rupture; repair; personality disorder; alliance

Introduction

This paper aims to describe and explore music therapy with patients with personality disorders (PD), including borderline personality disorder (BPD). It provides a clinically based rationale for why music therapy by nature is an intervention with great treatment potential, while at the same time it could be a potential challenge for this population. Why is this important to us? As we have experienced this in clinical practice, we see the need to include these perspectives in the literature. We have also observed that improvisation as an intervention is used less than it was previously, perhaps because some patients react

strongly to anything new, unfamiliar, and spontaneous, as often is the case when improvising. Finally, we believe that case studies have a natural bias towards providing clinical examples that illustrate the advantages and the positive aspects of music therapy (e.g., Hannibal, 2003; Pedersen, 2003, Strehlow, 2013b). A focus on the challenges related to this patient group are described in Foubert et al. (2020) and by Strehlow et al. (2016). Foubert has mentioned challenges concerning rupture and repair relationships, but the focus in these articles is more on the relational patterns in improvisational music. Strehlow describes typical relational patterns found in music therapy with this population. Challenges are also mentioned briefly by Haslam et al. (2022), Havsteen-Franklin et al. (2019) and Heiderscheit and Murphy (2021), but only as a statement: Doing music therapy with this population involves challenges.

We will view the dynamics of treatment from a more clinically based perspective, oriented towards inter- and intrapersonal reactions during treatment. Our perspective on music therapy is founded in theory, for example Strehlow et al. (2019), but concepts are not the focus here. Concepts such as transference, countertransference, and mentalization are used from a more common-sense perspective. We will introduce alliance and common factor concepts, as these are relevant in relation to the rupture and repair of the relationship. We believe that it is of vital importance to present and discuss music therapy from the perspectives of advantages and challenges, in order to increase awareness of risks: patients who drop out, and patients for whom music therapy is not meaningful or does not provide a vehicle for development and change. In some cases, music therapy is even contraindicated. This is a topic that is beginning to appear in the literature (e.g., Carr et al., 2013; Murakami, 2021). Providing music therapy includes ethical considerations and therapeutic expertise to ensure that patients are treated optimally. It is a balance between challenging and confirming and supporting. However, this article is not meant as a warning, but as a reminder that engaging with patients with personality disorders in improvisation includes challenges that need to be considered and dealt with if it is to help the patient. It is our ambition to provide such a perspective on using improvisation with this population.

In psychotherapy research, the interpersonal ability to maintain a good therapeutic relationship (alliance) despite conflicts and hostile interactions (ruptures) is described as an essential therapeutic factor (Eubanks et al., 2018; Flückiger et al., 2018; Wampold & Flückiger, 2023). A therapeutic alliance is a concept originally introduced by Freud, but Zetzel coined the term alliance in 1956. In the seventies, Bordin (1994) proposed the term the working alliance based on Greenson's ideas (Horvath et al., 2011). The working alliance consisted of a bond between therapist and patient, agreement on goals of treatment, and agreement on the tasks in treatment. Horvart et al. (2011) write, "the 'new' alliance concept emphasized the conscious aspects of the relationship (as opposed to unconscious processes) and the achievement of collaborative, 'work together' aspects of the relationship" (p. 10).

The formation of a working alliance is viewed as a common factor in therapy (Wampold & Imel, 2015). Wampold and Imel (2015) state that common factors include alliance, empathy, expectations, cultural adaptation, and therapist differences (p. 270), and it is our opinion that this also is the case when we look at music therapy. Utilizing these factors in treatment depends on how well the therapist and patient can work together, and in that perspective also how well they manage to repair the relationship when the alliance ruptures. Based on this background, we propose to examine the challenges of treating patients with personality disorders in a music therapy context. Alliance ruptures have been studied for 30 years (Eubanks et al., 2023; Safran & Muran, 1996). Ruptures represent breakdowns or messiness of the current relationship between patient and therapist. The importance of "alliance rupture and repair" has proven to be a crucial factor in treatment. Therefore, in addition to the advantages, it is also important to look at the difficulties, i.e.,

the challenges. Eubanks et al. (2018) have stated, "Patients with rupture-repair episodes averaged larger gains, suggesting that rupture resolution contributes to a good outcome" (p. 509). We want to include this alliance and alliance rupture perspective in the discussion section.

The music therapy literature on alliance in active music therapy has been investigated in music therapy with different populations (e.g., Frederiksen et al., 2021; Hannibal et al., 2013, 2023; Hannibal & Schwantes, 2017; Silverman, 2011, 2016). Our purpose here is not to discuss the concept of the alliance per se, but simply to emphasise the importance of establishing and maintaining a working alliance. Here the focus on challenges and advantages is relevant. In this article, we have chosen to separate therapist and patient challenges and advantages. Doing this comes at a price, as the dynamics in therapy always unfold in an interpersonal context, where both participants constantly engage and take part in the negotiation of the relationship. We have still chosen to focus on the two perspectives separately but will take a more holistic perspective on these dynamics in the discussion. Here we will also include some theoretical material about rupture and repair. Finally, we are aware that we only represent two clinical music therapists, and our style and way of working is an active factor (Jørgensen, 2004), therefore the perspective of common factors will also be included in the discussion.

We hope that our reflections and many years of clinical experience can serve as inspiration to other music therapists. It is our ambition to enhance knowledge about risks and challenges when providing music therapy, because this emphasises why music therapy always needs to be undertaken by a skillful and highly educated professional music therapist.

Our Method

The paper is based on our clinical experience and clinical practice in music therapy in psychiatry for many years. We have both worked extensively with patients with personality disorder issues. One of the latest theoretical models and practical approaches in the treatment of patients dealing with personality disorder issues is the mentalization-based treatment (MBT) model. This has inspired us both and we have written about music therapy with this population for more than twenty years (Hannibal, 2001, 2013, 2014; Hannibal et al., 2011, 2012, 2019; Hannibal & Schwantes, 2017; Strehlow, 2009, 2013a, 2013b, 2014, 2021a, 2021b, 2023a, 2023b, 2023c; Strehlow & Linder, 2016; Strehlow & Hannibal, 2019). We have both found the MBT model to be a useful model in our clinical practice, as well as a tool for explaining and disseminating the process of music therapy. Over the last twenty years, this model has proven to be so versatile that it has been embraced and incorporated into different levels of psychiatric treatment and even educational contexts (Bateman & Fonagy, 2019).

The content for this article was originally developed and presented at a round table at the European Music Therapy Confederation 2019 conference in Aalborg, Denmark. This text was created after the conference, over a long period. The writing process included working with text separately and then reading it out loud and editing on the spot. This way of working ensured complete ownership of overall aspects of the content. The first author oversaw the review process, but neither author has more ownership than the other. It is our text. This was also our method in the article from 2019 (Strehlow & Hannibal). It is important for us that the text is based on a clinical reality from our clinical practice in psychiatric contexts in Denmark and Germany. We are both researchers and teach at the university level, and we share an interest in the theoretical understanding of clinical practice. However, this publication does not utilize a hermeneutic analysis of case material. In that sense, this article is not research and does not seek to explore a specific theoretical

concept but will discuss the common factor perspective.

The case material has not been subjected to systematic analyses and is only included to illustrate and help translate a more theoretical and abstract description into something concrete and exemplifying. The points in our description of advantages and challenges represent the essence of our clinical experience and theoretical understanding. It is the merging of our music therapy understanding. The content we present in this work is the product of this dialogue. We both share an interest in theory, especially psychodynamic theory, mentalization-based treatment, and common factors, to mention some of the theoretical foundations for our view on treatment. But every aspect of our ideas is always related to something we have experienced in treatment. The analysis mostly resembles an abductive reflection where reflection and experience interchange in the developmental process, but without analysis of data in a strict sense. We aim to illustrate that music therapy with patients with personality disorders holds both advantages and challenges. The strength of our argumentation is grounded in making a meaningful connection between theoretical understanding and clinical experience. Through our discussions, we were able to generalize more and more different aspects into both advantages and challenges. This is an illustration of our aim and not a final statement.

The article is structured in four parts. The first part introduces our understanding of the dynamics of treatment, followed by our approach to music therapy, and the nature of therapy with patients with PD. The second part focuses on exploring challenges for the patient and challenges for the therapist. The third part focuses on exploring the advantages and potential benefits music therapy has to offer to this group of patients. The fourth part is the discussion.

Part One: Our Approach to Music Therapy

Music therapy in psychiatry, in our understanding, is based on the following elements: music, relationship, and language. How much and in which way each element is unfolded depends on the therapist and patient's collaboration. This flexible approach to treatment was manualised in 2012: Process Oriented Music Therapy or PROMT (Hannibal et al., 2012). Musical activity and especially improvisation is a way to interact meaningfully where explicit semantic meaning is not necessary. In music therapy, the experiences that emerge during musical activities may have aesthetic meaning, interpersonal meaning, and intrapersonal meaning in themselves. The focus here is the experience of something meaningful in a music therapy context, and not on whether the music itself has any meaning. That is a different discourse. We argue here that meaning in this context is not only cognitive sense-making (reflection), but just as much an experiential and bodily perception of meaning (sensation). This is grounded in our understanding of the unconscious as described extensively in the psychoanalytic and psychodynamic literature (Alanne 2023; De Backer & Sutton, 2014; Strehlow 2023b). Our actions and perceptions of music are influenced by past experiences, and this creates reactions in the form of transference and defences. But our understanding of interaction in music is also inspired by Daniel Stern, where the implicit and explicit modes of the mind are viewed as constituting our experience of ourselves and our interaction with others. This theoretical framework has inspired the music therapy profession for a long time (e.g., Hannibal, 2001; Pavlicevic, 1997; Trondalen, 2016). Meaning includes the element of rationality (making sense – explicit), but just as important is the experience of making sense (feeling right – implicit/procedural). The implicit level is often not verbal, but through music, there can emerge meaningful relationships and musical expression. However, for some patients, the musical experience may not make any sense or even create confusion. Musical interaction is not always a pleasant experience (Strehlow et al., 2016).

Music therapy is a practice that utilizes all possible forms of musical expression, creation, and performance to facilitate a therapeutic process in collaboration with the patient. It may be active and/or receptive music therapy, but music is the specific vehicle and agent that drives the therapeutic process and possible change forward. It can take place in the form of free improvisation, composing, songwriting, performance of music, or listening to favourite songs (Bruscia, 2014). The patient engages in, perceives, and experiences themselves and the therapist through this medium. Their relationship and bond are built, challenged, investigated, explored, and strengthened through musical activities and/or through musicking (Small, 1998). This is important in setting the stage for what music therapy is. However, for some patients, music does not seem obvious in a therapeutic setting. They have no experience in playing music, have no musical skills, or rely on talking and reflection in language as the primary vehicle for change in therapy. The musical element is strange, unfamiliar, and even potentially threatening.

Research in music therapy for patients with a personality disorder is growing (e.g., Christensen et al., 2007; Foubert, 2020; Foubert et al., 2017; Foubert et al., 2021; Foubert et al., 2020; Kenner et al., 2020; Odell-Miller, 2007; Odell-Miller, 2016; Pool & Odell-Miller, 2011). In line with most other authors, we focus in this article on improvisation as the main method for this population group. We believe that the improvisation method offers the patient the opportunity to become active in the here and now, and that the new experiences during improvisation eventually become meaningful in relation to the challenges of daily relationships.

This research focuses on documenting, describing, and investigating music therapy in this context. However, the body of knowledge about the effectiveness of music therapy with this population is still lacking.

Some Theoretical Views on Patients with PD and BPD

A literature review on the aetiology of borderline personality disorder reported by Cameron et al. (2019) "identified five primary psychosocial risk factors: (1) childhood trauma/abuse, (2) unfavourable parenting, (3) object relations, (4) insecure attachments/loss, and (5) symbolization-reflectiveness capacity" (p. 369). Developmental issues are also described in Daubney and Bateman (2015). Many of these characteristics also apply to patients with a personality disorder in a more general sense. Patients with PD often tend to react very sensitively to interpersonal dynamics that resemble or are reminiscent of these early experiences. This is why interpersonal relationships are referred to as the fundamental pathology of BPD (Daubney & Bateman, 2015). All of these dynamics happen outside of conscious control or any form of cognitive interference. Viewed from a MBT perspective, the patient cannot view themselves from the outside and the other person from the inside (see also Strehlow & Hannibal, 2019). This is a pre-mentalizing state of mind and could mean a momentary breakdown in the ability to mentalize, and in a therapeutic context, this constitutes a challenge. Knowledge about these challenges, including the risk of dropout, is particularly important for the formation of alliance. Patients with personality disorder issues are often full of confusion, doubt, anger, low self-esteem, and shame. Their mood is often low, full of thoughts, feelings, and experiences that make being alive a challenge and something full of pain and discomfort. When a person in this state of mind enters a therapeutic setting there is much at risk, and the expectation that change is possible is often not even there. When a person experiences personality disorder issues, their problems are relationship-based. Here, the feeling of *who I am, how I feel, what I think, and what I do* in general depends on the response from others and the way other patients perceive the person.

Patients with BPD often experience a painful intolerance of loneliness and thus the need to avoid real and imagined abandonment. Patients with BPD are always in a position where

the other person is needed for reassurance and protection against feelings of emptiness and meaninglessness (Bateman & Fonagy, 2019). Patients with PD in general often have ambivalent or disorganized attachment patterns (Bartholomew & Horowitz, 1991).

Patients who suffer from and deal with personality disorder issues carry a lot of relational baggage that is implicit, due to their difficulty to mentalize. They experience a breakdown in their mentalizing capacity and interact with others from a pre-mentalizing perspective (see also Allen et al., 2008). Pre-mentalizing stances are the following: teleological stance *in which meaning is determined by physical outcomes* (Daubney & Bateman, 2015, p. 133). The patient might say: You looked at the clock, you are bored with me. Psychic equivalence means that *the patients believe their state of mind reflects reality* (Daubney & Bateman, 2015, p. 133), expressed this way: I feel afraid, therefore you are dangerous. The last pre-mentalizing stance is pretend mode, *which is a form of intellectualization.* It is difficult for them to navigate their relationships because they respond automatically or implicitly to their emotional responses to the ongoing interaction. This tells us that any therapeutic process building on establishing a relationship and potentially an alliance begins in a vortex of a fluctuating reality that is highly sensitive, unpredictable, unsafe, and unattractive. It is obvious that with this client population, the beginning of therapy is a delicate situation in which even a small unintentional facial expression, tone of voice, question, etc. can trigger all kinds of responses that affect the mental state of the person being treated. Music therapy is often used in a short-term setting, so the start of therapy is of particular interest. It is with this in mind that we engage in the elaboration of challenges in music therapy.

Part Two: General Perspective on Challenges in Music Therapy with Patients with Personality Disorder Issues

What do we understand by a challenge? The concept of challenge is associated with overcoming something or doing something that is beyond the comfort zone. It can be viewed as both positive and negative, depending on what challenges you, how you are challenged, etc. However, to challenge someone in a therapeutic setting is normally not something a therapist wishes to do deliberately without consent and before there exists some kind of working alliance: Why are "we" here, where do "we" want to go, and how should it be done? It is our experience as music therapists that entering a therapy session with a person with personality disorder issues is, as described above, in its nature a challenge. When treatment begins, the patient and the therapist are often not aware of and do not know what might be felt as a challenge and how it will unfold, when it will happen, how strong a response it will create, what emotions and thoughts it might evoke, etc. This is the unknown territory. Interpersonal abilities and skills are tested. The patient might ask themself: *Am I able to get help? Will I be able to engage in a way the other person expects? Is there hope for me? Will it ever be different? Am I being tested for who and what I am as a whole, and if I experience unbearable emotions (fear, anger, hopelessness, meaninglessness, and so forth), have I failed the test?* Everything about this person's identity and sense of self is potentially at stake. It is high risk. At the beginning of treatment, there is great potential for ruptures in the relationship in the form of negative transference and enactment. We recognize that even describing these challenges as something only related to the patient or the therapist, as stated above, is arbitrary, because of the relational dynamic in the ongoing interaction. We choose this form of description to reduce the complexity of our argument, by just focusing on one participant in the relationship at a time.

What we find most challenging for people with PD in a music therapy setting can be summarized into four issues. These challenges all describe different aspects of the use of active music in this setting. They have to do with unfamiliarity, possible low levels of

feeling in control, or little or no mastery of musical instruments.

Challenges for the Patient

These four themes are the result of our generalisation process. They all related to the beginning of therapy, where unfamiliarity with music as a therapeutic means and the therapist as an unknown person is omnipresent.

1. The first meeting: The first challenge in music therapy is twofold. It is about establishing a relationship with the patient and presenting and introducing the patient to the music in music therapy. This is a challenge for several reasons: everything in this situation and context is new; active music is unfamiliar; and improvisation is uncontrollable and unforeseen.

2. The utilitarian question: What is it good for; how will playing music help me? Patients with personality disorder issues often focus on concrete action (teleologic stance), and help can only be experienced when something practical is offered. Playing music can evoke questions such as: How is playing the drum going to help my state of mind, my abusive husband, my insecurity, etc.? These are often big questions for patients in this population.

3. The question of mastery when playing music is especially difficult when a person has high expectations of oneself and wants to do everything perfectly. Music therapy is for everybody. But playing an instrument is often or always associated with performing music. Doing something you cannot master is challenging and can evoke feelings such as vulnerability, shame, fear of loss of control, and anxiety. Musical activity evokes a sense of mastery and thereby also the element of potential failure, humiliation, shame, anxiety, and finally, engaging with a therapist may evoke attachment patterns and attachment behaviour.

4. The experience of sounding when a person plays an instrument or sings. This sound potentially holds information about how the person feels, or the person's state of mind. This experience may create a feeling of frustration and anger and be overwhelming. Overwhelming music may remind the patient of traumatic relationship experiences and can be felt in the body.

These four themes are always active and part of the process of entering the music therapy setting. But for patients dealing with other psychiatric issues, this often does not create strong negative reactions in comparison to patients with PD. The themes described above are relevant in the establishment of the alliance because they deal with intimacy, tasks (method), and goal setting. All these elements are at stake and especially active until the person becomes familiar with how music is utilized in the music therapy method. Creating a therapeutic environment in which the patient can remain in treatment is of paramount importance (Gabbard, 2014) and therefore the aforementioned elements must be considered.

In the following, we present vignettes from our clinical practice with reflections. They are all anonymized.

Vignette 1:

In the first session of a group music therapy setting, the patients are asked to pick an instrument. One man chooses a guiro. Everybody is asked to share with the group how their instrument sounds, one by one. When it is this man's turn, he makes a sound and says that sitting here with this instrument is a symbol of how much he has failed in life. He experiences himself as completely ridiculous, reduced to a small child with a stupid instrument. The therapist mirrors his emotion and validates his experience by verbally saying: This must be both distressful and

difficult. The patient accepts this statement, and he can stay in treatment.

This vignette illustrates the unfamiliarity and the teleological side of sitting with an instrument when being insecure and having low self-esteem (challenges 1 and 2), and he encounters the feeling of being a little child sitting with an instrument he does not know how to play (challenge 3). The whole situation increases his negative sense of self in a concrete form.

Vignette 2:

A young woman in her twenties is referred to music therapy and is dealing with PD issues. She plays bass in a band. In the first session, she is invited to improvise on a xylophone but is hesitant. The therapist invites her persuasively, and she enters in a simple improvisation with a focus on playing quiet – louder – quiet. She participates in the music, but it is an uncomfortable experience for her. She completes the sessions but never shows up again.

This vignette 2 illustrates meeting the therapist for the first time, and when the therapist suggests playing an unfamiliar instrument in an unstructured manner it increases anxiety (challenges 1 and 3) The therapeutic space becomes unsafe for her, and the therapist cannot repair the relationship.

Vignette 3:

A woman in her thirties improvises in the first session. The play rule is: Play only one note at a time. The therapist accompanies her. Both play on an electric keyboard with a piano sound. After a while, the notes from each of them merge into a musical structure. It is calm, gentle, and connected in rhythm, tonality, and form. When the music stops, she comments on how she felt in the music. It was calm and peaceful. It felt like dying. She seems surprised by this last intimate sharing of feelings and her combination of peacefulness and death is unexpected. After this first sudden intimacy, she cannot reengage through active music, and it is necessary to change to receptive methods for more than 20 sessions before she is ready to reengage through improvisation.

This vignette 3 illustrates both the possible intensity in the first meeting (challenge 1), but also how musical interaction and expression may reveal hidden, private, or unconscious material (challenge 4). In this case, there is a sudden level of intimacy that is potentially negative and threatening.

Challenges for the Therapist

The challenges described in this section have two perspectives. One is related to the patient's actions in the music, and the second challenge is related to internal reactions in the therapist to the patient's music.

1. Extreme ways ($+-$) of sounding/playing: When a patient is either extremely silent or very loud. This can be a challenge because high volume can be overwhelming. No noise or low noise may also be a challenge, as this could indicate that the patient is overwhelmed or anxious. Especially in a group setting, extreme musical behaviour might divide or rupture group cohesion. The therapist is confronted with different music wishes of the patients. The therapist has to be able to deal with this diverse situation in a way that keeps the group together. This is also seen when a patient shows rigid or chaotic behaviour. It can be a challenge for the therapist if the patient refuses to engage in musical activity. These patterns are

also described in the literature (see Foubert et al., 2020; Strehlow et al., 2016).

2. Countertransference (CT) issues in the music: The therapist can be drawn in and entangled with strong and uncomfortable emotions in the music that are difficult to deal with. This might create emotional responses in the therapist such as feeling tension, shame, helplessness, fear of failing, disgust, etc. (Alanne, 2023; Bruscia, 1998; Pedersen, 2007; Strehlow et al., 2016). This could influence the therapist's ability to be creative while playing. Not recognizing the countertransference (understanding defence and resistance) could threaten the alliance/relationship between patient and therapist, because the therapist loses their ability to mentalize. The therapist should engage with CT either in the session or in supervision.

Vignette 4:

In a group of patients, some patients look forward to free play (improvisation), because they want to make loud noises without restriction. Within the same group, some of the other patients are very afraid of the loudness and the imagined lack of control. The music therapist discusses with the group how and whether, despite differences, both wishes and needs can be implemented in the group session.

This vignette illustrates a typical group dynamic where different needs and interests collide. If not dealt with, such a dynamic may destabilize the group cohesion and there is a risk of musical abuse for the part of the group who are afraid of loud expression (challenge 1).

Vignette 5:

While the client and therapist are improvising on the piano, the therapist senses energy in the music (CT), becomes entangled and is inspired to push the intensity further. This takes about 20 seconds. After the music, the patient is angry and says to the therapist: Is it you or me who is in therapy? The therapist is surprised and offers to listen to the music here and now, so the client can point out what in the music made her react and hear what happened. When listening to the music together, she notices that the therapist's music is only briefly louder than the patient's. This dialogue makes the patient aware that she feels the therapist is too dominant. In contrast to the therapist, who experiences the music as a shared experience, she experiences the therapist as ego-centred, thinking only of himself, which makes her angry. They reflect together on why that might be.

This vignette illustrates the transference-countertransference unfolding in the music (challenge 2) The therapist responds and engages in the music in a way that frustrates the patient. This is unintentional but not something to avoid. The shared listening and reflection contributed to a new and important dynamic between the therapist and the patient: aggression.

Reflections

First of all, it is important to state that challenges for both patients and therapists are not to be avoided or controlled, as already mentioned. They are necessary for the therapeutic process; to let the healing begin and unfold. To encounter these difficulties, it is important to explain to the patient how music therapy works as a healing and symptom-relieving tool.

The described case vignettes can be viewed as mentalization breakdowns of different kinds. Bateman et al. (2021) describe the importance of experiencing rupture and repair

as part of the process of thinking together, in other words, to mentalize misunderstandings (Bateman et al., 2021; Eubanks et al., 2023). The challenges described by both patient and therapist may lead to a rupture in the therapeutic relationship. Acknowledging the rupture is necessary for the repair process to begin. Re-establishing the relationship is one aspect of repairing the rupture, which ultimately also improves the ability to mentalize. Ruptures occur because of insecure attachment patterns, negative transference reactions, defence responses, and dissociation taking place within the relationship dynamics. The therapist must be able to acknowledge their own implicit or automatic response while beginning to regulate the emotional tension down or up to an adequate level.

What the therapist must do, according to the MBT philosophy, is to begin by recognising every reaction of the patient as a real and valid reaction to something that has just happened. No matter how misunderstood or distorted the patient's reactions are, the therapist must recognize the patient's interpretation of what happened as their reality. This validation is the first step in the process of establishing trust and repairing the rupture.

When the therapist is challenged and acknowledges this, there are different ways to continue. One can use the "stop and go back" approach, where the therapist and patient together investigate what happened, as seen in vignette 5. This can be done verbally and/or, if possible, by listening to a recording together. This will open the possibility of sharing the experience and increase mentalization. Another option is to use music to help regulate arousal, create a secure relationship, and re-establish or repair the relationship that was ruptured. How this is done depends on the kind of rupture and/or breakdown in mentalization. Describing these strategies is beyond the scope of this article, but more theory about rupture and repair will be included in the discussion.

Part Three: Advantages of Music Therapy with Patients with Personality Disorder Issues

In this context, we use the term advantage in the meaning of favourable to the process of therapy. We investigate how music and musical activities, musical artefacts, etc., may help the patient in their struggle to get help and to increase well-being and quality of life, and how music, musical activities, improvisation, and artefacts help the therapist to facilitate this process.

Advantages for the Patient

We did not invent these advantages, neither for the patient nor the therapist. The advantages presented below are described throughout the music therapy literature (Bruscia, 1987; Pavlicevic, 1997; Wigram, 2004). We specifically focused on patients with personality disorder issues (see above and Foubert et al., 2020; Odell-Miller, 2007; Strehlow et al., 2016). As part of our generalization process, we identified three topics with different aspects, which are presented in unprioritized order.

We find the following aspects advantageous for patients with personality disorders in music therapy:

1. *Music for changing mood.* Music is a way of feeling vital and powerful. Music affords (Rolvsjord, 2004) the patient the opportunity to play as a child. Music allows "me" to be loud and aggressive. "I do not need to feel ashamed about playing loud, or childish." Loosening control and feeling lively can be a new helpful experience for BPD patients.

2. *Music as a safe place (predictable).* In some cases, engaging in music is experienced as a safe space for the patient. It can be safe in different ways. Talking might be too concrete and direct, therefore playing music seems less dangerous and

confrontational. The focus is more on *how* we are together than *what* we think of and talk about. Meaning in sounds is more open and less specific. Music can also become a form of distraction from agonizing thoughts, sensations, and rumination. In this form, music gives access to tangible, bodily experiences, and can even open the door to joy, fun, and humour.

3. *Music forms a new relational experience.* Musical interaction in improvisation unfolds in a nonverbal context. Participating in musical improvisation can be the onset of a new and different way of relating to oneself and the surroundings. The patient's spontaneous musical output is met by the therapist's musical response. Through attunement (matching, holding, etc.), framing and grounding, or mirroring and containing, the therapist offers a communicative environment where the patient's expression is met, validated, and potentially transformed. This is an important element in the music therapy toolbox. The patient can experience a shift from chaos to togetherness. From being alone and isolated, to the subtle experience of attention, empathy, and inclusion, the patient has the power to engage or distance themself. They may experience being in control.

Vignette 6:

A young woman patient who is unable to reflect verbally often experiences tension in her solar plexus during a verbal conversation; a reaction that makes her unable to verbally process her thoughts and feelings together with the therapist. When moving to musical expression, she is active and plays small melodies in a steady rhythm. Even though she does not respond to the therapist's direct matching, she accepts that the therapist plays with her in a shared tonal and rhythmic way. After playing this way for some time, she is able to engage in verbal reflection.

This illustrates music as a safe space in contrast to verbal discourse. In the music, the patient's position changed from passive to active. Even though the patient did not engage directly with the therapist, there was mutual sounding, and the therapist was allowed to be in proximity and show empathy, attunement, and holding (advantage 2). The vignette illustrated that the verbally-based relationship was creating more stress and tension, and verbal dialogue was not helping. Her music became an escape from a situation where the patient had no self-efficacy and no trust in an open dialogue. The music provided a safe space, and it had a gentle quality to it. This way of playing gave way to a negotiation of the intersubjective level between therapist and patient, which changed the emotional tension. What followed was more trust in the relationship, and the ability to open up and share thoughts and feelings in the verbal dialogue.

Vignette 7:

Many of the group participants come to music therapy frustrated and discouraged. No one likes to play or talk. Despite everything, the music therapist suggests free improvisation, with the idea that the feelings behind the frustration will be able to find expression.

The group begins to improvise freely, and a large number of the participants are mainly preoccupied with themselves in the musical event. No one is listening to the others. The therapist even considers stopping the improvisation but does not. After a while, one patient quietly begins to play a regular beat on the djembe. The therapist picks up on this regularity and supports it. Individual rhythmic beats are played particularly loudly so that they stand out. A common rhythmic pattern emerges. The other participants notice the musical relationship between the patient and therapist and join the beat or allow themselves to be drawn into it. Even a patient with a glockenspiel orients his melody to the beat. The music becomes more connected, and the dynamics and liveliness increase as more patients join in. After the improvisation, there is a lot

of surprised positive verbal feedback. Before improvisation, it was unimaginable to this group of patients that they could make music together without a conductor.

Especially gratifying is the voluntariness with which the participants can join in and still stay with their own playing. The gloomy mood of the beginning is not yet understood, but for the time being in the background. The patients can experience that their mood changes to a livelier mood, probably also due to the community experience.

This illustrates all the advantages presented above. The mood in the group changed during the music, it was a safe space to explore and unfold the therapeutic process and a spontaneous relationship pattern emerged that connected the group members (advantages 1, 2, and 3). In this vignette, there was tension, and the music provided a setting where each person could find their own space. They stayed in this private space, but after a while a rhythmic structure emerged from someone in the group. It was spontaneous and voluntary. The patients chose to join, engage, and become part of something shared, and they experienced the ability to change the mood in the group. This was a powerful correctional experience.

Reflections

When the events described above occur in music therapy, it is often a sign that the therapy is progressing, the patient is engaging, and the music provides the means and context for the therapeutic process to unfold. For the patient to be able to engage with the music, there must be a certain level of alliance between the therapist and the patient. These vignette examples are not meant as illustrations of specific methods or interventions used to handle difficult emotions or chaotic situations. They became advantages for the therapeutic process because the therapist was able to facilitate the process through the music, to contain the emotions, to recognize when to give space, and to let the structures emerge spontaneously. What is also important is how these examples illustrate how music acts as an alternative to verbal dialogue that is a spontaneous, chaotic, and to some extent uncontrollable/unpredictable endeavour. This is why this way of engaging with the patient is a delicate thing. During this process, the therapist must be able to "navigate" and manage the therapeutic process as it unfolds in the music, so that the patient appropriates what the music affords (Rolvsjord, 2006).

When patients begin to improvise, this often intensifies implicit relational patterns (Hannibal, 2001) that potentially have a transference quality, as well as potentially becoming the basis for the development of emergent new ways of relating, expression, and experience. It is in this musical context that musical interaction becomes a vehicle for the therapeutic process.

Advantages for the Therapist

These themes are not in prioritised order.

1. A not knowing stance in music. We are as music therapists trained to engage in a musical interaction without knowing what is going on inside the patient's mind. It is not necessary to have an explicit understanding or meaning of the musical interaction and sound to engage. This means that we are familiar and comfortable with interaction and playing in a musical environment, where what we do and how we do it is important, and what it means is not. What it means might be the focus after the music, and it might be very important and give new meaning and insights. But while playing it is not relevant. A not knowing stance is a term directly related to mentalization-based therapy theory and is also described in the music therapy literature (e.g., Hannibal & Schwantes, 2017; Strehlow et al., 2019).

2. Music affords expressive, communicative, and relational possibilities in the therapeutic relationship. If the patient can appropriate the music, it offers the possibility for development and change. How this is done depends on the dynamics between the therapist and patient, as well as the patient's state of mind (Rolvsjord, 2004).

3. Unconscious, implicit patterns. Musical expression and interaction give the therapist access to the patient's unspoken, unconscious, implicit patterns, and themes (hear the unheard). Improvisation can be used as a "diagnostic tool" for the implicit relationship dynamic patterns that the patient cannot yet talk about (Pavlicevic et al., 1994; Pedersen, 2000; Strehlow, 2023b).

4. Opportunity to regulate the level of intimacy in the relationship through a "third object." Regulating the balance between proximity and distance. Engaging through music can provide the patient with a sense of control that makes the relationship safer. The patient doesn't need to focus on the therapist (Strehlow et al., 2016).

5. Music provides an opportunity to regulate the emotional level, for example in using music with an activating effect or music with a calming or relaxing effect (Stegemann, 2018; Strehlow, 2019).

Reflections

To engage music together with the patient, the therapist must be able to orientate and find their "way" while playing. This requires certain competencies such as self-awareness, the ability to use disciplined subjectivity (Pedersen, 2000), and the ability to reflect while being in the music. This process of navigating the relationship during music is a subtle task. It also requires the ability to be sensitive to micromanagement of musical cues and signs from patients. The therapist has different options such as mirroring, matching, inspiring, holding, and containing what the other person is playing, and by doing so potentially aiding the patient in letting go and engaging in the music as it unfolds.

As we stated above, it is problematic to talk about the patient and the therapist as two separate entities, when engaging in therapy in fact is a joint venture.

We have presented seven vignettes to illustrate and exemplify our argumentation but viewing all the vignettes from the perspective of the advantages, as we have done below, shows that even though there were challenges for the patients and the therapist in vignettes 1 to 7, it is only vignette 2 that illustrate an example where the process led to disruption of the relationship at an irreparable level.

Table 1. Advantages for therapists in the vignettes.

	1	2	3	4	5	6	7
1 Not knowing stance in music	X					X	X
2 Affordance and appropriation of music			X	X	X	X	X
3 Unconscious interaction patterns			X		X		X
4 Level of intimacy			X			X	
5 Regulation of emotion	X			X		X	

This table illustrates that in each case vignette, several advantages played a role in the therapeutic process.

Part Four: Discussion

In this discussion, we want to focus on three topics: 1. Did we present a more nuanced picture of music therapy with a more diverse understanding of challenges and advantages? 2. What is the relationship between challenges/advantages and rupture/repair as described by Eubanks et al. (2023) and others? and 3. How does music therapy reflect on the common factor theory described by Jørgensen (2004)?

Topic 1

This paper reflects on the challenges and advantages of music therapy with patients with PD. We have tried to explain and describe what can happen to patients with this kind of mental health issue when they receive and participate in active improvisational music therapy. We need to emphasize again, that we do not view challenges as disadvantages or something that should be avoided. Challenges are always a part of psychotherapy, and entering treatment comes with a risk. This is natural, as patients often enter treatment because their life situation is out of balance, their strategies for managing life do not work, and they are seeking help. We focused specifically on challenges, because challenges come with a risk of the patients not being able to benefit from the treatment. We have shared seven vignettes and only one (vignette 2) describes a situation that was beyond repair. In the following, we use our vignette examples to show how challenges/ruptures can be utilized in therapy. Vignettes 1, 3, and 4 were all challenging, but repair and continuation were possible. Which is another way of saying, it was difficult, but "we" managed.

We did not present any information that included contraindications for music therapy or information about music therapy being damaging to the relationship, other than vignette 2. We have tried to give a warning and present examples that illustrate the necessity of being aware and cautious and knowing that sometimes there is a risk when introducing improvisation with this population. But it is also our view, retrospectively, that engaging in this way is essential for the therapeutic process, and to illustrate this change is possible. In this sense, our writing shows a bias towards sharing material aiming to illustrate that improvisational music therapy with this population is possible.

Topic 2

While writing about challenges and advantages, we were inspired to include some thoughts about rupture and repair. It is clear, in our view, that challenges in music therapy also pose a greater risk of rupture in the therapeutic relationship and potentially irreparable damage to the alliance. The ability to repair a rupture in the relationship and learn from it is the essence of a therapeutic process.

What needs to be done, of course, is to prevent a rupture from developing into dropout and termination of treatment. Tronick (2007) has emphasised that "reparation of messiness rather than synchronization might be a key change-inducing process in therapy and development" (p. 14). This dynamic of messiness is related to the continuous experiences in life as in therapy: "With repeated experiences of repair, positive moods are generated; with repeated experiences of failure of repair, negative moods are generated" (Beebe & Lachmann, 2015). Rupture and repair in music can unfold differently than in verbal dialogue (Strehlow, 2023a, 2023c). Rupture is often described as either a withdrawal or confrontation (Eubanks et al., 2023). Withdrawal in music is often a more subtle movement away from each other while playing. In music, this movement does not risk severing the tie to the other person. This was the case in vignettes 2, 3, 6 and 7. In vignette 2, the patient and therapist were unable to repair the rupture and the patient withdrew from treatment. In vignette 3, the rupture happened due to a sudden and unexpected experience of intimate feelings, and the patient withdrew from engagement in

active music therapy for a while. In vignette 6, withdrawal in music gave the patient space to manoeuvre and still maintain some level of musical engagement. In vignette 7, withdrawal also happened when the members of the group were not connecting with each other, and everyone played for themselves. Confrontation as rupture is a movement against the other. This is also possible to experience in music, as aggression can be shown in the music. Vignette 5 illustrated a situation where the patient experienced the therapist's playing as confrontational, and this threatened their alliance. No matter how rupture unfolds in the musical relationship, it is necessary to repair the rupture by engaging in the music, by addressing what happened verbally, or both. Further details about verbal strategies can be found in Eubank et al. (2023), and this is also described in a music therapy context by Strehlow (2023a, 2023c). In this text, we aim to increase awareness about challenges in this work, and to inspire music therapists to offer music therapy to this population, even though it is not an easy endeavour.

Topic 3

Are challenges and advantages specific to music therapy? Is the introduction of music in a therapeutic setting an element that alters the therapeutic context? This depends on how the patient can afford the music (Rolvsjord, 2004). Music is something unique and special in music therapy compared to verbal and other kinds of therapy. But the process of music therapy is, in our view, not different from the process that unfolds in other kinds of therapy methods or media. According to the integrative and common factor model (Wampold & Imel, 2015), all psychotherapy relies on non-specific factors. Jørgensen (2004) concludes in his article: Active Ingredients in Individual Psychotherapy – Searching for Common Factors, the following:

> The individual therapist's ability to catalyse the common mechanisms of change depends on his having been part of—and having internalized central elements of—a good therapeutic culture. Factors such as good clinical judgment, empathy, social intelligence, relational competence, ability to handle interpersonal conflicts in a sensible and growth-enhancing way, and ability to articulate, organize, and legitimize the patient's subjective experience—all of which are important elements in good psychotherapeutic practice—are unlikely to be developed significantly by formal technical training alone. (Jørgensen, 2004, p. 536)

Jørgensen argues that it is the therapist's ability to catalyse therapeutic factors that is an important element of therapy, and we would argue this also includes music therapy.

This paper aims to illustrate some of the dynamics that unfold in music therapy with this population, and we would claim that for a therapist to handle these challenges and provide an environment for change, the therapist must be able to handle all these non-specific factors in a musical context. And in that sense, specific and non-specific becomes entangled. In our view, music therapy is one way to build a relationship, including an alliance. This is essential for the treatment to have any impact on the patient. The literature points out that there are individual differences in how well therapists succeed in building a strong alliance (Wampold & Flückiger, 2023; Wampold & Imel, 2015). Nevertheless, therapy also needs to challenge what is difficult or problematic for the patient, or as it is expressed in the phrase: *No pain – no gain* (Erkkilä et al., 2021). However, the level of distress (psychological pain) must be within the limits of the patient's tolerance, or the relationship will break down. Therefore, focusing on what potentially may challenge the treatment is necessary. This is the aim of this article. Conversely, we also focus on the advantages of implementing music with this population. There are benefits as described above for both the patient and the therapist. These advantages are not seen as a stimulus, where music is used as an intervention and the outcome is certain. For music to be beneficial, there needs to be a music therapist who can monitor the process and adjust if needed, as stated by

Jørgensen (2004). The non-specific factor model is well-known and described and, according to Luborsky et al. (2002), meta-analyses comparing treatments show a smaller effect size than in the case of different methods. We therefore must assume that music therapy may perform at the same level as other treatment modalities, but we do not yet have the research that supports this claim. Luborsky and his colleagues concluded in their study of the factors determining therapeutic success the following: "the therapist's ability to form an alliance is possibly the [single] most crucial determinant of his effectiveness" (Luborsky et al., 1985, p. 610), thus emphasizing the importance of the alliance (Jørgensen, 2004, p. 522). This may also be the case regarding music therapy; that some therapists are better than others at working with different populations, and this is an essential factor.

Conclusion

This article aims to increase awareness of the challenges and advantages of music therapy with patients with personality disorders. This is done by reflection and exemplification. We did not prove anything. This is not about right or wrong, but, in our view, about the recognition of dynamics within psychotherapy and the importance of intense psychotherapeutic training, and thus ultimately also about the training of music therapists, so that they can manage these dynamics professionally.

We believe that challenges in therapy are necessary and unavoidable, but also difficult and potentially destructive for the therapeutic relationship. We believe our claim has been supported by reflections based on our clinical experience, our theoretical perspective, and illustrative vignettes. We hope that our thoughts will inspire music therapists to include improvisation in their treatment portfolio, and if difficulty emerges during treatment, they will use this as information about the therapeutic process. Repairing the rupture will strengthen the alliance and help the patient to develop and heal in the long term.

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