Interview with Dr Stella Dickinson, author of 'The Clinician's Guide to Forensic Music Therapy'

Dennis Relojo

Editor-in-Chief

Correspondence: editor@pjp.psychreg.org

ISSN: 2515-138X

On 28th April 2017, I had the chance to visit the Freud Museum in London – a place dedicated to Sigmund Freud, who lived there with his family during the last years of his life. It was an amazing experience seeing both Anna and Sigmund's house. It brought the history of psychology to life and offered a glimpse of what it was like to live through World War II. But the visit became even more memorable because I had the chance to meet and interview Dr Stella Compton Dickinson.

Dr Compton Dickinson is the author of *The Clinician's Guide to Forensic Music Therapy.* She is a London-based Consultant Psychotherapist, Health and Care Profession Council registered music therapist, accredited supervisor, professional oboist and lecturer, UK Council for Psychotherapy registered Cognitive Analytic Therapist and Supervisor. Dr Compton Dickinson has her own private psychotherapy practice and twenty years' experience in the National Health Service (NHS) as a Clinician, Head of Arts Therapies and Clinical Research Lead. Also, her research was awarded the 2016 Ruskin Medal for the most impactful doctoral research.

Why did you choose to work as a forensic music therapist?

My whole life has revolved around music and horses. My father discouraged me from following in the family footsteps toward the latter. Having had a successful career as a classical musician, and after a life-threatening illness I trained as a music therapist because I wanted to explore formally how music could be healing.

While I was at the Guildhall School of Music and Drama, I had a placement in intensive care psychiatry and on a residential adolescent unit. I knew that I had found my calling.

At that time, there was a move toward community care and a choice had to be made between continuing to work in acute psychiatric settings where patients come and go quickly, or in a secure hospital setting where there was the possibility to do research.

At a deeper level, considering how the human species, and in particular the brain, may evolve, my curiosity was stimulated at a conference exploring Darwin's *Origin of the Species* and how creatures adapt to their environment. Survival of the fittest is sometimes misunderstood as linked to aggression, but 'fit' also means an ability to adapt to the environment as well as to be cooperative and smart. I treat men and women who have instinctually responded aggressively. Animal behaviourists have learned that species such are the Bonobo apes sustain a harmonious society without aggression by having highly developed social structures and empathy, for example by caring for an orphaned infant.

If apes can do this, surely human beings should be able to develop more compassion and understanding for what makes an individual go wrong. I hope that greater understanding of the brain and the mind, rather than judgements, may develop in society helping us move toward building a culture in which kindness and a compassionate approach to disability and mental illness will prevail.

What does your work involve?

Patients with serious mental illnesses who have committed an offence are admitted under a mental health section to a secure hospital setting. A multidisciplinary team will assess, from different perspectives, the individual's needs and they will explore why the individual has responded negatively to a situation: whether they know the difference between good and bad, right and wrong, whether they are motivated to strive towards the light or are consumed by darkness.

The ways we relate affect all of us and our behavioural responses are triggered by our thoughts and emotions. These can become polarised between love or hate, resentment and bitterness, or alternatively a desire to understand oneself and make amends for wrongdoing. The latter is called restorative justice and this process can sometimes follow from retributive justice after an individual has served a prison sentence.

When working with men and women who have killed, one has to see the better side of the patient in order to form a therapeutic rapport and yet still assess risks of violence. The high secure hospitals are actually quiet, safe places where the patients have a lot of time to think about what went wrong in their lives.

In contemplating just how aggressive the human species can be one of my friends once said to me: 'There but by the grace of God go us'. He meant that there is the capacity within every human being to be violent. I have treated numerous patients during my time as Head of Arts Therapies in a High Secure Hospital and with only rare exceptions, they all had redeeming qualities and they all taught me something about human nature and the mind.

Forensic psychiatric treatment is focused on breaking the vicious circle of abusing to abused, attacking to attacked, humiliating to humiliated, enactments between individuals, organisations and society. Research suggests that this is possible if patients are thoroughly assessed for their risks and need principles; the treatment can then focus on preventing relapse (Marlatt & George. 1984), which is to everyone's advantage.

There are three levels of security in forensic psychiatric treatment: low, (short stay); medium; and high secure (long stay) hospitals. I have worked in all three. If the offence was not premeditated and the individual has a mental illness that is deemed to be treatable, the court sentences them under grounds of diminished responsibility, meaning that the person was psychotic when he committed the offence. The secure hospitals are run within the NHS because anyone with a mental illness is entitled to treatment towards recovery and a more normal life. The main concern in forensic psychiatric treatment is towards reduction of risks of harm to the general public, or to the patient who may feel suicidal with shame.

What results have you seen?

Music therapy was new to the hospital in 2001, when I was appointed. Many treatment-resistant patients who had been incarcerated for many years started to change in music therapy. This was quite shocking for nursing staff, some of whom thought that these patients would never change.

In forensic music therapy the overall goal is focused around the impact on the brain and the body of carefully attuned, jointly created musical improvisation. In this way, creative expression, primarily through music rather than words, can help to transform the lives, responses and functioning of individuals who have been profoundly damaged and damaging.

The active ingredient of change that was tested in the research project was jointly-created musical improvisation within a carefully structured, manualised form of music therapy that is integrated into an evidence-based form of psychotherapy. The model is known as Cognitive Analytic Music Therapy.

The patient works interactively with the music therapist who can enable the patient to extend his range of self-expression, even if he has never seen or played an instrument before.

The results of the randomised controlled trial that I implemented compared a group of patients who had standard multidisciplinary treatment (MDT) with a demographically- matched group who had the same MDT treatment plus Group Cognitive Analytic Music Therapy (G-CAMT).

The analysis showed that with the additional G-CAMT intervention patients became more sociable, not only in their therapy groups but replicated in behaviours on the ward. There were fewer risk incidents and their behaviour became less intrusive or possessive.

At two-year follow-up, those in the treatment group moved on more quickly from high secure treatment and so this provides a cost-effective element. These are very exciting results that require a larger multi-centred randomised controlled trial. That is just one reason why the book has been published –because it includes two treatment manuals so that Forensic Music Therapists in other countries across the world can implement this evidence-based model and participate in a future research project.

You have recently written the book *The Clinician's Guide to Music Therapy,* what do you hope this will achieve?

Treating these patients is challenging, requires enormous commitment, dedication and resilience on the part of all members of the care team, and yet it can be extraordinarily rewarding. The motivation of myself and my co-author in writing *The Clinician's Guide to Forensic Music Therapy* has been to encourage future generations to build on what has already been done, by learning from what, to date, is recognised as acceptable to patients and stakeholders. The two treatment manuals were painstakingly and systematically developed, so that future music therapists can safely conduct their forensic clinical practice starting from the best available clinical evidence to date.

With the development of functional magnetic resonance imaging scanning, our knowledge of the brain has increased and there is a changing attitude in mental health towards the hope of recovery. Through this understanding of the plasticity of the brain, some conditions that were previously considered 'untreatable' might improve and adapt to injury, thereby leading to the instillation of hope and recovery. Laurien Hakvoort and I are the only two music therapy researchers who have developed and tested models of forensic music therapy that are specific for the treatment of offenders. We would like music therapists to use the manuals and all the advice all the tools that we have provided because vulnerable adults who are incarcerated have limited choice. In our research projects they consented to participate in our ethically approved research – this is very different to being the unwilling subjects of 'experiments'

in areas of the world where human rights may not be so rigorously upheld. I hope that I may be actively involved in mentoring and supporting the next generation of music therapists to develop their own research.

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In my private practice, I specialise in Cognitive Analytic Therapy, to which I integrate aspects from my research findings as well as creative processes. I have successfully treated people with generalised and social anxieties and depression; young men and girls from the age of 16 who have suffered physical or sexual abuse and who may have self-harmed; busy mothers and businessmen who often have a tough time as they are stressed in juggling both family and work commitments.

I provide services for charitable funding organisations such as the Royal Society of Musicians, Help Musicians UK and Equity Charitable Trust who assess financial means of applicants and provide funding so that I can treat performing artists. I understand their difficulties because I have been there myself.

My clients are lovely people, often incredibly caring of others to such a degree that it is to their own detriment. To make it in the performing arts means total dedication and focus on one's goal, therefore putting in lengthy hours similar to an athlete.

The use of drugs and alcohol is so all pervading now and yet so damaging to motivation, the brain, and creativity that quite a lot of the work involves addressing alcohol and substance misuse. I have also moved back to my first area of specialism in working with people who are in recovery from cancer. This was my first area of interest in music therapy too, because I had just recovered from a life-threatening illness after which I had to re-evaluate my lifestyle. Recovery for me was at a holistic level of psychological growth and in learning how to connect healthily to my own body, so there is an autobiographical aspect in using my self-development to help others.

Reference

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