Adrian Wangberg Seberg

A liberating music therapy

A qualitative study on music therapy in the meeting with Norwegian compulsory mental healthcare

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Adrian Wangberg Seberg

Abstract

This study asks what music therapy can be for service users within compulsory mental healthcare. As a humanistic and recovery-oriented approach, Norwegian music therapy may be viewed as part of a social-academic movement that aims to enhance the participants' possibilities for action, and Norwegian work ethical guidelines stress that music therapists should support self-determination for the service user. These values, however, are challenged when working within cultures of involuntary treatment.

Today we witness changes within the mental health care in Norway regarding both compulsory treatment and the emphasis on alternatives to medications. At the same time music therapy is on its way to be established within mental healthcare across the country. It is important that music therapists are educated about coercion and aware of their attitudes when they are positioned within discourses historically characterized by different coercive measures.

Previous research on user experiences points at self-determination and freedom within music therapy as important aspects of music therapy within mental health care and in adjacent practices. Also, previous research teaches us that people with low motivation for treatment may profit from music therapy and that music therapy can be experiences as something else than other treatments. The overarching research question for this study is: '*What can music therapy be for service users within compulsory mental healthcare?*'

The researcher works through a humanistic perspective on music therapy, which includes notions from recovery-oriented music therapy, resource-oriented music therapy, and community music therapy. A postmodernism-informed critical perspective has influenced this study. Especially Foucault's notion on discourse have impacted the author's understanding of attitudes and practices within modern mental healthcare; the status quo of mental healthcare is not necessarily the result of a knowledge-based approach, but also a result of ruling discourses. Dis/ability-studies is a perspective that seems to go well with both the humanistic perspective on music therapy and a postmodernism-informed critical understanding of the community; this perspective also aligns with the Convention on the Rights of Persons with Disabilities that is used to point at the relationships between society and individual health, and to stress the importance of maintaining human rights for persons with mental health challenges. Notions from critical psychiatry

and notions about positive and negative liberties are also part of the researcher's foundation for discussing music therapy within compulsory mental healthcare.

The design of the study is a qualitative one. The empirical material is constructed through joint interviews in which seven music therapy participations undergoing coercive mental healthcare were interviewed together with their respective music therapists. The interviews were transcribed verbatim and analysed thematically.

Three main themes were constructed through the thematic analysis: 1) *voluntary music therapy*, 2) *motivating music therapy*, and 3) *health promoting music therapy*. The participants in this study tend to regard music therapy as voluntary although they are currently being treated involuntarily otherwise. They want access to similar activities beyond their therapy process, they want others to have the same access to music therapy, and some of the participants have taken the initiative to increase the frequency of music therapy appointments. Some aspects of music therapy are mentioned frequently for why people want music therapy: The participants already have a close relationship with music, and they are familiar with the potential positive by-products from music and from participating in music activities; music therapy participation comes with a break from treatment, coercion, medications, sterile wards, and other service users; in music therapy people are free to be themselves and free to explore, regardless of musical background or skill level; music therapy is a social arena for growing relationships with the therapist, as well as with peers. Participation in music therapy can affect the recovery process in several ways: music therapy is sometimes regarded the highlight of the week and is something to look forward to during a hard time; music therapy can help people to get going, and for some people music therapy is the only activity in which they participate during a regular week; music therapy participation comes with meaningful experiences and a spectrum of positive emotions; sometimes taking part in music therapy helps to reduce symptoms and mental health challenges, such as anxiety and run of thoughts.

The author of this study suggests the term 'liberating music therapy' as an answer to the initial research question of what music therapy can be for people within compulsory mental healthcare. In the description of what a liberating music therapy can be, attention is drawn towards freedom-enhancing perspectives on three layers: 1) within the music therapy sessions, 2) within the recovery process, and 3) within society. These three layers are also discussed in regards to three different levels of music therapy as: 1) a practice, 2) a profession, and 3) an academic discipline. The author argues that music therapists have the responsibility to enable a sense of freedom within the music therapy session, as well as to strive for self-determination

within the mental healthcare-system. As part of an academic discipline, the author argues, music therapists should oppose unnecessary use of compulsory mental healthcare, and support self-determination and recovery-enabling structures, both in mental healthcare and in society as a whole.

Sammendrag

Denne studien undersøker hva musikkterapi kan være for brukere innen tvungent psykisk helsevern. Musikkterapi som en humanistisk og recovery-orientert tilnærming kan sees på som en sosialakademisk bevegelse som søker å styrke deltakerens handlemuligheter, og norske yrkesetiske retningslinjer fremhever at musikkterapeuter bør støtte opp om deltakernes selvbestemmelse. Disse verdiene utfordres når musikkterapeuten arbeider innen praksiser som fremmer ufrivillig behandling.

I dag er vi vitne til endringer i psykisk helsevern i Norge både når det gjelder tvungen behandling og krav om medikamentfri behandling. Samtidig er musikkterapi på vei inn for å etableres i psykisk helsevern rundt i landet. Det er viktig at musikkterapeuter besitter kunnskap om tvang og er bevisst sine holdninger når de trer inn i diskurser som historisk sett har vært preget av ulike tvangsmessige tilnærminger.

Tidligere forskning peker på selvbestemmelse og frihet i musikkterapi som viktige elementer i musikkterapi innen psykisk helsevern og i nærliggende praksisfelt. Tidligere forskning viser også at brukere med lite motivasjon for behandling kan ha utbytte av musikkterapi, og at musikkterapi kan oppleves som noe annet enn annen behandling. Det overordnede forskningsspørsmålet i denne studien er som følger: '*Hva kan musikkterapi være for brukere innen tvungent psykisk helsevern?*'

Forskeren støtter seg til et humanistisk perspektiv på musikkterapi som inkluderer tankesett fra recovery-orientert musikkterapi, ressursorientert musikkterapi og samfunnsmusikkterapi. Forskerens forståelse av holdninger og praksiser i moderne psykisk helsevern er påvirket av et postmodernisme-informert kritisk perspektiv, og særlig av Foucault sine betraktninger om diskurser; psykisk helsevern slik vi kjenner den i dag er ikke nødvendigvis et resultat av en kunnskapsbasert tilnærming, men også et resultat av styrende diskurser. Dis/ability-feltet ser ut til å gå godt sammen med både et humanistisk perspektiv på musikkterapi og en postmoderneinformert kritisk forståelse av samfunnet; dis/ability-perspektivet støtter seg også til *Konvensjonen om rettighetene til personer med nedsatt funksjonsevne* som benyttes i denne studien til å peke forholdet mellom samfunnet og individets helse, og til å tydeliggjøre viktigheten av å opprettholde menneskerettigheter for mennesker med utfordringer tilknyttet psykiske helse. Tanker fra kritisk psykiatri og tanker om positive og negative friheter er også del av forskerens grunnlag for å diskutere musikkterapi i tvungent psykisk helsevern.

Studien har en kvalitativ design. Det empiriske materialet er konstruert gjennom intervjuer med syv musikkterapideltakere underlagt tvungent psykisk helsevern, og hvor

deltakernes respektive musikkterapeuter var deltakende i intervjuet. Intervjuene ble transkribert og analysert tematisk.

Tre hovedtemaer ble konstruert på bakgrunn av den tematiske analysen: 1) *frivillig musikkterapi*, 2) *motiverende musikkterapi*, og 3) *helsefremmende musikkterapi*. Studiens deltakere anså musikkterapi som frivillig til tross for at de ellers var underlagt tvang: Deltakerne ønsket tilgang til liknende musikkaktiviteter utover terapiforløpet; de ønsket at andre får tilsvarende tilbud om musikkterapi som dem selv; og noen av deltakerne har tatt initiativ til å øke hyppigheten av musikkterapiavtaler. Noen aspekter av musikkterapi synes å gå igjen når det gjelder grunner til å delta i musikkterapi: Deltakerne har allerede et nært forhold til musikk, og de er kjent med de positive bieffektene som kan komme av musikk og deltakelse i musikkaktiviteter; med musikkterapi følger et avbrekk fra behandling, tvang, medisinering, sterile avdelinger og andre brukere; i musikkterapi er deltakerne frie til å være seg selv og til å utforske, uavhengig av musikalsk bakgrunn eller ferdighetsnivå; musikkterapi er en sosial arena for å dyrke relasjoner med både musikkterapeuten og andre deltakere. Deltakelse i musikkterapi kan påvirke bedringsprosessen på flere måter: Musikkterapi er noen ganger ansett for å være ukas høydepunkt og noe å se frem til i vanskelige perioder; musikkterapi kan hjelpe deltakerne i gang i aktivitet, og for noen av deltakerne er musikkterapi den eneste ukentlige aktiviteten de deltar i; med deltakelse i musikkterapi følger meningsfulle opplevelser og et spekter av positive følelser; deltakelse i musikkterapi kan i følge deltakerne bidra til å redusere symptomer og utfordringer innen psykisk helse, som angst og tankekjør.

Forfatteren av denne studien foreslår begrepet 'frigjørende musikkterapi' som svar på det innledende forskningsspørsmålet om hva musikkterapi kan være for brukere i tvungent psykisk helsevern. Beskrivelsen av hva en frigjørende musikkterapi kan være inkluderer frihetsfremmende aspekter i tre lag: 1) i musikkterapisesjonen, 2) i bedringsprosessen og 3) i samfunnet. Disse tre lagene er også diskutert i sammenheng med tre ulike nivåer av musikkterapi: 1) praksis, 2) profesjon og 3) akademisk disiplin. Forfatteren av denne argumenterer for at musikkterapeuter innen tvungent psykisk helsevern har et ansvar for å legge til rette for opplevd frihet i musikkterapisesjonen og legge til rette for brukernes selvbestemmelse i psykisk helsevern. Som del av en akademisk disiplin bør musikkterapeuter, i følge forfatteren, motkjempe unødvendig bruk av tvang, og støtte medbestemmelse og helsefremmende strukturer, i psykisk helsevern og i kulturen for øvrig.

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1 Introduction

Now I understand
What you tried to say to me
How you suffered for your sanity
And how you tried to set them free

They would not listen; they did not know how
Perhaps they'll listen now

Excerpt from *Vincent*
by Don McLean (McLean III, 1972)

Music therapy within Norwegian mental healthcare is developing rapidly. Only since the millennial shift, music therapy within Norwegian mental healthcare has gone from a few individual trial programs to be recommended as an effective and evidence-based treatment by the Norwegian Health Directorate (2013). Taking into account the national guidelines for treatment, the on-going political climate relating to mental healthcare, and the current development of medication-free treatments, there is reason to believe that music therapy will continue its swift growth in the following years.

As music therapists enter mental healthcare they step into a multi professional web of discourses. Although most professionals within mental healthcare are probably united in working towards the same goal, namely to help people with mental health challenges, the different disciplines are founded on various traditions, carrying a vast amount of perspectives and attitudes. Different values and philosophical notions come with different views on recovery processes, and may cause disagreements regarding the various treatments and priorities within mental healthcare. Music therapists in Norway are taught to implement humanistic values and fundamental human rights in their work. Thus, music therapists are encouraged to promote self-determination for the participants (Norwegian Musicians' Union, 2017). Mental healthcare, on the other hand, comes from a long history of involuntary treatment (Kringlen, 2007). This study may be understood as an attempt to explore the meeting point between Norwegian music therapy as a humanistic tradition (Drøsdal, 2013; Nebelung & Stensæth, 2018; Norwegian Musicians' Union, 2017; Ruud, 2008, 2015a, 2015b), and the involuntary approach to mental healthcare. The recovery-perspective on mental health and mental healthcare is considered relevant for this study (Hummelvoll, Karlsson & Borg, 2015), and may be understood as highly accommodating with the basic assumptions of a humanistic music therapy (Solli, 2014).

A cumulative amount of music therapy research suggests that music therapy can be beneficial for people throughout their recovery processes (Erkkilä et al., 2011; Geretsegger et al., 2017; Aalbers et al., 2017). And in our society people with severe mental health illnesses are treated involuntarily. Thus, we might say that people with certain health difficulties should be treated with music therapy, and that music therapy should not necessarily be different from compulsory treatment in general. Previous research, however, implies that music therapy is experienced as something else, and that this otherness of music therapy might even be a reason for why and how music therapy works (Ansdell & Meehan, 2010; Solli, 2014; Solli & Rolvsjord, 2014). If music therapists are to facilitate the best treatment possible for service users of mental healthcare, it is important to learn more about what music therapy can contribute with for this client group. This study is intended to provide new knowledge about what music therapy can be for people within compulsory mental healthcare.

Thus, the agenda for this study is two-fold: I attempt to 1) introduce the field of compulsory mental healthcare into the music therapy literature (and vice versa) and discuss some relevant topics regarding the crossing of these two academic fields, and 2) contribute with new knowledge on how music therapy can benefit people within compulsory mental healthcare. Important theoretical contents for this study include both literature on Norwegian compulsory mental healthcare and literature on music therapy and mental healthcare. The empirical investigation of the study is based on qualitative interviews with seven research participants participating in music therapy processes while being treated involuntary within mental healthcare. A postmodernist-informed critical perspective inspires the researcher; mental healthcare is thus understood as social constructions founded on ruling discourses, which partly works to maintain hierarchical structures in which someone's interests are enhanced and others' are repressed. Consequently, part of this study is regarded an emancipatory project that seeks to reveal injustice, to point at potential areas for change, and to take a political stance that supports the repressed part. Ethical and political discussions in the study are also informed by dis/ability-studies, critical psychiatry, positive and negative liberties, and the Convention on the Rights of Persons with Disabilities (CRPD).

1.1 Background

In 2013 I graduated as a music therapist. I was offered a job at a mental health clinic in the capital of Norway only weeks later, where I worked for 14 months before I started on the PhD program in music therapy at the Norwegian Academy of Music.

As a music therapist I am trained to value and promote self-determination for the participants. When working within the mental healthcare institution, however, I felt that the concept of self-determination was challenged; to a certain extent I was able to promote self-determination for the clients within the music therapy sessions, but the frameworks of the music therapy sessions and the participants' overall treatment programs were still subjects to coercion for several of the participants. Participation in music therapy was regarded as voluntary, yet I sometimes asked my self whether people *experienced* music therapy as voluntary when otherwise treated against their will.

1.2 The relevance of this study

During the last years we have been witnessing an increased amount of attention towards the use of coercion among service users, researchers, health professionals, and politicians (Hem, Molewijk & Pedersen, 2014). For a long time the use of coercion within mental healthcare has also been publically criticized, and Norwegian media frequently reveal stories about illegal or unethical practices. Different voices within the society have stressed the need for more control and preventative measures that work to reduce the amount of coercion, including user organizations and politicians. Overall there seems to be a consensus in that there is too much unnecessary use of coercion in the present mental healthcare system, and there have been national plans to reduce the amount of coercion (Norwegian Directorate of Health, 2006). Despite different political documents (Norwegian Directorate of Health, 2006, 2016a) and previous changes in the Mental Healthcare Act (Syse, 2017), few changes have followed as regarding the total amount of coercion (Norwegian Directorate of Health, 2016a).

If the tabloid media picture reflects an actuality (Hansen, Brustad & Monsen, 2013; Jåsund, 2015; Åsebø, Norman & Daae, 2016; Åsebø, Skiphamn et al., 2016), and people are frequently subjected to illegal and unnecessary use of coercion, then music therapy as a profession and discipline cannot passively partake in these discourses as neutral outsiders; either we accept the discourses or we criticize the discourses. Either way, I believe that music therapy as a rather new discipline within the discourses of compulsory mental healthcare has an ethical responsibility to seek knowledge about this field. I hope the present study might enlighten the music therapy discipline about Norwegian compulsory mental healthcare, through both the national jurisdictional framework and the CRPD, together with previous research on the field.

Music therapy appears to be appreciated by the service users within mental healthcare (Ansdell & Meehan, 2010; Rolvsjord, 2007; Solli & Rolvsjord, 2014), and service users seem to be motivated by music therapy as an approach to mental healthcare (Gold et al., 2013). Previous research tells us that music therapy can benefit service users' lives and recovery process, also in areas where other approaches struggle to reach the service users, such as with negative symptoms and low motivation for treatment (Geretsegger et al., 2017; Norwegian Directorate of Health, 2013). Even though music therapy within compulsory mental healthcare is not heavily investigated before, previous research on music therapy and mental healthcare has partly targeted the same population such as people with schizophrenia and schizophrenia-like disorders, who are often exposed to coercion (Bjørngaard & Heggestad, 2001; Fugleseth, Gjestad, Oedegaard, & Johansen, 2016; Geretsegger et al., 2017; Iversen, Berg, Småvik, & Vaaler, 2011; Solli, 2014). And although the population within compulsory mental healthcare overlaps with the population within the general mental healthcare, I believe that there are also certain unique traits within compulsory treatment that are worth investigating. It is likely that music therapy can benefit persons within compulsory mental healthcare, and I belive that this study will provide some new answers about what music therapy can be for this client group.

Today we are witnessing the implementation of three structural changes that have the potential to transform the Norwegian compulsory mental healthcare: 1) the governmental demands of medication-free treatments, 2) a revision of the Mental Healthcare Act, and 3) the implementation of new 'pathways to recovery'. From the 1st of June 2016, people are supposed to have access to medication-free treatments (Norwegian Directorate of Health, 2016b), as a substitute to the outspread use of involuntary medication that we have seen throughout the last few decades. And from the 1st of September 2017, compulsory mental healthcare cannot be decided for service users who are considered competent to consent, and who are not regarded as immediately dangerous to either oneself or others (Syse, 2017). From January 2019 new standards were implemented in mental healthcare, which demands a stronger emphasis on the service users' rights, the service users' competence, and the role of the service users as experts of their own lives and recovery processes (Norwegian Directorate of Health, 2018).

All three of these structural changes have been implemented after the empirical investigation for this study was performed; thus, there is a chance that several of the research participants who are interviewed in this study can no longer be treated compulsorily. Needless to say, the field of compulsory mental healthcare in Norway is a relevant topic on a national level. Even though the empirical research for this study was performed before the three structural changes, I believe that the interviews with service users still provide useful knowledge on music therapy and compulsory mental healthcare. With

the current structural changes, music therapists now have the opportunity to partake in the revision of mental healthcare in Norway, and to contribute to provide a mental healthcare that affords approaches that benefit the service users' recovery processes.

1.3 The aim of the research

My thoughts and curiosity about music therapy and compulsory mental healthcare, together with my interests for ethics on a community level, have led me towards the following research question:

> ***What can music therapy be for service users within compulsory mental healthcare?***

This question is rather open, mirroring a somewhat inductive approach to the field. I believe that this wide question opens up the scope of investigation; I wonder what music therapy can provide through individual sessions on a clinical level, but given the circumstances within compulsory mental healthcare, and a system of discourses possibly performing unnecessary use of coercion, I also wonder what music therapy as a humanistic and recovery-oriented discipline can be for the service users in excess of the mere clinical session.

During the planning of this research I have wondered about certain aspects of the topic of music therapy within compulsory mental healthcare, thus, the following working-questions were composed:

- Do service users experience music therapy as voluntary when they are otherwise treated involuntarily within the mental healthcare, and if so, how do they describe this?
- What motivates service users within compulsory mental healthcare to participate in music therapy?
- How can music therapy benefit service users within compulsory mental healthcare in their recovery processes?
- In what way should music therapists engage in ethical and political discussions regarding compulsory mental healthcare?

I do not take for granted that service users experience music therapy as voluntary when otherwise exposed to coercion in various ways; legislated coercion and experienced coercion do not necessarily correspond.

Previous research implies that people with low motivation for treatment are still motivated to partake in music therapy activities (Gold et al., 2013). Providing that people do experience music therapy as voluntary, it is interesting to find out more about why they still participate in music therapy. I hope that new knowledge on this matter may for instance help to activate and inspire even more participants in the future.

An important part of this study is also to find out how music therapy can benefit people within compulsory mental healthcare. One might argue that engaging in music therapy activities, and being motivated enough to follow up music therapy treatment programs, can alone make up important steps of the participants' recovery processes. And there is a growing field of previous research to verify that music therapy may indeed promote health within mental healthcare. Still, I would like to learn more about how the participants themselves think about and describe music therapy as part of treatment within compulsory mental healthcare. I believe that the participants hold valuable information about the potentially beneficial aspects of music therapy. Compulsory mental healthcare comes with extraordinary circumstances for the service users; it is my wish that this study describes new ways to understand what music therapy can be for this client group.

It is my opinion that music therapy, both as an academic discipline and as a health profession, has a responsibility to partake in ethical and political discussions on a community level. I hope to provide an adequate answer as to in what way music therapy as an academic discipline should take part, and perhaps even take sides, in the national discussions on compulsory mental healthcare.

1.3.1 Inclusion criteria and the research participants

When recruiting research participants for this study I used two inclusion criteria: I asked working music therapists for 1) service users who are or recently have been treated within compulsory mental healthcare[1], and who also 2) participate or recently have participated in music therapy as part of mental healthcare. A total of seven research participants were interviewed in this study.

1 By compulsory mental healthcare I refer to the jurisdictional articles §3, §4, and §5 in the Mental Health Care Act. See chapter three for further information on the jurisdictional framework of Norwegian mental healthcare.

The legal status of the included research participants

At the time of the research interviews, all of the research participants were treated involuntarily somehow; I did not ask the research participants specifically about legal status, but this criterion was given to the music therapists during the earlier recruitment phase. Examples of legislation status were also mentioned within the interviews: Some research participants were involuntary admitted (§3), and at least one participant was subjected to compulsory mental healthcare through a court of law (§5). Also, several of the research participants seemingly had first-hand experience of compulsory treatments, such as involuntary medication (§4). Given the recent changes in the Mental Healthcare Act, some of the participants probably would not have qualified for compulsory mental healthcare after the 1st of September 2017. Further details of the Mental Healthcare Act will be outlined in chapter three.

Participation in music therapy

All of the research participants attended music therapy regularly at the time of the interviews. Questions about the music therapy processes were included in the research interviews. These questions provided some relevant information about the frequency of music therapy sessions and the duration of the overall music therapy processes: mostly people attended weekly music therapy sessions, and the duration of the therapy process varied from a few weeks at the least, to about 18 months at the most.

Institutions and music therapists included in the study

The interviews were performed at four different institutions located in the southern parts of Norway, in the range between locked mental health wards for inpatients, and open mental health wards for outpatients in the local community.

A total of five music therapists participated in the interviews, divided among the seven research participants. One music therapist (in addition to the researcher) partook in every interview conversation. This joint interview method will be further outlined in chapter five. In order to maintain confidentiality the music therapists and the institutions are never referred to by name. This, I believe, also helps to make the interview extracts in chapter six more comprehensible: the only names presented from the data set, are the pseudonyms of the research participants.

1.3.2 Clarification of terms

Terms regarding coercion

Throughout this dissertation I use different terms for describing coercion. I have tried to stay true to the terms of the cited literature when I refer to specific texts or law bills. Terms on coercion will be outlined more profoundly early in chapter three, when describing the jurisdictional framework of Norwegian compulsory mental healthcare. In general I understand the meaning to be the same for words such as coercive, compulsory, and involuntary.

Research participants

When I speak about the research participants in this dissertation, I refer to the interviewees in the empirical investigation of this study. I prefer to call them participants because they partake actively in the research, and they voluntarily share of their life worlds and their experiences with music therapy. I do not view these people as passive sources of information. The present study depends on the contributions from each of these seven research participants.

Music therapy

Throughout the dissertation I often mention music therapy. Although a lot of music therapists might agree about certain common factors for music therapy, there is no such thing as a universal understanding of what music therapy is, and what it is not. When I speak about music therapy I do so from within Norwegian music therapy discourses, with an emphasis on Nordoff/Robbins-inspired creative music therapy, framed by humanistic and resource-oriented values (Nebelung & Stensæth, 2018; Ruud, 2015a, 2015b). Community music therapy is also a part of the Norwegian music therapy context that will be exemplified during the presentation of the data set in chapter six. I will depict my position, my pre-understandings, and my values regarding music therapy later in this chapter.

Whenever necessary I aim to make transparent on which level I speak about music therapy, whether it is on the level of practice, profession, or discipline (Stige, 2002). This may help to structure specific lines of thought, or to pinpoint the relevance of certain arguments throughout the text.

1.4 Voices

Throughout this dissertation I make a vast amount of laden statements, and I believe that I am required to do so; as I understand the role of academic disciplines in modern society the researchers have a responsibility to enable new and trustful knowledge but also to make use of knowledge to facilitate for change or development that make life better for someone. An essential part of any research is the process of verbalising the study into a final manuscript, but this call for great caution, especially regarding the pronunciation of findings, interests and conclusions. When carried away it is easy to proclaim that *we* need new knowledge on music therapy and compulsory mental healthcare, or that *we* need to take into account both research-based knowledge and user experiences in order to understand better this complex intersection between professions and discourses. Thus, it is important that I clarify for whom I speak. I will try to make transparent whether I talk on behalf of my self, the music therapy community, health professionals, the research participants, or perhaps even the potential or hypothetic music therapy participants.

Even though I want to clarify whenever I make statements on behalf of a specific population, it is still not problem-free to do so. I may have the most honest intentions, but the truth is that I can never really speak on behalf of anyone but myself, as a researcher, as a music therapist, or as a human being. As I will elaborate in chapter two, I think that music therapists have a responsibility to support marginalized groups in the society. But regardless of how much I want to support certain parts of the population, I cannot really speak directly on behalf of anyone.

What I can do, however, is to present extracts from the interviews with the research participants. I can share their thoughts about music therapy and about life within compulsory mental healthcare. As part of the development of music therapy within compulsory mental healthcare, the presentation of the service users' statements may in turn contribute to a broader music therapy service in the future, though the research participants themselves are not likely to benefit directly from their contribution to this research. Even though I can speak their cause to the community, I cannot change their present life situations. I want the research participants' voices to be heard through this dissertation, and I have structured the contents of the interviews into themes I have believed are important to them. But still, *I* am writing the dissertation. I decide what to include and what to discard. I will do my best to write cautiously; throughout this dissertation I will try to make transparent for whom I speak, and I will seek to elucidate why I feel the urge to speak on behalf of anyone in the given situation.

1.5 Researching through the worldview of a Norwegian music therapist

When I perform research on Norwegian music therapy contexts, I also research from within Norwegian music therapy discourses. My attachments to certain traditions and worldviews are bound to affect my research process, and how I speak about music therapy. For both ethical and ontological reasons I believe that I am obliged to make transparent for the reader what these Norwegian contexts might be, and how music therapy can be understood through Norwegian discourses. I will present my understanding on music therapy ideologies in Norway, mostly based on my previous investigation of Norwegian music therapy discourses (Drøsdal, 2013). The recovery-perspective, which has recently been added to the music therapy discourses, fits well into the previous ideologies and values of the already existing theoretical foundation of Norwegian music therapy (Solli, 2014). The recovery-perspective as part of a humanistic music therapy will be outlined below.

There is a danger in differentiating between Norwegian music therapy discourses and the rest of the world. When I do so it is not because Norwegian music therapy is necessarily something else; Norwegian music therapy is indeed intertwined within the globalized music therapy world, yet I need to make transparent what music therapy often looks like in Norway.

1.5.1 Music therapy as a socio-academic movement

In a previous study (Drøsdal, 2013) I studied the ideological foundation in Norwegian music therapy discourses through the investigation of nine doctoral theses written by music therapists in Norway, where I looked for ideological or value-laden statements (Garred, 2004; Krüger, 2012; Mohlin, 2009; Rolvsjord, 2007; Ruud, 1990; Stensæth, 2008; Stige, 2003; Trondalen, 2004; Aasgaard, 2002). Because the former research process about ideologies and values in Norwegian music therapy is an important part of my understanding of music therapy as a humanistic discipline, I will present the main findings below.

Five categories describing ontological and ideological points of view were found from the analysis of the nine theses: 1) The creative human being, 2) the social human being, 3) a broad understanding of health, 4) cultural boundaries, and 5) social change. In the following I will describe a synthesis of the results, which can be understood as a narrative about Norwegian music therapy discourses:

> Human beings are active, playing, and intentionally participating beings, with the need for creative expressions; everybody (should) have the rights to access music activities. Human beings are also social in nature, with the need for belonging, communication and relationships. Health is not a binary matter of the presence or absence of symptoms; good health includes empowerment and growth, the use and development of ones different resources, and the experienced quality of life. Health is not only an individual matter; health is dependent on societal structures and are often inhibited by boundaries and health-degrading structures within our society. Attitudes, policies and cultural norms inhibit participation and engagement for neglected and repressed groups in the society. Music therapy as both an academic discipline and a health profession should help to reveal such health limiting mechanisms in the society. Music therapists should thus help under-privileged service users to be heard, and fight for a societal change that benefit repressed sub-groups in the community. (Drøsdal, 2013)[2]

In that study I argue that the Norwegian music therapy discourses are highly influenced by the humanistic perspectives of Even Ruud (2008), a scholar who has been immensely important for the academic and professional development of music therapy in Norway (Drøsdal, 2013). Different meta-theoretical perspectives found in the investigated dissertations, such as resource-oriented music therapy, community music therapy, and relational music therapy, all share corresponding values and ontological perspectives found in Ruud's overview of music therapy as a humanistic discipline (Ruud, 2008). I believe that Even Ruud set the agenda in 1979 when he introduced his definition of music therapy as a way to enable new possibilities for action.

Community music therapy is a broad movement that overlaps the assumptions within the Norwegian humanistic perspective to a great extent (Drøsdal, 2013; Ruud, 2015a, 2015b; Stige & Aarø, 2011). Without going into all of the aspects of community music therapy I find it relevant to name seven key concepts according to Stige and Aarø (Stige & Aarø, 2011), spelling the acronym PREPARE: *participatory*, *resource-oriented*, *ecological*, *performative*, *activist*, *reflective*, and *ethics-driven*. Community music therapy is in part about enabling participation for marginalized or challenges groups in society, and to build down structures that lead to exclusion and stigmas (Stige & Aarø, 2011; Stige, 2003). One way to challenge the social and structural boundaries that limit participation in the community for challenged sub-groups, is to facilitate performance; to demonstrate the resources of marginalized participants, and to humanize the unfamiliar for the community, may help to minimize both stigmas in the community and the

2 I changed my last name from Drøsdal to Seberg in the beginning of 2019.

social constructed gaps between groups of people (Ansdell & DeNora, 2016; Pavlicevic & Ansdell, 2004; Stige & Aarø, 2011; Stige, 2003).

I agree with Rolvsjord (2007) who sais that music therapy may be seen as a social-academic movement with an ethical responsibility to promote health, in order to emancipate marginalized sub-groups, and to work for an including and just community that enables good health for as many as possible.

When I refer to music therapy as a humanistic approach further in the dissertation I apply to the sections above, and especially the narrative based on the former study on Norwegian music therapy discourses.

1.5.2 The recovery-perspective

In recent years the recovery-perspective has been more or less integrated into the Norwegian music therapy discourses, especially through the works of Solli, Rolvsjord, and Borg (Solli, 2014; Solli & Rolvsjord, 2014; Solli, Rolvsjord & Borg, 2013). I support the recovery movement, and I will in the following argue that the branch of recovery perspectives in music therapy is connected to the stem of the whole humanistic music therapy discourse. Even though the recovery movement rises from activism by service users and user organizations, the person-centeredness that is an important part of recovery today, can be viewed as a continuation of the humanistic psychology started by pioneers such as Carl Rogers in the 1940's (Hummelvoll et al., 2015). It is perhaps not so strange that ideals within the recovery movement correspond with humanistic traditions.

There is no complete or one-sided definition of recovery, but an overarching principle of recovery in mental healthcare is hope, and the belief that it is possible to 'regain a meaningful life, despite persistent symptoms' (Jacob, 2015, p. 118). According to Solli (2014) we can recognize many recovery-like elements in the music therapy literature:

> Although the recovery perspective has been peripheral in the theory and research of music therapy, a rather large amount of the theoretical underpinnings of recovery has been elaborated upon in previous music therapy texts. This includes empowerment (Procter, 2002; Rolvsjord, 2004), well-being (Ansdell, 2014; Ansdell & DeNora, 2012; DeNora, 2013), social capital (Procter, 2004, 2011), anti-oppressive practice (Baines, 2013), resource orientation (Rolvsjord, 2010; Ruud, 2010), agency (Ruud, 1998, 2010; Rolvsjord, 2013, Stige & Aarø, 2012), and last but not at least, community orientation and community music

> therapy (Ansdell, 2002, 2005, 2014; Jampel, 2007; Stige, 2002, 2012a; Stige & Aarø, 2012). (p. 15)

Accordingly, there is reason to believe that music therapists and supporters of the recovery movement in general stand on the same side; recovery- and music therapy-perspectives seem to share a common ontological understanding about health, and about the individual needs that follow from being cultural human beings.

Hummelvoll, Karlsson, and Borg (2015) propose four important aspects that health professionals should pay attention to in regards to implement a recovery-oriented mind into relevant mental healthcare practices:

- Realising the radical change involved in placing the person at the centre
- Acknowledging mental health problems as both personal and social
- Recognising and using knowledge embedded in the lived experience of service users, family members and practitioners
- Paying genuine attention to the spiritual process of recovery (Hummelvoll et al., 2015, p. 1)

From these four points we can recognise ideas presented above regarding music therapy as a humanistic approach; service users are complex human beings with individual strengths and resources, living in cultures that are not always fit to maintain health and well-being of their citizens. The relationships between the service users and the community will be outlined further in chapter two.

A systematic review by Leamey, Bird, Le Boutillier, and Williams (2011) found five key features prominent in the literature about recovery in mental healthcare, which form the acronym CHIME; connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. These key features mentioned are part of my understanding of the content of recovery processes.

In Solli's (2014) PhD thesis he presents a model that describes how music therapy may be understood from a recovery-perspective. Participation in music therapy may help the participants without necessarily targeting challenges and symptoms. Instead a positive spiral from music therapy participation that help facilitate recovery through several steps; episodes of well-being may lead to an improved sense of self, which may lead to agency, which may lead to symptom alleviation, which may lead to hope, which may lead to well-being, etc. I support this view on thinking about music therapy within

mental healthcare. In order to integrate the recovery-perspective into music therapy, Solli (2014) suggests that:

> […] Music therapy as recovery oriented-practice can best be understood as the affordance of a therapeutic and social arena in which people with mental health difficulties can work on their process of recovery through musicking, rather than a process of systematic diagnosis-specific interventions. (Solli, 2014, p. 57)

This short description of a recovery-oriented music therapy as suggested by Solli reminds me of Ruud's (1990) classic definition of music therapy mentioned above, that music therapy is a way to enable new opportunities for action. Music therapy can be many different things, and perhaps the most important things are not about what we do in music therapy, but also *how* we do it, *for whom* we do it, and *why*.

According to the recommendations from the Norwegian Directorate of Health (2013) regarding healthcare for service users with schizophrenia and schizophrenia-like disorders, fundamental notions found in music therapy correlate with national expectations [my translation]:

> Early discovery [of psychotic disorders] and early efforts with knowledge-based effective interventions increase the possibilities for recovery. The interventions needs to be individually adapted, take into account the individual's resources and contribute to increased mastery and participation in the community. (Preface)

In the very preface of their recommendations, it seems as though the Norwegian Health Directorate indirectly welcomes a resource- and recovery-oriented, humanistic community music therapy.

1.6 Personal views on compulsory mental healthcare

Throughout this thesis the reader will get to know more about this author's views, values, and thoughts, regarding mental healthcare. In order to make the text transparent from the beginning, I find it relevant to mention my current understandings of the Norwegian mental healthcare at an early stage. I oppose neither the use of pharmacies nor compulsory treatment. However, I believe that such measures need to be handled carefully, and more carefully than seems to be the case today. As will be presented in

chapter two, I agree with the critical psychiatry movement in that the present status of mental healthcare does not take seriously enough the cultural and social aspects of mental health. I believe that it is possible to move past the current status quo of mental healthcare and provide health services that are more adapted to meet multifaceted, social, and cultural human beings. In line with the Convention on the Rights of Persons with Disabilities (CRPD), I also agree with voices that reject 'the treatment criterion' as a valid argument for coercion as it is not compatible with fundamental human rights (Blesvik, Diseth, Husum, Lossius, Kogstad, Orefellen & Tune, 2006).

Today I cannot imagine a mental healthcare without *any* use of compulsory approaches, but I can indeed picture mental health services that go further in providing hope and in including the service users to a greater extent in decisions-makings, in the choice of activities and treatments, and in the planning of the future. By acknowledging each individual service user, by giving enough time for the service users to recover, and by supporting all the aspects of the service users' health and resources. In this way there may be less need for treating superficial symptoms that sometimes could have been prevented in the first place, by facilitating for better everyday lives.

Compulsory mental health care is a complex field with many possible conundrums. Throughout the research process the researcher's view on compulsory mental health care has also changed, together with a deeper understanding of the research on the field. And even the jurisdictional framework for executing compulsory mental health care in Norway has changed quite a bit parallel with this process. I believe that compulsory mental healthcare needs to be discussed, and hopefully this dissertation will contribute to a nuanced and research-based debate about the future of Norwegian mental healthcare.

1.7 A qualitative design

In this short section I will describe the frame of the study as a *qualitative research* (Alvesson & Sköldberg, 2000). With the term qualitative research follows certain expectations regarding the empirical investigation of the study; in a qualitative design one is usually more interested in a deeper understanding of a phenomenon rather than measurable and predictable evidence (Alvesson & Sköldberg, 2000). But there is more to the process and the design of the study than the mere empirical investigation and the selection of research methods. I believe that especially three elements are important components of this research: 1) a qualitative-empirical investigation, 2) an engagement with the research field, and 3) ethical discussions that may potentially emancipate a repressed group of people in society. The combination of these components is by far

unique for this study, but I would like to clarify in the following how I understand the role of these components in this study, and how much attention they are given in this dissertation.

The act of implementing the literature about Norwegian compulsory mental healthcare is considered as one of the main components in this study. If music therapists are to work within the frames of compulsory mental healthcare, I believe that we have a responsibility to understand the research base of compulsory mental healthcare. As I see it, a valid discussion about music therapy within compulsory mental healthcare needs to take into consideration the already existing knowledge on the field.

Semi-structured joint interviews with seven music therapy participants make up the empirical investigation for this study. I believe that a valid discussion on music therapy within compulsory mental healthcare should include the user perspective. And even though the findings in the study are based on a rather small sample of participants, I believe that this empirical investigation provides valuable knowledge about their experiences with music therapy.

In order to keep the discussion about music therapy and compulsory mental healthcare fruitful, I believe that it is important to take into account ethical and philosophical perspectives as a third main component in the study; different ontological and axiological perspectives will provide different answers. As we will see in chapter two of this thesis, I believe that discourses and local truths are important for our understanding of relevant subjects such as health, mental healthcare and coercive interventions. Notions from The Convention on the Rights of Persons with Disabilities will colour the ethical discussions in this dissertation, together with thoughts about negative and posive liberty, dis/ability studies, and critical psychiatry.

In this research project, all three of the afore-mentioned components are valuable. While I am not saying that the same value is placed on each of the three components, I can say that this research would not be the same if it were to be without any of the three. To illustrate, neither would I say which side is the most important for determining the volume of a hexahedron; all three dimensions need to be considered in order to describe the object properly.

1.8 The structure of the thesis

A total of nine chapters make up this thesis. This first chapter is meant as an introduction to the whole thesis. The second chapter aims to present the researcher's positioning,

including a presentation of the researcher's scientific worldview, together with perspectives on dis/ability studies, critical psychiatry, the CRPD, and positive and negative liberties. Chapter three is meant to portray the field of Nowegian compulsory mental healthcare, including legislations and existing peer-reviewed literature on the field. Chapter four is devoted to literature about both music therapy within mental healthcare and music therapy within forensic mental healthcare. Chapter five targets methodological issues regarding the empirical investigation, and describes the procedures of analysis of the empirical material. The empirical findings are then presentd in chapter six. The discussion part of the thesis is divided into two chapters; chapter seven discusses the three main themes from the empirical findings directly, whereas chapter eight targets aspects of freedoms in music therapy, and presents ideas of 'a liberating music therapy'. In chapter nine follows a conclusion in which I summarize how the study have provided answers to the initial research questions, before some comments are delivered at the end regarding further research.

At the beginning of most chapters I have chosen to include excerpts from song lyrics that I find appropriate. Some might be considered descriptive for the following chapter, while others might point more to the broad theme of music therapy within mental healthcare. This measure, I believe, remind both the researcher and the reader to stay in touch with the music throughout the engagement with this rather theoretical perspective on music therapy. Also, the song lyrics might perhaps provoke some relevant understandings or thoughts regarding this research project.

2 The researcher's positioning in the construction of ethics and evidence

Words are flowing out like endless rain into a paper cup,
They slither while they pass, they slip away across the universe
Pools of sorrow, waves of joy are drifting through my open mind,
Possessing and caressing me

Excerpt from *Across the Universe*
by The Beatles (Lennon & McCartney, 1970)

In this chapter I will outline my view on the construction of knowledge, which is inspired by both critical theory and postmodernist ideas. These ideas affect both the way I research, and the way I interpret previous knowledge. Also, this worldview is defining for how I perceive the modern psychiatric institution and the use of coercive means for people with mental health challenges. Hence, this worldview is important for my research project on music therapy as a voluntary based part of coercive mental healthcare. I will try to clarify how I come to think of my philosophical stance as a 'postmodernism-informed critical perspective'.

As an introduction to this chapter I will describe how I understand the terms epistemology, ontology and axiology, and the relationships between these concepts. Then I will portray my understanding of critical theory, before describing postmodernism as an umbrella term, which is strongly influenced by the scholar Mats Alvesson (2002). Two postmodernist ideas are especially are important for my current worldview, and I will investigate these more profoundly: the idea of discourses as understood by Michel Foucault (2002, 2009a), and the idea of deconstruction as presented by Jacques Derrida (1997, 2004a, 2004b). Later on I will give a short introduction to the field of disability studies, as I see this approach as relevant for both my postmodernist worldview and my role as a health researcher. Further, I will present notions from the Convention on the Rights of Persons with Disabilities (CRPD), from critical pshyciatry, and from ideas about freedom, as part of the ethical-philosophical foundation for this study.

2.1 Methodology

The concept of truth is dependently related to our understanding of knowledge and to our view on being in the world. The history of science shows that different views on knowledge affect the research; methods used, language used to present findings, and objects of research, all is dependent on the researcher's understanding of knowledge (Thornquist, 2003). And vice versa; the researcher's choices can indirectly tell us a great deal about the researcher's view on important fields, her favourite area of investigation, the research traditions she is a part of, and of what she wants to find out, through the methods she believes will give adequate answers to the research questions.

With the term *methodology* I refer to the underlying attitudes, expectations, values and beliefs that make the foundation for academic work; there are reasons for what we do and how we do it. In order to understand better the choices I make as a researcher, it is vital that I also make transparent my view on the construction of knowledge. I will start by introducing my fundamental view on the metaphysics, and describe how knowledge, understanding and ethics are highly connected with each other.

2.1.1 Epistemology, ontology, and axiology

As we embark the ship of philosophy, and leave the steady ground for a while, I will start by introducing three terms as a matter of precaution: *epistemology*, *ontology* and *axiology*. Whenever the shores feel too unsteady, these terms may guide the way back to safety, knowing that every obscure or farfetched theory can always be reduced down to these three ideas.

Epistemology is the matter of what we can know and what we cannot (Ruud, 2005). Although the concept of metaphysics has been mused upon for ages within the humanities, and is still an important part of certain academic circles, the same cannot be said to be true for all academic environments. There are theories in our culture that are held to be truer than others. Within certain scientific milieus there are also methods that are claimed to reveal unshakeable facts about our nature of existence. I do not support the idea that knowledge is a neutral concept or some sort of bottomless source of truth, from which we may acquire useful information whenever we want. I do not believe that the perfect methodological approach reveals the truth. Later in this chapter I will present my understanding of how Michel Foucault (2002) challenges thoughts on knowledge through the idea of discourse; he argues that a deep network of discourses within a given institution provide rules for how we think and what we know. It is a matter of epistemological doubt when researchers question the positivistic definition of truth, and

when people criticize the 'evidence' developed by leading pharmacological corporations. Also, it is a question of epistemology when I believe that I cannot possibly know what the research participants of this study think or experience; I can never know more than my interpretation of their narratives.

Ontology is the concept of *being* (Ruud, 2005), of what *is* and what is *not*. Or perhaps we should pay more attention to *what* it is. Questions pertaining to ontology scrutinize what we think about everything around us, either abstracts or concretes, and potentially criticizes the beliefs taken for granted that define our understanding. When I research on *human experiences* about *music therapy* as a *voluntary* part of *treatment* in *coercive mental healthcare*, there are several questions that could be raised regarding the nature of my research theme. When the French-Algerian[3] linguist and scholar Jacques Derrida (2004a, 2006) speaks of *deconstruction*, as will be presented later in this chapter, he occupies a critical attitude towards terms that are taken for granted, and stresses that we fail to understand this specific signifier if we do not view it in relation to its opposites, or that which is left behind. Deconstruction is a way to think critically about ontology.

Axiology refers to 'the study of values' (Oxfordreference.com, 2016), and is a relevant term whenever we want to investigate the hierarchy of importance, or in which order we organize what we believe is right. When I say that people should have the same opportunities in life, regardless of ethnicity, religious background or sexuality, this is in line with my values. This point of view is no *truer* than any right-wing populist's belief that we must protect our national heritage, - keep it as clean as possible, and get rid of all abominations that hold a threat to our beautiful kingdom. The latter view is possibly further away from the basic human rights declared by the United Nations (1948), which values every person equally, but these declarations are also a matter of axiological questions. It is a matter of axiological questions when we try to find the 'right' balance between self-determination and protection of both service users and health professionals in compulsory mental healthcare.

Sometimes it may seem artificial to distinguish between the three; epistemology, ontology and axiology. To me, the question of knowledge and reflection is overarching; how we perceive the world will determine what we think is right. And vice versa, what we believe is right will decide how we understand the world. My wish to be part of a culture that supports equality and dignity is a matter of axiology. This is tied to how I understand human health and well-being, which is a question of ontology. My critical view on mental healthcare, together with my investigation of voluntariness in compulsory mental healthcare, is connected with both axiology and ontology. The fact that I am

3 Jacques Derrida was born and raised in Algeria but lived most of his academic grown-up life in Europe and in The United States of America.

often critical towards economic reports and quantified data saying something truthful about human nature comes from my epistemological view: what we think we know about human needs, mental health, and the proper treatment of people using medication and coercion, are all part of the ruling discourses within different cultures. What I think is right does not appear in a vacuum; rather, it is a result of how I understand human culture and the construction of different realities.

2.2 From the hermeneutics to postmodernism, through critical theory

In the academics, there is a long and multifaceted history of trying to understand different kinds of empirical material. And in a way, I would say that there is a certain connection, a red line, which ties together the early hermeneutics and the postmodernists of the late 20th century. In short, I believe that hermeneutics and phenomenology came up with relevant ways of understanding human beings, as an option to the existing positivistic ideas. While hermeneutic theory takes into account both the context of the interpreted text, and the contextual subjectivity of the interpreter, critical theory (hermeneutics of suspicion) goes even further, and interpret/question the agendas within the cultural frames prior to the text; whether consciously or unconsciously, there may be reasons for why the text is how it is, and the reasons may have to do with repressing forces within the culture. Postmodernists might go even further, and perhaps note that the text is the result of local discourses, constructed through a language that is both defining and limiting its content. As we will see later on, Foucault (2002) argued that new lines of though are always based on previous ideas. And in the same way, I believe that critical theory and postmodern ideas would not have been possible without the traces of early hermeneutics.

Later in this chapter I will describe how I agree with critical theory and postmodern theories. However, there are parts of the hermeneutics I find important for researching human beings, and I understand the hermeneutics as a necessary step towards critical theory and postmodernist ideas. So, let us start with a brief introduction to hermeneutical thinking.

2.2.1 The hermeneutics

The *hermeneutic*s was developed as a way of interpreting texts, originally *text* in its literal sense, but later on text became a figuratively speech for almost every interpretable item

made by human beings. When I analyse interview transcripts for the interview investigation in this research, these scripts can surely be considered texts. And I believe, as do most followers of the hermeneutics, that all my 'findings' from the empirical material are always based on my own *interpretations* of the interview, which are also affected by my interpretations of the interviewees (Loewy & Paulander, 2016).

An important notion within the hermeneutics, as opposite to positivism, is the perspective that the researcher is always already *in* the world that is being investigated. Thus, researchers cannot simply perform neutral observations in the world, as if they were looking at the world from a distance, perhaps through a microscope in a laboratory. Human researchers are always already full of preunderstandings that affect both what to look for and the interpretation of what they see (Gadamer, 2012).

When scholars read biblical texts during the development of the hermeneutics, it was clear that a singular text could not only be interpreted singularly; rather, smaller parts were seen as building bricks in the wholeness of the large collection of different texts, written by several contributors, with origins from different times and places. By the same token, to fully grasp the meaning of the Bible as a whole, one needs to understand each of the individual parts. When interpreting a singular text it also makes sense to investigate both the text as a whole together with small fragments of it, such as minor phrases or particular words. This *hermeneutic circle*, the process of going back and forth between the wholeness and the small sections of a text, in order to understand better the message of the given statement, is something I can relate to when trying to interpret and understand the interview transcripts in my own research (Alvesson & Sköldberg, 2009).

One important discussion within the philosophy of science, especially when performing textual interpretation, is the aspect of *meaning*. The goals and methods for attaining the meaning in texts differ in terms of both goals and methods. One view of meaning is that we search for that which the creator meant by the statement (Mantzavinos, 2016). Even if the author changes her opinion after the text is written, the meaning still remains within the text, though the significance of the text might change. In this case it is important to know a lot about the author, the circumstances, and the time in which the text emerged. If an old children's song contains offensive terms for describing minorities in the culture, it might be a result of the cultural discourses in a specific time and place, and it does not mean that the composer was really trying to be offensive. The 'meaning' we read into the term today is not necessarily the same as was intended in the past. Thus, I would argue that it is completely fine to alter the original song lyrics, and make them more adapted to contemporary understandings, while at the same time stay true to the intended meanings in the lyrics.

I agree that there may exist a sorts of meaning preserved within a text; there were probably reasons for writing the text, and the author chose the words more or less intentionally. In this research I interview music therapy participants within compulsory mental health care because I believe that they will share some thoughts on the matter, and that the statements presented will, to some extent, reflect an intentionally given meaning. If I did not believe that their statements were meaningful, I would not bother to interview these people. I believe that the research participants will answer some of my questions directly, and that I sometimes can understand their thoughts through the conversational language. I will never know exactly what they mean, but I believe that it is possible to interpret the accounts well enough to learn something useful.

One challenge in interpretation of intrinsic meanings, however, is that the receiver of the text will meet the statements differently. The difficulty of balancing the relationship between understanding and preunderstanding is a task for the *alethic* hermeneutics (Alvesson & Sköldberg, 2009). I cannot simply perceive a statement neutrally, as in a vacuum. In the presence of a text I always encounter it through my personal glasses of prejudice. My entire horizon and life-world determine the interpretation of the statements. Perhaps is it not the original meaning I am in touch with, rather, it is a new meaning, emerging at the crossing of two horizons, the horizon of me as the researcher and interpreter, and the horizon of the participant making the statement (Gadamer, 2012). As we will see from the analysis of later on, the statements from the interview differ in regards to their relationships with my research questions; some of the statements seem to answer questions more or less directly and intentionally, yet others responds are interpreted and categorized as themes by the researcher in order to provide answers to questions they have never heard.

In sum, I support some ideas from the hermeneutics as a researcher and a music therapist. I believe that there may exist some sort of meaning within the text itself, and that it is sometimes possible to understand the intention of the statement. For this research it is at least important for me as a therapist to *try* to understand how they experience music therapy participation. At the same time the interpreter should to be aware that the experienced meaning is not necessarily attained from the account itself, as much as it is an interpretation based on prejudgments from the life world of the person interpreting the account. Through the hermeneutics we learn to take into account different variables colouring our interpretation of the meaning. Let us now regard later hermeneutics, or critical theory, which pay even more attention to the cultural frames in prior of the meaning making.

2.2.2 Critical theory

Within the *poetic* tradition of the hermeneutics, aspects such as metaphors and narratives were taken into account (Alvesson & Sköldberg, 2009). The practical use of language through texts and storytelling should sometimes be interpreted through symbols; the semantic of the words cannot always be interpreted from the traditional understanding of their meaning. But it may be possible that the author of the text, without being aware of it, speaks in symbols that are clearly interpretable in different ways by others. Perhaps the language and metaphors being used are actually influenced by authorities of repressive powers. The hermeneutics of *suspicion* relate to thinkers such as Freud, Marx, and Nietzsche, and stress the idea that the text sometimes contains 'hidden' messages, and that these illusive text are results of repression: either from the subconscious mind, through economic interests, or from the human will for power (Alvesson & Sköldberg, 2009). The thought of illusive representations in society are brought on into the *critical theory*, and as described by Rolvsjord & Hadley (2016): 'In general terms, critical theories seek to expose and therefore create an impetus for action against subjugation' (p. 477). In order to 'expose' subjugation the researcher needs to investigate the cultural frames, including language and norms, in which the subjugation is being legitimized as something natural within society. The researcher needs to: 'make visible the oppression and inequities that have been taken to be the natural order of things' (Rolvsjord & Hadley, 2016, p. 477).

Important writers of the Frankfurt school of philosophy, such as Adorno, Horkheimer, Marcuse, and Habermas highlighted the suppressive forces and social differences in modern societies, and argued that the social sciences should serve 'an emancipatory project' (Ruud, 2005, p. 38). According to critical theory, once oppression is exposed, researchers cannot act neutrally through their works; the researchers will either confirm or challenge the already established ideas within the academic institutions. And if the researcher does not look for inequities, the researcher actively maintains potential inequities.

Critical theorists are critical towards the overwhelming trust in the modern project. Effectiveness, mass production, and economic growth are values held by the economic elite, and are not necessarily beneficial for the common people; the modern project even leads to repression of the lesser fortunate. Voices within critical theory stress the investigation of restrictions in society, which may be understood as socially constructed inhibitors, yet are often mistaken for naturally occurring obstacles (Alvesson & Sköldberg, 2009). This point is especially relevant when discussing 'dis/ability-studies' and the CRPD (Convention on the Rights of Persons with Disabilities) later in this dissertation; when people are excluded from parts of the society, seemingly because

of their disabilities, they are really excluded due to constructed obstacles and scarce accommodations. A Marxist-inspired voice of critical theory might say that as long as people with disabilities are deliberately held out of powerful positions in society, then the repressive part can maintain these iniquities continuously, because the repressed parts will not get the opportunity to change the system top-down.

As I investigate the field of compulsory mental health care my critical view affects my understanding of this psychiatric domain; it is important not to take for granted the current mental healthcare as a naturally occurring final stage of a teleological necessity, rather there are political and economical interests defining the ways of a proper psychiatric care. Psychiatric medicine is an enormous industry providing millions in income for certain privileged people. The use of coercive treatment creates the idea that the government keeps the population safe from 'ticking bombs', without necessarily developing a health promoting society for the same people. The attention towards an effective production of patients, gives the impression of successful leadership and well-performed politics, without necessarily developing the health services needed for enabling long-term recoveries. The examples mentioned are notions that are part of my life world, and my horizon, when interpreting literature on coercive mental health care, especially when interpreting governmental and jurisdictional documents on mental health care and coercive means.

2.2.3 The postmodern bouquet

In the following paragraphs I will outline some different approaches and traditions that are often labelled *postmodernism* (Alvesson, 2002). One common assumption within this wide label of theoretical directions is that we cannot understand the way we think an act in the society merely as a result of sense and sensibility, rather they stress that we are *always already*[4] part of certain traditions, discourses, and language systems significant for what we think, how we think, and how we understand the foundation of are thoughts. I will try to explain how some of these concepts are part of my eclectic preunderstanding when researching on music therapy within coercive mental health care.

To speak of postmodernism as a homogenous category is in no way unproblematic. First of all, postmodernism is a broad concept, drawing upon a vast amount of theory from scholars in different fields (Alvesson, 2002). Second, some of the theorists we often refer to when describing postmodernism, reject this label themselves (Alvesson, 2002). Third, but not least, a central idea in postmodernism is to avoid such use of

4 *Always already* is an important saying from the phenomenological and hermeneutical traditions, which was brought forth by Jacques Derrida (Derrida, 1997), and is part of his vocabulary on deconstruction (Gundersen, 2006).

categories per se; we need at least to be highly aware that these categories are socially constructed, and that such categories are culturally biased. When we view the world through different categories our attention is led towards overrated differences, rather than actual similarities (Alvesson, 2002). To speak of postmodernism, then, comes with the risk of overrating the differences between these thinkers and others, and perhaps reducing important ideas and nuances to superficial labels. Baring this in mind, I will describe what it is about postmodernism that intrigues me; if I succeed in making my current worldview transparent for the reader, I might diminish the potential bias of getting stuck in categorical boxes.

Five key features of postmodernism

Alvesson (2002) presents five key themes that are central to postmodernism as a whole. Every theorist will not necessarily agree with the relevance of all of the following concepts, and the *degree* of *how much* one agrees to each theme probably differs as well. I will use the following five key themes to clarify where I stand in the postmodern scenery: 1) centrality of discourse, 2) fragmentation of identities, 3) critique of representation, 4) the loss of foundations and master narratives, and 5) power-knowledge connection.

Centrality of discourse

Alvesson (2002) explains *discourse* as 'language use anchored in an institutional context, expressing a fairly structured understanding or a line of reasoning with active, productive effects on the phenomenon it claims to understand 'neutrally''(Alvesson, 2002, p. 48). In music therapy, a work worth mentioning is the PhD thesis of Gary Ansdell (1999), one of the early studies investigation discourses within music therapy; taking into account both the limitations and the constitutional aspects of language, Ansdell (1999) argues that there is an avoidable gap between the practiced music therapy and the language that is supposed to represent these practices.

Alvesson (2002) differs between two discoursive approaches: a *linguistic* approach, and a *Foucauldian* approach. The linguistic approach highlights the language as a prerequisite for meaning. We perceive the world and construct meaning through the language, and our experiences ought to be understood as inseparable from the language through which they are constructed. The Foucauldian approach to discourse is not all about language; this approach also investigates practices and the environments that allow certain statements to take place (Foucault, 2002). The latter approach to discourse has influenced my worldview the most, and this way of thinking has surely affected my

understanding of compulsory mental healthcare. I will return the Foucault's perspective on discourses later on in this chapter.

I agree that we need to take language and local traditions into account when we try to understand people's perception, understanding, and knowledge. At the same time, I believe that we cannot totally abandon the importance of individual experiences. For this study I have interviewed people within compulsory mental healthcare because I believe that they possess valuable information, knowledge, and first-hand experiences that are important to the field of music therapy. To some extent, I believe that the individual experiences presented through the research interviews are influenced by discourses in a linguistic sense; the language used about coercion and mental health may influence service users' thoughts, narratives, and perhaps even feelings. And yet, I am not the one to derive people from their actual experience from music therapy or compulsory mental healthcare. Although experiences from music therapy may be affected by local discourses, the experiences may still be *real* for his or her everyday life, for his or her sense of pride, and for his or her motivation to stay strong throughout every recovery process and treatment program. When we choose terms such as patients or service users in order to describe the same group of people, we also choose between different networks of connotations and traditions following that single term. The notion of discourse, especially the Foucaultian tradition, is central to my understanding of executed compulsion in mental healthcare, and will be further outline below.

Fragmentation of identities

Taking into account the impact of discourses in everyday life, postmodernism suggests that the idea of an individual identity is overrated (Alvesson, 2002). Identity is fragmented and fluid. The contexts in which the individual engage will over time define the subject, and the identity will differ as it moves between discursive fields. The illusion of individuality and free will is convenient for power execution and for 'the inclination to impose order and unity' (Alvesson, 2002, p. 50).

There are variations in the degree of how far different theorists go in rejecting identity as a stable core in human beings (2002). I follow this line of thought in part; I agree that my identity is somewhat fluid, and that my opinions, my worldview, and my way of experiencing the world are all dependent on the discourses in which I have lived. Also, I believe that my identity and sense of self will change in the future, according to the paths I choose, the people I meet, and the books I read. In chapter four we will look into Tia DeNora's (2014) theory on 'music asylums'; this compound theory includes the idea that our sense of selves are partly formed by respectively successful or unsuccessful performances on the 'front-stage', as a metaphor for public engagements with in which

we are vulnerable to prejudgments and expectations by others. Performance theories, including the example of the front-stage performance, may be labelled postmodernist perspectives.

If we look at how certain discourses have put their mark on human history, such as the Holocaust or organized slavery, it is not without reason that postmodern theorists question the role of the individual in the bigger discoursive picture; research from the field of social psychology has revealed that the right context will drive people to act in monstrous ways, and act against that which many would call 'human nature' (Myers, 2007). Thus, the concept of human nature is, according to Alvesson's (2002) presentation of postmodernism, all but an illusive description of the human repertoire.

I support that we change and adapt during life. Yet, I still support the idea of a core self: The experience of *me*, and the feeling that *I* will never be anyone else. I also support the theory of personal traits within personality psychology; even though personality changes over time, and every individual action is dependant on a particular situation, it is likely that we also possess certain personality traits that are more or less stable over time (Larsen, 2005).

I believe that identity is partly constructed through the discourse and the complexity of contexts in which one is born and raised. At the same time we are individual human beings with a sense of self. In a given situation I will always have a choice to act the way I want, regardless of ruling discourses. Within a broader picture, however, I believe that people are determined by discourse and social structures; wealth, education and health are inherited from generation to generation, and people within marginalized sub groups do not have the same possibilities in life as do the healthy and 'able' everyday worker (United Nations, 2006; Goodley, 2014).

As mentioned in chapter one, the sense of identity is considered a key aspect of the recovery process (Leamy et al., 2011). If mental healthcare service users are described and understood as creative and resourceful human beings with individual needs, dreams, and hopes for the future, the identity and sense of self may be affected, perhaps leaving the service users wanting take responsibility in the recovery process.

Critique of representation

Central for postmodernism is the critique of representation, the idea that we can neutrally describe the world through words, and in this way convey a precise and objective definition of a given object or phenomenon. Alvesson comments that: 'Postmodernists find such a position to be illusionary in the same way as the conception of identity. The *stuff* of the world only becomes an *object* in a specific relation to a being for whom it can

be such an object' (Alvesson, 2002, p. 52). This is not the same as to say that nothing really exists. Even though we might technically have direct access to the world through our senses, our interpretation and understanding of objects happens through our language and cultural context. A classic example is that of human gender; everyone can see that there are physical dissimilarities between the sexes, but our understanding of gender is rather complex. We always already understand *man* from within a discourse. We also already understand *woman* through the same language and cultural contexts. Understandings are local and limited.

Let us look briefly at another example. A handbag from Louis Vuitton is valued highly by certain people. However, it is only within a given discourse that this object is understood as valuable. And when we are first made acquaintance with the status and symbols of luxury handbags, we can no longer view these objects neutrally as if they were merely pieces of fabric. When we perceive the world, the world appears to us through traditions and through language. Both small objects and complex ideas exist because they are given meaning by the culture. And the understanding of such objects and ideas will differ depending on the discourses through which they appear. We cannot un-learn the local 'meanings' of the over-prized handbag, but we can choose to relate to it as we do to cheaper bags, and decide that its main function is no better than others. When learning about The Convention on the Rights of Persons With Disabilities (United Nations, 2006), as outlined in chapter three, we can challenge the representation of persons with disabilities: The common understanding of disability is that people with disabilities are out of work as a natural result of their capability of partaking. Instead, we can choose to look to the cultural circumstances, and make sure that the necessary accommodations are made in order to include every person in society, regardless of individual variations within the population.

As will be presented below, Michel Foucault (2009a) challenged the concept of madness as a static phenomenon; he argued that 'madness' as a concept was constructed by the discoursive rules in a given time and place. In one possible image of a postmodern mental healthcare, as portrayed by scholar Bradley Lewis (2000), a humanistic and multi-disciplinary approach replaces the modern medical psychiatry in which evidence and universal truths about illness and treatment are considered the golden standard. In his description of the postmodern mental healthcare would be much more service user-oriented taking into account the individual needs for recovery. Given the two examples mentioned, it becomes evident that both 'madness' and 'mental healthcare' cannot be taken for granted as universal ideas that occur to us neutrally; rather their existence is based on local discourses and understandings.

At the same time we cannot understand the world only as it appears to us through discourse. Every time we look at an object our understanding of this object is also affected by what it is not. Part of the postmodern understanding that underpins this study is the idea of *différance*, introduced by Jacques Derrida (2006). He reminds us that we always understand a *something* as opposed to *something else*. We categorize and draw lines. We organize the world and define objects through similarities. And we exclude all that does not fit within the given category. This is not necessarily a matter of choice; rather, these are processes that happen unconsciously in the everyday life, and are determining for how we perceive the world. The result is that we always understand *woman* as something other than *man*, *us* as something other than *the others*, and *sick* as something other than *healthy*. Dis/ability studies, as described below, challenges the representation of disability, and argues that *disability* is commonly associated as something opposed to *ability*, which is a much more valued conception in neoliberal cultures. By the same token, our understanding of compulsory mental healthcare is dependant on our culturally informed perception of freedom. Thus, the matter of representation is important for my current life world, and for how I perceive the situation for the service users of mental healthcare. Later on in this chapter I will return to Derrida and a couple of his ideas, which I believe is a useful foundation for relating to the concept of for dis/ability studies.

The loss of foundations and master narratives

Another important feature of postmodernism is the illegitimacy of grand narratives (Alvesson, 2002). Taken for granted ideas and beliefs, or *master narratives*, ought not be held as valid arguments in any fruitful debate, such as the Darwinist 'survival of the fittest' and the Marxist 'class struggle'. Metaphysical foundations are also rejected as a valid argument per se, such as the belief that empirical investigations will provide neutral and truthful answers about the objective, social world (Alvesson, 2002).

According to a similar critical approach we could perhaps refuse any grand or minor narrative as true; no idea can be held valid because of its historicity, or the scale of its support. Then I cannot blindly accept ideas such as freedom in neoliberalism, or the importance of a user-driven mental healthcare. Instead, I need to keep in mind a critical and reflexive worldview if I am to see through fallacies that are taken for granted and that perhaps too often make up the political discussions and governmental implications for mental health service users. And perhaps music therapists should pay attention to potentially dogmatic grand narratives within music therapy, such as 'the power of music', or 'the importance of self-determination for the participant'.

When we derive grand narratives of their legitimacy it doesn't mean that grand narratives exist without a reason. Some ideas, I believe, are worth following, and certain master

narratives bring indispensable value to our community. However, the sole presence of a grand narrative does not provide a legitimate point of view. It may well be that democracy is the best way to govern western countries, and that the concept of countries is the best way to organize the world, but the fact that this is the present status quo does not mean that this is the perfect end-state of a teleological evolvement. In order to say anything about what is right, and what is real, we need to discuss and reflect upon ideas, consequences and discourses beyond the grand narrative: '[...] an emphasis on multiple voices and local politics is favoured over theoretical frameworks and large-scale political projects (Alvesson, 2002, p. 47).

Power-knowledge connection

According to Alvesson (2002) the issue of power and oppression is not always a priority in postmodern thinking, due to a deeper interest in: 'political issues in such a fragmentation- and micro-oriented way that issues of domination and force become neglected' (Alvesson, 2002, p. 56). One exception is the works of Michel Foucault, which according to Alvesson, is the most explicit postmodern scholar regarding the matter of power.

For Foucault, power is fiercely connected with knowledge (Alvesson, 2002). It is through ruling discourses that power is executed; through knowledge, statements are used to define others:

> Power resides in the discursive formation itself – the combination of a set of linguistic distinctions, ways of reasoning and material practices that together organize social institutions and produce particular forms of subjects. (Alvesson, 2002, p. 56)

Ruling discourses settle categories of people, define rules for what is normal and acceptable, and determine how we reproduce the next generation to fit within the given discourse. Alvesson (2002) celebrates researchers who succeed in combining postmodernist thinking with critical philosophy of the Frankfurt School:

> Although there are clearly tensions between the positions, the sceptical emancipatory project of the Frankfurt School, with its uncompromising cultural critique, and the Foucauldian interest in how power and knowledge are intertwined, and the insistence that seemingly progressive knowledge is dangerous, encourage an interesting blend shared interests and productive dissensus. (Alvesson, 2002, pp. 55-56)

I support this combination of postmodernist awareness of power-knowledge connections, and the emancipatory project of critical theorists. I believe that academics hold a responsibility to support suppressed people and marginalized groups of our community.

Now that we have seen the broader picture of postmodern concepts that have altogether affected my worldview as a researcher, I will in the following head a bit deeper into the discursive thinking of Foucault and the idea of deconstruction as proposed by Derrida.

The Foucaultian heritage

Foucault was involved in a broad spectre of fields, such as: psychiatry, psychology, criminology, linguistics, economics, biology, medicine, philosophy, history, ethics, arts, music and literature. Hence, it is 'difficult to distil from all this activity a singular Foucaultian framework' (Kendall & Wickham, 2007, p. 129). And needless to say, the part of Foucaultian theory that has influenced me as a researcher is based only on a small fragment of his rather sizeable bibliography. I will try to present some of his thoughts that have influenced my view on ontological and epistemological matters. I support Foucault (2002) in the idea that the researcher constructs both truth and knowledge through academic traditions; new knowledge always builds on previous thoughts, and follows certain rules within a specific discourse.

Governmentality

Even though Foucault contributed to a wide area of academic disciplines, he has not been taken too seriously in most of them; his contributions were spread out, and the scientific methods he used were not familiar within most academic circles (Kendall & Wickham, 2007). He did, however, leave quite a mark concerning the study on knowledge:

> The disciplines that Foucault examined do not seem, in the main, to have reciprocated his interest in them. Foucault has more frequently found a home in the 'meta-disciplines' – the study of studies – and perhaps especially in that branch of sociology that is philosophically nervous about the status of knowledge. (Kendall & Wickham, 2007, p. 129)

One of the traces Foucault has left us with is the tradition of *governmentality*, that is, the investigation of *how* it is that governmental forces come to be. In our culture we are governed by 'a collective mentality'. This shared understanding and driving force is not found merely at the governmental level of the society as a whole, rather there are determinant understandings intrinsic to every part of the culture, all the way down to the individual layer. Foucault teaches us that the practiced examples of governing lead to

an actual government, and not the other way around (Kendall & Wickham, 2007). This perspective will not necessarily affect my research directly concerning research design or the methods chosen for the empirical investigation, but the governmentality view on practices forming social constructed power hierarchies is part of my understanding as I enter the realm of compulsory mental healthcare, through different institutions and several jurisdictional articles. The power for someone to define and make decisions about mental healthcare is constructed and maintained by a collective understanding of experts governing potent health services.

Discourse

Discourse is a significant term for grasping the governmental mechanisms in different cultures. Again, this is a way of thinking that is not necessarily determining for the practical execution of this research, but one that is still relevant for my understanding of knowledge production, and for the power relationships that exist within compulsory mental healthcare, not to mention the relationships between society and the understanding of mental health ontology per se.

In his methodological work, *The Archaeology of Knowledge*, Foucault (2002) delivered a critique on the history of ideas. That is, he scrutinized that which he thought was a narrow-minded view on the historical lines and the abruptive shifts that seem to have defined the different eras and paradigms of thought. He believed that the traditional view on discontinuity is biased, and that this modern organization of history is merely constructed through an exaggerated examination of change, written by western academics. Foucault relies more on the methodology of historic research and the historians' view on the bigger picture; instead of looking for determining changes they pose questions of another kind:

> What types of series should be established? What criteria of periodization should be adopted for each of them? What system of relations (hierarchy, dominance, stratification, univocal determination, circular causality) may be established between them? What series of series may be established? And in what large-scale chronological table may distinct series of events be determined? (Foucault, 2002, p. 4)

On the *microscopic scale* of history there certainly have been a number of revolutionary events that have made their mark on time and space, but all these take place in, and are responses to the on-going history on the *macroscopic scale*. Foucault borrowed this

image from Canguilhem, and argued that the histories are written differently on each of these levels (Foucault, 2002).

Leading us through three of his previous works, Foucault (2002) describes his historical analyses of ideas and institutions. He believes to find an evidence of ruling discourses within the history of knowledge; at least he found *one* way to understand the development of knowledge that should not be neglected. Instead of looking for the meaning behind the statements, we need to investigate the statements themselves:

> The analysis of thought is always allegorical in relation to the discourse that it employs. Its question is unfailingly: what was being said in what was said? The analysis of the discursive field is orientated in a quite different way; we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it, and show what other forms of statement it excludes. (Foucault, 2002, pp. 30-31)

In other words, it is not enough to investigate what statements are supposed to represent (signified). Nor is it enough to look at the mere contours of these statements (signifier). We need to understand better the matrix in which these statements occur. From whom does the statement come? What traditions are the statements based on? How can it be that the statement is regarded to be valid? In which setting is this statement legitimate? How did this statement even come to be?

If we follow this line of thought we need to inspect the web of discourse, or the vast network of statements, that always already exists prior to the statement. Whenever new ideas are built, the foundations and landscapes are already there. The landscape will even decide the ruling principles for how these ideas can possibly be constructed. As for the mind, ideas always evolve within a certain discourse:

> I shall abandon any attempt, therefore, to see discourse as a phenomenon of expression – the verbal translation of a previously established synthesis; instead, I shall look for a field of regularity for various positions of subjectivity. Thus conceived, discourse is not the majestically unfolding manifestation of a thinking, knowing, speaking subject, but, on the contrary, a totality, in which the dispersion of the subject and his discontinuity with himself may be determined. It is a space of exteriority in which a network of distinct sites is deployed. I showed earlier that it was neither by "words" nor by "things" that the regulation of the objects proper to a discursive formation should be defined; similarly, it must now be recognized that it is neither by recourse to a

> transcendental subject nor by recourse to a psychological subjectivity that the regulation of its enunciations should be defined. (Foucault, 2002, pp. 60-61)

Every statement occurs within certain discourses, and the new statements will then be part of the discourse. And so on, the statements will continue to provide rules for other statements, in a severely intricate network of statements. Several discursive networks occur simultaneously, and parallel discourses intertwine whenever people view the world through dissimilar discursive lenses:

> If I suspended all reference to the speaking subject, it was not to discover laws of construction or forms that could be applied in the same way by all speaking subjects, nor was it to give voice to the great universal discourse that is common to all men at a particular period. On the contrary, my aim was to show what the differences consisted of, how it was possible for men, within the same discursive practice, to speak of different objects, to have contrary opinions, and to make contradictory choices; my aim was also to show in what discursive practices were distinguished from one another; in short, I wanted not to exclude the problem of the subject, but to define the positions and functions that the subject could occupy in the diversity of discourse. Lastly, as you have observed, I did not deny history, but held in suspense the general, empty category of change in order to reveal transformations at different levels; I reject a uniform model of temporalization, in order to describe, for each discursive practice, its rules of accumulation, exclusion, reactivation, its own forms of derivation, and its specific modes of connexion over various successions. (Foucault, 2002, pp. 220-221)

The way I understand Foucault, as presented in the cited extracts above, there is no universal understanding. Instead, the discursive backgrounds are deciding for how we interact with the world and how we think about it. I agree with Foucault in this view on the construction of ideas. Even though human beings are thinking and creative individuals, no one is a genius in a vacuum; it is probably wise not to underestimate the impact of the discourses in which new ideas are established, and in which institutions are developed over time. This point of view is relevant for me, both as a researcher, and as a music therapist, especially regarding the idea of the compulsory mental healthcare; today's discourses within mental healthcare derive from specific cultures in a specific history, and cannot be regarded a neutral answer to what modern mental healthcare *should* be like. Although I will not analyse the discourses within compulsory mental healthcare per se, the discourse perspective highly affect my understanding of compulsory mental healthcare. And further, the discoursive perspective is relevant for critical

remarks about compulsory mental healthcare. Based on Foucault's *History of Madness* I will in the following introduce some thoughts on discursive thinking regarding the mental healthcare and mental illnesses in our contemporary culture, which are also part of the theoretic foundation in critical psychiatry and post-psychiatry outlined in chapter four.

The history of Madness

In his work 'History of Madness'[5], Foucault (2009a) investigates the discourses of madness in modern times. He describes some differences and developmental features that have influenced how we speak of madness, and how we *have* been speaking about it since the classical age and until the end of the 20th century. Translator and editor of History and Madness, Jean Khalfa, summarizes Foucault's perspective this way:

> (…) Foucault does not look at madness from the point of view of the classical historian of a scientific discipline, here psychiatry, who would trace the development of a science from inchoate early notions towards its modern, rationale state. Rather he is interested in decisions, limits and exclusions which took place at particular points in time and indicate shifts in the way certain phenomena were experienced. (Khalfa, 2009, p. xv)

As described above, Foucault is not only interested in the language that is used, and the practices that are performed; rather, he wants to investigate both the environmental circumstances that make these statements possible, and *how* discursive networks afford different understandings. As Alvesson (2002) puts it, madness is artificially and falsely objectified as a 'something':

> 'Madness' is thus not something that exists 'out there' in the minds of particular individuals; it is something that has been brought to the fore during a particular period and with the help of carious techniques and procedures as a special object of knowledge and attention (incarceration, treatment). The 'raw material' is there, in the shape of behaviour, gestures, biochemical processes and so on, but hat is perceived as possession by evil spiris [sic], the wrath of God or mental illness is the result of a process of differentiation, classification and positioning on material and epistemological dimensions. (Alvesson, 2002, p. 56)

5 When first published, in 1961, the title of the work was *Madness and Civilization: A history of Insanity in the Age of Reason* (Folie et Déraison: Histoire de la folie à l'âge classique). Later editions often contain additional such as relevant appendices. The edition mostly referred to in this dissertation is a Norwegian translation of *Histoire de la Folie á l'âge classique.*

Through his works, Foucault describes how madness has been given different meanings dependent on dissimilar discursive networks. He gives lots of examples of the psychiatric institutions have developed seemingly arbitrarily, almost by chance, and to how certain practices have outlived the idea behind the practice. At one point in time, for instance, buckets of iced water were dropped on mental health service users from great heights for beneficial purposes, together with other potentially painful interventions; similar statements were later used as punishment, in order to force proper behaviour onto the mad people, implying that madness was a matter of moral choice. The meaning of the practices changed together with the discoursive web of rules.

During the 17th century a major event took place, which is referred to as *The Great Confinement*. In great numbers mad people were imprisoned and kept away from society, together with criminals, poor people and other *outcasts*. Foucault writes that these happenings defined a threshold in which *reason* takes control over *madness*:

> Confinement was an institutional creation peculiar to the seventeenth century. It immediately took on a scale that bore no relation to the practice of imprisonment in the Middle Ages. As an economic measure and a social precaution, it was an invention. But in the history of unreason, it signals a decisive event: the moment when madness is seen against the social horizon of poverty, the inability to work and the impossibility of integrating into a social group. It was the moment when it started to be classified as one of the problems of the city. The new meanings assigned to poverty, and the importance accorded to the obligation to work and the ethical values surrounding it were ultimately determining factors in the experience of madness, transforming its meaning. (Foucault, 2009a, p. 77)

A large group of challenged people were confined, marginalized, and excluded, and would no longer live with their families, nor would they be part of the community in general. As the mad people were kept out of sight and out of mind, and were assembled in institutions, they became available as research objects for medical researchers at the brink of the age of enlightenment. When reason took control over madness, and when mental illness was objectified to a great extent, Foucault argues that the gap between the sane and the mad increased dramatically (Foucault, 2009a).

In the preface of *History of Madness*, Foucault (2009b) argues that the statements within modern psychiatry have been monological, and that this expert-service user discourse of reason and madness could only emerge in this absence of dialogue. What went wrong, Foucault claims, is that the: 'modern man no longer communicates with the mad man' (Foucault, 2009b, p. xxviii). If one of the main challenges in the development of mental

healthcare is the absence of dialogue between service users and health professionals, it is perhaps not enough to inspect the mere discourses in mental healthcare; rather, it may also prove necessary to inspect the monological environment that makes this language possible: 'My intention was not to write the history of that language, but rather draw up the archaeology of that silence' (Foucault, 2009b, p. xxviii).

Foucault has been criticized for being selective with his historical sources, and for neglecting certain parts of the whole picture in his elaboration on the history of madness (Merquior, 1991). And obviously, this presentation of *modern psychiatry* anno 1961 does not necessarily represent the contemporary mental healthcare 50 years later. Nevertheless, I believe that Foucault's contributions are of great importance when it comes to understanding psychiatric institutions today as a status quo in mental healthcare, more than it is a final stage of a teleological development. Health professionals today might not want to take for granted that the contemporary stage of modern psychiatric institutions are the way they are merely because this works for everyone; mental healthcare today is the result of ruling discourses representing certain traditions and values. Throughout history, mental healthcare has come to objectify mental health as a medical object that experts should remove, and people with mental health difficulties have been regarded obstacles for a well functioning society. I will return to the matter of excluding tendencies in our current neoliberalism when I describe some facets of dis/ability studies later on in this chapter.

When Foucault speaks of the absence of a dialogue as an important explanation for the development of psychiatry, I understand this as a call for more communication about mental healthcare. We cannot accept that modern mental healthcare is founded on a medical monologue alone. There are probably several good reasons for including the user perspective in the debates and research on mental healthcare, and this is one: An actual dialogue might just decrease the existing gap between the 'sane' and the 'mad', two parts that could really play on the same team towards the same goals. If we try to understand the discoursive background of each other, we might even play on the same field. I believe that it is a good thing, then, that The Convention on the Rights of Persons with Disabilities demand that relevant user organisations are involved in decision-makings on a national level. I will now introduce some thoughts on *deconstruction*, another approach within postmodernism, or poststructuralism (which I include under the umbrella postmodernism), that has influenced my ontological sense of reflection in general, and my understanding of compulsory mental healthcare in specific.

Derrida, différance, and deconstruction[6]

The concept of *deconstruction*, as promoted by the Jacques Derrida (1997, 2004a, 2006), is a grand topic to mention without fully submitting to all of its potential. Still, the ideas of deconstruction and différance are also important parts of my attitude towards ontological conundrums regarding this current investigation of music therapy within compulsory mental healthcare. In the following sections I will head into some of his ideas, with an emphasis on deconstruction as an academic approach as well as the concept of *différance* concerning our understanding of objects and ideas through their existing counterparts in language and culture.

From structuralism to post structuralism

As Derrida (1997) points out, our way of understanding the world is dependent on this specific historical context that we are always already part of. The history of western philosophy shows us a line of thinkers posing questions of ontology and epistemology; they speak of being in the world, and of a sense of meaning. But this way of philosophizing is, according to Derrida, a result of this particular historical context. In the same way, our way of viewing phenomena around us rely on the last millennia of culture, theology, language and history. Tales, histories, and myths make up the foundation and structures that influence our whole understanding and being in the world.[7]

Saussure, another French Linguist who precedes the works of Derrida, claims that we tend to understand phenomena in relation to their opposites (Dyndahl, 2008). We grasp an understanding of light because we can relate to darkness. And we relate to winter as the opposite of summer. If we were not familiar with the concept of night, we would not even start to count the days. This is all imprinted in the deep cultural structures, which form our perception and interpretation of the world. We know no other way of understanding the world.

Derrida also acknowledge these structures, and that our knowledge is forged within these boundaries (Derrida, 1997). However, as these structures are culturally constructed, they can also be deconstructed. Poststructuralist ideas are embraced by many scholars in different disciplines, such as feminism, holding that there are structures in our culture that repress women in favour of men, and that this hierarchy has existed for a long time

6 Parts of this section were presented in a paper called The Dichotomy of Freedom, held at the Nordic Music Therapy Conference in Oslo, august 2015. The paper was also made into an essay, published in the Norwegian journal *Musikkterapi* (Drøsdal, 2015b).

7 The anthropologist Lévi-Strauss recognized such structures across different cultures during his field across different cultures. He noticed how certain myths, such as tales of good and bad, existed independently around the world (Leví-Strauss, 2009).

(Lykke, 2010). But to acknowledge that these structures exist, is not the same as accepting them as necessary and unavoidable. To be aware of these structures makes it even more important to avoid them. If wanting to change these structures, the answer could be to deconstruct and rebuild new ways in which to understand the world, ways that are not only based on taken-for-granted truths and traditions (Derrida, 2004a, 2006).

Deconstruction

Jacques Derrida (2004a) gives Heidegger credit for the idea of *deconstruction*. The idea of deconstruction is meant as an approach of critique towards the institutionalized and taken for granted notions about the ontological world. Philosophy and theory of science have, according to Derrida[8], neglected that the way in which we think, and understanding meaning, is dependent on a history of cultures (Dick & Ziering, 2003). It is through this very specific line of cultural evolution, through language and theology, that we understand the world today. This cannot be ignored (Derrida, 1997). In a round-table discussion at the Fordham University, Derrida gives an example about laws when he speaks of deconstruction:

> There is a history of legal systems, of rights, of laws, of positive laws, and this history is a history of the transformation of laws. That why they are there [sic]. You can improve law, you can replace one law by another one. There are constitutions and institutions. This is a history, and a history, as such, can be deconstructed. Each time you replace one legal system by another one, one law by another one, or you improve the law, that is a kind of deconstruction, a critique and deconstruction. So, the law as such can be deconstructed and has to be deconstructed. That is the condition of historicity, revolution, morals, ethics, and progress. (Derrida, 2004a, p. 16)

The way I understand this we have to rethink and revalue our basic concepts and taken for granted truths, as were they only a few appropriate alternatives out of many. Progress implies deconstruction.

Deconstruction is, as I understand it, a critical approach in which we do not take for granted any knowledge or ontological reality, because they are always constructed within certain academic traditions.

8 This reference is based on statements by Derrida himself, but presented in a documentary film by Dick and Ziering (2003).

We understand our ontological world through language. But words can neither represent the physical world nor abstract ideas or knowledge. When reading texts by Derrida we can notice that some of the words are physically crossed out: Because the word (the signifier) cannot truly represent what it is meant to (the signified), the word is marked so that the reader becomes aware of the fallacy of the given word (Derrida, 1997). The word is not removed, because the word is always there for a reason. But it is important that the ~~signifier~~ is not left untouched, so that the ~~signifier~~ cannot continue to falsely represent an actual reality (the signified).

Différance and dichotomies

Derrida challenges the taken for granted truths, which appear to be truths only because they appear to us through language. Diversities in language need to be taken into account if we are to understand important nuances of what we perceive. The different words and concepts *afford* different views and understandings. Derrida teaches us that we need to question the relationships between language (signifier), and what language supposedly represents (signified) (Derrida, 1997).

When we approach a term, we cannot simply internalise its meaning, as if the word affords some kind of doorway into a one sided or unquestionable, ontological reality. A word is always already part of cultural traditions, and is loaded with culturally constructed connotations. As a reminder, Foucault also stresses that statement is always made, and understood, from within certain discourses (Foucault, 2002). What Derrida emphasizes, however, is that our understanding of a term is also dependent on that which is *not* mentioned; each time a signifier is proposed, other signifiers are deselected. The specific signifier is chosen because it is meant to represent something in particular. Hence, the signifier is given meaning due to its limitations and oppositions, and all that the signifier is *not* meant to represent. Derrida (2006) introduces the term *différance* as a signifier to all that is connected with our understanding of the signifier. Différance reminds us that the meaning of a signifier will always be dependent on all that which is not given by the signifier itself. As we can remember from the postmodernist critique of categories, focus on *one* thing can facilitate a neglect of the *other*. And as Derrida (2006) points out, the same counts for words.

Signifiers always leave something behind, and they often possess equivalent counterparts (Derrida, 1997). These binary oppositions, or dichotomies, compliment each other. That is, each of the signifiers is given meaning as something opposed to the other. Derrida (1997) tells us that we tend to think about these dichotomies as pairs, which occur naturally and are equally valued. But this is not the case; the challenge is that we do not really perceive the contradictory terms as containers of the same value, rather we seem

to appreciate one half more than the other in many circumstances. As the Norwegian professor Petter Dyndahl (2008) understands it: 'One end of the dichotomy appears truer or carries more authentic qualities than the other, which is then interpreted culturally as inferior to the first' (p. 128). We understand light as better than dark, good as better than evil, democracy as better than oligarchy, and perhaps quantitative research as better than qualitative research.

Deconstruction, as presented by Derrida (1997), may be used in order to investigate language, thus revealing culturally adapted values and beliefs. Hierarchical dichotomies are not eternal structures that define our world; instead, they are arbitrary relations. By deconstructing words and their relationship with cultural attributes, we may intrude with taken for granted attitudes, and question the values they represent. Then, perhaps we might also reveal some of the power relationships that assist to preserve the current societal development the way it is. Maybe health professionals can also point to the fact that some people benefit from the current hierarchically valued categorisations, and that some do not. Within the deep cultural structures of presumptions there are both winners and losers.

2.2.4 Dis/ability studies

We will now look briefly into the field of disability studies, an approach that has indeed taken into account the impact of binary oppositions in its ontological discussions. *Disability studies* is a rather wide academic movement that involves thoughts from feminism, queer, crip and postcolonial studies (Goodley, 2014). The theoretic foundation on disability studies for this research project is based on the book 'Dis/ability – Theorising disablism and ableism studies' by Dan Goodley, professor of Disability Studies and Education at the University of Sheffield[9]. This meta-theoretical point of view is included because it has recently become an important part of my worldview as an academic and as a music therapist. The way I see it, disability studies, as explained by Goodley, combines postmodernist thinking and axiological reflexivity regarding suppressed sub-groups of modern society: 'Disability theory emanates from the perspective that disability is a sociological, economic and cultural thing rather than a psychological, embodied or medicalised problem' (Goodley, 2014, p. 3). This perspective may indeed look like the fruitful combination of critical theory and postmodernist perspectives that Alvesson (2002) calls for.

Central for disability studies, according to Goodley (2014), is the idea of *disablism*:

9 Although this research project is influenced by Dan Goodley I owe it to professor Randi Rolvsjord at the Grieg Academy Music Therapy Research Centre that I am familiar with this theoretic approach in the first place. She has previously implemented these thoughts onto music therapy in her article *The Competent Client and the Complexity of Dis-ability* (2014a) among others.

> Disablism relates to the oppressive practices of contemporary society that threaten to exclude, eradicate and neutralise those individuals, bodies, minds and community practices that fail to fit the capitalist imperative. (p. xi)

Disability studies stress that individual challenges, such as physical or mental health difficulties, are not the main reason that people are all too often left behind; instead, it is the absence of facilitation and inclusion that continuously keep *the others* out of society, out of work life, out of leisure activities, and out of physical and mental well-being.

An understanding of *disability* needs to be interpreted as something opposed to *ability*. And whereas the Derrida-inspired ones might want to cross out the term ~~disability~~ as a reminder that this sign cannot represent the signified idea on its own terms, Goodley instead co-constructs the term *dis/ability* (Goodley, 2014). Both ~~disability~~ and *dis/ability*, suggest that we understand 'disability' through some specific contexts, through différance: Our perception of disability is dependent on an understanding of the embrace of ability in our community. The ruling discourses within our culture afford a system in which people are judged and valued by their ability to produce (Goodley, 2014). Goodley (2014) argues that the modern Western societies are neoliberal cultures in which we appreciate ability so much that disability is constructed as a term to include all those who are not normative enough to fit within the neoliberal agenda:

> The neoliberal agenda produces winners and losers. If you are judged to be fit, able and rational enough for work (or perhaps, more fairly, amenable to exploitation) then a place waits for you at the neoliberal table. (2014, p. 38)

Neoliberal cultures gladly welcomes all those who are able to contribute to society, and those who are capable of promoting economic growth. The exaggerated devotion towards success turns to individualism, and is a suitable recipe for establishing an anti-social community (Goodley, 2014). Goodley even suggests the term *neoliberalism-ableism* in order to underline the current geo-political influence on ableism: 'Neoliberalism provides an ecosystem for the privatization of ableism; a state of affairs I define as *neoliberal-ableism*' (Goodley, 2014, p. 26).

If researchers and health professionals want to maintain an including society, our task, as representatives of academic disciplines, is to highlight the diversities:

> One of the most powerful things we can do around dis/ability and ab/normalcy is to have conversations about them. I suggest that now is the time for a politics of abnormality where each of us move out of our normative shadows and embrace our inherent potential to be non-normative. (Goodley, 2014, p. xvi)

If the population in general talk normally about differences and similarities, then the culture might eventually overcome some of the prejudices that are too often the reason for conflicts, stigmas, misunderstandings, and even traumas. Speaking as a health professional within mental healthcare that have seen what exclusion, violence, or abuse can do with people, I believe that the population needs health workers who flag acceptance and embrace a plurality in skills, interests, sexual orientations, ethnical backgrounds, and mental states of mind. It is important to be aware that the conformist community per se are causing disability (Goodley, 2014). According to Goodley (2014) it is also important express these thoughts out loud: 'Disability studies is not simply a reaction to the medicalization and individualization of disability but also an antidote' (Goodley, 2014, p. 6).

2.3 Towards 'a postmodernism-informed critical perspective' and its implications for this study

The different theoretic perspectives described above bring some implications for my research on music therapy within compulsory mental healthcare. Although the mentioned perspectives differ in many ways, I find them valuable for my interpretation of user accounts and for my understanding of the status of compulsory mental healthcare. I will in the following describe my eclectic philosophical position as 'a postmodernism-informed critical perspective'.

Hermeneutical thinking teaches us cautiousness when interpreting phenomena in our culture, and reminds us that as human beings we cannot make neutral observations from a distance; we are always already part of the world we are observing. All research is coloured by the researcher and the researcher's interests, but the subjectivity of the researcher is an even more problematic when human beings investigate human beings. When interpreting the meaning of a 'text', in a broad sense, we need to take into account the circumstances of the meaning making, as well as the prejudgments of the interpreter. We need to accept that we can never really understand the true meaning of an account, as the horizons of both sender and receiver melt together and possibly make up new meanings. All this considered, we can still make use of insights that derive from the interpretation, regardless of the potential gap between interpreted meaning and the original thoughts behind the text.

The text will sometimes carry meaning that was not necessarily part of the initial idea behind the text. There is always already a culture in prior of the text. The culture is a great part of the language that is used, and whether or not intended, the text brings with it specific traditions and ways of thinking. And as long as the same language is being used,

the culture will continuously renew and legitimate itself. But as suggested by critical theorists, unfortunately the culture does not provide the best frames for everybody to flourish, rather there are privileged people on the top who benefit from keeping the culture unbalanced. We learn from critical theory to look for, and to reveal, iniquities in society. And according to voices within critical theory, I support that research within the social sciences and within the humanities should stress being part of an emancipating project, which seeks to make society a little more just. From critical theory I also bring with me the belief that a researcher, at least within social sciences, can never stay neutral: either I accept iniquities, or I criticize inequities. I also very much support music therapist Brynjulf Stige (2003) when he writes about music therapists' responsibilities for supporting marginalized groups in society:

> While working directly with the individual and/or group, crucial interventions in the process may also be directed toward the community itself, for instance in order to work with attitudes and traditions that create barriers in the community. Very often, lack of economic priorities given by the municipality or other funding agencies limit client's possibilities for growth and development. The work of the music therapists therefore also has a political dimension to it. Therapists cannot be indifferent about the political discussion of education, health, and culture. (Stige, 2003, s. 264)

Critical theory brings me closer to a position in which I, as a researcher, am more aware of the iniquities of marginalized groups in society. Critical theory also makes me believe that it is important that I write about repression when revealed. I believe that it is in line with critical theory that I include notions from The Convention on the Rights of Persons with Disabilities in the study, and consequentely take an active stance in rejecting the 'treatment criterion' as a valid argument for coercive options.

Postmodernist ideas affect my worldview to a great extent, and are thus relevant for my engagement with the field of compulsory mental healthcare. Through postmodernism I am reminded that what we think is limited to the language we use, and that the interpretation of phenomena around us are affected by the words we use to describe them. Through postmodernism I have come to believe that researchers cannot merely accept modern institutions in society as results of natural or flawless evolutions, rather they are constructed and maintained through webs of discoursive rules. This means that I cannot take for granted that mental healthcare in its current form is necessarily formed to serve the service users as best as possible. The mental healthcare has been socially constructed over time through ruling discourses, and a multiple-layered collective mentality have helped to maintain a patriarchal mental healthcare since the beginning of the

modern age, in which ~~experts~~ have had the power to define people's health challenges with few attempts of creating the necessary dialogue with the service users.

Dis/ability studies make up a compound theoretical field that includes postmodernist perspectives. One central part of dis/ability studies is the relationship between the terms disability and ability, and how the terms are comprehended in cultures that significally value ableism. Through the deconstruction (or rather co-construction) of the term dis/ability, it becomes clearer that we need to provide new understandings of disabilities; it is not disabilities that limit persons, as much as the elevated view on ableism in neoliberal cultures, and the scarce accommodation to include different persons despite their individual variation.

Randi Rolvsjord (2014) describes two different and important perspectives regarding her engagement with disability studies: 1) the feminist perspective connects with perspectives on gender, race, class and disability, and 2) a critical perspective towards the medical model includes thoughts from 'positive psychology, empowerment philosophy, contextual models in psychotherapy, and recovery models' (Rolvsjord, 2014, p. 2). Rolvsjord stresses the similarities between disability studies and a critical approach to modern mental healthcare:

> In my understanding, there are clear similarities between these perspectives and disability studies with regard to the critique of the medical model, the focus on human rights and anti-oppressive practice, the focus on strengths and participation, and the critique of individualist models. (Rolvsjord, 2014, p. 2)

Music therapy as an academic discipline needs to be critical to the society we are part of, and to not take for granted the present medicalised and individual understanding of mental health. Disability, challenges, stigmas, and exclusion do not happen in a vacuum; rather, the challenges for the client group in this study occur within cultural discourses.

I agree with Rolvsjord in that it seems relevant to combine the two: 1) dis/ability studies, inspired by postmodernist ideas, and 2) critical perspectives. In the quote above Rolvsjord mentions both a critique of the medical model and the focus on human rights. Below I will include perspectives from both critical psychiatry/post-psychiatry and The Convention on the Rights of Persons with Disabilities. I find that both of these perspectives also fit with the combination of postmodernist ideas of representation and a critical perspective that call for emancipation. I believe that discourses make up the Norwegian mental health institutions the way we see it today; different understandings, beliefs, and local truths about compulsory mental healthcare will occur, depending on the discourses from which people perceive the institutions. I believe that the idea of

compulsory mental healthcare is made up of multiple discourses, from the political and governmental level all the way down to everyday life inside the institutions. The assorted work staff, the service users, and the politicians speak differently about compulsory mental healthcare, and they understand coercive measures differently. I also believe that it is the researcher's task to look for injustice, and to speak it out loud if injustice is revealed. Thus, I find my self in the crossing between different traditions. And for the reasons mentioned above I will name my eclectic philosophical stance '*a postmodernism-informed critical perspective*'.

The philosophical stance that I have outlined in this chapter presupposes ontological challenges, particularly regarding the representation of user perspectives. A postmodernist approach is not self-evident when trying to understand the actual world through 'empirical investigations', such as interviews. Discourse analysis or a proper deconstruction may seem to hold a more immediate relevance to postmodernism. When I choose to interview music therapy participants in this study, it is performed with an awareness of the limitations of mediated information. I believe that I can never acquire first hand knowledge about the participants' experiences. At best I can interpret their stories of the experience, constructed through language and discourses. Hence, the *findings* that I refer to in the dissertation can never be held as true, or at least not as the *one* truth. It should be made clear that the themes that 'appear' through a thematic analysis of the interview scripts are really constructed areas of interests, and a means to answer semi-specific research questions. At the same time I need to be aware of, and to clarify as much as possible, the traditions that I am part of, in order to make transparent the ruling discourses that lay the foundation for my interests, for the area of investigation, and for the construction of the research as a whole.

As a researcher I also need to be aware of the relationship between power and knowledge, for with power follows ethical dilemmas. I write my thesis from within certain discourses, as a researcher but with a music therapist identity, and I speak to readers within certain discourses. When writing this thesis I do not firstly speak to the service users whose lives and recovery processes I define throughout the research process. It is crucial that I scrutinize my own works, and make sure that I make use of the power in a way that is advantageous for the ones I seek to aid. I believe that it is my duty, as an academic of a health profession, to take part in both political and professional debates, and to take sides with marginalized groups that are often suppressed and disabled in our neoliberal culture, including people within compulsory mental healthcare. I will not take for granted the current medicalised mental health institution as a natural and final end of a teleological development. Until we truly have tried other alternatives to coercive means, we need to be critical of the ruling discourses that make up the master narrative of compulsory mental healthcare.

2.4 The Convention on the Rights of Persons with Disabilities

In 2013, Norway ratified the Convention on the Rights of Persons with Disabilities (CRPD) from 2008 (United Nations Association of Norway, 2019). Mental health illnesses are regarded disabilities in this matter, thus people treated within Norwegian mental healthcare should be protected by the CRPD. Kjersti Skarstad, a Norwegian scholar within political science, makes an interesting note regarding the languages used in the CRPD, especially for those with interests in discourses and in dis/ability studies. The English version of the convention stays true to the term 'person with disability', whereas the Norwegian translations makes use of two different approaches: 1) 'personer med nedsatt funksjonsevne' [persons with reduced capabilities for functioning], and 2) 'personer med funksjonshemming' [persons with inhibited functioning], but the latter is only used for describing situations in which cultural barriers make the 'dis/ability' an actual problem (Skarstad, 2019). Skarstad argues that the latter understanding of disability is clearly more in line with the general content of the CRPD.

The Human Rights convention from 1948 targets all people, thus people with disabilities should really have been protected by the convention in the first place. Unfortunately, this has not been the reality for people with disabilities, who have been exposed to more comprehensive violations to the Human Rights. And The CRPD was eventually decided, due to both an increased awareness about the situation and political pressure from user organisations of people with disabilities (Skarstad, 2019). Although the situation for people with disabilities has been much worse in the past, it is still quite horrific all around the globe; still in modern times there have been examples of medical experimentation on persons with disabilities, and people are sometimes restrained with chains (Skarstad, 2009).

Also in Europe there are still countries in which violence against people with disabilities are considerable acceptable in institutions (Skarstad, 2019). In Norway people with disabilities are exposed to forced sterilisation and forced abortions, and according to Skarstad (2019), people with disabilities do still not access to the same information, services, and participation due to scarce facilitation. For instance, at least four people with disabled eyesight met challenges in the recent Norwegian election, because local facilities were not adequately adapted, and because the responsible staffs were not sufficiently educated about the rights for people with disabilities (Tvilde, 2019). Only about 20 per cent of Norwegian elementary schools are properly adapted for people with reduced mobility. And according to previous court cases, sexual assaults towards people with mental health disorders or intellectual disabilities receive milder verdicts

than normal (Skarstad, 2019). According to the CRPD information that is meant for the general population should be made available, for instance by adapting the formats to the premises of the users. A contemporary issue worth mentioning is the current digitalisation of the welfare services that seems to make it much harder for people with disabilities to receive their rightful economical transactions (e.g. Fjeldstad, 2019; Hansen, Lundberg & Syltevik, 2017; Mathisen, 2018).

In Norway, 85 000 people with disabilities want to work, but do not have the opportunity (Skarstad, 2019). Through working as a music therapist for people with challenges within mental health and substance abuse, I have met lots of people who could have contributed to society in many ways, if the circumstances were adapted properly. I have also met many people who have been able to work, due to small adaptions such as reduced workweeks and flexible hours. In several ways, the CRPD is meant to protect participation in society for people with disabilities, including participation in the cultural life of society (Skarstad, 2019). As a working music therapist, one of many different weekly tasks, at the moment, is to order the transport for one of the participants, and to adapt the session so that it corresponds with the transport possibilities. At the time, this gesture is necessary for the participant's ability to participate in music therapy.

When the CRPD stresses that services need to be adapted for persons with disabilities, they also give some description as to how far one is supposed to go to meet the necessary accommodations (excerpt from Article 2):

> "Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. (United Nations, 2008)

Terms as 'disproportionate' and 'undue burden' imply that one should indeed go quite far when prioritizing funds and effort for adapting the circumstances for people with disabilities, in order to answer to the Human Rights.

National states that have ratified the CRPD are obliged to ensure the Human Rights, and the responsibility lies with the government. Skarstad (2019) sum up two important responsibilities for national states, (based on article 4): 1) Ensure rights are included equally for every group in politics and legislations, and 2) Ensure that different groups are taken into account through accommodation and measures that guarantee equal treatment in practice. Thus, it is a concern on a national level if persons in mental healthcare experience violations to the CRPD. Additional international conventions are

ratified by Norway and thus shape Norwegian legislations; the 'Act relating to equality and a prohibition against discrimination (Equality and Anti-Discrimination Act)', impose measures of accommodation for all public authorities, employers, and others, so that no group is discriminated or kept outside (Equality and Anti-Discrimination Act, 2017; Skarstad, 2019).

Among eight central principals for the CRPD, three of these seem especially relevant for this study (from Article 3):

(a) *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*

(c) *Full and effective participation and inclusion in society;*

(f) *Accessibility; (United Nations, 2008)*

Regarding compulsory mental healthcare in specific, the first (a) of the mentioned principals are perhaps the most obviously relevant one. The national state is responsible for ensuring individual autonomy and self-determination for people, and is obliged to go a long way doing so. Regarding the first principle (a), Skarstad (2019) points out that without the understanding and respect for the intrinsic value of every human being, we get much closer of treating human beings as objects (my translation): 'One of the main reasons for the widespread violations against people with disabilities is that the violations are not understood as wrong, but rather as natural and legitimate discrimination due to biological and medical differences' (Skarstad, 2019, p. 82). But as a music therapist I also value highly the accessibility (c) - and possibilities for participation (f), for those in need for potential health promoting services and activities, such as accommodated music activities. Access to- and accommodation of music activities will also be a relevant perspective later on in this study, when discussing the user experiences portrayed in chapter six. The right to participate in cultural activities, leisure time activities, and sports, are further outlined in Article 30 of the CRPD (United Nations, 2008; Skarstad, 2019). The right to participate includes accommodated transportation to such activities if necessary.

The article 4 of the CRPD denotes that user organisations are involved in decision-makings and accommodations to ensure that necessary considerations are being made, and that professionals working with people with disabilities are educated about the CRPD. For music therapists both of these measures may prove relevant in order to provide the best services as possible. I would even like to insist that information about the CRPD must be part of the educational programs for music therapists. And participating

with user organizations may indeed provide useful insight for music therapists in both research and practice.

2.5 Critical psychiatry and post-psychiatry

Critical psychiatry has become an international movement during the last couples of decades of the 20th century and the beginning of the new millennium, due to changes in national policies on mental health care, and the emerging voices of user organizations (Thomas & Bracken, 2004). Thomas & Bracken (2004), two spokespersons for critical psychiatry, describe a change in British mental health policies going away from paternalistic approaches in the health services in favour of more democratic health service that recognizes individual self-determination for the service user. In addition, the new British healthcare recognized social, cultural, and economical aspects of health issues. Thomas & Bracken (2004) argue that the rise of the user organizations and the change in health policies do not occur as singular events from within a vacuum, rather they are part of the globalized worlds of mass medias, with an emphasis on individual freedoms and consumerism.

One classical study made a critical point about the subjectivity of diagnoses that have been part of the inspiration for the critical psychiatry movement (as described in Double, 2002): In 1973, Rosenhan conducted a study in which eight pseudo-patients told they were hearing voices in prior of admission to different hospitals. At admission, and for the rest of the experiment, however, the pseudo-patients acted normally, answering honest to all questions. All of the pseudo-patients were attributed with psychiatric diagnoses, and seven out of eight were diagnosed with schizophrenia (Rosenhan, 1973). Based on the findings, Rosenhan speaks rather critically about the directedness of the observing health professionals, and the centrality of the psychiatric circumstances for determining diagnoses:

> It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. […] Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation, rather than being motivated by a malicious disposition. In a more benign environment,

> one that was less attached to global diagnosis, their behaviors and judgments might have been more benign and effective. (Rosenhan, 1973, p. 257)

Further Rosenhan argues that the tremendous perspective on diagnoses goes in the way for the actual therapy: 'The consequences to patients hospitalized in such an environment – the powerlessness, depersonalization, segregation, mortification, and self-labeling – seem undoubtedly counter-therapeutic' (Rosenhan, 1973, p. 257). I agree with Rosenhan in that a mental healthcare that removes the attention away from the services users' actual challenges, life situation, and resources, in favour of diagnostic labels, is not necessarily a healthcare that provides the best treatment as possible.

Thomas & Bracken (2004) give credit to Ingleby (1981) and colleagues as central to the rise of the critical psychiatry movement. About Ingleby's (1981) work, Thomas & Bracken (2004) states the following:

> The underlying premise of Ingleby's ideas is that mental illness is a political issue. Although he refers to Foucault, his book was written before Foucault's ideas had made their full impact. Ingleby accepts the existence of states of profound suffering and alienation seen in psychosis, but questions the interpretations psychiatry makes of such states. He argues that we can best understand conflicting viewpoints about the nature of madness in terms of underlying philosophical systems, and that these systems of thought are ultimately driven by moral and political considerations. Thus, his analysis is conceptual rather than empirical. (pp. 362-363)

In the same way that postmodernist theories have criticized modernism, post-psychiatry challenges the bio-medical modernity that derived from the modern culture. Included in the critique is the view that the biomedical comprehension of mental illnesses is built on a narrow approach to science and knowledge, due to the empirically orientated understanding of truth, within modern discourses. Modern psychiatry is founded on positivism, which base knowledge on empirical observations and explanations of causality, and is therefore not compatible with the understanding of the psychological world of human beings (Thomas & Bracken, 2004). In addition, for a long time the discoursive rules of causality seeking have not really acknowledged other theoretic models, which take into account different sides of the human existence. Researchers more in line with phenomenology and hermeneutics are perhaps more comfortable with the notion that not everything can be explained through universal causalities, especially not human beings. Instead of observing the behaviour of the service user, the phenomenologist is perhaps more interested in the essence of the experienced psychosis. The critical

theorist is perhaps interested in the repressing cultures that facilitate mental health challenges and difficult life situations for repressed groups of society, in favour of keeping the psychiatrists well positioned within the middle class. The postmodernist theorist may perhaps question the idea of the whole psychiatric institution per se, and perhaps discard the concept of diagnoses in favour of looking at individual human beings, with individual, local challenges, depending on social circumstances. Although superficial, and maybe even close to a caricature, at least the examples mentioned above depicts several reasons for including different perspective on both mental health and mental healthcare, more than what has seemingly been the case for the last century or so. And even though modern mental healthcare is not necessarily stuck within an all-in positivistic bubble, I support the critical voices that call for a wider perspective on mental health and mental healthcare, in which person-centred approaches to recovery count at least as much as universal rules of causality counting on singular variables.

Inspired by critical and postmodernist theory, post-psychiatry seek to look past the seemingly neutral position of mental healthcare, in order to reveal that modern psychiatry is a result of ruling discourses, in which a certain hierarchy is maintained:

> Our essential argument is that the modernist agenda that shapes current thinking and practice in psychiatry serves to disempower patients, while justifying professional authority. Thus, there is a need for a fundamental rethink of psychiatric theory and practice if we are genuine about a move to ”user-centered” or ”recovery-oriented” services. (Bracken & Thomas, 2013)

According to Bracken & Thomas (2013) there is fundamental need for new approaches in order to apply health services that offer the best treatment as possible. Post-psychiatry is part of the broader critical psychiatry movement, but with the ‘central claim that many of the problems of psychiatry rise from its identity as an enterprise of modernity’ (Thomas & Bracken, 2004, p. 368). The post-psychiatry movement seeks to understand why and how psychiatry has come to its status quo, and seeks to make use of this knowledge to take mental healthcare into new directions.

Critical psychiatry, including post-psychiatry, is not an anti-psychiatric movement, but a movement that seeks to limit the bio-medical psychiatry, and make room for social and cultural understandings of complex mental health difficulties (Double, 2002; Thomas & Bracken, 2004). Double (2002), another spokesperson for critical psychiatry, describe how certain diagnoses have skyrocketed in few years together with the use of pharmaceutics, and argues that the large amount of children diagnosed with ADHD is really a result of children being bored, frustrated, anxious, abandoned, or stressed. A study from Norway supports Duncan of his critiques towards the increasing medicalization

of children behaviour: out of half a million children, the researchers found significant correlations between subscriptions of ADHD medications and birth month (Karlstad, 2017). Children born in the first half of the year were diagnosed and treated more rarely with ADHD medications than did the children born in the autumn half of the year. The study reveals an unbalanced prevalence of ADHD diagnoses, which indicates that the social circumstances are an important variable in the question of ADHD; perhaps it is simply harder for the youngest ones in the classroom to sit still, pay attention, and comprehend the content of the education. A Norwegian doctor and researcher, Ole Petter Hjelle (2018), argues that we often put diagnoses and prescribe medication, especially for ADHD, when it is obvious that physical activity is more effective: From an evolutionary perspective, Hjelle (2018) argues, children are really not made for sitting still.

The case of ADHD is only meant as an example, but it is a describing one, for what I believe that the critical psychiatry movement mean when they want to limit the increasing role of psychiatry in modern cultures. I do believe that symptoms correlating with ADHD can really be frustrating, and even painful, for those who struggle with them. And I do believe that medications can help in many of these cases. I still believe that we to often run to pharmaceutics, when 1) other interventions may be at least as effective, and 2) the symptoms are not necessarily biological founded, but rather a result of biological bodies within specific cultural frames. According to Double (2002) there is also a development similar to that of ADHD when it comes to medication as treatment for depression, anxiety, social anxiety, PTSD, and OCD.

Thomas and Bracken (2004) (referring to Miller & Rose, 1986, two voices inspiring the critical psychiatry movement) make a point of how Foucault's theory of government may be used as one way of understanding mental healthcare and diagnoses. We govern our selves within a language that is known for us, and we relate to the concepts we are familiar with. Terms found in mental healthcare are part of the ruling discourses that enable us to process ideas of mental health. This may be one of the reasons that clinical terms and diagnoses are used in the daily language, such as when people say that they are depressed when they are sad, and that they have anxiety when they are uncomfortable. Thomas and Bracken (2004) argue, in line with Foucault (2002), that such mechanisms of self government helps to maintain the power-relationships that exalt the status of the bio-medical psychiatry. If people mention ADHD each time a child is running around or finds it hard to sit still on a wooden chair, then this attitude helps to maintain the same repertoire of thinking. And as a consequence, the next hundred times children act the same way, it is easy to resort to the same pattern. If an ADHD diagnosis is what we think of, it is probably also what we look for, at least more than what comes 'naturally', if the term was not a big part of our daily language in which we comprehend the world.

Mental healthcare has changed throughout history, as we have also seen through the works of Foucault. And the modern bio-medicalised psychiatry has not always been regarded the best way to handle mental healthcare, although the status of the psychiatrists have been somewhat stable since the beginning of the modern age (Bracken & Thomas, 2013). What some critical voices wish, is that we go back to a mental healthcare in which social and psychological perspectives are considered important aspects of both health and treatments:

> Psychiatry needs to return to a biopsychological view to limit its excesses—in other words, it needs to temper and complement a biological view with psychological and social understanding, thus recognising the uncertainties of clinical practice. Such an approach conforms to the new direction that has been called "post-psychiatry". (Double, 2002, p. 903)

I support the critique of the modern mental healthcare brought by the critical psychiatry movement, in terms of the argument that are outlined above. I also support the notion from post-psychiatry that the status of mental healthcare today is unbalanced in favour of a positivist bio-medical perspective, due to modern discourses of empirical observations and causality. I believe that we need to include social and cultural aspects of mental health to a much greater extent in order to provide mental health services that promote health.

2.6 Perspectives on freedom

In a study that targets compulsory mental healthcare, like this one, it is, logically enough, important with a broad investigation of compulsory treatment, which I believe that I can stand for in chapter three of this dissertation. But as we have seen above in this chapter, concepts such as coercion cannot be understood solely through the inspection of the phenomenon itself. We describe, interpret, and understand coercion through culture and through language. And as Derrida teaches us, we also understand coercion through that which is left behind by its term: The signifier alone cannot adequately represent the signified. Coercion, or ~~coercion~~, needs be understood, at least partly, as something different of what it is not. In order to understand what coercion is, and what meanings compulsory treatments have in our culture, we need to discuss what coercion is an absence of, namely freedom, and what the absence of freedoms look likes in modern

liberal cultures.[10] [11] I agree with Thomas and Bracken (2004) when they understand the critical psychiatric movement, and the rise of user organizations, as related to an increasing attention towards individual freedom, especially in western countries. And as the title of this dissertation foreshadows, together with descriptions in the introduction chapter, the concept of freedoms have proven relevant from working with this material over time, and have thus become central to the discussion parts of the study, especially in chapter eight: 'A liberating music therapy'.

One might understand coercion as the opposite of freedom, and freedom as the opposite of coercion. If we take into consideration Derrida's term différance neither ~~freedom~~ nor ~~coercion~~ is a signifier that can neutrally represent something actual in our physical world; both of these concepts can be understood in various ways. As Derrida suggests, we should not take for granted the meaning of a word as it appears to us; our interpretation of the word is biased and depends too much on both the cultural connotations that follow the term and the cultural connotations that follow the term's oppositional others (Derrida, 1997). Thus, our understanding of coercion is reflected through a culturally biased attention towards freedom, and vice versa. That is, we need to open up the terms and look more into what sorts of freedoms we have to do with. Below we will look into some ideas of freedoms that I find relevant for this study.

2.6.1 Negative liberty and positive liberty

The philosopher Isaiah Berlin has been an influencing philosopher in the discussion of freedom, especially due to the idea of negative liberty and positive liberty[12] (Cherniss & Hardy, 2018). Although a few theorists have provided different meanings for *liberty* and *freedom* respectively on this matter, these attempts have not really lead to an establishment of different meanings for the two signifiers (Carter, 2019). Neither will I distinguish between the two, liberty and freedom, as I experience them both signifying the same signified. In short we can say that 'negative liberty' is related to the absence of obstacles that allow us to act freely, while 'positive liberty' has to do with possibilities for acting

10 I started to write about the relationships between freedoms and coercions early in the research process, but left most of the ideas behind as I was trying to navigate between relevant and less relevant perspectives to include in the dissertation. Nevertheless, I agree with the members of the Ph.D. adjudication committee, who advice that I include a philosophical discussion on freedom in the dissertation, as part of their recommendations for improvements in their preliminary report. The committe also recommended specifically to use ideas from Isaiah Berlin.

11 I addressed this topic in a paper presentation held at the 8th Nordic Music Therapy Congress in Oslo in 2015 (Drøsdal, 2015a). The paper was slightly revised, translated into Norwegian, and published the following fall (Drøsdal, 2015b). This section may contain paragraphs that are similar to previously presented material, as the original paper was part of the reflective process for this thesis.

12 According to Carter (2019), the concept of negative and posivie liberties is an old one, and goes at least back to Immanuel Kant, yet Berlin has contributed to this term through in-depth discussions.

freely, and for being in control of one's life (Carter, 2019). Regarding positive liberty and negative liberty, Isaiah Berlin himself states the following: [13]

> There are two separate questions. One is "How many doors are open to me?"; the other is "Who is in charge here? Who is in control?" These questions are interwoven, but they are not the same, and they require different answers. How many doors are open to me? The question about the extent of negative liberty is to do with what obstacles lie before me. What am I prevented from doing by other people – deliberately or indirectly, unintentionally or institutionally? The other question is "Who governs me? Do others govern me or do I govern myself? If others, by what right, what authority? If I have a right to self-rule, autonomy, can I lose this right? Can I give it away? Waive it? Recover it? In what way? Who makes the laws? Or implements them? Am I consulted? Does the majority govern? Why? Does God? The priests? The Party? The pressure of public opinion? Of tradition? By what authority?" That is a separate question. Both questions, and their sub-questions, are central and legitimate. Both have to be answered. (Jahanbegloo, 2011, p. 53-54)

According to Berlin it is thus important to distinguish between the two: 1) 'How many doors are open to me?' and 2) 'Who is in charge?' As I understand Berlin on this matter, the amount of open doors depends on how many doors that are not currently blocked by others. If no doors are blocked, then one may act freely (negative freedom). If there really is a lot of doors, but the person only has the time to open two of the doors at the time, perhaps due to legislations that oblige the person to open doors for the national state at the same time, then the person is prevented to act freely, and thus the person's negative liberty is reduced. When *nothing* (negative) interferes, and when the subject is left alone to act out all of his self-determination there is negative freedom. Whenever there is a *something* that interferes with the subject, and makes the subject act or be in other ways, we have to do with positive liberty. Carter (2019) explains negative liberty as the *absence* of potential boundaries, which allows the freedom to act, and positive liberty as the *presence* of something that interferes with the subject in a way that makes the subject act differently.

2.6.2 Liberty in modern society, in a Norwegian context

Questions of freedom are central to the politics that define our cultures. The importance of freedom is described in documents of political parties, in both ends of the political

13 Some of the statements I refer to in this chapter are not retrieved from works by Berlin, rather from conversations with Berlin, published in the book 'Conversations with Isaiah Berlin' by Ramin Jahanbegloo (2011).

continuum (Fremskrittspartiet, 2017; Rødt, 2019). A fair share of the political debate seem to be an ideological discussion of freedom; ontologically different views on freedom, and on human needs, lead to an endless debate of values. And although I will not aim at ending political debates regarding freedom once and for all, I will discuss the topic briefly. The concept of positive and negative liberty are also used by political activists, although positive and negative liberty are usually regarded differently from respectively the left-wing and the right-side of the political landscape: 'While negative liberty is usually attributed to individual agents, positive liberty is sometimes attributed to collectivities, or to individuals considered primarily as members of given collectivities' (Carter, 2019, 1st paragraph).

Liberalistene [The Liberalists], a Norwegian right-wing political party, although small in numbers, state the following on their web-site (my translation[14]):

> The individual is thus sovereign and inviolable. This means that no one else has the right to prevent the individual from living his or her life as desired, as long as it does not affect others. The individual is entitled to negative freedom, freedom from something. Freedom from abuse, theft, scams, threats, violence and so on. The individual is not entitled to positive freedom, that is, freedom to something. This could be, for example, freedom to free school or health services. If an individual is to have positive freedom, it cannot at the same time have negative freedom, as the two mutually exclude each other. One cannot be protected from the use of power by others and at the same time be forced to sponsor the costs of others. (Liberalistene, 2019)

Liberalists tend to value individual sovereignty and self-determination as fundamental properties for creating good lives; in order to provide free self-realization, then there should be few intervening others, such as a national authorities. Some, as we have seen above, believe that it is impossible to afford both negative and positive liberty (Liberalistene, 2019). On the other hand, critics of such liberal thinking argue that self-realization can hardly be pursued without the attributes afforded by the collective interventions (Carter, 2019). In other words: negative liberty allows for the subject to open as many doors as the subject wishes, but a lot of the doors would not even exist in an all-liberal society. Liberalists, again, argue that there will be even more doors to open without the interference of a national state; when there are no narrowing frames from the state, people will develop and create a plurality of industries, shops, schools, insurance companies, and health services, in a society where everybody can choose to pay for exactly what they want, without being forced by others (Liberalistene, 2019).

14 Almost all of the translation for this exact paragraph was delivered by 'Google Translate'.

Isaiah Berlin, who has been regarded a defender of liberalism (Cherniss & Hardy, 2018), is critical of how power has been misused in human cultures, yet seems to take for granted that no culture can be without both negative and positive liberty:

> The only reason for which I have been suspected of defending negative liberty against positive and saying that it is more civilized is because I do think that the concept of positive liberty, which is of course essential to a decent existence, has been more often abused or perverted than that of negative liberty. (Jahanbegloo, 2011, p. 54)

For Berlin it is obvious that we need both positive and negative freedom. And unlike far-right liberals, Berlin finds that a liberal society may still follow universal principles, which ensures human rights for vulnerable groups:

> The idea of human rights rests on the true belief that there are certain goods – freedom, justice pursuit of happiness, honesty, love – that are in the interest of all human beings, as such, not as members of this or that nationality, religion, profession, character; and that it is right to meet these claims and to protect people against those who ignore or deny them. There are certain things which human beings require as such, not because they are Frenchmen, Germans or medieval scholars or grocers but because they lead human lives as men and women. (Jahanbegloo, 2011, p. 53)

I believe that different cultures define differently what it will say to live good lives, and that individual human beings are the most capable of deciding *their* lives. Yet I agree with Berlin in that there are certain aspects of life that are fundamental for human beings regardless of culture. And although history has shown us that humans have not always treated other humans as humans with universal rights, Berlin still believes that ideas of universal human needs and rights have probably existed in most cultures:

> I think that every culture which has ever existed assumed that there exist such rights – or at least a minimum of them. There may be disagreement about how far to expand this minimum – to helots, slaves, Jews, atheists, enemies, members of neighbouring tribes, barbarians, heretics – but that such rights exist and that they are an empirical precondition of the leading of full human lives – that has been recognize by every culture. Denial of humanity to certain classes of human beings sometimes occurs in practice, but less often in theory. (p. 52)

When asked whether a political philosophy can be founded on the basis of human rights, Berlin states that it is not enough, but that a basis of human rights is a 'sine qua non' (p. 53), a necessity for the political philosophy. In reflections of what else is needed for a political philosophy, Berlins states the following:

> It depends. You have to add an analysis of important concepts. You must have a view of what justice is, what freedom is, what social bonds are; you have to distinguish types of liberty, authority, obligation and the like. Political theories often differ in the way they answer a central question – "Why should anyone obey anyone?" – not why do they obey, but why should they; and how far. Most political theories are answers to this kind of question. (Jahanbegloo, 2011, pp. 53)

I believe that Berlin pinpoints an important question above; liberty is extremely important in modern cultures, and people need good reasons in order to accept limitations of self-determination. How people would answer the question raised by Berlin, though, probably differ across the political landscape in nuanced and complex ways. When referring to the political party Liberalistene above, it was at least partly because they apply the terms negative and positive liberty as per se. Other Norwegian political parties, with much greater political impact than Liberalistene, speak of individual freedom as central to their politics, but seem less categorical in terms of positive freedom (Fremskrittspartiet, 2017; Høyre, 2017; Venstre, 2020). As a self-pronounced social-liberal party, the political party Venstre (2020) even articulates an aim to fight social injustice, but still wants to limit interventions from a national state that reduces negative freedom [my translation]:

> We want a state that actively fights social injustice in society. At the same time, we want to prevent the state and selected interest groups from gaining too much power at the expense of the individual and the diversity of civil society. (Venstre, 2020)

The political party Venstre also points at basic human rights as an important part of the individual freedom in a liberal society. On the left-side of the political landscape, the poltical party Rødt (2019) states that:

> Freedom is the right for everyone to make the most important decisions in their own lives. Freedom is also everyone's actual right to assert their honest opinion, defend their dignity, and act in solidarity with others, without fear of punishment from people with more power, be it the authorities, the family

> or the boss. The one who is dependent and left to the other's benevolence is not really free. Freedom therefore requires equality. (Rødt, 2019)

Individual freedom is highlighted across the political continuum from right to left, at least in Norway, and not only among the 'liberal' parties. But the political parties differ when it comes to the interpretation of what freedom is, and to which extent the government, or the national state, should intervene in order to facilitate freedom. So when Berlin, as mentioned above, asks 'why should anyone obey anyone?' the question will probably rely on different ontologies of freedom. On the far-right side of the political landscape, there is a belief that individual freedom comes from as little intervention from others as possible. On the left side there is a belief that someone needs to intervene, because freedom cannot exist for everyone until equality is ensured.

In line with the dis/ability-perspective that was portrayed earlier in this chapter, I support the critique of neoliberalism, and neoliberalism-ableism. I believe that a society in which everyone are free to act as they plead, with little or no intervention from others, only the 'strongest' will actually be able to act freely. Let us return to the analogy of the open doors, in which negative freedom means that others block no doors. The strongest and fastest may perhaps decide freely, and even use several of the doors. But some of the doors may be placed in difficult places, perhaps on the top of a narrow staircase, or on the other side of a hole in the ground. It does not matter much whether the door is open or not, if one is unable to reach the door in the first place. A lot of people may need some sort of assistance in order to achieve the same amount of freedom as others. To answer Berlin's question, I would gladly 'obey anyone' if it means that I would share some of my own negative freedom, and consequently provide positive freedom for others who need it. When we have a closer look at the CRPD in chapter three, we will return to the matter of providing positive freedom through necessary accommodation for people with different needs. In order to 'give up' freedom voluntarily, however, it is essential that my right for self-determination is maintained as far as possible, and that there is a clear connection between my own losses and the affordances for people who need freedom more than I do.

As mentioned above, Berlin states that we need both freedoms. But both negative and positive freedom can be targets for misuse:

> Negative liberty is twisted when I am told that liberty must be equal for the tigers and for the sheep, and that this cannot be avoided even if it enables the former to eat the latter, if coercion by the state is not to be used. Of course unlimited liberty for factory-owners or parents will allow children to be employed in the coal-mines. Certainly the weak must be protected against the strong, and

> liberty to that extent be curtailed. Negative liberty must be curtailed if positive liberty is to be suffieciently realized; there must be a balance between the two, about which no clear principles can be enunciated. Positive and negative liberty are both perfectly valid concepts, but it seems to me that historically more damage has been done by pseudo-positive than by pseudo-negative liberty in the modern world. That, of course, may be disputed. (Jahanbegloo, 2011, pp. 54-55)

I do not support liberal positions that neglect the absence of actual freedom for people with different circumstances, by saying that everyone have the same legal rights and the same opportunities to choose directions in life. I do however support liberalism as a reaction to the power-relationships that existed at the time wherein liberalism was born. I agree with Berlin in that a lot of damage has been done throughout history from misuse of power, be it from national authorities, military forces, the church, or the psychiatry. As described by Foucault and by voices within critical psychiatry, there is a dark history to look back to regarding the treatment of people with mental health challenges. And I believe that people in the future will look back to this very moment, and criticise mental healthcare as it is performed today. Thus, I do support liberal notions that criticises authoritarian regimes and patriarchal healthcare services, in favour of individual freedom and self-determination for the individual human being, as long as safety and dignity is maintained for both the individual person and for others.

If we again return to the matter of negative and positive freedom, and at the same time pay attention to the CRPD, I believe that it is important to think two thoughts at once. First, as a society we are obliged to make the necessary accommodations in order to include people with different disabilities as equal parts of the community, including persons with mental health challenges. Such accommodations require effort and economical support, which needs to be given by the people of the community. And such effort needs to be made collectively, regardless of how many individuals who believe they are being deprived of their negative freedom, for example by paying taxes. I do not believe that it is possible to hold the doors open for everyone, while at the same time accommodate the circumstances so that everyone actually reaches the door. Second, self-determination is a fundamental right that is considered immensely important for human beings. Self-determination needs to be protected for everyone as far as possible, especially for people with disabilities, as the CRPD reminds us. In other words, the society has a two-fold responsibility: 1) To make sure that accommodations are made in order to provide positive liberty for persons with disabilities, and 2) to maintain negative liberty and self-determination as far as possible, especially for persons with disabilities.

For this study, I believe that the perspectives of freedom discussed above helps to understand the meaning of compulsory treatment in society. We live in a culture that value self-determination highly, which is also stressed by fundamental human rights. The CRPD is clear; nations that have ratified the convention are obliged to facilitate and maintain self-determination for persons with disabilities, including people with mental health challenges. At the same time society is obliged to go a long way in order to provide circumstances that afford and maintain human rights for these persons, in a culture that is surely divided regarding in the opinion of how much one person needs to take responsibility for others.

2.6.3 Freedom and responsibility

Freedom, as we have seen, is not a valid signifier for describing *one* thing. The term ~~freedom~~ holds nuances and different meanings, which are not necessarily observable merely through a freedom/coercion-dichotomy. The French philosopher Sartre (1994) understands freedom as fundamental for human beings; to be human is to execute freedom. But he is also clear in that freedom needs an awareness of responsibility; freedom is not freedom if it is limiting for another's freedom. Thus, we may also understand freedom as something connected with responsibility. But it is not an easy task, though, to tell where one's freedom ends and where another's consequential limitations start. Political parties all across the left/right-continuum argues that the boundaries of individual freedom ends where the freedom of others are reduced, although it seems that different parties do not agree on 'when' the freedom of others is limited.

Fellow citizens have some responsibilities for each other, through legislations or through social norms and ethical assumptions. For instance, a person is obliged by law to stop and help if the person drives by a crashing site along the road. Health professionals may have different ethical standards to follow at the same time, such as profession-specific work-ethical guidelines and general health legislations. And in health service settings the amount of spoken responsibility will probably follow certain hierarchical structures; part-time working assistants are not, in legal terms, responsible for the overall standard of the services that are provided in a given hospital ward. But in general, health professionals are responsible for the well-being of health care service users, some way or another.

Many health professionals may also *experience* some sort of responsibility and care for service users, and sometimes, experienced responsibility contradicts the legal framework. It does not matter how much responsibility the health professional experience, and how much care and they want to provide, if the service users withstand from treatment and refuse to follow medical advices. Within somatic health care, the legal

frameworks entrust the services users to take responsibility of their own lives, at least to a certain agree. If a person wants holy spirits to cure cancer, health professionals do not enforce medical treatment. On the other hand, only a few nations accept voluntary euthanasia, meaning that health professionals are allowed to grant the service user's wish to end life. And if a person decides to hunger strike, for example while being imprisoned, the person is allowed to do so without interference from professionals at the ward. When it comes to mental health, however, coercive treatment is a widespread practice around the world. In other words, the society, including health services, do not trust that persons with mental health challenges take responsibility of their own lives the same way as do persons with somatic health challenges. And persons with mental health challenges are consequently not provided with the same liberties as persons with somatic health challenges.

As we will see in chapter three, there are two main criteria for executing coercive treatment in Norway: 1) 'the danger criterion', in which the service user is considered to hold an immediate threat towards others, and 2) 'the treatment criterion', in which the service user is considered incapable of taking care of him- or herself to the extent that an absence of treatment will lead to severe worsening of the person's health. From 2017, the treatment criterion can only be used if the person is regarded incompetent to consent. If we take into consideration the CPRD, and its demand to take seriously the individual rights and freedom for persons with mental health challenges, in addition to the fact that persons have the right to withstand treatment within somatic health-care, one might indeed argue that 'the treatment criterion' may not be regarded a valid argument for imposing coercion (e.g. Høyer, 2000; Blesvik et al., 2006).

The recovery-perspective stresses that both liberty *and* responsibility is to be regained for persons with mental health challenges. Personal recovery does not simply occur from more individual freedom, if the person does not *take* responsibility of his or her own well-being. Health professionals should thus encourage and facilitate self-determination and responsibility for the service users. But no matter how much help and support professionals may provide, the person itself is the one who needs to fill life with health promoting contents, such as life goals, relationships, and meaningful activities.

Although the relationships between coercion and individual freedom come with lots of ethical challenges, these conundrums and difficulties have not been discussed widely in the international literature (Hem, Gjerberg, Husum & Pedersen, 2016). During the next chapter we will look into the legal frames of compulsory mental healthcare in Norway. But let us keep in mind notions from the CRPD, a dis/ability-oriented perspective, a recovery-oriented perspective, and critical psychiatry as we go trough both legislations and research on Norwegian compulsory mental healthcare.

3 Plowing the fields: Navigating and harvesting the landscape of compulsory mental healthcare

Hello
Is there anybody in there?
Just nod if you can hear me
Is there anyone at home?
Come on, now
I hear you're feeling down
Well I can ease your pain
Get you on your feet again
Relax
I'll need some information first
Just the basic facts
Can you show me where it hurts?

Excerpt from *Comfortably Numb*
by Pink Floyd (Gilmour & Waters, 1979)

This chapter presents Norwegian compulsory mental healthcare. We will start off with a brief view on the law and practices about the use of involuntary mental healthcare before we proceed to investigating previous research that I find relevant for this current project. In this chapter we will encounter research about how coercion is used and for whom coercive means are typically executed. The following elaborations about coercion include numbers and prevalence of coercion, user experiences on coercion, staff attitudes towards coercion, characteristics for use of coercion, ethics and legal protection for service users, and suggestions from the literature on how to reduce the use of coercive approaches. We will also inspect some interesting reviews about the outcomes of coercive measures, which might point at an imbalance between these widely used practices and the un/documented effects.

The whole system of healthcare, including the use of coercive means, is dependent on current trends, political lines, and existing jurisdictional standards in a given culture. Hence laws, practices, and attitudes regarding coercion will differ between nations. And because this specific study is performed within the frame of the Norwegian mental healthcare system, I find reason to pay a considerable amount of attention towards the system of coercive mental healthcare within our national boundaries. This will help to understand the surrounding scenery that is inextricably integrated to this research

project. Some international research is referred to as a supplement to the Norwegian literature. Also, several of the Norwegian reports that we will look into, such as literature studies, also seem to sum up the relevant international research field of compulsory mental healthcare. Throughout this chapter I will look through the lens of a postmodernism-informed criticical perspective, and carry with me ideas from postpsychiatry, dis/ability studies, and the CRPD.

3.1 The frame of compulsory mental healthcare in Norway

Let us now take a brief look at the framework of compulsory mental healthcare in Norway. This includes the jurisdictional outline for executing compulsory treatment, and the current trends within the political landscape. In addition, I will shortly describe *Tvangsforsk*[15], a research network that is a result of a specific political action plan for reducing coercion in Norwegian mental healthcare.

3.1.1 The legislation of compulsory treatment in Norwegian mental healthcare

The use of coercion within Norwegian mental healthcare is regulated by the 'Act on provision and implementation of mental healthcare' (Law Library, 1999a; Psykisk helsevernloven, 1999; Norwegian Directorate of Health, 2016a), hereby referred to as the Mental Healthcare Act. According to the legal text, the purpose of the Mental Healthcare Act is to maintain a satisfactory application and implementation of mental healthcare services (§1-1). Also, the Act aims to 'ensure that the measures described in the Act are grounded on the needs of the patient and respect for human dignity' (§1-1) (Law Library, 1999a; Psykisk helsevernloven, 1999). The latter segment strongly emphasizes that mental healthcare is meant to serve the needs of each person.

Below I will briefly describe extracts from the Mental Healthcare Act, with an emphasis on the articles that concern compulsory mental healthcare, namely §3) *Application and termination of compulsory mental healthcare*, §4) *Implementation of mental healthcare*, and §5) *Court order for transfer to compulsory mental healthcare*.

15 The name *Tvangsforsk* is short for tvangsforskning, and could be translated directly as 'coercion research'.

§3 Application and termination of compulsory mental healthcare

Compulsory mental healthcare can only be applied after a physician has personally examined the concerned part, and has found that the legal conditions for compulsory mental healthcare are fulfilled (§ 3-1). If a medical examination is required and the person concerned refuses to be examined, *compulsory observation* may be used (§1-2; §3-1).

In order to be transferred to compulsory observation, the responsible mental health professional will decide whether certain conditions are met (§3-2) (Law Library, 1999a, pp. 4-5); if voluntary mental healthcare has been tried out (unless a voluntary approach is deemed to be pointless); *and* two physicians have examined the concerned part, one of them independent from the responsible institution; *and* the person is judged to lack competence to consent[16]; *and* it is highly probable that the person will meet the criteria for further compulsory mental healthcare; *and* the given institution is capable of offering a satisfactory treatment and care for the person; *and* the concerned person has been given the opportunity to state his or her opinion. In addition, an overall assessment needs to conclude that compulsory observation clearly appears to be the best solution for the concerned person, unless the person 'constitutes an obvious and serious risk to the life and health of others' (Law Library, 1999a, p. 5). Also, when making a total assessment of the given case, special attention must be given to: 'how great a strain the compulsory intervention will entail for the person concerned' (Law Library, 1999a, pp. 4-5). Within a short time[17] the person under compulsory observation must be released from the legal status or transferred to further compulsory mental healthcare (§3-3).

The criteria for being referred to compulsory mental healthcare (§3-3) are similar to the conditions for being transferred to compulsory observation as mentioned above, except for one additional requirement: the person needs to be suffering from a serious mental disorder. And the disorder needs to potentially culminate in either of the two: 1) constituting an obvious and serious risk to his or her own life and health or those of others, or 2) the magnitude of the disorder makes the prospects of a significantly improved health to be judged as considerably reduced, or that 'it is highly probable that the condition of the person concerned will significantly detoriate in the very near future […]' (Law Library, 1999a, p. 5).

16 The criterion of the competence to consent was recently added in the revision of the Mental Healthcare Act that was applied the 1st of September 2017 (Lov om endringer i psykisk helsevernloven mv. (økt selvbestemmelse og rettssikkerhet), 2017). Hence, only a small amount of the cited research literature in this dissertation takes into consideration this revision (Norwegian Directorate of Health, 2017a).

17 According to §3-2 in the Mental Health Care Act, compulsory observation cannot exceed 10 days without the consent of the concerned part. However, if absolutely necessary, and by the consent of the head of the supervisory commission, the observation period may be prolonged for an additional 10 days (Law Library, 1999a, p. 5).

It is also possible to follow up compulsory mental healthcare as an outpatient (§3-5), and to attend appointments for examination and treatment while otherwise living at home or in other adapted institutions. The people that do not meet for their appointments, however, may be committed involuntarily, using force and police assistance if necessary (Law Library, 1999a, p. 6). Some of the research participants that were interviewed for this study belong in this category.

§4 Implementation of mental healthcare

In article four of the Mental Healthcare Act, we find regulations for the implementation of mental healthcare. The act stresses that: 'Restrictions and coercion shall be limited to what is absolutely necessary', and the viewpoint of the involved person ought to be taken into account as far as possible (§4-2) (Law Library, 1999a, p. 9). And coercive measures may only be used in the cases wherein the favourable effects clearly outweigh the disadvantages of such measures. When committed involuntarily to a hospital, the legislation is meant to safeguard the person concerned gets to make decisions for him or herself, as far as possible. The institution is supposed to make an effort so that the people may take part in shaping their daily life, have the opportunity to cultivate their private interests and hobbies, have access to the activities offered, and have the possibility to engage in daily outdoor activities.

The core of §4 is that people within compulsory mental healthcare may be treated, without their consent, according to professionally recognized psychiatric methods, including forced medication, and forced nutrition regarding the most severe cases of eating disorders (§4-4). Such compulsory treatment may only be given after a profound examination of a person, and may not be applied at the stage of compulsory examination (§3-2).

When absolutely necessary, coercive means may be used in order to prevent harm or to avert significant damage to physical things such as buildings, furniture and clothing (§4-8) (Law Library, 1999a, p. 12). Coercive means that can be used are mechanical restraints meant to reduce the person's freedom of movement, such as belts, short periods of detention/isolation without the presence of any staff, small doses of medicines with short-term effects for calming the person, and briefly holding the person with bare hands (Law Library, 1999a, p. 12). Coercive means are not necessarily bound to people treated compulsorily; they may also be applied for voluntarily admitted service users when regarded absolutely necessary (Norwegian Directorate of Health, 2016a). Coercive means cannot be applied to people below the age of 16 (Psykisk helsevernloven, 1999).

Seclusion[18] is regulated by article §4-3, and may be used to separate the service user from fellow service users or staff, for therapeutic reasons, or for the matter of safety for other service users (Psykisk helsevernloven, 1999). This measure is not viewed as a *coercive mean* such as short periods of detention or mechanical restraints (§4-8). Many people still describe experiences of coercion and powerlessness when exposed to seclusion (Norwegian Directorate of Health, 2016a). Decisions of seclusion can be made for two weeks at a time (Psykisk helsevernloven, 1999).

According to the Norwegian health Directorate, there has lately been a change in the use of coercive means. Since 2009, the reported use of mechanical restraints and forced medication has declined, whereas the reported use of detention and seclusion has increased (Norwegian Directorate of Health, 2016a).

§5 Court order for transfer to compulsory mental healthcare

According to chapter 8 in the General civil penal code (§62-65) a person may be transferred to compulsory mental healthcare by a court of law, if the violation of the law occurred due to mental illness (Psykisk helsevernloven, 1999). If so, the case will be regulated by the Mental Healthcare Act, but with some exceptions (§5).

Generally, people within compulsory mental healthcare, or their next of kin, may normally request that the treatment or observation is terminated. If so, the health professional responsible needs to make a new decision on the matter (§3-7). When regulated by §5, however, such requests are only valid 6-12 months after the transfer to compulsory mental healthcare, depending on the degree of violation and risk of repeated violations. Neither the responsible health professional may request an end of treatment within this time period. The prosecutors, however, may terminate the verdict at any time (the General civil penal code, §65). The verdict should normally to be terminated within three years, but for severe violations the court of law may decide to extend the treatment period (Psykisk helsevernloven, 1999).

As we can see, the legislation regarding both compulsory observation and further compulsory mental healthcare are rather strict ones. When looking at the legal text on its own, there should be little room for unnecessary use of compulsory hospitalisations and coercive treatment. As we will se later on in this chapter, however, there is a vast amount of examples from the literature in which compulsory alternatives should have been avoided. As an anticipating example we will for instance learn that, more than half of the service users within compulsory observation have their legal status changed

18 In the English translation of the Mental Healthcare Act that I use, the word *segregation* is used instead of *seclusion* (Law Library, 1999a, p. 9). I choose to make use of the word seclusion, as this is the term used in the research literature (e.g. Norvoll, Ruud & Hynnekleiv, 2015).

from involuntary to voluntary within 24 hours (Norwegian Directorate of Health, 2019b; Tørrissen, 2007) whereas the legal text for compulsory observation explicitly requests that it needs to be 'highly probable that the patient satisfies the conditions for compulsory mental health care' (Law Library, 1999a, p. 4). Hence, there seem to be a mismatch between the protective features of the legal text, and the applied practices of mental healthcare in reality.

When interviewing the respondents in this study I did not ask about diagnoses or legal status. I contacted music therapists that helped to recruit research participants that participated music therapy as part of compulsory mental healthcare. Still, I learned a lot about their situations through the interview conversations, and it turns out that the empirical material includes stories from compulsory treatment for both inpatients (§3-3) and outpatients (§3-5), and from compulsory treatment referred by a court of law (§5). Most of the participants seem to have received compulsory treatment, such as medication (§4-4), and there is a good chance that several of the participants are familiar with coercive means such as mechanical restraints or forced medication with short-term effects (§4-8).

3.1.2 Governmental policies on compulsory mental healthcare

There seem to exist a common understanding in society that compulsory treatment should be held at a minimum level, and the Norwegian Directorate of Health (2016a) states that it is both a political and a professional wish that mental healthcare is executed voluntarily as far as possible. A national strategic *Escalation Plan for mental health*[19]*,* in the period of 2012-2015, was quite explicit regarding the safeguarding of the individual person:

> The mental healthcare services shall support the individual service user's autonomy, dignity and mastery of his or her own life, of the individual service user (Norwegian Directorate of Health, 2016a, p. 4)[20].

In this strategic plan, municipal health services in particular were enhanced, with the purpose of helping people in the communities where they live (Prime minister's office, 2009).

19 In Norwegian: *Opptrappingsplanen for psykisk helse*.
20 My own translation. The Norwegian text is as follows: 'De psykiske helsetjenestene skal understøtte den enkelte brukers autonomi, verdighet og mestring av eget liv, og være basert på frivillighet og respekt for den enkeltes ønsker og behov' (Norwegian Directorate of Health, 2016a, p. 4).

In Norway, the national health system is divided and organized into four health-regions; in 2014 one of these four regions launched an action plan with seven strategic points, in order to reduce coercion in mental healthcare (my translation):

> 1) As far as it is possible and justifiable, every patient shall be given the opportunity to choose between different treatment options, non-pharmaceutical treatment.
> 2) Medication regarding normal life challenges should be avoided.
> 3) Psychotropic drugs shall only be prescribed when there are good indications of effects, and shall be discontinued if there is no effect.
> 4) If the dosage exceeds the recommendations from the WHO, this needs to be reasoned.
> 5) Side effects shall be monitored systematically.
> 6) Doctors are obliged to keep themselves updated on the psychopharmacologies.
> 7) Usage of psychotropic drugs should be registered and compared to the practices at other hospitals. (Helmikstøl, 2014, p. 1018)

Every mental healthcare unit in the region were given instructions to follow this action plan (Helmikstøl, 2014).

In late 2015 all four of the health regions in Norway were requested to establish non-pharmaceutical treatment practices within the 1st of June 2016 (Ministry of Health and Care Services, 2015). In addition, service users should also be offered a supervised de-escalating of the medications. During 2017 some new wards have been established in the different health regions, where people are offered non-pharmaceutical treatments. How these wards will develop, and what role they will have in the future in mental healthcare, is not yet certain.

Seemingly, there have been some attempts to reduce the use of compulsory mental health treatment, through top-down regulations and political action plans. The last attempt in this chain is the revision of the Mental Healthcare Act that was applied on the 1st of September 2017. Again, the purpose is to reduce the total use of compulsory treatment, and to safeguard the human rights and dignity of the persons within mental healthcare as far as possible. In June 2019, an appointed group of experts launched their proposal for even new legislations regarding limitations for using compulsory treatment (NOU 2019, p. 14).

Since the recent changes in the Mental Heathcare Act, it seems that even health professionals struggle to understand the legal framework in Norway, and apparently there

are variations in how different professional groups interpret the legislations (Aasland, Husum, Førde & Pedersen, 2018). Interpretations of legal practices rely, among other things, on the interpretation of terms such as 'severe mental illness' and 'competence to consent'. One court case will soon be taken to the highest level of the national court, in which the person's competence to consent is one of the deciding variables for the outcome (Tvangsforsk, 2019).

3.2 Compulsory mental healthcare and the Human Rights

As mentioned above, the Norwegian legislations regarding compulsory mental healthcare aim to: 'ensure that the measures described in the Act are grounded on the needs of the patient and respect for human dignity' (§1-1) (Law Library, 1999a; Psykisk helsevernloven, 1999). At first glance this concern seems to go well with the Universal Declaration of Human Rights (Article 5): 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment' (United Nations, 1948). As we will see in the following, though, not everyone agree that Norwegian compulsory healthcare lives up to the expectations promoted by the United Nations (Norwegian Directorate of Health, 2015).

Blesvik et al. (2006) argues that there exist lots of examples of people who feel humiliated or degraded from being treated within Norwegian mental healthcare. Although there is no international legislation performing mental healthcare, Blesvik et al. (2006) argue that this does not mean that nations may decide freely how to execute compulsory options. Blesvik et al. (2006) argue that even though there are few concrete examples of court decision from Strasbourg, the European Court of Human Rights tend to value personal freedom highly in general, and that compulsory measures need to be immensely well reasoned.

3.2.1 CRPD and compulsory mental healthcare

As some have noted (e.g. Blesvik et al. 2006), there is an obvious incongruence between the human rights and compulsory mental healthcare. Already in the first article of the CRPD we can read that:

> The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. (United Nations, 2008)

The freedom and dignity of people with mental health illnesses are thus to be protected as far as possible. Although it holds great challenges, everyone is entitled to full freedom, as far as possible.

Earlier in this chapter we saw that compulsory treatment can be used if persons with severe mental health illnesses are in danger of harming them selves or others (the danger criterion). If the person is not considered competent to consent, compulsory treatment may also be used for the sake of treatment in order to prevent further health decline (the treatment criterion). When it comes to somatic health, however, people are free to turn down treatment services whenever they want. Anyone can say no to potential life saving cancer treatments or vaccination programs.

Especially the treatment criterion of the Mental Health Care Act is regarded as incompatible with the Human Rights. As Diseth and Høglend (2014) remark: 'From a critical user perspective, the only reason for using coercion to require mental health treatment is that the individuals are in a state where they are an immediate danger to themselves and/or their surroundings' (p. 168).

Although Skarstad speaks mostly of intellectual disabilities in the following quote, I support Skarstad, and believe that it is also highly relevant for the sake of mental illnesses (my translation): 'Politics and legislations need to clarify that all human beings are entitled to self-determination. The principle of self-determination must be the basis for all help- and support services' (Skarstad, 2019, p. 116). As I have come to understand the CRPD and agree with its fundamental principles, I support the notion that the 'treatment criterion' is not compatible with universal human rights.

3.2.2 The compulsory conundrum

I believe that most service users and health professionals want as little compulsory treatment as possible. At the same time the community accepts that in some cases, a certain amount of coercion is necessary in order to save lives and to prevent harm. The difficult part is where to draw the line, and how to define exactly when compulsory means are necessary, both in theory and in actual everyday life, when health professionals try to understand the totality of each individual situation. The matter of coercion *is* difficult, and it will always be possible to criticize the procedures from either side:

> They may say in The Times today that 'old, defenseless [sic] woman was removed from her home by force' or it could be written in The Observer that 'an old lady is perishing in her home and nobody interferes'. (Hem, Molewijk, et al., 2014, p. 4)

When dealing with coercion, the answer to what is right or wrong is seldom clear and unified, and it is impossible to do everything right for everyone. Today we are witnessing revisions of The Mental Healthcare Act (Lovdata, 2017; Syse, 2017) and only the future can tell whether we are actually relaxing the rules to the extent that there is an unnecessary risk of people causing harm, whether to oneself or to others.

When we scrutinize the law texts, it seems that the legislation regulating compulsory mental healthcare is already a strict one, and has been at least since 1999. If compulsory mental healthcare was performed according to these laws, it appears that compulsory treatment would have been used more ethically; coercion is only to be used when absolutely necessary. However, the *interpretation* of 'absolutely necessary' is not written in stone. Perhaps the internal discourses and the different understandings within the health services are a relevant place to start looking, in order to understand why compulsory treatment is still used to a greater degree than that which seems to be acceptable by the politicians, researchers, and many health professionals (Dahm et al., 2017; Norwegian Directorate of Health, 2006, 2016a). Even if we look past the sake of 'the treatment criterion' as an invalid argument for coercion, it will become obvious throughout this chapter that coercion is used more than acceptable according to Norwegian legislations. Thus coercion is also used much more than accepted by the CRPD.

As we have seen, the purpose of the Mental Healthcare Act is to serve the needs of the service users, and to preserve human dignity. The Act also describes compulsory measures as a last resort when other options fail. And yet, the Act may also help to *preserve* compulsory treatment because the legal text also legitimates the use of compulsory treatment. Even though the purpose of the law text is to explain how rarely compulsory treatment should be used, the legislation also defines and justifies what measures *can* be used (Syse, 2017).

From the 1st of September 2017, the competence to consent is central when the revision of the Healthcare Act is applied, in order to reduce the number of compulsory incidents (Lovdata, 2017; Norwegian Directorate of Health 2017b; Syse, 2017). And since the health professionals can no longer make decisions about compulsory mental healthcare merely due to serious mental health disorders, unless the person is considered icompetent to consent, there is reason to believe that the amount of compulsory treatment will be reduced to some extent. At the same time, local understandings and internal discourses will still be important both in the decision making, and in the process of interpreting the new terms, although the Norwegian Directorate of Health published their understanding of 'competence to consent' in prior of the law changes (Lovdata, 2017). And according to the law text: 'The healthcare provider shall decide whether the patient lacks competence to give consent […]' (§4-3 in *The Patients' Rights Act*) (Law Library, 1999b, p. 6). I believe

that we cannot simply take for granted the fact that this new revision of the Mental Healthcare Act will on its own change the internal discourses and the performed mental healthcare. There is still a need to scrutinize the field of compulsory mental healthcare. For instance, I have clearly judged all of the research participants in this study positively regarding their competence to consent. And seemingly, so have my supervisors, the music therapists that take part in the research interviews, and the ethical research boards that have approved this research. According to the revision of the Mental Healthcare Act applied the 1st of September 2017, most of these participants can probably no longer be treated compulsorily (Psykisk helsevernloven, 1999; Syse, 2017).

As we proceed throughout the chapter and learn more about compulsory mental healthcare, let us try to remember that, according to the legal text, the needs of the service users should be the top priority in mental healthcare. And as we go on, let us keep in mind that the wish to preserve human dignity is mentioned as one major purpose of the Mental Healthcare Act (§1-1) (Law Library, 1999a; Psykisk helsevernloven, 1999).

3.3 Literature on Norwegian compulsory mental healthcare

In 2006 The Norwegian Directorate of Health (2006)[21] published an action plan on reducing coercion in mental healthcare, and pointed at the need for more research-based knowledge. This led to the establishment of The Norwegian Research Network on Coercion in Mental Healthcare, hereby referred to as Tvangsforsk (Tvangsforsk, 2016). In Tvangsforsk's research plan for the period of 2014-2019, they state that 'The network's main goal is to stimulate research activities and develop new knowledge on the use of coercion in Norwegian mental healthcare' (Tvangsforsk, 2014). The administration of Tvangsforsk is located at the University of Tromsø, at the Department of Community Medicine (Tvangsforsk, 2016).

One of the main targets for Tvangsforsk is to gather information and to collect works on coercion within the Norwegian mental healthcare (Tvangsforsk, 2016). Texts on compulsory mental healthcare in Norway are put together in a database called Tvangspub[22]. Included in this database are public documents, PhD-theses, master theses, peer-reviewed articles, books and book chapters, and other Norwegian texts such as news articles, brochures, reports, and non-reviewed papers.

21 The Norwegian Directorate of Health was in 2006 known as the Norwegian Directorate of Health and Social Affairs [Sosial- og helsedirektoratet].
22 http://tvangspub.tvangsforskning.no

3.3.1 Literature included in this study

In order to obtain a broad view on coercion in Norwegian mental healthcare, I investigated the peer-reviewed articles in the database of Tvangsforsk. For a music therapy researcher, with little former knowledge about the existing research scape of coercion, it felt necessary to pay the most attention towards the peer-reviewed articles; in this way I hoped to maintain an overall quality of the applied literature. The PhD-theses in the database were briefly investigated, but due to a great correspondence in both themes and author names between the PhD-theses and the peer-reviewed articles in the database, the dissertations were not thoroughly examined.

Only articles published the last 15 years were included, due to a rapid modernization and development of mental healthcare. Hence, seven items were excluded out of the 143[23] peer-reviewed articles in the database.[24] Three more articles were excluded because they were hard to obtain. Another two articles were excluded, as the following themes seemed irrelevant for my current investigation: Biographical and historical view on one specific researcher, and traits of narcissism in mental healthcare. Three additional articles have been obtained from working with the field, which was not mentioned in the database (Jesper Bak et al., 2015; Moljord et al., 2016; Olsø et al., 2016). One included article was previously found in the database but is no longer present (Jesper Bak, Zoffmann, Sestoft, Almvik, & Brandt-Christensen, 2014).

Altogether 134 articles were investigated inductively, in order to find important subjects or special areas of interest investigated by the experts on the field. The following themes are constructions based on my own subjective interpretation of the research base, and should not be read as the one true story about Norwegian mental healthcare:

- The prevalence of involuntary treatment in Norwegian mental healthcare
- Characteristics in compulsory mental healthcare
- No clear evidence of positive outcomes or effects from compulsory mental healthcare
- User perspectives on compulsory mental healthcare
- Staff attitudes on compulsory mental healthcare
- Ethics and legal protection for people within compulsory mental healthcare

23 The database has been updated occasionally throughout the research process and writing of this dissertation. The last thorough investigation of the contents of this database was performed April 4th 2019.
24 The inclusion criteria were set early in 2015; hence, articles back to 2000 are included in the study.

- Reducing coercive approaches in the mental healthcare services

I believe that this chapter will provide useful information about compulsory mental healthcare in Norway for the reader of this thesis, as well as to bring up relevant knowledge that will be part of the further discussion of the study, answering the research question of what music therapy can be for people within compulsory mental healthcare.

3.3.2 The prevalence of involuntary treatment in Norwegian mental healthcare

The prevalence of compulsory admissions

Based on the official numbers from the Norwegian Patient Registers, about 5600 service users were admitted involuntarily in 2014. The number of involuntary admissions have been somewhat stable between 2010 and 2014, but with a slight decrease from 209 to 198 out of each 100 000 inhabitants. 17 per cent of all new admissions in mental healthcare in 2014 were involuntary. And out of the total amount of stay days for inpatients, 32 per cent were involuntary (Norwegian Directorate of Health, 2016a). Newer figures from the Norwegian Directorate of Health published February 2019 show that there has been a reduction in involuntary admissions during the last months of 2017, due to the changes in the Mental Healthcare Act (Norwegian Directorate of Health, 2019a). Statistics from the start of 2018, however, do not point at a further decrease in use of involuntary admissions (Norwegian Directorate of Health, 2019a).

When comparing different national registers, civil commitment rates for Norway is among the highest in Europe (Iversen, Høyer, & Sexton, 2009). These figures are, however, based on registers of varying quality, and the quality per se is seldom mentioned in the international literature (Høyer, 2008). A systematic review of the peer-reviewed literature also implies that Norway has a relatively high amount of involuntary admissions (Wynn, 2018). The research base is however scarce, and it is difficult to know anything certain about the magnitude of compulsory mental healthcare world wide, and whether there is actually more use of involuntary hospitalisations in Norway than in other countries.

Also in Norway the documentation of compulsory treatment seems to be rather flawed. Iversen, Høyer and Sexton (2009) investigated the accuracy of the data registry by comparing the register to the actual amount of compulsory treatment in four psychiatric hospitals in Norway: They found that the records were incomplete, and that the data registered in the Norwegian Patient Registry underestimated the actual numbers significantly. Poor documentation and control of compulsory treatment is also noted by Tøgersen, Bjerke, Gjelstad, and Ruud (2014). The Norwegian Directorate of Health (2016a) describes that the registration process is now becoming much more accurate,

even though the documentation of compulsory mental healthcare is not totally under control. Procedures for electronic and digital registrations are under progress, thus more accurate registrations and control will probably follow in the near future (Norwegian Directorate of Health, 2016a).

The duration of involuntary treatment is another reason for why it is difficult to calculate the exact prevalence of coercion. Studies imply that about half the people admitted involuntarily for observation have the legal status lifted the next day (Gjelstad, Løvdhl, Ruud, & Friis, 2003; Tørrissen, 2007). Official numbers show that about half of all involuntary admissions start with voluntary observations (Norwegian Directorate of Health, 2019b), and that one third of the observations lead to further involuntary treatment.

Although the number of people admitted involuntarily is relevant, the total number of involuntary stay days is also a measure for understanding the magnitude of coercive treatment for the people concerned. Based on numbers from the Norwegian Patient Registry, The Norwegian Directorate of Health (2016a) states that the amount of involuntary long-term inpatient stays is small and decreasing, and that half the amount of inpatient stays ends within a week. Iversen, Høyer and Sexton (2009), who investigated the accuracy of the national registers, have found a slightly deviant result. Out of 2043 admissions, those admitted involuntary for observation were admitted for 8,5 days on average, whereas the average for long-term detention service users was 34,3 days.

Tøgersen et al. (2014) investigated emergency admissions in one specific region in Norway, Østfold; they found a significant increase in voluntary emergency admissions, but a stable number of overall involuntary admissions. The percentage of emergency admissions that are involuntary has dropped significantly, but the total number of incidences is kept unchanged (Tøgersen et al., 2014). Tøgersen et al. (2014) did, however, find a significant increase in the number of substance-related disorders, a result that probably has to do with a health reform from 2004, in which mental healthcare received an expanded responsibility for such diagnoses (Tøgersen et al., 2014). Furthermore, such substance-related disorders correlate with coercive interventions (Hustoft et al., 2013; Knutzen et al., 2011). Thus, there is a chance that the increase in substance-related disorders within mental healthcare is sustaining the high level of coercion, and that there could have been a decrease in coercive admissions without the inclusion of substance-related disorders.

According to the numbers presented in a study from 2002, there are seemingly few signs that point to a reduction in compulsory admissions during the last couple of decades. According to Hatling, Krogen and Ulleberg (2002) the prevalence in 1996 for compulsory admissions was 147 per 100 000 inhabitants. Compared to this, the present prevalence

of 200 per 100 000, is not a reduction at all. However, these numbers occur at a time with scarce control and registration routines. Nevertheless, it seems to be clear that we have yet to see a significant change in compulsory mental healthcare resulting in a reduction of involuntary admissions, something that is requested by a large group of politicians, researchers, health professionals, and user organizations (e.g. Dahm et al., 2017; Ergo & Bjørnå, 2017; Norwegian Directorate of Health, 2006; Sørensen, 2019; Tvangsforsk, 2008).

There are regional variations regarding the frequency of involuntary admissions in Norway, but some researchers explain these differences as a result of different diagnoses and different service user groups (Bjørngaard & Heggestad, 2001; Hatling et al., 2002), or in different reporting procedures (Norum, Olsen, Nybrodahl, & Sørgaard, 2012), and not necessarily as an inconsistency in ward cultures or in the ruling discourses in the different hospitals. Perhaps differences in ward-cultures cannot explain variations among larger districts or areas. From a postmodernist perspective it is interesting to wonder just how far 'local discourses' might travel; perhaps it is possible that the ruling discourses within a hospital ward might affect the culture of the whole hospital in general, and perhaps even other cooperating institutions. In turn, these discourses might again be set as examples for a plural of the institutions in the given region. Some authors argue that organizational and environmental factors should be taken into account if the purpose is to reduce the use of coercion (Husum et al., 2010a; Myklebust, Sørgaard, & Wynn, 2017).

Although involuntary treatment seems to be better monitored and adequately registered during the recent years, it is quite alarming that such severe interventions are not sufficiently controlled and registered by the responsible health facilities, both in Norway and in other countries.

Prevalence of compulsory treatment and coercive means

The exact prevalence of coercive means, such as the use of isolation and physical restraints, is difficult to identify. The degree of reported incidents is uncertain, and the reported numbers, including the National Patient Registry, need to be understood as a minimum estimate (Norwegian Directorate of Health, 2016a). One study found that Norway reported the least episodes of physical restraints out of 11 countries[25] that were compared (Bak & Aggernæs, 2012).

25 The countries were Denmark, Sweden, Norway, Finland, Iceland, Belgium, The Netherlands, United Kingdom, Ireland, France, and Italy (Bak & Aggernæs, 2012).

According to the official reports, 29% of the 5100 people within Norwegian compulsory mental healthcare, also received compulsory treatments in 2014, such as involuntary medications (Norwegian Directorate of Health, 2016a). According to these reports there were also 7100 episodes of coercive means (§4-8), divided among 1400 service users, and there were 4500 episodes of seclusion (§4-3) among 2000 service users (Norwegian Directorate of Health, 2016a).

A literature review on coercive treatments, however, found two articles that point at a higher frequency of compulsory treatment than which has been estimated in the national registers:

> In the present review, one study [25] found that 14% of the patients at an emergency ward had been physically and/or pharmacologically restrained, while another study [9] found that 10% of the involuntarily admitted patients had been physically restrained. These figures are higher than the aggregated numbers reported in the most recent national surveys (2012) [41], where 4.6% were reported episodes of physical restraints (and 4.9% had been held). (Wynn, 2015, pp. 7-8)

As mentioned in a literature review by Wynn (2015), two[26] studies might support the statement from the Norwegian Health Directorate that numbers from the National Patient registry should indeed be understood as a minimum estimate (Norwegian Directorate of Health, 2016a).

One study investigated the distribution of mechanical restraints and forced medication for people's first episode of compulsory treatment at acute psychiatric wards (n=371). They found that mechanical restraints alone were used for 47,2% of the service users the first time, and forced medication alone was used for 17,5%, whereas a combination of both physical restraints and medication was used for 35,3% (Knutzen et al., 2013).

According to Wynn, (2015) a large survey insinuates that there are considerable variations between different institutions regarding the rates of physical restraints, and also possibly regarding the registration and report of these events.[27] Similar results were found in a study by Husum, Bjørngaard, Finset, and Ruud (2010a): From a study of 32 acute psychiatric wards, 1214 service users were committed involuntarily, which made

26 The two studies referred to are 1) (Knutzen, Sandvik, Hauff, Opjordsmoen & Friis, 2007) and 2) (Husum, Bjørngaard, Finset & Ruud, 2010a).

27 This information is based on a source from the literature review by Wynn (2015). As I did not manage to find the original source, I only refer to Wynn's representation of the original report: 'R. Bremnes, T. Hatling, and J. H. Bjørngaard (2008). *The Use of Coercive Measures in Mental Health Care in 2001, 2003, 2005, and 2007*, SINTEF, Oslo, Norway, 2008'.

up 35% of the total sample. The percentage of service users exposed to coercive means varied between 0% and 88% between the wards. 424 service users were secluded (35%), 117 restrained (10%), and 113 (9%) were involuntarily forced to inject depot medication. Even when taking into account the differences in psychopathology from ward to ward, the authors argue that the substantial between-ward differences show that ward factors influence the use of restraints. Some wards in the study have the potential for improvement, and as the authors argue: '[…] interventions to reduce coercion should take into account organizational and environmental factors and not only factors at the individual level' (Husum et al., 2010a, p. 8).

Studies on the prevalence of both involuntary admissions and compulsory treatments and restraints, imply that Norway has still a way to go in order to reduce the amount of coercion. In addition, there seems to be too little control of the executed coercion, especially since the practises vary a lot between different wards and health facilities, although researchers do not agree where these differences come from.

3.3.3 Characteristics in compulsory mental healthcare

There is some previous research that describes the characteristics in Norwegian compulsory mental healthcare. These studies investigate the potential connections between the use of coercion and different variables. If we know in which situations coercive events occur, there is a chance we might come up with alternate interventions, thus preventing the need for coercion in the first place. In the following section I will go through research reports that portray the characteristics in compulsory mental healthcare.

Characteristics for compulsory admissions

In acute psychiatry 44% were committed involuntary and 56% committed voluntary, according to one study (Hustoft et al., 2013). Predictors of involuntary hospitalizations to acute psychiatry are: male gender, substance abuse, aggressive behaviour, low function scores (GAF), contact with health services before admission but not contact with mental health specialists, lower education, disability pension, received social benefits, civil status as single, and less often having the responsibility for children (Hustoft et al., 2013; Sørgaard, Rezvy, Budanov, Sørlie & Bratlid, 2013). The chance of being committed involuntary is slightly reduced for older service users (Bjørngaard & Heggestad, 2001).

Involuntary mental healthcare also correlates with immigrant background (Fugleseth et al., 2016; V. C. Iversen et al., 2011). 'People with immigrant backgrounds' is however a diverse group which includes people with a broad spectrum of life situations. Iversen and Morken (2004) found differences regarding both diagnoses and legal status between

asylum seekers admitted to mental healthcare and refuges who had already been granted asylum; four times as many asylum seekers were diagnosed with PTSD disorders, while the refuges where diagnosed four times as often with schizophrenia than the asylum seekers. Refugees were admitted involuntarily more than twice as often as was the asylum seekers, which has likely to do with the severity of the mental health disorders. Iversen et al. (2011) found that the highest prevalence of involuntary hospitalisations for immigrants correlated with male gender and diagnoses in the range of psychotic disorders. I am no expert to tell whether 'refugees' and 'asylum seekers' are actually to completely dissimilar groups of service users, with completely different clusters of symptoms, or not. But it would be interesting to know if the 'tradition' of diagnosing refuges and asylum seekers differentely is all based on mental health challenges, or if this categorization of sub-groups is somewhat culturally biased. Either way, to me it seems obvious that there are good reasons why refugees and asylum seekers may struggle with mental health challenges. Thus, national health facilities should go a long way in order to provide services that are not inflicting more harm to persons who have often experienced war, threats, and even torture.

One study concludes that the Sami people are not committed involuntarily more than the population in general (Norum et al., 2012).

Referrals to compulsory observation and compulsory mental healthcare

The process of referring service users to mental healthcare is investigated in several studies (Deraas, Hansen, Giæver & Olstad, 2006; Johansen, Mellesdal, Jørgensen & Hunskaar, 2012; Myklebust, Sørgaard, Røtvold & Wynn, 2012; Røtvold & Wynn, 2014, 2016, 2017; Tørrissen, 2007). Casualty clinics, regular general practitioners, and specialist psychiatric services were compared in a study in order to investigate the characteristics in the circumstances of referrals to compulsive mental healthcare and to compulsory observations: The authors found that more use of police assistance and coercive legal statuses were used for those referred by the casual clinics (Johansen, Mellesdal, et al., 2012). Doctors working in public out-of-hours clinics have little knowledge about the committed service user, compared to the family doctors, and may also have less overall work experience (Johansen, Mellesdal, et al., 2012). These findings indicate that a substantial amount of coercive commitments could have been replaced with alternatives if referred by psychiatric specialists or general practitioners that know the service user. Another study also showed that casual clinics had a leading role in referring people involuntarily to mental healthcare, in which the researcher implies that more research is needed to find whether referrals by general practitioners in casual clinics causes unnecessary involuntary admissions (Tørrissen, 2007).

Røtvold and Wynn (2014, 2016, 2017) studied the characteristics of situations in which 74 general practitioners referred service users to compulsory mental healthcare. The service users were detected by other branches of the health service (52%, n = 39), by family (25%, n = 19), or by the police (17%, n = 13), in prior of the examination by the general practitioners (Røtvold & Wynn, 2016); many doctors find it difficult to base judgments on medico-legal criteria, instead they feel pressured to commit service users due to requests from the service users' families, the police, or by other parts of the health services (Røtvold & Wynn, 2014). The general practitioners where asked how they thought the involuntary admissions could have been avoided (Røtvold & Wynn, 2017); according to the general practitioners possible solutions could have been 1) 'that the patient took the prescribed medicine' (28%), 2) 'that they personally had the opportunity to closely follow up the patient in the following days' (22%), 3) 'that other care staff could follow up the patient closely in the patient's own home' (19%), or 4) 'that a family member of the patient could help the patient' (8%). The general practitioners believed in alternatives to coercion, making the matter of involuntary admissions a question of resources and assistance from other and assistance from other parts of the health services (Røtvold & Wynn, 2017).

Another study examines the relationship between decisions made by general practitioners at a casual clinic and the understanding of psychiatric hospital specialists (Deraas et al., 2006): Out of the 101 referrals from general practitioners that were inspected, only one case of involuntary admission was not agreed upon by the specialists. Also, the specialists agreed on most of the diagnoses suggested by the general practitioners, and on the application of the legal criteria that were used. Perhaps there are fewer differences between general practitioners and psychiatric specialists than some believe. But these contradictory findings may also be the result of a bigger than average homogeneous client group suffering from severe illnesses in the study:

> Diagnoses of psychoses or suicidal attempts accounted for 76% of the total referrals. Substance abuse was noted for 43%, and in 22% of all admissions the patients had stopped taking their psychopharmacological medication. (Deraas et al., 2006, p. 1)

Thus, it might be that the client group at casual clinics that are only open out-of-hours, suffer from more severe illnesses and symptoms than those who are normally referred by general practitioners at day-time. Another study that may support these findings found that acute cases are more likely to lead to involuntary admissions (Myklebust et al., 2012).

Seemingly, some researchers question the referral procedures and competence found in casual clinics due to their high amount of involuntary admissions (Johansen, Mellesdal, et al., 2012; Tørrissen, 2007). Others disagree that there is a considerable gap in attitudes and knowledge between mental health specialists and the referring general practitioners in a casual clinic (Deraas et al., 2006). The relatively high share of involuntary admissions referred to by casual clinics might as well have to do with the incidences that occur at out-of-hours clinics (Deraas et al., 2006; Myklebust et al., 2012). One study based on the records from different casual clinics in Norway (N=28527) found that service users were not always given diagnoses within mental health or substance abuse in relevant situations (Johansen, Morken & Hunskaar, 2012). The researchers argue that the reported number of people with mental health challenges in contact with the casual clinics may be greatly underrated. The preciously reported rate of mental health cases admitted to further mental healthcare may also be exaggerated according to these findings; only one third of the service users with mental health challenges and/or substance abuses were referred to inpatient treatment, mostly non-psychiatric wards.

According to a study by Tørrisen (2007), almost half the service users admitted compulsorily to one acute psychiatric ward had their legal status referred to voluntary within 24 hours (45%, N=49). A later study of 3338 admissions showed that 78,2% of involuntary admitted service users kept the involuntary legal status at the re-evaluation after 24 hours of admission, while 21,8% were converted to voluntary hospitalization (Hustoft et al., 2017). Numbers from the Norwegian Health Directorate show that two thirds of service users referred to compulsory observation are not referred to further compulsory mental healthcare (Norwegian Directorate of Health, 2019b). As described in the Mental Healthcare Act described presented early in this chapter, decisions of compulsory observations may only be applied when it is highly probable that the person will meet the criteria for further compulsory mental healthcare (§3-2). And still, somewhere in between 20 and 45 per cent of the people referred to compulsory observation are not referred to further compulsory mental healthcare. All though a 'high probability' is not a fixed entity, I intuitively interpret the law as a need for a better accuracy than 30-40 per cent. Thus, the law text alone does not prevent the use of unnecessary coercion as it is supposed to. One contributing factor to the high number of compulsory observations may derive from the case of alcohol and substance abuse, and a contemporary mental distress, in which people are less likely to be referred to further compulsory mental healthcare (Fugleseth et al., 2016). The Norwegian Directorate of Health (2016a) states however that the amount of people who were admitted for observation, but who were not hospitalised further for compulsory mental healthcare, declined by 11 per cent between 2010 and 2014. Figures from 2013 to 2017 indicate a stable situation, in which one third of service users within compulsory mental healthcare are only referred to

compulsory observation, and about 15% are referred from compulsory observation to further compulsory treatment, whereas half of the total group are referred to compulsory mental healthcare without compulsory observation (Norwegian Directorate of Health, 2019b).

Because there is a high number of people admitted to compulsory observation who are then not referred to further mental healthcare, it is possible that there are too many unnecessary referrals to compulsory observations in the first place. But evidently, one might also regard this situation differently, assuming that many people are released after the observation, whereas the majority should instead have remained within compulsorily treatment:

> Although some conditions result in disallowance because they have a natural course of quick clinical improvement, reports of high disallowance rates that vary with referring agent raise suspicion that not all disallowed referrals are warranted. Knowledge of factors associated with disallowance might therefore increase assessment proficiency. (Fugleseth et al., 2016, p. 411)

Fugleseth et al. suspected that too many people were disallowed from further compulsory treatment due to the competence level of the referring agents (Fugleseth et al., 2016). Their results imply that low levels of competence of the referral agents correlate slightly with disallowance, but other factors are however more deciding for whether people are in general referred to further compulsory mental healthcare: People with high function scores, and a lower symptom load, were more likely to be disallowed, whereas people immigrant background correlated positively with further compulsory mental healthcare (Fugleseth et al., 2016).

With the revision of the Mental Healthcare Act, applied from the 1st of September 2017, the 'treatment criterion' for referring people to compulsory mental healthcare was revised; the general wish to promote health for people with mental health illnesses is no longer a valid argument for using compulsory treatment, unless the persons is regarded incompetent to consent (Lovdata, 2017; Syse, 2017). Prior to these legal changes there has been a discussion about the treatment criterion within the field of coercion, both nationally and internationally (Wynn & Røtvold, 2015). As a contribution to this discussion, Wynn and Røtvold (2015) interviewed general practitioners who had referred service users to involuntary admissions at one major Norwegian psychiatric hospital; they wanted to find out which criteria were used in the decision makings, and whether the general practitioners could have used other referral criteria in the specific situations. Of the 74 doctors interviewed, 23% (N=17) had applied the treatment criterion only, 38% had applied the danger criterion (N=28), and 32% (N=24) had applied both the

treatment criterion and the danger criterion. It is the 23% of service users referred by the treatment criterion that will no longer be admitted compulsorily due to the recent law changes. 74% of the doctors claim they could not have applied other criteria in each situation (Wynn & Røtvold, 2015). We will have to wait and see whether the number of compulsory admissions will decline due to the revisions of the treatment criterion. Preliminary numbers, however, do not seem to underpin the same significant reduction in compulsory admissions (Norwegian Directorate of Health, 2019a).

Since 2001, specialized psychologists qualify for making legal decisions about coercion (Wynn, Myklebust & Bratlid, 2007). In a study by Wynn, Myklebust and Bratlid (2007), 340 psychologists answered questionnaires regarding the use of coercion in three cases. The most of the psychologists would use coercion towards a service user using violence. When the service user had challenges coping with daily life activities, more than a third suggested coercive interventions. For a service user with few symptoms, in an early schizophrenic development, only a few psychologists wanted to use coercive options. Regarding the non-violent service users, psychologists accepted involuntary admissions significantly more than they accepted involuntary use of neuroleptics. Psychologists' higher age, female gender and prior experience with coercion predicted solutions of coercive interventions. In another study, questionnaires about fictitious cases were tested at the staff in eight wards, at two different psychiatric units (Wynn, Kvalvik & Hynnekleiv, 2011). Findings showed only a limited degree of variation between the wards: different units and different groups of staff suggested the same interventions. In incidences with physically violent service users staff favoured strictly restrictive interventions. Restrictive interventions were significally more often suggested by male and unskilled staff. Additionally, in this latter study we probably find decisions of compulsory treatment that would not have been acceptable today due to the recent changes in the Mental Healthcare Act (Lovdata, 2017; Syse, 2017), such as in the case description above depicting service users in early developmental phases of schizophrenia with few symptoms, or in the case description of service users with challenges of coping with daily life tasks.

Diagnosis characteristics for people admitted to compulsory mental healthcare

A study on the experienced early phases of psychosis showed that service users who recognize the early signs as psychoses or have close others who do so, and are also capable of communicating this, have better preconditions for establishing a dialogue with mental health services, and for preventing full scale psychoses. Those who did not perceive the state of their mental health as early stages of psychoses, and did not have close others to help speak their case, were at risk of delayed treatment, poor communication, and

coercive interventions (Sebergsen, Norberg & Talseth, 2014). Without the preconditions necessary to prevent and cope with the early signs of psychoses, there is a chance that the mental state advances and serious symptoms will develop. For some service users this in turn will lead to emergency referrals, as diagnoses in the category of psychoses correlate with coercion (Myklebust et al., 2012).

Severe psychopathologies and low levels of functioning correlate with involuntary admissions (Opjordsmoen et al., 2010). Organic disorders and schizophrenia-like disorders are also predictors of involuntary admissions (Bjørngaard & Heggestad, 2001; Fugleseth et al., 2016; V. C. Iversen et al., 2011). By the same token, predictors for service users being transferred to voluntary hospitalisation after 24 hours are fewer hallucinations and delusions (Hustoft et al., 2017). And one study states that more than half of the long-term hospitalisations within Norwegian mental healthcare concern service users with psychotic symptoms (Færden, 2001). Previous episodes of coercion predict additional coercive treatment in the future (Bjørngaard & Heggestad, 2001). Disorders in the range of anxiety, however, correlate negatively with involuntary admissions (Myklebust et al., 2012). According to Fugleseth et al. (2016), people with a reported risk of suicide, and people with personality disorders, who are referred to compulsory observation, are more likely than others to be disallowed from further compulsory treatment than people with psychotic symptoms.

A national study found that one third of service users within acute mental health services in Norway were abusing alcohol or other substances in prior of admission, and accordingly received double diagnoses (Anne Opsal, Kristensen, Ruud, Larsen, & Gråwe, 2011). For these service users voluntary admissions correlated with the combination of alcohol abuse and either mood disorders or multiple mental disorders. Involuntary admissions correlated with poly drug use and schizophrenia, also: 'patients with mental and behavioral disorders due to psychoactive stimulant use had a significant higher risk for involuntary hospitalization' (Opsal et al., 2011, p. 89). Hustoft et al. (2017) also found that alcohol abuse correlates positively with transferal from involuntary hospitalization to voluntary hospitalisation at a re-evaluation of legal status within 24 hours after admission.

Characteristics for service users exposed to coercive means

There seems to be some similarities between those who undergo the most use of coercive means, as will be presented below. Sometimes, the findings across different research seem to be inconsistent, and sometimes the research reports portray a slightly different story than do the reports from The Norwegian Directorate of Health. The following

section depicts some important facets for health professionals to be aware of when trying to understand the field of coercion, and of when coercive means are performed.

Men are more often treated with mechanical restraints than women, and episodes of mechanical restraints are shorter for women (Knutzen et al., 2013; Knutzen et al., 2007; Norwegian Directorate of Health, 2016a; Wynn, 2002). However, women are more often held with bare hands, without any mechanical instruments such as the use of belts (Norwegian Directorate of Health, 2016a). Some studies imply that women are also more often treated coercively with medication (Knutzen et al., 2013; Knutzen et al., 2011; Wynn, 2002). Official numbers from 2009-2014, however, show that men are involuntarily medicated slightly more often than women, though as part of the treatment and not for the short-term tranquilizing effects (Norwegian Directorate of Health, 2016a). In an older study, no differences between genders were found regarding use of restraints and coercive medication (Knutzen et al., 2007).

According to several studies, physical restraints are used most for younger adults and least for older service users (Knutzen et al., 2014; Knutzen et al., 2011; Knutzen et al., 2007; Wynn, 2002). Older age might however correlate with more involuntary medication and seclusion (Knutzen et al., 2013).

Also immigrant background predicts the use of restraints (Furre et al., 2014; Knutzen et al., 2011; Knutzen et al., 2007). One possible explanation for this could be communication difficulties or situations that occur because of cultural differences, rather than it being a matter of systematic discrimination based on ethnicity. In some cases it might be that people with immigrant background suffer from a heavier symptom load at admission because they encounter health services later than the ethnic majority (Fugleseth et al., 2016). Either way, there is reason to believe that ethnic minorities are treated differently and that this had better cease. Service users with immigrant background are also more likely than others to be treated with the combination of both involuntary medication and physical restraints (Knutzen et al., 2007), a combination that correlates with longer episodes of restraints than the use of restraints alone (Knutzen et al., 2013). All in all, people with immigrant backgrounds suffer from more coercive means than others; they are exposed to simultaneous coercive means, and they experience longer episodes of coercive means.

A study on the characteristics of adolescents exposed to restraints in acute psychiatric units in Norway show that there is a higher amount of coercive treatments used for those living in institutions or foster care, and for those involved with the child protection services (Furre et al., 2014). Characteristic disorders for adolescents exposed to

restraints were psychoses, eating disorders and externalizing disorders[28]. Lower scores on the Children's Global Assessment Scale[29] also seemed to predict the use of coercion (Furre et al., 2014).

Longer hospital stays and a high frequency of admissions correlate significantly with the use of restraints according to three individual studies (Furre et al., 2014; Knutzen et al., 2014, p. 714; Knutzen et al., 2011). In a study by Knutzen et al. (2014), we learn that a small group of service users were exposed to a fair share of the coercive means: out of all service users in three psychiatric wards (N=373) who had been subjected to both pharmacological and mechanical restraints, 34 persons (9,1%) had been restrained six times or more, and accounted for almost 40% of restraint interventions at the ward during the research period of two years.

Substance use, schizophrenia and psychotic disorders, and bipolar disorders also predict use of restraints according to one study (Knutzen et al., 2011). Another study, however, claims that restraints are preferred for nonpsychotic service users (Wynn, 2002). Seemingly, psychotic illnesses predict use of restraints, but on-going episodes of psychoses might not.

A literature review informs us that the research on the use of coercive treatment in Norway has shown a relatively great deal of attention towards the characteristics of coercive treatment in the research; 14 out of 28 reviewed articles describe rates and predictors for coercive means, with an extra emphasis on service user-related characteristics such as age, sex, ethnic background and diagnoses (Wynn, 2015). Only a few studies look at variables exterior to the service user.

Coercive means tend to harm people in less privileged positions, such as immigrants, people with severe mental illnesses, people with low function scores, and people previously helped by the child welfare or other welfare programs intended for the less fortunate. It might be helpful to know for whom and in what situations coercive means are used. But in the future researchers might want to target other variables causing unnecessary use of coercion, other than the affected parts themselves. We cannot simply blame the individual service user for the amount of coercion that is used, especially if we take into account the perspectives of dis/ability theory arguing that societal structures

28 Externalizing disorder is a broad term including several socio-emotional and physiological states, such as attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), and oppositional defiant disorder (Jenson, Harward & Bowen, 2011).

29 The Children's Global Assessment Scale was published by Shaffer et al. (1983), a further developed version of The Global Assessment Scale developed by Endicott, Spitzer, Fleiss and Cohen (1976). These are standardized measurements of functioning in social settings, daily life tasks, and how people cope with emotions (Dyrborg et al., 2000).

continuously contribute to the disablism of marginalized subgroups (Goodley, 2014). According to the CRPD, these persons should rather be protected.

3.3.4 No clear evidence of positive outcomes or effects from compulsory mental healthcare

There seems to be little research to verify any positive or health beneficial effect for people treated coercively (Diseth & Høglend, 2014; Kisely, Campbell & O'Reilly, 2017; Wynn, 2015, 2018). Even though the main reasons for executing coercive treatment is more related to security than it is an approach for promoting health, compulsory mental healthcare has still been used as part of the treatment, although the 'treatment criterion' can no longer be used if the service user is regarded competent to consent, due to the revision of the Mental Healthcare Act 1st of September 2017. According to some researchers there are too few documented effects to answer for the magnitude of coercive interventions that is used today (Diseth & Høglend, 2014; Wynn, 2018). Mostly through literature reviews, we will in the following section look at different parts of coercive mental healthcare, regarding the documentation of outcomes and consequences from compulsory mental health.

Outcomes of compulsory admissions

Through a meta-analysis, Diseth and Høgeland (2014) investigated research reports on compulsory mental healthcare in regards to *treatment criteria*, *coercion*, and *coercion in mental healthcare*; they structurally looked at articles from the last decade, and manually investigated the cited literature within these articles. They found that there was little consensus about any positive effects of compulsory mental healthcare: only a few studies compare voluntary and involuntary means, and the results seemed to be ambiguous regarding the effect on compulsory treatment. The authors stress that additional RCT-studies are required in order to say something about the potential effects that coercive means have on the treatment results. The authors support the many voices from user organizations that have called for clearer treatment criteria regarding the use of compulsory treatment, which has now been revised by the Norwegian government. The authors also question whether adjudicatory processes, rather than individual psychiatrists, should conduct the decisions about compulsory treatment, as practiced in other countries (Diseth & Høglend, 2014).

An observational study investigated the outcome for service users treated in a psychiatric emergency unit, wherein service users were examined at admission and at discharge,

through standardized tests[30] (Svindseth et al., 2010). Throughout the hospitalisation, 56% of the service users showed a significant change in pathology, 42% had some degree of improvement, and 2% remained unchanged. The researchers found that neither poor admission experiences nor legal status influenced the outcome of the hospitalisation. People with the most severe mental health challenges during admissions had the most significant change during the stay.

A study about inpatient treatment for people with substance use disorders showed that mental distress was reduced significally for both voluntary and compulsory treated service users (Pasareanu, Vederhus, Opsal, Kristensen & Clausen, 2017). In a 6-month follow-up, the voluntarily assisted service users had improved regarding their mental distress, whereas the service users treated compulsorily deteriorated, and showed an even higher degree of mental distress compared with the pre-test baseline. The authors of the study suggest that extra support should be provided for treated compulsorily:

> The CA [compulsory admitted] group showed increases in depression, obsessive-compulsive symptoms, paranoia, somatization, and interpersonal sensitivity. This outcome appeared to have resulted from a relapse to drug use on a group level. This could suggest that those who sought treatment voluntarily may have been motivated and ready to make changes in substance use whereas those who were compulsorily admitted may not to the same extent have seen their drug use as a problem or were not ready to consider reducing use. This might highlight the need for extra supports to build motivation toward change within the CA group (both during the inpatient stay and as part of aftercare). (Pasareanu et al., 2017, p. 6)

Even though this study primarily refers to people with substance use, it might also say something important about the use of compulsory treatment within mental healthcare in general, and the need for a closer follow-up for people who undergo compulsory treatment. These findings are also relevant because substance-related disorders take up an increasing large part of compulsory mental healthcare (Tøgersen et al., 2014). A study published in 2010 did not find differences in outcomes or in treatment adherence between voluntary commissions and involuntary commissions after a two-year follow up after first-episode psychosis treatment (Opjordsmoen et al., 2010).

30 As described by the authors: 'The instruments used were the Brief Psychiatric Rating Scale (BPRS), the Narcissistic Personality Inventory-29 (NPI-29), the Hospital Anxiety and Depression Scale (HADS), a combination of questions measuring negative experiences and Cantril's ladder measuring experienced humiliation' (Svindseth, Nøttestad & Dahl, 2010, p. 363).

Another study on service users with substance use disorders compared the effect size between compulsory treatment and voluntary treatment (Pasareanu, Vederhus, Opsal, Kristensen & Clausen, 2016). They found that the use of amphetamine was reduced by 61% for voluntarily admitted service users and 37% for the service users admitted compulsorily. Six months later the rates of reported overdoses were higher for those committed involuntarily than for the voluntarily committed service users. Even though the voluntary treatment bore better results, the authors remind us that the other option of treating some people involuntarily would be to leave them untreated with life-threatening drug use behaviours. Hence, the authors support the continuation of compulsory admissions for people with life-threatening substance abuse, even though the treatment results are poor for compulsory treatment compared to voluntary treatment (Pasareanu et al., 2016). In the latter example we have to do with substance abuse more than mental healthcare per se, although there are usually great overlaps between the two. Still, the example shows us that voluntary treatment leads to better results, perhaps due to a stronger personal motivation for change. Although involuntarily treated service users stood for the most overdoses six months later, this correlation may not necessarily say anything about the involuntary treatment, rather the most severe cases of substance abuse may predict both involuntary treatment and overdoses. Pasareanu et al. (2016) argue that the negative consequences of involuntary admissions may be legitimized since it may help to save lives. I agree with Pasareanu et al. (2016) in that every one overdose is one to many, but if we take into account the fact that persons have the right to withstand from somatic healthcare, it does not necessarily make sense to admit persons involuntarily from substance abuse, at least if the given person is not posing a threat towards others.

Outcomes of compulsory treatment

Based on a literature study of Norwegian research on compulsory treatment, Wynn (2015) found little evidence regarding documented effects and outcomes of coercive treatments, neither one way or the other. Out of the 28 investigated research reports, 27 reports described observatory studies, and only one report represented an intervention study. As we have already seen, some research on the rates and the characteristics of compulsory treatment exists, as does research on different people's perspectives on compulsory treatment, but according to Wynn (2015), there is both a need for more research and for a greater variety of research designs.

Also, when it comes to the use of seclusion[31] there seems to exist a scarce amount of research-based knowledge on the effects of this approach, despite the fact that this is widely used and health politically controversial (Norvoll, Ruud, & Hynnekleiv, 2015). Norvoll et al. (2015) found that seclusion correlates with emergency wards, and confirms that there is a wide gap between the amount of knowledge on seclusion and the widespread use of this therapeutic method.

The effects of compulsory community treatment, which is starting to become a widely used approach in several countries, were investigated in a review published by the *Cochrane Database of Systematic Reviews* (Kisely et al., 2017). The review included three studies, with low- to moderate-quality evidence. The authors conclude that there is 'no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge' (Kisely et al., 2017, p. 2).

The latter review verifies well the research and reviews executed by Norwegian researchers: there is a scarce amount of high quality research about the effects of coercive treatment, and there is certainly little evidence that speaks in favour of coercive interventions as an effective approach to mental healthcare. And even though there is little knowledge about the effects of coercive treatments, they are widely used; it is believed that coercion helps the treatment process and reduces the suffering that legitimates coercion, together with a paternalistic view that people are not able to decide for themselves what is best (Høyer et al., 2002). Even though coercive approaches may sometimes be regarded necessary due to safety reasons, the effects of coercive means as a form of treatment does not answer to the amount of coercive means used, and the variety of potential side effects and distress that may follow from such practices.

Medication as compulsory treatment

A systematic literature review about forced medication in mental healthcare shows that there is little research that supports this widespread practice (Brun, Husum, & Pedersen, 2017). According to the authors of this review it is hard to say anything certain about the consequences of forced medication: There is a small amount of research, the answers are unclear, the effects that are found are small, and there is little consistency between different studies (Brun et al., 2017). Another finding in the study is that the

31 Seclusion, or segregation, may be used either for reasons related to treatment or for the sake of other service users: 'If a patient's mental state or aggressive behaviour during a stay in an institution makes segregation necessary, the responsible mental health professional may decide that the patient, for reasons related to his or her treatment or in the interests of other patients, shall be kept completely or partly segregated from fellow patients and from personnel who do not take part in the examination, treatment and care of the patient' (The Mental Health Care Act, §4-3) (Law Library, 1999a, p. 9).

caretakers seem to overrate the acceptance that service users give to forced medication; when first asked, the service users would rather suggest other options (Brun et al., 2017). The authors suggest that more research is needed in order to understand the consequences and effects of forced medication. Morken, Widen and Gråwe (2008), however, found that adherence to antipsychotic medications reduce both relapses of psychotic symptoms and admissions to mental healthcare. Following, they argue that it is important to find ways to increase adherence to medications in order to reduce the need for admissions in general.

Drivenes, Bergan and Saether (2016) performed a study on the use of drug therapy for outpatients undergoing compulsory mental healthcare. They found several challenges regarding the use of medication in the outpatient setting: In the treatment of 51 service users, 68 drug-related problems were identified, such as 'lack of monitoring', 'adverse reaction', and 'unnecessary drug' (Drivenes et al., 2016, p. 43). Even though most of the problems revealed were concurred by psychiatrists at the time, few immediate alterations were made to make up for the mistakes. Drivenes et al. (2016) suggest that ambulant interdisciplinary teams within compulsory mental healthcare could make use of consultant pharmacists in order to improve the drug therapy.

There is also reason to believe that the use of prescription drugs as part of compulsory treatment is not applied according to international guidelines (Kroken, Johnsen, Ruud, Wentzel-Larsen, & Jørgensen, 2009). Krokenet al. (2009) analysed the data from 486 discharges from emergency psychiatric units for people diagnosed with schizophrenia. Only 7.6% of the service users were treated without antipsychotic treatment. Out of the rest, 45,6% of the service users were treated polypharmically, with two or more drugs applied simultaneously. In addition, 41,9% was treated with at least one first-generation antipsychotic[32]. According to Kroken et al. (2009) a great deal of the medical combinations found in this study point at violations of the international guidelines for medical prescriptions. Prescriptions incoherent to international guidelines were found more often for those with high relapse rates, comorbid conditions, and previous inpatient treatment history.

Christensen and Onstad (2003) also investigated the use of coercive medication. Out of 340 service users within compulsory mental healthcare at a psychiatric hospital, 64 (19%) service users were medicated coercively. Most of the service users being treated compulsorily with medications had not followed up their outpatient treatment the

32 *First-generation antipsychotics* is a common term for the early neuroleptics, developed in the 1950's. An important difference from the *Second-generation antipsychotics*, developed in the 1980's, is that the first generation antipsychotics come with a higher risk of severe side effects such as movement disorders and sedative effects (Seida et al., 2012).

preceding six months. Christensen and Onstad (2003) suggest that the results point at poor cooperation with these service users, even though these results also might correlate with a lack of insight in the illnesses, and low motivation for treatment. As in the studies mentioned above, Christensen and Onstad (2003) also found deviations from certain guidelines (Drivenes et al., 2016; Kroken et al., 2009): In one third of the circumstances, the health services chose to avoid standard procedures because of the service users' state of health. 43 (67%) of the involuntarily treated service users, however, made complaints about the legal decisions, to which 19 (44%) had the intervention successfully removed or shortened (Christensen & Onstad, 2003). The high number of successful legal complaints might indicate an overuse of compulsory drug treatment.

Not only is there a need for better research results in order to legitimate the vast amount of different medication in compulsory mental healthcare (Brun et al., 2017), but the implementation of such medication may also cause more side effects than what seems to be necessary (Christensen & Onstad, 2003; Drivenes et al., 2016; Kroken et al., 2009). Thus, several of the studies point at practices that are clearly violations to the CRPD.

3.3.5 User perspectives on compulsory mental healthcare

There seems to be emerging an increasing amount of research reports concerning the user narratives within Norwegian compulsory mental healthcare. Out of the 23 investigated articles related to user perspectives that were obtained from the Tvangspub, 22 articles targeted the service users directly whereas one article investigated the narratives of close others. Several of the researchers behind these articles stress the need for more research on the user perspectives, partly due to ambiguous findings, but mainly because the experiences from service users, as well as from close others, on a general basis are regarded as important for developing well functioning health services (Husum, Legernes & Pedersen, 2019; Opsal, Kristensen, Vederhus & Clausen, 2016; Pedersen, 2008).

Coercion is experienced as degrading

In several research reports we can read that service users feel degraded when undergoing coercive treatments, due to a lack of autonomy and not being recognized (Husum et al., 2019; Lorem, Steffensen, Frafjord & Wang, 2014; Pedersen, 2008; Svindseth, Dahl & Hatling, 2007; Thorvik, 2012). In addition, people report experiencing little influence or participation in the decision-makings, and in the processes of working out different treatment programs (Lorem, Steffensen et al., 2014). Service users treated coercively also experience limitations of freedom as an important aspect of the perceived coercion (Norvoll & Pedersen, 2016; Riley, Høyer & Lorem, 2014). Especially the admission process

can lead to experiences of humiliation, through which the service users might be exposed to verbal or physical force (Svindseth, 2015; Svindseth et al., 2007; Svindseth, Nøttestad & Dahl, 2013). One contributing variable for experiencing the admission process as negative is when the service users are convinced that 'the commission was not right' (Svindseth et al., 2007, p. 47). Experiences of humiliation at admission also correlate with compulsory admission, being outside of paid work, male gender, not being heard, physical power, and high levels of hostility (Svindseth, 2015; Svindseth et al., 2013).

One article investigated the user perspectives on dignity for psychiatric inpatients directly (Skorpen, Thorsen, Forsberg, & Rehnsfeldt, 2014): One important aspect pointed out by the service users in the study was the wish to be met like an equal human being. They also spoke of the possibility of experiencing both, dignity despite of suffering, and suffering due to inferior feelings. Accordingly, service users described both dignity-inhibiting and dignity-promoting experiences. Fighting for one's own dignity was a theme brought up by the service users, a struggle that was apparently affecting the everyday life for mental health service users. These perspectives seem to match well with those described in a study by Norvoll and Pedersen (Norvoll & Pedersen, 2016) wherein service users had a wide range of experiences about coercion, across different links of the health- and welfare-chain. Service users experienced a great deal of powerlessness in a system that seems to rely too much on coercive options, and too little on voluntary services and treatment methods that are viewed as more helpful by the service users themselves (Norvoll & Pedersen, 2016).

Even though the use of physical restraints may calm some service users down, restraints may also cause a series of unfortunate outcomes. Wynn (2007) argues that the use of restraints evoke feelings of anxiousness, anger and hostility. For some people, the calming effects are experienced first after receiving additional medication, meaning that the physical restraints do not necessarily lead to the expected effect by itself. Some of the service users report suffering from minor physical abrasions during the interventions, and for some, memories of prior abuse are revived due to the coercive episodes (Wynn, 2007). One case study inspects an episode of physical restraints that nearly killed a man in his 30's due to a heavy weight load on the torso during the event (Nissen, Rørvik, Haugslett & Wynn, 2013).

Summing up, the cited studies above show that lack of autonomy seems to be an important theme for service users within the frameworks of coercive treatment. Both verbal and physical force, including the use of mechanical restraints, is experienced as degrading for many service users. Some service users call for more influence and participation in decision-making processes regarding their own health and treatment. The CRPD

demands that persons with disabilities are protected from humiliation and degration, yet such experiences seem to be common within compulsory mental healthcare.

Legislated coercion and experienced coercion

Inpatients in mental healthcare live a daily life of rules and restrictions. For both voluntarily and involuntarily committed service users the doors are sometimes locked, and meals may be served at certain hours. Medication, appointments, and participation in different interventions of treatment are part of many service users' situations. For service users treated voluntarily, participation in activities might still be expected. Evidently, legal status does not necessarily predict how service users experience coercion, which is also confirmed in studies of user experiences (Iversen, Høyer, Sexton & Grønli, 2002; Kjellin, Høyer, Engberg, Kaltiala-Heino & Sigurjónsdóttir, 2006; Opsal, Kristensen, Vederhus & Clausen, 2016). A study of 223 service user admissions show that those who were involuntarily admitted experienced coercion in a greater manner than did those with a voluntary legal status; still, one third of the voluntary service users also perceived high levels of coercion (Iversen et al., 2002). 41% of the involuntarily admitted service users perceived low levels of coercion. Thus, out of all service users admitted voluntarily, only a marginal majority experienced low levels of coercion compared to the minority of persons experiencing high levels of coercion. Similar experiences are found for people treated for the combination of both mental health illnesses and substance abuse, through a study by Opsal et al. (2016): 63 people admitted involuntarily reported perceiving a higher rate of coercion from legal sources, whereas 129 people admitted voluntarily perceived a higher rate of coercion from internal sources, though the degree of perceived coercion was the same for both groups. In one study, the researcher found that a considerable part of the participators did not even know their actual legal status (Sørgaard, 2007). According to an international study differences in perceived coercion varied between the Nordic countries for people admitted involuntarily to mental healthcare; at the top, high rates of perceived coercion were found in 100% of the interviewees in Iceland, whereas only 49% of the Norwegian interviewees reported high levels of perceived coercion (Kjellin et al., 2006). The latter study also found variations regarding the level of perceived coercion between different Swedish environments (from 29% to 90%). As the researchers imply, the local care traditions may account for a fair share of the variations, at least the variations within one country.

In an article on anti-psychotic medication the researcher observed service users being pressured into consent (Terkelsen & Larsen, 2012). Service users do not necessarily agree with the decision-makers, but cooperate in absence of other options; service users might voluntarily accept medication, but often perceive this as coercion nevertheless.

According to Sørgaard (2007), service users reported restriction on movements, forced medication and patronizing communication, as part of mental healthcare. Both those committed involuntarily, and those persuaded into cooperation, experienced a lack of influence and forced medication to a greater degree than those who were voluntarily admitted. This study concludes that: 'involuntariness was associated with increased likelihood of feeling excluded from participation in the treatment' (Sørgaard, 2007, p. 214).

According to Svindseth et al. (2007) it is more common to experience negative events during the admission process for service users who are admitted involuntarily than it is for voluntarily admitted service users. Negative events are, however, also reported for many of the voluntarily admitted service users.

One study examined three interventions that were implemented in order to reduce the perceived experience of coercion: 1) engagement of the service users in the formulation of the treatment plan, 2) frequent and regular joint service user and staff evaluations, and 3) renegotiation of treatment plans if necessary (Sørgaard, 2004). The interventions led only to marginal changes for 2 out of 8 measured parameters, namely 'staff's respect and understanding' and for the 'total satisfaction with the received help' (Sørgaard, 2004, p. 299). None of the investigated interventions led to reduced perception of coercion. One third of the service users experienced insulting communication from the staff during their stay, and ten per cent reported physical harassment from the staff. The average experience of coercion was, nevertheless, quite low. Taking part in planning and evaluation of treatment had marginal effect on perceived coercion when the health services were otherwise not experienced as helpful, and when the service users did not experience the staff as respectful and understanding. Seclusion was the strongest predictor of experienced coercion (Sørgaard, 2004).

Some differences seem to exist between voluntarily and involuntarily committed service user groups regarding experienced coercion, yet service users treated voluntarily may also experience coercion (Iversen et al., 2002; Opsal et al., 2016; Sørgaard, 2007; Terkelsen & Larsen, 2012). Involuntarily committed service users report exclusion from decision-making processes to a greater degree than voluntary service users do (Sørgaard, 2007). Opsal et al. (2016) stress that involuntary admissions should be handled carefully, so that counterproductive feelings of coercion are reduced. According to the authors, service users are more likely to experience better recovery processes if met by more information and collaboration. And since voluntarily admitted service users are also likely to experience coercion during the hospitalisations, a higher degree of information and collaboration might be beneficial for this client group as well.

Experienced satisfaction within coercive mental healthcare

Research on user experiences point at ambiguous findings when it comes to the degree of satisfaction within compulsory mental healthcare. In one study questionnaires pointed to a general satisfaction for service users hospitalized in an acute psychiatric ward (Horn & Martinsen, 2007). A reduction of symptoms correlates with satisfaction, especially for those with a change in depressive symptoms. Length of stay and demographic variables did not determine the degree of satisfaction. Sørgaard (2007) also reports a high degree of satisfaction for the service users regarding the general treatment. One study targeted the satisfaction of service users with psychoses after acute admissions to mental healthcare (Bø et al., 2015); in this research the level of satisfaction was positive in general, and there were few differences between voluntary and involuntary admitted service users. The involuntary admitted service users were still clearly less satisfied with the information provided, thus the authors argue that a stronger effort should be made regarding the provision of sufficient and adequate information. Satisfaction of the acute admission correlated with insight in symptoms and challenges. An additional survey regarding involuntary admissions for people viewed to be suicidal claims that the participating subjects described the hospital stay as 'something safe', even though several of the interviewees were also critical towards the involuntary interference by the health services (Thorvik, 2012). Another study on user perspectives found that inpatients' overall satisfaction with treatment was poor, for both voluntary and involuntary admitted service users (Wynn & Myklebust, 2006). The latter authors discuss whether other factors might perhaps be more determining of service users' satisfaction of mental healthcare than legal status, such as the duration of the treatment and the nature of the disorder.

One study shows that overall satisfaction was significally reduced with a higher frequency of coercive events (Iversen, Høyer & Sexton, 2007). Neither legal status nor perceived coercion affected the state of satisfaction in the same way, as did the actual coercive interventions. In another study, negative experiences were characterized by a lack of influence and options, and by unnecessary use of coercion (Lorem et al., 2014). According to Lorem et al. (2014), service users reported positive experiences when their needs and interests were met. Also, one study points to the service users' key workers as an important contributor for satisfaction (Sørgaard, 2007). Diverging personalities correlated negatively with satisfaction according to a study by Horn and Martinsen (2007); without knowing the exact reasons for this correlation, the authors suggest that service users with deviant personalities either 1) regard the world differently than others, 2) are treated differently by health professionals than others, or 3) have a greater need for help than others.

Also when it comes to compulsory mental healthcare for outpatients, narratives of satisfaction point at somewhat ambiguous findings (Stensrud, Høyer, Granerud & Landheim, 2015a; Stuen, Rugkåsa, Landheim & Wynn, 2015). Some service users treated compulsorily as outpatients mention that they feel safe and secure, and appreciate that they have easy access to healthcare staff and services (Stensrud et al., 2015a). A more common conception, according to Stensrud et al. (2015a), though, is the feeling that life is put on hold, and even though the service users are not hospitalised, the medical focus makes it hard to take back the responsibility of their own lives, and to continue with their recovery processes. A high degree of control measures seem to reduce the experienced quality of life, according to the authors (Stensrud et al., 2015a).

Another study of user experiences for outpatients within compulsory mental healthcare also refers to ambiguous findings (Stuen et al., 2015). While the service users in that study often reported a loss of autonomy, several of the service users also reported helpful services such as financial aids and help regarding housing or other daily life challenges. The overall degree of satisfaction with the general treatment might thus be dependent on the total amount of beneficial services, the researchers argue. Also, the relationships between the caregivers and the service users seem to be important for how the treatment and restrictions are perceived (Stuen et al., 2015). In an earlier study, the experience of the treatment with an outpatient team depended on both variations in the treatment, and characteristics of the service users themselves; positive experiences correlated with female gender, older age, better self-perceived health, absence of inpatient history, longer treatment episodes, frequent consultations and acceptable waiting times (Bjørngaard & Heggestad, 2001).

Also the experiences of relatives to a family member under outpatient commitment orders have been investigated (Stensrud, Høyer, Granerud & Landheim, 2015b). Even though the relatives felt they were responsible for the health of their family members, they did not feel that they were taken seriously by the healthcare services: the information stream was poor, and they were met with little recognition for their effort and roles in the treatment. Family members call for more cooperation with the healthcare services. The implementation of new integrated pathways for treatment for adults with mental health challenges emphasise predictability and clearer communication for both service users and their next of kin (Norwegian Directorate of Health, 2018).

Too much coercion – too little cooperation

According to a study by Lorem et al. (2013), service users seem to recognize the need for pharmacies but would prefer cooperation and communication as regarding the treatment. The authors suggest that negative service user experiences could be avoided by

'providing information and participation in a dialogue about drug treatment' (Lorem et al., 2013, p. 347). Another study also shows that service users understand the need for coercion in certain circumstances. They want, however, the use of coercive interventions be reduced to a minimum (Lorem, Hem & Molewijk, 2014).

In an additional study, some service users felt that the use of restraints were necessary, while others were more critical to which circumstances restraints were used. According to many service users, use of restraints could have been avoided (Wynn, 2007). Some service users understand that restraints are used for protection, and those with psychoses during episodes of restraints were more understanding of these interventions.

According to a study on the perspectives of service users' next of kin, several informants reported that police-assisted commission was eventually regarded as being their only option after being neglected by the health services. In some cases voluntary commissions were tried in cooperation with health services. Next of kin would like to be met as collaborative partners and caretakers, but often feel neglected and disempowered (Pedersen, 2008). A later study proves of these findings, that next of kin are too often neglected and excluded from the healthcare processes (Førde, Norvoll, Hem & Pedersen, 2016). As Førde et al. (2016) state, this neglect does not only leave the next of kin in a difficult situation, but accordingly, vital information about the service users never reach the health professionals. A study on adolescents and young adults, who are in the role of next of kin, also calls for more information and collaboration; the young next of kin want more help in order to maintain the relationships with their relatives, and they tend to perceive coercive treatment negatively (Martinsen, Weimland, Pedersen & Norvoll, 2017). All of these studies call for more information for, and collaboration with, the service users' next of kin.

According to the research outlined above, some service users seem to agree that coercive alternatives are sometimes necessary (Lorem et al., 2013; Thorvik, 2012; Wynn, 2007). However, there seem to be a consensus from several authors that service users experiencing too much coercion, and that different use of coercion could sometimes be avoided (Lorem, Hem & Molewijk, 2014; Thorvik, 2012). Several reports imply that the service users want more cooperation and dialogue where concerning their own treatment (Bø et al., 2015; Thorvik, 2012; Wynn, 2007).

3.3.6 Attitudes on compulsory mental healthcare

In the following we will look at literature concerning attitudes towards coercion, and mainly attitudes from health professionals. Above we have learned that general practitioners may feel pressured to refer service users to compulsory mental healthcare due to requests from family members, the police, or other health professionals (Røtvold &

Wynn, 2014). And in a psychiatric casual clinic in Oslo monitoring of involuntary referrals showed large variations in amount of referrals between the health professionals' (Ness et al., 2016). We have also seen that decisions of coercive interventions made by psychologists correlate with higher age, female gender, and previous experiences with coercion (Wynn et al., 2007). These three examples just mentioned imply that serious decisions that are made regarding compulsory mental healthcare may be determined by variables on the level of individual health professionals.

Health professionals acknowledge that compulsory mental healthcare is a difficult topic with several potential ethical dilemmas. A study on the experiences of 439 health workers with different professional backgrounds found 7 common ethical dilemmas regarding coercion:

> (1) Doubt and uncertainty related to the formal use of coercion; (2) Doubt and uncertainty about other kinds of restrictions and use of force toward patients; (3) Involuntary medication; (4) Disagreement between the parties involved; (5) Implementation of coercion in daily care; (6) Organisational factors and lack of resources and (7) Overuse of force, abuse of power and unsuitable staff. (Husum, Hem, & Pedersen, 2018, p. 1)

Needless to say there is a lot of potential conundrums regarding compulsory mental healthcare. When we further inspect the attitudes on different aspects of coercion we will learn more about the discourses that possibly make up the rules for the practiced mental healthcare.

Ward cultures and attitudes

A questionnaire named the *Staff Attitude to Coercion Scale*, developed by Husum, Finset and Ruud (2008), aims to measure staff attitudes, based on three categories found in the institutions: *coercion as offending*, *coercion as care and security*, and *coercion as treatment*. In a later study, this questionnaire was used to investigate attitudes among 651 staff members, within 33 Norwegian acute psychiatric wards (Husum, Bjørngaard, Finset & Ruud, 2010b). The analysis indicates that there are significant attitude variances between the wards, yet these variances seem to come from individual staff members. The authors conclude that: 'it is likely that staff attitudes are influenced, to a large extent, by each individual staff member's personality and values' (Husum et al., 2010b, p. 893).

Although attitudes towards coercion differ between wards, as well as between individuals, the implementation of coercive treatment is not something that health professionals enjoy. And even though coercive approaches come with unfortunate consequences

they are still viewed as necessary. Wynn (2003b) found that most staff favour the use of physical restraint, although they believe it is the intervention service users are the least favourable to, and such interventions violate the service users' integrity, may harm the provider–service user alliance, and may frighten other service users. Larsen and Terkelsen (2014) found that staff members feel guilty in violating the dignity of the service users, even though the coercive interventions causing these responses are seen as necessary (Larsen & Terkelsen, 2014). An international focus group interview study investigated attitudes of informal coercion in health professionals from ten countries[33] (Valenti et al., 2015). Even though health professionals believe that informal coercion is effective they feel uncomfortable when performing these interventions. In addition, there seems to be a gap between attitudes and practice; the health professionals reported to make use of informal coercion more than they believed was professionally correct. And interestingly, the health professionals in the wards with high usage of restraint and seclusion seem to be the most critical to the amount of coercive treatment (Wynn, 2003b). One might wonder why the wards with the most coercive measures continue with these trends even though the staffs in general remain critical towards these practices (Wynn, 2003a). Perhaps the local web of ruling discourses enables certain practices through powerful individuals and established routines (Foucault, 2002). As mentioned above, Husum et al. (2010b) argue that differences in ward cultures are likely to be influenced by values and personalities on an individual level. From a Foucaultian discursive perspective (Foucault, 2002), one might argue that the individual values do not emerge from within a vacuum; there are always already certain established traditions, practices, routines, and perhaps even a local language that describes and justifies their practices. Still, as Husum et al. (2010b) imply, it seems relevant to have a closer look at the attitudes of health professionals working within mental healthcare.

Even though a theoretic conception of a proper practice is not necessarily enough to perform the same way in the heat of the moment, it is perhaps more likely to expect a reduction in the unnecessary use of coercive approaches if staffs in general have moral doubts about the use of coercion, and instead look at other options (Molewijk, Kok, Husum, Pedersen & Aasland, 2017). As we will see below, to teach health professionals to use other alternatives than coercion is one way to reduce the amount of coercion.

Attitudes among health professionals

According to a study by Wynn (2003b), highly educated staff members are not more critical to the use of restraint and seclusion than other staff, although this trend might have changed somewhat during the last decade and a half since this study was performed.

33 Canada, Chile, Croatia, Germany, Italy, Mexico, Norway, Spain, Sweden and United Kingdom (Valenti et al., 2015).

Perhaps more decisive for attitudes on coercion than length of education may be connected with type of profession: One study implies that psychologists in particular are critical towards the use of coercion, but that psychiatrists as well experience moral doubts regarding coercion much more so than nurses and other staffs (Molewijk et al., 2017). Molewijk et al. (2017) argue that experienced moral doubt regarding coercion is higher for the actual decision-makers of the coercive interventions. According to a study on attitudes from both health professionals and the general public in Norway (N=1094), professional attitudes are in line with the attitudes in the general public; both groups support involuntary admissions to a greater extent than involuntary use of neuroleptics (Wynn, Myklebust, & Bratlid, 2006). In the latter study the authors also found correlations between supporting coercion and factors such as previous experience with performing coercion, female sex, absence of a higher educational degree, having a profession other than social worker, and not working within the psychiatric services (Wynn et al., 2006).

Attitudes towards coercion may also depend on the distance to the service users: Larsen and Terkelsen (2014) found that staff members close to the service users, both physically and emotionally, are more likely to view service users as individual beings with different needs. More distanced professionals, on the other hand, are more likely to think of the service users as a homogeneous client group with common needs (Larsen & Terkelsen, 2014). In an interview study about healthcare workers' experiences of working with service users who self-injure at an inpatient setting, the health professionals described a chronological change in approaches following the amount of professional experience (Mattson & Binder, 2012); coercive interventions and frustration characterized the early stages, whereas alliance and different ways of working with self-harm characterized the later periods.

In a study by Wynn (2003b) the majority of the staff members believed that using restraints and seclusion made service users calmer and did not cause aggression, anxiety or injuries; yet about 70% of the staff members had been assaulted by service users in connection with coercive interventions (Wynn, 2003b).

Molewijk et al. (2017) found a relationship between moral doubt and the normative attitude towards coercion when working within mental healthcare. The authors call for more research on the area, and argue that further studies could imply whether moral doubt should be stimulated for health professionals, and that such ethical debate may evoke more critical thinking and the potential of finding alternative measures to coercive ones (Molewijk et al., 2017). Other articles, with several corresponding authors, also address the possible relationship between moral deliberation and a more precise and ethical use of coercive approaches (Molewijk, Engerdahl & Pedersen, 2016; Molewijk,

Hem & Pedersen, 2015; Norvoll, Hem & Pedersen, 2017). As Engerdahl, Molewijk and Pedersen (2016) remind us; the national goal has been to reduce the amount of coercion, but also to make it more righteous (Norwegian Directorate of Health, 2006).

Mental health workers who have had access to clinical ethics committees experienced this as a useful way in which to handle ethical dilemmas. Syse et al. (2016) argues that such committees may prove useful for mental health professionals, and suggest that such committees should include members with varied and interdisciplinary experiences (Syse et al., 2016). Music therapists may perhaps be part in such interdisciplinary committees, or in other organized forms of supervision and counselling, that help to maintain the best health services as possible.

Systematic interventions for promoting ethical awareness, communication among health professionals, and improving the therapeutic relationships, are regarded as important steps towards better mental healthcare services (Hem, Molewijk, et al., 2014). The aim of improving the therapeutic relationships may be of importance to music therapists, as increased relational competence is one possible outcome of music therapy participation (Monika Geretsegger et al., 2017). We will return to the potential outcomes of music therapy participation in chapter four.

Attitudes and interpretations of the legal criteria for implementing compulsory mental healthcare

One study investigated how decision makers interpret the legal criteria for involuntary psychiatric admissions (Feiring & Ugstad, 2014). Given the modernisation of Norwegian mental healthcare and the Mental Healthcare Act during the past years, and an increasing attention towards human rights, both globally and nationally, Feiring and Ugstad (2014) expected a 'more human rights focused approach' (p. 1).[34] Instead they found that a paternalistic view was very much alive among the clinicians interviewed in the study, with little attention towards self-determination or inclusion of the service users' opinions. The criteria for admitting people involuntarily are vague, and they enable different interpretations: The result is that people are admitted involuntarily based on individual interpretations of open terms such as 'serious mental disorder', 'best interest', 'risk of harm', and 'need of treatment and care' (Feiring & Ugstad, 2014, p. 2). Feiring and Ugstad (2014) thus call for supplementary professional guidelines for admitting

34 Feiring and Ugstad (2014) speak of a modernisation of mental healthcare during the last years; however, they refer to the years before 2014, and do not include the newest changes such as the update in the Mental Health Care Act from 2017 (Lov om endringer i psykisk helsevernloven mv. (økt selvbestemmelse og rettssikkerhet), 2017; Syse, 2017), the implementation of pharmaceutics-free treatment (Norwegian Directorate of Health, 2016b), and the implementation of integrated pathways for treatment (Norwegian Directorate of Health, 2018).

service users to mental healthcare. If we take into account the most recent changes in the Mental Healthcare Act, we may include 'competence to consent' to the list of terms that are subject to interpretation (Norwegian health directorate, 2017; Lovdata, 2017). Thus, supplementary professional guidelines suggested by Feiring and Ugstad (2014) may still be relevant in the future.

Different attitudes, and the tension between the health professionals and the service users

One study suggests that there exist certain differences in attitudes between the service users and the staff members at mental health wards (Terkelsen & Larsen, 2013). The study shows that the health workers wanted to use the capacity of the hospital ward for real treatment, and not as a comforting hotel (Terkelsen & Larsen, 2013). This was a contrast to the attitudes of the service users, even for those involuntarily admitted, who wanted a locked ward for rest and safety. The staff also understood service users with double diagnoses as people in need of the staff's expertise and help, whereas the service users often experienced the stay as a detention camp and punishment, as they were locked in and held out of society. In another study, the same researchers show that service users and staff members can also interpret dangerous situations differently (Terkelsen & Larsen, 2014). They found that 'the professionals applied stereotypes when interpreting dangerous situations' and that 'the professionals and the patients had different interpretations of what triggered dangerous situations' (Terkelsen & Larsen, 2014, p. 308). The authors stress that a stronger aim on dialogue and ethical frameworks can be a useful approach for preventing dangerous situations, which often come with coercive means (Terkelsen & Larsen, 2014). A dissonance between service users' and health professionals' understanding of the health service was also pointed out in a study by Husum, Legernes and Pedersen (2019); the service users 'longed for recognition, care and comfort' (p. 153), and did not have their expectations fulfilled regarding the content of the care provided.

The health workers in an Assertive Community Treatment team (ACT-team) experienced that the framework of this health model leads to a humane, holistic, and dynamic work practice, with a strong focus on user involvement (Stokmo, Ness, Borg & Sommer, 2014). Another study, however, teaches us that it is sometimes hard for the professional health workers out in the community to find a proper balance between the two: to provide healthcare and to facilitate for autonomy (Stensrud, Høyer, Beston, Granerud & Landheim, 2016). The professional staff seemed to pay the most attention towards the service users' lack of insight and need for treatment, rather than the importance of autonomy, which sometimes challenged the therapeutic relationships (Stensrud et al., 2016). Stensrud

et al. (2016) suggest that a stronger perspective on the autonomy of the service users might improve cooperation, and they argue further that a less paternalistic approach might reduce the need for coercion.

Diseth, Bøgwald and Høglend (2011) investigated stakeholders' attitudes towards compulsory mental healthcare. The researchers collected responses to statements about coercion from former service users, relatives, members of supervisory commissions, psychiatrists, other physicians, and lawyers. One common attitude was that: 'a trusting relationship between service user and therapist is more important than the right to have an attorney' (Diseth et al., 2011, p. 1). Also they found a common opinion in that the hospital doctor should not make decisions about involuntary hospitalization; such decisions should instead be made by a court of law. Psychiatrists and physicians were more content than the others about the current legislation processes. The authors argue that this 'may have implications for the legal protection of mental healthcare service users' (Diseth et al., 2011, p. 1). The ones who spoke positively about the status quo of modern psychiatry and about coercion seem to be the ones who also made the decisions on such matters. A representative sample of the Norwegian population (n=2001), however, seems to support the current practices, and the use of coercion as it is today[35] (Joa et al., 2017); 34% even regard the current levels of coercion as too low, whereas only 9,9% supported a reduction of coercive treatment. Higher education correlates with a critical attitude towards coercive treatment, and in general people are more supportive of coercive means in order to prevent suicides than to prevent violence to others (Joa et al., 2017).

Kogstad, Ekeland and Hummelvoll (2011, 2014) flag a humanistic and recovery-oriented approach to mental healthcare in two articles. Based on analyses of service users' narratives (N=347/ N=492) the authors argue that there seems to be a gap between the traditional professional view on beneficial interventions and the service users' understandings of helpful approaches. The service users report of a wish and need to be recognized as individual subjects, but feel objectified by the health professionals. The authors argue that the mismatch in discourses between service users and health professionals contributes to unfortunate circumstances in which: 'the health services are also deprived of information that would be essential for planning, management, and further improvements in the field of mental health care' (Kogstad et al., 2014, p. 5).

Based on the research on attitudes mentioned in the last sections, there is reason to believe that ward cultures and individual values are important variables regarding the amount of coercion that is used within mental health institutions. Service users often

35 The study is based on data from 2009 and 2011. Thus, 'today' refers to the practices before the recent changes in the Mental Healthcare Act (Joa et al., 2017).

feel degraded and humiliated, and would like to partake in decision-makings to a larger degree. Service users tend to believe that coercion is sometimes necessary, but stress that coercion should indeed be reduced to a minimum.

3.3.7 Ethics and legal protection of people within compulsory mental healthcare

Hem, Gjerberg, Husum and Pedersen (Hem et al. 2016) performed a systematic literature research on the area of ethics in coercive mental healthcare. They found that the most important justification for using coercive alternatives is the attempt to promote the service users' best interests. They also found that a core challenge with any use of coercion is the interference with people's autonomy. The authors state that the ethical challenges regarding compulsory mental healthcare is not discussed sufficiently, according to the considerable significance of such interventions:

> There is a lack of literature explicitly addressing ethical challenges related to the use of coercion in mental healthcare. It is essential for healthcare personnel to develop a strong awareness of which ethical challenges they face in connection with the use of coercion, as well as challenges related to justice. How to address ethical challenges in ways that prevent illegitimate paternalism and strengthen beneficent treatment and care and trust in connection with the use of coercion is a 'clinical must'. By developing a more refined and rich language describing ethical challenges, clinicians may be better equipped to prevent coercion and the accompanying moral distress. (Hem et al., 2016, p. 92)

Hem et al. (2016) call for a greater awareness, and a more nuanced language, about the use of coercion. I believe that this study offers a meaningful contribution on this matter, as the language about coercion is presented to the field of music therapy, and the study intertwines music therapy thinking.

I will in the following paragraphs present some topics that are previously discussed regarding legal rights and ethical issues within Norwegian mental healthcare. As we will see, both national laws and The United Nations Declaration of Human Rights are mentioned in several articles on the topic. Both Høyer (2000) and Wynn (2003b) claim that the long tradition of coercion in mental healthcare has not been backed up by the expected amount of research; although the amount of research is increasing, there is still little research that speaks well for the outspread use of compulsory mental healthcare. In a health perspective there seem to be few benefitting arguments in favour of

coercion; instead, the literature suggests that coercion comes with complex legal, ethical and clinical implications (Wynn, 2006).

The Human Rights in mental healthcare

According to Diseth and Høglend (2011), it is the confidence in psychiatry as a profession that makes up the Norwegian legislation. They argue that more decisions of compulsory treatment in mental healthcare should be based on court judgments, as is the common procedure in some countries. Singular and subjective opinions from one person should not determine interventions that may be regarded as violations of the basic Human Rights, except for the sake of life-threatening situations; the Human Rights have precedence over national laws. However, the European Court of Human Rights lays trust in local psychiatric customs to some extent, as some verdicts allow for different, inter-boarder interpretations on the practical implications of the human rights (Syse, 2006). Despite an increasing attention towards human rights in mental healthcare, service users still haven't been protected, according to Syse (2006). As a researcher on the jurisdictions he advocates that there is too much use of unnecessary coercion in our culture, thus it is important to increase voluntary alternatives whenever possible.

Kogstad (2009) analyses 335 mental health client narratives. She points out that mental health clients' experiences: 'cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights' (2009, p. 383). I agree with Kogstad in that the Human Rights should work as instruments for protecting mental health clients' human rights, and that more attention should be devoted to the CRPD. Although the CRPD have now been ratified by Norway, there are still reported violations of the human rights within mental healthcare in Norway (Moe, 2017). And as mentioned in chapter two, I agree with critical voices that regard 'the treatment criterion' as incompatible with basic human rights (e.g. Diseth & Høglend, 2014).

Consent

Two singular authors (Hofmann, 2007; Aasen, 2009) present their thoughts on service users' consent. Aasen (2009) stresses that the service user's confirming voice is crucial when executing treatment. This is an essential aspect in national laws, western philosophy, and in the declaration of Human Rights. In both voluntary and involuntary admission, however, autonomy, freedom and dignity are threatened, Aasen (2009) argues. Not only should the results of compulsory treatments be analysed, but also the processes, to make sure that the service users' voices are heard as often as possible, and so that they may keep their dignity and experience of justice (Aasen, 2009).

To judge that some people are incapable of expressing consent, and to choose what is best for others' lives, are significant decisions to make. Hofmann (2007) points out that there are several psychological tests to help deciding service users' competence to consent. These, however, are not used in Norway, Hofman (2007) argues. Hence, cautiousness is crucial; the author advocates that service user opinions ought never to affect health worker's decisions, although the reliability of the service user may vary. A moral responsibility rests with the caretakers if the goal is to respect the person's self-determination. The matter of consent is especially significant after the revision of the Mental Healthcare Act applied 1st of September 2017. Perhaps standardized tests are, as suggested by Hofmann (2007), useful instruments when deciding competence to consent.

Coercion in everyday life

Two articles discuss the ethical implications of coercion outside of hospitals (Løvsletten, 2014; Syse, 2002). In some cases the use of coercion has, until recently, been brought to people's homes, influencing their daily lives. There is currently no complete knowledge on how, or for how long, service users have been treated with coercion in their homes, according to Løvsletten (2014), and there is little research on the field. In general we know little about the effect of the use of coercion, also outside of institutions (Løvsletten, 2014).

The minor amount of investigation in this field might lead to poor legal protection for the parts involved. This may also be the case when nursing and healthcare workers are to let in service users' homes. Syse (2002) advocates that we need more awareness of what is going on, and that there might exist unjustifiable use of coercive interventions and violations on the Human Rights, due to economic demands, and at the expense of service users' dignity.

In one discussion, the Italian contemporary philosopher Giorgio Agambens is mentioned in an attempt to illustrate one of the consequences of long lasting coercive medication; this may be seen as a permanent state of treatment in which people are deprived of their status as citizens (Terkelsen & Larsen, 2012). This philosophical perspective seems to go well with the user narratives that describe lives as being 'on hold', as the compulsory treatment interferes with people's daily lives, and makes it hard to carry on with the outlived experience of cultural and societal human beings.

Because of the newly applied revisions of the Mental Healthcare Act, however, the practices of coercion outside of the institutions will perhaps change in the future. The national commitment of establishing new ambulant FACT teams where service users

live (Norwegian Directorate of Health, 2019c), may however tell us that compulsory mental healthcare will in the future be executed while the service users live at home. The possibility for these service users to reject mental healthcare might provide some concerns for close others, who in turn may experience even stronger responsibilities for their beloved ones (Helmers, 2017)[36]. More knowledge about the current practices will follow in the future.

We need more knowledge about legal and human rights

One study presents an intervention wherein service users were systematically informed of their legal rights (Johnsen, Øysæd, Børnes, Moe & Haavik, 2007). Post intervention questionnaires only pointed at a slight improvement when it came to the service users' general satisfaction, but service users reported of an increased knowledge about their legal rights. The authors advocate the importance of working systematically on this matter, as knowledge about ones legal rights is important for people in both voluntary and involuntary admissions.

Two articles advocate that mental health workers ought to be taught about the declaration of Human Rights (Blesvik et al., 2006; Husum & Hjort, 2009). Husum and Hjort (2009) point at an increasing focus on user perspectives and empowerment as factors that have led to more awareness of the Human Rights in mental healthcare, and that mental healthcare services need education about human rights in order 'to safeguard the human rights of patients' (2009, p. 1169). The authors seem to agree that coercion is used more than necessary, and that this may be seen as a violation according to the UN. More knowledge about human rights may prevent the use of unnecessary coercion. Blesvik et al. (2006) claim that the low frequency of cases brought to the European Court of Human Rights in this manner is due to the mental health clients' challenges in presenting their cases. The number of verdicts in favor of victims to coercion could, according to Blesvik et al. (2006), have been much higher if service users were given proper support. The latter authors also argue that health professionals within mental healthcare should pay more attention to the United Nations' committee against torture, who witnessed severe violations to the Human Rights in Norwegian mental healthcare on a visit to Oslo.[37] As a working music therapist within mental healthcare for a few years, I have still heard little about the Human Rights, or the CRPD, as arguments for current

36 The referred item is a news article in the journal Sykepleien [The Nursing], published by the Norwegian Nursing Association. The article was published 1st of September 2017, the exact date for the implication of the revised Mental Healthcare Act. The information in this article is partly based on comments by professor emeritus Aslak Syse, a well-known scholar within different fields, including compulsory mental healthcare.
37 As described by Blesvik et al. (2006), the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment published the findings that were uncovered during their visit: Preliminary observations made by the delegation of European Committee for the Prevention

practices by health professionals. I support that health professionals should indeed be informed by the content of the CRPD, and evaluate and discuss our practices accordingly.

3.3.8 Reducing coercive approaches in the mental healthcare services

Not many studies have targeted interventions for reducing the amount of coercion, even though this has been a national goal in Norway for quite a long time (Norwegian Directorate of Health, 2006). Still, a handful of studies that will be outlined below provide useful knowledge on a possible reduction of coercion in Norwegian compulsory mental healthcare, which often come with solutions that seem highly applicable.

Reducing compulsory admissions

According to a research report by Ness, Steen, Reichelt and Walby (2016) the amount of coercive admissions, referred from the psychiatric casual clinic in Oslo to further psychiatric emergency wards, was reduced from 80% to 42% during a period of 13 years. Even though there has been some structural changes for mental healthcare services, and a few governmental action plans for reducing coercion during this period, Ness et al. (2016) argue that the results correlate with 'a systematic change work that has focused on changing attitudes, facilitating awareness, monitoring the coercion, and providing individual feedback.' (p. 630) Even though the research design of the mentioned study did not investigate the effect of individual variables the researchers believe that the monitoring and comparing of referrals was an important part of the picture; the researchers were surprised of the variation between individual health professionals regarding the amount of referrals (Ness et al., 2016). The authors further stress that their methods should be used elsewhere in Norway as well, and that these measures do not require intricate adaptions or institutional change.

An international review targeted the literature on possible approaches for reducing compulsory admissions (Bone et al., 2019), in which 15 psychosocial interventions[38] were investigated. The review article states that crisis plans and self-management interventions with an emphasis on relapse interventions seem to be effective approaches for reducing involuntary hospital admissions. For most of the other interventions investigated, including ACT teams, the literature were too scarce or potentially too biased to

of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which visited Norway from 3 to 10 October 2005. Strasbourg: Council of Europe, 2005.

38 Interventions included: acute day units, adherence therapy, assertive community treatment (ACT), cognitive behavioural therapy for psychosis, community rehabiltation services, compulsory community treatment, crisis houses, crisis plans, crisis resolution teams, early intervention services for psychosis, family intervention for psychosis, housing intervention, self-management interventions, and vocational interventions (Bone et al., 2019).

be held as evidence (Bone et al., 2019). These findings may be regarded as a support for recovery-oriented perspectives in mental healthcare, in terms of the service users taking control of their own life and mental health challenges (Hummelvoll et al., 2015).

Available hospital beds

A few studies have targeted easy access to hospital beds (Heskestad & Tytlandsvik, 2008; Moljord et al., 2016; Myklebust, Sørgaard & Wynn, 2014; Olsø et al., 2016). User-administered beds have been tried out within mental healthcare services in order to prevent symptoms from escalating, and giving the service users the opportunity to learn more about their own needs (Olsø et al., 2016). In one study, the hospitalization frequency increased when people were allowed to express their need for a hospital bed on a short-term notice, yet the total hospitalization periods decreased by 33%, and the involuntary amount hospitalization was reduced by about 50% (Heskestad & Tytlandsvik, 2008). Moljord et al. (2016) also found that the frequency of admissions increased, and that the total amount of stay days was constant.[39]

A qualitative study implies that the opportunity to make use of voluntary hospital beds may enhance the confidence for the service users regarding their ability to cope with mental health challenges in everyday life (Olsø et al., 2016). This approach could be one way to implement more self-determination in mental healthcare, which has been called for earlier in this chapter. An RCT-study were performed for the same research project as the qualitative study performed by Olsø et al., (2016), which included the same group of research participants (Moljord et al. 2016): Two questionnaires measured outcomes of user involvement and recovery after a four month-period with access to voluntary hospital beds. The first questionnaire named Patient Activation Measure targeted: 'patient knowledge, skill, and confidence in self-management' (Moljord et al., 2016, p. 3), and the second questionnaire, the Recovery Assessment Scale, measured: 'personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and degree of domination by symptoms' (Moljord et al., 2016, p. 3). Though the research participants spoke positively about the opportunity of user-administered hospital beds in the qualitative research (Olsø et al., 2016), no measurable effects were found in the quantitative study regarding service user activation or recovery (Moljord et al., 2016).

39 Even though Moljord et al. (Moljord et al., 2016) did not find a reduction in stay days for their service users with voluntary access to hospital beds, they refer to three studies that did find a reduction in stay days, including the one by Heskestad and Tytlandsvik (2008) that is presented in this text.

Structures within mental health services

An investigation of the organization of mental health services in Norway supports the findings that available beds may reduce the need for acute admissions, although the study does not target user-administered hospital beds per se (Myklebust et al., 2014, 2017). Based on every admission to the specialized mental healthcare in Norway between 2003 and 2006 (N=5338), Myklebust et al. (2014, 2017) found that hospital beds in the local community may be an important source for preventing acute admission to greater hospitals, compared with local environments that do not offer the same opportunities for hospital beds in the local community. Myklebust et al. (2014, 2017) argue that the organizational aspect of mental health services may indeed affect the outcomes and practices of mental healthcare.

One study targeted the degree of hospitalisation for service users enrolled into Assertive Community treatment (ACT) (Clausen et al., 2016). For both service users with or without substance abuse in addition to the mental illnesses, the total amount of inpatient days was reduced. Service users with a problematic substance abuse also had fewer involuntary inpatient days after being enrolled into ACT.

A study based on interviews with 74 general practitioners who had recently referred service users to compulsory mental healthcare showed that the physisians believed that a closer follow up by other health professionals and follow up at the service users' homes could have been possible solutions for avoiding involuntary treatment (Røtvold & Wynn, 2017). Also this study points at the possibility of different outcomes, depending on the capacity, the amount of resources, as well as the organizational aspects within the mental healthcare system (Røtvold & Wynn, 2017).

Compulsory treatment for outpatients, also referred to as outpatient commitment, is probably a relevant topic for ACT and FACT[40] in the future, which are priorities on a national level. A study targeting outpatient commitment showed that involuntary medication is central for this client group, and that less than half of these service users were referred to additional compulsory mental healthcare (Rugkåsa et al., 2019). Involuntary treatment for outpatients may thus be viewed as a way to reduce other compulsory interventions, though this model raises other ethical dilemmas. As Rugkåsa et al. (2019) argue we will know more about the development of outpatient commitment in the future given the recent changes of the Mental Health Care Act, which precludes compulsion for service users with competence to consent, unless the 'danger criterion' is used.

40 Flexible Assertive Community Treatment.

A Norwegian report published by 'Nasjonal kompetansetjeneste for samtidig rusmisbruk og psykisk lidelse' (NKROP)[41] support the findings that ACT may reduce the amount of inpatient days for the target group, based on international studies (NKROP, 2014).[42] ACT, and now also FACT, are recommended models for reaching service users with severe mental health challenges and/or substance abuse in Norway. The Norwegian Directorate of Health help financing the establishment of FACT units across the nation (Norwegian Directorate of Health, 2019c). We will know more about the possible effects of FACT in the future, as this model is still new in most areas of Norway. NKROP recently received 15 000 000 NOK for researching the implementation of FACT in Norway (Wiig, 2018).

Reducing coercive means

A Danish-Norwegian study investigated whether different preventative measures are determinant for why mechanical restraints are used twice as frequently in Denmark than in Norway (Jesper Bak et al., 2015). The researchers found six preventative factors in that can partially explain the differences between the two countries: 'staff education (– 51%), substitute staff (– 17%), acceptable work environment (– 15%), separation of acutely disturbed service users (13%), service user–staff ratio (– 11%), and the identification of the service user's crisis triggers (– 10%)' (Jesper Bak et al., 2015, p. 1715). Even though the findings by Bak et al. (2015) refer to Danish findings, they point at interventions observed in Norway that seem to prevent unnecessary use of mechanical restraints. Their findings are partly supported by a meta-study that points at two interventions that seem to reduce coercive measures in mental healthcare for adults: 1) Risk assessment of aggressive behaviour and 2) counselling towards staff (Dahm, Odgaard-Jensen, Husum & Leiknes, 2015). Even though there is a need for more research to confirm the effects of such interventions, neither of these alternatives comes with negative side effects, and they should in most cases be highly achievable to perform; consequently, there are few reasons for not trying out these interventions (Jesper Bak et al., 2015).

Reduction in the use of restraints is investigated in three other articles (Jesper Bak et al., 2014; Veland & Jacob, 2016; Wynn, 2003b). Wynn (2003b) argues that a broad knowledge of interventions may lead to less use of restraints in situations of emergency, as there are other ways to calm service users, such as talking, especially in the time

41 Direct translation to English: 'National competence service for simultaneous substance abuse and mental illness'.

42 Among others the report lean on the findings in a review published in the Cochrane Data Base, written by Marshall and Lockwood. However, when searching online for this review (April 3rd, 2019) it turns out that it has been withdrawn from publicity in the Cochrane Data base. URL: <https://www.cochrane.org/CD001089/assertive-community-treatment-for-people-with-severe-mental-disorders>.

before service users act dangerously. Bak et al. (2014) found three preventive factors for reducing mechanical restraints: mandatory review, service user involvement, and no crowding. Bak et al. (2014) argue that further attention should be paid to implement preventive interventions like these, and points out that no reverse effects followed from the possible preventive interventions.

An intervention study of mechanical restraints was performed at an acute psychiatric ward in Norway over a period of one year, from November 2013 to November 2014, with the purpose of reducing the use of restraints (Veland & Jacob, 2016). During this one-year intervention period, mechanical restraints were used three times. This was a reduction from 66 incidents of mechanical restraints in 2012 and 20 incidents in 2013 (Veland, Olstad, & Jacob, 2016)[43]. Mechanical restraints with a median duration of 5,6 hours[44] was substituted with physical holding of the service users with an average of eight minutes for women and 13 minutes for men. We can see in the study that the number of mechanical restraints was reduced even more between 2012 and 2013, before the interventions were performed and tested. Still, a reduction in the use of mechanical restraints of 85% within the intervention period is still rather promising. The health professionals at the ward have consciously worked with attitudes, cultures and organizational aspects to reduce the unnecessary use of coercive means. As part of this intervention study belt beds were removed from the hospital area; instead, portable belts were stored in small suitcases out of sight, which had to be fetched after making legal decisions about the use of mechanical restraints. In addition, conversation interviews were applied in order to monitor and reduce aggression and risk of violence. The health professionals were more flexible, thus avoiding unnecessary rigid hospital rules, and they worked to cooperate and to maintain good communication with the service users. The authors argue that similar interventions are applicable for other institutions. They also stress that such an attempt to change ward cultures needs to be rooted within the leadership (Veland & Jacob, 2016). From a Foucaultian discoursive perspective I agree with the authors in that a change in practices, routines, and language, may be largely dependant on the ruling discourses (Foucault, 2002); there are probably major differences in a hospital ward regarding power-relationships, and in whose opinions are valued the most.

43 Details about the number of coercive means are obtained from a different source (Veland et al., 2016), a Power Point-presentation retrieved from the Internet, because the original article (Veland & Jacob, 2016) does not provide the necessary information about the total amount of coercive episodes.

44 The duration of the stay in belt beds is not measured in this research; the authors refer to an estimate from a previous study (Knutzen et al., 2014).

During the report of their intervention study, Veland and Jacob (2016) pose question about the legislation criteria of coercive means, and whether it is too easy to legally apply mechanical restraints:

> Is it reasonable that it is up to the individual ward to define the correct use of coercion, or should decisions about coercive means be granted stricter access criteria in the legislation [author's translation]? (p. 48)

According to the Mental Healthcare Act, however, mechanical restraints is only to be used when 'absolutely necessary', and after every other alternative have been tried out, or at least been considered as clearly non-effective (§4-8) (Law Library, 1999a). Perhaps the legal criteria are already strict enough, yet there is a gap between the laws and the performed mental healthcare. And perhaps Veland and Jacob (2016) could well have asked whether it is too easy to illegally apply mechanical restraints. In a PhD study Storvik (2017)[45] found systematic violations to the legal justice of service users within Norwegian compulsory mental healthcare. Storvik (2017) found for instance that belt beds were used as punishment, which is illegal. And based on approximately 3500 episodes use of belts as mechanical restraints, service users spent 12,3 hours in belts on average (Strand, 2017); according to Storvik (2017) a duration of more than 6 hours in belts are usually recognized as violations to the Human Rights (Strand, 2017). Storvik (2017) does not blame the health professionals who perform the illegal practices; rather, he points at the governmental responsibility of organizing mental healthcare in ways that enable the best possible practices.

In an American prospective study, Smith, Ashbridge, Davis and Steinmetz (2015) investigated 12900 records from 1801 involuntarily admitted service users in Pennsylvania's state hospitals. They found that a major decrease in the use of restraints and containment-procedures, from 2001 throughout 2010, does not correlate with a higher frequency of assaults. The authors argue that a philosophical change towards a recovery-oriented model of psychiatric healthcare has facilitated the changes in attitudes and routines. Some changes that seem to have decreased coercive means were:

45 I did not manage to obtain the actual thesis, thus the reference is supplied with three secondary sources found online:
1) A presentation of the thesis published on the web-page *Forskning.no*, written by the communication advisor at the Norwegian Arctic University (Moe, 2017): <https://forskning.no/juridiske-fag-partner-psykiske-lidelser/avdekket-flere-menneskerettighetsbrudd-i-norsk-psykiatri/340014>.
2) A video in whit Storvik speaks about his PhD works published on the web page of the student's newspaper *Midnattsolposten* (Holm, 2017): https://midnattsolposten.no/meninger/2017/10/skjult-tvang-innen-norsk-psykiatri.
3) An interview with Storvik published on the web page *Psykologitidsskriftet.no* [previously published in the Journal for Norwegian Psychologists association] (Strand, 2017): <https://psykologtidsskriftet.no/na/2017/07/fant-systematiske-lovbrudd?redirected=1>.

> Better leadership, data transparency, use of clinical alerts, workforce development, policy changes, enhanced use of response teams, implementation of dialectical behaviour therapy, and discontinuation of the psychiatric use of PRN orders. (Smith et al., 2015, p. 303)

Among the policy changes that were made in the state of Pennsylvania during the investigated period, the allowed duration of restraints was reduced to one hour, with a possibility to extend the period for only one additional hour at a time (Smith et al., 2015). In addition, an examination by a physician is required within 30 minutes after decisions of restraints are made, and a structured debriefing is demanded after each incident of restraints. This aligns with Veland and Jacob (2016) who call for stricter legislations regarding the use of coercive means, as mentioned above. At least the reduction in the use of mechanical restraints in Pennsylvania correlates with stricter legislations.

Changes that might have reduced coercive means in America are not necessarily transferable to Norwegian mental healthcare. Still, a general philosophical change towards a recovery-oriented mental healthcare may be similar to the values and attitudes depicted in Norwegian studies, such as attention towards the service users' resources**,** cooperation with the service users, and a more flexible way in which to approach the individual, different needs. In line with this recovery-oriented perspective on the service users' cooperation and responsibility, Roaldset and Bjørkly (2010) investigated the accuracy of self-reported risks of violence and self-harm. The researchers found no previous relevant literature on the matter, but according to their study the service users' statements at admission correlated significantly with the actual events during the hospitalisation periods. Self-reports at discharge correlated moderately with the actual events within a three-month follow-up. Reports of moderate or higher risk predictions remained significant during the follow-up, as well as did reports of self-harm for women. As the researchers themselves state we need more research on this topic, but their results imply that self-reports may indeed be helpful for cooperation between service users and health professions and for enabling responsibility and ownership of the service users' own recovery processes. Surveying the potential risk of harm may also help to reduce the amount of coercion, as mentioned above (Dahm et al., 2015). One study found that repeated violent behavior correlated with lower levels of high-density lipoprotein in the body, thus the authors argue that lipid analyses may help to assess potential risks and to prevent violent behaviour (Roaldset, Hartvig, & Bjørkly, 2013).

A Norwegian report (Dahm et al., 2017) ordered by the Norwegian Health Directorate investigated the literature[46] on coercion reducing interventions and concluded with the following main findings (my translation):

> Use of 'emergency plans' for outpatients probably reduce the number of admitted patients.
>
> Systematic evaluations of the risks for aggressive and violent behaviour for patients admitted to acute mental health wards possibly reduce the use of coercive means.
>
> Advising and supporting of staff in security wards possibly lead to less use of coercive means for patients.
>
> For other interventions the documentation is too scarce to draw conclusions. (Dahm et al., 2017, p. 3)

As with the matter of potential relationships between structural aspects of mental healthcare and the amount of involuntary admissions (Myklebust et al., 2017), one might also pay attention to the influence of structural aspects for the amount of coercive interventions. Veland and Jacob (2016) spoke of the importance of attitudes anchored in the leadership in order to reduce the use of mechanical restraints, as well as the physical removal of belt beds from the ward facilities. And as Storvik (2017) argues, the structures of the mental healthcare enable illegal practices, and the health professionals are only doing their jobs the best as they can within the already established routines. According to the CRPD the ruling government is responsible for maintaining human rights for persons with disabilities, but every facility and ward are also obliged to make the necessary accomodations to avoid violations to the human rights. It seems clear from the previous research that health facilities do not do enough to avoid unnecessary use of coercion. But several researchers also point at the need for more resources in mental healthcare in order to provide better services.

46 Only two out of the 21 included articles were Norwegian, but all of them investigated the effects of interventions that is used in Norway (Dahm et al., 2017).

3.3.9 Conclusive remarks about the Norwegian compulsory mental healthcare

So far, we have learned that the use of coercive measures is problematic. Coercion may lead to an abuse of people's dignity, and often come with violations on fundamental Human Rights. Both health workers and service users think that coercion and restraints are sometimes necessary, yet there is much literature that suggests that the amount of coercion is reduced.

The Mental Healthcare Act is specific in that compulsory treatment and coercive means are only to be used when absolutely necessary. The research literature, on the other hand, implies that coercion is used too often; local attitudes and discourses are described as important factors for the maintenance of unnecessary coercive interventions.

There is little evidence of the effects of compulsory treatments, far from enough to answer for the amplitude of coercion that is used within the modern mental healthcare system.

Service users treated within mental healthcare state that they want to be met as human beings, not as diagnoses, and they want to be informed of and to take part in decisions about their lives and treatment programs. Legal status does not necessarily predict the experience of coercion, but legal status might predict whether the service users feel included in communication and decisions about the treatment. The loss of autonomy is often experienced as degrading, and the Declaration of Human Rights is not always easy to apply together with the restricts of human freedom that are found in compulsory mental healthcare.

Also, there seems to be a tendency towards already underprivileged groups in the Norwegian society being treated the most through coercive measures, and the probability for being treated coercively is higher for: adolescents involved with child care cervices or living in foster care, for ethnic minorities and refuges, for those with little education, for people with the most severe mental illnesses, such as bipolar disorders and psychotic illnesses, for people previously treated coercively, and for people receiving disability pension or other social benefits. It seems then, that the most severe violations of people's autonomy and self-determination are often exposed to people that already struggle, some way or another. This, I believe, may be considered clear violations to the CRPD.

There seem to exist professional differences regarding thoughts on coercion. Staff members who are close to the service users tend to see them as individuals with different needs, whereas more distanced professionals view the service users as homogenous groups sharing the same needs. Whereas service users, close others, politicians, user organizations, and lawyers want changes in the procedures of deciding legal statuses,

psychiatrists have been more content about the status quo of the modern mental healthcare system.

Although we need more research on coercive mental healthcare in the future, we could say that there already seem to exist a certain amount of knowledge that may prove helpful in order to predict and prevent coercion, and for reducing the total amount of coercive means (Bone et al., 2019; Dahm et al., 2017; Knutzen et al., 2014; Knutzen et al., 2011). It seems that there is a strong need for training professional staff about the negative by-products of restraints, and to teach about other interventions (Dahm et al., 2015; Dahm et al., 2017; Wynn, 2003a). As we wait for more research to be done, and in the meantime spread this knowledge to society, we may hope to develop and implement alternative interventions for the service users who are the most likely to be exposed to compulsory mental healthcare.

Regardless of the exact line between necessary and unnecessary use of coercion, there are different ways in which to *perform* coercion, and some argue that there are differences between actual coercion and perceived coercion (Iversen et al., 2002; Opsal et al., 2016; Sørgaard, 2007). Even though coercive approaches are sometimes necessary, it is possible to perform coercive measures in respectful ways (Hem, Molewijk et al., 2014). An attention towards ethical and moral deliberation about the use of coercion can provide a useful route towards less degrading mental health services (Hem, Molewijk et al., 2014; Hem, Pedersen, Norvoll & Molewijk, 2014; Lorem et al., 2014; Molewijk et al., 2016; Molewijk et al., 2015; Molewijk et al., 2017; Norvoll et al., 2017; Weidema, Dartel & Molewijk, 2016).

4 Music therapy within mental healthcare

When I wake up it's everyday the same
put the music on, it's nothing but a game.
(…) Every week I'm waiting for the music therapy
that's how it is to make my pain free.
My soul, my pain, it's all disorder
when I hiss scandal, it's nothing but to order.
(…) Critical decisions gonna pull me through
thanks for supporting I know what to do.
Trapped behind bars is nothing but the truth
so listen to me (…) let the things come true.
Never wants to stop what the music means to me
I try and I try, what do I want to be?

A farewell rap by 'Donald' at the end of the rap music therapy treatment program, as presented by Hakvoort (2015).

In this chapter we will have a look at music therapy within mental healthcare. First I will describe shortly the role and prevalence of music therapy within Norwegian mental healthcare. Then we will look at some research that I find relevant regarding music therapy within mental healthcare; both quantitative measures of effects, and qualitative studies on user perspectives will be considered. Later in this chapter I will also go through the results from a literature research on music therapy and compulsory mental healthcare; this leads to an outline of research on music therapy and forensic psychiatric settings, as no previous research was found regarding music therapy and compulsory mental healthcare as described in chapter three. Towards the end of the chapter I will pay a considerable amount of attention to 'music asylum' as presented by Tia DeNora (2016), before I look at examples from the literature through the lens of DeNora's theory.

4.1 Music therapy in Norwegian mental healthcare

In Norway, music therapy grew out off the field of special education during the nineteen seventies, and Nordoff and Robbins-inspired practices for people with special needs were the main area of practice throughout the eighties and nineties (Almås, 2008; Næss,

2008; Ruud, 1999). Some early projects in the area of mental healthcare were performed some decades ago[47] but were abandoned before music therapy got a proper foothold as an integrated practice and form of treatment.

It was not until the post-millennial years that Norwegian music therapists and music therapy researchers started for real to explore the diverse area of mental healthcare, and publically documented their practices. Important pioneers and contributors to music therapy within Norwegian mental healthcare have been Brynjulf Stige (1999) with a position in a rural mental health facility; Ruth Eckhoff (1997) and Gro Trondalen (2004) with their early works on music therapy regarding service users with eating disorders; Randi Rolvsjord with her empowering perspectives on music therapy with female mental health inpatients (Rolvsjord, 2007); and Hans Petter Solli with the inclusion of the recovery-perspective in his research on user experiences of music therapy for people suffering from psychoses (Solli, 2014).

In 2013, the Norwegian Directorate of Health recommended music therapy on the highest level in the national guidelines for assessment, treatment, and follow-up for people with psychoses (Norwegian Directorate of Health, 2013). In addition, music therapy is mentioned as a reasonable approach to detoxing, treatment and rehabilitation for people with substance-dependent challenges (Norwegian Directorate of Health, 2016c, 2017c). And from 2016 the Ministry of Health has proclaimed the development and implementation of pharmaceutics-free treatments (Ministry of Health and Care Services, 2015; Norwegian Directorate of Health, 2016b), of which music therapy will potentially be implemented as one of only a few, explicated approaches which are: user involvement, physical activity, cooperation with close others, and cognitive behavioural therapy (2016b)[48]. Pharmaceutics-free treatments were supposed to be established within each national health region by the 1st of June 2016. The Norwegian Health Directorate also facilitates new standards for mental healthcare through integrated pathways from the 1st of January 2019 (Norwegian Directorate of Health, 2018). The integrated pathways lean on the previously announced guidelines, thus music therapy is supposed to be part of mental healthcare in the future.

In 2016 it was estimated to be about 20 music therapists working within mental healthcare services in Norway (Solli, 2016). Even though music therapy within mental healthcare is expanding, together with music therapy in adjacent areas of practices, such as child welfare and care services for people with substance abuse, there are way too few music

47 Erdal and Hovden mention contributions within adult mental healthcare by Ruth Eckhoff from working at Kongsskogen videregående skole (Erdal & Hovden, 2008).

48 See chapter three for a broader presentation of governmental policies on compulsory mental healthcare.

therapists to be able to provide the possibility for music therapy participation across the nation. A questionnaire for people within mental healthcare in Stavanger, the fourth biggest city in Norway, showed that none of the respondents had been offered music therapy at all, although two thirds of the respondents would like to try music therapy if given the chance (Jensen, 2015)[49]. In 2015 there was a debate on a national-political level, regarding an expansion of the music therapy education programs; politicians from almost every political party in the government joined the view that the music therapy education programs need a stronger capacity, in order to better meet the growing need for music therapists within mental healthcare (Rune Rolvsjord, 2015). Also as late as in April 2017 the need for more music therapists has been requested by members of parliament (Wøien & Toppe, 2017).

Today, about seven years after music therapy was recommended in the treatment and rehabilitation for people with psychoses, there are still few jobs for music therapists within mental healthcare services. Evidently, there is not only a lack of music therapists, but there is also a lack of will when it comes to offering jobs and funding music therapy programs.

4.2 Research on music therapy and mental healthcare

Mental healthcare is a large and complex area of practice. In mental health institutions we find service users with a great variety of diagnoses and symptoms, and I will not go into all facets of mental healthcare. Rather, I will pay attention towards some areas that are particularly relevant for compulsory mental healthcare. As we have seen in chapter 3, there are some diagnoses that predict the use of compulsory treatment and coercive means more than others, such as affective disorders and illnesses in the spectrum of psychoses (Færden, 2001; Knutzen et al., 2011; Myklebust et al., 2012). In addition, coercion correlates with longer treatment periods and admissions (Furre et al., 2014; Knutzen et al., 2014, p. 714; Knutzen et al., 2011), which are often true for people diagnosed with affective- and schizophrenia-like illnesses. Thus, a fair share of the literature outlined in the following section targets music therapy for people with psychotic and affective illnesses.

49 The original report has not been published, according to an E-mail correspondence with the author himself. Extracts from the report, including the questions posed regarding music therapy, are available online as part of a Power Point-presentation from the author: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwi1kKCD7uXXAhXhK5oKHbe3BlEQFggzMAA&url=https%3A%2F%2Fwww.napha.no%2Fattachment.ap%3Fid%3D1101&usg=AOvVaw0hHnLCVOZipvNESoqHLoMF (retrieved April 12th 2019).

In the following I will portray some of the research literature about music therapy within mental healthcare, both quantitative and qualitative. This is not meant to be a full investigation of the literature on the field; rather I will outline some perspectives relevant for this study, based on the literature I have encountered.

4.2.1 Effect studies on music therapy and mental healthcare

Some studies have been performed on the effects of music therapy that have seemingly had a certain impact on the status of music therapy in Norwegian mental healthcare. Some of the results from these works have been much cited in the meta-literature.

Music therapy for people with schizophrenia and schizophrenia-like disorders

A meta-study from the Cochrane Database points at positive outcomes from music therapy for people with schizophrenia and schizophrenia-like disorders (Geretsegger et al., 2017); 18 studies met the inclusion criteria, with a total of 1215 participants. The studies investigated vary in quality, providing overall moderate- to low-quality evidence, with a variation between seven and 240 sessions of music therapy. The authors still conclude that the numbers speak well for the different effects of music therapy:

> There is evidence that music therapy, as an addition to standard care, can help people with schizophrenia improve their global state, mental state (general negative, depressive and anxiety symptoms), functioning (general and social), and quality of life over the short to medium term. Music therapy seems to address especially motivational, emotional and relational aspects, and helps patients improve regarding their social activities and roles. (Geretsegger et al., 2017, p. 25)

The results, however, show some inconsistencies across studies, and the effects of music therapy seem to depend on the number of sessions and on the quality of the therapy (Geretsegger et al., 2017). Even though the latest version of this review takes into account 115 studies, there is still a need for high quality research, especially regarding long-term effects of music therapy, and regarding the necessary amount of sessions needed for beneficial outcomes (Geretsegger et al., 2017).

Carr, Odell-Miller and Priebe (2013) investigated the literature on music therapy in regards to acute psychiatric care in general; they found several studies that pointed at positive effects in various ways, but conclude that these studies suffer to methodological

challenges and small samples. More high quality research is needed to learn more about the potential effects of music therapy in acute psychiatric settings.

Music therapy for service users with affective disorders

Also the research on music therapy and depression was investigated in a meta-study in 2008 (Maratos, Gold, Wang & Crawford, 2008). However, too few randomised controlled studies had then been performed in order to draw strong conclusions. In November 2017, a new meta-study was published, which included nine studies with a total of 421 participants (Aalbers et al., 2017). The latter study points at short-term beneficial effect regarding music therapy for people with depression. In addition, music therapy may reduce symptoms of anxiety, and enhance functioning in people with depressive symptoms.

Not much research has seemingly targeted long-term effects of music therapy (Maratos et al., 2008; Aalbers et al., 2017), but at least one randomised controlled study speaks well for music therapy on a three-month follow-up (Erkkilä et al., 2011). Although the numbers were not statistically significant on the six-months follow-up, these numbers do show a clear advantage for the people who had previously participated in individual music therapy.

Music therapy for people with low motivation for treatment

Regardless of diagnoses, or other mental health challenges, Gold et al. (2013) performed a study targeting people with low motivation for treatment. The authors found that music therapy together with standard healthcare is more effective than usual care alone, regarding negative symptoms, functioning, clinical global impressions, social avoidance, and vitality. In addition, music therapy participation may be linked to moderate effects on motivation for treatment.

Through a postmodernist perspective, as well as through a humanistic view on health, I find it meaningful to look at general challenges for people within mental healthcare, rather than classifying or researching people based on specific diagnoses attributed by expert opinions. In addition, low motivation for treatment is a difficult variable that often makes it hard to engage in activities, to partake in the recovery process, and to maintain fruitful relationships with health professionals (Gold et al., 2013). As Gold et al. (2013) point out, diagnosis is not usually the most used criterion for referring service users to a music therapist; low motivation for treatment is perhaps a more frequently used reason for offering music therapy. Accordingly, low motivation for treatment might be

an especially important area of investigation, and a critical issue that music therapists should pay attention to.

4.2.2 The user perspectives on music therapy in mental healthcare

According to Solli and Rolvsjord (2014) not many studies target the user perspectives on music therapy within mental healthcare. Some studies are performed though, and I will in the following describe some of the knowledge that I find relevant for this study.

Music helps in various ways

Through his investigation of user experiences for service users receiving music therapy in an adult psychiatry unit, Ansdell (2010) reminds us that the benefits of music therapy can target in a broader manner than measurable symptomatic changes: The joy of participating in music therapy can occupy the participant and keep the mind off the illness, and sometimes the participants feel that music therapy helps, even though it is hard to explain how (Ansdell & Meehan, 2010). In addition, music therapy can be something that affects the whole experience of living with mental illnesses, such as general moods, concentration, experienced isolation, and low confidence:

> Yeah, I never feel worse coming out of here. I might feel the same, but usually I feel better… At best I feel my mood has changed completely, and I'd feel a bit more relaxed and less isolated… [L]. (Ansdell & Meehan, 2010, p. 34)

Participation in music therapy is also said to work as a stress releaser, and for some people music therapy may help to concentrate and to clarify goals and wishes (MacDonald, 2015).

Music therapy can be motivating

Music therapy participation, and even the thought of music therapy, can motivate service users; when having a bad day the expectations and hope of positive or joyful outcomes can revive sparks of engagement:

> You know, they say music soothes the savage soul, but also, it can also ignite it too, you know, because every day is not a good day, but every day isn't a bad day either. But on that bad day, you look forward to things like music therapy. I might just need those instruments to shake, shake it out, shake the anger out, you know. [Frank] (MacDonald, 2015, p. 6)

Also Ansdell and Meehan (2010) found that music therapy have the potential to engage participants who are regarded as 'isolated, treatment-resistant, and difficult to access therapeutically through verbal insight-oriented approaches' (2010, p. 31).

In a study by Silverman (2006) the participants reported that music therapy was regarded as more helpful than other treatments and psycho-educative approaches. Also more than half of the participants (N=73) named music therapy as their favourite class/therapy:

> […] music therapy appeared to be the dominant class/therapy. It was consistently ranked higher than any other offered class/therapy despite what therapeutic aspect of patient treatment was being evaluated. Music therapy was rated as the most relaxing, fun, and motivating program offered. Participants also rated it higher than other programming for increasing communication, self-esteem, anger management, mood, and self-expression. Additionally, 57% of participants rated music therapy as their favorite group and 54% notet they felt most comfortable in music therapy. (Silverman, 2006, p. 120)

Solli and Rolvsjord (2014) also mention that certain people are more motivated for attending music therapy than other treatments. For some, music therapy is the only thing to look forward to during the week within the hospital walls, and people wish they had more than only one music therapy session a week.

Service users' relationships with music

Music therapy resonates well with music therapy participants' previous relationships with music, and their previous experiences of the relationship between music and health (Ansdell & Meehan, 2010). Music holds and intrinsic value of experienced meaningfulness, and music therapy participants highlight this perspective in research on music therapy within mental healthcare (MacDonald, 2015). Service users' relationships with music might be a relevant part of their motivation to participate in music therapy; they like music and are familiar with the roles that music can have in their life, and for their experienced health.

Music therapy may provide a sense of freedom

Solli and Rolvsjord (2014) mention explicitly that eight out of nine research participants were treated compulsorily in their study on user experiences of music therapy for people with psychoses, making their study directly relevant for my own research. They found four key themes emerging from interviews with the research participants: Freedom, Contact, Well-being, and Symptom relief. The research participants speak of experienced

enjoyment, satisfaction, mastery, hope and motivation through music therapy. They also state that music therapy enables an extended contact with oneself, with emotions, and with other people. An important aspect as regards this study, I believe, is the key theme of freedom: music therapy enables a time and place away from illness, from the everyday life within mental health treatment, and from the stigmas that follow people with mental health challenges:

> I think I got to express some thoughts and stuff without necessarily having someone trying to fix it. Just see how it is…(…) Often when someone talks… or if I say something… almost always someone will suggest what I should do with it, or give me extra pills, or whatever… Whereas when we made up [a] song, then it wasn't… there wasn't any answer… it was just a sort of expression. (P2) (Solli & Rolvsjord, 2014, p. 9)

Other participants in music therapy seem to appreciate the openness within music therapy improvisations, and the ability to create music without moral restrictions or aesthetic boundaries:

> I think it's the freedom to play… whatever. What I've enjoyed the most is being able to improvise… there's no structure… you can just play freely and build up from there… which has been good fun... and the freedom of doing that's been great… not to feel restricted. [D] (Ansdell & Meehan, 2010, p. 33)

The latter study also found that service users seem to experience equality between the participant and the therapist within the musical companionship (Ansdell & Meehan, 2010). One could question if this makes it easier to pay less attention to social and musical norms within the music activities. MacDonald (2015) found that expression through music therapy activities for people within adult psychiatric care help to clarify such feelings and their relationships to the experienced life.

Especially for service users within compulsory mental healthcare, it is essential to offer activities that afford free and creative expression. For people treated through coercive measures, and perhaps even for people treated voluntarily within the locked ward, there are already many restrictions for what people are allowed to do, where they are allowed to be, and what they are allowed to say. It makes sense that people appreciate such free engagements with music.

Even though not entirely related to the field of mental healthcare, I find it relevant to mention an article by Tuastad and O'Grady (2013), in which the authors discuss music therapy as a *freedom practice* for people in correctional services. They argue

that engagement with music can facilitate for freedom in two ways: 1) 'escaping reality', which points at the 'free space in an authoritative, suppressing and institutionalized environment' (Tuastad & O'Grady, 2013, p. 210), and 2) 'entering reality', which refers to the process towards a normal life, and the sense of becoming re-humanized, and re-connected with an emotional life.

Music therapy and the participants' resources

In a qualitative study about user experiences, Randi Rolvsjord (2015) demonstrates that she does not only write about recovery- and resource- orientations, she also performs these mind-sets throughout her research; instead of interviewing the clients as passive receivers of therapy, she investigates what the participants do themselves to make music therapy work. Rolvsjord identified four main themes regarding the engagement and agency of the participants: taking initiatives, exerting control in sessions, commitment to the relationship, and engagement across contexts. Several of the participants took the initiative to engage in music therapy in the first place, and a recurring topic was the effort given to actually attending the appointments when having a bad day. In general the participants tended to give of themselves, contributing in the musical activities, and to committing to the therapeutic relationships and the music therapy processes.

Based on a structured literature review on music therapy within acute psychiatric settings, Carr et al. (2013) support a resource-oriented approach to music therapy, as they conclude that: '[…] an emphasis on building a therapeutic relationship and building patient resources may be of particular importance' (Carr et al., 2013, p. 17).

The attention towards the participants' resources seems to be important for understanding music therapy processes in mental healthcare. The focus on the participant engagement reminds us that music therapy is not something that can be applied to anyone, and be expected to merely work on its own. According to the citation below by DeNora and Ansdell (2014), in might argue that music therapy works because of the engagement and the different activities music affords, as a social and cultural form of art, and as a way to facilitate togetherness:

> In all cases it is not the music per se that accomplishes this enhancement but rather what is done with, done to, and done alongside musical engagement. It is music plus people plus practices plus other resources that can make a change for the better. In a sense then, music can do nothing and everything. Its potential to promote flourishing, even in extremis, is simply waiting to be tapped. (discussion)

4.3 Music therapy in compulsory mental healthcare

In this part of the chapter I will outline the literature that seems relevant regarding music therapy and compulsory mental healthcare. That is, I will look at music therapy within *forensic* psychiatric settings; as we will see, there is currently little research that describes music therapy in compulsory mental healthcare as similar to the Norwegian model described in chapter three, at least that is how it appears from performing literature searches as described below.

4.3.1 Investigating the literature

Literature researches were performed using the following databases: MEDLINE, The Cochrane Library, JSTOR, and Music Periodicals Database (delivered by ProQuest). Different searches were performed by joining *music therapy* together with *coerc**, *involunt**, *compuls**, *forensic*, *secur**, *admi**, and *commi**[50]. The searches were performed 19th-20th of October 2017. Only literature published in English[51] was considered.

No relevant literature was found when searching for music therapy AND *coerc**, *involunt**, or *compuls**, implying that there is little or no previous research regarding music therapy and compulsory mental healthcare written in English. Ten articles were found, however, when searching for music therapy and *forensic*. Also one additional contribution was found concerning music therapy in a high *security* psychiatric institution. One edited book was found, containing twelve independent chapters about music therapy in security hospital settings (Dickinson et al., 2013). Another related book was also looked at, although this was written more as a hand-on, practical guide for working music therapists (Dickinson & Haakvort, 2017). The investigation of the literature led me to further writings, especially through a previous literature review on the use of music in forensic settings (Coutinho, Hansen, Waage, Hillecke & Koenig, 2015a, 2015b).

50 The search words *admi** and *commi**, in combination with the JSTOR database, both resulted in more than 2000 hits, of which most seemed highly irrelevant at first glance. As the JSTOR database had not proven fruitful regarding either of the other search words, this huge amount of literature was excluded from the investigation. The mentioned search terms also gave a large amount of research results in combinations with the MEDLINE database; in these cases I chose to include the search word psych* and mental*, yet without any further success.

51 For pragmatic reasons I chose not to include the Scandinavian languages when searching for literature, and consequently I might have overlooked something. When thinking critically of the literature searches 18 months later (April 12th 2019), I admit that Scandinavian languages could have been included. I think that the main reason for excluding Scandinavian languages in the literature search was due to a belief that I had become familiar with the local literature on music therapy within mental healthcare, and that I would have known about relevant literature on music therapy and compulsory mental healthcare, at least findings from Norway. Similar literature searchers may include Scandinavian words in the future to be sure that relevant literature is not missed.

Music therapy literature, including the structured literature review on forensic settings by Coutinho et al. (2015a, 2015b), does not always differ particularly between regular prison- and psychiatric settings. Although there are clearly similarities between prisons and close mental health wards regarding the structural frames, the deprivation of freedom, and in potential mental health difficulties, I have not considered the literature that explicitly relate to prison settings. Thus, it has not always been easy to target relevant literature from previous reference lists. I have tried to look carefully for literature concerning music therapy in forensic mental health settings, but I cannot guarantee a perfect accuracy for this method; there probably exists relevant literature that has been overlooked in the search through both databases and through previous reference lists.

Altogether 39 sources were considered, including the twelve chapters of the book *Forensic Music Therapy. A Treatment for Men & Women in Secure Hospital Settings: A Treatment for Men and Women in Secure Hospital Settings* (Dickinson, Odell-Miller, & Adlam, 2013a). This part of the chapter is not meant as a complete literature review of the field, rather it can be understood as a relatively thorough investigation of music therapy in forensic mental health settings, with the aim of finding potentially relevant topics for this particular study.

4.3.2 Music therapy and forensic mental healthcare

Since there is seemingly no literature that directly addresses music therapy and compulsory mental healthcare similar to the Norwegian model, I looked at the literature on music therapy within forensic mental healthcare for relevant knowledge. There are some similarities between these two umbrella categories: In both settings service users suffer from different mental health difficulties, and in both settings service users are locked inside, partly in order to protect the society. Even though there are clear similarities between forensic mental healthcare and compulsory mental healthcare, there are also differences. Some service users within the Norwegian compulsory mental healthcare are sentenced to mental healthcare due to previous offenses, but most service users in compulsory mental healthcare are not, or they are dangerous to themselves only. The people within forensic mental health institutions have a history of felonies prior to admission. The level of security follows the impression of danger; in one description of music therapy within high security hospital frames we can read that: 'All assessment and therapy in high secure hospitals is carried out under high levels of observation. Therapy rooms have excellent visibility and other staff members observe from outside or inside the room' (Annesley & Jones, 2013). This description is quite far removed from my own experiences from working as a music therapist at a locked psychiatric ward in Norway, in which I have never felt unsafe or been observed from the outside. Comparing the international literature on forensic psychiatric settings with Norwegian

compulsory mental healthcare may also come with a potential gender bias; In Norway there is a marginal majority of male service users of 52% (Norwegian Directorate of Health, 2016a), whereas in the literature on forensic psychiatric settings an example from the British literature speaks of a majority of 88% in favour of males (Hughes & Cormac, 2013), and an example from the Dutch literature describes a vast majority of 94% for male persons (Hakvoort, 2015).

Despite the differences between the two, knowledge about what music therapy can be for service users of forensic psychiatric settings abroad may have a transfer value for what music therapy can be for services users in Norwegian compulsory mental healthcare. In both settings we have to do with music therapy for human beings with mental health challenges who are restricted to live normal lives by law.

The content of previous research

A few published articles present overviews of previous research; one article partly aims to outline theory, practice, and research of arts therapies in general in forensic psychiatry (Smeijsters & Cleven, 2006), and two articles refer to a literature review about the use of music within different forensic settings (Coutinho et al., 2015a, 2015b). Coutinho et al. (2015a, 2015b) performed a systematic review on the literature about music making in adult forensic settings[52], which was published in two separate parts; part I points to group interventions (Coutinho et al., 2015a), whereas part II is given the name *Case studies and Good vibrations* (Coutinho et al., 2015b). The authors conclude that most of the literature concerned 'qualitative and narrative reports including articles on group music therapy, educational music making, choir interventions, individual music therapy sessions and musical projects' (Coutinho et al., 2015a, p. 40). The review includes literature about the use of music in general, and not only music therapy. Also, the authors do not distinguish between regular prisons and other high security facilities meant for people with mental health challenges. And even though music therapy for people with a history of offences started within the psychiatric domain (Hoskyns, 1995), the majority of music activities today are found in more regular prison settings (Coutinho et al., 2015a, 2015b), and accordingly, not all of the findings in the literature review are directly relevant for this study. Nevertheless, I regard this literature review as a source for acquiring valuable information about the use of music activities in forensic settings. Relevant literature for this study has been found from reading the review by Coutinho et al. (2015a, 2015b).

52 By *forensic settings* the authors refer to: 'forensic psychiatry or correctional facilities at different security levels' (Coutinho et al., 2015a, p. 40).

Most of the contributions in the literature on music therapy in forensic psychiatric settings are devoted to descriptions of different music therapy programs, methodological concerns, or theoretical legitimisation of the music therapy approaches within forensic settings (Dickinson, 2006, 2013a; Dickinson & Gahir, 2013; Fulford, 2002; Gallagher & Steele, 2002; Hakvoort, 2015; Hakvoort & Bogaerts, 2013; Maguire & Merrick, 2013; Nolan, 1983; Reed, 2002; Roberts, 2013; Short, 2017; Smeijsters & Cleven, 2006; Spang, 1997). Already in 1987, Thaut described music therapy techniques and stressed the importance of music therapy in forensic settings due to the high number of mental health challenges also in regular prisons. Smeijsters and Cleven (2006) interviewed working music therapists about forensic care, aiming to define 'consensus-based treatment methods' (Smeijsters & Cleven, 2006, p. 37). Hakvoort (2015) proposes a step-by-step guide of a *rap music therapy*. Hakvoort and Bogeart (2013) have tried to pave the way for a *cognitive behavioral music therapy*, and Stella Compton Dickinson presents her engagement with *Cognitive Analytic Music Therapy*, highly inspired by the psychodynamic tradition (Dickinson, 2006, 2013a; Dickinson & Gahir, 2013). Nolan (1983) also seems to be inspired by the psychodynamics in his description of a case study using both *supportive music therapy group* and *insight-oriented guided imagery and music*. Other descriptions of music therapy programs within more or less different perspectives are also found (Fulford, 2002; Gallagher & Steele, 2002; Reed, 2002; Roberts, 2013; Short, 2017; Spang, 1997)[53]. One book chapter by Maguire and Merrick (2013) incorporates recovery thinking, describing a service user-led music therapy group.

I have only found a few intervention studies that have been performed regarding music therapy and forensic mental healthcare. Hakvoort, Bogearts, Thaut and Spreen (2013) found an improvement of anger management skills for persons in forensic psychiatric care that participated in a standardized, anger management music therapy program. Jeon, Gang and Oh (2017) found a decrease in psychiatric symptoms for people participating in the *Nanta-music therapy program*. In an old interventions study based on self-rating scales, Thaut (1989) found that music therapy participation can seemingly promote change in mood/emotion, relaxation, and thought/insight. Through a pilot study, Lawday and Dickinson (2013) investigated the change in how people relate to others after participation in a group cognitive analytic music therapy program; although the study only relies on a few participants (N=4), the results indicate 'that risks of harm were reduced during the treatment period for those who participated. There were fewer incident reports for those engaged in the therapy than in their control period

53 I did not find the original source from Spang (1997), but refer to this source based on the description in Coutinho et al. (2015a, pp. 43-44). The original source is, for the sake of keeping things correct, included in the literature list.

and in comparison with the results for the nonattender' (Lawday & Dickinson, 2013, pp. 198-199).

A multi-faceted book[54] about music therapy in forensic psychiatric was published in 2013, which mainly aims at music therapists and music therapy students with special interests in this area of practice (Odell-Miller, & Adlam, 2013b). In this book we can read about the frames of high security settings, including necessary precautions and their implications for practice (Annesley & Jones, 2013), supervision for the music therapists (Odell-Miller, 2013), and cooperation with other health professionals and staff members (Hughes & Cormac, 2013). We also find examples and descriptions of different clinical work, mostly through case descriptions, together with recent academic research studies.

Another book, *The Clinician's Guide to Forensic Music Therapy*, was published in 2017; this book includes some of the same perspectives as the first book mentioned, but with a stronger emphasis on two treatment manuals, namely the Group Cognitive Analytic Music Therapy (G-CAMT) and Music Therapy Anger Management (MTAM) (Dickinson & Haakvort, 2017).

The dearth of the user perspective

To my knowledge no previous studies have looked at the user experience regarding music therapy within compulsory mental healthcare. Solli and Rolvsjord (2014) state that there is generally a scarcity of research regarding user perspectives on music therapy in mental healthcare. Based on the literature searches performed for this study, the same might be is true regarding music therapy and compulsory mental healthcare. One older study within a forensic setting asks for participant feedback, through questionnaires as part of an intervention study of self-rated psychological change (Thaut, 1989). Two studies aim at the experiences and knowledge of the music therapists within forensic psychiatric settings (Codding, 2002; Smeijsters & Cleven, 2006). Also, one study explores 'staff responses to the implementation of a music therapy service for patients in their care' (Hervey & Odell-Miller, 2013, p. 206).

Occasionally, different texts integrate shorter user narratives. In a text about the recovery perspectives and a user-led music therapy group, we meet 'Barry'. After more than 30 years at high security hospitals he takes the initiative to form a band, taking the roles as the frontman and the song writer: 'My songs are about many things, but chiefly about lost love, the courage needed to face life without a partner… and hope for the future' (Maguire & Merrick, 2013, p. 112). Such quotations provide useful insight; from a short statement we can learn a lot about the personal thoughts, conflicts and processes that

54 *Forensic Music Therapy: A Treatment for Men and Women in Secure Hospital Settings* (Dickinson et al. 2013).

occupy Barry's mind. Even though certain user narratives exist within the literature, I believe this are not enough. User perspectives can provide relevant knowledge when trying to adapt useful and meaningful therapy processes. We will return to the story about Barry later on in this chapter.

This researcher's critical remark on behaviour in forensic music therapy

During this chapter I will ask a few critical questions about the examples of forensic music therapy found in the literature, mostly concerning the seemingly strong emphasis on the behaviour of the service users. As a music therapist and researcher with no practical experience from high security settings, I need to act cautiously when criticizing practitioners and scholars within the field of forensic psychiatry. Still, I feel the urge to explicate that the way we speak of forensic music psychiatry will affect how we understand forensic psychiatry, and how we understand the overall values and goals of music therapy within this domain. If we speak about negative behaviour, look at negative behavior, and treat negative behaviour, we might forget the personal history that leads to this way in the first place.

4.3.3 Relevant knowledge from the previous literature on music therapy and forensic psychiatric settings

In the following we will have a brief look at some of the aspects of the forensic music therapy literature that I have found relevant for this study. We will see that music therapy is often used as a way to work with emotions, and that music therapy can reach people who are not motivated for other therapeutic approaches. Through some quantitative investigations the previous literature also implies that music therapy can promote change.

Music therapy and emotions

One reoccurring theme within the forensic music therapy literature is that of emotional works. Or perhaps it is more accurate to speak of an emotional awareness connected to working with music. The literature on this topic is mostly devoted to qualitative descriptions of music therapy processes and case examples; thus, these lines of thought appear through relevant theory and practical knowledge more than they are the results of empirical research studies per se. Nevertheless, this is a relevant area for understanding the potential roles of music therapy within compulsory mental healthcare.

Occasionally service users with mental illnesses lack an adequate emotional spectrum, or at least they lack contact with some of their emotions; especially for service users

suffering from previous traumas, certain emotions can be repressed or unacknowledged. In some cases music therapy might work as a door opener, providing new possibilities to acknowledge and experience difficult emotions (Dickinson, 2006, 2013b; Dickinson & Gahir, 2013; Loth, 1994; Nolan, 1983).

Music therapy is also described as a tension releaser, and music therapy is said to provide a safe place to express tough feelings (Dickinson, 2006, 2013b; Dickinson & Gahir, 2013; Loth, 1994; Nolan, 1983; Spang, 1997). In music therapy one might express, or even act out, feelings of anger in adequate, creative and supportive ways. And within group settings music therapy may provide a place to experience, express and talk about these emotional processes together with peers. In one case example, a service user is challenged to withdraw to his room and to make use of rap as a coping strategy in stressful situations, in order to alleviate tension (Hakvoort, 2015).

Music therapy and motivation

One common denominator for music therapy in forensic settings appears to be that music therapy is applied when other approaches show no effect, or are rejected by the participants themselves. In their literature review on music in forensic settings, Coutinho et al. (2015b) conclude that: 'music attracts prisoners who refuse other treatment options and participants in music programs might display more engagement in other educational activities' (p. 57). Thus, music therapy and other music activities are not only motivating in itself; such participation may also facilitate for further engagement and participation.

The previous literature depicts a couple of examples in which service users are institutionalized for a long time before partaking in music therapy. Dickinson and Gahir (2013) describe a man who lived within high security circumstances for more than ten years without participating in treatments or offence-related work, until he had the opportunity to learn to play the violin, just like his grand-father did. Prior to music therapy, the participant had not committed to any trusting or sustainable therapeutic relationships with female staff, but the interest for music therapy enabled both his will to participate and developed his relational sphere. And in another case presentation by Maguire and Merrick (2013) we meet Barry who considers himself done with the different therapeutic approaches he has been offered; he even states that he has retired from therapy. Nevertheless, he contacts two music therapists through a letter, taking the initiative to form a band within the closed ward. These to examples described above depict cases in which service users have opposed therapeutic interventions for more than a decade, yet they are motivated to participate in music therapy. In both examples music therapy represents an approach that reaches the service users in new ways, and

in both cases music therapy participation facilitated for such a degree of substantial change that the levels of security were subsequently lowered.

Perhaps there will always exist some examples of people who remain dangerous for a long time, who also need to spend most of their lives in high security wards. Sometimes I cannot help but wonder how much effort and creativity has been given when people are not recovering, or not even participating in activities, after so many years in institutions. Perhaps the professional approaches do not always fit with the individual service user, as Annesley and Jones (2013) put it: 'It is also important to acknowledge that patients can sometimes be dismissed as 'not engaging' when it may be that the type of therapy that is offered does not meet their needs' (p. 23).

For some service users music therapy is reported to be the favourite activity within the institution (Gallagher & Steele, 2002). Music therapy might also reach people who are otherwise regarded as unattainable for therapy (Coutinho et al., 2015a). Also, participation in music therapy can lead to engaging in music as part of the participants' leisure time, both in-between music therapy sessions and as a hobby outside of the institutions (Coutinho et al., 2015b; Spang, 1997). Sometimes the main goal for music therapy can be to promote motivation for treatment, and especially for service users who demonstrate resistance (Hakvoort, 2015,). In an intervention study on different effects of a music therapy program for service users with substance abuse and mental health challenges, Gallagher and Steel (2002) found that 91% of the participants participated actively during the sessions, out of 188 documented participations.

Documented changes through music therapy in forensic settings

Coutinho et al. (2015b) conclude in their literature review that several studies indicate positive long-term effects in various ways after participating in music programs:

> (i.e. increase in confidence, communication and social skills; improved relationships with staff; decreased levels of self-reported anger; a greater sense of calmness; increased participation in other educational programs; and positive emotional, psychological and behavioral change). (p. 56)

This cited review, however, addresses music making in general and include a large variety of prison settings. Consequently, not all the findings from Coutinho et al. (2015a, 2015b) do necessarily apply to the field of compulsory mental healthcare.

A meta-study presents music therapy as an approach to improve mental health for people with a history of offenses in correctional settings (Chen, Leith, Aarø, Manger &

Gold, 2016). This meta-study targets wider than the aim of my own investigation, but I choose to include the study because it provides useful knowledge regarding mental health challenges in forensic psychiatric settings. It also tells us something about the quantity and quality of effect studies on correctional settings. After searching for both randomized controlled trials and quasi-randomized controlled trials, the authors included only five studies. Despite the small number of effect studies, the meta-analysis implies that music therapy can improve both self-esteem and social functioning. The effects of music therapy on anxiety and depression seem to rely on the quantity of sessions; the effect size significantly improved for therapy processes with more than 20 sessions, compared to therapy process with less than 20 sessions. The study found no effect variations between different music therapy approaches (Chen et al., 2016).

Jeon, Gang & Oh (2017) investigated the effects of a special music therapy program called the Nanta-Program, for forensic service users diagnosed with schizophrenia. The program included 12 sessions over 12 weeks. The Nanta-program is described as a group music therapy program focusing on non-verbal rhythmic music with an emphasis on low frequency drumming, with both western rhythm and Korean Samulnori rhythms, which are easy to join for the participants. The authors studied the effects regarding psychiatric symptoms (The Brief Psychiatric Rating Scale BPSR), interpersonal relationships (The Relationship Change Scale RCS) and Quality of Life (The Subjective Well-Being in Patients with Scizophrenia under Neuroleptics SWN-K). The authors found significant improvements regarding the total score on psychiatric symptoms ($p=.01$), mostly based on improvements on the activity subscale ($p<.001$), with close to significant findings regarding the subscales of negative symptoms ($p=.061$), positive symptoms ($p=.085$), and the resistance ($p=.06$). Non-significant findings were found for reducing affective symptoms ($p=.48$). They found a slight improvement regarding interpersonal relationships and no effect on the quality of life. Since the study by Jeon et al. (2017) is based on a music therapy program with only 12 sessions, I find it relevant to question whether the authors could have found other effects if they had made use of previous knowledge regarding the probable relationship between effect size and the number of sessions needed (Carr et al., 2013; Chen et al., 2016; Gold, Solli, Krüger & Lie, 2009). Another study confirms the potential for music therapy to promote a change in the participants' ability to relate to others, and to prevent unwanted incidents (Lawday & Dickinson, 2013).

In one study Hakvoort & Bogaerts (2013) report that participation in music therapy improved the participants' anger management skills. They also found an improvement in coping skills for the participants. On the other hand, this study is referred to in the meta-study by Chen et al. (Chen et al., 2016), which concludes with no significant outcomes for changes in behavioral management from the overall meta-literature.

Based on self-rating scales, before and after three months of music therapy, one older study implies a positive change in all three of the investigated parameters: relaxation, mood/emotion, and thought/insight (Thaut, 1989). Also one study investigated three years of music therapy participation retrospectively, through intervention notes written by other present health professionals (Gallagher & Steele, 2002). The observing health professionals reported a positive change in affect for 68% of the participants, but self-reports showed that 68% of the participants did not experience a change in mood during the sessions (Gallagher & Steele, 2002). The study by Gallagher & Steele (2002) shows indigenous findings, which may in part be explained by their research method. The research seems to be mostly based on individual session notes that do not take into account the probable cumulative effect of participating in several music therapy sessions (Chen et al., 2016; Gold et al., 2009; Hakvoort et al., 2013).

There is a small amount of literature that documents the effects of music therapy within the field of forensic mental healthcare, and there is need for more research on this topic (Chen et al., 2016; Coutinho et al., 2015a, 2015b). The current research base, however, points at numbers that are promising for further research on music therapy within forensic psychiatric settings.

Music therapy for promoting behavioural change

Several examples in the literature address behavioral perspectives of the music therapy process (Dickinson & Haakvort, 2017; Hakvoort, 2015; Hakvoort & Bogaerts, 2013; Hakvoort et al., 2013; Smeijsters & Cleven, 2006). In a way this is logical; in forensic settings health professionals meet service users who have offended[55], and the health professionals wish for the services users to avoid offensive behaviour in the future. And seemingly, arts therapies and music therapy can prevent recidivism and promote alternative coping skills (Hakvoort, 2002; Smeijsters & Cleven, 2006). If the main problem for a person is an uncontrollable and irrational rage, then cognitive techniques and psychoeducation can prove fruitful for coping with frustrations in everyday life.

I support the notion that forensic psychiatry is more about rehabilitation and security than it is a matter of punishment:

55 The term *offender* is frequently used in the literature, but I try to avoid this word. Dickinson and Hakvoort (2017) mention that the term offender may be perceived as pejorative, but they still use the term for expedient reasons. I believe that health professionals need to distinguish between the person and the offensive actions *by* the person. The instant we talk about the person *as* an offender, we intrinsically attribute personal traits to the person; to me it makes more sense to speak about the person as a service user who has previously acted offensive, but who will hopefully act otherwise in the future.

> The purpose of treatment for people with mental disorders, who have committed offences, is towards recovery rather than punishment (Shepherd, Boardman, & Slade, 2008). This process promotes risk minimisation, rehabilitation and restorative justice. An extensive psychiatric assessment explores the motivation for offending behaviour. In therapeutic treatment, patients are encouraged to look at themselves with a view to gaining insight into their own behaviour and to understand the reasons why they committed an offence (Dickinson & Haakvort, 2017, p. 13).

But it seems that the aim of forensic psychiatric institutions are often more about protecting the society outside of the forensic units, more than they are a matter of recovery for the service user:

> Treatment meets the needs of patients after thorough assessment of their risk behaviors. Its purpose is to meet the needs of society for safety and security. Treatment should also miminise the risk of reoffending by enhancing patients' functional skills towards recovery (Douglas Broers 2006). This involves providing them with anger management skills social skills, coping skills and relational abilities, aimed towards the reduction of impulsive behaviours in a way that builds on their strengths and interests. (Dickinson & Haakvort, 2017, p. 15)

At least in the way forensic psychiatry is described by Dickinson and Hakvoort (2017), it can be interpreted in such a way that the goal of forensic psychiatric care primarily orbits around security issues, and that the sake of mental health recovery therefore is given secondary priority.

From a humanistic and recovery-oriented perspective, however, health professionals need to be careful about focusing much on superficial symptoms. The behaviour is of course the dangerous part, but there are always personal stories, emotions, and experiences prior to that behaviour. And with a disability-perspective in mind, as presented in chapter two in this thesis, we need to understand the individual's behavior through a larger cultural context; often it is the context that disables the individual, for instance through prior neglect or abuse from care givers or close others. At least in the long run, health professionals need to promote hope and afford lots of meaningful experiences; eventually service users might have a reason to participate and to regain control of their own recovery processes (Solli, 2014). And then, hopefully adequate behaviour will follow. Such a positive spiral of music therapy and recovery can help us to understand

why 'music making is often found to have therapeutic impact without a primary defined therapeutic goal' (Coutinho et al., 2015b, p. 57).

Sometimes we can read about an ambiguous approach to therapy goals, stressing both behavioral change and empowerment of the individual: 'The treatment goals are related to behavioral change, anger management, stress regulation, as well as improving healthy self-esteem, self-confidence, and expression of emotion' (Hakvoort, 2015, p. 184). Traditionally we might understand these treatment goals as belonging to different philosophical views on health and healthcare. However, we can also understand this pragmatic and multi-faceted approach as a way to incorporate recovery- and resource-oriented perspectives into a healthcare system that is already ruled by other discourses and accentuated demands about cost efficacy and measurable evidence (Dickinson & Haakvort, 2017; Short, 2017).

The recovery perspective in forensic music therapy

As we will see below, the primary goal of mental health recovery and empowerment is not all missing from the forensic music therapy literature. Even though behavioural change has received a great deal of attention within the forensic discourses, there are also aspects of humanistic and recovery-oriented discourses within the literature. Jeon et al. (2017) describe the main goal for forensic psychiatric rehabilitation to prevent crimes and maintain public safety, which I would regard as a behaviour-oriented aim; however, the authors look for outcomes of music therapy regarding the quality of life and interpersonal relationships, which I regard as more humanistic- and recovery-oriented measures towards mental health services. Also Galagher and Steele (2002) seem to work according to a humanistic ontological understanding of health as something multi-faceted and complex: 'The treatment approach for criminal offenders who are dually diagnosed must address all aspects of the individual's life, including social, emotional, physical, spiritual, family, and criminal behavior' (Gallagher & Steele, 2002, p. 117).

The case study about Barry, which has been referred to earlier in this chapter, describes a therapy process that was highly informed by the recovery-perspectives (Maguire & Merrick, 2013). After living in high-security wards for more than 30 years, Barry took the initiative to form a band, together with a fellow band member hospitalized for more than 20 years; altogether, two occupational therapists, a hospital chaplain, two music therapists, and two participants were involved in the weekly rehearsals. The project was predetermined to last for nine months, and that they would close the process after some selected songs were arranged, rehearsed, and recorded. The authors remark: 'This fixed term contrasted starkly with Barry's own seemingly interminable stay in high secure services.' (Maguire & Merrick, 2013, p. 112).

Maguire and Merrick (2013) discuss the conundrum of going into a band setting as the role of band members or supporters for the frontman. But later they experienced that the front man paid more attention to the collaborative process of the band, and the development of the music, and eventually he seemed to appreciate input and constructive feedback from the occupational therapists. The experiences of leadership and the practicing of new roles seemed to facilitate for more change than did the former 33 years at high security units. In the beginning of the process Barry had trouble with walking all the way to the rehearsal locations, but eventually the authors observed great changes in both his appearance and symptoms of health:

> […] he lost weight and became visibly fitter and healthier. His long grey ponytail was cut into a neat new hairstyle, and he became considerably brighter in presentation, and paradoxically demonstrated a new level of humility about his own performance. […] In Barry's case, this was by means of improving his general wellbeing and sense of self-respect and agency. (Maguire & Merrick, 2013, p. 116)

Maguire & Merric (2013) discuss the golden mean between security and treatment; both real life experiences and examples from the literature suggest that the level of security should neither get too sloppy, nor too strict. The authors stress that a reduction of security precautions can eventually reduce the need for such matters:

> It is clear that staff must provide more than just security, so that patients' lives are made more meaningful. Such a sense of meaning encourages responsibility on the part of the patient that is a further feature of the recovery approach (Shepherd et al. 2008) and interestingly, helps to make the hospital more secure as patients adopt a less oppositional stance and focus on their own recovery. (Maguire & Merrick, 2013, p. 107)

In the case presentation Maguire and Merrick (2013) discuss the potential implications of the rehearsing facilities; mostly for practical reasons the band walked together to the hospital chapel where they set up the music equipment, a room that can be associated with symbolic meanings such as transformation and redemption. As a music therapist, I agree with the authors that the appearance and experienced atmosphere of the facilities are relevant. The symbolic and ceremonious parts that follow the chapel facilities might be of importance. And maybe it was important that the rehearsal facilities were in overall experienced as *something else* than the general ward, as remarked by the research participant P1 in Solli and Rolvsjord (2014):

> P1: There's a freedom from all possible illness, then… and psychosis and everything that's bothersome. There's something good and creative in this room.
> HP: Did you notice that when you came into the room now?
> P1: Yeah, I mean I've always noticed that it's good to be here. It's peaceful, you know. It's peaceful in this room. There's no disease in this room. There are no negative spirits here, somehow. There's peace. (p. 73)

Other studies within forensic music therapy point at similar aspects. The music therapy room can be experienced as peaceful, and music therapy can be work as a safe place, a place where people within high security settings are free to practice decision-making (Loth, 1994), and a safe place to express hopes, fears, and mental states together with peers (Spang, 1997). The safety and trust developed through the therapeutic and musical relationships can also open for the sharing of individual stories and feelings (Dickinson, 2006).

Occasionally the music therapy participant, or the whole band, can perform live music or play recorded pieces of music from music therapy in the hospital environment, accompanied by a potential boost in self-esteem (Hakvoort, 2015). And as Coutinho et al. (Coutinho et al., 2015b) conclude after investigating the existing literature, such live performances can facilitate for several challenges and developmental by-products:

> To achieve a goal such as performing in a concert, many smaller steps need to be taken involving cognitive, emotional, musical and social skills. For example, participants need to learn how to work in a team and simultaneously take over responsibility for their own musical part. Furthermore, the inmates have the possibility to contribute their own, creative ideas and to think of ways how to put them into practice. (Coutinho et al., 2015b, p. 55)

In the case of Barry, his songs were performed and heard within the institution, and eventually the tunes became part of a common culture within the ward.

To promote hope is viewed as an important part of recovery-oriented works (Jacob, 2015; Solli, 2014), and such views on recovery are also found in the forensic settings:

> The clinical teams in long-stay settings have an important role in holding and sustaining hope, however difficult the circumstances, until such time as patients can regain some hope of their own recovery and a better future for themselves. (Hughes & Cormac, 2013, p. 71)

Even after more than 30 years in high security settings Barry, is able to sustain the notion of hope through his engagement with music and music therapy: 'My songs are about many things, but chiefly about lost love, the courage needed to face life without a partner… and hope for the future' (Maguire & Merrick, 2013, p. 112).

4.4 Music Asylums

4.4.1 The affordances of music

Throughout this chapter we have encountered several ways in which music and music therapy may help people in terms of mental well-being. We have seen some examples of what people benefit from music therapy, in which settings music therapy can be helpful, and from what symptoms people may be relieved from through music therapy. Some user perspectives also describe important aspects of what music therapy gives, and why music therapy is actually helpful. The reason(s) music therapy is helpful is of course multi-faceted, and most music therapists probably agree that the potential 'effects of music therapy' are afforded by different sides, or even by-products, of participation in music activities, such as: changes in levels of released biochemical messengers (e.g. serotonin, cortisol, dopamine, oxytocin, adrenaline, and noradrenaline (Gangrade, 2011)), activation of different parts of the brain, activation of different body parts, experienced togetherness, learning, and sense of mastering. What people get out of music therapy is intrinsically related to *who* they are, *what* they like, *how* they partake in music therapy, *why* they partake in music therapy, what they *want* to get out of music therapy, what they *think* they will get out of music therapy, and much more. In other words: it is hard to describe in few words what it is with music that makes it helpful in therapy.

The music sociologist Tia DeNora (2000), however, has provided a useful perspective on the *affordances* in music and music activities, and perhaps changed the question from "what comes from music?" to "in what ways do we understand and appropriate potential outcomes and meanings in music and music activities?" That is, instead of expecting an automatic transferral of (positive) outcomes from the music to the consumer, we need to look for a broad understanding of what music is in our culture, how music is positioned in our lives, how and when music is present, what music can be for us – and in every way music is, or can be, appropriated. With DeNora's perspective on affordances, it makes sense to think of what music and music therapy can possibly afford, rather than what it is with music that directly creates well-being.

4.4.2 Asylums

Further, in a later book DeNora (DeNora, 2016) introduces the term music Asylum as a description of '… a place and time in which it is possible to flourish' (p. 1).[56] With this term, I believe, DeNora brings us closer to an understanding of the 'field' or 'space' in which it is possible to appropriate the potential affordances in musical activities. I will now take both the time and space to linger in the music asylum term for a while, as it proves useful for later discussions about what music therapy can be for people within compulsory mental healthcare.

DeNora argues, that despite the evidence of outcomes, and despite the search for the 'active ingredient' in music and health, we still have not come closer to answer *how* music works. According to DeNora the ontology of music is too often neglected, and that in order to come closer to an understanding of music and health, we urgently require a social and ecological paradigm:

> … a paradigm that understands music and musical activity as embodied social practice and understands the practice as responsible for what we come to understand as music's health-promoting properties. (DeNora, 2016, p. 6)

Further, DeNora argues that: 'it is in music's role as a cultural practice and as a meaningful and shared practice that we can identify its active ingredient for wellbeing' (p. 6), and through the introduction of music asylum DeNora will make an 'account of how illness, health, the body, mind, culture and agency are intertwined' (p.6).

DeNora depicts an ecological understanding of health, seemingly in line with the dis/ability perspective I have outlined in chapter two: DeNora argues that the dichotomy between health and illness is misguiding for a constructive understanding of health per se, and that perceived health is very much dependent on the surrounding milieu in which the potential boundaries or '~~disabilities~~' are maintained or handled in different ways. As problematized in chapter two in this dissertation, DeNora also points at the danger of understanding ~~disability~~ as an individual responsibility in cultures that are indeed maintaining symptoms or challenges as actual disabilities. DeNora (2016) goes quite far in her distance to a sole-biological perspective on health, and states that 'all health/illness is mental/physical, cultural and situationally varied' (p. 31).

The inspiration for DeNora's term music asylum comes from Erving Goffman's work *Asylums* from 1961. The term Asylum is meant to generally represent: 'a place of residence

56 The Ph. D. Adjudication Committee recommended this book and pointed out its relevance for in their preliminary report of this dissertation.

and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life (1961:xiii)' (DeNora, 2016, p. 34). One way to understand the context of an asylum, as DeNora explains (through Goffman), is the metaphor of the front- and back-stage regions: the waitress can return to the kitchen from the public performance in the restaurant area, as well as the performing artist may retire in the greenroom after the stage appearance. Most people have areas and times in their lives in which they go on and off stage: one daily self-appearance could consist of being off-stage in the morning, being onstage on the metro, being off-stage in the office, being on-stage in a meeting, being off-stage in the toilet, being on-stage in the grocery store, and so on. In the back-stage area we are freed from cultural constraints, such as norms and expectations from others, and may thus relax and 'let one's guard down' (DeNora, 2016, p. 36). In Asylums, and perhaps within compulsory mental healthcare for the sake of this dissertation, the frames are however altered:

> The very framing of what is public and what is private (which is what counts and does not count as cultural) becomes increasingly prominent in Asylums and is linked to the politics of identity, in particular to the classification and differentiation of the well from the ill. (DeNora, 2016, p. 36)

Especially when people lose touch with their back-stage areas, and thus are being continuously monitored by others as performers on the front stage, their capability to fit with others expectations will decide whether their performances are regarded successful or unsuccessful. The success of the performing individual depends on the will and capability to adapt to the surrounding cultural codes, thus the framework of free agency is in reality limited due to ruling discourses: 'The same performance is not the same performance because it is contextualized or framed (locally) in different ways through the act of perception' (DeNora, 2016, p. 40). Well-being, then, is shaped in relation to the environments, and whether the performer makes use of the culture as tools for success, or whether the performer performs unsuccessfully due to cultural limitations.

The asylum can be regarded as both off-stage and on-stage. Within the asylum one might be on-stage with others in the asylum, yet at the same time the asylum may function as the back-stage area of the world outside:

> … asylum can be defined as a space, either physical or conceptual, that either offers protection from hostility (a refuge) or, more positively, a space within which to play on/with one's environment, whether alone or in concert with others. (DeNora, 2016, p. 47)

As DeNora (2016) explains it, asylum is both: 1) ' … a place where one can relax, let one's hair down metaphorically' (p. 47), and 2) '… a room in which to remake features of one's world, to play in ways that foster changes in that world' (p. 47). The room, though, is merely symbolic, and does not have to do with physical boundaries such as walls or roof. Each performance will necessarily happen within time and space, yet the asylums 'do not need to be of any temporal duration' (p. 48). Within an Asylum (with a capital a, referring to the institution like Asylum) there are also asylums from the Asylum, such as recreational activities, or *removal activities*. The asylum, or the 'room', may also be *refurnished*, when we take actions to create pleasant vibes to the room for oneself and for others. So far we have encountered some of the aspects in Goffman's theory on asylums that DeNora have dealt with. As we proceed we will look further into some music-specific perspectives on asylums, with an emphasis on DeNora's developed theory on musical asylums, inspired by Goffman.

4.4.3 Music Asylums

Music activities may create rooms, used as removal activity to make the time pass by, or as refurnishing to make the time more pleasant. As DeNora points out, music also inflects space. And as the sound waves pass by, the music may indeed cross the boundaries between public and private spheres. Listening to music through headphones on the morning train, either as removal from other passengers or as refurnishing the travel, mostly targets the personal space. When the volume is turned up to loud, however, the music also enters the public sphere, especially if seated in the 'silent car' of the morning train. It is easy to see that music at least has the potential to fill the room, and that music affords a meeting point for several people at a time. Especially at stadium concerts music refurnishes the collectively shared room for thousands of people, and according to Wikipedia Queen still holds the record for the highest-attended concert with 300 000 people. Needless to say, music may indeed fill up lots of space, and depending on the technology of the sound systems, there really are few boundaries of how many people *can* partake in the same musical space and wave their hands and sing along to the beats of the music, together with thousands of other fans. At the same time, one might also visit the opera house alone, not really talking with anyone, and watch the Swan Lake, and perhaps experience the room as only a personal one, although sharing time, space, and music with others. And as DeNora points out, 'the public and the private are by no means mutually exclusive terrains' (DeNora, 2016, p. 57).

To distinguish between removal and refurnishing asylums, DeNora explains that:

> […] on the one hand, asylums can be created through removal; they can offer protection against a distressing social world. As such, the asylum is a place for fantasy, day-dreaming and the recovery of personal time and rhythm. On the other hand, asylums can be created through refurnish, and here they involve collaborative play that remakes or renegotiates social worlds. (DeNora, 2016, p. 55)

There seemingly is a social element that separates the two ways of achieving asylums. As for the examples mentioned above, we can say that to go and see the Swan Lake alone may be regarded a removal strategy, while singing along to a rock band together with others looks more like a refurnishing strategy to achieve asylum. A more obvious refurnishing strategy for achieving asylums, according to DeNora, is to engage in musical activities such as bands or choirs.

Although the social dimension of the refurnished room comes with cultural demands and expectations from others, the prize is high for performing well on this front-stage: 'Refurnishing allows actors the latitude to be and act in certain ways, to feel at ease while so doing and to pursue various projects and trajectories that involve navigating (which is also the making of) social space/time' (p. 55).

There are also clear similarities between the two strategies for achieving asylum: 'In both forms of asylum, individuals and groups can establish ontological security, a sense of at least partial control, opportunities for creativity, pleasure, self-validation, a sense of fitting comfortably into some space, scene or milieu, flow and focus' (p. 55). The positive outcomes of the social refurnishing strategy, as I understand it, will still depend greatly on the performer's ability to adapt and to make use of the culture as tools to perform successfully within local, ruling discourses. If performed successfully, however, the performer may achieve even more strategies to succeed in refurnished rooms in the future. If stuck with removal strategies, on the other hand, there is a potential risk of alienation, absence of social bonds, with little or no practice in social skills for future socialisation.

An important feature of music is that music affords collective participation, at least partly through the semiotics of the music (DeNora, 2016). The messages or meanings in the music come from direct utterances and/or from traits that needs to be interpreted within local discourses. The semiotics in the music affords people to share experienced meaning in the music with peers, or even to send messages to rivals. For instance, the Norwegian artist, Moddi, released an album in 2016 called Unsongs, in which he interprets and performs twelve songs that have previously been banned in twelve different nations, with an overweight of regime critical lyrics (Knutsen, 2016). Needless

to say, the messages in certain music is more than some people tolerate. Music can also connect people, as we saw in Norway after the tragic terror attack on politically engaged adolescents on Utøya, July 22th 2011 (Knudsen, 2014; Maasø & Toldnes, 2014). A few songs were played at memorial ceremonies across the nation, and were spread in social media, and thus united millions of Norwegians through new meanings of grief, but also of love, youth, openness, and democracy. Music affords inter-relational rooms of shared meaning and togetherness.

Musical rooms can afford a great variety of activities and opportunities for expression. As an example, DeNora describes in her book a music project named BRIGHT (Borough Centre for Rehabilitation, Interaction, Group Activity, Hospitality and Training), located at a centre for people with mental health challenges. Based on the description of BRIGHT mentioned both by DeNora (2016) and DeNora & Ansdell (2014), it seems as though BRIGHT is the same thing as SMART described later by Ansdell and DeNora (2016). I will therefore use the name SMART when referring to this project further in the dissertation. SMART is a place that affords meaningful place to visit for both people within current treatment programs and others in the community with need for adapted milieus, or simply a safe place to meet for a coffee with peers.

Ansdell, among others, have established a weekly music café at SMART. Several musicians attend the music activities regularly, and others in the open café area group together at tables and sing along. Through a graphic illustration DeNora (2016) describes different elements in the musical room, such as different genres, different band constellations, different instruments, different roles in the soundscape, and changes between compositions and free improvisation. Participants and audiences may slide in or out of the musical togetherness, and take different roles within the share musical room. Perhaps it takes time for some of the musicians to go from curious observers in the audience to active music makers or soloists, but the café is open and seem to afford a flexible room in which people may adapt as they plead. The musicians in SMART have also performed concerts outside of the café, and in a way left the on-stage asylum in the café for an even more on-stage asylum on other venues. Sarah, one of the music therapists involved in the SMART music project, wrote the following in her field note diary a few days after the SMART singers' first public concert:

> Lovely atmosphere, everyone clearly pleased with themselves after the concert. Comments made about the audience, their participation, how many there were etc. and how special it was on the ward, in particular the enthusiastic man who asked for 'Swing Low'. Lots of talk about musical achievement, not 'mental health' ones. (DeNora, 2016, p. 123)

It seems as the participation in the music asylums within the SMART café, and their ability to adapt into the cultural codes within the music group, has afforded even new asylums and further capabilities for performing successfully on public stages in the future.

DeNora makes a point of the aesthetics in music, and problematizes the quality of the music in relationship with its potential outcomes; DeNora separates between 'what music is' and 'what music does' (DeNora, 2016, pp. 123-125). Without heading deep into this discussion, I agree that this is a valid discussion, and that every working music therapist could benefit from reflecting upon this topic (if they do not already). I believe that people are generally into music because there is 'something' in the music that move, whether it is the expression of the voice, the flow in the lyrics, the beat of the bass drum, the groove of the slap bass, the harmonic structure of the chorus, the timbre of the church organ, the chorus effect of the electric guitar, og the soundscape of the whole symphonic orchestra. Although there is much more to the musical/aesthetical experience than mere sound, I do not believe that the extra-musical elements, such as band outfits, smoke machines, or chandeliers, are enough to engage the audience on its own. Music affords aesthetics, and as DeNora argues, I believe that the aesthetics is a vital reason for the possibility for achieving music asylums, both as removal and refurnishing strategies. I also believe that whether the music is considered 'good', or whether the outcomes of the musical activities are 'good', is dependent on the given situation. Some music is de facto more thought through and worked through than others, but the amount of work hours behind a musical piece is hardly a valid measure of the potential musical experience. As a working music therapist, currently with at least one foot within community- and recovery-oriented settings, I still value different qualities in the music that is performed together with participants, especially when performing for an audience. And often there is a goal from the participants to perform music 'as best as possible' within the given frames. The participants know a lot about what they like, and what they value in musical performances. As we have seen some aspects of musical asylum, let us now take a look at literature examples from earlier in this chapter, and see whether the idea of musical asylums may enlighten our understanding of affordances in music.

4.4.4 Examples of musical asylums from the previous literature

The first example from the music therapy literature that comes to mind when thinking about music asylums is that of Barry, who took the initiative to form a band within a high security forensic ward (Maguire & Merrick, 2013). Barry eventually seems to perform with success both within the band, and at the front-stage as he performs for an audience together with the band. As described by Maquire and Merrick (2013), his social interaction and collaboration with other band members develop throughout the process, and his appearance changes in a way that is recognized by others. It looks as

though Barry achieved musical asylum through his refurnishing band strategy, and that he managed to adapt within the local culture, using culture as tools for success. While managing the performances in the band, the band perhaps turned into a back-stage area in which he could let his guard down, maybe facilitated by the general atmosphere in the band and by the demeanour of the other band colleagues. The successful social performances within the band may have enabled successful performances outside of the band, through concert performances for both staff and residents at the ward. The music asylum could first be achieved in the band practices, usually in places some distance away from the ward, and sometimes in the chapel. It seems there are several factors that have the potential of enabling musical asylum for Barry, such as the distance from the ward (removal), the physical appearance and resources in the rehearsing room, the band members, and the aesthetics of country, blues, roots, and classical rock music. The aesthetics is probably important facets of musical asylums, and for some participants, fond relationships with music make up reasons to try music therapy in the first place (Ansdell & Meehan, 2010; MacDonald, 2015).

In another case description by Dickinson and Gahir (2013) we met a man who did not seem to achieve asylums in the same way as when learning to play the violin together with the music therapist. Learning an instrument may perhaps be regarded a removal strategy for achieving asylum, but it seems likely that there were refurnishing elements to this story, especially as the man did not previously accept collaborating with women but made an exception working with the female music therapist, and thus altered his social sphere. In this specific case, motivation for learning to play the violin came at least partly from the fact that his father also played the violin, thus there is an intrinsic 'meaning' in the violin in itself. The semiotics of the musical instrument per se may have been one element potentially affording musical asylum. At least the case study depicts a man who has not participated in other therapies or activities for more than a decade, until he seemingly achieved musical asylum through violin lessons with the music therapist.

Another example of how music asylum seems obviously relevant is found already in the title of the paper by Solli and Rolvsjord (2014): 'The opposite of Treatment: A qualitative study of how patients diagnosed with psychosis experience music therapy', in which participants describe music therapy as something 'other' than 'regular' treatments. In Solli and Rolvsjord (2014) P1 speaks positively about the music therapy room as peaceful, with something good and creative in it, and without illness or negative spirits. And Ansdell & Meehan (2010) describe D in their interview study, a music therapy participant who also speaks of the experienced freedom within the music therapy settings. Perhaps is it the openness and relaxed atmosphere in the therapy that enables D to achieve music asylum, as he points out how great it is to improvise without feeling

restricted. Perhaps are the therapeutic skills of the music therapist helping to enable shared musical experiences. Perhaps is the possibility for expressing emotions through physical gestures on the instruments also important part of the music's affordances in this setting. Perhaps would neither D nor P1 agree that music asylum is describing for their experiences with music therapy after all. But as I understand musical asylum by now, I find that the experienced freedom in music therapy, and the relational bonds that may derive from these processes, may well be understood as part of music asylums that can be achieved from the affordances of D's and P1's engagement in music activities.

When Tuastad and O'Grady (2013) argue that music activities may facilitate freedom in two ways, either as 'escaping reality', or as 'entering reality', we may perhaps understand this in terms of music asylums as well. Maybe is 'escaping reality' analogous with a removal strategy of achieving asylum, and 'entering reality' a result of successful performances on the front stage of a refurnished asylum.

Randi Rolvsjord (2015) make an important point, I believe, when she points at the active approaches made by the participants them selves. Recovery through music therapy requires effort from the participants. Rolvsjord found that the participants took initiatives, exerted control in the sessions, committed to the therapeutic relationship, and were generally engaged across different contexts. If we believe that asylum is something that is achieved through different strategies, than it is likely that these strategies also requires a certain amount of effort. I do believe that music can 'strike us when least expected', and perhaps pull us into some kind of music asylum. Yet, I feel quite sure that one is more likely to perform successfully on the front-stage when attempting to succeed. Thus, I believe that music asylums through refurnishing strategies do not usually emerge from nothing, rather the more effort given in the refurnishing strategy, the more likely is it to succeed on the front-scene of shared togetherness. When music therapy participants have never really profited from other forms of therapy in the past, it may be that the motivation to engage into refurnishing strategies have not yet been triggered the same way.

When adapting the music asylum theory to different stories found in the music therapy literature, I believe that it makes sense to understand music asylum as the 'room' or 'space' in which music therapy can happen. Music and music activities do come with lots of affordances. When music therapists appropriate these possibilities, together with the participants, something good can come out of this shared meeting point. Almost as the synaptic space between communicating neurons, the music asylum come with possibilities for 'something' to happen, and for change for the performing artist to flourish.

5 Methods

It seems the more I look for you the more I fail to find the truth
Maybe I'm affecting what I view with heavy veils and fairytales
Maybe my research was sound but maybe I just fooled around
All flags and footprints but nothing further down to find you, to find you

Excerpt from *Flags and Footprints*
by Threshold (West, 2004)

In this chapter I will elaborate upon the practical choices that have been made throughout the research process, with an emphasis on the empirical investigation. I will describe how my worldview indicates certain practical implications regarding the research process. I will also discuss the choices that were made in order to maintain safe surroundings for the participants, as well as for providing the research process quality, trustworthiness, and transparency.

I will discuss methodological issues regarding my version of the *joint interview*, and how the empirical investigation was performed. I will clarify how I understand the relationship between inner thoughts from the participants at one end, and the report of constructed findings at the other. Likewise, I will illuminate my view on the interview situation as a scientific method, and on the limitations of the research interview as a reference to truths and realities outside of the interview situation.

Later on I will explain how the data was thematically analysed, and in what way the emerging themes were constructed. At the end of the chapter I will discuss some dilemmas about ethics before I review the research process critically with some reflective remarks at the end of the chapter.

5.1 Choice of method

Area of investigation and focus of research must determine which method to use; in other words, what tool we use should depend on the task we wish to perform. I have already chosen human experiences as the area of investigation, and I have selected a version of the research interview to learn something new about what music therapy can be for service users within compulsory mental healthcare. The outline of these paragraphs is an attempt to explore the research tool in relation to the task it is meant to perform,

and to describe my thoughts on this matter. Let us now see if we can tighten the wrench a little bit, and find out whether this method seems to be suitable for the given task.

5.1.1 The researcher as a truth-seeker and a truth-constructionist

The concept of truth is dependently related to our understanding of knowledge and to our view on being in the world. The history of science shows that different views on knowledge affect the research (Thornquist, 2003). Methods used, language used to present findings, and objects of research are subjects of the researcher's understanding of knowledge. And vice versa: The researchers' choices can indirectly tell us a great deal about their view on important fields, their favourite area of investigation, the research traditions they are part of, and what methods they believe will give adequate answers to their research questions.

As we have seen, most postmodernist perspectives go quite far when it comes to understanding truth and knowledge as something constructed by the researcher and academic circles, and as a researcher with a postmodernism-informed critical perspective I partly follow these ideas (Alvesson, 2002). Also, I agree with Foucault (2002) when he stresses that new knowledge always builds on previous thoughts, and follows certain rules within specific discourses. The constructionist approach, and the view on knowledge as local and temporary, can be criticized for not fitting entirely with the empirical investigation of people's experiences through interviews and thematic analyses. I will in the following try to explain why I find the constructionist approach compatible with this research.

5.1.2 Research on human beings

The objective of researching human nature calls for ontological reflexivity. Our understanding of human nature is determining for what we think we can know about the human being. Scientists throughout the last few centuries have developed methods to investigate and analyse the laws of nature through controlled trials. This is, some would say, the proper approach to seeking knowledge about the world. This knowledge may help us predict the world, and interact with it, in a better way. The 19th century's thinker Auguste Comte wanted to implement scientific laws and predictions to the field of human nature (Thornquist, 2003). The new *sociology* would execute controlled trials, so that empirical data would give us information about human behaviour. Also behaviourist psychologists have, to some extent, tried to predict and cause human acts by exposing them to different stimuli (Teigen, 2004).

This sort of prediction of human agency could be handy for the field of healthcare, and for several other academic disciplines. If we could forecast acts of crime, addictiveness,

or harmful behaviours in general, based on predictable factors, then we could intervene in advance of the occurring emergencies. Thus, the empirical research would soon pay off through the saving of both lives and money. I believe though, that human beings are not that easy to predict. I therefore find it useful to investigate the experiences from music therapy participation for *some* service users. Even though this knowledge cannot be generalized into a common law of about experiences from music therapy, I believe that the acquired knowledge may still be relevant for *someone*.

5.1.3 Research on human experiences

In this very study the aim of the empirical investigation is directed towards participant experiences of music therapy, as a voluntary based part of compulsory treatment in mental healthcare. It follows then, that an interpretation of *experiences* needs to be defined.

As mentioned earlier, not everything that goes on within the person's mind is necessarily part of the conscious experience. We might argue that all we know and experience is dependant on a body through which we participate in the world (Merlau-Ponty, 2007), yet there are limitations for what can be transferred verbally. As the philosopher Michael Polanyi (2000) puts it: 'we can know more than we can tell' (p. 18). In chapter two of this thesis we also briefly addressed the discoursive works of Gary Ansdell (1999) in which he points out the challenge of describing music therapy practices with words. There is bound to exist a gap between what is performed and what is described. In the initial phase of this research project I planned to perform each of the interviews directly after a music therapy session. In this way, the participants' accounts about music therapy experiences might at least get closer to the experience of the music therapy participation (Stensæth & Næss, 2013). Due to practical implications, however, only one out of seven interviews was actually performed in the wake of a music therapy session. Hence, user experiences need to be understood as something broader than the real time experience of music therapy activities; rather, we have to do with hindsight considerations and explanations about important aspects of the music therapy sessions.

Based on previous literature on user experiences from music therapy within mental healthcare (Ansdell & Meehan, 2010; Solli & Rolvsjord, 2014), it seems that user experiences include the perception of the client-therapist relationships, feelings of being met, and thoughts about music therapy as something that facilitates for a sense of freedom, and positive occupation of the time spent within mental healthcare. For this study as well, the interview guide targets themes that refer more to the research participants' thoughts about music therapy and music therapy participation (see appendix 1). Experiences

then, include notions about the importance of music therapy, motivating elements in music therapy, and the potential in music therapy for helping people.

Regarding the postmodern perspective on knowledge and meaning production, I argue that I also believe that experienced meaning is affected by language (Alvesson, 2002). I believe that expressed meaning may influence the experience retrospectively, at least over time. How people experience hospital environments and the use of compulsory treatment is partly constructed through the ruling discourses in the culture; the discourses differ between communities and within institutions, thus the experience of the situation will differ as well. Knowledge is local and temporal, and so is experienced meaning, as this is also constructed and understood within particular discourses (Foucault, 2002). When I choose to interview participants about their experiences, the answers cannot simply represent copies of their innermost feelings and thoughts. Rather, the intention is to offer participants ways to form their own story of the experiences. I support Kvale & Brinkmann (2010) when they argue that the interview intervention functions as a *construction site* for knowledge.

Summing up, the user experiences that I speak of in this study must be understood widely; these experiences include thoughts, ideas, and reflections about music therapy participation, and about their relationships with music in general. In addition, some of the reflections that are expressed need to be understood as retrospective elaborations that follows from the interview situation itself. This being said, every user experience is useful in order to understand music therapy within compulsory mental healthcare, regardless of the construction of the expressed statement.

5.2 Investigating the joint interview

I will now discuss the use of *joint interview* as a research method; that is, I will try to clarify how joint interviews were used in *this* version of it, in *this* particular investigation. Joint interview is not a widely used method within my own academic environment. And the way that joint interviews are depicted in the previous literature, such as targeting couples as equal peers in the interview, did not fit entirely with what I wanted to do (Arksey, 1996). Rather, I am interested in the accounts of the music therapy participant, but wanted to include their respective therapists as participants in the interviews. For this reason, and because I would like to discus the method from several perspectives, I will try to compare my use of joint interview to other well-known research methods as stimulated recall interview, focus group interview, and the more classical one-on-one

interview situation. In this way I try to reveal strengths and weaknesses of the chosen method.

5.2.1 The semi-structured interview

Semi-structured interviews allow the researcher to present themes and questions. At the same time, the researcher may guide, explain and adapt questions when needed. Semi-structured interviews, when used cautiously, may provide adequate structure, as well as make enough room for the participants to contribute on their own terms. For this to happen though, 'the researcher has to be prepared to allow the interview to unfold in whatever direction the consultant takes it' (Rowe, 2009, p. 435). Due to this study's aim on user experiences, and the study's interests in certain topics, semi-structured interviews seemed to go well with the study's research design.

Important strengths of the semi-structured interviews are that it gives the interviewer an enhanced freedom to speak their mind, and that it gives the researcher opportunities that are not found in questionnaires or in other rigidly structured interviews (Rowe, 2009). It is the nature of the interview that someone asks questions, and does not know the answers in advance. Thus, follow-up questions are essential when the participant, through unexpected turns, invites us on a journey (Kvale & Brinkmann, 2010). Hopefully, these follow-up initiatives will also motivate the participant to continue contributing. After all, this interview setting might feel unusual and stressful. The search for relevant information is important, but not as important as the well-being of the research participants who are interviewed. Let us now look more closely at the specific interview method that was used, *joint interviews*, in which both the research participants and their respective music therapists were present during the interview situations.

5.2.2 The joint interview, as a joint method

The research method that is used for this study is a version of the *joint interview*, which is inspired by several different approaches. I have already suggested that a semi-structured interview is beneficial for the project's purposes, and I will now explain in more detail why I chose this version of the interview, and how I have tried to cope with the practical, ethical, and theoretical challenges that I encountered during the research process.

Providing safe surroundings – the presence of the music therapist in the interview

Early in the planning of this research I decided that it was vital to provide a safe surrounding for each research participant during the interview situation. I had never met

any of the research participants prior to the interviews; all contact between me, as the researcher, and the music therapy participants was made through their music therapist. Except for a document with information about the study, and a request for their consent to participate in the study, the participants only had the information that was articulated by their music therapist. For me it was natural that the research participants had the opportunity to bring their music therapist into the interview situation.

When acknowledging the importance of the music therapist's presence during the interview, it felt natural that the music therapist could also be part of the interview conversation. This of course, comes with some implications regarding the findings of the study, and I will come back to this matter as I deliver some critiques of the study towards the end of this chapter.

The joint interview as 'a stimulated recall dialogue'

The research interviews for this study varied in terms of how close to the last music therapy session they were performed: one interview was performed immediately after a music therapy session, one interview was held two weeks after the last music therapy session, and five interviews were held within a week after the last music therapy session.

The inclusion of the music therapist in the interview situation may sometimes work as a reminder of certain episodes or special themes from their therapy process. This beneficial side product is in some ways similar to the idea of *stimulated recall interview*, in which participants are reminded about events during the interview session, for instance through video or audio recordings (Haglund, 2003; Rowe, 2009). In this way, both the interviewer and the participant can assess particular moments, and discuss these events more precisely.

The use of stimulated recall is dated back to the early 50's at least (Haglund, 2003). Early interventions in this manner were intended for practical pedagogic purposes, wherein participants could reflect and discuss what choices were elected or avoided in a given situation. In these interventions the teacher may suggest alternative actions, and learn more about the student's thoughts and reasons for acting in a particular way. Stimulated recall can be an adequate method for gaining knowledge, especially within the field of didactics, but also in the field of music therapy.

Although not defining for the totality of the joint interview as a research method in this study, particular situations occurred in which the research participant had the chance to reflect on something brought up by the music therapist, as in the interview with Sarah:[57]

57 Whenever I cite interview conversations throughout this thesis I use the initials R for the researcher and MT for the music therapist. The research participant's pseudonym is written out.

MT: What I remember the best with Sarah, something we've also talked about, is that... we hear it being said that 'to sleep on it', that is to say, if you study for your exam you should sleep, because then the brain gets time to process, and this becomes evident for Sarah because when she arrives she is somewhat uncertain: 'no, I don't know if I'll manage this'. And then we work through it. So she is a bit shaky before she is done with the session; then she leaves, and comes back the next week, and then we try to play it, and then it works! It's the one week of rest. And you don't have the opportunity to rehearse [in between].
SARAH: No, hehe.
R: Do you recognize this?
SARAH: Yes.
R: Yes. How does it [feel][58], when it suddenly works?
SARAH: It's really nice, hehe (…) don't know what's happened, you know, but it just works. (Interview with Sarah)

Prior to the statements above, the researcher asked both of the interviewees, first Sarah and then the music therapist, whether there was something they remembered in particular from their music therapy process. Other times, recalled episodes appeared naturally from speaking about a topic; in the example below, Lee's music therapist suddenly remembers an episode from music therapy she wants to tell about:

MT: Then I just… If I can add, I just remembered from the last session on Tuesday, when we had a really nice session, then we also had the music therapy student here.
LEE: Yes.
MT: And we played for quite a long time, you on the drums and me on the congas, and her on the bass, and we, like, made it
LEE: M-m.
MT: It sounded good, we made it!
LEE: Yes.
MT: It grooved, and you said afterwards, I remember, that everybody experienced that this right here…
LEE: Yes

58 In Norwegian, the word *feel* was not used in the question. A more direct translation of the words used would be: 'How is it, when it suddenly works?'

MT: – this is going somewhere.
LEE: I remember that! (Interview with Lee)

Even though the stimulated recall process may provide for a better memory of a given situation, it is vital to remember that neither of these memories are exact copies of previous experiences. In the same way as with other memories and reflections, these may change over time, and differ from situation to situation. It is for this reason that the scholar John Lyle (2003) suggests we rename the method of stimulated recall; he argues that 'stimulated reflection' is more suited as this expression more precisely addresses the process of talking and thinking about previous situations. Perhaps the joint interview, as presented in this study, may in the future be renamed a 'peer-stimulated reflection interview'.

The joint interview as a trialogue: the dynamics of the conversation between the participant, the therapist, and the researcher

Another side effect of including the therapist in the interview situation, next to the recall of certain episodes, is that it may lead the interview situation towards a more natural *conversation*, in which both of the interviewees are familiar with each other; perhaps a classical one-on-one interview would more easily afford a superficial dialogue that is based on questions from the interviewer and answers from the interviewee. Because of the familiarity and the therapeutic relationship, the therapist may respond with confirmation and appreciation throughout the interview conversation.

In some way there are certain similarities between the joint interview and a small focus group interview. In focus group interviews questions and themes may be directed to several people at the same time. The group of people can exist 'naturally' as a group in advance, as a football team, treatment group or as a family. The group can also be put together for the sake of the interview, by gathering experts on a topic, members of an organization, or people sharing common interests, diagnosis, faith or fortune (Rabiee, 2004). Regarding this research, what the interviewees have in common is the participation in the same music therapeutic process. And although the interviewees experience music therapy from different sides of the client/therapist-relationship, they are together in promoting the participant's stories in the interview situation, as in the interview with Kim wherein the therapist underpins Kim's statement:

R: What do you think would've happened, then, if it [music therapy] wasn't voluntary – if you had to come here once a week?
KIM: Then I would sit down in a chair, and they would've needed to carry

me up here. I have no difficulties, you know, in saying and doing what I mean.
MT: No.
KIM: If I absolutely didn't wanted to, then they would never get me up [here to music therapy]. And if they got me up, they couldn't force me to do anything, you know. I could just sit here and not say a word, not playing anything, not doing anything.
MT: Yes, they can't force you to sing.
KIM: That's just it. (Interview with Kim)

When the therapist is able to comment on the participants' statements, this may in some cases contribute to a wider understanding of a topic. As I experienced the research interviews, the music therapists were mostly supportive of the participants' statements. And occasionally the music therapists contributed with additional information that enhanced my understanding of the participant narratives, as in the interview with Peter below:

R: Do you find it easy to come here [for music therapy]?
Peter: No, I have to take the bus, you know, so… it's a long way
MT: It is quite… The bus connection is poor, he needs to make quite a few bus changes to get here, especially from [name of city].
R: Yes. So it takes a while to get here?
PETER: Yes. (Interview with Peter)

Peter has already told me that he needs to travel by bus quite far to get to the music therapy appointments. The music therapist confirms this information and makes it obvious that this is a relevant issue. This verification of the participant statement should really not be necessary, but I find that it does make a difference for my understanding of the participant narrative. The account is verified as trustworthy when the therapist takes the initiative to underline the statement: Peter comes to his appointments even though there are some geographical obstacles he needs to overcome every week.

Participation in groups, or in pairs together with their respective therapists, makes no guarantee for the perception of a safe atmosphere. For some people and in certain situations the group interviews may even cause more uncertainty than would the circumstances of the one-on-one interview setting. Perhaps some participants feel like experts on their own, but in the same room with others they hesitate to advocate their own opinion, or are afraid to say something wrong. At least we should not take for granted that the presence of another expert, with a degree in higher education, will open up for honest opinions and narratives of experiences from participants with

little academic background from the discipline of music therapy (MCGrath, Palmgren, & Liljedahl, 2018). In the interview with Alex, higher education was even brought up in the interview after I answered that I agreed to one of his considerations about mental healthcare:

> ALEX: Yes, or else you wouldn't have studied music therapy, master's [degree], or sorry, doktorgrad [doctoral degree], it is master's in English, isn't it, doktorgrad?
> R: PhD, it is a bit like, post master's, after the master's.
> ALEX: Wow, impressive.
> MT: Yes, hehe. One needs the master's degree to become a music therapist.
> ALEX: You have got a master's?
> MT: Yes, I got a master's, hehe.
> ALEX: Oh.
> R: Good [girl]! [Flink!]
> MT: Yes, hehe.
> R: Yes, because it is a continuing… or, the education in music therapy, traditionally it has been people with other previous professions, teachers, nurses, or social workers, and everything, and in a way built on with music therapy. Today, as well, the music therapy [education], even though it is on a master's level, it's only three years, in Oslo.
> ALEX: Yes.
> R: Because many [music therapists] have done other things before [studying music therapy].
> MT: One needs two years with something else, or a bachelor's degree with something else to get, maybe, a bit versatile competence.
> ALEX: I want [to study] developmental studies, eventually.
> MT: Yes, right.
> R: Yes?
> ALEX: Working for the UN, as I said. (Interview with Alex)

I do not think that this small abstract about educations, which appeared towards the end of the conversation,[59] influenced Alex's experience of the interview as a whole. Yet I felt a bit uncomfortable with the situation, which was possibly enhancing the power/knowledge relationships between the sole music therapy participant and the two music therapy experts. In turn, I tried to joke and laugh away the seriousness of the education of the music therapist. Also I started to give an explanation of the structure of the

59 When looking back to this situation the audio recordings are already deleted, but the abstract is found at pages 28-29 out of 32 in the transcription of the interview.

education, in order to reduce or justify the magnitude of a master's degree. Alex followed up with his thoughts on studying developmental studies. It is impossible to know what the research participants in this study experienced from the research interviews, but the example mentioned above demonstrates that situations or topics can derive from the dynamics and the asymmetrical relationships within the group. More experience as a researcher and interviewer might however reduce the effects that such unexpected and challenging conversations have on the researcher and the research interview (Kvale & Brinkmann, 2010).

The collaborative approach of the joint interview

Throughout the planning of this research, and during the execution of the research interviews in this study, I believed that the *collaborative research interview* was the term closest to the approach suited for my study. When describing the project for the ethical committees and for the research participants in this study, I used the term collaborative research interview. The term *joint interview*, which is the term I use to describe the research method today, was unknown to me until after the empirical investigation was performed for this research. However, this study was designed the way I found appropriate, regardless of the familiarity with the terms collaborative interview or joint interview. I will here briefly describe my version of the joint interview, as performed in this study, in relationship with the collaborative interview approach described in the previous literature.

Traditionally, the collaborative interview has been used within therapy, such as in family counselling (Laslett & Rapoport, 1975). The therapist then communicates with several family members at the same time in order to learn something valuable about the family dynamics and the therapy processes. This sequence is then recorded or videotaped so that it is possible to re-visit the dialogue at a later point in time, either for research purposes or for educational means. The recordings may be discussed among several therapists, which Laslett and Rapoport (1975) argue will provide a stronger internal validity of the interpretations. In addition, the family may in turn watch the therapists who discuss the recorded counselling.

In music therapy, Blom (2014) has used the collaborative research interview. Blom investigates therapy processes from sessions with Guided Imagery and Music (GIM). The researcher interviews a music therapist while the client is present and listening. Then the researcher interviews the client, both about the therapy, and about listening to the former dialogue between the researcher and the therapist. These steps are followed by an open conversation between all parts. In this way, the client has the opportunity to observe the therapist when reflecting about music therapy and the therapy process.

Even though I was initially inspired by Blom's (2014) research, I did not follow the strict procedure as suggested. In my own research I wanted to investigate the participants' experiences, not the therapists'. I did, however, plan some questions toward the music therapists as well, hoping this would trigger some new information about the therapy processes that could be relevant for the study's research questions. For instance, I asked the therapists whether there was something they remembered in particular from the therapy process:

> R: Is there something you remember best from the weeks with music therapy?
> MT: Hmm, I don't know, I think I especially remember one song you brought [into music therapy], the 'Living in colour-song' that we've played.
> KIM: Yes, City in Coulour. 'Against the Grain'
> MT: Yes
> R: Is there a special reason you remember this, you think?
> MT: I just think that the song, just the way we played it, it suited us perhaps.
> KIM: Perhaps
> R: Mhm
> KIM: Yes, we sort of nailed it! (Interview with Kim)

Asking the therapist questions was a good way of establishing a conversation in which all parts were included, I experienced. Although I posed a few questions towards the therapists, this was not done extensively. In the future it could be interesting to pin point other adequate questions for both the therapists and the participants.

The support and presence of the client's therapist in the interview may, as mentioned, contribute to easier access to previous events from the music therapy process. The therapist may also contribute with interpretations and follow-up questions regarding client narratives. In the interview with Peter, I struggled to understand all of his accounts, due to language implications and the lack of a frame of reference; then the music therapist was able to contextualize the story, making it easier to comprehend for me as an outsider (Stensæth & Næss, 2013):

> PETER: Back when, I… I am divorced, I am divorced with my ex-wife.
> R: Yes.
> PETER: So it was… [Not understandable]
> MT: Yes, you have… We have talked quite a bit about it, that you have used music a lot, in the time after the divorce?
> PETER: Yes

MT: And you listened a lot to music in that period?
PETER: Yes. (Interview with Peter)

A collaborative way to new understandings may potentially lead to new insights, for the researcher, for the music therapy participant, or for the music therapist.

5.2.3 Summing up the joint interview

Interviews come with methodological challenges and limitations, as do all research methods, and it is important that choice of method is suited to give answers to the aim of investigation. Perhaps we will never truly understand what is going on in other people's mind, but as I have argued throughout this chapter, to ask them is possibly the closest we will ever get.

As I have advocated, positive advantages from stimulated recall-interviews and focus group interviews may be found in this study's version of the joint interview method. The presence and participation of the client's therapist in the interview seemed to enhance the memory of previous moments and reflections. According to my own experience, the joint interview also provides safe settings and naturally situated conversation in which the music therapist and the music therapy participant could comment on each other's accounts.

It was primarily the music therapy clients' experiences I was interested in knowing more about through this investigation. The inclusion of the therapists as part of the interview was mostly meant as a support for the music therapy participants, although the therapists have provided additional knowledge for the study, by supporting the research participants and motivating them to reflect on the topics addressed within the interview conversations.

5.2.4 The interview guide and the guided interview

The process of forming the interview guide has been a journey on its own. Yet, it has also been closely attached to the becoming of the research project as a whole. During the work of this research three main challenges in particular arose regarding the creating of the interview guide: 1) the interview guide was formed in an early phase of the research; 2) I wanted the interview guide not to mirror the research questions; and 3) I did not successfully manage to anticipate entirely how the interview situations would be. The three challenges will be further addressed in the following.

Due to governmental research guidelines, a research application was sent for approval from the Norwegian Centre of Research Data, and the interview guide functioned as part of the application. This means that I had to decide at an early stage what sort of questions to include in the interview guide. Accordingly, the interview guide was more or less set at an early point in time, and only minor changes were applied between the research application being approved and the interviews being executed (see Appendix 1 for a closer look at the interview-guide).

One intriguing conundrum in every kind of research concerning human experiences, I would say, is the sake of asking about something quite specific, and at the same time providing the possibility for someone to speak more or less freely. Ever since the idea of this study was born I have wondered how to pose questions in a way that will facilitate for knowledge about the user perspectives. As outlined earlier when describing the interview as a research method, no clear answers can simplify this dilemma. From my ontological view, no question can really allow the participant to speak freely, and no answer can truly describe feelings or experiences. I agree with Braun & Clarke (2006) when they say that there should not necessarily exist a strong relationship between the research questions, the questions posed during analysis, and the questions asked to the research participants. If the interview questions were similar with the 'hidden' research questions, the results of the study might have been given from the very start. One of my overall research questions asks what motivates people to participate in music therapy. When performing the interview, however, I did not want to bring up the word motivation my self. At the same time, I tried not to take for granted that there are obvious reasons for people to participate in music therapy. Hence, I used questions such as: 'Are there any particular reasons for why you show up to the music therapy sessions?' and 'How do you feel about participating in music therapy?' [See appendix 1].

I also wanted to know if there was anything that the participants thought of as the most important contributions from music therapy. However, I struggled to disguise this completely in the interview guide, and ended up asking: 'Do you have any thoughts about anything that might have been important for you in music therapy?' Even though I tried not to transfer to the participant my own view on music therapy as being important, I may still be criticized as a researcher for leading the participant's attention in certain directions.

Another challenge was to plan the interviews in advance, trying to anticipate the outcome of the interview situation. Due to practical implications and unforeseen circumstances a pilot interview was not performed as planned. I did not know in advance how long it would take to talk through the interview guide, how talkative the participants would be, or how much time and effort the participants wanted to give. In addition, I did not

know exactly how directly I needed to address the participants in order to lead the interview conversation into relevant directions.

At first I planned to perform two interviews with each participant. This was determining for the synthesis of the interview guide, especially when it came to the number of questions; I would probably have tried to sharpen the questions, and remove some of the content aiming for an introductory and pleasant conversation about music therapy and the music therapy process. For instance I planned to ask quite similar questions in the two interviews, such as: "Why do you participate in music therapy?" (in the joint interview), and "Are there some particular reasons that you want to participate in music therapy?" (in the one-on-one interview). The slight differences in both questions and interview settings were intended to facilitate additional nuances to the data set, but remain hypothetical due to the change of plans during the practical implementation of the interview guide.

5.2.5 Transcription of the interviews

In advance of the interview sessions I decided that only verbal statements would be used for the empirical investigation. That is to say, I did not use video recordings or notebooks during the interview in order to encapture accounts such as body language or facial expressions. On a few occasions I added informative remarks in the transcription, whenever this seemed necessary for the understanding of the plain text, and when these were attainable either from memory or from the audio recordings:

> KIM: Yes, I do … [his cell phone is ringing – theme from Star Wars]
> R: Did you see the new Star Wars movie?
> KIM: Yes, I did, hehe [laughing]
> Music therapist: Hehe
> Researcher: I haven't seen it yet
> KIM: It's fantastic! (Interview with Kim)

In this particular situation I chose to comment on the music and the movie both to acknowledge Kim's interests for Star Wars and to imply through a friendly tone that I was not bothered about his phone ringing. Since the ringing phone affected the content of the conversation it was added into the transcription.

Already when performing the first interview I realized that a transcription that only pays attention to verbal statements runs the risk of reducing a lively conversation to an empty shell; a lot of smiles and happy faces, from speaking about music and therapeutic relationships, are lost somewhere between ink symbols and white paper. Still,

the verbal statement will tell the most about other people's experiences, and these are also found in transcriptions without the rich details of non-verbal statements, as Braun & Clarke (2006) note:

> However, thematic analysis, even constructionist thematic analysis, does not require the same level of detail in the transcript as conversation, discourse or even narrative analysis. As there is no one way to conduct thematic analysis, there is no one set of guidelines to follow when producing a transcript. However, at a minimum it requires a rigorous and thorough 'ortographic' transcript – a 'verbatim' account of all verbal (and sometimes nonverbal [e.g., coughs]) utterances. (p. 88)

Also, I suspected that too many different descriptions could take the attention away from the interview and the participants' life stories. However, because I did not want to miss out on crucial affective emphases made by the participants, I included descriptions of strong emotional/bodily accounts, such as laughter. Laughter in fact appeared several times in every interview and this mood is descriptive for how I too experienced the interview sessions overall. There are indefinite nuances of laugher, and laughter can mirror both joy and nervousness; for pragmatic reasons, however, laughter was usually reduced into 'hehe' in the transcription. Occasionally the laughter was outlined precisely, when seen as important and describing for the general atmosphere of the dialogue, as in the interview with Sarah cited below:

> SARAH: But [name on music therapist] uses in a way… ehm… when we play the piano and things like that, she sort of talks like 'yes, that's how it is in life as well', hehe.
> R: hehe.
> MT: hehe, yes.
> SARAH: So …
> MT: Yes, I like to relate it out [to comparable situations], hehe.
> SARAH: yes, hehe.
> R: You have to act a little as a therapist?
> [Everybody laughs]
> MT: For good and for worse.
> SARAH: I think that's really okay. (Interview with Sarah)

For several reasons the interviews were transcribed as soon as they had been performed. Even though there is no limitation for how much, and for how long, memories can be stored in the long-term memory, some memories of the interview situation will always

slip the mind as time goes by. I though that immediate transcriptions would minimize the transcription fallacy.

5.2.6 Translation of the findings

During the writing of this thesis the selected data extracts were eventually translated into English. Almost all the extracts were translated from Norwegian to English by the researcher, except for some statements that were originally spoken in English. All translations presented in the study were assembled in a document with both the Norwegian and the English version, so that the translations could be investigated throughout the research process; the researcher scrutinized these translations several times during the writing of the dissertation. A native English-speaking music therapist proofread the whole dissertation, thus a few citations were edited towards the end of the writing process.

5.3 Analysis

In this part of the chapter the goal is to clarify my view on analyses in social research, and to make transparent how the analysis was conducted in this specific study. As the analysis process in social research will never be completely obvious to anyone other than the researcher, I believe that it is important to explain thoroughly how the researcher understands the process of analysis; the closest we get to a trustworthy analysis, I believe, is through the combination of an honest and well-articulated description of the process, and an open dialogue about what the analysis is and what we expect to get out of it.

5.3.1 Analysis as an on-going process

The process of analysis is going, and our attention is always directed towards something while other aspects are kept in the background. Even though I tried to investigate the interview transcripts openly, and not let the research questions decide the outcome of the analysis, I think it is neither possible nor desirable to set aside my project and research questions entirely.

I transcribed the first interview and investigated this before performing the other interviews, in order to evaluate my interview skills, and to see whether my interview guide provided answers for the research questions. This action may seem problematic; if the researcher is constantly tweaking the experiment in order to provide the proper answers, we get close to the process in which we also construct our answers. The

interview guide was not changed, but I adjusted the interview technique slightly due to this self-critical approach.

5.3.2 Thematic Analysis

I have tried to lay it open, that this researcher is influenced by the sceptical view of postmodernism; I view categories as social constructions. I also doubt the researcher's ability to encounter the empirical data with enough openness and neutrality so that an essence of the material can come forth and show itself through its mere existence (Alvesson, 2002). And I believe that the findings from the analysis of this study needs to be regarded as only *one* out of an endless number of possible outcomes. But that doesn't mean there is no reason to structure the procedure, and to make this process transparent for the reader. In order to do this, I have used the thematic analysis as: 'a method for identifying, analysing, and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79).

In my analysis I have tried to adapt the process of analysis of my research to the ideas of the psychology scholars Braun and Clarke (2006). They argue that this manner of analysing empirical material may provide guidelines without necessarily embracing the theoretical framework that follows other research methods, such as IPA and grounded theory. A social constructivist perspective, closely related to this research project, is mentioned as an example of methodology that can be combined with thematic analysis (Braun & Clarke, 2006).

Braun and Clarke (2006) view thematic analysis as a method in its own, and by following their guidelines I have administered the empirical data with caution; since I, as a researcher, have been reminded to approach the empirical material through certain steps, this systematic process have probably lead to less subjective results. At the same time I needed to adjust the method to fit with my own research questions, and not forget the flexibility that qualitative research offers:

> However, nor do we think there is one ideal theoretical framework for conducting qualitative research, or indeed one ideal method. What is important is that the theoretical framework and methods match what the researcher wants to know, and that they acknowledge these decisions, and recognize them as decisions. (Braun & Clarke, 2006, p. 80)

Braun and Clarke highlight the research process as a series of active choices. Below I will try to explain which choices I have made, and how my process of thematic analysis relates to six steps suggested by Braun and Clarke.

5.3.3 The procedure of analysis

One might say that the process of analysis already started at the very birth of the research project, but these first thoughts are not necessarily tied to the actual empirical material; rather, they are suspicions based on previous theory and experience. The empirically founded analysis may also start at an early point in time, according to Braun and Clarke (2006): 'The process starts when the analyst begins to notice, and look for, patterns of meaning and issues of potential interest in the data – this may be during data collection' (p. 86). This was the case for me during the first interview; I specifically recall listening to participant accounts, wondering whether the later research participants would share some of the same experiences as the first.

The constructed themes should derive from the empirical material. At the same time the sorting of interview transcripts into themes will always remain an active process wherein the research constructs the final themes, at least according to a postmodernist understanding (Alvesson, 2002). The structured analysis was then important in order to ensure that the constructed themes were founded in the data set, even though other research questions could also have discovered different themes.

I actively chose not to engage with too much literature during the process of analysis. There are different views on this choice (Braun & Clarke, 2006), but I wanted to maintain an open approach to some extent, and possibly reduce the directedness of my conscious and subconscious scope of investigation; perhaps this openness have lead me to noticing *something* from the empirical data that would otherwise have been neglected. Yet I cannot know for sure.

Below follows the procedure of the analysis, and the description of my attempt to adapt to the six phases suggested by Braun and Clarke (2006). As the authors stress, their instructions and examples have been working as guidelines, and I have been trying to fit their ideas to this research and this data material. Also it is necessary to point out that these phases are not equivalent to moving chronologically from step to step:

> Moreover, analysis is not a linear process where you simply move from one phase to the next. Instead, it is more recursive process [sic], where you move back and forth as needed, throughout the phases. It is also a process that develops over time (Ely et al., 1997) and should not be rushed. (Braun & Clarke, 2006, pp. 86-87)

I think that the latter point is important to keep in mind; it might be useful to dwell a bit on the data, and to scrutinize the findings a second time. I have presented preliminary

findings from this study at a conference[60], only to find out that I could no longer stand behind the composition of the themes. At the same time it has been important to not be trapped within the maze of the analysis; the results of the analysis can always be changed, but at some point fastidiousness will not necessarily provide more quality to the study.

Phase 1: familiarising myself with the data

I led the interviews myself, and moreover, I transcribed the conversations verbatim while listening to the audio recordings for hours; consequently I became familiar with the empirical material at an early stage. Still, it was important for me to put in a certain amount of effort during this first phase: 'Regardless, it is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content' (Braun & Clarke, 2006, p. 87). Interviewing, transcribing and reading have been different ways of working with the material, thus dissimilar understandings have been attained through these individual approaches.

As Braun & Clarke (2006) suggest, I made sure that I read through the whole data set at least once before I started the process of structurally coding, trying to minimize the chance of overlooking substantial statements within the transcribed material. Notes about possible themes were made during this first reading.

Phase 2: generating initial codes

In the second phase I started 'the production of initial codes from the data' (Braun & Clarke, 2006, p. 88). I had already gathered an idea of some interesting topics from the data set, and now I needed to name these topics. In this phase I re-read the data set, while writing comments in the margin connected to the statements. For each code given, I interpreted the statement and described shortly what I believed would be close to a translation of the meaning expressed by the research participant, either through descriptive words, or with short sentences, as described in table 1. As Braun and Clarke (2006) stress, several codes were applied for each statement whenever necessary. In this way I might have enhanced my understanding of each particular statement, and potentially I avoided the immediate loss of vital remarks to more obvious codes or themes.

Before generating the initial codes I authored three questions that would help secure the relation between the original account and the attributed codes:

60 The presentation of preliminary findings was held at the fourth Norwegian Music Therapy Conference, June 3rd 2016 at Fana Folkehøgskule [Fana Folk High School].

1. Would other researchers agree that this code summarizes the meaning of this statement?

2. Would the participant agree that this code might represent the content of this specific statement?

3. Would other professionals, both including and excluding music therapists, agree that this code is adequate for representing the basic meaning of this statement?

Especially when the researcher is doing empirical investigations alone, with low or non-existing inter-rater reliability, it is necessary to act carefully throughout the analysis. The questions mentioned above were constructed to work both as a guideline for the coding procedure, and as a reminder along the way, hoping that they could help to hold the attention towards the given task.

Braun and Clarke (2006) argue that coding may vary, and that some findings may be more 'data-driven' or 'theory-driven'. If coding is influenced by a few research questions, one might overlook most of the data, and direct the scope towards certain information. Within the interview transcripts in the present research there were sometimes large sections that did not seem relevant for the study, such as empty small talk and longer digressions. Although the process of commenting the interview transcripts with initial codes was somewhat structured, it was also a pragmatic process in which parts of the interview transcripts that seemed irrelevant were not coded. Even though my whole research was driven by certain research questions it felt necessary to keep an inductive attitude throughout the coding, and to some extant, hold on to a data-driven route towards the final results.

The codes from all the interviews were eventually gathered into a list. From this process I had an overview over potentially important subjects within the complete data set. The codes were investigated, and used as inspiration for the following analysis. However, these codes were not used in a structured way further on in the analysis. That is, the following themes constructed from phase three and on, did not emerge by combining and sorting the exact code material. Even though I did not structurally make use of every code per se, the step of coding the empirical material was still important; in this way I was familiarized with the interviews in a new and deeper way, and I had the opportunity to look at potential patterns and areas of interests through a compressed version of the interview transcripts. The structured coding also reduced the probability of overlooking relevant subjects.

Phase 3: searching for themes

Initially I planned to do the thematic analysis manually on my work desk, using scissors to cut out the statements and then organize these into appropriate piles based on their initial codes. I did however quickly experience that the statements were often given several codes at the same time, and that this would call for several copies of the entire data set, causing a tremendous amount of sheets of paper, without providing the structural procedure I felt was necessary to get a proper hold on the data set. Hence, the search for themes was eventually performed electronically, using the NVivo software on a MacBook Air computer.

Inspired by the earlier coding phase, I started to organize longer statements, into emerging themes so that data extracts were placed into one or more theme that seemed appropriate. Great caution was required when sorting out these themes. To minimize the arbitrariness of the adapted themes, it felt necessary to examine the imminent themes critically, to alternate between themes, and to make use of gaps in time in order to return to the themes with 'new glasses'. The data extracts that were categorized in this phase were much larger than the smaller coded chunks from the previous step, and preserved as larger interview extracts for a long time, so that the contexts of the statements were not lost. Not until a much later point in time, when writing out the dissertation, were the extracts shortened and compressed in order to make the narratives more readable, as depicted in table 2.

Sketches and flow charts helped me to organize 'the relationship between codes, between themes, and between different levels of themes' (Braun & Clarke, 2006, p. 89). From time to time I ran into extracts that didn't seem to fit into obvious themes; these were temporarily sectioned under the heading 'ambiguous codes'.

Phase 4: reviewing themes

The amount of work put in in the previous phase came in handy in the next step. I tried to make an effort to precisely point out relevant themes and sub-themes. Still, there was room for improvement when the themes and sub-themes were reviewed and revised during this phase. I tried to follow the instructions from Braun and Clarke (2006): 'Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes' (p. 91). According to Braun and Clarke (2006) there are two levels of reviewing and refining the themes; the first level concerns the relationship between the coded extracts and the synthesized themes, and the other level regards the relationship between the themes and the entire data set.

The process of adjusting and tweaking the coded extracts, themes, and sub-themes, is by nature a never-ending process, according to Braun & Clarke (2006), as there are endless potential combinations of words and meaning in the interpretation of the data material. This view harmonizes with my experience during the analyses process. It also supports my ontological view on categories as social constructs (Alvesson, 2002); no matter how hard we try to organize meaning extracts from an empirical material, the final results will always be determined by the researcher, within current discourses. Still, I returned to this phase of reviewing and redesigning the themes a few times throughout the following year and both headlines and content of the themes occasionally changed.

Phase 5: defining and naming themes

At this point I was starting to gain an understanding of the different themes and the story I believed they could tell about the research participants' experiences with music therapy. The aim of this phase was: 'identifying the 'essence' of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures' (Braun & Clarke, 2006, p. 92). In other words, I went further in defining each theme, and in figuring out what these themes could be all about. The search of 'an essence' might be associated with a phenomenological ontology, which I do not support all the way; i.e. that an inherent core or essence can possibly exist within these constructed themes. And if it did, we would not be able to grasp this essence neutrally; we could only experience this phenomenon from within a specific culture (Alvesson, 2002). If we take into account that these themes are merely social constructs based on local truths from within a particular time and place, and that 'the essence' can at best be a description of *my* understanding of the material, I agree that the ~~essence~~ is a term which describes well some common features that both unify and separate themes.

For me as a researcher it was important to start writing out the findings into the dissertation at this point, with the purpose of challenging myself to describe the themes the way I understood them, and to test whether the substance of the organized themes still seemed logically constructed: 'One test for this is to see whether you can describe the scope and content of each theme in a couple of sentences' (Braun & Clarke, 2006, p. 92). When I tried to explain in words that which defined the different themes and sub-themes, it was obvious that the themes still called for certain adjustments. It turned out that I needed to revise the themes and sub-themes several times to make sure that: 'Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes' (Braun & Clarke, 2006, p. 91).

Some working themes had existed already since the first interview was conducted. During this phase, however, it was time to give attention to the final names, for both

themes and sub-themes: 'Names need to be concise, punchy, and immediately give the reader a sense of what the theme is about' (Braun & Clarke, 2006, p. 93).

Phase 6: producing the report

The last phase of the analysis was dedicated to the written presentation of the findings. When transcribed and printed out, the data set for this research extended over a couple of hundred pages. Only a small portion of data set will be presented as findings in this dissertation. Therefore, great caution was required in order to select the appropriate extracts for the presentation.

I tried to extract the material so that it could represent the findings in a clear and readable way, and at the same time illustrate that there were 'enough data extracts to demonstrate the prevalence of the theme' (Braun & Clarke, 2006, p. 93). In the end I had to trust my own understanding and the construction of the empirical material, and present extracts that I believed were adequate.

Braun and Clarke (2006) stress that the researcher ought not merely report plain data, rather the material should be used analytically:

> Extracts need to be embedded within an analytical narrative that compelling illustrates the story that you are telling about your data, and your analytic narrative needs to go beyond description of the data, and make an argument in relation to your research question. (Braun & Clarke, 2006, p. 93)

I argue that analysing the interviews thematically is already an analytical approach; as long as the plain data is presented underneath a headline the accounts are already *used* in order to say something that was not necessarily intended by the interviewee. Because music therapy within compulsory mental healthcare is not a widely explored area, I personally think that a purely descriptive presentation of the user experiences could also provide useful information for the field of music therapy. A pure description of the participant's statements could also serve justice to the actual statements. However, I agree with Braun and Clarke (2006) that the researcher's description of the themes and narratives is an important part of the research, for both clarifying the content of the themes, and for using the themes adequately as part of the research process.

In the presentation of the themes I have tried to find a golden mean; I wanted to portray an honest and authentic presentation of the actual conversation, and at the same time I wanted to make a structured presentation comprehensible for the reader (Kvale & Brinkmann, 2010), based on themes that benefits the research. Sometimes quotations

stand alone, but other times it felt necessary to include the context of the given statement and preceding questions in order to promote trustworthiness. As illustrated earlier in table 2, I have compressed the interview extracts to make it readable when presented in the text. The idea has been to promote statement clearly, the way I think the research participants intended. Hence, filler words and disrupted sentences are sometimes removed if this clarifies the statement without changing the content of the statement. Also parts are removed whenever there are long digressions, or when the topic changes during the statement. Sometimes the researcher's questions are also condensed slightly to make the presentation more readable, without changing the content or the way the questions were posed (See table 2).

5.4 Methdological discussion

5.4.1 Trustworthiness and research quality

In order to define the quality of a research process, two terms have traditionally been used: *validity* and *reliability*. If there is a high degree of validity there is a good chance that the chosen research method, and the instrumentalisation of variables, really measure what they are meant to (Heale & Twycross, 2015). For example, if we want to know the temperature outside, the best way is probably to look at a thermometer. If we use standardized thermometers, check several different thermometers, and let other researchers verify the data, there is a good chance that we come up with a reliable result. It is easy to see that these two terms remind us of important aspects of the quality of the research, especially within the quantitative domain.

It is not all difficult to superficially review the quality of my own research using the concepts of validity and reliability. I want to investigate user experiences, hence I ask users about their experiences. And I want to depict reliable results about user experiences; consequently I portray quotations so that everyone can see for themselves how user experiences are found in the field. In a way we could already end the discussion without much further ado. However, the concepts of validity and reliability come with certain limitations when estimating the quality of a qualitative research.

In qualitative research it is not always natural to speak about the reliability of the results, nor if the chosen research method provides adequate answers for the research question (Brynjulf Stige, Malterud, & Midtgarden, 2009). To the contrary, in qualitative research the researcher might not even know in advance what questions to pose. And as outlined earlier in the chapter, there are no clear answers for how to investigate human

experiences. Speaking from the perspective of social constructivism, I take it for granted that I cannot find or portray any neutral results through the research. The overarching goal is still to depict findings that are valid and reliable, but we need additional criteria for judging the trustworthiness of a qualitative research process.

Stige et al. (2009) suggest a broadminded approach when evaluating qualitative research. They note that specific criteria or rules are not necessarily the best way to understand the quality, the depth or the relevance of the research: 'The practice of rule-based evaluation is only defensible when the study to be evaluated is based on a corresponding epistemological foundation. But this premise is often not present in qualitative research' (Stige et al., 2009, p. 1505). Through the acronym EPICURE, the authors instead introduce 7 items that could be included in the *agenda* of evaluating a research:

> We suggest that these two dimensions of an evaluation agenda could be communicated through use of two acronyms: EPIC and CURE. The first cluster, EPIC, refers to the challenge of producing substantive stories based on engagement with a phenomenon or situation, processing of empirical material, interpretation of the evolving descriptions, and critique in relation to research processes and products. The second cluster, CURE, refers to the challenge of dealing with preconditions and consequences of research, with critique, usefulness, relevance, and ethics related to social situations and communities. Our arguments above indicate that neither of these two dimensions can be seen in isolation. Therefore, we have chosen to integrate them in the compound acronym EPICURE. (Stige et al., 2009, p. 1507)

The first part, EPIC, refers to the research as an active process in which the researcher is always an engaging part in the construction of data; presumptions, expectations, and interests are part of the interpretation processes, and we need to be aware of these elements in the construction of knowledge. The other half, CURE, points at the external world outside of the research, and might answer questions of 'how' we research, and 'for whom' the research is relevant.

Trust may be earned through transparency. I have for example outlined my postmodern-informed critical worldview on knowledge, and tried to describe in detail the whole research process, including a step-by-step analysis of the empirical investigation. However, there will always be parts and procedures that are concealed from everyone but the researcher. There is perhaps no easy solution to this challenge in qualitative research, but I have tried to demonstrate honesty regarding both fortunate and unfortunate choices that I have made throughout the research process. In this way the reader

may evaluate the research process, and gain a better understanding for judging the overall quality of the research.

If the study is to be considered trustworthy the researcher also needs to clarify the intensions behind the study: how the results may be mis/used, and how people might be mis/treated as a result of this research. It is the researcher that is responsible for the perpetuated report (Trondalen, 2007). Even though the researcher may change opinions throughout an academic career, when first published, the works will always remain available for misuse in the future. Since I am not capable of deciding who will mis/use this research, I can only try to clarify my intentions for the research, and present my arguments in an organized manner. Then perhaps it will be more difficult to misunderstand or to deliberately misuse the given statements. One time during the empirical investigation I experienced that the information offered by the research participant were so private that I asked whether there was anything of the information the research participant wanted not to be published.

5.4.2 Methodological challenges and limitations

Throughout the chapter I have tried to clarify some weaknesses and limitations of the chosen research method, and the shortcomings of a qualitative study such as this one. To perform research on human experiences through a postmodernist point of view may provoke a few ontological and epistemological challenges. Below I will highlight some of the practical implications and methodological difficulties that I have encountered during the research process, as well as some critiques that seem legitimate due to the presence of hindsight.

Interviews and social research as a craftsmanship

One might think of the research interview method as a tool, and the research performance overall as a craftsmanship. As with other professions, it takes time and practice to master the art of the research interview (Kvale & Brinkmann, 2010). There is no shame in admitting that I am not an experienced researcher, neither within music therapy nor within mental healthcare. Hence, I did not administer the interview process flawlessly. Especially as regards follow-up questions, the study might have benefitted from a more experienced interviewer. And even though there was a music therapist present in every interview, I have noticed retrospectively from the interview recordings that interesting topics occasionally may have slipped away in the absence of adequate follow-up questions:

> R: Do you have any thoughts about what it means for the whole week, to have music therapy on the schedule?
> SARAH: Sometimes I look forward to Thursday a little, because then it's music therapy you know.
> R: Yes.
> SARAH: So it means something.
> R: Yes. But you also… You said that you participate in hikings?
> SARAH: Yes, that's not as fun [as music therapy], hehe. (Interview with Sarah)

In the example above it could for instance have been interesting to learn more about the importance of meaningful appointments on the weekly schedule, such as music therapy: 'How often does she eagerly look forward to music therapy?'; 'How does this affect the other days?'; or 'When does it mean the most to have something to look forward to?' The potential questions are many, and maybe I would have learned a lot just by saying: 'That's interesting. Could you say anything more about this?' Hopefully I caught some of the participant's thoughts on the matter at a later point in time, but it is likely that the data set would have looked differently if a more skilled researcher had performed the interviews.

Especially during the first interview I realized afterwards that I had not been completely neutral in the way I posed the questions. Even though the interview guide was designed to be quite neutral in its formulations, when translated to a verbal state these questions were not always as unbiased, as we can see from the transcription below:

> Do you have any thoughts about what has been the most important – you've said something about this already, but if you have something more to apply – in that you're allowed to have music here? (Researcher, in the interview with Lee)

Even though I transcribed, evaluated, and learned from my mistakes prior to conducting the next interviews, I might occasionally have posed the questions in value-laden ways. Seemingly, I sometimes failed the assignment of 'gently nudging without bias' as scholar Tim Rapley puts it (2007, p. 20).

Another potential bias that I encountered was my researcher feedback within the interviews. I have that there were comments and responses within the data set that appeared value-laden. When trying to tune in on the participants, and to respond enthusiastically, the directedness of the feedback may potentially have triggered similar responses, or even coloured the general experience of what made up the right answers. It seemed

for instance that I, as the researcher, had the tendency to follow up the participants' statements with the word 'cool':

> L: It's a stress releaser for me, to write tunes.
> R: Yes, I see… to relax?
> L: Yes, relax.
> R: Cool. Is that something you do now, or something you did a long time ago, or something you do occasionally?
> L: I do it rarely.
> R: Yeah… Stress releaser.
> L. Yes, stress releaser.
> R: Cool, that's fun to hear. (Interview with Lee)

In this example, which is also an extract from the first interview, my comments might seem value-laden. And even though the comments were only meant as positive and human responses, they might have been interpreted as judgements about the quality of the statements.

Limitations of the interview as the only research method in this study

I agree with the French philosopher Sartre in that human beings can have no access to other minds (as described by Onof, 2020). And previously in this chapter I have pointed at an inevitable gap between that which is thought and experienced by others and what I can comprehend as a researcher outside of others' minds. In the following I will deliver a few critiques of the interview as the only research method in this study, and discuss briefly how additional research methods could potentially have benefitted this study.[61]

I previously described the interview setting as a construction site for knowledge (Kvale & Brinkmann, 2010). And in several ways the research interview is a method that provides little ecological validity to the study. The interview conversation is constructed by the researcher, and is intended for a specific purpose: 'In terms of the level of engagement, most interviews represent something related to an experimental practice within interpretivist research, because the researcher has to set them up; in this way, they are artificial (Keith, 2016, p. 234).

Early on in this research process I wondered whether I could obtain user perspectives in other ways than through mere interviews that would perhaps provide a more 'natural'

61 The Ph.D. Adjudication Committee recommended including more critiques of the interview as the only research method, in their preliminary report of this thesis.

access to the research participants' experiences. I initially thought about different ways to describe experiences, such as 'diary notes' or 'field notes' written by the participants, song lyrics made in music therapy sessions, audio tapes of spoken reflections, or E-mail correspondances in which the research participants were given more time to digest the questions and answer whenever they felt ready. I believe that all of the mentioned methods could have provide new insights if performed in addition to the research interviews. Although I decided to only stick with interviews in this study, for pragmatic reasons, I believe that researchers, including myself, may benefit from thinking creatively in regards of data collection in the future.

Another relevant research method that could have complemented the interview is observation (Keith, 2016). Observations from real music therapy sessions could have provided useful information about what is actually going on in the therapeutic process of the given participant, such as the contents of the sessions, the therapeutic relationships, the 'atmosphere' in the room, the accomodations made by the therapist in order to motivate the participants, or the change of affection or body language throughout the session. In other words, there is a lot to learn about a situation when having the possibility to witness it. Insights from observation could have been used to comment on the interview accounts, or perhaps even form new categories on its own. Without actually performing observations in the first place it is hard to tell excactly what this study has missed out on, but it is certaint that *something* relevant is lost, depending on the chosen type of observations. Perhaps could I even have invited other health professionals to observe music therapy sessions, and help describe the outcomes from music therapy through the lense of other professional backgrounds. Perhaps could observation of the music therapy sessions inspire and facilitate new questions and conversation material, and lead the interviews to new directions.

Given the postmodernism-informed critical perspective I claim to represent, I could also have made use of discourse analysis as a research method (e.g. Talbot, 2016). I could for instance have investigated how music therapists speak about music therapy compared to the language that the participants use to speak about music therapy; perhaps would I discover important nuances regarding user experiences from the terms that belong to the participants, which differ from the language used by music therapists.

Needless to say, there are many ways to perform a study, and I would like to stress for the reader that this study comes with vast methodological limitations. Still I believe that the choice of interview as research method answer to its purposes to a certain degree. And since no study is perfect I find comfort in the wisdom of Bruscia (2014):

> Practice, theory, and research are interdependent and equally important; however, ultimately, each serves a different purpose. Music therapy is first and foremost a discipline of practice, with the specific purpose of helping clients to promote health. The purpose of research and theory is to enhance our knowledge about clinical practice and thereby facilitate its aims. (Bruscia, 2014, p. 269)

I do believe that the research interview is a decent method for learning something from the user perspective. And I know that the study is intended to improve music therapy for persons within compulsory mental healthcare. Also, I hope that the combination of participant accounts, an exploration of compulsory mental healthcare, and a post-modernism-informed critical perspective that aims to liberate persons from injustice, will enhance our knowledge to the extent that music therapy practices are imporived in *some* way.

The researcher is not also the music therapist

In qualitative music therapy research it is quite common to possess the roles as both researcher and music therapist for a population simultaneously. This can be a methodological and ethical issue for several reasons, but there is also a chance that the therapeutic bond opens doors that are otherwise closed. In this study I was not known to the interviewees, hence they could possibly hold back information that would have been available for the therapist. Some information may be available for the researcher only when the client's therapist is present during the interview. And some information may be hidden within the participant, and revealed only to those sharing a close, personal or therapeutic relationship.

Some information, on the other hand, may have remained hidden because of the therapist's presence. The client maybe wanted to share thoughts about the therapist, or about how the therapist works, but was afraid to do so out of respect for the therapist's feelings. Perhaps the research participants did not believe in any effects or outcomes from the music therapy interventions at all, but were afraid to say so because this could affect the music therapy process, the music therapists' feelings, or the music therapist's position and status in the hospital ward.

When I interviewed unfamiliar participants, it means that I did not know much about their current or previous therapy processes either. Hence, the participant's respective therapist would perhaps be more capable of posing relevant questions regarding specific situations from recent months or years.

I believe that the large amount of groundwork regarding the interview guide, together with the presence of the participant's music therapist, made the interview situation *safe enough* for the interviewees. I will never know whether any important information was lost due to the presence of the music therapists within the interview situations, or whether relevant information was acquired because of the inclusion of the music therapists.

Trustworthiness of the participants

Hospitalization in mental healthcare often includes medication, which is also the case for several of the research participants in this study. Such medications may come with sedative effects, and they might influence both thinking and judgment skills (Otsuka America Pharmaceutical Inc., 2014)[62]. It was important that I took these matters into consideration when doing research with the interviewees. However, from my experience with talking with the research participants I did not find any of the participants delusive, or not able to speak their minds in the interviews due to medications.

Severe mental illnesses might correlate with the difficulty of performing a conversation. Some service users within mental healthcare might respond to a verbal inquiry with a latency of several seconds. Others might be more mind-taken about spoken hallucinations or delusive thoughts, and struggle to relate to a given topic. When I chose verbal language as the medium for learning more about participant experiences, I laid trust in their capability of expressing themselves verbally. I do not think that the study suffers in any way due to the participants' state of mind. I think I can trust the participants when they open their hearts and talk about their experiences with music therapy.

Response latency may have affected the interview situation at least for one of the research participants. A few times the research participant answered the questions, or continued a line of thought, after pauses up to 10 seconds. During this interview I tried to adjust to the participant by providing enough time for the participant to speak freely without interruptions. I do not know, however, whether I always waited long enough, or if I proceeded with other questions too quickly.

The potential voluntary bias

The findings on voluntariness in a research like this can be criticized regarding the selection of research participants; a small number of participants who participate voluntarily in music therapy are asked about their opinions and experiences. I expected

62 The chosen example refers to Abilify, one of many substances that are frequently used in mental health facilities in Norway. The reported side effects are collected from the company's own web site.

the participants to be more or less fond of music therapy, and they provide answers thereafter. This area of critique may be especially true when it comes to the question of voluntariness of music therapy. Research participants, who experience music therapy as involuntary or something negative, might not be the first to volunteer for this research project in the first place. Thus, it is important to remember that the empirical findings in this study should not be understood as evidence for universal truths about the voluntariness of music therapy. Rather, the findings portray a description of the voluntariness of music therapy participation as experienced by *some* research participants.

5.4.3 Ethical concerns

In this part I will discuss some of the choices that were made, and thoughts that have appeared, regarding the ethical concerns of this study. The research process always entails ethical conundrums. I do not want to justify my choices; rather, I want to make transparent the thoughts behind the choices that were made, as well as to promote awareness about ethical concerns that may prove relevant for further investigations.

Other music therapists selected the research participants

In order to reach the research participants I contacted music therapists working within mental healthcare, and except for the interview situation I had no direct contact with the participants themselves. Hence, I was neither able to decide nor approve the participants in advance of the scheduled meeting. Instead, I needed to communicate with the therapists in advance to make sure we shared a common understanding of the potential candidates. Only a few instructions were given in the dialogue between me and the working music therapists, in addition to the inclusion criteria mentioned in chapter one. It was relevant that the participants did not struggle too much with verbal communication, and that the participants were physically and mentally well enough to go through the potentially stressful situation of a research interview. It was also important that the potential research participants understood that participation in the research was voluntary, and that this was communicated clearly by the music therapists when informing potential research participants about the study.

As I see it, to let other music therapists select research participants could involve challenges, but I think that the selection worked well. In this case the music therapists who collected participants were all trained music therapists, mostly with a lot more experience from working in the field of mental healthcare than myself. The therapists were also the ones who knew the participants the best.

Gender bias

I did not set gender balance as a criterion prior to the research, and consequently, there is a certain gender imbalance in the study, with one female and six male participants. Hence, the research could suffer from gender bias. Even though the plan was never to generalize any findings, the gender imbalance may affect the findings of the study. Perhaps there are differences between genders regarding preferred music activities or aims for the music therapy process? According to previous literature on compulsory mental healthcare, as described in chapter three, it seems that male and female service users are treated somewhat differently regarding compulsory interventions (Hustoft et al., 2013; Iversen et al., 2011; Knutzen et al., 2013; Knutzen et al., 2007; Norwegian Directorate of Health, 2016a). Also male gender correlate with experiencing humiliation during admission to mental healthcare (Svindseth, 2015; Svindseth et al., 2013). For service users receiving mental healthcare by outpatient teams, the service user's female gender correlated with satisfaction of the service provided (Bjørngaard, Ruud, Garrat & Hatling, 2007). If female and male service users experience compulsory mental healthcare differently, it is also possible that female and male service users have different needs in music therapy within compulsory mental healthcare.

This is a methodological concern, but also an ethical issue. Though I support the notion that the genetic and physical differences between genders are often exaggerated in society, there are *constructed* differences between the genders due to myths, social norms and attitudes (Alvesson, 2002; Lykke, 2010). Repressing beliefs and attitudes about gender, may in turn create relevant differences in behaviour. And these potential differences are not mirrored in this particular research.

Although the male gender is over-represented in the study, the participants' gender was never the minority within the interview situation. In most interviews both the researcher and the research participant were male, and the music therapist was either male or female. In the interview with a female research participant the present music therapist was also female.

Consent and coercion

Each of the research participants were given a consent form with information about the study form by their music therapist in advance of the scheduled interview, and the documents were signed by all parts in advance of the interview. The music therapists and the music therapy participants signed different, and slightly dissimilar, consent forms (see Appendix 2 and 3). It is vital that the client is given the opportunity to withdraw from the research. This information must be presented in such a way that the participant

truly understands that he may actually withdraw at any time, and for no reason at all. This was highlighted in the consent document that was signed by every participant in prior of the interviews (see Appendix 2).

An important criterion for recruiting research participant is that of competence to consent (Mohlin, 2009). The participants must be judged to understand what participation in a research project implies. It is important to notice, though, that no one can ever *fully* understand what participation in a research might include. The conundrum of participating in other projects when one should perhaps pay more attention to one's own health and recovery is not a phenomenon restricted to people within mental healthcare. No one can really know what sort of impact the written report will have in the future, when it is too late for the participants to withdraw from the study.

The matter of consent is an interesting conundrum when facing compulsory mental healthcare. This is especially true after the newest revisions of the Mental Health Care Act as outlined in chapter three (Lov om endringer i psykisk helsevernloven mv. (økt selvbestemmelse og rettssikkerhet), 2017). On the one hand service users are treated involuntarily because experts decide that they are not capable of taking care of their own life and health, and that they are not able to make appropriate judgments that are safe for themselves or for others. According to the law text today, the view on service users' ability to consent will decide directly whether or not people are treated involuntarily through the 'treatment criterion'. On the other hand, I, as a researcher, and the music therapists involved in this study trusted the participants' competence to consent. My experience was that the participants are individual human beings who were able to decide for themselves that they wanted to contribute to knowledge; they wanted to share something from their repertoire of stories and feelings, and they could decide for themselves what they wanted to share. All of the interviews in this study were performed prior to the applied law changes, and I do not know for how many of these participants compulsory treatment is still relevant after September 1st 2017.

Formal approvings for the research

The study was sent to the Norwegian Regional Committees for Medical and Health Research Ethics (REK) for approval (see Appendix 4); they determined that the research was not affected by the Act for Health Research because the projected aimed at the *experience of* a treatment, and not at *the treatment* per se. Accordingly, REK instead suggested that the Norwegian Centre for Research Data (NSD) should approve the research. NSD approved the research the 22nd of October 2015 (see Appendix 5).

One of the institutions, from which participants were recruited, demanded internal approval of the study on an organizational level. For the sake of confidentiality, all names and details that may reveal the geographical location of the institution are censored in the attached document (see Appendix 6).

Confidentiality

The names of the research participants were anonymized already from the phase of transcribing the interviews, as a way of securing confidentiality. The research participants had the opportunity to suggest aliases themselves. I have also avoided using names on involved geographical areas, mental health institutions, and the music therapists participating in the research.

5.4.4 Potential positive outcomes for participants in the research

A significant difference between music therapy and music therapy research, is that research may seek knowledge for the sake of knowledge, whereas therapy processes are executed in order to promote health (Bruscia, 1998). Even though the interview situations may possibly be stressful for the participants, participation in a research project may also afford positive experiences. An interview situation may also lead to positive outcomes similar to those we try to achieve in therapy situations, by focusing on the participant's resources and perhaps providing new insight about the potential of music as a health resource. In the classic definition of music therapy, as mentioned in chapter one, Even Ruud (1990) suggests that music therapy's main task is to promote new opportunities of action for the participant. To challenge participants to participate in new activities, such as the research interview, can be a health promoting intervention, if taking into consideration a broad perspective of human health.

In Norwegian mental healthcare, experiences of mastery are highly valued in governmental documents (Solli, 2009). And it is possible that the ability to aid the researcher can be experienced positively. The participants are chosen because they know something that the researcher does not. Hence, the participant's competence and reflections are valued as important. Hopefully this may be transferred to other parts of life; the participant is unique, and his contribution in the world is something that cannot be replaced by someone else.

6 Empirical findings

In this chapter I will present the findings of the study, based on the analysis of the interview transcripts. Through the thematic analysis three main themes have been constructed. The theme first presented contains three sub-themes, whereas the next two themes contain four sub-themes. The themes and sub-themes are as follows:

- Voluntary music therapy
  - The participants experience music therapy as voluntary
  - The participants attend their music therapy appointments
  - The participants want more music therapy

- Motivating music therapy
  - The participants' relationships with music
  - Freedom from coercion, treatment and hospitalization
  - Freedom within music therapy
  - The social dimension of music therapy

- Health promotion through music therapy
  - Something to look forward to
  - Getting up and involved in activities
  - Uplifting and meaningful experiences
  - Symptom release, self-development and recovery

The constructed themes will be presented in the same order as in the overview above. Each of the themes will be given an introduction, and each of the sub-themes will be exemplified with quotations from the data set. First I will explain what thoughts lie behind the construction of the three main themes.

6.1 The construction of the main themes

In chapter four I tried to clarify, and to make transparent the whole technical process of the thematic analysis. I also wish to explain why the themes were organized the way they are.

I analysed the data set thematically. One way to do this, and perhaps the most obvious one, would have been to organize all statements within the same topic into a theme. Thus, every statement about for instance motivation could have been placed in the theme 'motivation'. Also, every statement about voluntariness could have been placed together in the theme 'voluntariness'. This is not exactly what I have done.

Let us think about the thematic headlines as were they organized side by side on an x-axis. Underneath each of the theme headings we find columns of statements that fit with each theme. However, when I started to scrutinize the data set and organize the statements into themes, I came across a challenge that made me think differently about the nature of the themes: I felt that the different statements answered different kinds of questions. And in a way, the various statements also provided knowledge on different levels. Thus, I will in the following argue that a horizontal organization of the themes, on an x-axis, was not necessarily the most productive way to organize the data set. In addition to thinking horizontally about the emerging themes, I tried to organize the themes vertically, on the y-axis. This two-dimensional view on empirical material, I believe, helped me to understand the different qualities of knowledge within the data set (see figure 1).

In the first theme, *voluntary music therapy*, we find a collection of statements related to the experience of music therapy as something voluntary. In a way, we can say that this theme orbits around a rather superficial level of knowledge and is partly to do with events occurring in the actual world. The research participants *did* attend their music therapy appointments despite having to travel long distances, or despite lacking energy. And some of the participants *had* taken the initiative to increase the frequency of music therapy sessions. We can say that this first level of knowledge provides answers as to '*what* is going on in music therapy'. Through this first theme, voluntary music therapy, we have also provided answers to a closed research question: 'is music therapy experienced as voluntary?' The construction of the theme *voluntary music therapy* teaches us about participation in music therapy, and also about the nature of its voluntariness. But the theme voluntary music therapy doe not tell us *why* the participants partake in music therapy, or what music therapy participation can contribute with. I understand the theme voluntary music therapy as a scratch on the surface, or as a doorway into the following two themes: *motivanting music therapy* and *health promotion through music therapy*.

The second theme is devoted to statements regarding a *motivating music therapy*. Already in the previous theme, voluntary music therapy, we learned something about music therapy and motivation: As arguments for the description of music therapy as voluntary, I included the initiatives of more frequent music therapy appointments, and

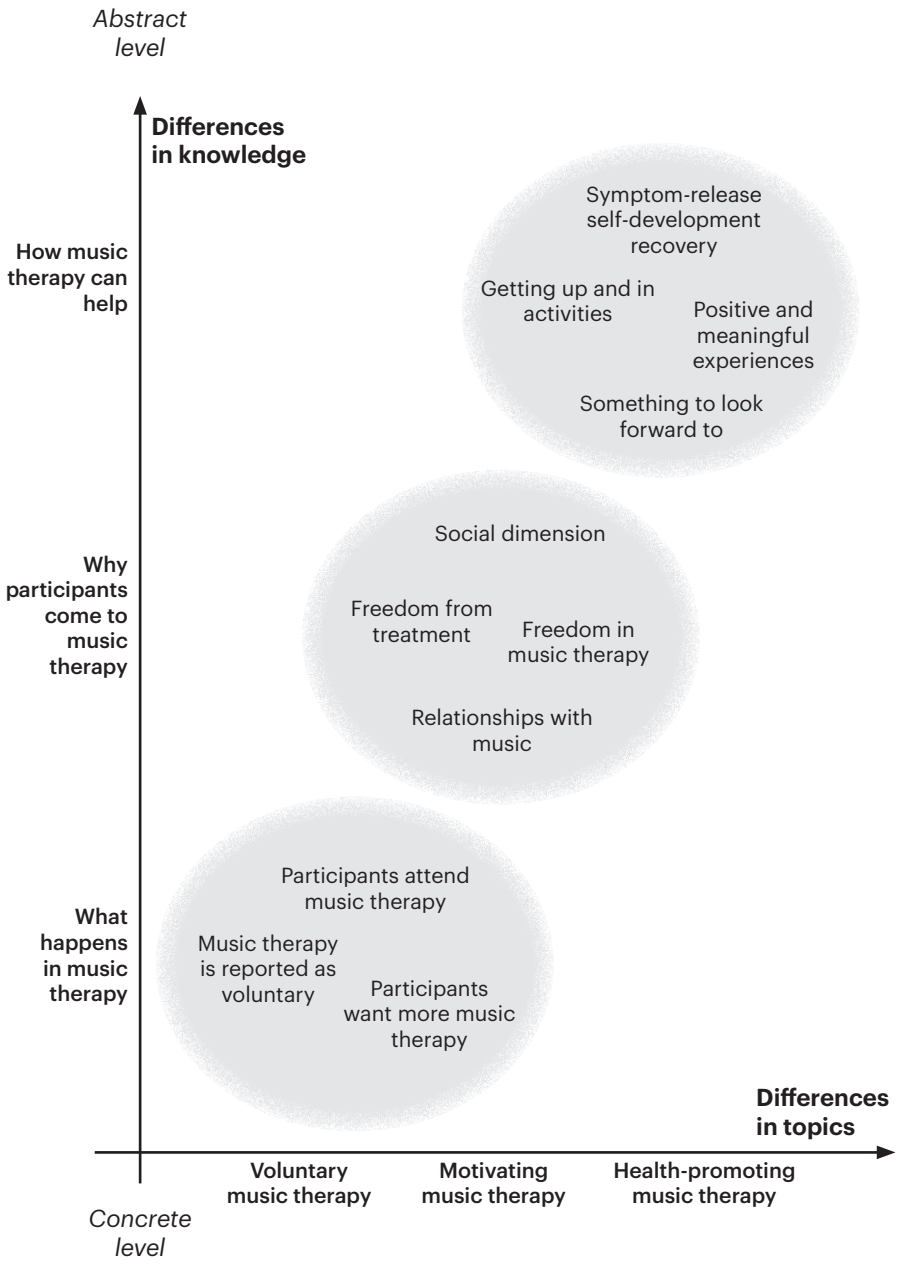

Figure 1: The figure depicts my understanding of the themes constructed through the thematic analysis of the research interviews. The themes are not exclusively constructed from the given topic of the interview accounts (x-axis); rather, the themes also consider the nature of the given accounts, and the potential differences in knowledge they afford (y-axis).

the fact that the participants did attend their appointments in spite of their everyday challenges. These two facets from voluntary music therapy could have been included in a broad theme focused on 'motivation' alone. I argue, however, that the second theme, *motivating music therapy*, encompasses statements that provide answers to knowledge on a different level. We have already learned that people are motivated to engage voluntarily in music therapy activities, but in the theme *motivating music therapy* we proceed deeper into the matter as we encounter statements that may provide answers as to *why* people come to music therapy. Trying to think both horizontally and vertically, the theme motivating music therapy includes statements that follow on from direct questions about motivation, as well as the researcher's interpretation of potential coherent connections between statements and motivational causalities. Thus, motivational concepts for participating in music therapy, as outlined in this study, are about the following: the participants' relationships with music, music therapy as a break from treatments and hospitalisation, a sense of freedom within music therapy and the social dimensions of music therapy.

As with the potential correspondences between the first and second theme, the same is true for the first two themes and the last theme, *health promotion through music therapy*. One might say that weekly engagement in music therapy is health promoting on its own, or that it is impossible to separate experienced voluntariness from experienced joy or experienced well-being. From the third theme, health promotion through music therapy, we learn that music therapy can give the participants something to look forward to in their everyday life, and that the planned appointments help them to get out of bed, out of their rooms, or out of their homes, in order to meet for their music therapy sessions. Through music therapy the participants get to partake in meaningful moments, and they experience joyful aspects of life. The participants also report other beneficial by-products of music therapy engagement, such as symptom release and self-development. As I see it, this last theme, health promotion through music therapy, does not only differ from the others regarding the topics; in addition, the nature of the statements affords a qualitatively different kind of knowledge than in the previous themes, and may answer another kind of research question: '*How* can music therapy participation benefit people within compulsory mental health care in their recovery processes?' We may think about this third theme also as a third level of knowledge.

A qualitative research process will never be completely transparent, nor possible to be verified by other researchers. However, I have now tried to explain how the themes have come to be, not only through a step by step-analysis as described in chapter four, but also as a bi-dimensional construction taking into account both the horizontal themes on the x-axis, and different levels or qualities of knowledge on the y-axis. As I have previously stated, I believe that a thematic analysis from a data set will always be a result

of subjective and social constructions (Alvesson, 2002). And even though no one else would have come up with exactly the same thematic presentation, I believe that the findings in the study portray a valid image of the data set. That is, I think that I have presented *one* valid construction out of an endless stream of different combinations and structures. Although the findings can merely represent subjective constructions, I still hope that I have managed to keep the reader informed both about the choices that were made, and about the degree of systematic work that has been performed, in order to provide an overall sense of trustworthiness for this study.

6.2 Theme 1: Voluntary music therapy

From the beginning I have based this study on the pre-understanding that participation in music therapy is voluntary. However, I did not know for sure whether this was all true, or if participation in music therapy was *experienced* as voluntary, when otherwise treated involuntarily. Some findings derive more or less from direct questions in the interview guide regarding the experience of music therapy participation as voluntary. Other findings are based on statements that otherwise appeared in the interview conversations, for instance when talking about the therapeutic process, and the frequency of music therapy appointments.

The sub-themes in *voluntary music therapy* are a) The participants experience music therapy as voluntary; b) The participants attend their music therapy appointments; and c) The research participants want more music therapy.

6.2.1 1a – Music therapy participation is experienced as voluntary

The research participants seemed to welcome music therapy voluntarily, and they reported that they were free to reject music therapy if they wanted to. The participants could not think of any negative consequences for skipping music therapy appointments, except for their own wish to participate, and for not wanting to let the music therapist down, such as Alex mentioned:

> R: Do you feel that it is voluntary, your participation in music therapy?
> ALEX: Yes! Because I'm the kind of person that, if I don't want to participate, I say "no thank you". Like with the physiotherapist last week, I was very tired and had a rough day, and she says: "Yes, but you know, sometimes it gets better when you get it going, even though you're tired". So I said: "You

> know what, I'm tired. I understand that you try to do your job, and you're doing a fantastic job, and you're inspirational and all that, but today I don't wish to work out. (Interview with Alex)

All of the participants were quite clear about their view on music therapy as something voluntary, and as we can see from the statement, Alex was also specific about the capability to reject the requests for other voluntary treatments or activities. The participants in this study attended music therapy because they wanted to.

Even though the music therapy participation is experienced as voluntary, conscientious bonds and social commitments within the therapy relationships may, in a way, influence the sense of freedom:

> R: Have you always experienced it [music therapy] as voluntary, in a way?
> FRANK: Yeah, definitely! Like, I can't not go.
> R: Yes, for you own sake?
> FRANK: Yeah, 'cause it gives me so much. It's been voluntary, but you always feel bad if you show up late or you don't show up, for there were a couple of times were my dad came, and then we decided to go out instead of having music therapy, and then I felt bad.
> R: Yes, for yourself, or…
> FRANK: Yeah.
> R: … or for the music therapist?
> FRANK: And for her, not being able to play with me, you know, he he [everybody laugh]. (Interview with Frank)

Even though Frank perhaps was joking about feeling bad because the therapist did not get to play with him, it is still possible that strong therapeutic relationships affect the quality of freedom, and thus provokes the feeling of *having to* attend the appointments.

Despite being treated involuntarily within the mental healthcare system, and partly loosing their right for self-determination, the participants were clear about the choices they *could* make:

> R: Do you feel that it's voluntary, that you may decide for yourself whether or not to have music therapy?
> KIM: Yes, if not… Well, if there is something I don't want to do, I don't, as simple as that. Nobody can force me to do something I don't want to. Basically. (Interview with Kim)

Even though Kim was sentenced to mental healthcare, and was involuntarily hospitalized for several years, he thought highly of his freedom to administer his own life whenever possible. Later on in this chapter we will return to this topic more profoundly, when we encounter the hypothetical issue of obligatory music therapy.

Even though music therapy is experienced as voluntary, this is not necessarily something music therapy participants think about on a daily basis. When engaging in meaningful activities, few people probably stop to think about the degree of voluntariness in what they do. The opportunity for Ian to attend weekly music therapy sessions was important for him, and probably more important than abstract questions of voluntariness:

> R: Do you feel that you are the one who decides whether or not you will have music therapy?
> IAN: Well, it is for my advantage. It is… well… to me, it doesn't matter who decides, as long as I'm allowed to have it [music therapy]. (Interview with Ian)

Sometimes philosophical and ethical questions of freedom and voluntariness are more for those who are particularly interested. For Ian, it was a matter of doing what he liked.

Parts of the findings in this sub-theme is devoted to a more hypothetical issue, as we address the question of what it could have been like if music therapy participation was not voluntarily based, and if the participants had to attend music therapy as part of the compulsory mental health treatment. The findings are based on real user accounts, but the accounts derive from a topic that was fictitious for the research participants. The fictitious scenario of obligatory music therapy participation seemed to be imaginable for the research participants, who were all familiar with being exposed to other involuntary interventions. And even though the topic of a potential obligatory music therapy may remain hypothetical also in the future, I still believe that the opinions from the service users are relevant, and that their viewpoints may reflect features about the crossing over between voluntary music therapy and compulsory mental healthcare. Several of the participants commented that an involuntary aspect of music therapy would probably change the overall experience of music therapy negatively. When forced to do something, inner motivation may be affected counterproductively. Sarah described how coercive measures might provoke a desire to get away:

> R: What would it be like, do you think, if you had to be here, and was told that "you are going to have music therapy once a week"? That it was, in a way, something you couldn't decide for your self?
> SARAH: I don't think that would have been quite as nice.

> R: No?
> SARAH: Because… I think the psychologist and I talked about that once, that at the moment it is a matter of coercion, so… if you are coercively admitted, you want to get away at once. So in a way, you want to escape, or you want to get away, and then at least you don't want to be there. So if it [music therapy] was something I had to do, I don't know if I would have appreciated it as much. (Interview with Sarah)

Alex agrees that the idea of coercion works counterproductively, because it is so easy to react oppositely towards coercion:

> R: But if [name of music therapist] had contacted you and said: 'here music therapy is obligatory, and on Wednesdays you are going to attend music therapy', what would that be like?
> ALEX: For me, personally? Well, when thing starts to get obligatory, and people say to me 'you have to', then I get like: 'No, I don't want to'. Then I become a fourteen-year-old: 'I don't want to!' But if people used a bit more psychology, or if [the music therapist] had been more like: 'Alex, now we all see that you have stayed in your room all day, couldn't you come with me down [to the music room] and play some music?' Then I'll join in: 'That's nice, let's do that!' I believe that it will work for most patients, because most patients are here compulsorily. So to be forced to attend even more things, that is, to be forced to attend even more things within the strong coercion in which we already live, does so that few people are present.
> R: So, one needs some voluntary things as well, something to decide for oneself?
> ALEX: Yes. (Interview with Alex)

In the example above, Alex called for an honest and personal invitation to the music activity, and argued that such motivational works might be the most effective way to facilitate for participation. Previously in the interview however, Alex stated that the physiotherapist's attempt to motivate him in this way did not work very well, merely because he had already decided he did not feel like it. Hence, there is reason to believe that the pleasant appearance of a motivating music therapist, as described by Alex, will not necessarily be enough to provide participation on its own. If the activities or treatments are voluntary, then the participation needs to come from the participant as an active decision maker. We know that Alex did actually attend his music therapy appointments, because music therapy is something he was motivated for.

The matter of obligatory treatments is not always a question of legal status. When it comes to voluntary activities, a motivational push or 'nagging' from staff members can feel obtrusive, and may in some cases work counterproductively as this affects the mood of the person negatively:

> R: If we had a group that was obligatory, that everyone had to participate in the group, do you think that would make any difference?
> LEE: Then people would have felt that they were there coercively. Not voluntarily, but coercively.
> R: What do you think it would… would it affect how people are, when they're there?
> LEE: Yes, I think it would have contributed to a negative mood. Because one should not be forced to do something, you know. [It's] Better to do what they want, if it's something they want and are passionate about, to sign up for the group, instead of everybody needing to participate obligatorily.
> R: How much does one have to nag before you feel that you have to [attend]?
> LEE: Well, to me, for music therapy I need no nagging; I go there anyway. But with other therapies, then it's more like 'Lee, you have an appointment', this type of nagging to get up [out of bed].
> R: Yes. How… What does that to you?
> LEE: It makes me get negative thoughts.
> R: If you're nagged at?
> LEE: Yes. But everything's ok, it is ok.

In mental healthcare, the golden mean of an adequate motivational push is not easily accessible. Pushing too much can feel intrusive; yet too little motivational work may not be very therapeutic. At the same time, these user narratives teach us the value of finding activities that service users are actually motivated for; there will always exist activities, potentially with therapeutic effects, that are more motivating to engage in than others.

The participants in this study engage in music therapy voluntarily, and they participate mostly due to their inner motivation. The fact that the participants choose to partake in music therapy is likely to affect the overall experience of music therapy; as Sarah explains it below, it is probably easier to participate, and listen to thoughts and advice from the therapist when she is voluntarily attending music therapy in the first place:

> R: If you had not come to the music therapy [appointment] once, do you think [the music therapist] would be angry, or…?

SARAH: No, hehe. I think she'd wonder why not, and then we would probably talk about it the next time.
R: Yes, so you don't feel there is any pressure to come here [to music therapy]?
SARAH: No, it's something I want to.
R: Yes. What do you think that does with attending music therapy, that it's something you want?
SARAH: I think it makes it much easier. I'm willing to learn, and in a way, I'm willing to hear about those comparisons between the piano and life, hehe. (Interview with Sarah)

When people are motivated to participate in music therapy, it is understandable that they enjoy music therapy, and there is also a chance that this enjoyment comes with engagement and an extra effort throughout the therapy process. At least the joy of attending music therapy helps Sarah to meet with the well-intentioned advices and narratives from the music therapist.

When interviewing Peter about a hypothetical obligatory music therapy, he states that he would refuse to participate in music therapy if it was a matter of coercion. He also reminds us that his state of health is not something he has chosen freely.

R: What do you think would've happened if [music therapist] said that you had to come to music therapy, that you could not decide yourself? It sounds maybe a bit strange?
PETER: No, well, yes, you speak about coercion. If it is coercive I say: 'no thank you'.
R: Yes?
PETER: Yes.
R: Is it not as fun, then?
PETER: No.
R: Do you think it's important, to be able to choose for yourself?
PETER: Yes, it's really important.
R: Yes. Do you have any thoughts about why, why it's important?
PETER: Yes, not everybody wants to get sick, you know. (Interview with Peter)

Peter did not choose to be ill, and he has not chosen compulsory mental healthcare. All in all, there is probably a lot that he cannot decide for himself. But music therapy is a part of Peter's daily life that he can choose. He could even suggest increasing the

frequency of appointments with the music therapist. And even though he has quite a long way to travel, Peter attends his music therapy sessions every week.

6.2.2 1b – The participants attend their music therapy appointments

The participants in the study reported that they usually met for their music therapy appointments, and music therapists confirmed this in several of the interviews. In service users' lives there will always be unpredictable variables and obstacles that prevent participants from attending their weekly activities. Yet, the participants in this study seemed to go a long way in order to follow up their music therapy appointments. Despite different challenges the research participant had in their daily lives, we will in the following examples see that they did attend their appointments. During one and a half years of music therapy Ian had showed up all but one time:

> R: Are there times when you don't want to come here [to music therapy]?
> IAN: Barely.
> R: Mhm, but you usually show up?
> IAN: Yes. The other week my throat was aching, and things like that.
> R. Yes, physical issues as well, it happens. But you usually get here?
> IAN: Yes.
> R: And want to?
> IAN: Yes, it means a lot to me. (…) There's only been one time I didn't come, and then there was a combination of many things. (Interview with Ian)

During the interview Ian mentioned that he went to his outpatient music therapy appointments by taxi every other week, and that people from where he lived drove him by car the other times. Perhaps this system helped Ian to actually attend music therapy every week.

For service users going through healthcare as outpatients, geographical distance is a potential obstacle for attending appointments. Peter, however defied travel distance and early mornings, and joined the music therapist each week. For him, other appointments were often made in conjunction, so that he did not have to travel more than necessary.

> R: Is it easy to get here?
> PETER: No, I have to take the bus, you know, so it's a long way.
> MT: The bus connections here are poor, so he needs to change busses quite a lot […] but we often organize it so that you have other appointments the same day, so there is a reduced need to travel back and forth.

[…]
R: Are there times you want to stay at home, instead of coming out here?
PETER: No.
R: No? You always want to come here, even though it's a bit far?
PETER: Yes.
[…]
R: Do you find it easy to get up then?
PETER: No.
R: A bit hard?
PETER: I'm sick. So it's a bit tiring to get up, you know. But I use the alarm [clock], so it doesn't matter.
MT: You manage to get up when you're going [to music therapy].
R: Is it different to get up if you know you're going to music therapy?
PETER: Yes. If I don't go to music therapy I lie in bed and sleep, you know. (Interview with Peter)

Despite mental health challenges and long distances to travel the attendance at music therapy was still worth the effort. In Peter's case it was of course possible that the other appointments, which he attended on the same day as music therapy, were not voluntary. As an outpatient he might have needed to meet for regular conversations and medications in order to avoid compulsory admissions. Nevertheless, Peter spoke about participation in music therapy as voluntary.

The ability to continue participation in music therapy is not always a matter of motivation; sometimes the question of showing up to the music therapy appointment is solely dependent on the degree of structure, planning and communication.

R: Has it ever occurred that you have not showed up to music therapy?
ALEX: No.
MT: There was one time, because you weren't informed.
ALEX: I was out.
MT: That was my fault. And then you got the information a bit abruptly, so I understand that; one has a schedule and things to relate to.
ALEX: Yes, that's true. (Interview with Alex)

Especially for inpatients, the office hours at the ward can be filled with both a busy treatment schedule and personal appointments. Thus, unorganized schedules and miscommunication might affect whether the users have the opportunity to actually follow up certain treatment programs.

Previous joyful experiences can be helpful for motivating the participants on days with a more troublesome mood and energy level. Thus, the research participants might show up to the music therapy appointments even when having a bad day, as Sarah explained it:

> R: Are there times when you don't want to attend music therapy?
> SARAH: Only if I'm having a bad day and I don't feel like it. I usually go anyway, but then we have a shorter session, for instance when I'm really tired.
> R: Yes. Do you feel like you're allowed to say so, that you don't endure so much?
> SARAH: Yes.
> R: And [the music therapist] listens?
> SARAH: Yes.
> R: So, you usually attend music therapy [appointments]?
> SARAH: Yes.
> R: What is it that makes you go anyway, even if you're having a bad day?
> SARAH: Because I know that it's nice, and it can give me something, even if I'm really tired or having a hard time. It's something with… to master something, and things like that.
> R: So you manage to think that, even if you have a bad day?
> SARAH: Yes.
> R: That's nice. Do you manage to think the same when you're going hiking as well? [63]
> SARAH: No. Hehe. (Interview with Sarah)

It seems that music therapy appointments were endurable for Sarah because she knew that they might do her good, but also because she had the opportunity to adapt the length of the sessions according to her current state of mood and energy level. Hence, she usually attended her appointments, even when having a bad day.

For some music therapy can be the one activity they are motivated to take part in during hospitalization:

> R: Does it occur that you don't endure or want to have music therapy?
> KIM: No.
> R: No. How is it with other things you attend during the week?
> KIM: I don't attend anything else.

63 To go hiking was mentioned by Sarah previously in the interview, when describing other activities organized by the institution.

R: No, only the music [therapy].
KIM: I don't attend hikings or yoga or anything like that.
R: No.
KIM: He he, I do nothing else.
R: But you get to music therapy?
KIM: Yes. (Interview with Kim)

Service users are different, and service users like different activities and treatments. Yet, sometimes music therapy attracts service users who are not motivated to participate in other treatment programs or activities. It follows therefore that music therapy might be the only organized social activity that certain service users engage in.

For health professionals who work within mental healthcare, an important part of the job may be to motivate people to participate in different activities and treatment programs. But sometimes it is the activity that is motivating on its own; motivational talk from staff members is not necessarily the dependent variable for whether service users want to participate in different treatment program, here illustrated by Lee:

LEE: Music therapy is one of the coolest groups I joined here.
R: What had happened if they had not nagged?[64]
LEE: If they didn't have music group?
R: No, if they hadn't nagged, like: 'Come on, come on, come on'
LEE: If they hadn't nagged, I would probably… or, with the music group I would come anyway. But with the other groups I might not have come.
R: What groups are there?
LEE: We have workouts, and things like that.
R: But with music therapy you'd come anyway?
LEE: Yes, then I come… running! (Interview with Lee)

Although I believe that motivating people is a crucial and never-ending part of working as a health professional within mental healthcare, I think that Lee reminds us of an important thing: If we give the opportunity to partake voluntarily in activities that are experienced as meaningful and fun in their own right, then we have already come a long way in affording arenas for mental health recovery.

64 Earlier on in the interview Lee stated that the health professionals often nagged about participation in the ward activities.

6.2.3 1c – The research participants want more music therapy

The research participants seemed to want even more music therapy when first introduced to this form of treatment. They wanted music therapy more often as part of their treatment program, and they would have liked to participate in similar activities exterior to their current hospitalisation. In addition, the research participants acknowledged the limited access to music therapy within mental healthcare today; they appreciated their opportunity to attend music therapy, and hoped for a development of music therapy so that more people will in the future have the same access to music therapy as themselves.

Several of the research participants in the study had taken the initiative to increase the frequency of music therapy appointments, as part of their current treatment program. At the time of the interviews, some of the participants had already had their wish granted by the music therapists, and others were still waiting for a vacancy in the therapist's schedule to get access to more music therapy.

> R: When did you have your last session?
> IAN: Two weeks ago
> R: Yes, two weeks. Is that the norm, every other week?
> IAN: Yes, in the beginning we had [sessions] every other week. Then we changed to every week, because I felt I needed progress in my skills, and in how often I practiced, and things like that.
> R: Yes. Did you take the initiative to have music therapy more often?
> IAN: To increase the frequency, Yes.
> [...]
> MT: You have also wanted [music therapy session] several times a week?
> IAN: Yes. So now, maybe it will be once one week, and twice the other week.
> MT: Yes. (Interview with Ian)

Ian had already gone from one session every other week, to a regular frequency of weekly sessions. And he hoped to increase the frequency even more, so that he got three sessions every fortnight.

Peter had also previously taken the initiative to increase the frequency of music therapy appointments. He explained that he gets tired if he does not get out and meet people. For him, the music therapy appointments are apparently an important part of maintaining his health in everyday life. And perhaps more importantly, he acknowledged the beneficial aspects of music therapy participation, and used this as an argument for wanting more frequent appointments.

R: You told me that you had [music therapy] every other week at first, and then once a week?
MT: Yes.
R: Who came up with that idea? Was it your idea?
MT: I think it was yours?
PETER: Yes it was what I wanted.
MT: Yes, it was.
MT: You wanted it?
PETER: Yes, I have to get out. Due to my illness, I have to get out and be with friends[65], or else I get tired.
R: Yes, so you would rather come every week?
PETER: Yes. (Interview with Peter)

As we have seen earlier, Peter had to travel quite a long way, with several buss changes, to get to his music therapy appointments. But the outcomes of music therapy overweighed the extra effort to get to the appointments.

One of the research participants did not directly ask for more music therapy, but chose music therapy when her psychologist suggested spending more time each week doing what she liked most:

R: You have [music therapy] sessions once a week?
MT: Yes. We are going to try to increase it to twice a week, if I manage to find a vacancy for it. So we are working a bit on it. We were thinking… We spoke a bit with the psychologist, and thought it could be good, especially because there is so much mastery in the music.
R: Did you suggest two sessions [every week], then?
MT: no, it was the psychologist.
SARAH: Yes.
MT: Through conversations with you. But then he suggested it to me.
SARAH: We talked about what was the best thing on my schedule, and then I said music therapy. Then he said: 'Not talking with me?' [Everybody laughs], and so it was more music therapy. (Interview with Sarah)

As we have seen, several of the participants wanted more music therapy then they had, and they had taken the initiative to increase the frequency of appointments. This is information that appeared casually within the interview conversation; I did not ask about a

65 During the interview Peter referred to the music therapist as his friend. Accordingly I believe that music therapy appointments were included when Peter said that he needed to go out and meet friends.

change in the frequency of appointments in particular, and I do not know whether this have been a topic for the other participants, or whether someone else have taken the initiative to decrease the frequency of music therapy appointments.

A couple of the participants wished they had started with music therapy earlier, and reported that they found out about individual music therapy sessions merely by chance. Both of these users had already participated in other music activities prior to their individual sessions. Still, they had not fully grasped the different possibilities within the music therapy program, and would have liked to get the opportunity to participate in individual music therapy sessions at an earlier stage.

> R: How did you start… really… with… having music [appointments] here?
> LEE: Well, I had…. There was a patient here who attended music therapy on [playing the] the guitar, and then I also wanted that on the drums, I thought. Now that I was… referred to music therapy… And that… I have been here for a while now, and I didn't know that, that one could get individual appointments.
> […]
> R: And then you wish… you'd started a bit earlier?
> LEE: Yes. (Interview with Lee)

Good communication and thorough information is necessary in order to give the participants the music therapy process they want. Even though service users are motivated to participate in music therapy, miscommunication might prevent participation.

A recurring topic in the data set is the wish for continued music therapy, also after ended treatment. Some of the research participants partake in music therapy activities as outpatients, and at least for two of these participants, it seems they may continue with music therapy for as long as they want. For inpatients at closed wards however, service users might have access to music therapy only for a limited amount of time, until they are discharged after some weeks or months. When first introduced to music therapy, some would have liked the opportunity to continue with it:

> R: Had you heard about music therapy before?
> ALEX: Music therapy outside of this institution – that it exists? No, but I would like to continue with it, actually. (Interview with Alex)

Even though the duration of the participants' music therapy process varied between a couple of weeks and a couple of years, prior to the interviews, an overall finding is that

the research participants have had a good impression of music therapy, and that they wish to continue with it in the future.

Some of the research participants had little experience of musical activities before participating in music therapy, but learned that playing an instrument could be an enjoyable leisure activity. The participants stated that they would like to continue with music activities, such as music lessons or playing in a band, outside of music therapy.

> R: Do you think you will continue to engage in music [activities] in the future?
> LEE: Yes, that's something I would like to do when I'm discharged. [Playing the] Drum kit is something I want to do, also outside of the hospital. Perhaps having some individual lessons by a teacher. It's a nice hobby.
> […]
> R: So you'd like further follow-up?
> LEE: Yes.
> R: Would you want individual sessions or bands, or…?
> LEE: Start a band, perhaps. (Interview with Lee)

To be able to play in a band can be a motivating aspect of going to music therapy sessions, and we will get back to this matter later on in the chapter. For now, it is interesting to see that both the beginners and the more experienced musicians among the research participants express a wish to continue with music therapy services, or other forms of music activities. Hence, the participation in music therapy as part of mental healthcare may afford new interests and activities to engage in, as part of their daily lives.

Alex got both me, as a researcher, and the music therapist thinking when he asked where to go for music therapy outside of the institution where he was hospitalized. It seems that the music therapist was not familiar with so very many relevant options in the local community, and found it hard to come up with a proper suggestion for the participant's wish to engage in further music activities after discharge.

> ALEX: But where can I receive music therapy outside of this house [hospital]?
> MT: Yes, well, there are so few services you know, at least music therapy specific ones. But we actually need to start talking about that already – which alternatives you would like – and then we have to try and find something. When it comes to music therapy there are few options, but we will go through them, and then there are of course choirs. It's not definite that that's something for you, but there is adult education. (Interview with Alex)

The matter of finding potentially fitting music activities is something Alex and the music therapist agreed to discuss soon, as he was both about to leave the hospital ward and to loose touch with the music therapy at the same time.

One way to access music activities beyond the music therapy process is to facilitate for individual music activities. Sarah is learning to play musical pieces on the piano by watching the music therapist play, and remember them by heart. They are thinking about videotaping a whole musical piece, so that she can follow up her playing when she no longer has the opportunity to watch the therapist play.

> R: Do you think you will play some piano later? When you no longer have music sessions with [music therapist]?
> SARAH: Yes, I think so, maybe. But we have talked about it, that we should perhaps videotape when I play, so that I can see where I press [the keys] and so, and bring it back when I get a bit: 'oh, I'd like to play that one!'
> R: Yes. It will be, sort of, like Sheet Music, just that it's a movie.
> SARAH: Yes. (Interview with Sarah)

In this way, Sarah would bring a 'piece of music' with her when she is discharged from the treatment services that are currently her home, and a big part of her everyday life. These video clips might be a pleasant memory of her mastering pretty pieces of music, while at the same time they afford musicking in the future.

For service users wanting to engage in musical activities, one weekly session of 45-60 minutes is not much. Therefore is it not surprising that some of the participants call for more opportunities to practice music. Ian wished for a place in which to engage in music activities outside of the music therapy sessions, and suggested that the health institutions should provide facilities that are available outside of music therapy hours:

> R: Is there something that could have been better, or something you miss, or something that you would like to be different in music therapy?
> IAN: Well… yes! There is one thing, and it's that in addition to having music therapy, the institution is responsible for rehearsal facilities. You know, a lot of the musicians have illnesses, [they] are on social welfare moneys, and are actually too poorly financed, most of them, to have access to rehearsal facilities at all. So if one had a music therapist, and in addition, a rehearsal room that the music therapist had the responsibility for.
> R: Yes… a sort of service in the municipality you could have made use of?
> IAN: Yes, it's just that, where do you find a good… you cannot have people

> at 33, 34, 35 years old, with mental illnesses, and place them in an adolescent's club. (Interview with Ian)

As Ian himself points out, adolescents might have access to different clubs and local services for youth in the districts. However, for grown-ups and young adults it may be more difficult to acquire both the appropriate facilities and the necessary equipment with which to play music. Proper equipment for rehearsing clearly affects the experience of musical activities. It is not only a matter of being physically able to play: as Sarah expresses it, it does not sound good when she plays the piano at her parents' house.

> R: Would you have wanted to rehearse if you had a piano in your room or something like that?
> SARAH: We have a piano at home with Mum and Dad.
> R: Yes?
> SARAH: But it hasn't been tuned in several years, or something like that. So I notice it if I'm home, which I am from time to time. I try to play a bit. But it doesn't sound good, hehe. (Interview with Sarah)

Especially when participants in music therapy want to learn and master musical instruments, there seems to be a desire for more opportunities to engage in musical activities in-between the music therapy sessions.

As mentioned above, conscientiousness may affect the degree of freedom in the voluntariness. In the following extract Frank also speaks of a moral obligation as the reason to participate in this study; his contributions can enhance music therapy. In turn, more people can participate in similar activities as himself, because of his shared story.

> FRANK: […] That's why I got involved in this project, for instance.
> R: Yes?
> FRANK: Because I know I have a lot [of knowledge] that is useful for others, and that music therapy may be expanded to the all of the Norwegian health-service, that it'll be a service for everyone, not only for certain pioneer projects. […] I strongly believe that we need more of it [music therapy]. I was one of the lucky ones who got in, because there was a limited amount of time [vacancies]. It's unfair that I get this sort of help, and other people don't. Even though I definitely needed it, it should be available for everyone. (Interview with Frank)

The fact that service users are eager to promote the things that are experienced as helpful for oneself may not be unique for music therapy. Still, when service users, like Frank here, voluntarily participate in a research study in order to promote music therapy for others, this is a gesture that reflects some of the engagement and connectedness some experience for music therapy participation. The research participants want more music therapy, and they want others to have the same opportunities as themselves.

Alex speaks of the importance of activities for people in general, and suggests that music therapy is used, not only within mental healthcare, but also for all people with long-term health issues. The answer for service users doing nothing cannot be to continue doing nothing, according to him:

> ALEX: Well, I'm no doctor, but this is my personal… it's a free country, I can speak freely, I believe that some people are [hospitalized] here longer than necessary. And longer than what is good for them. I see people lying in bed all day, for whom there are no activities. Activity, activity, activity, activity, activity, activity, activity. That also goes for people on welfare money. Why not offer music therapy for those on long-term sick leave? (Interview with Alex)

Instead of seeing unmotivated service users lying in bed, Alex saw service users without sufficiently adapted activities.

6.2.4 Summarizing *voluntary music therapy*

Music Therapy participation is experienced as voluntary by the participants in this study, although they are otherwise subjected to compulsory mental healthcare. They seem to think rather poorly about the hypothetical idea of obligatory music therapy; the research participants suspect that involuntary music therapy would affect both the experience and the outcome of music therapy negatively.

We have seen that the participants in this study wanted more music therapy and more musical activities in their daily lives. Several of the participants had taken the initiative to increase the frequency of music therapy appointments, and there is a tendency in that people would have liked the opportunity to follow up continuous music therapy programs or other similar activities in the future. There was also a wish for better opportunities to engage in music therapy activities that are not led by music therapies, such as access to rehearsal facilities. Some music therapy participants also stressed the need for more music therapy in mental health services, so that other people will have the same access to music therapy as themselves in the future.

The participants in this study tend to show up to their appointments, despite various mental and physical health issues, and despite challenges regarding geographical distances and time of day. Overall, the participants in this study seem to be highly motivated to participate in music therapy as a voluntary part of compulsory mental healthcare.

6.3 Theme 2: Motivating music therapy

We have seen that the participants in the study seem to be very motivated when it comes to attending music therapy. In the following theme *motivating music therapy* we will learn more about the potentially motivating aspects of music therapy, through the sub-themes: 1) the participants' relationships with music, 2) freedom from coercion, treatment and hospitalization, 3) Freedom within music therapy, and 4) the social dimension of music therapy.

6.3.1 2a – The participants' relationships with music

It seems that the research participants' relationships with music, and previous experience with music activities, is a vital motivational factor for participating in music therapy. The research participants report that they are positively engaged in music therapy because they are into music in general.

> R: If anyone had asked: 'why do you want music therapy?' What do you think you'd answer?
> KIM: [It's] The best form of therapy!
> R: Yes, well, why is that?
> KIM: Because I love music! (Interview with Kim)

The fact that music is a great part of the research participants' lives may contribute to positive expectations in advance of the music therapy participation. The research participants like music in general, and might suspect that they will like music therapy as well, even though they are not really familiar with the concept of music as treatment in advance of trying it:

> R: If I'd ask: 'why do you attend music therapy', what do you think you'd answer?
> SARAH: It's a part of the treatment that is offered. And I like music very

much, so I thought it sounded really nice.
R: Yes, because you like music in general?
SARAH: Yes. (Interview with Sarah)

For Sarah, as for other participants in the study, music as part of therapy was unfamiliar. Nevertheless, the expectations for music therapy were optimistic due to her overall passion for music. It seems that music therapy has an advantage over other treatments in that nearly everyone has affection for music already. Hence, the expectations and motivation for attending music therapy are individually enhanced.

The joy of music in life may provide an interest for musical engagement in general. Several of the participants are playing, or have previously been playing, instruments in their leisure time, and some of these would even like to become professional musicians. On the other hand, not everybody is familiar with practically engaging in musical activities, but even people with little or no previous experience of playing musical instruments seem to be highly motivated to do so in music therapy.

R: Do you feel that it's different to meet for music therapy than other things? You've said something about it already.
LEE: I'm more motivated when I'm going to music appointments than other appointments.
R: Yes. More motivated. Is that about anything particular?
LEE: Well, to get to play the drums and have fun. Music, for me, has always been something that is very nice.
R: Yes.
LEE: I have always enjoyed music. So to be able to play an instrument; I've always wanted to learn an instrument, guitar or anything at all, but now that I get to learn the drums, it's all positive. (Interview with LEE)

Everyone has seen musicians perform, in some way or another, and many people around the world look up to particular artists or bands. Even though Lee has never really played a musical instrument before, he can still relate to the idea of playing the guitar or the drums. For him, learning to play was an important part of his motivation to attend individual music therapy sessions.

Music is also commonly used in the research participants' everyday lives, and several of them use music actively for beneficial outcomes in various matters, such as motivation for exercising. Alex uses music consciously when walking, and has also used music actively as an instructor for group exercising:

> ALEX: I've done everything from step, to aerobic, and all of that. And then I was also a bit DJ, because then I made my own playlists, and I think that's… Then there was a lot of Beyoncé and a lot of RnB, and…
> R: Does music help when you exercise?
> ALEX: Yes! Yes, it gives… music helps for everything. Really, I could not have walked in the city centre without wearing headphones with music.
> […]
> R: But you use music when you're out walking. Do you use it… do you feel that it helps you… or, do you use the music consciously, in a particular way, or is it just that you like to listen to music?
> ALEX: I use it really consciously, because I like to walk fast. (Interview with Alex)

The research participants are acquainted with the motivational aspects of music listening from their daily lives; music helps people to get things done. By the same token, the research participants are familiar with the potential in music to enhance performance:

> LEE: When I do sports, I listen to music to hype myself up. Workouts and such, then I listen to music. There is a lot of interaction between music and workout.
> R: Yes. Then music can motivate you to…
> LEE: Yes, to workout harder. (Interview with Lee)

Music is part of most people's everyday lives, and music is used for motivational purposes as well as for performance enhancing effects. Music affects us all, both consciously and sub-consciously, and it is likely that these features of music experiences are part of the research participants' positive expectations towards music therapy. The research participants have already experienced some of the beneficial side effects of musicking, and they know they enjoy music; thus, they think there is a good chance that something positive may come from music therapy as well.

When listening to music, several participants report that they select music that matches their emotional state. Selecting music can sometimes be hard because it's difficult to find something that feels' right. And other times we know exactly which music we need, because we understand so well our present mood.

> LEE: Music is something that helps me. It gives me joy. And yes, it… I enjoy music.
> R: Yes. Do you use music when you're alone, like, because you said that you

enjoy it …
LEE: Yes, yes.
R: Or do you think that 'now I need music?'
LEE: Yes, music helps me in bad times as well. It does. [I] Put on songs with relations to my feelings there and then. (Interview with Lee)

The research participants are aware of the connection between the choice of music and their current state of mind. In music, the research participants have access to a health resource that they make use of in order to match, to meet, and to endure challenging feelings:

R: Are there any other reasons for why it [music therapy] is the best therapy, as you said?
KIM: It distracts you. You think of other things.
R: Yes, think of other things.
KIM: If you're mad or sad one day, you put on a tune or something, it can get you into another mood. It depends on what song you listen to.
R: Yes, right. Do you usually do that?
KIM: Yes, I was quite pissed here the other day, so then I put on something heavy just to get even more pissed, hehe. […] Really angry music, just to steer into the skid, just keep going, feel what you feel. (Interview with Kim)

Music may enhance feelings, as Kim explains. Or perhaps the affect level is stable, but there is a change in the attention towards the feelings. But perhaps more importantly: it seems that Kim uses music consciously to withstand difficult feelings. He may turn to music as a strategy for mastering a difficult everyday life.

Sometimes it is the whole soundscape or the total experience of a song that 'speaks' to our affective state of mind. In the example below it is the lyrics of the song that helps Alex to cope, through comforting and encouraging phrases:

ALEX: (…) it's something about those lyrics, if you listen to Beyoncé for instance, they are very much about emancipation, that is, to become a better version of yourself, to become assertive – and especially for me who has gone through depressions, and I've struggled a lot with anxiety in the past – it's really comforting listening to songs with the message: 'Yes, you can do it! Yes, you can make a better life for yourself!' (Interview with Alex)

6.3.2 2b – Music therapy as a contrast to coercion, treatment and hospitalization

Music therapy may be experienced as a free zone. The research participants state that they appreciate the voluntariness of music therapy participation as a break from the overall pathology-oriented health system, and freedom from being treated coercively and locked in at uninspiring facilities.

> ALEX: But I think that it's really fun to have music therapy with [music therapist], just because it gives me a short break in the daily life here, that is characterized by this monotonous… there are really, well, rooms without inspiration, without fantasy. At the ward it is really calm and silent, and yes, the appointments with [music therapist] is in a way a small break. (Interview with Alex)

To take part in music therapy is a way in which to interrupt the monotonous weeks that would otherwise define everyday life in a closed ward. Even for those with permission to leave the ward for a couple of hours a day, alone or together with members of staff, they still have to spend the most of the time indoors. And as Alex reminds us, the inside of a hospital ward is often colourless and scarcely decorated.

Participation in music therapy may also contribute to 'breaking up' the week by providing a wider, and more fun, range of activities.

> FRANK: It's not just 'talk to the psychiatrist' or psychologist, and… be with the people, talk, play cards, read the newspaper... it breaks up the week into something better [sic]. That you… you know you can be yourself. Like we were just talking about, like, especially when you're treated compulsorily, you usually aren't allowed to go out that much. So being able to go somewhere and just make noise for an hour, it really helps.
> R: Yes. So it differs from the rest of the week then?
> FRANK: Yeah. (Interview with Frank)

Music therapy differs from other treatments and other in-ward activities. Instead of talking, both with other service users at the hospitals, and with psychologists and other staff as part of the treatment, music therapy affords activities. Even though one hour might be a small part of the whole week, it seems that the weekly appointments still influence the experienced everyday life within compulsory mental healthcare.

Both music therapy participation and the everyday use of music listening are used as diversions and leisure activities to handle the long time at an institution. This might be especially true for Kim, who is committed for several years due to a verdict from the court of law.

> KIM: In a way it is free musical lessons, the music therapy. At least I see it that way, hehe.
> MT: Yes, that's how you think about it?
> KIM: Someone might need the therapy, but now I have come so far. The only reason I'm [still] here is that I'm sentenced. There is no illness in the picture anymore, and it hasn't been for many years. If I hadn't been sentenced I'd be discharged after one, two months after I got here in 2012. Two months into 2013, and I'd be out again. Now that I'm sentenced, I'm still here. That's what I struggle with, that I don't get to meet people and things like that, and that gets a little annoying. So then I use music to calm down my nerves from time to time, and to focus, think about other things, dream a little. Just lie down and listen. And now I've bought a new headset, it cost nine thousand [NOK], so now I'm able to enjoy the music properly. (Interview with Kim)

Both music therapy appointments and individual music engagement are important ways in which to spend time when hospitalised for a long time. We will see later that the music therapy appointments also afford ways to occupy Kim musically in between the weekly music therapy appointments.

Frank talks about how the psychiatrist sees all of his words as delusions and symptoms of mania, whereas for himself, these thoughts are part of himself, his knowledge and his present life world. Frank does not agree that medication is the primary solution to his troubles, and he feels that music therapy is an underlying foundation that helps him cope with his current life.

> FRANK: I have a psychiatrist that is a bit of a problem… he is solution oriented, but he really is a problem finder. So he just throws medications for everything he knows. And I've tried… now it is about 22 different medications since I got here the 27th of December [11 weeks prior to the interview]. So it's… If it weren't for music therapy I'd have taken my own life by now. (Interview with Frank)

Clearly, I have no way verifying the number of different medications that Frank has received during this period of hospitalisation, and in some way this is perhaps irrelevant.

What I believe matters in this context, is the experience of being involuntary medicated, and the feeling of a lost autonomy; Frank does no longer control his own life, nor his recovery processes. He is not even in charge of his own body. But music therapy is something he attends voluntarily, something that provides meaning and continuity to his daily life. Through music therapy, Frank can be in charge of at least one thing that he really cares about.

Music therapy can be something positive that adds colour to an everyday life that is otherwise characterized by hospitalisation and compulsion. For some research participants, music therapy makes a nice contrast to coercive means such as forced medication:

> R: Do you think it [participation in music therapy] affects other treatments?
> SARAH: In my case, the medical treatment have been very… It's been, throughout the past two years, it's sort of been the main focus, that: 'you have to take your medication!' And I'm sort of involuntary hospitalized to receive the medical treatment, which I don't want. It's nice to have other inputs, in a way, something that I like. Because I don't think it's nice to be medicated involuntarily. (Interview with Sarah)

For Sarah who was being treated compulsorily, music therapy participation afforded a contrasting approach to therapy.

Conversations with psychotherapists and other staff members can also be draining for some service users. And on this matter, it seems that music therapy was experienced as a longed-for substitute for Peter. Music therapy provided the opportunity to engage in activities, together with others, without going through all the questions that are often a major part of therapeutic conversations:

> PETER: (…) There's only medication. And questions. They pose a lot of questions. But the music doesn't pose questions.
> R: Yes. Do you think it's good that [the therapist] doesn't pose a lot of questions?
> PETER: Yes. (Interview with Peter)

Lee is not particularly fond of conversations with the psychologists either:

> R: How is it, do you have a lot of conversations and such with…?
> LEE: I have lots of conversations with psychologists. I'm not that motivated to go to those.

R: You're not?
LEE: No. (Interview with Lee)

For people going through years and years of mental healthcare, conversations and questions can get tiresome. Especially for people that are not the most talkative, music therapy seems to afford a more motivating approach to social engagement.

Participation in music therapy can also function as a break from other service users at the hospital ward:

ALEX: Well, I find it a bit hard to participate in group activities. Not because I don't want to, or because I feel that I'm too good or things like that, but it's more that I get very easily affected by others' circumstances, or their opinions, and that's why I've chosen to stay away from group activities here at the ward. I've had a rough period before I was hospitalised, but I don't struggle with the same things as many of the others at the hospital, and that makes it a bit frustrating, sometimes, to be with them, because it is… Yes, I can be here, and I can [could] even work here as a health worker, but when you live together with them twenty-four-seven, so to say (…) It [music therapy] is one out of the few, small things, which I look forward to at the ward.
R: Yes. You look forward to it?
ALEX: Yes.
R: Is there a particular reason for why you look forward to it?
ALEX: A neutral room with a pleasant human being, and not to be interrupted by people who break into conversations or scream, well, that occasionally happens at the ward, and a little break from the room in which I stay quite a lot. I isolate myself quite a lot, I've done that lately because I don't want to be together with the other patients constantly. And I find little inspiration at the ward, so the short appointments with [music therapist] are in a way … [gesticulating joy and relief with his arms]. (Interview with Alex)

Everybody who has shared an apartment with other people can possibly relate to some of the challenges that emerge when spending a great amount of time together. In a hospital ward you are not grouped together due to friendships, family relations, or common interests; merely the presence of certain diagnoses decide who should live together. Perhaps it does not come as a surprise that Alex sometimes needs time off

from the people at the closed ward. Music therapy might well be an awaited break from the social milieu within the hospital walls.

A recurring topic from the interviews is that music therapy participation is experienced as a meaningful use of time. Apparently, and quite understandably, it is not always easy to articulate what music therapy participation feels like, or why one is motivated to engage in music therapy activities. Nevertheless, to say that music therapy is experienced as meaningful, somehow, comes easily for the research participants.

> R: If anyone asked you, for instance: 'Yes, why do you bother to go out there [to the appointments] to have music therapy?' What do you think you'd answer?
> IAN: Hehe, 'Well, I think it is really pleasant to go there and play music. I am recording at the moment, so that's interesting as well, has been going on for a couple of months, to get a new tune out on the Internet. It's meaningful to me, the music therapy,' I would say. (Interview with Ian)

Music therapy participation affords meaningful activities for Ian. Without saying that musical activities are experienced as meaningful for everybody, experienced meaning may provide a boost in the motivation to engage in potentially therapeutic activities. For some, music therapy is experienced as more meaningful than other available treatments and activities.

6.3.3 2c – The freedom within music therapy

Not only do the research participants in this study highlight the voluntariness of music therapy, as a contrast to the coercion in their daily lives; they also report that they appreciate the openness and voluntariness *within* the music therapy room. Music therapy provides a chance to participate as oneself, and it affords possibilities for a time and place wherein personalities, thoughts, and ideas do not suffer from expert censorship.

When being hospitalized involuntarily, there are certain restrictions regarding where to be. In addition, there are limitations for what people are allowed to do or to say within the hospital ward. Music therapy can provide a temporary release from these restraining decrees.

> R: It sounds like you view music as something important?
> FRANK: Yes, extremely important
> R: But… How come you like music therapy do you think?
> FRANK: The ability to express oneself; the possibility to create something,

> which has not been created before.
> R: Yes?
> FRANK: You simply decide your own destiny. (…) To make people come out of their shells. We are a bit like turtles here at the closed ward. And the longer you're here, the harder the shell gets.
> R: But do you feel that music therapy helps to open up a little?
> FRANK: Yes, a lot. Because then I can say and feel exactly what I want.
> R: Okay?
> FRANK: I can sing about exactly what I feel like. I can enjoy the moment, and no one mentions that what I say is wrong. But at the ward they say, like: 'Don't talk about this, don't talk about that… talk about other things!' (Interview with Frank)

Frank had a lot to say about the experienced freedom within music therapy; this freedom appeared to be greatly appreciated, and was apparently one of the reasons why he liked music therapy. For him, music therapy provided an arena to be 'himself' in a time and place where certain aspects of free expression were otherwise revoked.

Music therapy may be experienced as a free zone wherein every initiative can be viewed as music, creativity, and a resource. Hence, the participants are allowed to play freely, without the feelings of playing badly or doing something wrong, which was also pointed out by Alex:

> ALEX: I'm… I never get satisfied. I'm never satisfied with what I have… or, yes, I'm satisfied with what I'm given, but I never get satisfied enough with myself. And if there is something I don't master, if I do something wrong, I can get all… well, I get easily affected by it, and it can affect the whole day, and I get slightly obsessed with it.
> R: Yes. Do you feel so in music therapy as well?
> ALEX: Yes. I'm really hard on my self, too hard. But it was really nice that you [the music therapist] said 'Alex, there is no exam here'. I remember you said that: 'There is no exam; here you can play freely, and we'll have some fun'. So it was… then it comes, right, it comes by itself. And that's what made me want to play around with the drums. (Interview with Alex)

It may take time to learn to trust oneself, or to dare to participate in creative activities, as well as in other areas of life. However, an open-minded music therapist, with a resource-oriented philosophy might facilitate for further engagement, as we learned in the extract above. Even though Alex might be hard on himself, also when playing

music, the freedom within music therapy may enhance moments of mastery, and in turn reduce the feelings of failure.

Sometimes the experienced openness, and the play-like atmosphere, can make it easier to let go in the creative activities. For Frank, the experienced freedom within music therapy, it appears, facilitates engagement as well as motivation to explore different sounds. As long as there is no right or wrong in the music, everybody has the opportunity to participate, regardless of background and skill-level.

> FRANK: You can write a song about anything (…) there are no limiting beliefs in music therapy, and that's what makes it so special.
> R: Yes. How do you think that affects the participation in music therapy, if you're allowed to do anything [you want]?
> FRANK: (…) I think that, for people to go into a music therapy session, getting asked: 'What kind of music do you like? Do you wanna listen, or do you wanna sing? You wanna try the drums?' Drums can be very cathartic, you just bang around and nothing's wrong... and like, if you don't have rhythm - that is rhythm!
> R: So do you feel that anyone can participate in music therapy, regardless of skill level or background or experience?
> FRANK: Yeah! (…) Like, picking up the guitar, and just making noise (…) and you just try out different things. Like my favourite sound of the guitar is when I don't hold a chord, when I just play it freely. And you sing with the voice you have... and everyone can become better ... but, as long as the music therapist doesn't say, like; 'that was bad, that was off!', as long as people are allowed to do whatever they want, then, that is therapy enough. (Interview with Frank)

Music therapy affords a time and place in which Frank and other particpants can be who they are and do what they want. This seems to be a motivating aspect for participating in music therapy, and for committing to the activities when first attending the sessions. In addition, the experienced freedom within music therapy may in turn lead to experienced health prompting aspects of music therapy. We will come back to the potential health beneficial outcomes of music therapy towards the end in this chapter, but let us keep in mind that the open-minded music therapist seems to provide an arena that the participants enjoy.

Musical activities hold a lot of possibilities, and for some participants the opportunity to choose the activity themselves is vital for their experience of music therapy, and for the motivation to engage in these activities.

R: But you said that you wanted to play the drums, so you knew… You had not seen the drum kit previously, you knew in a way that this was what you wanted?
LEE: Yes, I wanted…
R: You had a plan?
LEE: Yes (…) It was the drums; I was determined about the drums, that's what I wanted to learn. In a band, I think that… Well, a band cannot work without the drums. So, it's like the heart of the band. And I think it looks cool, when I see people hit those things. That's why I want to learn the drums.
(…)
R: You've talked a bit about it already, but is there anything in particular that motivates you to join in the music [therapy]?
LEE: That I get to try out instruments.
R: Instruments. Play yourself.
LEE: Yes, play myself. That motivates me the most. Because I don't… here, it's the first time I've ever played the drums, I've never done that in my life [before], so that's fun. (Interview with Lee)

Music therapy provides the possibility for Lee to engage in new activities. Lee had never played the drums before, but when a fellow service user told him that he played the guitar in individual music therapy sessions, Lee was not at all in doubt of what to do with his music therapy appointments. And even though the activities were new to him, Lee was well familiar with the idea of the role he associated with the drummer in a band and on stage.

The mere act of choosing the activities may also be an important aspect of music therapy; the choice will of course lead to certain preferred activities, but it seems that the decision-making might in itself be of great importance:

R: Is there anything you… remember the best? Because now you've been here [attending music therapy] for a whole year… Is there anything you remember in particular, from what you've done together?
PETER: Yes, I remember that [the music therapist] played the guitar, and I told him that I'd rather sing.
R: So you got to choose to sing?
PETER: Yes. (Interview with Peter)

Peter has been playing the guitar most of his life, and there may have been some underlying expectations about the guitar taking the lead role in the music therapy sessions. But Peter remembered clearly how he got to influence the content of the music therapy, by taking the initiative to customize the sessions the way he wanted them to be.

As the participants are free to choose activities within music therapy, it can be adjusted to meet the energy level of the participants. For Kim it was easier to participate in music therapy because it was not physically exhausting.

> R: Why do you bother[66] to come to music therapy?
> KIM: It doesn't get me tired, for one thing.
> R: No, like, physically speaking?
> KIM: I'm not that fond of getting tired. I was before, but I've become a bit… I had an episode where I tried to jog a bit. A few years back ago I went for a long run, and that's when I was smoking the most, and I had so much pain in my lungs that I just… I got done with working out, because I took it too far. But I always liked to work out before; I was in a great shape in the past.
> R: Yes, but is it easier to get going with music therapy?
> KIM: Yes, to focus on something new in life, instead of… well, my goal was to get good at martial arts and things like that, I have a silver medal in the national championships in [martial arts][67]. (Interview with Kim)

As we remember from earlier, Sarah also thought highly of the flexibility in the structural frame of the music therapy appointments; when she had a bad day she was allowed to articulate this, and to conduct a shorter appointment depending on her current state of mind and her physical endurance. Participation in music therapy seems to be feasible also for people with a low energy level. The flexibility of the structural frame of the appointments, and of the music therapy content, can help to maintain participation also when the research participants have a bad day.

6.3.4 2d – The social dimension of music therapy

The participants bring up different social aspect of music therapy in the interviews. Conversations, musical listening and playing together, with both music therapist and

66 Here, *to bother* is used as a translation of the Norwegian word 'å gidde', a term that is somewhat difficult to translate. In general I would say that this Norwegian term includes the meanings of 'to want', 'to bother', and 'to endure', depending on the context. In this setting it is used as a combination of 'to bother' because Kim did not want to partake in any other activities, and 'to endure' because he also argued that he did not like to get fatigued.

67 In order to protect the confidentiality of the research participant I have chosen to conceal the specific sport.

fellow service users, are important parts of music therapy within compulsory mental healthcare, and for the motivation to follow up the appointments.

Within the hospital ward different service users may live together for days, weeks, months, or even years. Still it is not always easy to get to know other people through the hospital environment, together with staff members and other service users. Sometimes natural conversations need familiar circumstances in order to flourish. And it may be easier to get to know people through common activities, rather than through superficial and polite conversations in the sterile hospital environments.

> R: Is there anything you remember in particular from the weeks with music therapy?
> KIM: The first group session with… when we were two, I remember that one.
> R: Yes. Was there anything special that happened then?
> KIM: No, I don't think it was anything special, really. I thought it was a success. [I] Got to know her a bit as well. She doesn't say much down there [at the ward], so I got to know her better.
> R: Yes, got to know her better, because you both attended the group?
> KIM: Yes, then there was at least one common interest. (Interview with Kim)

When participating together in music therapy the participants already share common interests. Engagement group-activities, such as in music therapy, can function as a doorway for making new acquaintances and relationships that can prove important for the further stay at the given hospital ward.

Music therapy groups provide the opportunity to collaborate and to have fun together with peers. Regardless of the potential development of further social relationships between inpatients, the social interaction there and then may still prove enjoyable. To engage in music therapy groups can be fun.

> R: What's it like to play [music] with other people?
> LEE: It's fun! That's what's fun! That's what's best, to play and to create a song together.
> R: Yes? You create music together?
> LEE: Music together, that's the coolest; jamming.
> R: Yes, jamming. Have the others played before, or is it [skill level] various?
> LEE: No, I don't think it is… I think they are as good as me, beginners.
> R: But you manage to create music nevertheless.

LEE: Yes.
R: What's that like, when you have not really played music a lot before, but still manage to create music?
LEE: It's fun. Some are better than others, but that's just how it is.
R: Yes, that's how it is, some have played more that others. But what's that like, when you say for yourself that you're a beginner, and some are better, what is it like to play with them?
LEE: I get inspired, when I watch people who are better than me, from whom I can learn. (Interview with Lee)

As pointed out by Lee, participating in musical activities together with other participants can be inspiring and motivating for further engagement in musical activities. Music therapy groups also provide the opportunity inspire others:

R: What is it that makes you want to come there [to music therapy groups]?
LEE: To listen to the musical tastes of others. Because we're asked what music we want to listen to, and then I hear the musical taste of others.
R: Yes, is there a great variety?
LEE: Yes, a great variety.
R: What's it like to share your musical taste, then?
LEE: No stress.
R: Yes, do you feel that others listen, [and are] interested?
LEE: Yes. I've joined the music group and shared several songs. And also when I've attended the music therapy, I have written some songs, that others have listened to.
(…)
R: What's it like when you show others something you like, and then they think that it's good?
LEE: It's satisfactory. Yes, satisfactory. (Interview with Lee)

Through an individual and unique musical background, every participant possess a certain amount of cultural capital that can be shared, discussed, and admired, together with peers. The opportunity to bring something personal into the group, and to learn about the musical preferences from others, was for Lee a motivating feature of music therapy group sessions.

Sometimes the music therapist can be a motivating variable for participating in music therapy. For Alex it was inspiring to meet a smiling face through music therapy.

Occasionally, the fact that the activities circle around music may perhaps be of secondary importance, compared to the actual meeting with another person:

> ALEX: But I think it's really fun to have music therapy with [music therapist], just because it gives me a little break from everyday life here […] and to be met by a smiling face, and in addition, a person who masters music, and understands in a way what music can evoke, everything from negative feelings, positive feelings, and well, yes. (Interview with Alex)

Later on in the interview Alex explained that there were certain people in the healthcare system that he was particularly fond of, people he would be glad to meet outside of the hospital in the future.

> R: Are there anything you will take with you from the appointments with [music therapist] in music therapy, when you are discharged?
> Alex: Well, I see it this way: 'Who do I greet on the street when I get out of here?' Well, If I'd meet [music therapist], then I'd say: 'Hi, how nice to see you!', and then I'd wear a fantastic outfit, and then [music therapist] would have said to me: 'Alex, now you look absolutely fantastic', something like that. No, but, there are people here who have touched my heart, and if I'd meet [music therapist] after six months somewhere, perhaps downtown, at a bar, then I'd buy her a glass of wine, and then we'd talk about how it goes, and it's really hard, you know, because I've been a patient, and she's been a therapist, and we're not supposed to have any contact, but there are certain humans who are close to my heart right now. And if I'd meet them at the street I would thank them for the inspiration I've been given during a time that has been a rollercoaster for me. (Interview with Alex)

To participate together in joyful activities might facilitate for growing relationships; it might help that the participants tend to regard the music therapists as open-minded and inclusive of different music, of different personalities, and of all kinds of musical engagement.

Depending on factors such as the length of the therapy process, the depth of the therapeutic relationship varies in music therapy. Especially for Peter, who attended music therapy as an outpatient, the therapeutic bonds developed over time came with the motivation to continuously follow up therapeutic processes:

R: How long have you participated in music therapy?
PETER: A year now.
R: A year?
MT: Yes, I think it is actually one year.
PETER: Yes.
R: Is it something you would like to continue doing?
PETER: Yes, for me… I wish to continue because we're good friends, you know. (Interview with Peter)

The relational bonds that grow from a year of music therapy might affect the degree of motivation, and perhaps the experienced obligation, to meet for the weekly appointments.

Several of the research participants would like to get together with peers and form bands later on. Music therapy, then, may be regarded as a way to get better at playing music, and the participants can be motivated to participate in music therapy in the presence in order to improve enough to play with other musicians in the future. To improve as a musician was an important part of Ian's motivation:

[…] And I've got the sense of mastery, in that I rehearse enough to be able to take the transition to practice with a band. A couple, or three times a week. And that's what I think happens eventually, I hope, that I get a band going and can release some records and things like that. (Interview with Ian)

Music therapy was used as a way for the participants to improve as singers, musicians, and songwriters. Frank already plays in a band and used the music therapy appointments to write songs and to develop as a musician, whereas Kim, Ian, and Lee hoped to be part of bands at a later point in time. For all of them, music therapy participation was viewed as a possibility to develop, and for all of them, the ideas and hopes of playing together with others seemed to follow with the music therapy participation.

Several of the research participants also speak of a collaborative dimension of music therapy. Both Ian and Kim spoke of nice moments from music making together with the music therapist. Frank spoke of his mixed, yet positive feelings, when he trustfully let go of his personal lyrics, and laid trust in the creative hands of others:

R: Is there anything you remember the best from the time with music therapy?
FRANK: Here?
R: Yes, or generally, something you, like… something that comes to mind?
FRANK: I distinctively remember… Like, I had made this song, [name of

> song]. I had different lines of text, and it ended up in a place far away from where I intended it to be. But it turned out so well. But it was kind of like someone was stealing my baby and genetically modified it, that's what it felt like: 'No, you're not gonna have blond hair, you're gonna have blue hair!' 'Ok, I guess I have to deal with that now'.
> R: Was that during music therapy with [music therapist]?
> FRANK: Yeah, it was with [music therapist] cause he knows more about building a song than we do. But I'm very proud of that song, and I sing it occasionally to people, and [I have] never had any negative comments about it. (Interview with Frank)

Through the collaborative process of song creation within music therapy, the participants can end up with a song that can be shared with others, either as a live performance or as a recorded piece of music. Hence, music therapy participation, which consists of social processes, can in turn enable further social engagements through the sharing of music therapy by-products, like it was for Frank.

6.3.5 Summarising *motivating music therapy*

Motivation for participating in music therapy will, for each participant, be complex and multifaceted. Nevertheless, the findings within this second main theme have pointed at some topics that can be important for our understanding of music therapy within compulsory mental health treatment.

It seems that the participants carry positive attitudes towards music therapy right from the beginning, because of their previous relationships with music; they like music, and therefore they might also like music therapy. Several of the participants also report that they use music more or less actively on their own for beneficial purposes. Thus, optimistic expectations in advance of music therapy are quite common, even for service users who are not already acquainted with music therapy per se.

Several participants seem to be motivated to attend music therapy because these sessions give them a break from an everyday life of compulsory mental healthcare; they get away from uninspiring hospital wards, medications, never ending questions from health professionals, and from the other service users living at the hospital ward. Music therapy provides activities that are experienced as meaningful, and as positive ways in which to fill the hours of the day when hospitalized involuntarily.

The participants also seem to be engaged by the freedom they find within music therapy; they can be who they are and say what they want, and everyone can participate regardless

of musical background, interests, skill level, or state of health. The research participants seem to appreciate that the music therapists welcome their initiatives and take their suggestions seriously. This openness seems to afford a low threshold for participation, in which the participants attend music therapy in spite of low self-esteem or varying energy level.

The research participants in the study seem to appreciate the social dimension of music therapy, and these social engagements are stated to be reasons for going to music therapy. Some report directly that musicking together with the music therapist and other music therapy participants is a motivational cause for attending music therapy, while others highlight the collaborative process of music making and pleasant meetings through common interests. Music therapy is a place to inspire, to get inspired, and to collaborate with both the music therapists and fellow service users.

6.4 Theme 3: Health promotion through music therapy

This third theme, *health promotion through music therapy*, points at the health benefits of participating in music therapy for the research participants within compulsory mental healthcare. This theme is made up of the four sub-themes: a) Something to look forward to; b) getting up and involved in activities; c) uplifting and meaningful experiences; and d) health promoting music therapy.

6.4.1 3a – Something to look forward to

For both the hospitalized participants, and those who attend music therapy as outpatients within the mental health services, one common feature is that they seem to look forward to music therapy. Sarah states that she sometimes looks forward to Thursdays, because of music therapy.

> R: Do you have any thoughts about what it means for the whole week, to have music therapy on the schedule?
> SARAH: Sometimes I look forward to Thursday a little, because then it's music therapy. So it makes a difference. (Interview with Sarah)

As mentioned earlier, Sarah suggested music therapy when the psychologist recommended that she would fill her weekly schedule with more of the activities that she liked the most. She also mentioned that, because of a tough period in her life, she had conversations with her psychologist everyday at the time of the interview. Music therapy

can seemingly be understood as a reason to look forward to something positive, also when other aspects in life may be more challenging than usual.

Music therapy might even be the only organized activity in which service users participate during a normal week; Kim, who has been hospitalized for several years, looks forward to music therapy, yet reports that he does not look forward to, nor participate in, other similar activities.

> R: Does the music therapy participation affect the rest of the day or the week, or is it just [valuable] here [in music therapy]?
> KIM: Well, it's something I look forward to.
> R: Yes. Does it happen that you don't bear to, or want to attend music therapy?
> KIM: No.
> R: How is it with other things you attend during the week?
> KIM: I don't attend anything else. (Interview with Kim)

In the interview, Kim mentioned other activities at the ward, such as yoga and hikings, but he did not go to either of these offers.

Several of the participants look forward to music therapy, and for some, music therapy can even be the highlight of the week, as Frank stated it:

> R: Do you have any thoughts about what it does to a regular week, or weekday, that you have music therapy, once a week? It's not that much.
> FRANK: You have a highlight of the week.
> R: Yes?
> FRANK: You have something to look forward to. (Interview with Frank)

Despite a poorly expressed question from me as the researcher, Frank seemed to think highly of the music therapy appointments. And for him, the highlight of the week, the music therapy, was something to look forward to.

Alex also stresses the importance of participating in activities he looks forward to. From his perspective, activity-based approaches are vital, and important ways of rehabilitating people more quickly back into society.

> ALEX: If we had slightly more resources for psychiatry, and a little more resources, for instance, for music therapy, physical activity, creative therapy, for everyone in the house, then we could have led people faster back into

the society, and then they would maybe have a chance.
R: Yes. Why is that, do you think? Why do you think they would get back faster?
ALEX: Because then they'll have something to look forward to.
[…]
R: You mentioned: 'something to look forward to'.
ALEX: Yes, something to look forward to.
R: Do you look forward to music therapy?
ALEX: Yes. I do, I do. Absolutely. (Interview with Alex)

6.4.2 3b – Getting up and involved in activities

Music therapy may function as a kick-starter for getting the research participants up and in activities. When asked about the role of music therapy participation in their everyday life and recovery process, several of the research participants reported that music therapy made it easier to get out of bed and out the door. Motivation to get out might be just as important for both outpatients for going out of their homes, and for inpatients for leaving their room at the ward.

R: What do you think music therapy can be, while you're here?
LEE: Well, I'm a bit unsure. It helps me in several ways, makes me more motivated.
R: More motivated, yes, right. Motivated for other things as well?
LEE: Yes, other things.
R: Any examples?
LEE: It can motivate me to get up in the morning. Motivate me to, well, to really make an effort when I have first come to the music therapy. (Interview with Lee)

Though it is not always clear how music therapy helps, Lee had some sort of sensation about the motivational aspects of music therapy. When being currently hospitalized, music therapy motivated him to get up in the morning, and when first attending music therapy he was motivated to really make an effort in the activities.

Also for the participants living in their homes, music therapy appointments could work as a necessary motivational push to get up in the morning, as for Peter:

R: Do you find it easy to get up then [to music therapy]?
PETER: No.

R: A bit hard?
PETER: I'm sick. So it's a bit tiring to get up, you know. But I use my alarm clock, so it doesn't matter.
MT: You manage to get up when you're going [to music therapy].
R: Is it different to get up if you know you're going to music therapy?
PETER: Yes. If I don't go to music therapy I just lay in bed and sleep, you know. (Interview with Peter)

For Peter, it is easier to get out of bed on days with music therapy on the schedule. In another part of the interview the music therapist informs the researcher that Peter's music therapy appointments are often scheduled on the same day as his other appointments so that he does not have to travel a long way an unnecessary amount of times. From Peter's statement it is not clear whether it is easier to get out of bed because of music therapy or because of an appointment in general. Nevertheless, as Peter stated it would be more likely to continue sleeping without his appointments on the schedule.

The degree of self-organized time varies among service users in mental health care. Even though Sarah is active and busy during the week, she might well isolate herself in their room in their spare time when she does not find clear reasons to go elsewhere.

SARAH: Yes, I go to hiking groups, and music therapy, and the psychologist, and, well… And I go to school, and that takes some time.
R: Yes, can't just have music therapy all the time.
SARAH: No, hehe, but it's music therapy I like the most.
R: It is?
SARAH: Yes
R: Is there any particular reason for that, you think?
SARAH: Hmm… I don't know exactly… [I] Think it has a bit to do with feeling that you accomplish something, in a way.
R: Yes, some new things?
SARAH: Yes, and to learn and… and not just sit in my bedroom doing nothing. (Interview with Sarah)

According to the citation above it seems that Sarah likes to have appointments that get her out of her room, and into activities. Sarah participate in several activities during the week, but it appears that there might still be hours in the day that are more difficult to fill with meaningful activities when she is on her own.

Ian mentioned that he previously used to pick up the guitar at home, and that he does not do this much nowadays.

R: So is it the rehearsal that drives you a bit?
IAN: Well, before I started here, I played quite rarely. I've lost the initiative to get the guitar [and play], even when I sit at home and sing. I always did that before. So this [music therapy] was an arena to do it.
R: Do you do it [play] more often at home as well, now that you attend music therapy?
IAN: No.
R: No, so you want to play here [in music therapy] because it's easier to get started, or to get it done?
IAN: Yes. (Interview with Ian)

Ian used to spend some time playing the guitar, and a lot of time making playlists and listening to music on the Internet. Lately, however, a great deal of his time was devoted to his subscription on Netflix. For him, it seems that it is easier to engage in music activities when attending music therapy regularly. Even though music therapy does not necessarily keep the participants active in their daily lives, outside of the actual appointments, the weekly hour of music therapy may still prove valuable. The possibility of playing together with another musician might just provide the necessary motivation for partaking in joyful activities, especially when finding the initiative on one's own is difficult.

The weekly music therapy session may also provide a steady ground for Ian when he is in need of stabilizing routines:

R: We've talked a bit about music therapy being, in a way, treatment.
IAN: Yes.
R: Do you have other thoughts about that?
IAN: Yes, well, I need the treatment, music therapy has kept me… to have something regular to go to makes a rather big difference.
R: Yes, something regular to go to. Why is that nice, to have something regular to go to?
IAN: Well, it stabilises.
R: So a bit… the whole week or?
IAN: Yes, to get the same routines and things like that.
R: Yes. Is that good for you, to have routines?
IAN: Yes, as long as they are nice routines. (Interview with Ian)

For Ian, the positive routine of music therapy participation made a difference, and he thought highly of music therapy as a steady part of his everyday life.

6.4.3 3c – Uplifting and meaningful experiences

Based on the data set there seems to exist a common opinion that music therapy comes with pleasant experiences; participation in music therapy provides fun and joyful moments.

> ALEX: […] And I had an appointment with you Wednesday, and that was very nice. We sang […] and you played the drums. And I carefully explored the piano. It was very fun, very exciting […] some bright sounds, when we had an improvisation.
> MT: Yes, that's fun.
> ALEX: It's really fun.
> MT: We play… We have played a lot together and sung together. I really appreciate it.
> ALEX: I really appreciate the conversation, and well, all the projects with you; it's been a pleasure. (Interview with Alex)

The content of music therapy consists of a broad spectrum of activities, which also afford a broad variety of experiences. For Ian music therapy provided positive experiences through a variety of activities, such as improvisation, conversations, singing, and playing.

Sometimes, music therapy facilitates for special experiences or episodes that are rather hard to fabricate in other ways, such as public performances. Frank spoke eagerly about an episode in which he played a concert for a couple of hundred people, together with the music therapist and another band colleague:

> MT: It went quite well, didn't it?
> FRANK: Yeah, well, I was on a high that day. I remember, cause there's a girl at the supermarket near where I live, who I wanted to ask out, and I was like: 'I can do anything in the world, I can ask out anyone', but she wasn't there.
> R: One becomes a rock star then.
> FRANK: Yeah, it was pretty cool. And I want to get that feeling again, so I'm eager to get working on a concert again as soon as possible.
> R: Was it the performance that made you feel well?
> FRANK: Yeah. Everyone was, like, giving me hugs and saying it was awesome, and the people that were speaking after us were like: 'these guys did something that their bodies didn't want to do, but they did it anyway'.
> MT: We got rather high when we got out there.

> FRANK: I actually went outside, and then sort of, went the other way, so I could meet as many people as possible, and be like: 'Yeah, that's how I roll'. (Interview with Frank)

After the performance Frank sought crowded areas deliberately because of the high after the gig, in spite of his social anxiety. Not only did music therapy afford a sense of mastery, or a 'high' as Frank put it, this experience also culminate in a change in self-confidence or self-efficacy, which in turn also enabled him to act in new ways.

Special episodes and overall positive experiences in music therapy may appear as pleasant memories in the future. Ian also mentioned a special episode, which he remembered well:

> R: Now, you've been here for a long time, more than a year with appointments with [music therapist]. Are there any special moments, or thoughts you remember especially well?
> IAN: Yes, in the summer we brought two guitars, and brought two people working in healthcare, and then we went down to [name of a place] and played the guitar and sang […] we were four people out by the rocky shore there, with a diving board.
> R: That sounds nice.
> IAN: Yes, it was.
> […]
> R: Had you imagined that could be part of music therapy, by the rocky shore, with a barbecue in the summer?
> IAN: Hehe, well, no. (Interview with Ian)

The interview was performed during the springtime, more than half a year after the summery episode Ian referred to. Even though this memory is not typical for the music therapy appointments in general, it was a fond memory for him that he carries with him.

Music therapy may affect the way participants recall the hospitalization, and may thus afford pleasant memories about their stay and treatment program in the future. These joyful recollections come with motivation and the wish to continue doing pleasant activities:

> R: Are there any special experiences or something that you…
> LEE: There are pleasant experiences, obviously.
> R: Yes. What do you think that does when you get out from here?
> LEE: I get a positive memory. So I will continue with it [playing the drums]

> outside of the hospital as well. Because it's something I… It's not something I'm passionate about, but I want to learn. It's useful to learn, to have something to do, at least, not just sit on my ass when I'm discharged. (Interview with Lee)

I do not know whether Lee is still engaged in music activities today, but it seems from the interview that the music therapy participation triggered some desires and thoughts in him about the future. Through music therapy he has learned to play the drums, and this newly acquired skill is something he can make use of outside of the hospital walls.

Positive experience and emotions that are attained in music therapy do not necessarily burn out at the end of each session; a positive change in mood can influence the state of mind for some time, like for the rest of the day:

> R: How do you feel about having music therapy here?
> PETER: To start with, I have severe mental challenges. When I was hospitalized with psychosis, I was very happy when I was here.
> R: Yes. You get happy in music therapy?
> PETER: Yes, and every time I take the buss home [after music therapy], I'm very happy.
> R: Yes. How long does it last for, do you think?
> PETER: It lasts for the rest of the day.
> R: Yes, so for the rest of the day you're happy?
> PETER: Yes.
> R: How nice. Do you have a little less anxiety as well, then?
> PETER: Yes. (Interview with Peter)

Peter experienced a positive, immediate effect from attending music therapy. When asked, Peter reports that his mood is back to normal the next day. Still, Peter is affected by the music therapy session, and he is aware about his change in mood, as he takes the bus home after his weekly music therapy appointments. Peter partook in music therapy as an inpatient, and continued to attend weekly sessions as he was treated as an outpatient by the institution. From the statement, it seems that Peter has experienced music therapy positively as both inpatient and outpatient.

Participation in music therapy may facilitate a sense of mastery, as Sarah states below. Through music she has a good time and learn something new at the same time.

> SARAH: I think it's important for me to learn something new, and to feel that I master something, in a way. That's really nice.

R: Yes, how does that feel?
SARAH: I usually go out of that door, occasionally, and am like: 'Okay, that was a nice appointment, now I've accomplished something', in a way.
R: What do you think afterwards, or how does the day become then?
SARAH: I don't know, I've never thought about it.
R: No, but there and then it's nice at least.
SARAH: Yes. (Interview with Sarah)

Learning can be an important part of music therapy. As we will see in the next sub-theme, *health promoting music therapy*, Sarah finds it soothing for her mind to concentrate on learning and playing the piano. And based on the statement above, the exercise could culminate in a sense of mastery that puts her in a lighter mood at the end of the music therapy session.

Another way that music therapy may offer sense of mastery, or a sense of accomplishment, is for the participants to be able to create something concrete, such as a recorded CD or digital music files.

R: Had you heard about music therapy before?
IAN: Yes, I've had the tendency to borrow the music room and things like that, but never followed it up as part of treatment. And I'm much more content with it than I thought I'd be.
R: Yes, so you're positively surprised?
IAN: Yes, it is, among other things, when I'm in shape, it gives me a sense of mastery. To a great extent. And as a musician, mastery is the most important part of one's subject [profession].
[…]
R: Do you feel that music therapy has any influence? Does it do anything with the way you are outside?
IAN: Yes, well, when I have the feeling that I master music, and get things recorded occasionally, it can be published online and things like that. So regarding the music, because of music therapy I've come further than ever before. That gives [me] joy.
R: Yes. How does it feel to make recordings that are actually quite good?
IAN: I think that would have been important to a lot of people.
R: But mastery is a key term?
IAN: Yes. But there are a lot of people who work a bit on writing songs for themselves and things like that, and I would recommend to everybody, at

> least those with [mental] illnesses to have music therapy. (Interview with Ian)

For Ian it is important to end up with a recorded piece of music that he can listen to, promote online, and administer as he pleases. He appreciates both the recording phase and the end product, and he would recommend other people in his own situation to take part in music therapy and song writing.

6.4.4 3d – Health promoting music therapy

The research participants in the study speak of several ways in which music therapy can be helpful in their lives; symptom release, self-development, and ways to cope with their everyday mood and challenges are some of the positive outcomes that people get from engaging in music activities. In this last sub-theme we will see examples of the research participants experience health promotion directly from engaging in music and music therapy within compulsory mental healthcare.

For Sarah, music therapy may provide activities that focus her attention, which is especially helpful when her mind is otherwise occupied with stressful thoughts.

> SARAH: At least I get a bit calmer, maybe, from having music therapy. And it gives me something, in a way.
> R: Calmer. Is it in the body, or in the thoughts, or…
> SARAH: In the thoughts. Because I used to have a lot of racing thoughts and things like that. But I think that, maybe to sit down and concentrate on a song, and learn it, and feel that you master it, may… Yes, it gives me something in a way. (Interview with Sarah)

Music therapy can provide activities that are adapted to individual interests and skill level, and Sarah uses much of her time in music therapy to learn to play songs on the piano. For her, it seems clear that this activity can be calming; to play the piano may give her a break from her thoughts.

One way to think of music therapy is to see it as a playing ground; participants get to explore and learn in safe environments, before they take the big step out into the real world, with all of its challenges. Frank was clear about the potential transfer value for experiences acquired in music therapy:

> FRANK: And it [music therapy] helps you in other facets of life, like if you feel free and open, and you feel that you can be vulnerable here, it gives you

stronger armour for when you're out in the real world.
R: So you feel that there's a certain transfer value, to be able to be free here [in music therapy]?
FRANK: Yeah.
R: And to dare to do things, and play around?
FRANK: Yeah. (Interview with Frank)

In music therapy Frank is allowed to improvise and play around; in the music, it is never dangerous to make mistakes or experiment with new sounds and voices. When learning not to take everything he does too seriously, it may be easier for Frank to handle life itself when things are not going his way.

For Sarah, the task of learning to trust her own capability to play the piano may be transferred into a relaxed state of mind regarding life itself. This mind set may work as a coping strategy for facing different challenges in everyday life for participants like Sarah.

R: Is there anything you remember especially well from these months with music therapy?
SARAH: I guess it's all those times I've sat in front of that piano, or the one time I learned that I could press a bit hard [on the key] if it was difficult, and that it was easier if I just jumped into it.
R: Yes. Dared to give into it a little?
SARAH: Yes.
R: How did that affect the playing?
SARAH: It actually got a bit easier, and if I jumped into it, not quickly, but without thinking too much, it worked. 'Cause we've talked about it a lot, that if I stop and think, and then I play a bit wrongly in a way, or press the wrong key, or something like that.
R: Maybe to trust yourself?
SARAH: Yes, but [the music therapist] usually says, when we play the piano and such, she says like: 'Yes, that's how it is in life as well', hehe. I think that's really nice, because it gets a bit metaphorical in a way, that if you play a bit incorrectly it's not the end of the world, and that it's the same in life as well, that if something goes wrong, it's not the end of the world neither, it goes on in a way. Just like the song continues as well. (Interview with Sarah)

In music therapy Sarah experiences that it is not dangerous to make mistakes, and that sometimes a relaxed attitude might even bring more fortunate outcomes.

From the examples above we have seen that music therapy can function as a safe way to explore and to learn how to handle musical challenges, and perhaps alter the experience of challenges in real life as well. As described below, therapy groups can also function as a safe place for the participants to engage in activities together with others. During the interview with Kim, he emphasised that exposure to social interaction is vital in order to cope with similar situations in the future. Even though it was a bit challenging to engage in large groups, he was eager to play with other service users at the ward.

> R: A slightly bigger group, or a bit more group playing, is that what you miss, more people to play with simultaneously?
> KIM: Theoretically I miss it, but when it comes to… and if a lot of people come, then it gets a bit scary, at least the first ten minutes. I get used to it swiftly, but still. I think that if you have problems with something, or are scared of something, there is no use in avoiding it if you want to do something about it. It's not always that you can do something about fear, but at least get used to it.
> R: Yes, to get exposed…
> KIM: That's a form of therapy.
> R: And to get more secure about oneself, really?
> KIM: Yes, and I've done that a bit after I was admitted. But it's not only… it's not directly because of music therapy; it's because I've gone into my head so much and thought a bit, and thought about what I want with my life. Not what I want with my life, but what I want to become myself, what person I want to become. So I've tried to work on my self, and I've accomplished a great deal.
> R: Yes… become more secure?
> KIM: Only five years ago I would have been a completely different person. (Interview with Kim)

Music therapy alone cannot take credit for all of Kim's transformations during the past few years. His recovery process depends on his willingness to change, and on the rest of his everyday life within the compulsory treatment program. Still, music therapy affords scenarios that seem to fit well with his need for social exposure during his recovery process.

Music therapy can afford ways of expression, of which Frank stated:

> R: But music is something you value as important, it sounds like?
> FRANK: Yes, extremely import.

R: But what makes you like music therapy, then, you think?
FRANK: The possibility to express oneself. (Interview with Frank)

Frank explained in the interview how he wrote a song about social anxiety, with help from the music therapist, and that he performed this song for a crowd of unfamiliar people. For him, the ability to express himself was an important part of music therapy. As we saw earlier, both Alex and Frank were motivated to participate in music therapy activities because of the possibility to play freely, to say what they want, and to be who they are. It is not all clear what Frank puts in his need for expression, as mentioned above, but it seems that music therapy affords expression, and that Frank appreciates this facet of music therapy.

A more direct practice of expression was mentioned in the interview with Alex:

R: Yes… is it the singing and playing the piano you have done the most, or have you done other things as well?
ALEX: We have talked in the microphone as well?
MT: Yes, we have done that.
ALEX: Because I want to become part of the debate community eventually, so I´ve been thinking a bit towards 'Feministic Forum' […] so we have worked with the microphone and get rid of that anxiety with talking in the microphone and listen to oneself. (Interview with Alex)

For Alex music therapy was used as a way to work with the self-confidence and to prepare for speaking his mind out in public. Alex spoke of being bullied during childhood and his anxiety to speak in social arenas. Alex is engaged in societal topics, and music therapy is one way to help him participate in the debate.

Even though it is sometimes hard for the participants to express exactly what music or music therapy can be good for, or how it helps, my impression is that it is still possible to understand music therapy as beneficial to them. And as Peter exemplifies it is possible to imagine the everyday life without music or music therapy.

R: Is it different to work out after music therapy, and not after music therapy?
P: Yes, it's a big difference.
R: Oh? How?
P: One gets worse and worse if you have no music, you know.
R: Yes. Is it harder to work out then as well?
P: Yes. (Peter)

Previously, Peter stated that he felt happier for the rest of the day after his music therapy appointments, and also that he usually worked out everyday, including days with music therapy. It is somewhat unclear from the statement above whether Peter answers the question in regards to working out, or if he addresses a more general state of well-being. However, he does answer that the music therapy makes a difference. He also says he experiences music as a vital part of his everyday life.

6.4.5 Summarising *Health promotion through music therapy*

All of the participants in this study suggest that music therapy participation one way or another come with several potential benefits for their health, their recovery processes, and/or for their ability to cope with the everyday life. Music therapy can be something to look forward to, and music therapy might even be the one highlight of their week. Music therapy appointments provide reasons and motivation for participants to get out of bed, for travelling outside of the house, and for actively engaging in activities, together with other people. According to the participants' narratives, it appears that music therapy can help to pull people out of isolation, and that this is experienced as beneficial for their everyday life. Regular appointments in music therapy may also work as a stabiliser. Both outpatients and inpatients seem to appreciate how music therapy helps to facilitate for participation, and gives reasons for engaging actively.

Music therapy participation provides a variety of uplifting experiences for the participants. They report that they feel happy both within music therapy and after music therapy on a short-term basis. Some experience a sense of mastery, and others enjoy special events that follow as fond memories in the future, which might in turn lead to positive recollections to the mental healthcare services, and colour the recovery processes positively. All of the participants spoke of fun, joy, or good times as part of music therapy participation.

Although some of the participants have not previously paid much attention towards the potential outcomes of music therapy, statements about beneficial by-products of music therapy come easily when they talk about their experiences. Music therapy may function as a training ground where they can prepare for life; participants learn to play, to communicate with others, and to make mistakes in safe surroundings. These learning processes are likely to come with some transfer value for coping with the real world and all the challenges that are parts of their everyday lives. In addition, music therapy is reported to be an elevating activity in which the attention and concentration is pulled away from busy thoughts and stressful minds. Music therapy can also enable arenas in which to express oneself; through song writing and musical activities participants are allowed to put melody and lyrics to their inner life, for themselves and for others.

7 Discussion of the main themes

And that's what music is for me
When I feel something, whether it's anger
Um, it's a passion about something, or frustration
Like, this is where I go
This is, this is, that's the whole 'NF Real Music thing', man
This is real for me, I need this
This is a therapy for me

Excerpt from *Therapy Session*
by NF (Feuerstein & Profitt, 2016)

The discussion of this thesis is dived into two chapters. In chapter seven, *Discussion of the main themes*, I will specifically go through and discuss topics found in the three main themes from chapter six. In the discussion of the main themes I will look at some of the findings through previous knowledge about both music therapy and compulsory mental healthcare, as presented in chapter three and four, with an emphasis on music asylum as a way to understand potential outcomes in several of the examples from the data set. Notions from the CRPD, described in chapter two, are also used as argument for understanding the potential role of music therapy within compulsory mental healthcare. In chapter eight I will coin the term *liberating music therapy*. The discussion in chapter eight will refer to different aspects of freedom potentially promoted by music therapy, both inside and outside of the music therapy room. Chapter eight culminates in a descriptive figure in which I try to integrate different aspects and layers of freedom, in relation with different levels of music therapy. During the discussion chapters I will also reflect upon some critiques of both the findings and the limitations of the study that I find relevant to address along the way.

7.1 Remarks upon voluntary music therapy

7.1.1 Music therapy is experienced as voluntary

When I first started to plan this research I wondered whether music therapy was actually offered as a voluntary treatment within mental health care. I do not know for sure whether music therapy is always considered a voluntary approach, but I decided only

to look for research participants following voluntary music therapy programs. Hence, the voluntary aspect was described when I established the first contact with the music therapists participating in this research.

Even though I decided to target voluntary music therapy participation, I still wondered whether the participants tend to experience music therapy as voluntary, when they are otherwise committed to involuntary treatment. As described in chapter three several researchers within the field of compulsive mental health care have previously discussed the relationship between the experienced coercion and the actual legal statuses; there is not a one-to-one relationship between the experienced coercion and the actual legal statuses (Iversen et al., 2002; Opsal et al., 2016). Sometimes service users do not even know their actual legal status (Sørgaard, 2007), and often service users merely cooperate because they know that there are no other options (Terkelsen & Larsen, 2012). All of the research participants in this study regard music therapy as voluntary. They go a long way to meet for their appointments, and they report that they participate for their own good. I still cannot say whether music therapy is experienced as voluntary for other people, but at least music therapy *can* be experienced as voluntary, also for people who are otherwise treated involuntary through the mental health care system.

This study may be criticized for trying to describe music therapy as voluntary when actually only targeting voluntary participation. It would be interesting to know whether music therapy is actually made mandatory for someone, and if so, to what extent persons are pressured into participation in music therapy, and what this actually does to both outcomes and experiences of the music therapy processes. And as I have only chosen to include persons who participated voluntarily in music therapy in the first place, I cannot really tell what music therapy is experienced like in other situations. Even though the participants in this study express negativity towards the idea of obligatory music therapy, my conclusions are still only based on hypothetical assumptions from both myself and from the research participants.

7.1.2 Engagement and participation in music therapy

All of the research participants in the study think highly of their music therapy appointments. Several of the interviewees state that they have attended almost all the sessions, and these accounts are confirmed by the partaking music therapists. High attendance rates for music therapy may not come as a surprise, as this finding corresponds well with previous research; Gold et al. (2013) found that music therapy may improve the overall motivation for treatment, and that the drop out rates were quite low for music therapy, especially when taking into account that the research targeted people with low motivation for mental health treatment. Surprising or not, I think the findings in

this study are important because they say something about the potential impact music therapy may have on the participant's recovery processes.

A strong engagement for music therapy on an individual level may also be described by other findings in the study: Several of the informants stated that the frequency of music therapy appointments have increased due to their own needs and wants, mostly these initiatives came from the participants themselves. The respondents in this study typically attend their appointments, and if not, there are usually comprehensible reasons for their absence, such as somatic illness mentioned by Ian and Peter, and bad communication mentioned by Alex. Based on the interviews it seems that there is a common understanding between the therapists and the participants that the music therapy sessions are for the participants' own good. The participants report that they do not want to miss the sessions for their own sake.

Sometimes music therapy may be one out of very few other regular activities that the participants are engaged with during their everyday lives. In chapter six of this thesis, for instance, we read about Kim who does not participate in any of the activities afforded by the institution, except for music therapy.

> R: How is it with other things you attend during the week?
> KIM: I don't attend anything else.
> R: No, only the music [therapy].
> KIM: I don't attend hikings or yoga or anything like that. (Interview with Kim)

I will not argue that music therapy provides the same effects or outcomes as any other activity, and sometimes a physical workout might be more important for the health than musical activities within the hospital walls[68]. Also, I do not think that the nature of the activity is irrelevant. I do believe, however, that it is much better to participate in *some* activities rather than *no* activities. And for some service users, music therapy might be the one activity, or one of few activities, that motivates for participation. Within the literature on music therapy and forensic mental health care we can find several similar examples of service users who are not motivated for participation in activities or treatment programs, except for music therapy (Coutinho et al., 2015b; Dickinson & Gahir, 2013; Maguire & Merrick, 2013).

68 New national standards with integrated pathways for mental health treatment, applied the 1st of January 2019, demand a stronger follow-up on the physical health of the service users, implying both a working cooperation with the service user's regular physician, as well as attention towards physical activity. One important reason for this is that people with sever mental health challenges dies earlier than the general population due to a poor physical health (Norwegian Directorate of Health, 2018).

Mental health facilities are required to implement medication free treatments from the national health authorities from 2016 (Ministry of Health and Care Services, 2015; Norwegian Directorate of Health, 2016b), and self-determination for the service-users is highlighted both in the revision of the Mental Health Care Act in 2018 (Lov om endringer i psykisk helsevernloven mv. (økt selvbestemmelse og rettssikkerhet), 2017) and in the new implementation of pathways of recovery within Norwegian mental healthcare (Norwegian Directorate of Health, 2018). When developing the modern mental healthcare in Norway, it may prove valuable to be aware about the potential engagement that may follow from participating in music therapy: if the approach with medication free treatments is to work, it is important to find methods that are motivating enough to facilitate participation. For some, music therapy can be an important option in terms of providing health services that the service users want to follow up.

I think that participation in for instance music therapy sometimes may ignite positive experiences, and that several positive experiences may in turn pave the way for further engagement in the recovery phases and in life in general (Solli, 2014). Thus, the participations' motivation for music therapy is of vital importance. In a more direct sense, music therapists might also encourage people taking part in the individual mental health treatment by collaborating with other health professionals and planning other appointments close to the music therapy session, which was the case for Peter who had to travel a long way for his appointments.

Although the user accounts referred to in this study proves speaks well for music therapy, I have indeed experienced, as being a music therapist my self, that participants do not always attend their music therapy appointments, especially in closed mental healthcare units. Quite contrary, motivating, engaging, and reminding persons about their appointments can be an important part of working as a music therapist. Even though the findings in this study show attendance rates close to a hundred per cent, these examples may be far away from the average attendance rates for music therapy processes within mental healthcare. There are different reasons for why service users are not always fully engaged in the music therapy process, and one reason for this might be to do with the state of the recovery process; there are differences between going through an acute or semi-acute phase at a closed ward, and holding on to a more stable phase as an outpatient. When working in closed wards, I have surely experienced not being able to reach everyone. For this study I have initially asked music therapists about research participants, to which the music therapists have suggested candidates who have been eager to contribute to the research. The music therapists have probably also suggested participants who were likely to show up for the interview, because the usually attend the music therapy sessions. Thus, this study says very little about attendance rates for anyone, except for the qualitative descriptions provided by a few participants. What the

study does show, however, is that *some* persons find music therapy engaging enough to participate quite regularly.

7.2 Remarks upon motivating music therapy

The reasons for attending music therapy are individually dependent. Through a recovery-oriented perspective the most important factor for participation is the participants themselves; no matter how motivating and fun an activity may seem, it is not enough if the participants choose to stay in bed. It looks impressing when a music therapist enables an attendance rate of almost hundred per cent after more than a year an a half of weekly music therapy, as with the case of Ian; but it would not even be a music therapy process if it was not for Ian's contribution and engagement to follow up the appointments. The findings under this theme, *motivating music therapy*, still enlighten us of some potentially motivational or inspiring parts of music therapy participation that can prove valuable in several occasions; when recruiting and motivating new candidates for music therapy, when developing methods and educating music therapy trainees, and when seeking to understand what music therapy can offer people undergoing compulsory mental health care.

7.2.1 Motivation for music therapy through motivation for the music

Through the engagement with the data set, the research participant's relationships with music and musical artists seemed more and more important for their fascination for – and commitment to – music therapy. When the research participants are asked directly about why they go to music therapy, one common answer is that they love music. The research participants listen to music, are inspired by the messages in music, use music actively for health beneficial outcomes, relate and look up to musical artists, and live their lives through music. The findings in this study support two previous examples from the literature that suggest a relationship between the participants' understanding of music therapy and a preceding understanding of music as meaningful or as a health resource (Ansdell & Meehan, 2010; MacDonald, 2015). Previous literature also supports the impression that people in the general population tend to be aware of the potential health promotional aspects of music listening (Beckmann, 2014; Skånland, 2011).

Perhaps are the participants, in a way, already familiar with the potential of achieving asylum through music; the participants use for instance music listening actively in their daily lives as removals, in order to get away from difficult or tiresome thoughts, from

the crowd on the bus, or from physical exertions when working out. They have perhaps also experienced ways in which music activities may function as refurnishing strategies for achieving asylums, such as singing together in church, in school, or in karaoke bars. Several of the participants in the study want to play in bands with others, which may be regarded a suitable refurnishing strategy for achieving asylum. The participants in the study are probably not familiar with DeNora's (2016) theory about music asylums, but Some way or another, it is likely that the participants are familiar with the potential of music activities to afford som kind of 'room' in which 'something good' may occur.

Regarding the topic of music in everyday life I find it pertinent to mention the Norwegian music therapy scholar Even Ruud's (Ruud, 1997, 2013) thoughts on music and identity. Music is part of people's everyday lives, and music is intrinsically interwoven with people's identity in several ways. Both consciously and subconsciously, musical narratives are part of the individual life world on a social level, a personal level, and a transcendental level, as well as a connection with time and space (Ruud, 1997, 2013). I believe that it is impossible to separate the research participants' strong personal bonds with music from the motivation to participate in music therapy activities.

Some of the research participants, such as Kim, Frank, and Ian, also view themselves *as* musicians. Although they are aware that they are still musicians on an amateur-level and still need practice in order to make it as professional musicians, the ability to manage a musical instrument or write songs, can lead to an identity *as* a musician. For people within mental health care, such a vivid identity marker may be of utmost importance. Stigmas and social attributes that can follow both from mental health issues and from being involuntarily committed to mental healthcare can be a highly degrading part of everyday life (Rolvsjord, 2007; Solli, 2014). The possibility to grow and develop as a musician might reduce the experience of being a mental health service user. One might understand such changing experiences of the self as due to successful performances within music asylums. As the participants engage in music activities together with the music therapist, the participant may achieve asylum. When making use of culture, such as knowledge about music, music instruments, musical terms, and genre-specific godes, the participant may learn to succeed on both the back- and front-areas of the stage. Understood through a postmodern perspective on identity as something fragmented and elusive, it makes sense to suggest that flourishing through music asylums may further enhance the sense of a musician's identity, as described well by a music therapy participant in a recent Norwegian newspaper (my translation):

> To me it was a matter of creating a new identity. I'm no longer he who uses drugs – now I'm the one who makes music. At last I have something to look

> forward to. It has actually [rett og slett] become a replacement for the drugs. (Gulbrandsen, 2020)

A similar quotation is made by another musician who started playing in a band that was established as part of music therapy, which is now almost running itself (my translation): 'There was a time when I defined myself only as an alcoholic, now I define myself as musician and human being' (Buer & Audestad, 2020).

As a music therapist myself, with experience from recruiting participants to music therapy within mental healthcare, I know well the feeling of working with people who are already significantly devoted to music and musical activities, such as Barry who took the initiative to form a band within a forensic setting, described in chapter four. And it seems that several of the research participants in this study also attended music therapy because of previous experiences of playing instruments. I believe, though, that music therapists should keep in mind the possibility of music therapy engaging and motivating people with less experiences of playing music. Those who 'only' listen to music are also potential candidates for music therapy. And a lot of people like to play instruments in music therapy, even though it may be their first time. Lee, for instance, had never played a musical instrument, but was still excited to learn the drums. Out of the seven participants in thus study four of them, Ian, Frank, Kim, and Peter, had lots of experiences in active music making before music therapy. As for the service users within compulsory mental healthcare in general, the amount of people with lots of experiences in making music is probably less than four out of seven. The research participants in this study speak enthusiastically about musical activities, regardless of how close they regard themselves as musicians. It can be unfortunate if 'non-musicians' are referred to music therapy much more seldom than those with previous experience with music making. The probability of achieving asylums through music activities may be the same regardless of previous experiences with playing musical instruments.

7.2.2 Music therapy as a break from compulsory mental healthcare

Participation in music therapy is regarded a positive break from everyday life within mental health care by several of the research participants; when they *enter* the music therapy room, they also *leave* the sterile walls, the medication, the nagging professionals and all their questions, the decrees and routines, and the potentially intense co-existing with peers at the ward.

Lee is not motivated for conversations with specialists, as he described in chapter six, but to music therapy he comes running. We might also recall Peter who said that: 'There's only medication. And questions. They pose a lot of questions. But the music doesn't

pose questions.' Franks says that he feels like a 'lab rat', and that 'music therapy is the one cornerstone I have that is good.' Even though I will probably never know what it feels like to go through enforced medications, it is easy to comprehend the emotions that are potentially evoked from such events; service users exposed to coercion often feel degraded due to a lack of autonomy and not being recognized (Husum et al., 2019; Lorem et al., 2014; Pedersen, 2008; Svindseth et al., 2007; Thorvik, 2012). Experiences of humiliation are quite common for both voluntarily and involuntarily admitted service users (Svindseth, 2015; Svindseth et al., 2007), but probably more common for the involuntarily admitted group (Svindseth et al., 2013). From the previous literature about music therapy for people with mental health challenges we can recognize that people tend to experience music therapy as a free zone in different ways (Ansdell & Meehan, 2010; Solli, 2014; Tuastad & O'Grady, 2013). And in an article by Solli and Rolvsjord (2014) a music therapy participant speaks of music therapy as *the opposite* of treatment. The latter account describes well one of the important features about music therapy that may facilitate for motivation, also for service users within compulsive mental health care in specific.[69]

Perhaps this free-zone or 'opposite', experienced by music therapy participants, may as well be understood through the theory of music asylum. Music therapy may afford different activities and strategies for achieving asylum, and in several ways the participants may be provided breaks from compulsory mental healthcare, and from potentially degrading and humiliating experiences. The CRPD, as described in chapter two, aims to protect persons with disabilities from degrading treatments. Accordingly, I wish that something is done with the amount of coercion in mental healthcare. But until that happens, perhaps it is good that music therapy may at least provide some sort of 'asylum', or shelter, wherein the participants may hide from undesirable situations, at least for a while.

Through notions on the recovery-perspective, Solli and Rolvsjord (2014) highlight the conundrum of performing therapy on people who are already tired of being treated. I believe this conundrum is relevant for this study as well, and it is also a topic addressed within the field of music therapy and forensic mental health care; several examples from the literature base describe eagerness and fascination for music therapy and musical activities, when not otherwise motivated to participate in other treatments or activities provided by the facilities (Coutinho et al., 2015b; Dickinson & Gahir, 2013; Maguire & Merrick, 2013). Music therapy may therefore be experienced as a break from compulsory mental health care. It may be of great importance then, to know what it is about music

69 As mentioned in chapter three, eight out of nine research participants in the study by Solli and Rolvsjord (2014) were treated compulsorily.

therapy that makes it different from other treatments or activities. We already know that most of the participants in this study already experience strong connections with music and musical activities.

7.2.3 The freedom within music therapy

One advantage of music therapy in compulsory mental health care, as brought forward by the research participants in chapter six, is the experienced openness and flexibility. It seems that the freedom provided within the music therapy sessions enables a safe place for participation. The experience of safety and openness helped motivate Alex to participate; for him, it was important to be met with a tolerant and including approach, and the assurance that it was impossible to make mistakes in music therapy. Focusing on the resources, and removing the attention away from pressure and performance, as part of a resource-oriented music therapy (Rolvsjord, 2007), might have been defining for the motivation for Alex to continue participating in music therapy.

Another resource-oriented approach that was important for Sarah's participation in music therapy was the freedom to adapt the sessions according to her current mood and energy level; even on bad days she met for her music therapy appointments because she knew that she was in control of the duration of the session. Such accommodations align well with the CRPD, which emphasises that accommodations are made in order to enable active and worthy lives, despite of different challenges. Too often are persons held out of participation due to scarce accommodations, and such exclusion is considered violations to the human rights. There are many ways in which to adapt music therapy to fit with the participants' resources, and I believe that the therapist's skill to accommodate is an inevitable feature of music therapy: Some music therapists accommodate music activities for persons with severely reduced functioning regularly, and consequently maintain fundamental human rights for participation. In the example with Sarah it seems there is not much that needs to be done, other than establishing an agreement in that 'some is better than nothing', and that shorter sessions evoke no hard feelings. As potrayed in the interview it seems that even small adaptions can provide the necessary comfort that maintains possibilities for participation.

Music therapy may also work as a safe place for the participants to say what they want and be who they are, as Frank put it:

> I can sing about exactly what I feel like. I can enjoy the moment, and no one mentions that what I say is wrong. But at the ward they say, like: 'Don't talk about this, don't talk about that… talk about other things!'
> (Interview with Frank)

There may be restrictions of what to say in the common rooms at mental health wards. Also there might be a chance that it is sometimes easier to be Frank with a therapist whose job is not to set diagnoses or prescribe new medications, like others health professionals must do. Hence, the therapeutic bonds between the music therapists and the participants might do well because of the openness, which I believe is a central part of a humanistic music therapy (Rolvsjord, 2007; Ruud, 2015a, 2015b). Frank might be right when he says that: 'there are no limiting beliefs in music therapy, and that's what makes it so special'.

The freedom within music therapy, as portrayed in chapter six, also includes the opportunity of different contents and activities in the music therapy sessions. Peter told us how he remembered when he decided he wanted to sing, and took control of the contents of the music therapy session. And Lee found motivation to participate in music therapy by playing the drums, something he had never done before. Within compulsory mental healthcare, service users are likely to experience little influence and participation regarding their own treatment program (Lorem et al., 2014; Sørgaard, 2007). Reduced satisfaction with mental healthcare and negative experiences may follow from coercive events and lack of influence and options during treatment (Iversen et al., 2007; Lorem et al., 2014). Positive experiences, however, may come when the service users' needs and interests are met (Lorem et al., 2014). It is also reported several times in the previous literature that the service users want more cooperation and dialogue regarding their own treatment (Bø et al., 2015; Thorvik, 2012; Wynn, 2007). Perhaps may participation in music therapy afford possibilities for self-determination to an extent that makes the overall experience of compulsory mental healthcare more positive for the service users. I do not think that music therapists should legitimize the absence of self-determination in mental healthcare by allowing the service users to make choices in music therapy. But it may be that a high degree of self-determination within music therapy is one aspect of what music therapy can be for service users within compulsory mental healthcare. In chapter eight I will return to the problem of music therapy trying to liberate service users within the same strucutural discourses that legitimize music therapy.

The freedom of choice seems important for the experience of music therapy for Alex, Frank, Lee, and Peter. It may not be a coincidence that the research participants in this study talked a fair share about the possibilities and openness in music therapy. Identity and empowerment are two of the highlighted elements in the recovery-oriented literature (Leamy et al., 2011), and if service users are expected to make changes in their lives, and take control of their recovery processes, it is vital to facilitate the confidence necessary to stand through these challenges. Compulsory mental healthcare come with restrictions and a diminution of the self-determination, whereas music therapy may provide new possibilities and promote self-determination within the therapy sessions,

and thus support the participants as autonomous and resourceful human beings. Perhaps participating in music therapy enables important aspects of self-determination and autonomy for the participants while they are otherwise treated compulsorily.

7.2.4 Contact with people

A humanistic perspective on music therapy, as that found in Norway, implies an ontological stance on the human being as social (Drøsdal, 2013; Krüger, 2012; Nebelung & Stensæth, 2018; Rolvsjord, 2007; Ruud, 2008; Stige, 2003; Stige & Aarø, 2011; Trondalen, 2016), which may in part describe the importance for socialisation as part of being motivated for music therapy.

In chapter six Kim mentioned that he misses going out with friends, going to concerts, and socialising. At the time of the interview he had already been admitted for some years due to a decision in a court of law, and it was likely that he would continue hospitalised for some time. The music therapist cannot do anything directly with the verdict; not even the specialists at the ward are probably able to change his legal status without the permission from higher prosecuting authorities (Law Library, 1999a), depending on the seriousness of the verdict. What the music therapist can do is to motivate for activities that appeal to Kim's fundamental human needs for social contact that is otherwise difficult to nourish within the hospital wards. Based on the research interview it seems that Kim used music listening a lot, and that this may have worked as a removal strategy for achieving asylum through his years in compulsory mental healthcare. But it also seems that the potential of achieving asylum through refurnishing strategies, such as participating in music therapy groups, got Kim engaged into activity, although he otherwise partook in few of the other activities available at the ward.

Lee also specified parts of the social interactions as a motive for attending group music therapy, and especially mentioned the sharing of song and listening to different music together. Social interaction may occur in different ways, and in a variety of situations for compulsorily admitted inpatients. But, we might imagine that a common denominator, such as music, facilitates for conversations among this study's participants more than do diagnoses, medications, and sterile ward facilities. Everyone is the expert in one's own taste in music, and everybody knows something about different music. Thus, speaking about music may be a way to handle culture, and cultural codes, in ways that enable successful performances at the frontstage area. As a working music therapist I have several times witnessed situations myself, in which persons say little most of the time, but seems to 'connect' to the group when sharing songs and conversing about music and musical preferences. When the music therapists arrange musical meetings, they also open doors for music asylums through shared togetherness.

For Ian, music therapy is a way to prepare for further social contact; he wants to be able to play in a band with other people and uses his music therapy appointments as a doorway into a social musical sphere. His motivation for music therapy seems to be attached with his will to improve as a musician, in a step towards playing music together with peers. Thus, the wish for social contact and belonging in a band may be part of the motivation for participating in music therapy. It may also be that Ian is not that uptaken with the social bonds within a band setting, rather his motivation for playing in a band may be tied to the fact that bands are cool. Still, Ian seems pretty set by the idea of mastering the culture necessary for succeeding on the frontstage areas, both metaphorically and literally.

Social bonds between the participant and the music therapist might also evoke motivation. As portrayed in chapter six Peter's bonding with the music therapist was apparently a vital part of Peter's wish to continue with the music therapy process, even after a year of weekly and biweekly appointments. The therapeutic bonds may sometimes grow so strong that the music therapy participant experiences the music therapist as a friend. Also Alex points out the importance of inspiring therapists and health workers with 'a smiling face'. I submit to the understanding that music therapy is social in its nature, and that there will always be both music and a therapeutic relationship in music therapy (Bruscia, 2014). Therapeutic relationship is considered one of the potential *common factors* that are vital in most therapeutic approaches within mental healthcare; regardless of the interventions specific to a singular therapeutic approach, the impact of the relationship with the therapist may potentially facilitate outcomes and effects on its own (Wampold, 2015). In music therapy, Carr and others (2013) found in their meta-study that 'an emphasis on building a therapeutic relationship and building patient resources may be of particular importance' (2013, p. 17). Regardless of the credit given to the therapeutic relationship within music therapy, the same relationship could probably not exist without music being part of it. I support DeNora and Ansdell (2014) in their description of the intrinsic relationships that are part of music therapy, presented in chapter four:

> In all cases it is not the music per se that accomplishes this enhancement but rather what is done with, done to, and done alongside musical engagement. It is music plus people plus practices plus other resources that can make a change for the better. In a sense then, music can do nothing and everything. Its potential to promote flourishing, even in extremis, is simply waiting to be tapped. (Discussion section)

Music alone cannot motivate or help any participants; engagement with music and people can. Still, participants in this study brought up qualities about the therapeutic relationships in the interviews, and it is probably wise to take into account the potential importance of such relationships as one of the reasons to devote to the therapeutical processes. *How* therapeutic relationships are best formed, is a question that opens up too many answers to be addressed in this study, but it may well be that 'music' is part of those answers.

If human beings are understood as social in its nature, as founded in a humanistic perspective, it follows that a humanistic mental healthcare should take into account the human needs for social contact, and thus facilitate for socialisation in several ways. Persons admitted to compulsory mental healthcare lose touch with many of their regular inter-personal meetings from their everyday lives, and should be given the opportunity to play out their social needs. Music therapy participation cannot replace the relationships to close others, but perhaps can music therapy afford social contact and a sense of belonging to some extent. The field of personality psychology has taught us that there are probably great individual differences in regards to what forms of social contacts that are valued and needed the most in persons' lives (although social networks are generally predictors for many positive outcomes, regardless of personality traits, as will be discussed later in this chapter). Therefore, person-centered healthcare services that seek to provide the best services as possible, adapted to individual, yet fundamental human needs, could perhaps afford both individual music therapy and group music therapy in order to reach persons with different social strategies.

Although I have suggested reasons why the participants are motivated to attend music therapy based on accounts found in the data set, I cannot know for sure what 'really' makes them participate. I have only portrayed my own interpretations of what 'seem' the most important for to the participants, based on artificial interview conversations, and partly based on direct questions about important aspects of music therapy, in which the research himself is the one who insinuates that there *are* important parts to speak of in the first place.

7.3 Remarks upon health promotion through music therapy

In the third and last main theme, health promotion through music therapy, we encounter a third level of knowledge. That is, the construction of this theme may help to provide

answers to a different sort of question than the preceding main themes. The theme health promotion through music therapy is, perhaps more than the other two themes, a composition of several different ingredients for new knowledge; more-or-less direct questions about what the research participants get out of music therapy are mixed with reflections about music and health, together with the researcher's interpretation about causalities and correlations between the music therapy sessions and the participants' well-being.

7.3.1 Activation through music therapy

The results from chapter six indicate that music therapy helps to activate the research participants. The fact that music therapy helps participants get into activities is also described in other research literature (Ansdell & Meehan, 2010; Coutinho et al., 2015b; Dickinson & Gahir, 2013; MacDonald, 2015; Maguire & Merrick, 2013; Silverman, 2006). One big challenge for service users with severe mental illnesses is the will to plan, initiate, and perform daily life tasks and other activities (ICD-10). The lack of initiatives and difficulty of getting involved in activities is one of the common negative symptoms that are often found with people with schizophrenia and schizophrenia-like symptoms. Such diagnoses may predict the use of compulsory treatment and coercive means (Færden, 2001; Knutzen et al., 2011; Myklebust et al., 2012), and coercion in turn predicts longer treatment periods and admissions (Furre et al., 2014; Knutzen et al., 2014, p. 714; Knutzen et al., 2011). Thus, it is reasonable to think that many service users who are admitted to compulsory mental health care are also those who may struggle to initiate activities.

Two examples from the literature about forensic mental health care illustrate that music therapy may help motivate people who have literally been given up by the health services because they had not attended any activities for years, and even decades (Dickinson & Gahir, 2013; Maguire & Merrick, 2013). Even though the two examples are only individual case portraits, the magnitude of a decade or three in high security wards is worth mentioning. One can only begin to imagine how it might be to live within high security settings, with few or no organized activities or treatments that really appeal to one's interests. None of the research participants in this study had been hospitalized in high security settings for decades, although Kim had was sentenced to several years of compulsory mental healthcare through a court of law. It is still worth to mention that music therapy was reported to help the participants out of bed and into activity in this study; this supports previous research that music therapy may help to engage people who are viewed as being little receptive for treatment (Ansdell & Meehan, 2010; Gold et al., 2013), a group of service users that might well be subjects to compulsory mental

health care. Gold et al. (2013) targeted people with low motivation for mental health treatment in their RCT-study, regardless of their attributed mental health diagnoses, as these people often suffer from long and frequent admissions; the study implies that people with low motivation for treatment in general are much more motivated for music therapy, and that participation in music therapy may further improve motivation for other treatments. Based on the participant accounts in this study, as well as previous research, the way music therapy seems to help persons into activity may well be part of the picture of what music therapy can be for service users within compulsory mental healthcare.

In a study of user experiences in which former service users of mental healthcare describe their 'dream hospital' (Mjøsund, 2020), one of the findings was that the service users wish for a lesser attention towards medications, in favour of a greater variety of acitivies and treatments. As we saw in chapter four, music therapy is still not that outspread within mental healthcare in Norway, thus service users within compulsory mental healthcare do not generally have access to music therapists. Since music therapy may help some service users into acitivites, but is not available for most service users, this situation is most definitely of concern to music therapy as a discipline. And I do believe that much is being done in order to implement music therapy in Norway on a national level, partly through the 'four part collaboration'[70] [Firepartssamarbeidet]. And even though there is not necessary much that a singular music therapist can do about the countrywide scarcety of music therapists in mental healthcare, it is possible to promote music therapy to begin with, and to work as ambassadors for both the profession and music therapy knowledge; if lots of music therapists actively engage in professional discussions, and help others to be more familiar with potential outcomes of music therapy, then perhaps will more service users eventually get access to music therapy due to overall investments and expensions of music therapy in different health facilities. I do believe that most music therapists are in position to create new positions for other music therapists, but I still believe that the music therapy as an ambassador for music therapy engagement may still be part of what music therapists *can* provide for service users within compulsory mental healthcare, which is worth mentioning.

7.3.2 Motivation and hope through music therapy

Music therapy is something to look forward to according to the research participants in this study, as described in sub-theme '3a something to look forward to' in chapter

70 The 'Four part collaboration' includes The University of Bergen, Norwegian Academy of Music, Norsk forening for musikkterapi [Norwegian association of music therapy], and CREO (the union that supports music-based professionals, including music therapists). See for instance: https://www.musikkterapi.no/nyheter/firepartsamarbeidet

six. Not only can music therapy help to engage them into activities, as described in subtheme '3b getting up and in activities', music therapy might also be one out of only a few things that they participate in during the week. As Sarah stated, 'it makes a difference':

> R: Do you have any thoughts about what it means for the whole week, to have music therapy on the schedule?
> SARAH: Sometimes I look forward to Thursday a little, because then it's music therapy. So it makes a difference. (Interview with Sarah)

In all modesty, Sarah tells us that *sometimes* she looks forward to Thursday, *a little*. Also Kim says that he looks forward to music therapy, and Frank calls music therapy the 'highlight of the week'. I believe that we need to pay attention to Sarah's modest account for two reasons. Firstly, she reminds us that it is ok to not always be thrilled by the music therapy appointments. It is enough that she *sometimes* looks forward to it. Sarah knows that she is always welcome to music therapy, and that she will have the possibility to attend music therapy for as long as she remains at the facility where she lives. She also knows that if she does not show up to the appointment there will be no consequences other than her therapist wondering if she is ok. Secondly, through Sarah's modesty I am reminded that sometimes *a little* is enough. During the interview Sarah mentioned that she was going through a difficult time, and that she contemporarily had appointments with her psychologist every day. When someone is going through the most difficult times, to actually look forward to something *a little*, might be just what that person needs. And over time, several *littles* might grow into something bigger. Sarah's modesty may of course also derive from the fact that music therapy is not that important for Sarah's week, and that the account was more a matter of providing a polite answer to a laden question from the researcher. I sincerely interpret Sarah's account in a way that speaks well for the role of music therapy in her contemporary everyday life, yet the statement would possibly be more convincing if she said that she *always* looked forward to music therapy *a lot*.

It is not possible, I believe, to know exactly in what ways music therapy may provide hope for the participants in this study, based on their interview accounts. But there are still some examples in the data set that seem to point at the crossing between the 'now' and the 'future', which also seem to paint the future in uplifting colours. Ian, as we have seen, seemed quite eager regarding his preparations towards playing in a band. Although I do not know whether 'hope' was an important part of Ian's outcome of music therapy, Ian made it very clear that he *hoped* to play in a band at a later point in time, and that this goal affected both the therapy process and the reasons for attending music therapy. Frank had previously experienced deeply moving concert situations

through music therapy, and *hoped* for similar experiences in the future: Rehearsing and producing songs in a small band setting was consequently the main target of Frank's music therapy process. Alex practiced talking though the microphone as part of music therapy, as a way to prepare for speaking his mind in public; he had a wish to engage actively in the community, study at the university, and attend local debates. The music therapist supported Alex' hopes, and the content of the therapy sessions was partly about enhancing the possibilities for Alex to do what he wanted in the future.

To restore and to maintain hope is regarded one of the core elements in the recovery-perspective on mental healthcare (Jacob, 2015). And Solli (2014) argues that 'music therapy may be a particularly promising approach to promoting hope for individuals with severe mental illness' (p. 48). As was mentioned in chapter four, Solli (2014) suggests a model in which hope is an important ingredient for change through a positive spiral: experienced well-being may lead to a strengthened sense of self and identity, which may lead to improved agency and control over the recovery process. This in turn may lead to symptom alleviation, which again may lead to hope for more well-being, and so on. When speaking about recovery from mental health illnesses, it is easy to value symptom alleviation and well-being highly. But in order to get there, every step on the spiral is essential, including hope. When we hit rock bottom it is crucial that hope is restored; if we believe that there is no way out, there are few reasons to start looking for the exit-sign. I think that Hughes & Cormac (2013) say it quite well:

> The clinical teams in long-stay settings have an important role in holding and sustaining hope, however difficult the circumstances, until such time as patients can regain some hope of their own recovery and a better future for themselves. (p. 71)

This view on mental health recovery processes is meaningful in my study as well. Even the smallest glimpse of well-being may be of the most utter importance; not necessarily on its own, but as a kindle of something that may ignite into a warm fire even on the coldest of nights, if given the right circumstances. If the firewood is cold and soaking wet, then we might need to provide enough time for the wood to dry out. But even then we need to be confident that even the darkest of logs may some day shine brightly.

7.3.3 The frames of music therapy and their influences on potential outcomes

A common opinion for all of the research participants in this study was that there should exist ways to continue with music therapy or similar activities in excess of the compulsory mental healthcare in general, and also some of the music therapists stated that it was not

easy to find relevant options for musical participation in the local environments. It might not be easy for the service users to fit with the organized activities in the community during certain phases of the recovery process, or as Ian said it in chapter six: '… you cannot have people at 33, 34, 35 years old, with mental illnesses, and place them in an adolescent's club.' Solli (2014) highlights the importance of enabling connectedness and social bonds in other ways, since participation in standard social meeting points in the community may be hard:

> My experiences from almost 15 years in practice are that it is not easy for all people with severe mental health difficulties to join community (musical) activities, especially not in certain phases of the illness. In order to promote the processes of personal and social recovery, it is important for the music therapist to work with complex systems, continuing to engage in the patient's everyday life situation and working to promote the various relationships that link people together. (Solli, 2014, p. 54)

One example of a meeting point for service users with mental health challenges is the SMART café described in chapter four (Ansdell, and DeNora 2016; DeNora, 2016). The SMART café works, at least partly, as a bridge between the hospital and the community and gives people a place to belong for however long they need it.[71] I would say that there is something *therapeutic* about such a meeting place, but at the same time it is a step down from *clinical therapy* according to a strict understanding of the term. Music therapists may indeed be part of such meeting points, whether the municipalities organize them, the health services, or the service users themselves. In Bergen, Norway, music therapists have established *The Three Step Model*[72], in which musical participation is intended through three steps; 1) music therapy in the local specialized mental healthcare, 2) music therapy outside in the community, at a centre of performing arts with connections to the mental healthcare, and 3) musical activities out in the community on their own terms (Bjotveit et al., 2016). Also in Bergen, a private foundation that runs a local psychiatric facility[73] recently opened an activity centre with

71 In August 2018 I started to work as a music therapist at 'Sagatun Brukerstyrt Senter' through a project funded by the Norwegian Health Directorate (www.Sagatun.no). Sagatun is an activity center for people with challenges regarding mental health and/or substance abuse, and is founded completely on the recovery perspective. This music therapy project also includes a position at the regional mental health clinic, so that therapeutic bonds may follow the participants from within the hospital and out to society. People are usually discharged from the hospital after about six weeks, but Sagatun is available for as long as they need. I belive that this therapy project to afford many similar ways of thinking about - and practicing music activities as in the SMART-music project.

72 As stated by Bjotveit et al. (2016), the three step model originated from music therapy in prison settings (Nilsen, 1996; Tuastad, 2014).

73 Stiftelsen Betanien Bergen/Betaninen DPS.

an emphasis on music facilities, called Lundefuglen[74] [the Puffin] (Gulbrandsen, 2020). Lundefuglen was established namely to provide opportunities for continuous musical and social meeting points after attending formal music therapy, and may also be an important base in-between of admissions, according to one of the music therapists. I believe that such platforms, and areas of practices, may be of importance when music therapists try to afford recovery and well-being for persons within compulsory mental healthcare in a long-term perspective. Such platforms may perhaps work as asylums for achieving asylum, after attending clinical music therapy. If music therapists do not have access to these kinds of facilities, perhaps music therapists could investigate the local community for appropriate options, and establish collaborations whenevere there are relevant options.

Without asking everyone about the future of the therapeutic process in the interview, at least some of the participants had an agreement with the therapist that the process continued for as long as the participants wanted it, such as for Peter and Ian who had attended music therapy as outpatients for a long time. This may not be the standard situation for most music therapists across the globe; there are several examples in the literature in which the authors suggest music therapy programs with a specific number of sessions (Dickinson & Haakvort, 2017; Jeon et al., 2017), a number that may not be high enough to provide the full potential of measurable effects (Carr et al., 2013; Chen et al., 2016; Gold et al., 2009). Also for some of the participants in this study, the therapy processes were about to end before reaching the necessary 'dose' of sessions, as the participants were about to be discharged, such as for Alex and Lee. From a resource-oriented perspective, Rolvsjord (2007) argues that the chance for the participant to make decisions about the length of the treatment program should be part of the therapeutic process, for the sake of empowerment and growth for the individual participant. Sometimes service users may even be afraid to show signs of improvement in case their improvement could equal the end of their health care, their treatment programs, and their social contact with important health professionals (Rolvsjord, 2007). Also from a recovery-oriented perspective the service user's opinion about personal needs in the recovery process should be taken into account (Hummelvoll et al., 2015). Economy is brought up in the literature as a reason for cost-effective music therapy models (Dickinson & Haakvort, 2017; Short, 2017). Other professional groups within mental healthcare, such as occupational therapists (Seberg & Eriksson, 2018), and physicians (Røtvold & Wynn, 2017) also point at poor possibilities for follow-up of service users. As mentioned in chapter three, general practitioners at a casual clinic referring

74 The name of the activity center was given because: '... the puffin lives at sea in all different kinds of weather. The bird has an inherent ability to cope with a challenging life using its own resources, and a community instinct. There is a puffin in everyone' (Gulbrandsen, 2020, picture caption).

service users to compulsory mental healthcare thought that involuntary admissions could sometimes have been avoided if allowed by the structures and funding within the mental healthcare system (Røtvold & Wynn, 2017).

The Norwegian Directorate of Health (2013) recommends music therapy on the municipal level for people with psychosis disorders, not only for inpatients in acute or intermediate phases. The research participants in this study support this call for music therapy across different phases of recovery. Even though music therapy in mental healthcare is in development in Norway it seem to be a long time until service users within mental healthcare in Norway are actually offered music therapy the same way as more established treatments. As a music therapy enthusiast and researcher myself, I wish more for the music therapy participants. If twenty sessions are what it takes for service users who struggle to actually get better (Carr et al., 2013; Chen et al., 2016; Gold et al., 2009), then twenty sessions is the least music therapists should strive for in the long run.

The participants in this study who are able to follow a long-term music therapy process seem to highly appreciate the sessions. Music therapy is a stable element in their everyday life that they can enjoy and look forward to. Several of the participants, both short-term inpatients and long-term outpatients, call for more music therapy in the future in addition to other possibilities for musical activities, such as organized band playing, rehearsal facilities, and music education. All too often service users are discharged into a void. As I see it, music therapy as a profession and as an academic discipline should work for enabling musical activities in the municipalities, both when debating in the newspapers and when voting individually in political elections.

7.3.4 Social contact

Previously, I suggested that the longing for social relationships and meeting with others is a motivational aspect for the participants to attend music therapy. I also think that social contact and social skills are positive outcomes from music therapy for the participants in this study. When Kim was asked what he remembered best from music therapy, he mentioned the time when he shared the group session together with a fellow service user. They found common ground in the music, and were perhaps more likely to interact normally because of the surrounding frames that afforded social interaction on their own premises. Kim also stated that he wanted more participants to come to the music therapy groups, even though he found larger groups a bit difficult. If we again return to the music asylum analogy, one might regard the successful meeting as occurring within music asylum. Although Kim usually finds social contact a bit challenging, it seems that music therapy groups may have afforded a framework in which Kim managed to make use of culture and cultural codes adequately, thus he performs successfully on the social

front stage. As presented by Kim, social gatherings are somewhat difficult for him, yet he seems to understand the importance of social contact, and he also seems to profit from successful relational meetings, as this was highlighted as an importan episode for him.

Improvement in social skills from music therapy is mentioned at least twice in the literature about forensic mental health care (Jeon et al., 2017; Lawday & Dickinson, 2013). And as we remember from chapter four in this thesis, music therapy participation can improve social functioning for service users with disorders within the psychosis spectrum, as Geretsegger et al. (2017) put it: 'Music therapy seems to address especially motivational, emotional and relational aspects, and helps patients improve regarding their social activities and roles' (p. 27). Kim misses spending time with his friends while he is hospitalized for years, and he appreciates the social contact provided by music therapy groups. Kim does not participate in other activities offered by the institution but is motivated to participate in music therapy groups, even though he finds it a bit challenging to socialise in groups. Music therapy may be especially important for keeping Kim socialized while being hospitalized within compulsory mental healthcare.

Music therapy involves a broad spectrum of activities and methods, and may thus facilitate social contact in several ways. One contact-enabling approach is band playing. Previously in this chapter I argued that Ian's motivation for attending music therapy was related to his wish for playing music together with others. About a year and a half after the research interviews were performed I saw Ian on a band picture on the Internet together with other band members; Ian's participating in individual music therapy did in turn open up for his long-term goal of playing music together with others, although the band constellation was still organized by a music therapist. Group music therapy in the form of band playing was also mentioned as a potent approach in a high security setting in forensic care: In chapter four we met Barry, through the text of Maguire & Merrick (2013), who had been living in high security wards for decades. He took the initiative to form a band with the help of a music therapist - among others - and eventually he acquired the identity of a musician, a front man, and a band member. Barry lost weight, cut his hair, and appeared to care more about his appearance. Also, as a band member he started to cooperate more and listen more to the advices from others regarding both the music and the performances, as they played concerts for staff and fellow service users.

As described in chapter six, Frank was quite taken by his experience of performing his music for an audience. Despite his social anxiety, he sang his song about social anxiety for a couple of hundred people, and mingled in the crowd afterwards, with a 'high' and with an elevated self-esteem. The idea of performing music for others and act *as* musicians is especially embraced within the discourse of community music therapy, as

mentioned in chapter one of this thesis (Ansdell & DeNora, 2016; Pavlicevic & Ansdell, 2004; Stige & Aarø, 2011; Stige, 2003). As a performing musician Frank was admired; he went from being mental health service user to a star – from the bottom of the societal hierarchy to the top. From a community music therapy perspective such performances may help change the societal structures in the long run, and reduce stigmas for people with mental health challenges (Stige & Aarø, 2011; Stige, 2003). For Frank it was probably more a matter of immediate rewards, in the form of increased self-confidence, following a positive experience mingling with strangers despite his social anxiety. The challenge of performing on a stage opened up for new possibilities for contact with audiences, and with the community.

As mentioned above, Alex practiced talking in the microphone in order to get used to the sounds of his voice and to promote self-confidence. This way Alex wanted to prepare for a future engagement in public debates. Despite the obvious differences between raising an opinion in a debate and performing music on a stage, such as Frank did, there are also clear similarities; in both examples the participants express themselves, stand forth as resourceful individuals, partake in new social settings, and engage in the community as active citizens. The example of Alex and the microphone may as well be understood through a community music perspective, in similar ways as with Frank mentioned above (Stige & Aarø, 2011; Stige, 2003). From a recovery-oriented perspective it is relevant to point at the development of Alex's identity and sense of self, by standing up and express himself (Hummelvoll et al., 2015; Leamy et al., 2011; Solli, 2014).

In the field of medicine, the impact of relationships and social networks has been brought up as important to maintaining good health. Holt-Lunstad, Smith & Layton (2010) found that social relationships are among the strongest variables that predict mortality for human beings; social bonds even predict survival to a greater degree than quitting smoking does. Other studies point at a negative correlation between isolation and high life expectancy rates (Pantell, Rehkopf, Jutte, Syme, Balmes & Adler, 2013; Steptoe, Shankar, Demakakos & Wardle, 2013). Also within mental healthcare, the importance of social networks have been investigated: Kogstad, Mönnes & Sörensen (2012) found that trust in social networks correlates well with trust in professional health services and positive experiences from health services. According to Kogstad et al., (2012) social networks can function as adequate substitutes for health services in many ways, and the authors argue that professional health professionals should help construct social networks as part of the provided health services. And as mentioned in chapter three, service users who do not have close others to monitor and to recognize early signs of symptoms, are more likely to be treated compulsorily in the end (Sebergsen et al., 2014). As we have seen, music therapy has the potential to enable social contact in several ways, such as through group music therapy, band playing, and public performances. Perhaps music

therapy may help to facilitate new networks, directly by bringing people together, or indirectly by improving social functioning.

7.3.5 Well-being and recovery through music therapy

As we have seen above, the experienced freedom in music therapy is mentioned as one of the motivating factors for attending music therapy. In addition, the very same freedom and openness is regarded as an adequate doorway towards a more secure sense of self, as Frank explained it. During the interview Frank spoke of his social anxiety, and he also mentioned that people within compulsory mental health care become like turtles; the longer they stay hospitalized the more they retreat into their evolving shells. According to Frank, the playfulness and the freedom to act out his human expressions help him to prepare for the real social society outside of mental health care. Even though anxiety is a disorder that correlates negatively with compulsory mental health care admissions (Myklebust et al., 2012), the comorbidity is in general high for several different mental illnesses; mental health difficulties seldom come alone, and several of the research participants in this study struggle with different symptoms and challenges, including various degrees of anxiety. Effects from music therapy on reducing anxiety have been pointed out in two meta-studies (Geretsegger et al., 2017; Aalbers et al., 2017). The experienced freedom and safety, or affordances of asylums, that may be found in music therapy may be part of this picture.

Sarah also spoke of musical activities as a way to be preparing for everyday life. At least on a cognitive level within the interview situation Sarah seemed to have altered her perspective on the consequences of wrongdoings or mistakes in the everyday life, through reflecting on 'errors' in the piano playing. Through playing the piano, Sarah also experiences that a bit more guts and self-confidence actually helps her to perform better and to complete her goals more accurately. And perhaps Sarah eventually copes with - and tolerates better - her daily life tasks and everyday challenges. If we take into account the recovery-spiral mentioned in chapter one (Solli, 2014), it is easy to imagine that a stronger self-confidence and an improved sense of self may be important if one, like Sarah, is to endure compulsory mental health care and stay strong throughout the recovery process. Without any kind of follow-up I have no ways of knowing whether Sarah actually has changed her mindset and improved her ways to cope with everyday life challenges due to cognitive reflections about piano playing together with the music therapist. Other research designs may be used in the future in order to look for qualitative changes in cognition from participation in music therapy over time.

Part of developing as a social and emotional human being is the ability and competence to express oneself. For Frank, music therapy affords a safe place wherein his thoughts

and expressions are welcomed. And the music affords a medium in which his lyrics may be shared and developed together with both a music therapist and another band member. In the interview with Frank he stated that his thoughts and beliefs were not always welcomed in the hospital milieu. For him, music therapy could relieve him of some of his ideas, because the openness in the music therapy afforded a safe place for his thoughts. Previous literature on music therapy within mental health care supports the idea of music therapy as a place for practicing expression, and a way in which to practice emotional works (MacDonald, 2015; Silverman, 2006, p. 120; Solli & Rolvsjord, 2014). Also the literature on music therapy in forensic mental health settings underpins the experienced value of music therapy as a safe place to express difficult feelings and to develop the emotional life world (Dickinson, 2006, 2013b; Dickinson & Gahir, 2013; Loth, 1994; Nolan, 1983; Spang, 1997). Within the interview Frank spoke about topics that were sometimes hard to believe, from international surveillance to near-death experiences. The topics were, nevertheless, important for him. Perhaps it is for the best for some of the other service users at a closed ward to be spared for certain topics. But as Frank clarifies, he has a need for expression, and in music therapy he gets an outlet from his thoughts. It does not help Frank to keep all of his ideas within himself, regardless of how real or not they might be.

Whereas Frank gets an outlet for his thoughts, focusing on learning to play the piano gives Sarah a break from her run of thoughts, as described in chapter six. Music therapy can thus provide activities that are adapted to individual interests and skill level, and Sarah uses much of her time in music therapy to learn to play songs on the piano. For her, it seems clear that this activity can be calming; to play the piano may give her a break from her thoughts. Thus, the act of teaching Sarah to play the piano may be an importan way to afford strategies to achieve asylum (through removal).

In chapter six the research participants described special occasions from participating in music therapy, such as a concert performance and a local excursion to a summer shore. In addition the participants describe minor events and different contents of music therapy, such as teamwork, trusting relationships, accomplishments, social connections, and meaningful activities that occupy both the individual interests and the concentration of the human mind. Important experiences that were mentioned by the research participants include joy, mastering, and happiness. One joyful moment may not be enough to facilitate change in a person's life. Several joyful moments on the other hand, may be just what it takes to turn the negative spiral upside down, and to facilitate for hope and the belief that tomorrow also may come with pleasant emotions. Episodes of symptom alleviations, as expressed by the research participants, may also help to support the belief that life can be good.

Even though mental healthcare is supposed to help people through their hard times, the very same system might also make people feel like 'a lab rat', as Frank puts it in the interview. Particularly when service users are treated compulsorily, they may feel degraded and humiliated due to the removal of the person's influence and self-determination (Lorem et al., 2014; Pedersen, 2008; Svindseth et al., 2007; Thorvik, 2012). And surely there exist certain negative side effects from being treated by the health services that are supposed to be helpful, as expressed by Solli (2014):

> Psychiatry has been blamed for catalysing a downward spiral in which the passivity, dependency, stigma and experiences of hopelessness lead to a reduced self-esteem and confidence followed by social withdrawal, which again leads to further experiences of hopelessness, thereby progressively increasing emotional, psychological and social distress (Frank & Frank, 1993; Repper & Perkins, 2003; Spaniol, Gagne & Koehler, 1999; Williams, 2012). (p. 50)

The stigmas and changes in agency that may follow from compulsory mental health care should not be underestimated, and there are probably good reasons as to why some experts regard certain acts of compulsory mental health care as clear violations of basic human rights (Feiring & Ugstad, 2014; Høyer, 2000; Kogstad, 2009; Storvik, 2017; Syse, 2006; Wynn, 2006). Music therapists should be aware of the potential humiliation and negative experiences that may follow from compulsory mental health care (Husum et al., 2019; Lorem et al., 2014; Pedersen, 2008; Svindseth, 2015; Svindseth et al., 2007; Svindseth et al., 2013; Thorvik, 2012). And perhaps music therapy can contribute to reversing negative outcomes by empowering the positive and healthy sides of the individual, as the research participants have described in this study. I also support Solli (2014) when he argues that whereas psychiatry may be accused of promoting stigmas, music therapy may help to reduce stigmatization through the strengthening of the participants' agency and sense of self.

As mentioned in chapter two, Rolvsjord (2014b) includes the Human Rights as argument for the critique against the medical model in mental healthcare. And as portrayed in chapter two, the CRPD comes with several arguments for why music therapists should pay attention towards to fundamental Human Rights. Music therapists in Norway are also instructed to follow the Human Rights Convention through national work-ethical guidelines (Norwegian Musicians' Union, 2017), yet I do not believe that music therapists in general are familiar with the Human Rights Convention to the extent that it makes up arguments for how music therapists work and interact within different areas of practice.

In music therapy the participants encounter positive experiences in various ways. Previously in this chapter, and throughout the thesis overall, I have declared my support

for the recovery movement and for the idea of a positive spiral of recovery, as presented by Solli (2014). And I sincerely believe that service users within compulsory mental healthcare need a fair share of positive moments and experiences. In darkness, all emotions are grey. And especially through the darkest of days, we need every glimpse of light possible in order to remember the bright sides of life and all the colours that make life worth living.

8 A liberating music therapy

She can't stop pacing, she never felt so alive
Her thoughts are racing, set on overdrive
It takes a village, this she knows is true
They're expecting her and she's got work to do

Even though she seems so high
He knows that she can't fly
And when she falls out of the sky
He'll be standing by

Excerpt from *About to Crash*,
by Dream Theater

When engaging with the data set in this study, with the literature about music therapy in mental health care and in forensic settings, and with the literature about compulsory mental health care, it seemed that the freedom aspect of music therapy was something that could be important to scrutinize deeper. The previous chapter discusses the three main themes from chapter six, using relevant research on both compulsory mental health care and music therapy within mental health care. In this chapter I will implement findings across different themes, as we will look into the freedom potential of music therapy, or rather, the *liberating* potential in music therapy. The following discussion aims to provide answers to the initial research question, of what music therapy can be for people within compulsory mental health care. For this purpose I will coin the term *liberating music therapy* and present a descriptive figure that has culminated from my study.

8.1 Toward a notion of a liberating music therapy

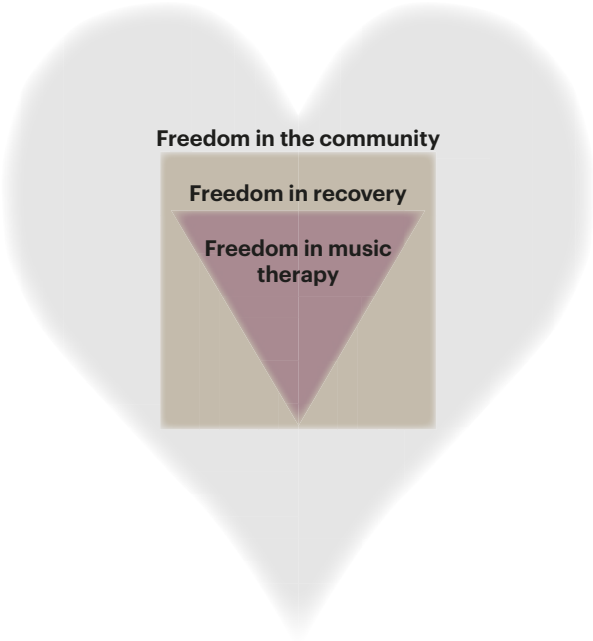

Figure 2: The figure illustrates the three layers to which music therapy can afford different freedoms: the music therapy session, the recovery process, and the community.

In the following I depict *a* liberating music therapy. That is, I will present how *one* liberating music therapy can be understood, based on findings from *this* study. The choice of arguments and examples in this text should not be considered the only pathway to what a liberating music therapy may look like. Neither may this text provide an accurate truth or definition of a liberating music therapy. Instead I present *some* ideas that I find relevant for this topic; notions that may portray and exemplify what this liberating music therapy can be. I believe that a *liberating music therapy* is not necessarily a specific direction or a new way in which to think about music therapy. Still, I believe that this term may open up for ways of thinking about the affordances of music therapy for people within compulsory mental healthcare, and perhaps for people within adjacent areas of the healthcare system as well.

Notions about negative and positive liberties, as discussed in chapter two, will be relevant for the understanding of what freedoms music therapy can potentially provide. As we have seen, negative liberty may be understood as the absence of obstacles, thus one might understand negative liberty as freedoms *from* something. When persons

are compulsorily admitted, their negative libery is restricted in many ways, such as where to go, what to do, what to say, and when to eat. We can say that doors are locked when a person's negative liberty is limited. Positive liberty on the other hand, has to do with freedoms that are enabled by others – and that there are freedoms *to* something. When persons are offered music therapy, the person is also afforded access to certain possibilities that would not have been possibile without the intervention of others. We can say that new doors are opened when positive liberty is present.

As I understand the liberating potential in music therapy within compulsory mental health care, we may speak of three different *layers*: 1) *freedom in music therapy, 2) freedom within the recovery process,* and 3) *freedom in the community* (see figure 2). In the innermost layer we find the direct contact between the music therapist and the participant, within music therapy contexts and with an emphasis on individual appointments or group sessions. In the middle layer I refer to the potential in music therapy that affects the participants' recovery processes outside of the music therapy room, including the music therapist's role, function, and position within the mental healthcare system. In the outermost layer I point at the music therapy participants as being part of a community; both before and after compulsory mental health care, music therapy may have a role to play for the participant, either directly through the therapeutic relationship, or indirectly through the music therapist's participation and engagement in society.

In addition to the different layers described above, I find it relevant to pay attention to the different *levels* of music therapy; as Stige (2002) has proposed, I make use of the three levels: music therapy as a *practice*, music therapy as a *profession*, and music therapy as a *discipline*. In this way I portray a structured line of thought, and also pay attention to the ethical responsibility music therapists have to promote freedoms in the music therapy sessions, both as professionals in interdisciplinary environments, and as active fellow-participants of society.

Throughout the chapter I will possibly challenge the boundaries of what the liberty/freedom term should signify. Perhaps can many of the suggestions of 'freedoms' in music therapy instead be understood as 'affordances'. When I still chose to describe the freedoms of music therapy, I do so because I believe that this perspective provides new ways of looking at the potential of music therapy within compulsory mental healthcare.

8.1.1 Freedoms in music therapy

One finding from the empirical part of this study that appear to me as important, is that the participants appreciated the freedom and openness within the music therapy appointments. As I argued in chapter seven, this freedom affected music therapy participation

in several ways: the freedom within music therapy may have influenced the experience of music therapy as something voluntary, and this freedom may have contributed to an enhanced motivation for partaking in music therapy. In addition, the experienced freedom and openness within music therapy may have influenced both the therapeutic relationship and the recovery process positively. The freedom perspective is also mentioned in the existing music therapy literature (Ansdell & Meehan, 2010; Solli, 2014; Tuastad & O'Grady, 2013), which underpins that this is a topic of interests that may be worth developing. In the following we will look more closely into the potential of different freedoms facilitated by the music therapy process.

Freedom of expression within music therapy

The experienced openness and freedom within the music therapy sessions afforded ways of expression among this study's participants. When there are no rights or wrongs the service users are more open to express themselves through the music, and to involve themselves in the music activities. Frequently in the previous literature music therapy is mentioned as a safe place in which to express difficult emotions (Dickinson, 2006, 2013b; Dickinson & Gahir, 2013; Loth, 1994; Nolan, 1983; Silverman, 2006; Spang, 1997). There are different ways of expressing and experiencing emotions in music, be it through playing instruments, singing, speaking about music, or writing songs. Thus, one could say that music therapy participations afford new ways of relating to one's feelings, and that music therapy participation provides new doors to the service users. The service users, then, have been provided positive liberty, and gain the freedom to express- and cope with difficult emotions in new ways.

As discussed in chapter seven, Alex rehearsed on his free expression by talking in a microphone. And Frank could express his thoughts on social anxiety for a couple of hundred people through performing his own song, as part of music therapy. Frank also outlined the importance of free expression and the opportunity to speak his mind in music therapy; there are no censorships within the music therapy room. Sometimes service users within compulsory mental healthcare have thoughts that others find strange or illogical. According to Frank, the psychiatrist sees all of his words as delusions and symptoms of mania, thus he experiences that he is not allowed to say what he wants within the hospital environment, or speak about that which occupies his mind. No matter how strange or unbelievable Frank's thought may be they are evidently part of his present life world, and he needs a safe place to express himself. In a way, music therapy affords an asylum of positive freedom, as Frank is afforded the freedom *to* express himself in music therapy. But we may also turn it the other way around, and say that Frank has really been *re-afforded* the negative liberty of expression that is limited

by others within compulsory mental healthcare. Music therapy, then, does not 'give' something to Frank; rather music therapy sometimes 'gives back' what has been taken.

Freedom and self-determination within music therapy

Several of the research participants in this study spoke about topics that may be connected to the importance of self-determination. Lee spoke about the importance of choosing music for listening in music therapy groups; Sarah determined the duration of the sessions depending on her current state of mood and energy level; Kim spent time in between sessions to choose new songs to play in music therapy; Peter spoke about his memory of choosing to sing despite the expectations to play the guitar; and both Frank and Alex talked about the joy of improvising freely without restrictions of right or wrong. The research participants tend to appreciate the openness within the music therapy, and the music therapy room seems to be experienced as a non-judging and creative free zone. For some persons the mere act of determination may be of importance on its own. Also, all of the participants spoke about music therapy as something voluntary, and suspected that a hypothetical involuntary music would kill the joy of the musical activities. The openness and freedom within music therapy with the opportunity to do almost anything, and not to feel restricted is a subject that has been raised in both this study and in previous research (Ansdell & Meehan, 2010; MacDonald, 2015; Solli & Rolvsjord, 2014).

Research reports on user experiences within compulsory mental health care teach us that coercion often comes with degrading and negative experiences (Husum et al., 2019; Lorem et al., 2014; Pedersen, 2008; Svindseth, 2015; Svindseth et al., 2007; Svindseth et al., 2013; Thorvik, 2012). Negative experiences from compulsory mental health care also correlate with a lack of influence and options and with unnecessary use of coercion (Norvoll & Pedersen, 2016). Persons who are involuntarily committed, and persons who are persuaded or pressured into consent, may experience a lack of influence more often than those who are voluntarily committed (Sørgaard, 2007, p. 214). And contrary, positive experiences are reported from service users when their needs and interests are met (Lorem et al., 2014), and when they experience being met like human beings (Skorpen et al., 2014). Music therapy participation does not change the legal status or the actual use of coercion, but it can possibly improve the overall experience of the treatment periods, and improve the amount of experienced self-determination, as we have seen in chapter six and seven. Thus, music therapy can potentially provide freedoms that facilitate positive experiences for participants within compulsory mental healthcare.

User involvement and autonomy is already highlighted in the Norwegian work-ethical guidelines for music therapists (Norwegian Musicians' Union, 2017) and the importance

of self-determination for participants within compulsory mental healthcare is regarded essential in all music therapy. Based on the relationships between uplifting experiences from self-determination, and degrading experiences from limited self-determination in compulsory mental healthcare, however, I believe that the attention towards self-determination may be even more important when working with persons treated coercively. As I see it, facilitating for self-determination through the freedom and openness afforded in the music therapy session, is one central aspect of a liberating music therapy. If the participants are to take responsibility over their own life and their own recovery processes, it is vital that self-determination is practiced, rehearsed, and valued. Perhaps it may be, like Stensrud et al. (2016) suggest; a stronger perspective on the autonomy of the service users might improve cooperation, and that a less paternalistic approach might reduce the need for coercion.

Freedom for new and meaningful experiences in music therapy

Music therapy can afford new and meaningful experiences, as described in chapter six and seven. Everyone needs to experience pleasant moments in life, and especially when negative thoughts occupy minds most of the time, and when life feels like an endless darkness, it is vital to re-discover that living can be joyful and that there is more to life than suffering and mental health facilities. As Alex pointed out in chapter six mental health wards can be sterile and without inspiration or fantasy, and the daily life at the ward can be monotonous; the everyday life within compulsory mental healthcare is not necessarily the best ways to have an outlet of difficult thoughts or to have the mind distracted by other stimuli. Music therapy may afford asylums of music, of meaning, of togetherness, and of expression. Also on this matter one might say that music therapy affords freedom to 'colours', which have been taken from the service users' everyday life at admission. From a recovery-perspective mental healthcare should not only be about removing symptoms; people need reasons to survive, reasons to wake up in the morning, and reasons to take control over their own life and their own recovery process (Hummelvoll et al., 2015; Leamy et al., 2011; Solli, 2014). Joyful, pleasant, and meaningful moments make up reasons to live.

The research participants in this study value the joyful and meaningful moments in the music therapy sessions, together with the music therapist. These joyful moments are enabled through a various of activities, but as reported by the participants it appears that joyful moments often come from new activities or from experiences that are not generally part of the participants' everyday lives. One might say that participation in music therapy extended the participant's repertoire of meaningful moments and ideas of what life has to offer. Ian mentions how he remembers that summer day together

with the music therapist, a couple of other people, a guitar, and the seaside out in the sun. Lee speaks of how fun it was to learn to play the drums. Frank tells us about his special memories regarding a stage performance. Alex found it exciting and fun to explore the piano while the music therapist played the drums. Meaningful moments and joyful experiences manifest in several ways. What seems to be clear, though, is that music therapy may afford new experiences to the participants, which the participants can enjoy and treasure. One way to see this is that music therapy opens new doors, and thus provides positive liberty for new experiences.

8.1.2 Freedoms within the recovery process

When engaging with both the empirical material and the previous literature I have found relevant for this study, I have come to think that music therapy may potentially afford freedoms that can be important for the participants as part of their recovery processes. In the sections below we will look into different ways in which music therapy may affect the lives of the participants, when not focusing on the inside of the music therapy appointment. I believe that every form of therapy or treatment is meant to come with some sort of transfer value, long-term effect, or hope of providing health for the participant in exterior to the theraputical appointment in some way; still I find that compulsory mental healthcare come with some rather unique circumstances to which different affordances of freedoms may prove valuable for the everyday life outside of the music therapy room.

Freedom for participation

There is a motivating potential in music therapy within compulsory mental healthcare, as discussed in chapter seven. The participants in this study were engaged in music therapy activities for several reasons, and although each individual is motivated differently there were certain traits of music and music therapy that seemed to come easily to mind for them when discussing music therapy participation. The participants are familiar with music, they are generally fond of certain music, and they tend to understand the connection between music and emotions. Thus, the participants comprehend the potential beneficial aspects of music therapy and allow themselves the possibility to recover through music therapy processes. According to both the participant accounts in this study and the previous literature on music therapy in forensic settings, music therapy has the potential to reach individuals who are not engaged in other treatments or activities. When persons refuse to partake voluntarily in treatment, and avoid other activities, yet still engage voluntarily in music therapy, it is likely that music therapy affords 'something'

that the participant finds relevant. Perhaps would the participants engage in other activities if exposed to options that the participants find meaningful, yet they have seemingly remained less active due to a scarce selection of motivating activities. Because there might exist few otheres activities or treatments that facilitate the same will to participate, the possibility to choose music therapy as part of treatment may be regarded affordances of freedoms for engagement and participation. If so, the freedom may be regarded a positive liberty; music therapy opens a door in the lives of the service users, and thus affords something that was not there in the first place.

As discussed in chepter seven, the freedom to adapt the music therapy sessions according to mood and energy level probably affected Sarah's overall participation. And in addition to Sarah, both Ian and Peter have influenced the therapy process towards more frequent music therapy sessions, and were thus provided an increased freedom for participation. Peter and Ian had also attended music therapy for respectively one year and one year and a half. Such flexibility for adapting the frequency of sessions, as well as the length of the therapy process, requires both the will for the music to make such prioritizations and working frames that enable long lasting therapy processes. When investigating the literature on forensic music therapy in chapter four, we learned that several music therapists worked to establish different models and therapy programs, containing a given number of sessions, and often less sessions than recommended by certain scientific publications on music therapy effects. Sometimes - and *somewhere* - music therapists strive to maintain their profession and to offer music therapy at all, rather than practicing the best music therapy as possible. The position of music therapy within the health care system varies from country to country and the possibility of performing music therapy is, needles to say, often a question of economy. The possibility of the music therapy participant being able to influence the frames of the music therapy process is at least partly dependent on the structural frames of the health institution or even of society.

On the practice-level, the music therapy may open up for opinions and decisions regarding the therapy process. Music therapy as a profession may clarify the importance of this flexibility and the music therapist may try to influence colleagues, other professionals, and the management about the importance of self-determination and the relationship between effects and the length of the music therapy process. Music therapy as a discipline and an academic field may fight for service user's access to music therapy and musical activities, on a societal and political level. The last time the implementation of music therapy in mental healthcare was raised as an issue in the Norwegian Parliament, with reference to recommendations from the Norwegian Directorate of Health, the governing majority voted down proposals to

both strengthen the position of music therapy in mental healthcare and increase the capacity of the music therapy education programs. One of the main arguments for rejecting the proposals was the existence of demonstrational examples per se; case examples were used to describe the value of music therapy wherein music therapy *had* already been implemented, and this was held as evidence for arguing that the implementation of music therapy was already in progress, and consequently the recommendations from the Norwegian Health Directorate to implement music therapy were proved to work fine on their own (Norwegian Parliament, Innstilling [endorsement] 449 S, 2016-2017). Another argument was that music therapy is only one out of 80 approaches to treatment recommended by the Directorate of Health (2013), and that health authorities should not require this one approach; it is the health facilities that are responsible for provoding quality health services according to national recommendations. Supporters of music therapy, including the service users, lost with 47 against 51 votes, and 41 against 57 votes.[75] This example describes well the potential effect of political engagement for music therapists. Music therapy institutions can help to promote well-argued endorsements in the Parliament through active political engagement. And the mere standings of political parties in the national elections may directly affect service users' access to music therapy. Political engagement may thus be part of what music therapists can do to promote health through music therapy, and to afford freedoms for activation for service users within compulsory mental healthcare.

Freedom for engagement beyond the music therapy process

When the participants engage in music therapy, their engagement for musical activities may exceed the music therapy session per se. Sometimes the participants rehearse in between the music therapy sessions, as Frank mentioned in the interview. Or they might spend time finding and preparing new songs to present for the music therapist, such as Kim stated.

75 47 versus 51 votes for proposals: 1) 'The Parliament asks the government to go into dialogue with the health facilities in order to suggest stimulating actions for knowledge-based implementation of music therapy in the services', and 2) 'The Parliament asks the government to increase the national education capacity in the music therapy education'. 41 versus 57 votes for proposals: 3) 'The Parliament asks the government to reintroduce and enhance the subsidies in the Directorate of Health for positions and projects within knowledge-based treatment methods, as for example music therapy, so that this form of treatment may be realized in more municipalities and in health facilities', and 4) 'The Parliament asks the government to provide resouces for follow-up-researc and other relevant research on the implementation of music therapy in the services, with emphasis on user experiences and ways of collaborating' [my translation] (Norwegian Parliament, Innstilling [endorsement] 449 S, 2016-2017).

Sometimes the participants would have wanted to rehearse in between sessions but are unable to do so because they lack the equipments or adequate rehearsal facilities, such as Ian and Sarah explained in the interviews. Sarah does not really have access to a proper piano, and although Kim occupies himself to some extent using his acoustic guitar in his room at the ward, he is also interested in fuzz and overdrive effects for the electric guitar and says he wants to play in a band. Frank and his band colleague practice a bit in one of their apartments in-between music therapy sessions. Lee seems to have found a new leisure activity in learning to play the drums and would like to continue doing this in the future. As proposed by Ian in chapter six, and as was furtherly discussed in chapter seven, service users in mental healthcare may probably benefit from an access to facilities adapted for music activities. Based on the participant accounts in this study, it is reason to believe that the freedom of adequate circumstances may promote additional activation of the service users, and help motivate them to engage in music activities from time to time. I know that some health facilities have music rooms that are available for the service users most times during the week. This is also true for my current workplace at Sykehuset Innlandet. In our case the music room is available for service users, but only when followed by staffs, as a strategy for securing that the room is somewhat respectfully maintained. However, a common challenge is that the staffs do not always prioritize to join the persons to the music room. On several occasions I have consequently granted individual service users access to make use of the facilities alone, when I am familiar enough with the persons and their capabilities of operating the equipment properly. Whenever possible, music therapists can provide access to facilities that enable activation and engagement, as a way to promote freedoms in the participants' lives and recovery processes, also in-between music therapy appointments. At another hospital in which I have worked (Lovisenberg Diakonale Sykehus), other music therapists had previouosy taken the initiative to establish another music room for this purpose. I support such initiatives, and believe that these acts may help to promote freedoms for activity during recovery.

As we saw in chapter six, some of the music therapy participants attended their weekly appointments as outpatients, such as Peter, Ian, and Frank. They were treated involuntarily, without the possibility of rejecting compulsory treatments, mainly through different medications. And still they attended the regular music therapy appointments voluntarily for a long time, a couple of them for more than a year. Even though some music therapists are able to follow up the participants for a long time, the music therapy process will always come to an end, sooner or later. The music therapist may teach the participants ways in which to engage in music and music activities on their own. In the interview with Sarah, she mentions that she and the music therapist plan to film her playing the piano so that she can bring this visualized sheet music with her back home

and play the piano when she no longer attends music therapy sessions. And for Ian it is important to work on his musical self-confidence in the music therapy sessions, so that he will someday be ready to play in a band together with peers. This way, the music therapist can help prepare the participants for an everyday-life without music therapy. And when the music therapists are familiar with different organized activities that are suitable for the participant, they may guide the participants from music therapy into other music activities.

Several of the participants that were interviewed in this study spoke of a wish to continue in music therapy or in music therapy-like activities after ended treatment. I do not believe that the transition from music therapy appointments into musical leisure activities comes easily in general. In this study however, the aim has been to learn about what music therapy *can* be for people within compulsory mental health care. It seems that music therapy can light an inspirational glow in the participants to the degree that they would like to continue with activities similar to music therapy in the future. Service users with severe mental illnesses are often viewed as difficult to motivate and to engage in activities. When participants, like the ones in this study, takes the initiative to increase the frequency of therapy sessions, and when they are actually motivated to partake in meaningful activities, thereby taking control of their own recovery and well-being, the taks of enabling such activities may prove valuable for both mental health services and service users. This also brings us back to the possibilities for music therapy-like settings discussed in chapter seven, such as the SMART-project, the 'three-step-model', and the activity house Lundefuglen [the Puffin], which music therapists should support and promote, at least on a discipline-level.

The singular music therapist may not solve the challenge of free access to music equipment and rehearsal facilities for everyone, but the therapist can try to inspire and motivate the participants, thus keeping them engaged in meaningful activities also outside of the music therapy session. The fight for service users' access to music activities and adequate musical equipment may be a matter for the music therapy discipline. And within the specific institution, the music therapist may perhaps help opening up the music therapy facilities in the afternoons, or work to establish separate rehearsal rooms that can be used by the participants, alone or together with other health professionals. Such affordance of freedom for activation may be regarded part of a liberating music therapy. Accommodations made as ways to facilitate participation and inclusion for persons with mental health challenges, such as within compulsory mental healthcare, aligns well with the CRPD.

Freedom from treatment

Some regard music therapy as a free zone, or a break from treatment. This topic is highlighted by some of the research participants in this study, as well as by participants in previous research (Ansdell & Meehan, 2010; Solli & Rolvsjord, 2014; Tuastad, 2014). Life within compulsory mental health care can be monotonous, and for many people everyday life is devoted to hospitals and medications, in sterile and hospital-like milieus. There are many things in the lives of people within compulsory mental health care that one might occasionally need a break from. Peter highlights all the questions from health workers, Sarah speaks of medications, and Alex isolates himself in his room at the ward in order to get away from fellow patients. And in between ward rules, routines, and compulsory treatment, music therapy represents freedoms, through measures such as voluntariness, playfulness, and free expression.

In chapter seven, music therapy as a break from compulsory treatment was described as one potential motivating factor, and music therapy participation was regarded an asylum in which to achieve asylum. The free-zone aspect seems relevant for understanding how the participants experience the actual music therapy intervention, as a contrast to coercion and treatment. But as I see it, it is also relevant to understand the function that music therapy may have as freedom *from* treatment within the recovery process, which is otherwise characterized by coercion. Participants in this study look forward to music therapy, and seem motivated by music therapy as a removal-strategy for achieving asylum. Thus, we might understand the music therapy free-zone as providing positive liberty, in which new doors are opened between locked doors, naked concrete walls, and grey linoleum floors.

Although I find reasons to differentiate between the two: 1) experiencing the freedoms within music therapy as a contrast to coercion, and 2) the function music therapy can have in the recovery process as providing freedom from coercion, I cannot necessarily pinpoint such nuances from the participant accounts found in the data set. These are interpretations I have made from investigating the interview accounts in relation with theory and previous studies. In order to come closer to how participants actually experience such nuances, at least more profound descriptions are needed on the matter.

Freedom for social contact

Sometimes it is hard to determine what comes first: mental distress, substance abuse, depression, or isolation. Different challenges influence each other and people within compulsory mental health care are often exposed to several complications at a time. The absence of social networks is a challenge for a lot of people within the compulsory mental

health care system. And as discussed in chapter seven, social networks are important for service users with both somatic and/or mental health difficulties. We also know that some of those who are submitted the most to compulsory treatments are people with potential challenged social networks or family relations, such as people raised within the child welfare system, and people with immigrant backgrounds (Fugleseth et al., 2016; Iversen et al., 2011). Based on the participant accounts outlined in chapter six, and the discussion of the accounts in chapter seven, it seems that music therapy may help to establish and maintain social contact for service users in compulsory mental healthcare. It is possible to think that music therapy provides new social contact for the service users, understood as positive liberty, but it is also possible to think that music therapy may try to *re-afford* social contact, and make up for the negative liberty that has been limited by coercion. Either way, music therapy may facilitate social contact for some service users, and this may be regarded a trait of a liberating music therapy.

Alex stated that he tends to isolate himself in his room at the ward to get away from other service users, and that he appreciates meeting the friendly music therapist in settings other than the hospital common rooms. Peter says that the music therapist is a good friend, and that he really wants to attend the appointments every week. Based on the description provided by Peter, it seems that the relationship with the music therapist is an important aspect of both his motivation for attending music therapy and his well-being within the therapy sessions. For outpatients coming to weekly music therapy sessions, these appointments may be the ones out of rather few regular encounters with familiar faces, smiles, and friendly conversations. Although singular therapeutical relationships do not necessarily provide the same benefits as functioning social networks, such as longer life-expectancy rates, it is reason to believe that *some* social contact is far better than *no* social contact. If isolation is the other option, then the freedom to engage in safe therapeutical relationships may be of great importance.

This study also shows that participation in music therapy may open up for new social bonds. There is no guarantee that participating in music therapy culminates in a vast and long lasting social network, and even the strongest participant-therapist relationships will eventually come to an end. Yet, both music therapy with the music therapist and group music therapy together with peers may enhance social functioning and confidence in the participants so that social contact can be established more easily in the future (Chen et al., 2016; Geretsegger et al., 2017). Group music therapy is also a way for participants to establish contact with peers during the admission, as Kim mentioned through the interview: '[…] then there was at least one common interest.'

The community-oriented branch of the music therapy umbrella is focused on the social agenda (Ansdell & DeNora, 2016; Stige, 2003; Stige & Aarø, 2011). Public performances

mentioned by Frank, is one community music therapy approach that can afford social contact and develop the participants' social space. Through concerts and music cafés, persons with different challenges, including mental health issues or substance abuse, may enhance their sense of self, as well as their position in the community; there are many tales of people who transform from mental health service users into performing artists through community music therapy or similar interventions, as presented earlier in this thesis, including in the discussion in chapter seven.

Music therapy may open up for social contact; one might say that music therapy affords the freedom of experienced relationships. For some, the individual music therapy session may enable vital therapeutic relationships with the music therapist, and the improved social functioning coming from music therapy may well be an important entrance to further social contacts at a later point in time. Group music therapy and community music therapy-oriented performances can enable new connections towards the local community and local music milieus.

Although I believe that music therapy *can* help to open up for social contact, and provide the freedom to experience meaningful relationships, and that these notions partly derive from engagement with the data set, this study comes with limitations for what is possible to know based on the empirical material. I do not know whether any of the participants in this study recovered from their mental health illnesses beause of the social contact within music therapy settings, or from potential relationships facilitated by for example group music therapy or concert settings. In a humanistic and recovery-oriented perspective, informed by critical psychiatry, I still believe that there are good reasons for supporting therapeutical approaches that strengthen social contacts and social functioning, completely without complicated, neurological side-effects.

8.1.3 Freedoms in the community

Music therapists and music therapy participants partake in the community as fellow-citizens. Therapeutic relationships will eventually come to an end, but one way to understand the societal bonds between therapists and service users, is that they never cease to exist, at least figuratively speaking. When trying to find answers to the overarching research question for this study, of what music therapy can be for people within compulsory mental healthcare, I cannot stop to think about the responsibility I believe music therapy as an academic discipline has on a community level. Throughout the research process of this thesis, and especially through the investigating of the Norwegian Mental Healthcare Act, precious research reports on Norwegian compulsory mental healthcare, and notions from the CRPD and from critical psychiatry, I have become more certain that the service users need changes to be made in mental healthcare. There are limitations

for what the singular, working music therapist can accomplish on behalf of service users with mental health challenges on a community level. But as a united profession and an academic movement, on the other hand, music therapy may possibly make a change. Below, I will argue that music therapists should work to promote recovery-enabling environmental structures. In addition, music therapists may work towards reducing the amount of coercion within mental health care, as well as to liberate people from repression, stigmas, and dis/ability, in line with fundamental Human Rights.

Freedom for recovery-enabling environmental structures

The recovery process needs engagement from the person itself, but also by the recovery-enabling surroundings (Goodley, 2014). In chapter six of this dissertation we learned that Ian had only missed one music therapy session in 18 months. That is impressive of him, and it reflects his motivation and strong will to participate. But his attendance rate may also reflect recovery-enabling factors in Ian's surroundings. When Ian was asked whether it was ok to get to his appointments, he answered that he takes a cab every other week, and that the people where he lives drive him the other weeks. Perhaps the people who drive him also help to motivate him, or even aid in other ways. Either way it looks as though Ian may have had some health benefitting or recovery-enabling surroundings, with the necessary structures to afford freedoms for participation in his weekly music therapy sessions. I do not know who pays for the transportation, and whether this is part of the municipal welfare services. And I do not know excactly who Ian refers to when he mentions those who drive him every other week. But such accommodations that enable participation for persons with dis/abilities seem to align well with the CRPD, which explicitly includes necessary transportation possibilities as part of maintaining human rights. Music therapy as an academic discipline may want to support such recovery-promoting structures in society, in order to maintain the actual freedom for participation. And working music therapists can at least familiarize them selves with the potential welfare services that exist, and help the service users to make use of such possibilities when necessary in order to enables freedom for participation, as was also exemplified in chapter two regarding one of my current music therapy participants attending music therapy as part of policlinical treatment.

For Peter, the travel distance is a greater obstacle; there is a long way to travel between his home and the clinic, which also requires bus changes. In Norway, outpatients are followed up by local mental health clinics out in the districts. Although these clinics are supposed to be local, they may still be quite far away from where people actually live. During the interview with Peter, his music therapist explains that the music therapy sessions are usually organized so that they correspond well with his other appointments

at the clinic. In this way he does not have to travel the long distance more often than necessary. So even though some societal structures may be comprehended as somewhat freedom-delimiting, such as the long travel distance and a poor system for public transportation, there are also important freedom-enhancing structures: There are different health professionals who cooperate to ensure that Peter's interests are maintained by allowing frequent music therapy over a long time, and there is a will to organize his appointments so that Peter gets a more adequate everyday life, as explained by the music therapist in the interview with Peter. And Peter usually attends his appointments, despite the long distance. I support the idea that music therapists may partake in the planning of the thereapy process in similar ways as, so that potential recovery-enabling structures are maintained, and so that freedom for participation is promoted. Also this, I believe, may be regarded at least a step on the way to protect the service users' rights for participation.

As an inpatient, Alex stated in the interview that he once missed a music therapy appointment due to miscommunication somewhere between the music therapist, the health professional who received the message, and Alex, who did not know about the appointment and therefore went ahead and planned to meet with his father. I do not believe that one music therapy appointment is likely to make a difference in a person's recovery process. The reason I hang onto this topic is that I recognize this issue from my own everyday life as a music therapist working in hospital settings. There is a lot going on in the wards, with both regular and unregularly appointments. There might be appointments with social workers, psychologists, physicians, occupational therapists, physical therapists, and music therapists. At the same time the person may want to pay attention to other parts of life, such as to meet with close others. I believe that it is important that the service users are entitled to operate their own time schedule as much as possible and to make their own priorities of what they believe are important activities and appointments. Thus, I believe that it is vital to maintain well-functioning procedures that keep the service users well informed about different options and rights they have as service users, as well as taking the service users' opinions and priorities seriously.

Local discourses may play a role in how active the service-users are in the decision-makings regarding their timetable. As a music therapist I have experienced both inhibitory and promotional cultures: Some health professionals tend to move or cancel their own appointments because they see that the service user benefits from making room for music therapy, while other times it seems clear that the more traditional and established treatments are prioritized over music therapy. I do not mean to say that music therapy should always be prioritized, but according to previous research mentioned in chapter three and four, as well as to the participant accounts from this research, service users appreciate the freedom to partake in decisions regarding their own lives. I support the

recovery-perspective in that the service user's need to experience ownership of their recovery processes and treatments (Hummelvoll et al., 2015; Leamy et al., 2011; Solli, 2014). Service users sometimes need help to systemize their days, but the long-term goal for should *always* be for the service users to regain as much control over their own life as possible and justifiable.

As discussed in chapter seven, not all participants have the opportunity to attend music therapy long enough to profit from the documented effects (Carr et al., 2013; Chen et al., 2016; Gold et al., 2009), regarding both the participants in this study and examples from the international literature on forensic music therapy (Dickinson & Haakvort, 2017; Jeon et al., 2017). One challenge for attending music therapy over time is the transition between different levels of the mental health services, as the discharge from the hospital mentioned by Lee and Alex. Another boundary is the economic and structural frame that may inhibit the amount of music therapy, and promote shorter therapy programs (Hakvoort, 2002). As with other psychotherapies or similar interventions, some people may benefit greatly from a few sessions. Others, on the other hand, need several sessions just to open up for change or to establish a safe relationship with the therapist. However, as long as research points at the need for twenty sessions in order to benefit fully, I believe that music therapists should work for enabling this amount of therapy for the participants.

Freedom from repression, stigmas, and dis/ability

In chapter two I portrayed my understanding of dis/ability-studies, and how this perspective can be relevant for the ontological view on mental health challenges and mental health care (Goodley, 2014). In western neoliberal cultures ~~disabilities~~ become a great contrast to the 'ideal citizen' who contributes both to society and to the economy. And whereas people could sometimes have been integrated into different occupations through a minor degree of extra facilitation, they are rejected, stigmatized, and excluded from important aspects of the modern society. Hence, the community is failing when it comes to maintaining human rights for persons with disabilities (Skarstad, 2019; United Nations, 2006). Through a postmodernist-informed critical approach I believe that music therapy, as a health discipline, cannot remain passive; the first step towards emancipation is to 'reveal' the injustice, and to point this out for others. By including the CRPD as an approach in this study, I hope to spread awareness about the human rights for persons with disabilities for others, and how these rights are continuously violated in our very own culture. To promote awareness about the CRPD, and to work in CRPD-informed ways, may be part of a liberating music therapy.

As mentioned in chapter one, the Norwegian perspective on music therapy may be understood as a social-academic movement that encourages societal change in order to create communities that are healthy and including for the population in general, and especially for those who are often left behind in the neoliberalism-ableism (Drøsdal, 2013; Goodley, 2014; Rolvsjord, 2007). Music therapists within the field of community music therapy, work actively to diminish stigmas and dismantle the boundaries between the music therapy participants and the community (Stige & Aarø, 2011; Brynjulf Stige, 2003). Through a resource-oriented perspective, and the associated empowerment-philosophy that is also integrated in the recovery-perspective, music therapists can work directly or indirectly in order to support and enable the participants' autonomy in modern society (Leamy et al., 2011; Rolvsjord, 2007; Solli, 2014). On the whole, working music therapists may contribute to the peoples' recovery in their everyday work with the participants. As an academic discipline, I believe that music therapy has a societal responsibility to maintain and to speak the cause of vulnerable groups of people, such as people with mental health challenges. According to Norwegian work-ethical guidelines, the music therapist's loyalty rests with the participant. Then perhaps the therapist's loyalty may also rest with other potential music therapy participants in the population, in a society that, according to dis/ability studies, continuously creates new needs for help in different ways, both directly and indirectly (Goodley, 2014).

Music therapists may help potential music therapy participants through the way we talk about mental health challenges at work and in everyday life. Through public performances, research reports, and media articles, music therapists may help to reduce stigmas by focusing on the vast amount of resources and qualities in every person. Both practitioners and scholars may cooperate with user organizations in order to learn more about how music therapists may be of support and how music therapists may promote the participant's needs. To react to the challenges for persons with mental health difficulties, to discuss their challenges, and to promote awareness about their challenges may in turn help minimize their role as marginalized outsiders in the community: 'Disability studies is not simply a reaction to the medicalization and individualization of disability but also an antidote' (Goodley, 2014, p. 6). If music therapists acknowledge dis/ability studies as a legit and reasonable perspective, which point at disabling structures in society, then perhaps a liberating music therapy may also be critical towards the repercussions of the current neoliberalism-ableism in western cultures (Goodley, 2014).

Although a liberating music therapy may include emancipatory perspectives on a community-level, as described above, I would like to clarify that these notions are not firstly founded on participant accounts from the empirical investigation in this study. Instead, these perspectives derive mostly from ethical awareness from an engagement

with music therapy traditions, dis/ability-studies, recovery-traditions, critical theory, and the CRPD.

Freedom from compulsory mental health care

As portrayed by the literature review in chapter three, coercion is experienced as degrading and humiliating. And the effects of coercion as forms of treatments are poor. Also, compulsory treatment and the use of restraints seem to be distributed unevenly within the population; people with the most severe illnesses, people with low levels of functioning, people raised in the child welfare system, and people with immigrant backgrounds are some of the people who receive the most compulsory treatments (Fugleseth et al., 2016; Furre et al., 2014; Knutzen et al., 2011; Knutzen et al., 2007). Thus, it seems that already challenged people are also treated the roughest within the ~~healthcare~~ system. I believe that everyone can agree that coercion must be avoided whenever possible.

In chapter three we had a close look at the jurisdictional frameworks of compulsory mental health care, as well as different research on compulsory mental health care, mostly within the Norwegian health services. The jurisdictions have for a long time stated clearly that compulsory treatment and coercive measures are only to be used when absolutely necessary, and only when everything else has failed. I believe that coercive means are sometimes the right option. And I believe that health professionals sometimes have the responsibility to take care of people, even when they do not want to be helped. According to the literature, however, it seems that mental health practices do not always correspond with the jurisdictional restrictions of compulsory treatment or with the Declaration of Human Rights (Blesvik et al., 2006; Husum & Hjort, 2009; Kogstad, 2009; Storvik, 2017). Differences between local in-ward discourses, individual values and attitudes, and discourses between different professional roles and backgrounds, seem to influence the practiced amount of coercive interventions (Husum et al., 2010a, 2010b; Molewijk et al., 2017; Ness et al., 2016; Terkelsen & Larsen, 2014; Wynn, 2015). Decision-makers sometimes base their choice about coercive options on pressure from others more than their own professional opinion (Røtvold & Wynn, 2014), and demographic variables as gender and age affect decisions about compulsory mental healthcare (Wynn et al., 2007). Another reason for why I argue that compulsory mental healthcare does not seem to live up to the strict jurisdictional framework is that several studies propose interventions that may reduce the use of coercion through specific interventions (Bak et al., 2015; Bone et al., 2019; Dahm et al., 2015; Dahm et al., 2017; Myklebust et al., 2014; Ness et al., 2016; Veland & Jacob, 2016). When specific interventions help reduce the amount of coercion, such as working with staff attitudes in the ward and discussing other alternatives to coercion, these are signals that there

was probably to much coercion in the first place; the Mental Health Care Act is very specific in that coercion is only to be used when all other options have been tried out and/or is considered useless (Law Library, 1999a). Through a postmodernism-informed critical perspective, which is also based on critical psychiatry, I believe music therapists working within mental healthcare need to take an active stance regarding coercion, and criticize coercion that violates both Norwegian legislations and the Human Rights.

Local ward discourses and individual attitudes may be one reason for the imbalanced use of coercion, but the organization of mental healthcare may also be part of the picture, such as time and resources for the health professionals to help as much as they want (Røtvold & Wynn, 2017; Storvik, 2017). The healthcare system is governed by politics. Hence, health disciplines need to be political. It is a noble thought to hold that professions or academic disciplines should not take political sides, but rather let apolitical or neutral knowledge in turn form the best practices as possible. I do not, however, believe that the signifier ~~political~~ can be understood as the opposite of something neutral or apolitical; neutral is closer to actively accept what is going on and potentially to passively watch the wrongdoings in our community. I believe that music therapy as an academic discipline has the responsibility to maintain health structures that benefit the people who need them. I believe that people's needs should define mental health care, and not the other way around. I cannot define what makes up a perfect mental healthcare, and the music therapy discipline cannot change mental healthcare on its own. But I do believe that there exists enough knowledge to support some sort of deconstruction of mental healthcare. A liberating music therapy may support both 1) measures that decrease the use of coercion down to an absolute necessary minimum and 2) governmental funding of adequtate health services in which both service users and health professionals are acknowledged and taken seriously.

Despite reforms and national effort to change mental healthcare during the last decades there still seems to exist a gap between health professionals and service users regarding the experience of mental healthcare and which interventions are perceived as helpful (Feiring & Ugstad, 2014; Husum et al., 2019; Kogstad et al., 2014). I do not believe that there is a quick fix to this complex societal difficulty, but perhaps it is a start to be aware of the challenges within the mental healthcare system. As we have seen, practiced coercion depends on discourses, knowledge and attitudes. Thus, knowledge about challenges and possibilities in compulsory mental healthcare may eventually come with changes. Music therapy, as health professionals, may investigate, discuss, and ask questions about coercive practices, regarding both their participants and the discourses in which they work. Music therapy as a discipline may be engaged in research and health politics, and work for humanistic and recovery-oriented practices wherein unnecessary use of coercive options are used to a lesser extent. Both knowledge about compulsory practices

and the discourses that enable these practices may be of importance for music therapy research and for music therapists' engagement and conversations about compulsory mental healthcare.

In this chapter I have argued that music therapy function as liberating, partly by freeing health services from a compulsory mental healthcare in which music therapy is already a part of. Considered through a Foucaultian discoursive perspective, one might say that music therapy is both freeing- and legitimitated within the same rulings discourses.[76] This may seem like a contradiction, and may thus influence the trustworthiness of this study negatively, especially viewed through postmodernist and critical perspectives. As a working music therapist within mental healthcare I do not intend to submit to all of mental healthcare's discourses during office hours, and then write critically about mental healthcare in the afternoons. And I do not want to spoil music therapy's chance of being implemented into mental healthcare by criticizing the whole premise of mental healthcare. Neither do I wish to support all practices within compulsory mental healthcare, and then 'make up for' the potential harm caused by coercion by simultaneously affording 'a liberating music therapy'. As a music therapist I work within mental healthcare because I love it, and I genuinely believe that much good is being done in order to promote health for the service users, and always with the aim of helping persons who need help. I am also happy that health services apply medication free treatments and activities, such as music therapy. And still I believe that there is much to be done in order to provide humanistic health services that take seriously the service users' needs and requests, and services that do not violate fundamental human rights. I think that it is possible to promote health and well-being through music therapy, and at the same time ask critical questions about discourses and practices within mental healthcare. Perhaps will critical discussions from within mental healthcare be an important step towards change; if so, this may also be an important part of a liberating music therapy.

76 This contradiction was pointed out by the Ph.D. adjudication committee in their preliminary report of this thesis.

8.2 Summarising a liberating music therapy

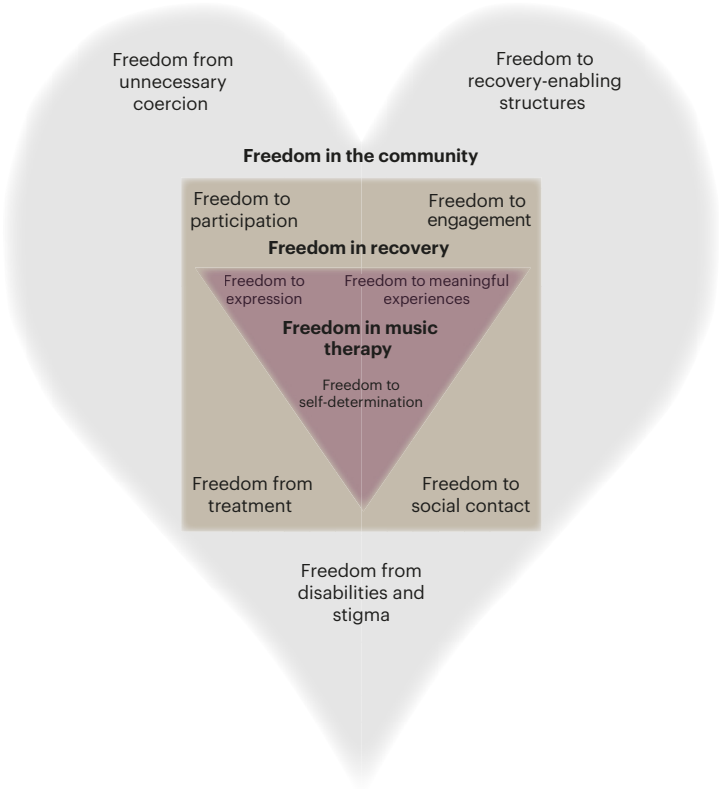

Figure 3: The figure illustrates my understanding of a liberating music therapy, and is a development of Figure 2, as presented earlier in this chapter. In each of the geometrical figures we find different freedoms that music therapy can afford on each level: in the music therapy session, in the recovery process, and in the community.

Throughout this chapter I have provided a description of what a liberating music therapy may be like. The point has not been to synthesize a perfect answer based on exact analyses. Rather, this last chapter has been one result of a deep engagement with the research project over time. As portrayed in chapter five, the empirical data set was analysed systematically into categories; these categories were presented in chapter six, and discussed in chapter seven. The content of this eighth chapter and the notion of a liberating music therapy, on the other hand, have not been compounded through the same structured approach; rather it has emerged from being in the research process over time, and from my interpretations of both the empirical material and relevant literature. The idea of different freedoms provided by music therapy has come from the Derridaen concepts of deconstruction and différance, and has been further inspired

by the notions of positive and negative freedoms as described by Isaiah Berlin. Even though the process behind the development of the liberating music therapy was not systematic on its own, I have tried to organize structurally both the ideas about this concept and the presentation of it. In an attempt to make clearer how I understand the different layers of a liberating music therapy, I have illustrated these in a descriptive figure (see figure 3).

Within the triangle in the very centre of the figure we find the music therapy sessions and the potential sense of freedom that is afforded within the music therapy activities, in relation with the music therapist. Through music therapy, the service users may have access to freedom of expression, experienced self-determination, and the freedom to engage in meaningful experiences.

The square in the figure corresponds to the participant's recovery process as a whole and the different freedoms potentially afforded by music therapy for the existing life world of the participant. Music therapy seems to enable participation as well as engagement for further activities, in the present and perhaps also in the future. Music therapy may also offer the freedom to experience social contact and meaningful relationships, and to enter a free-zone away from the treatment.

The heart encapsulates both the recovery process and the music therapy sessions, and illustrates the community round the participant. As I have argued throughout this chapter, music therapy, both as a profession and an academic discipline, has a responsibility to take sides with the music therapy participants. There are structures in society that are disabling for people with mental health challenges, and promote stigmas and challenges for both music therapy participants and potential music therapy participants. The Mental Health Care Act and the CRPD, which are both supposed to work as safety nets for the most unfortunate ones, do not seem to keep the service users protected from unnecessary use of coercive approaches. Music therapy as a humanistic discipline, including notions from both dis/ability studies and the recovery-perspective, may try to liberate the participants from unnecessary use of compulsory treatment, and fight for recovery-enabling structures, both within society and within the mental healthcare system. Music therapists may also help to free people from repression and stigmas through community-oriented practices, while at the same time spreading knowledge about mental health in our culture.

9 Conclusion

In this thesis I initially posed the question: 'What can music therapy be for service users within compulsory mental health care?' The short answer is that music therapy can be *liberating* in several ways, as I have attempted to portray tduring the last chapter. The long answer to this question is all that I have tried to outline the past eight chapters in this thesis. So let me briefly summarise certain main aspects of this study.

When previously working as a music therapist in mental healthcare wards, I found myself caught between certain conundrums in the crossing of a seemingly voluntary music therapy and compulsory treatment. This meeting point got me interested in the following sub-questions:

- Do service users experience music therapy as voluntary when they are otherwise treated involuntarily within the mental healthcare, and if so, how do they describe this?
- What motivates service users within compulsory mental healthcare to participate in music therapy?
- How can music therapy benefit service users within compulsory mental healthcare in their recovery processes?
- In what way should music therapists engage in ethical and political discussions regarding compulsory mental healthcare?

In order to provide useful answers to several of theses questions, I found that I needed information directly from the participants themselves. Consequently, research interviews have been performed, thematically analysed, and discussed together with relevant literature. For some of the questions however, I also felt that I needed to broaden the perspective, and look outside of mere music therapy settings. Ethical and political perspectives in this study include notions from postmodernism, critical theory, dis/ability studies, the CRPD, and positive/negative liberties.

The study was performed through a qualitative design, with an emphasis on the qualitative empirical study of participant experiences of music therapy, and with a prominent attention towards theoretical descriptions of Norwegian compulsory mental healthcare. Although I have not systematically analysed literature on coercion or legal documents as part of an empirical investigation, the rather extensive investigation of literature on Norwegian compulsory treatment has been regarded necessary for my ability to take a stance on a difficult topic. A thorough theoretical chapter on coercion has also been

regarded necessary for providing 'enough information', as it seems that this study introduces a somewhat 'new topic' into the international music therapy literature, although this study is anchored within local, Norwegian frameworks.

The study has been understood and performed through a humanistic perspective, which as I have argued includes notions from both community music therapy and the recovery-perspective. A postmodernist-informed critical perspective has influenced my understanding of both knowledge as social construction and mental healthcare as a result of traditions and ruling discourses. The Derridaen concepts of deconstruction and différance have influenced my understanding of dis/ability-studies and opened up for thinking about different freedoms in music therapy, and further enabled the concept of a liberating music therapy. Further, notions from the CRPD, critical psychiatry, and positive and negative liberties have provided perspectives for discussion the main-themes in chapter seven, and for describing the relevance of a liberating music therapy in chapter eight.

According to the research participants in this study, music therapy was experienced as voluntary, even when otherwise treated involuntary within the mental healthcare system. The participants wanted more music therapy and some of them had taken the initiative to increase the frequency of music therapy sessions. This study aligns with previous literature that describe music therapy as able to reach some of those who are not engaging voluntarily in other activities or treatments. Music therapy participants seem to be engaged in music therapy to the extent that they wish for continuos music therapy processes over time, and would like to have the chance to attend other music therapy or music therapy-like activities also after discharge. All of the participants interviewed in this study were critical towards the idea of an obligatory music therapy.

There are several reasons for why people are motivated to partake in music therapy. As understood through a recovery-oriented perspective, the strongest predictors for participation in music therapy are the participants themselves. Through the examination of the data set, however, certain key concepts have been targeted that may help to understand what it is with music therapy that interests service users within compulsory mental healthcare. The research participants already had a strong relationship to music before participating in music therapy, and they already 'knew' from experience that music affords something good. The research participants, as well as other participants within the previous literature, also describe the voluntariness and the freedom within music therapy as a core element of music therapy in mental health treatment. When the participants engage in music therapy activities they are temporarily freed from medication, from diagnoses, and from hospital wards. Thus, one might say that the voluntariness and freedom within music therapy is also one of the motivational

factors for wanting to engage in music therapy. In addition, one might also understand the human need for social contact as an important motivation for attending both individual- and group music therapy.

Through the analysis of the data set, four sub-themes are suggested for how music therapy may contribute to promoting health for people within compulsory mental health care: Music therapy may 1) give people something to look forward to, something to keep them going through the week, and 2) something to inspire them to get up in the morning, and out of isolation. And 3) participation in music therapy seems to come with a broad spectre of meaningful experiences: particiapnts experience mastery by learning to play instruments and by performing for others, they have fun by playing around, and some experience special moments and episodes that they will remember and carry with them in the future. The fourth sub-theme includes several ways in which the participants describe 4) other beneficial outcomes and contents of music therapy, such as self-emancipation, emotional and verbal expression, and symptom relief.

Each of the main themes were discussed in chapter seven, through a humanistic recovery perspective, using previous literature on compulsory mental healthcare, as well as literature on music therapy in mental healthcare and music therapy in forensic mental health settings. The music asylum theory, as presented by music sociologist DeNora (2016), has provided valuable perspectives throughout the discussion of the main themes. The picture of what music therapy can be for music therapy participants within compulsory mental healthcare is tried perceived in relation with research on compulsory mental healthcare, and knowledge about some challenges that often follow this client group. In a bigger perspective, notions from the CRPD are used as part of the foundation for arguing that music therapists have an ethical and political responsibility to maintain human rights for persons within compulsory mental healthcare.

In chapter eight of this thesis I have coined the term *liberating music therapy* and suggested that this is a helpful perspective for understanding what music therapy can be for people within compulsory mental healthcare. Towards the end of the chapter I introduced a descriptive figure that may help to clarify the different *layers* of which music therapy may affect the lives of the music therapy participants within compulsory mental healthcare: the innermost layer within the music therapy settings, the middle layer describing the overall recovery process, and the outer layer representing the overall society in which the participants try to live good and meaningful lives outside of the mental health institutions. In addition to these different layers I have paid attention to three different *levels* of music therapy: music therapy practice, music therapy as a profession, and music therapy as an academic discipline. I chose to describe music therapy as liberating because it affords different possibilities for freedoms, considering

a broad ontological understanding of the term ~~freedom~~, and taking into account notions of positive and negative liberties and how freedom is understood in a neoliberal culture. Based on a discussion of freedom that takes the CRPD into consideration, I have taken a stance that supports both positive and negative liberties; persons' self-determination and negative freedoms needs to be protected whenever possible in order to protect human rights, yet society is obliged to make accommodations to afford positive liberties for persons who need it, also in order to protect human rights.

Within the music therapy session participants are met with the freedom to experiment, play around, and express themselves where there are no delimiting boundaries for how to act. Through music therapy the participants are free to encounter new and meaningful experiences and to be self-determinant about the content of the music therapy process. Alhough music therapy cannot make up for the potentially degrading and humiliating experiences from coercive treatments, perhaps music therapy can help to make the overall treatment more positive by allowing the participants asylums of freedoms and experienced self-determination.

As part of the recovery process music therapy may afford the freedom of participation, also for some who are not motivated to participate in other activities or treatments. Furthermore, music therapy may engage people in activities outside of the music therapy session such as rehearsing, looking for new music, or engaging musically with peers outside of music therapy. Music therapy may also afford the freedom to engage in social relationships with both the music therapist and with peers. And an important part of music therapy participation is that it may provide a welcomed freedom without diagnoses, medication, hospitals, or compulsory treatments.

I have argued that music therapy as both a profession and an academic discipline has the potential to enable freedom for music therapy participants on a societal level. There are structures in society that both disable people with mental health challenges and promote stigmas. According to the previous research on Norwegian compulsory treatment, coercive options are used more than necessary and the excess of compulsory treatments seem partly to be the results of attitudes and traditions within different wards and within different professional perspectives. The Mental Health Care Act that is supposed to work as a safety net for the most unfortunate ones does not seem to keep the service users protected from unnecessary use of coercive approaches. Thus, I support the voices that call for a greater attention towards the CRPD, and I support those who argue that the 'treatment criterion' is not compatible with a humanistic mental healthcare founded on The Human Rights. Music therapy as a humanistic discipline, including notions from both dis/ability studies and the recovery-perspective, may try to liberate the participants from unnecessary use of compulsory treatment, and fight

for recovery-enabling structures, both within society and within the mental healthcare system. Music therapists may also help to free people from repression and stigmas through community-oriented practices, while at the same time spreading information about mental health in our culture.

This study suggests ways for understanding how music therapists may assist service users within compulsory mental health care. Music therapy as a profession within the field of mental healthcare and/or substance abuse is a growing one. Due to Norwegian governmental guidelines that recommend music therapy as a potent form of treatment mental healthcare, there is reason to believe that the amount of music therapists working in this area of practice will expand rapidly in the near future in Norway. Music therapists then, have a responsibility to familiarize themselves with the surrounding discourses and to reflect upon the conundrums of compulsory treatment. If music therapists are part of traditions or ward-cultures that violate human rights, I suggest through this study that music therapists then need to raise awareness about- and debate the current procedures. Even though music therapy is only one piece in the collaborative mental health puzzle, together with service user, close others, and other health professionals, the study argues that the music therapy might still have an important role to play in the support of the service user, and the music therapists can play important side-roles as helpers in the participants' recovery processes.

The goal for this thesis has been to investigate what music therapy *can* be for people within compulsory mental health care. I have not tried to find the one truth about the potential of music therapy within compulsory mental healthcare, rather I have suggested some answers, based on the empirical findings in this study, on previous research on music therapy in forensic settings and in mental healthcare, on the jurisdictional framework of Norwegian compulsory mental healthcare and of the CRPD, on previous research about Norwegian compulsory mental health care, through a postmodernism-informed critical perspective, and through a a humanistic- and recovery-oriented perspective on mental health. Hopefully this study - and the notions of a liberating music therapy - can inspire music therapists and provoke new thoughts on how music therapists may help their participants, as well as people with mental health challenges in society in general. I hope this study will have a place in future discussions about compulsory treatment, about music therapy in mental healthcare, or about the social-political responsibility for music therapy as an academic health-promoting discipline.

9.1 Further research and new directions for the future

Some research indicates that music therapy may help people with low motivation for treatment, and this study reveals some potentially motivating aspects for participating

in music therapy. Further research including motivational theory could be relevant for the field of music therapy, and perhaps especially within mental healthcare. Though the service user themselves need to be in charge of their recovery processes, it may prove helpful to know more about what inspires persons for further engagement.

For this study I have interviewed some participants who have tried music therapy and continued with it. It would be interesting to learn more about the experiences for those who do not continue with music therapy. If learning more about what the service users need, and why some abandon music therapy, then perhaps music therapists in the future can provide more adapted and motivating services, thus reaching more participants.

Research that can measure whether participation in music therapy might reduce the need for coercive interventions would be useful also. This probably calls for a larger population, several music therapists, a control group, and an immense cooperation with other health professionals. We already know from the literature that there have been cases in which the levels of security have diminished due to recovery through music therapy participation. A close follow-up in music therapy programs could influence the need for compulsory treatment, as service users eventually might be motivated for life, activities, for recovery, and for a change in their lives. If this happens to be the case, new knowledge on the matter could benefit service users of mental healthcare in the future.

My biggest regret concerning this study is that I have not collaborated with anyone with user experiences. I wish for researchers to collaborate more with persons with user experiences in the future, all the way from the design of the research to the written presentation of the study. This may function as eye-openers for the researchers, for instance regarding which questions to pose or in which places to look.

The field of compulsory mental healthcare is a tricky one that comes with many conundrums. It will always be hard to find the golden mean between self-determination for the service users and the responsibility to own their own lives, and the responsibility for the community to take care of people who will suffer greatly if nothing is done. Today we are witnessing changes in the mental healthcare system and it is impossible to know exactly what mental healthcare will be like in the future. It is my wish that this thesis is not perceived as a closure, but as a door opener for further discussion, and that the concept of a liberating music therapy finds its place within a broader debate on music therapy and compulsory mental healthcare.

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Appendices

1 Interview guide
2 Declaration of concent form for research participants
3 Declaration of concent form for participating music therapists
4 Response from REK
5 Letter of Approval from NSD
6 Letter of Approval from local health institution (anonymized)

Appendix 1: Interview guide

Collaborative intervju

When did you have your last music therapy session together?

What did you do in that session?

Of these activities, is there something you appreciate or like the most?

Is this what you usually do in music therapy, or are there other activities?

Is there something you have done that you appreciated the most?

Can you say something about your relationship with music?

Participated in music activities earlier?

What kind music do you prefer?

Why do you participate in music therapy?

Suggested by others? Motivation? Previous interests?

How did you start up with music therapy?

What do you remember the best from your time in music therapy?

And are there any other highlights?

Do you have any thoughts about something that might have been important for you in music therapy?

And for you as a therapist?

Have you come across some challenges regarding music therapy participation?

What do you think about music as part of the treatment, that we call it therapy?

Does music therapy affect your health in some way?

Can music therapy affect you, also beyond the music therapy session?

Semi-structured

How do you feel about participating in music therapy?

Are there some particular reasons that you want to participate in music therapy?

In what way do you feel that participation in music therapy is voluntary?

- What would have happened if you didn´t show up last session?
- Does this affect the session? That participation is voluntary?

What would happen if music therapy were mandatory? Something you *had* to do?

Are there any particular reasons for why you show up to the music therapy sessions?

- Is this different from other treatments or appointments?

In what way do you think music can be used to help people?

Do you wish to continue with music activities in the future?

Is there something from music therapy participation that you will take with you?

Appendix 2: Declaration of concent form for research participants

Samtykkeerklæring for deltaker i forskningsprosjekt: deltaker i musikkterapi

Forespørsel om deltakelse i forskningsprosjektet:

Musikkterapi i tvungent psykisk helsevern: En kvalitativ studie om opplevelsen av musikkterapi som frivillig behandlingstilbud for mennesker i tvungent psykisk helsevern.

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie. Studien har som hensikt å bygge opp en teoretisk forståelse av musikkterapi. Jeg ønsker å snakke med deg for å få vite mer om hvordan musikkterapi oppleves for mennesker i tvungent psykisk helsevern. Målet med studien er å lære mer om musikkterapiens styrker og svakheter, i håp om å gi et bedre musikkterapitilbud til mennesker innen psykisk helsearbeid. Du blir forespurt om å delta i studien fordi du er, eller har vært, underlagt tvungent psykisk helsevern, og deltar, eller har deltatt, i musikkterapi. Deltagelse i denne studien vil ikke ha noen innvirkning på behandlingen du får ved sykehuset. Undersøkelsen er del av et doktorgradsprosjekt. Det er Norges musikkhøgskole som står som ansvarlig for- og finansierer studien.

Hva innebærer studien?

Jeg ønsker å intervjue deg som del av forskningsprosjektet. Du vil bli intervjuet to ganger. I det første intervjuet vil både du og din musikkterapeut være aktive deltakere og samtalepartner i intervjuet. I det andre intervjuet er det du som er eneste informant, men hvor din musikkterapeut kan være til stede om det er ønskelig. I disse intervjuene ønsker jeg å spørre deg om hvordan du opplever å ha musikkterapi som en del av behandlingen. Det vil bli gjort lydopptak av begge intervjuene. Disse opptakene vil behandles med forsiktighet, og vil aldri oppbevares på enheter med tilkobling til internett. Lydopptakene vil transkriberes til anonymisert tekst, og vil deretter slettes.

Mulige fordeler og ulemper

Forskning viser at det å delta I musikkterapi ofte oppleves som noe positivt, og noe som kan bidra til bedret psykisk helse. En samtale som tar opp tanker omkring behandling og bruk av tvang kan i noen tilfeller oppleves tungt, men du vil ellers ikke ha noen spesielle ulemper ved å delta i studien. Samtalen vil også kunne fokusere på positive virkninger av musikkterapi, noe potensielt kan gi et bedre utbytte av musikkterapi. Erfaringer fra studien vil senere kunne hjelpe andre i samme situasjon.

Hva skjer med intervjuene og informasjonen om deg?

Intervjuene og informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger og intervjuer gjennom en navneliste. Det er kun undertegnede som har adgang til navnelisten, og som kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Hvis du sier ja til å delta i

Samtykkeerklæring for deltaker i forskningsprosjekt: deltaker i musikkterapi

studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger. Opplysningene blir senest slettet i 2018.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn, trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen nedenfor. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Adrian Wangberg Drøsdal på telefon: 47092775, eller på E-post: adrian.w.drosdal@nmh.no.

Samtykkeerklæring: **Jeg er villig til å delta i studien** ---------- (Signert av prosjektdeltaker, dato)	Jeg bekrefter å ha gitt informasjon om studien: ---------- (Signert, rolle i studien, dato)

Appendix 3: Declaration of concent form for participating music therapists

Samtykkeerklæring for deltaker i forskningsprosjekt: musikkterapeut

Forespørsel om deltakelse i forskningsprosjektet:

Musikkterapi i tvungent psykisk helsevern: En kvalitativ studie om opplevelsen av musikkterapi som frivillig behandlingstilbud for mennesker i tvungent psykisk helsevern.

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie. Studien har som hensikt å bygge opp en teoretisk forståelse av musikkterapi. Jeg ønsker å snakke med deg og din pasient for å få vite mer om hvordan musikkterapi oppleves for mennesker i tvungent psykisk helsevern. Målet med studien er å lære mer om musikkterapiens styrker og svakheter, i håp om å gi et bedre musikkterapitilbud til mennesker innen psykisk helsearbeid. Du blir forespurt om å delta i studien fordi din pasient som mottar musikkterapi også deltar i studien. Undersøkelsen er del av et doktorgradsprosjekt. Det er Norges musikkhøgskole som står som ansvarlig for- og finansierer studien.

Hva innebærer studien?

Jeg ønsker å intervjue deg som del av forskningsprosjektet, i et *collaborative* intervju, som en samtale sammen med din pasient. I disse intervjuene vil samtalen handle om hvordan din pasient opplever å ha musikkterapi som en del av behandlingen. Det vil bli gjort lydopptak av intervjuet. Dette opptaket vil behandles med forsiktighet, og vil aldri oppbevares på enheter med tilkobling til internett. Lydopptaket vil transkriberes til anonymisert tekst, og vil deretter slettes.

Mulige fordeler og ulemper

Du vil ikke ha noen spesielle ulemper ved å delta i studien. En samtale som tar opp tanker omkring behandling og bruk av tvang kan i noen tilfeller oppleves tungt for din pasient, men samtalen vil også kunne fokusere på positive virkninger av musikkterapi, noe som potensielt kan gi et bedre utbytte av musikkterapi. Erfaringer fra studien vil senere kunne hjelpe andre pasienter i samme situasjon.

Hva skjer med intervjuene og informasjonen om deg?

Intervjuet og informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger og intervjuer gjennom en navneliste. Det er kun undertegnede som har adgang til navnelisten, og som kan finne tilbake til deg. Musikkterapi et er lite og transparent fagmiljø. Derfor kan jeg ikke utelukke med sikkerhet at en musikkterapeut innen psykisk helsearbeid vil være ugjenkjennelig for andre. Så godt det lar seg gjøre vil det ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene

Samtykkeerklæring for deltaker i forskningsprosjekt: musikkterapeut

som er registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger. Opplysningene blir senest slettet i 2018.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn, trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen nedenfor. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Adrian Wangberg Drøsdal på telefon: 47092775, eller på E-post: adrian.w.drosdal@nmh.no.

Samtykkeerklæring: **Jeg er villig til å delta i studien**	Jeg bekrefter å ha gitt informasjon om studien:
---------- (Signert av prosjektdeltaker, dato)	---------- (Signert, rolle i studien, dato)

Appendix 4: Response from REK

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Silje U. Lauvrak	22845520	11.09.2015	2015/1259 REK sør-øst D
			Deres dato:	**Deres referanse:**
			16.06.2015	

Vår referanse må oppgis ved alle henvendelser

Adrian Wangberg Drøsdal
Norges musikkhøgskole

2015/1259 Musikkterapi i tvungent psykisk helsevern

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst D) i møtet 19.08.2015. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Forskningsansvarlig: Norges musikkhøgskole
Prosjektleder: Adrian Wangberg Drøsdal

Prosjektleders prosjektbeskrivelse
Denne studien søker å belyse hvordan pasienter opplever frivillig deltakelse i musikkterapi, under et behandlingsforløp som ellers preges av tvang. Målet med studien er flerdelt: den vil kunne 1) føre til bedret praksis, 2) bidra til økt refleksivitet innenfor musikkterapien som fagområde, og 3) gi klienten en stemme. Studien vil ta form av en multiple-case, hvor brukerperspektiv blir presentert på bakgrunn av semistrukturerte intervjuer. Dette vil settes inn i en faglig og etisk diskusjon. Musikkterapi ser ut til å fremme helse og motivasjon for mennesker med alvorlige psykiske lidelser. Musikkterapi er i Norge forankret i en humanistisk tradisjon, og skal foregå på klientens premisser, tradisjonelt på frivillig basis.

Om musikkterapi skal fremme helse og motivasjon for mennesker i tvungent psykisk helsevern er det nødvendig å vite hvordan dette oppleves. I lys av områdeetikk er det viktig at musikkterapien som fagfelt utøver refleksivitet omkring sin rolle i møte med TPH.

Vurdering
Formålet med prosjektet er å belyse hvordan pasienter underlagt tvungent psykisk helsevern opplever frivillig deltagelse i musikkterapi. Slik prosjektet er presentert i søknad og protokoll, synes hovedfokuset å være på pasientenes opplevelser rundt dette tilbudet, og det er ikke lagt opp til å måle helseeffekten av musikkterapien. Komiteen vurderer dermed at prosjektet ikke vil gi ny kunnskap om helse og sykdom som sådan, men snarere om opplevelser og erfaringer. Prosjektet faller derfor utenfor REKs mandat etter helseforskningsloven, som forutsetter at formålet med prosjektet er å skaffe til veie "ny kunnskap om helse og sykdom", se lovens § 2 og § 4 bokstav a).

Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet. Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern, samt innhenting av stedlige godkjenninger.

Vedtak
Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2 og § 4 bokstav a). Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Besøksadresse: Gullhaugveien 1-3, 0484 Oslo
Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

Klageadgang
REKs vedtak kan påklages, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst D. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst D, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Vi ber om at alle henvendelser sendes inn på korrekt skjema via vår saksportal: http://helseforskning.etikkom.no. Dersom det ikke finnes passende skjema kan henvendelsen rettes på e-post til: post@helseforskning.etikkom.no.

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen

Finn Wisløff
Professor em. dr. med.
Leder

Silje U. Lauvrak
Rådgiver

Kopi til: karette.a.stensaeth@nmh.no

Appendix 5: Letter of Approval from NSD

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Adrian Wangberg Drøsdal
Senter for musikk og helse Norges musikkhøgskole
Slemdalsveien 11
0369 OSLO

Vår dato: 22.10.2015 Vår ref: 44685 / 3 / LB Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 15.09.2015. Meldingen gjelder prosjektet:

44685	*Toner av frihet - En kvalitativ studie om opplevelsen av musikkterapi som frivillig behandlingstilbud for mennesker i tvungent helsevern*
Behandlingsansvarlig	*Norges musikkhøgskole, ved institusjonens øverste leder*
Daglig ansvarlig	*Adrian Wangberg Drøsdal*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.08.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Lene Christine M. Brandt

Kontaktperson: Lene Christine M. Brandt tlf: 55 58 89 26
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / *District Offices*:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 44685

Formålet er å belyse hvordan pasienter opplever frivillig deltakelse i musikkterapi, under et behandlingsforløp som ellers preges av tvang. Målet med studien er flerdelt: den vil kunne 1) føre til bedre praksis, 2) bidra til økt refleksivitet innenfor musikkterapien som fagområde, og 3) gi klienten en stemme.

Utvalget rekrutteres gjennom musikkterapeuter som arbeider i psykisk helsevern, og med hensyn til at pasienter skal være i en stabil fase. Personvernombudet legger til grunn at forespørselen rettes på en slik måte at frivilligheten ved deltagelse ivaretas. Det kan gjerne understrekes i informasjonsskrivet at forsker selvsagt ikke kjenner de som forespørres sin identitet før de eventuelt samtykker til deltakelse.

Utvalget informeres skriftlig om prosjektet og samtykker til deltakelse. Informasjonsskrivene er godt utformet, såfremt setningen "Lydopptaket(ene) vil transkriberes til anonymisert tekst, og vil deretter slettes" i begge skrivene omskrives til "Lydopptaket(ene) vil transkriberes til avidentifisert tekst, og vil deretter slettes", gitt at det benyttes koblingsnøkkel.

Det behandles sensitive personopplysninger om helseforhold, jf. personopplysningsloven § 2 nr. 8 c).

Personvernombudet legger til grunn at forsker etterfølger Norges musikkhøgskole sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 31.08.2018. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette lydopptak

Det er opplyst i meldingen at prosjektet er vurdert til å falle utenfor helseforskningslovens virkeområde. Ombudet ber om at REK-vedtaket ettersendes oss (til personvernombudet@nsd.uib.no).

Appendix 6: Letter of Approval from local health institution (anonymized)

Notat

Til:

Fra:

Kopimottakere:

Dato: 12.01.2016
Arkivref: 2015/12200 - 3324/2016

Godkjennelse av forskningsprosjekt - ID546

Forskningsprosjektet: «Musikkterapi i psykisk helsevern - En kvalitativ studie om opplevelsen av musikkterapi som frivillig behandlingstilbud for mennesker i tvungent psykisk helsevern».

Det vises til søknad vedrørende oppstart av ovennevnte forskningsprosjekt. Prosjektet har vært vurdert av forskningsansvarlig og prosjektet er registrert i vår database med referanse: ID546. Vi ber om at denne referansen oppgis ved alle henvendelser.

Nødvendige tillatelser foreligger. Basert på disse og forskningsprotokoll godkjennes oppstart av prosjektet.

Forskningsavdelingen ønsker å minne om at:

- Ved endringer i protokollen ber vi om å få en endringsmelding.
- Dersom innhenting av pasientopplysninger baserer seg på samtykke, må samtykkeskjemaene oppbevares i låsbart skap.
- Data skal slettes eller anonymiseres ved prosjektslutt og sluttmelding sendes Forskningsavdelingen.
- Dersom prosjektet ikke starter og/eller blir avbrutt må melding sendes til Forskningsavdelingen.

Forskningsavdelingen ønsker lykke til med gjennomføring av prosjektet.

Humanistic music therapy approaches stress self-determination for the participants; such values are however challenged when working within compulsory mental health settings. And whereas low motivation for treatment often characterize persons within compulsory treatment, it seems from previous literature that music therapy can help motivate this client group for participation. The question Adrian Wangberg Seberg investigates in this study is what music therapy can be for service users within compulsory mental healthcare.

Seberg argues that music therapy may afford different freedoms in several ways, and consequently coins the term 'liberating music therapy'. Music therapy may provide freedoms within the therapy settings and music therapists may try to facilitate freedoms for the participants in the recovery processes in exterior of mere therapy settings. In addition, Seberg argues, as both a profession and academic discipline, activists of music therapy may facilitate freedoms by working on a sociopolitical level.

The empirical findings in the study insinuates that music therapy is regarded voluntary for participants who are otherwise treated compulsorily, and that there are certain aspects in music therapy that seem to facilitate motivation, such as relationships with music, music therapy as a break from treatment, social contact through music, and the freedoms afforded in music therapy. The research participants also experienced health promoting aspects from participating in music therapy, such as having something to look forward to and helping them to get engaged into activities, experiencing uplifting and meaningful moments, alleviation of symptoms, and self-development.

The dissertation is a qualitative study, based on thematic analyses of research interviews with seven participants receiving music therapy while being treated compulsorily within Norwegian mental health services. A postmodernism-informed critical perspective has influenced the research process, including a critical view on the discourses making up practices within modern mental health institutions. Other influencing perspectives have been the Convention on the Rights of Persons with Disabilities, disability-studies, critical psychiatry, and notions of positive and negative liberties.

Adrian Wangberg Seberg has studied psychology and musicology at the Norwegian University of Science and Technology, and music therapy at the Norwegian Academy of Music where he graduated as a music therapist in 2013. He has worked in the field of mental health and substance abuse in both specialist health settings and in municipal settings.

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