Interview with Trygve Aasgaard

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On 13 January 2020 I paid a visit to Trygve Aasgaard at his home. Trygve is seen as a pioneer for the use of music therapy in paediatrics in Norway. His practice has also paved the way for the field in the rest of the Nordic region, and his voice therefore has a natural place in this anthology. Together with the editors of the anthology we decided that I would interview Trygve.

As well as hearing Trygve's views, we also wanted to provide a brief historical summary and create a kind of context for the fledgling work currently taking place in the field. The interview was conducted in Norwegian, then transcribed, lightly edited and translated.

> *Let's start with the beginning, Trygve. Can you say something about how and why music therapy was introduced in paediatrics in Norway?*

In 1994 I was working as a music therapist at Hospice Lovisenberg in Oslo. I'd only been there a few months when I received a request from a childhood cancer support charity asking whether I'd be interested in a permanent role at the child health clinic at Rikshospitalet. I accepted and started work there in 1995. On the first few visits I would be taken to a small room (designed for physiotherapy) where 5, 6, 7, 8 children stood lined up. I'd not been told what to do, or why, but I had to get to know them, and we did so through music. After about three weeks, I think it was, I was told that being confined to this tucked-away room was not enough. I should come down to the foyer in the child health clinic where they had a grand piano. There I could really get on with the music sessions. Every Tuesday at the same time for 45 minutes. Having held a couple of music sessions there I was given free rein to work individually with the children in their rooms, including in the isolation units. Entry to the isolation units was very strict, but as long as I observed the hygiene procedures – which were stringent – I was free to come and go.

A few months after I started working at Rikshospitalet I was asked by Ullevål University Hospital whether I wanted to do the same thing there. Again I accepted, but working conditions were slightly different. At Rikshospitalet I had my own little office, and right

from the start I had a good rapport with Sverre Lie (chief consultant and professor), who had recommended me for the job. There was none of that at Ullevål. You could say that the working conditions were rather miserable, but I managed to get a digital piano and the necessary musical equipment and worked extensively with individual patients and their next-of-kin. I was also fortunate to be able to follow patients from one hospital to the other when they were undergoing bone marrow transplants (stem cell treatment). It was amazing to learn what it was like to be a leukaemia patient when normal chemotherapy failed. The music therapist also became a kind of companion who was there to support their health in both good and bad times at the hospital.[1]

How much did you work back then?

My hours weren't clearly defined – I did a lot of other work, too (I was assistant professor in mental health at Aker School of Nursing and music therapist at Hospice Lovisenberg, but also free-lance musician/trombonist, specialising in early music brass/wind instruments) – but I'd often be at Rikshospitalet two days a week and at Ullevål one day a week plus numerous short visits in the evenings or on weekends. I also attended weekly seminars in Mesnali near Lillehammer with various groups such as children with radiation damage from previous treatments or families who had lost a child to cancer in the past year.[2] In the summers I was invited to something called Meaningful Holidays, where families with "cancer children" spent a week by the seaside or in the mountains.[3] There I would often be in charge of the final concert for the adults where the children (patients and siblings) would perform for the grown-ups. And of course there would be rehearsals in the days leading up to that with soloists and different "bands". My work in children's clinics really was a big part of my life in the late 1990s.

What international practices and literature on the subject were there back then?

Research and literature on music therapy in paediatrics were very limited when I started out.[4] In 1994 two German music therapists, Barbara Grießmeyer and Wolfgang Bossinger (1994), published a book called Music Therapy for Children with Cancer. I read it thoroughly,

1 See also chapter 6 in this anthology presenting Lena Uggla's work with children going through stem cell transplantation.
2 Organised by the Norwegian Cancer Society for families with children suffering from cancer.
3 Idem. See also: https://www.barnekreftforeningen.no/node/214
4 See also chapter 4 in this anthology providing a literature review of music therapy as procedural support and also a brief summary of the international development of music therapy in paediatrics.

contacted Barbara and was soon invited to join a working group comprising German and Belgian music therapists, among them Inge Bracke from Leuven. I made new international contacts at one of the very first international seminars on palliative music therapy. It took place at Sobell House in Oxford, and for the next two years I was invited there as a speaker. The thing is, when you talk about paediatric practice it's quite a broad umbrella term. I received my salary from the child cancer charity. But one of the conditions I set was that I would work with every child I believed could benefit from my music work. Maybe 75% of my hospital practice involved children with cancer. These were the children who would often spend the longest time in hospital, although I also worked extensively with young people who had received heart transplants, who had serious anorexia, various neurological conditions and so on.[5]

Could much of your work in the children's clinics be classed as palliative music therapy?

I've never been very keen on putting music therapy activities into palliative (or curative or preventive) pigeonholes. Much of what music therapists do, irrespective of client group, has a pain relief or palliative element to it. Pain relief can be intimately linked to providing care. In fact, the way I see it music therapy can also be care work to a greater or lesser extent; a view that might be interesting to explore further through research.[6]

Interest in "palliative music therapy" grew with the emergence of the hospice movement in the 1970s. As early as in 1984 Susan Munro wrote a book called *Music Therapy in Palliative/Hospice Car*e (Munro, 1984). She was Swiss but worked in Montreal in Canada at one of the first palliative hospital wards in the world. It was an informative book, albeit far too problem-orientated to my taste. I was just concerned with the fact that "my" patients, adults and children alike, in a hospice or in a hospital, were actually alive! There are no particular techniques reserved solely for patients on their deathbed. Music can be used to relieve pain and distressing symptoms such as nausea or to promote desired physiological parameters in people close to or far from the moment they depart life. In many of my texts on palliative music therapy for children I have also described patients who had been seriously ill, but who survived (Aasgaard, 1999, 2001, 2004, 2006). And I've done so with a clear conscience.

5 Music therapy with children with cancer is still a substantial part of music therapists' practice in paediatric hospitals, see for example chapter 6 and 7 in this anthology.

6 See for instance the discussion on family-centred neonatal pain management in chapter 1 in this anthology.

I have the impression that your focus would shift easily between the individual patient and the institutional environment?

Absolutely! In terms of understanding what the work involves, I wanted to understand and improve people's health (etc.) and help them live fulfilling lives while also taking an interest in what you could call *music medicine*, which was exclusively based on individual psychophysiological problems.[7] However, by the time I started working in the children's clinics I'd also developed a keen interest in milieu therapy in inpatient psychiatric treatment of adolescents and adults (Aasgaard, 1999; Aasgaard & Ærø, 2011). That way the children's clinics became a sort of laboratory for trying out different music-related activities where the objectives were more general, and perhaps more vague, than when working with individual patients. The weekly music sessions in the foyer at the Rikshospitalet children's clinic became an arena for activities where patients – and sometimes their siblings, next-of-kin and hospital staff, including the chief consultant and kindergarten teachers – sang, performed music, improvised and dramatised fairy tales together. The trick was of course to enable as many people as possible to gain something positive from it. The children were instrumental soloists, ranging from "three dongs on the cymbal" to renditions of Grieg's lyrical pieces on the piano or performances of songs they had created, often using tunes written by music therapy students or me. The chief consultant would also provide accompaniment on the piano while the music therapist played the trombone or recorder. One father impressed us with a drum solo on the congas, and so on. Next-of-kin would sometimes come and tell us later – after around an hour – that they'd forgotten they were in a hospital.

Music therapist Stine Camilla Blichfeldt Ærø continued to develop the concept with her "shift change sessions", which took place at a time of day when more staff were able to take part. The patients really got to see doctors and other staff in new and unexpected roles! Calling this traditional music therapy would be misguided (Aasgaard & Ærø, 2011).

Through my research into how young leukaemia patients created their own songs and what significance the songs might have had (Aasgaard, 2002), I eventually became convinced of how many psychosocial activities were meaningful to the patients and their families and that a family perspective was crucial in order to understand – and perhaps also to genuinely help – the sick child to improve their health despite serious illness.[8]

7 Music medicine – as different from music therapy – in paediatrics is addressed in chapters 1, 4 and 7 in this anthology.

8 See chapter 1 in this anthology for more about a family-centred perspective.

In 1999 I wrote a chapter entitled "Music Therapy as Milieu in the Hospice and Paediatric Oncology Ward" in the anthology *Music Therapy in Palliative Care. New Voices,* edited by David Aldridge (1999). There I proffered a definition of 'music environmental therapy': "A systematic process of using music to promote health in a specified environment inside or outside of institutions" (p. 34). This definition was later incorporated into the concept of "community music therapy", which has been useful in understanding music therapy at a system level. Today some of the things I helped develop could perhaps be described as *health musicking* (Stige, 2012)? Yet I also see music therapists in hospitals use environmental therapy as a theoretical term for their practices. At least I get the impression that today's music therapists working in Norwegian children's clinics have no problems switching their perspectives. I actually finished my engagement in paediatric music therapy writing two more general chapters on how music and art can be part of a truly integrative paediatric oncology (Aasgaard & Edwards, 2012; O'Callaghan & Aasgaard, 2012).[9]

Would you say that children with cancer have other characteristics than children with other life-threatening diseases?

Almost all the children in the children's clinic, not least those with cancer, were healthy children who went to kindergarten or school and who had wide range of skills, varied interests and big social networks. And then suddenly they are patients. They might have had an accident or been diagnosed with cancer, which quickly takes them away from much of their normality: away from their peers, their home, many of the things that make for a good life. Their lives become "high-tech-driven", i.e. filled with blood tests, x-rays, chemotherapy, stem cell treatment, surgery and radiation therapy, MRI and so on. They may be isolated for weeks, emaciated and with a changed appearance. It's as far from everyday life as you can get. Music therapists hope to bring elements of normal life and happiness back into their lives, thus giving a boost to the patients and perhaps also their next-of-kin at a difficult time in their lives. The hospital school also helps with this. One of the teachers told me: "To us, every child aged between 6–7 and 15 is a 'pupil'. If you start calling them patients, then many of them will realise that they are nearing the end."

Do the hospitals and wards you have worked at take an interest in music?

I dare say that one distinctive feature of the university hospital is that many people there are simply very knowledgeable about music. There is probably an expectation that the music

9 Chapter 2 in this anthology emphasises interdisciplinary insights and describes contributions of music educators to the use of music and arts.

therapist has to deliver, purely musically speaking. We can safely say that you will need every musical skill you've got and that you quickly work out where you need to improve. I chose to step out and put myself on display in the public areas. That can be taxing. Once I gave a lecture at a big hospital in Germany where I showed how, in Norwegian children's clinics and in addition to my one-to-one work, I would organise processions through the corridors with slapstick humour and put on puppet theatre in the music sessions. My German audience were less than amused! One of the four music therapists working in a German institution said: "I'm sorry, Dr Aasgaard. We cannot concern ourselves with such things here". When I asked why he responded that people would think they were clowns. I had to ask him whether it was wrong for music therapists to spread laughter and fun. Yes, that was wrong, they believed. When they were doing therapy – remember this was a neurological hospital with seriously ill young and old patients – they had a subordinate member of staff take the patient to the therapy room where most of the music therapy took place. Other music therapists have also said they don't want to be observed while working. One therapist once told me that "I've only done this once before, and the whole hospital might hear that I played it wrong or did something that wasn't entirely successful."[10]

Do you get the impression that music therapists in the field today work in the same way that you did?

I had to find my way and was allowed to do so. So I found that there was room for my somewhat anarchist, or at least improvisational, approach. Working conditions for music therapists in many big hospitals around the world are probably much more clearly (and possibly also more narrowly) defined now than they were then.[11]

Indeed, it might have something to do with today's music therapy training courses benefiting from extensive research and new findings.

I'd also like to mention that to market your psychotherapeutic credentials to the hospitals, you must demonstrate a clear therapeutic role. In any case, I've found that attitudes towards more milieu-based approaches are becoming ever more positive.

10 Stories like these highlight the need for music therapists to communicate the therapeutic relevance of their work to other health professionals in a comprehensible manner. Chapter 5 in this anthology discusses such challenges.
11 See for instance chapter 2 and 5 in this anthology for more about working conditions and music practitioners' roles in hospitals today.

We must also remember that there are still big differences around the world as to the perspectives on young patients.[12] Many music therapists in children's clinics worldwide never have to deal with the patients' families. The very idea of bringing in the family might be alien since family members are only able to visit once in a while.

You seem to have been especially keen to promote health in the middle of all the pain that probably still exists in modern children's clinics. Is that right?

Much of my learning curve was in a decade where there was a lot of "learning by doing", certainly. By jumping in at the deep end and trying things out, I ended up doing things every day that weren't much to brag about. But today I'm happy that I took some risks. After all, there aren't many potentially fatal outcomes when you're dealing with music. I've also learnt a great deal from some of the music therapy students at the Norwegian Academy of Music. My interest in salutogenesis has been a constant almost all of the time. One of the founders of the positive psychology movement, Martin Seligman, said something along the lines of "don't try to fix what's wrong, but build what's strong". I remember the first time I had explained to me the behavioural traits of different types of people, with some being "origins" and others "pawns". This thing about pushing people towards the "origins" is relevant to health work. It goes like this: "origins" have a certain realistic hope of succeeding, they use realistic reasoning and, eventually, take responsibility for their lives. A "pawn", on the other hand, is passive and frequently assumes the role of the victim amid a feeling of hopelessness. I met a large number of patients back when I was working with adults as a paramedic and for a care charity and, sometimes, I would meet entire families that seemed to be "pawns". Of course, when you go to hospital and have many of your usual attributes and roles taken away from you, it is possible to experience enduring hopelessness. But it doesn't do you any good. I think music therapy, almost regardless of client group, has the potential to promote a sense of achievement and hope. And as my mentor and friend David Aldridge, who sadly passed away this spring, said: music can be an excellent tool for *performing health* in yourself. I'd also like to add: "including in families and next-of-kin, who can sometimes suffer at least as much as their sick family member."

Where do the terms "origins" and pawns" come from?

As far as I'm aware it was Richard DeCharms, a professor of education and psychology, who in 1976 coined the term to describe different groups after studying behavioural traits in students.

12 Chapter 3 in this anthology discusses cultural, or multicultural, perspectives in depth.

The anthology in which this interview will appear has a Nordic perspective. Can you talk a bit more about how Nordic music therapy in this particular field came about?

I think Anne Olofsson, music therapist at Karolinska University Hospital in Stockholm, was the first music therapist in the Nordic region to work with cancer patients (Olofsson, 1993). Her primary focus was on adults, though. Around the same time that I began working at Rikshospitalet in Oslo, Ingrid Michaelsen started as a music therapist for children and adults at Karlstad Central Hospital. I was invited to lecture for medical and other staff in Karlstad, and Ingrid came to Oslo to participate in the music session at the children's clinic, where she impressed everyone by illustrating songs on a big blackboard at lightning speed as we sang. In around 2000 I presented my practice and lectured on the music therapy course at Aalborg University, where I also defended my PhD dissertation (Aasgaard, 2002). Eventually teachers and students began to practise the profession. Worldwide there were very few music therapists working in paediatrics in the 1990s. Those who did were mostly in Australia and Germany and some in the US, Israel and the UK.

Is there a typically Norwegian approach to music therapy in children's clinics?

I think there is. I think, but don't know for certain, that despite the hierarchical nature of hospitals in Norway and elsewhere, it may be easier in Norway than in other countries to involve different staff groups in the music sessions. I also think that wards in Norwegian hospitals provide a fairly safe setting for trying out new things. And it's great to see that there are now music therapists affiliated to all children's clinics in Norwegian university hospitals and that the aforementioned milieu perspective that I helped developed can perhaps be seen as having some of the markers of something "typically Norwegian". Still, it's the individual contact with the patient/family during the course of the therapy that makes up the core of music therapy in paediatric practice.

Thank you so much for the interesting chat, Trygve. And thanks for everything you've done for music therapy in paediatrics.

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