Music therapy with individuals who have experienced violence and abuse.

A qualitative study of music therapists' experiences with violence and abuse survivors

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Abstract

This thesis explores the use of music therapy with individuals who have experienced violence and abuse. Due to the limited research in this field, this study seeks to understand better the implications of using music therapy with this population. The main purpose of this study is to investigate if music therapy can promote health, a sense of safety, and help this population with self-regulation and describe how it can potentially do so. The study uses a qualitative research design and a hermeneutical approach. The method for collecting data is semi-structured interviews with four experienced music therapists, and thematic analysis is used for analysing the data. The results are summarized and discussed in four main categories: Safety, relational aspects, coping, and music therapist´s considerations. The discussion examines the previous categories based on recent trauma theories, developmental trauma theories and trauma wise care, and in relation to resource-oriented music therapy. The findings suggest music therapy´s potential for addressing trauma and promoting health in survivors of violence and abuse, but further research is needed in this field.

Keywords: Music therapy, violence and abuse, trauma wise care, trauma informed music therapy, mental health care, self- regulation.

Sammendrag

Denne masteroppgaven utforsker bruk av musikkterapi med mennesker som har opplevd vold og overgrep. På grunn av lite forskning på dette feltet, søker denne studien å bedre forstå implikasjonene av å bruke musikkterapi med denne målgruppen. Hovedformålet med denne studien er å undersøke om musikkterapi kan fremme helse, en følelse av trygghet, og hjelpe denne målgruppen med selvregulering, og beskrive hvordan dette eventuelt kan gjøres med musikkterapi. Studien bruker et kvalitativt forskningsdesign og en hermeneutisk tilnærming. Metoden for datainnsamling er semistrukturerte intervjuer med fire erfarne musikkterapeuter, og tematisk analyse benyttes for å analysere datamaterialet. Resultatene er oppsummert og diskutert i fire hovedkategorier: Trygghet, relasjonelle aspekter, mestring og musikkterapeutens vurderinger. Diskusjonen undersøker de tidligere nevnte kategoriene med utgangspunkt i nyere traumeteorier, utviklingstraumeteorier og traumebevisst omsorg, og i lys av ressursorientert musikkterapi. Funnene antyder musikkterapiens potensial til å adressere traumer og fremme helse hos mennesker som har opplevd vold og overgrep, men det er behov for ytterligere forskning på dette feltet.

Emneord: Musikkterapi, vold og overgrep, traumabevisst omsorg, trauma bevisst musikkterapi, psykisk helsevern, selvregulering.

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1. INTRODUCTION

1.1 Background for the Choice of Theme

In 2019, I worked for six months as a music and cello teacher at "Xiquitsi" music project in Mozambique. The project aims to contribute to the participants' social, cultural, and pedagogical development through free music education. There I got to know many children and young people who lived in vulnerable and difficult situations, often at risk of exclusion. I could experience how meaningful music was and how it gave them hope to carry on despite of the challenges. Unfortunately, some of them had experienced violence or abuse at home. Sadly, no one in the project had the experience or education to cope with the situation, and the community, political and societal factors in this context did not help solve or prevent this issue (WHO, 2022). We could not thus do much about it, which felt extremely painful. That challenged me to think about the possibilities of using music, in a therapeutical context, with a population who have experienced violence and abuse.

Violence and abuse are known severe problems in the world. They are not individual problems but a consequence of social, economic, political, and cultural structures. About 1 billion children aged 2-17 years experienced physical, sexual or emotional violence or neglect worldwide in the past year, according to World Health Organization (2022). In Norway, five per cent of the population state that they have been exposed to serious violence from their parents when they were growing up. *Nasjonalt kunnskapssenter om vold og traumatisk stress* (NKVTS) shows that more than 20% of women and almost eight % of men state that they have suffered sexual abuse before the age of 18. There has been an increase in cases of violence and abuse worldwide and in Norway after the pandemic outbreak in 2020, as NKVTS survey states.

Even though there has been a growing interest in researching the use of music therapy with victims of violence and abuse, there is still a significant need for further research and practice within this area (Brekke, 2019). Research about music therapy as a relevant treatment for children and young people who have experienced traumas is encouraged by the music therapist Viggo Krüger (et al., 2017).

All of this challenged me to think about the possibilities of using music, in a therapeutical context, with this population and how necessary and valuable can the work of music therapists potentially be in this context.

1.2 Research Questions

With the previous background information, choosing the theme: Music therapy for individuals who have experienced violence and abuse for this study felt natural. Due to insufficient research on this topic, I wanted to keep an open and exploratory attitude when formulating my research questions without assuming the possible positive outcomes of the study. Therefore, I have phrased my overall research question as follows:

> *Can music therapy promote health for individuals who have experienced violence and abuse? And if so, in which ways?*

Based on that overarching question, I have formulated two sub-questions:

- *Can music therapy promote a sense of safety for individuals who have experienced violence and abuse? And if so, how?*

- *Can music therapy help individuals who have experienced violence and abuse to self-regulate? And if so, how?*

1.3 Definition of Concepts

In the following section, I will briefly explain some of the central concepts of my study that stand out in my research questions. Due to the close connection between some of these concepts and my theoretical orientations, I will explain some terms in more detail in the upcoming theory chapter.

I understand *Music therapy* from a humanistic and resource-oriented perspective in which caring for the individual, self-determination, autonomy, relationships, and a multi-dimensional human view are central aspects, among others (Rolvsjord, 2008; Ruud, 2008). Though there are plenty of definitions of music therapy, I would like to explain my view of music therapy based on two central definitions. Music therapy can be seen as *"the use of music to give people new possibilities for action"* (Ruud, 1990, p. 24, own translation). Bruscia (2014, p. 36) states, *"Music therapy is a reflexive process wherein the therapist helps the client to optimise the client's health, using various facets of music therapy experience and the relationships formed through them as the impetus for change".*

Health is seen here from a humanist perspective and a salutogenic orientation. In this study, I have distanced myself from the biomedical definition of health as the absence of disease and have considered both physical, mental and social well-being (WHO). I have been interested in examining the different aspects that can promote health and not only focus on diseases or diagnoses. Seeing health as a continuum which constantly changes and not as a permanent condition has been especially relevant corresponding to new theories in trauma research, which I will discuss deeper in the next chapter. Health can be perceived as a condition, experience, resource and process (Medin & Alexandersson, 2000, cited in Ruud 2008, p.22). In line with Antonovsky sense of coherence (1996), health can also be described as the experience of well-being or meaning in life, which is emphasised by the humanistic view (Ruud, 2008).

Violence and abuse: Due to the scope of the study and the background of my informants, I have chosen to focus primarily on violence and abuse against children. Therefore, other forms of violence and abuse, such as domestic violence will not be mentioned or described. Nasjonalt kunnskapssenter om vold og traumatisk stress (2018, own translation) defines violence and abuse against children as follows: *"Violence and abuse against children include physical violence, psychological violence and sexual abuse. Absence of actions, in the form of physical and emotional negligence and neglect, is also violence and abuse against children."*

To clarify some of the terms mentioned above, FMSO (Fellesskap mot seksuelle overgrep) writes that *"physical violence means that an adult inflicts pain, bodily harm or illness on a child"* and *"sexual abuse of children is a situation where children and young people are involved in sexual acts that they are not mature for, consent to or understand*" (2018, own translation).

The World Health Organization (2022) states, *"Violence against children includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers".* Moreover, when referring to sexual abuse: *"One in 5 women and 1 in 13 men report having been sexually abused as a child aged 0-17 years".*

The consequences of experiencing violence and abuse in childhood can have a lifelong impact on physical and mental health, and they are one of our most significant public health problems according to Braarud & Nordanger (2017).

I will return to the terms *safety*[1] and *self-regulation* [2]later in the theory chapter in connection to theories on trauma-informed care and modern trauma research.

1.4 Literature Review

This study intends to throw more light on the existing literature and research about music therapy for individuals who have experienced violence and abuse. I wanted to conduct a thorough literature search that could contribute to answering my research questions from different perspectives. I conducted my search in both English and Norwegian using words related to music therapy and violence or abuse victims. I used search motors and databases such as Oria, Google Scholar, NMH-Brage, BORA, and journals like Voices, Nordic Journal of Music Therapy, Norsk Forening for Musikkterapi and Music Therapy Perspectives. The results were limited and mainly in English. Therefore, I tried to expand the search with "music therapy and trauma" to find out more about relevant research on this topic internationally and in Norway. Finding the article "Musikkterapi og traumebevisst omsorg i barnevernet" (Krüger & Nordanger,2017) was of great help, and it guided me towards modern trauma theories like the book "Utviklingstraumer" by Nordanger & Braarud (2017). That led me to other relevant names inside the trauma research field, like Van der Kolk and his book "The body keeps the score" (2014) and the three pillars of trauma-wise care by psychologist Bath (2005).

The majority of the international research was rooted in a more psychodynamic orientation. The words "music therapy with abused children" gave many results. Bruscia's (2012) "*Case examples of music therapy for survivors of abuse*" and "*Psychodynamic music therapy: Case studies"* by Hadley (2003) were useful examples of case studies from a psychodynamic perspective. When it comes to literature based on a resource-oriented music therapy perspective, I was quite much influenced by Rolvsjord's PhD "*Blackbirds Singing: Explorations of Resource-oriented. Music Therapy in Mental Health Care"* (2007)

When investigating other master's theses from the Norwegian Academy of Music and the Grieg Academy in Bergen, I only found two related to my theme.
Smith (2017) «Music at the centre: A qualitative interview study of music therapy practices at a centre for adults that have experienced sexual abuse», and «Musikkterapi med mennesker som har opplevd seksuelle overgrep: En kvalitativ studie av

[1] See chapter 2.2.1
[2] See chapter 2.2.3

deltagererfaringer» by Brekke (2019). Both theses focused on how adults who have suffered sexual abuse experienced music therapy.

By manually revising the bibliography from some of my central literature results, I could discover several interesting sources that were unknown to me before. Therefore, combining a digital and manual search has been important in the process.

1.5 Disposition of the Thesis

Next, in chapter 2, I will explain the most relevant theories and the theoretical framework of this study. Theories about trauma-wise care, recent trauma research, developmental trauma, and research connecting music therapy with survivors of violence and abuse will be highlighted. Chapter 3 describes the method, research design, data collection procedures, data analysis methods, and ethical considerations. In chapter 4, the empirical findings from the four interviews, divided into four main themes, will be presented. Chapter 5 consists of the central discussion part of the text, where the findings will be discussed and interpreted in connection to the research questions and theoretical framework. To conclude, chapter 6 will summarise the main findings, see further study implications, and a possible way forward.

2. THEORIES

In the following chapter, I will explain the theoretical perspectives that have served as the foundation for this research study. This theoretical framework has guided the research design, data collection, analysis, and interpretation of the findings, and it has helped me to establish the credibility and validity of this research. First of all, I will present the concept of trauma and some of its diagnoses, followed by theories about recent trauma research, including trauma wise care, trauma effects on the brain and body, developmental trauma, and explain some concepts such as self-regulation and window of tolerance that have been central concerning my research questions. At last, a summary of significant literature and theories that bring together music therapy and trauma, mainly in the form of violence and abuse experienced during childhood.

2.1 Trauma

The concept of trauma can be defined in different ways since it can comprehend many different types of people and situations. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV*, 2000) defines trauma as:

"Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror"

There are different types of traumas, and the effects of trauma can vary depending on the type and severity of the experience. Therefore, diagnosing trauma can be complex, as it can present a range of symptoms that affect individuals differently. Although there are different ways of categorising trauma, it is normal to differentiate between two main types. Type I or simple trauma refers to single traumatic events that occur unexpectedly in an otherwise safe life. Type II or complex trauma involves complex and repetitive trauma, often occurring during vulnerable periods in a person's life (Terr, 1991). If we look closer at trauma diagnosis, it is important to distinguish between Post Traumatic Stress Disorder (PTSD) and Complex PTSD.

PTSD diagnosis was included in 1980 in the third edition of the *Diagnostic Statistical Manual of Mental Disorders* (DSM-III). It was originally created to describe the symptoms of American Vietnam War veterans (Braarud & Nordanger, 2017). Its central symptoms can be mainly divided into intrusive memories (flashbacks, nightmares), avoidance (avoiding reminders of the trauma) and hyperarousal (trouble concentrating, muscle tension). Although complex PTSD is not a recognised diagnosis on the DSM-V (American Psychiatric Association, 2013), it was included in the 11th revision of the International Classification of Diseases (ICD-11, 2019). Complex trauma can be described as a multiple and prolonged childhood experience of developmentally adverse traumatic events such as sexual, emotional, or physical abuse, war, and community violence (van der Kolk, 2005). This kind of trauma has far more complex consequences than PTSD, and its specific symptoms include difficulties with regulating affects and attention, self-perception, relational functioning, and somatisation (Braarud & Nordanger, 2017).

Dissociation and dissociative disorders like dissociative identity disorder (DID) are examples of specific Complex PTSD symptoms.

Dissociative disorders are characterised by involuntary disruption or discontinuity in the normal integration of one or more of the following: identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements, or behaviour (ICD-11, 2019). Trauma-related dissociation is a psychic phenomenon with symptoms such as flashbacks, fugues (not present), body pain, spasms, feeling disconnected from your body, and numbness. The dissociative process can result from lacking integrative capacity after a traumatic experience (Kleive, 2009).

2.2 Recent Trauma Theory

2.2.1 Trauma Wise Care.

Trauma wise care emphasises that a big part of the healing process from trauma exposure occurs in non-clinical settings. This theory, developed by Howard Bath (2018), builds on three fundamental pillars for creating an environment that promotes healing and resilience. Trauma literature has shown a list of risk and protective factors in the life of trauma survivors. Bath (2015) defines in the next three pillars some of the core needs to keep in mind when working trauma informed. These three pillars are 1. Safety, 2. Relations, and 3. Coping, and they are all closely interrelated. Safety cannot be felt without positive connections, and coping and regulating can only develop within safe connections (Bath, 2015). I will next

explain the concept of safety, highlighted in my research questions, in relation to these pillars and Maslow's hierarchy of needs (1954).

Safety is considered a core developmental need for children by several developmental theorists, such as Abraham Maslow, Erik Erikson, John Bowlby and Mary Ainsworth (Bath & Seita, 2018). It is placed in the second level of Maslow's pyramid, closely following the first level of physiological needs but also connected to higher-level growth needs. It can be seen as an essential prerequisite for attending to normal developmental tasks and establishing a therapeutic relationship (Bath, 2015; Maslow, 1954). "*Healing starts with creating an atmosphere of safety; formal therapy is unlikely to be successful unless this critical element is in place"* (Greenwald, 2005, cited in Bath, 2015, p. 6). Children that have suffered trauma, especially complex trauma, experience brain changes. Consequently, their alarm systems can be easily activated since they lack the ability to distinguish appropriately between safe and dangerous environments (van der Kolk, 2014). I will come back to this later in this chapter.

Even though providing a sense of safety is central when working with individuals who have had traumatic experiences, minimal music therapy literature has described how to construct safety in their programs (Lai et al., 2021). Therefore, I considered focusing on safety when carrying out the methodological procedures particularly interesting. One of the limitations of explaining how safety is created revolves around what safety means. Safety can have many facets or levels and involves physical safety, psychological, social, and cultural or moral safety (Bath, 2015; Lai et al., 2021). Psychological safety entails being safe with oneself and showing self-control and self-protection. Social safety refers to being in a safe environment and feeling secure and trusted by others in relationships. Cultural or moral safety entails being safe in an environment with a structured, supported system, and *"in a world where diversity can be marked by discrimination"* (Bath, 2015, p.7). Some theorists like Herman (1992) and van der Kolk (2014) have focused on explaining various strategies to create safety, instead of merely trying to describe it. As mentioned by Lai (et al., 2021, p. 2), "*Herman emphasises a trusting client-therapist relationship and supported peer relationships to create safety for survivors. Van der Kolk describes relaxation and mindfulness breathing techniques to provide a sense of security for the participant".*

Very closely connected to safety, we find the second pillar, *connections*. This pillar is about establishing or re-establishing vital connections for the traumatised person. By connections, we refer to relationships with caring adults and normative connections like schools, sports teams or community (Bath, 2015). Experiencing trauma often leads to a lack of trust and disconnection from adults. This disconnection is caused because the young

person has experienced trauma, and the caregivers who typically protect, could not or would not protect or were themselves the source of the harm. Therefore, supportive and caring relationships are essential to foster healing and resilience.

The third pillar, *coping*, builds on the ability to manage external problems and internal emotions or impulses. Both conscious and unconscious strategies help the child cope with external challenges resulting from developmental trauma and strong emotions and impulses present in traumatic stress (Bath, 2015). Struggling with emotional self-regulation is one of the most significant consequences of developmental trauma (Bath, 2015; Braarud & Nordanger, 2017). In the next section, I will discuss the concept of self-regulation in relation to recent trauma theory about developmental trauma.

2.2.2 Developmental Trauma

The trauma field is constantly developing and has undergone significant changes over the last few years. There has been an increasing focus on children and the consequences of traumatic experiences in early caring relationships, like violence and abuse. Researchers have claimed that chronic traumatic stress happening early in life, and especially in close relationships, have far more complex consequences than PTSD diagnosis caused by accidents, war, or natural catastrophes, among others.

Experiencing violence and abuse as a child means that the child is exposed to traumatic stress in a developmentally sensitive life period, which can disrupt the child's development. In addition to these traumatic burdens, children are often exposed to neglect as well. This double load condition - where such conditions occur in combination while the child is not getting support to regulate affect - is referred to as *developmental trauma* within new trauma research (Braarud & Nordanger, 2017). The children who are exposed to developmental trauma will not only suffer the negative consequences associated with the traumatic experience, but they are also missing out important good experiences such as affect, body and internal states that the caregiver regulates. Because of that, they will need *"an overdose of good relational experiences, over a long time, so that it will compensate for what they have missed"* (Braarud & Nordanger, 2017, p. 24). Trauma treatment must consider compensating the child for the lack of these experiences. As explained by Van der Kolk (2014, p. 122) the treatment of developmental trauma must also address "*the consequences of not having been mirrored, attuned to, and given constant care and affection".* Consequences such as the loss of self-regulation, and difficulties as dysregulation of the functions that a good relationship usually promotes (van der Kolk, 2005).

2.2.3 Regulating and the Window of Tolerance.

Children have not yet developed the capacity to regulate themselves and therefore need help and support from primary caregivers. This secondary form of regulating the child is called regulating support (*reguleringsstøtte*) by Braarud & Nordanger (2017, p. 29). Infants depend on stable and safe caregivers that help them regulate physiological functions (like hunger and sleep), affects (like fear) and too-intense stimuli. The regulatory system that controls and regulates one's emotions is particularly underdeveloped in children who have experienced developmental trauma, due to the lack of regulatory support under traumatic stress conditions.

Good parenting, daily and repeated experiences and emotional investment make it likely that the infant will develop a safe relationship. These kinds of experiences strengthen the neurological network and are important for the gradual development of the child's system for self-regulating. The caregiver's emotional involvement and reflexive actions influence the child's self-perception of himself and the caregiver, something named the internal working model (Bowlby, 1969; Braarud & Nordanger, 2017). Internal working models are mental representations formed during the child's early experiences with their primary caregivers that will influence how the child interacts and builds interpersonal relationships as they grow. A child raised with love and safety has learnt that unmanageable stress can be coped with through regulating support from caregivers. Consequently, the child will probably have an identity and perception of himself as lovable and taken care of (Bowly, 1969). The infant will internalise the regulating support in the caregiver's relationship; thus, several stimuli that were too overwhelming before will no longer be it. The child has experienced that overwhelming situations are manageable or that the caregiver can mobilise for help, so the window of tolerance will be expanded little by little. Trusting that the caregiver can reduce discomfort is one of the bases for the development of safe attachments. Due to these safe connections, the caregiver can become a safe base for the further development of self-regulation (Braarud & Nordanger, 2017). Later on, and only because of having gotten regulating support early in life, the child will be more capable of regulating his own emotions and challenging the limits of his window of tolerance.

Next, I would like to explain a central concept in the understanding of regulating and development, *the window of tolerance (*see figure 1*).* Developed by Siegel (2012) this model describes *"a zone or span that represents optimal activation – not too high, not too low"* (Braarud & Nordanger, 2017, p. 38, own translation). Children and adults in this zone have

optimal concentration and attention towards other people and situations. This zone is also seen as the optimal state for learning and developing.

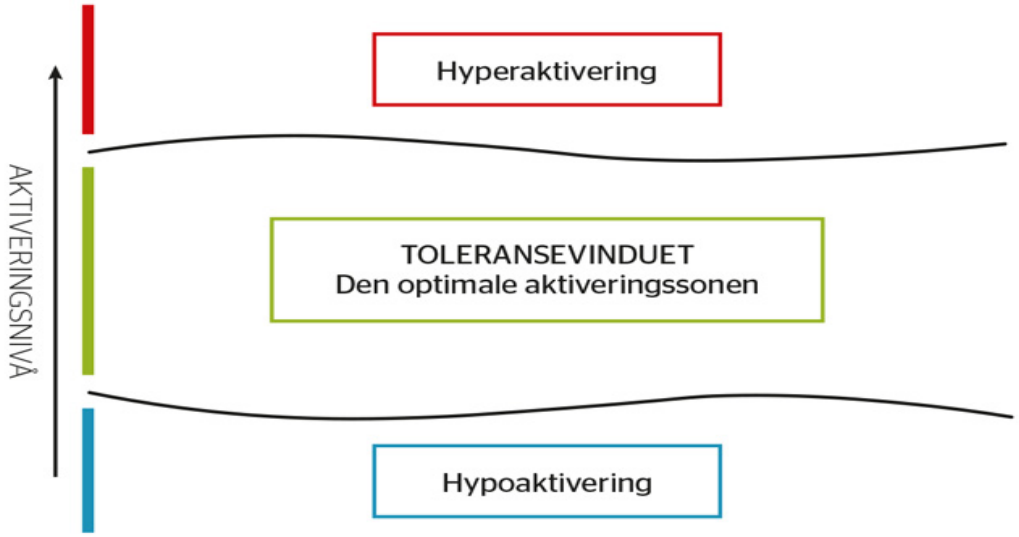

Figure 1: The Window of Tolerance (Braarud & Nordanger, 2017, p. 39)

If you are above the tolerance limit, you will find yourself in a *hyperactivated* state. Then, you will often have increased heart rate, breathing, and muscle tone. If you, on the other hand, are below the tolerance limit, we are then talking about a *hypoactivated* state, with symptoms like reduced heart rate, breathing, and muscle tone (Porges, 2007). The span of the window of tolerance is very individual and will vary from person to person, as well as from the individual's context. It is influenced by experiences and emotions but also by genetic factors. The social context plays an important role too; most people can tolerate more when they are together with someone they feel safe with (Braarud & Nordanger, 2017). I will come back again to this later in the discussion chapter. The window of tolerance's span and flexibility are specially formed by the individual's experiences from early interactions with primary caregivers (Siegel 2012, cited in Braarud & Nordanger 2017). Consequently, people who have experienced chronic trauma will often have a narrower window of tolerance. In addition, they can also easily come out of the optimal activating zone and quickly go up or down to the hyper-or hypoactivation state. These reactions in the hyper-or hypoactivation zone will also be more extreme and last longing because of the child's lack of strategies to

regulate himself back into the window of tolerance. When the regulatory system is underdeveloped, the alarm reactions in the hyperactivating zone can involve strong feelings of restless, aggression, impulsivity and chaos; the reactions in the hypoactivation zone include feelings of emptiness, numbness, low mood, and paralysis of action (Ogden et al., 2006). Using the window of tolerance model as a therapeutic tool can be beneficial when working with children and youths with a developmental trauma history. According to Braarud & Nordanger (2017, p. 180), they need help primarily with:

1. Getting better at not disappearing out of their window of tolerance
2. Getting better at returning to the tolerance window when going above or below it.
3. Expanding their window of tolerance.

In the next section, I will go deeper into theories about the impact of trauma on the brain and body from a neuroscientific perspective.

2.2.4 Trauma on the Brain, Mind, and Body

To understand better how our brain reacts to danger, particularly trauma, it might be helpful to look closer into our brain's structures and how it organises and processes experiences. Our brain is use-dependent, meaning the stimulated networks will develop while the ones not stimulated will not. As a consequence, repeated experiences of being regulated will strengthen and develop the regulation system, whereas repeated experiences of threat and stress will develop the alarm system and hinder the development of the regulation system (Braarud & Nordanger, 2017; van der Kolk, 2014). Trauma can interfere with the whole structure of our brain, all its three parts, as explained below.

In the 1960s, neuroscientist Paul MacLean proposed the triune brain – or three-part brain– model (1985, cited in Braarud & Nordanger, 2017), suggesting that the human brain can be divided into three evolutionary layers, each with different functions and capabilities. Our brain is built from the bottom up and develops layer by layer within every child in the womb, as well as during evolution. The oldest and most primitive part of our brain – *the reptilian or survival brain*– is located in the brain stem. It is responsible for body functions such as breathing, heart rate, and temperature regulation. Right above the reptilian brain, we find *the limbic system* – or mammalian brain – responsible for processing emotions, memory, and monitoring danger; the amygdala is located here. The amygdala, often called "*the alarm system*" of the brain, plays a fundamental role in detecting potential danger or threats. The limbic system is mainly organised during the first six years of life but continues evolving in

response to experiences. Trauma can majorly impact its functioning (van der Kolk, 2014). As recent discoveries in neuroscience and neuroplasticity have proved, neurons that "fire together, wire together". That means that when two neurons are activated simultaneously, their connection strengthens, making it more likely that they will be activated together in the future. As van der Kolk (2014, p. 56) *described, "if you feel safe and loved, your brain becomes specialised in exploration, play, and cooperation; if you are frightened and unwanted, it specialises in managing feelings of fear and abandonment".*
At last, *the neocortex* – or human brain– is the top layer and last to develop. It is responsible for higher cognitive functions such as language, abstract thinking, and problem-solving. Trauma also affects this and can make us unable to filter out irrelevant information (van der Kolk, 2014).

Our brains are programmed to ensure survival. When our brain's alarm system detects danger or threat, "*it automatically triggers preprogrammed physical escape plans in the oldest part of our brains"* (van der Kolk, 2014, p. 54). When the old brain is in control, it shuts down parts of our higher brain and our conscious mind, activating the fight, flight or freeze response in our bodies. If the fight/flight/freeze response succeeds and we escape the danger, we regain control of our senses and an internal balance. However, if that normal response is blocked for some reason – for example, when a child suffers maltreatment at home– the brain sends stress chemicals. Even long after the event, the brain keeps sending signals to the body to escape a no longer-existing threat (van der Kolk, 2014). Since at least 1889, it has been acknowledged that trauma survivors tend to continue the action or attempt at action that started when the actual event happened. If something triggers the past trauma, the body reacts as if the traumatic event was happening in the present, activating the fight/flight/freeze response. Trauma thus affects the whole organism – body, mind, and brain. In PTSD, the body keeps defending against a threat from the past; to heal from that, it is necessary to end this continued stress mobilisation and restore the whole organism to safety. Because of that, it is critical to engage the body, mind, and brain in treating trauma (van der Kolk, 2014). In the discussion chapter, I will come back to that and relate to music therapy as a potential means to engage the body, mind, and brain.

Older trauma theories – as Freud back in 1893 – claimed that remembering and talking about the trauma was the way to resolve it. As opposed to that, van der Kolk (2014) defends that language cannot substitute for action; finding words to describe what happened can be transformative but does not necessarily avoid having severe PTSD symptoms. To change posttraumatic reactions, we need to access the emotional brain – where the engines of

these reactions are located – and repair faulty alarm systems. In contrast to the rational brain, the emotional brain –and the imprints of a traumatic experience – are expressed in physical reactions. First on the agenda is *"to find ways to cope with feeling overwhelmed by the sensations and emotions associated with the past"* (van der Kolk, 2014, p. 204). Although music therapy is not explicitly named, van der Kolk (2014) mentions that some unconventional techniques or therapies – like group singing or drumming – seemed to work very well for traumatised people to get in touch with their bodies. All these techniques rely on interpersonal rhythms, awareness, and vocal and facial communication, which help get people out of fight/flight mode, reorganise their perception of danger, and develop their ability to manage relationships (van der Kolk, 2014). Techniques combining top-down approaches (activate social engagement) with bottom-up approaches (calm physical tensions) seem beneficial in trauma treatment. As described in van der Kolk's (2014, p. 85) example, simple, rhythmically attuned movements can create *"a safe place where the social-engagement system can begin to reemerge". Moreover, "severely traumatised people may get more out of…joining others in tapping out a musical rhythm on the chair seats than they would from sitting in those same chairs and discussing the failures in their life".*

As we may realise, many central aspects explained in recent trauma theories can easily be related to fundamental elements in music therapy work. In the following section, I will examine literature and research that connect music therapy and trauma theories.

2.3 Music Therapy and Trauma

As mentioned in my literature review, different music therapeutical perspectives and approaches have been used and researched concerning music therapy with trauma survivors. I will next focus on the psychodynamic perspective – more present in the US , a brief description of Guided Imagery and Music (GIM) in trauma treatment, and the resource-oriented perspective – central in the Norwegian music therapy tradition.

2.3.1 Psychodynamic Music Therapy

Even though the Norwegian music therapy tradition is firmly rooted in a humanistic and resource-oriented perspective, I considered it worthwhile to look into another perspective, psychodynamic music therapy, to have a broader understanding of how music therapy has been used with the target group of this study.

Hadley (2003) describes psychodynamic music therapy as exploring the human psyche using musical tools. The basic principles of this approach in music therapy involve using music to explore conscious and unconscious dynamics as well as the individual's internal world. There is a strong focus on the therapeutic relationship, especially the transference and countertransference dynamics between the client and the music therapist (Kim, 2016). Psychodynamic music therapy is based on useful constructs – like transference and countertransference – that provide a framework for the therapist to analyse and interpret behaviour. As Kohut states (1952, cited in Hadley, 2003, p.2): *"The therapeutic efficacy of musical activity at each level of functioning of the psyche depends upon the capacity of music to repeat an emotional conflict in a medium that is relatively free from conflict".* This fact supports why music can be an efficient medium for working psychodynamic-oriented with extreme emotional conflicts like trauma.

By musical activities, we refer to improvisation, songwriting and music listening, among others (Kim, 2016). Other basic assumptions of psychodynamic music therapy include that humans develop patterns of relating to the world based on past experiences from relationships with family members, and these relationship patterns are later used repeatedly. Also, the client and therapist bring their own relating patterns to the therapeutic relationship based on their pre-dispositions and life experiences (transference, countertransference, and defences) (Bruscia, 1998; Hadley, 2003). Transference can be defined as *"the reliving of a significant relationship from the past in the present"* (Hadley, 2003, p. 13). Through understanding and managing transference, the therapist better understands the client's problems and needs.

When working with traumatised patients, three roles are continually being played out in the therapeutic relationship: the victim, perpetrator, and caretaker (van der Kolk, 1987). The therapist needs to be aware of these shifting roles played by both therapist and client during therapy. Once the therapist understands the dynamics of these roles from a musical and verbal perspective, the client can start to feel more secure and in control and begin the healing process (van der Kolk, 1987).

Trauma leads to unintegrated traumatic memories that are difficult to express verbally. To regain control over yourself and process trauma, it is – according to van der Kolk (2014) – necessary to revisit the trauma, and confront what has happened to you, but only after feeling safe to avoid a possible re-traumatisation. Children who have suffered sexual abuse often use dissociation to escape from the horrific reality and separate it from conscious awareness, as if what happens to the body and self is not happening. Musical improvisation in music therapy

can help the client to bring hidden material to the conscious so it can be dealt with in a safe and supportive setting. As nicely explained by Amir (2004, p. 97), "*By encouraging the client to use music, both client and music therapist have the possibility of gaining access to parts of the client's unconscious world, where there may be found threatening and painful memories, but also possibilities of converting feelings of shame, anger and helplessness into a creative force that eventually brings power and healing."*

In her PhD dissertation, Hammel-Gormley (1995) explores how songs can serve as a powerful vehicle for people with histories of childhood sexual abuse, a vehicle for a diversity of processes such as accessing memories, confirming experiences, recognising feelings, disclosing oneself, building confidence, and making contact. Following the same line of work, Gitta Strehlow (2009) describes various ways in which music was used in her work with sexually abused children: Music as a way out of silence, as an arena for good, pleasant and safe experiences, as a way to mirror emotional experiences, as an arena to explore new relational experiences, as a way to clarify, preserve and modulate unbearable experiences.

2.3.2 Guided Imagery and Music (GIM)

Due to the scope of this thesis and the fact that GIM is a very specialised form of music-centred psychotherapy and receptive music therapy approach – not always used in music therapy– that requires specific training beyond general music therapy education, I will not go into detail about its description and use in trauma treatment but barely mention a few relevant literature sources. This method, developed by Helen Bonny in the 1970s, has been used to address various issues, including stress, anxiety, depression, trauma, and exploring unresolved conflicts (Hadley, 2003). GIM can be a powerful tool for self-exploration and contribute to accessing and processing emotions, memories, and insights that may be difficult to access through traditional talk therapy alone (Fuglestad, 2020). Because of that, GIM has been used and researched in trauma treatment. Some relevant publications within this field are Svein Fuglestad's (2020) *"I am not the same as when we met: Creating an identity beyond the victim of childhood trauma through Guided Imagery and Music"*, and Carola Maack's (2012) *"Outcomes and Processes of the Bonny Method of Guided Imagery and Music (GIM) and its Adaptations and Psychodynamic Imaginative Trauma Therapy (PITT) for Women with Complex PTSD".*

2.3.3 Resource-oriented Music Therapy

Working within a trauma wise care approach has many compatible elements with the core values of Norwegian music therapy and its resource-oriented perspective. This tradition focuses on user participation and collaboration, interpersonal relationships, mastering, and empowerment philosophy, among others (Brekke, 2019; Rolvsjord, 2010).

A recent music therapy study in Norwegian child welfare institutions (Krüger et al., 2018), showed how social workers considered music therapy a fruitful form of therapy for children and adolescents with a trauma history. Overall results convey those social workers experienced music therapy as an important and valuable therapy for young people in child welfare institutions. Data analysis showed four main themes in which music therapy was useful. (Krüger et al., 2018, p.6)

1. Can help establish a sense of safety and well-being
2. It provides the opportunity to establish relationships and experience mastery
3. It provides the ability to process complex emotions
4. Can contribute to continuity and stability over time and across situations

The study's main findings corresponded well with Bath's three pillars of trauma wise care (2015) since music therapy was seen as a potential means to promote safety, good relational experiences, and coping skills (Krüger et al., 2018). Music therapy's ability to provide a safe ground can help children and adolescents who have experienced trauma have the necessary basis for learning and developing. This ability can be crucial for children who have experienced trauma since the "learning brain" has been suppressed by the "survival brain" (Krüger et al., 2018; van der Kolk, 2014). As recent trauma research has shown, children who have been exposed to trauma tend to easily activate their alarm system and be faster overwhelmed by negative emotions, which hinders the learning process. In addition, they tend to have a narrower window of tolerance, as I have previously discussed (Braarud & Nordanger, 2017). The informants in Krüger (et al., 2018, p. 10) study explained*: "how music therapy could help expand the young people's window of tolerance, which is a goal for any trauma therapy as well"*. Music can give hope, self-confidence, and a sense of mastery and can increase the participants' ability to cope with stressful situations better in the future (Meyer DeMott et al., 2017).

A central name when discussing resource-oriented music therapy is the Norwegian music therapist Randi Rolvsjord (2007, 2008, 2010). She has been critical of sickness-oriented mental health care and has strongly defended a different view built on positive psychology and salutogenese (Antonovsky, 1996). Positive emotions and being present in the

here-and-now can counteract difficult and painful emotions (Roaldsnes, 2017; Rolvsjord, 2010). Rolvsjord´s work has been crucial in developing and promoting a resource-oriented approach within mental health care, as researched in her PhD *«Blackbirds singing Explorations of resource-oriented music therapy in mental health care"* (2007). Shortly summarised, Rolvsjord (2008) describes the fundamental aspects of resource-oriented music therapy as follows:

- Strengthening strong aspects, potential, and stimulating resources.
- The individual interaction with culture and society.
- Moving away from interventions and towards cooperation and collaboration.
- Seeing music as a health resource.

Looking closer at Rolvsjord's PhD (2007), we can see how some of her case studies within mental health care are about people who have experienced traumatic stress, such as abuse, during childhood. It is important to highlight that even though the resource-oriented perspective promotes positive feelings, that does not imply that the therapist ignores dealing with conflicts, problems, or other negative emotions. Well-informed resource-oriented music therapy aims to nurture resources and strengths and work with problems or negative emotions that may arise during the therapy process (Rolvsjord, 2007, 2010). However, to avoid the danger of re-traumatisation and to help the client cope better with the trauma, it is essential to foster safety and trust, emotional regulation, and control of the situation, as well as being aware of the strength and resources of the client (Rolvsjord, 2007). Songwriting and singing enabled the client in Rolvsjord´s case study to voice her traumas, connect with her emotions, and express and communicate experiences. Songs can intensify emotions, but at the same time, they can be a less threatening way of expressing and communicating. As stated by a client (Rolvsjord, 2007, p.167), *"It was safer to communicate things through music than through words"*.

3. METHOD

To answer the research questions, I have linked music therapy research towards new theories in the trauma field and existing research on music therapy and trauma. In the following chapter, I will provide a detailed description of the methodological procedures that have been carried out in this study to answer these research questions. As Brinkmann states (2013, p. 235), "*the reader must understand not only the description of analytical procedure but the intention or purpose of these choices*". In order to do so, I will first present the central research tradition used to understand and interpret the data. After that, the research design, the procedures of data collection and data analysis, and at last, ethical reflections.

3.1 Hermeneutical approach

This paper is based on the hermeneutical philosophical tradition, which I seek to understand and not just explain. Kvale and Brinkmann (2015) refer to hermeneutics as "the doctrine of the interpretation of texts" (p.73, own translation). Although the basis of the hermeneutical tradition was the interpretation of texts, this has been expanded to actions, spoken words and esthetic objects, in which we can include music therapeutical interactions, improvisations or spoken words in an interview (Johansson, 2016). Therefore, I have used both the text and examples from the interviews together with the theoretical framework and literature in my interpretations. The hermeneutical approach can be advantageous when it comes to understanding people, people's actions, and the results of those actions. This approach can be relevant for a research project that wants to understand different aspects of a phenomenon and apply several theoretical perspectives to provide diversity in the interpretation. Since I have collected my data from the perspectives of four different music therapists, I consider the hermeneutical approach relevant to my study. Hermeneutics claims that understanding a phenomenon does not necessarily exclude another understanding but increases the overall understanding (Johansson, 2016).

However, following the hermeneutical tradition, I have been aware of the critical role that I, as a researcher, have played in interpreting the text or data. Throughout the whole process of collecting, analysing, and reporting the data material, I have been conscious about my preconceptions, assumptions, and opinions on the subject and how this may influence the interpretation of the data (Thurén, 2009). Moreover, by doing so, I could see clearly the perspectives and interpretations that were not a part of my preconceptions (Johansson, 2016).

In the hermeneutical tradition, I actively participate in the understanding process. Thus the understanding and interpretation of the data material have been influenced by my background knowledge, theoretical orientations, and experience. Reflectivity during the process was crucial to be loyal and open with the data material and not let my positive expectations about the subject alter the outcome (Malterud, 2017).

The hermeneutical spiral refers to how the parts of a text can only be understood in relation to its totality and the other way around (Kvale & Brinkmann, 2015). Through a continuous movement between part and whole, one is constantly brought towards a more extensive and deeper understanding of both. The hermeneutical spiral has several layers but not a main core of the phenomenon. There are many possible interpretations, and the movements in the hermeneutic spiral, thus, in principle, never end. The hermeneutical process can be seen as a dialogue between the parts and the whole, the researcher and the text, and the preconceptions and understanding. (Johansson, 2016). Based on my hermeneutical approach, it was natural to identify my research within the qualitative method.

3.2 Qualitative research design

Qualitative methods are research strategies for describing, analysing and interpreting characteristics or qualities of the phenomena to be studied. They explore the qualities of a phenomenon in its natural context and are especially suitable for understanding and interpreting social phenomena. Qualitative research is particularly useful when seeking to understand human characteristics, experiences, thoughts, behaviour, interactions, and meaning in why people do what they do (Malterud, 2017). In this study, I intend to explore how music therapists work with individuals who have experienced violence and abuse, and if music therapy can promote health, a sense of safety, and self-regulation and how. The nature of all these matters are subjective experiences, and therefore I pursue to understand these phenomena from the music therapist's perspective by using qualitative interviews. Next, I will explain closely the method used to collect the data material.

3.3 Data collection

A qualitative interview aims to understand the world from the interviewee's perspective. It wants to bring to light the meaning of people's experiences and their experience of the world. (Kvale & Brinkmann, 2015). In interview studies, we use conversations with a purpose and exchanging opinions between two people as research (Ryen, 2002). I decided to use semi-

structured life interviews to explore the informants' meanings and experiences further. Semi-structured interviews provide flexibility to adjust the questions under the process, allowing the participants to guide the conversation and share their priorities. Due to the complexity of the research questions, I considered it relevant to have open-ended questions that could be modified if the conversation required it.

3.3.1 Interview Guide

As mentioned above, I used a semi-structured type of interview when designing my interview guide[3]. Therefore, I had some main questions and themes prepared and written in my interview guide, but not in a particular order. I changed and reformulated some of the questions during the interview and decided to skip some when they needed to be more relevant to the conversation. Since there was some time between the four interviews, I also adjusted the interview guide after each interview to collect as much relevant information for my research questions. Also, because one of the informants works with a specific method, I had to modify that interview to get a broader knowledge of the nuances of the method itself.

As mentioned by Malterud (2017), starting the interviews with more straightforward questions can be beneficial to let the informants warm up and get comfortable. After the first part of the introductory questions, I continued with some general questions that opened for sharing initial thoughts about my study topic. Next, I carried on with more specific questions connected to my research questions and their main themes. At last, some questions to end the interview, allowing the interviewees to add any information that had not been said (Ryen, 2002). I used an order of questions that felt natural for me, as well as being flexible to change the course of the interview when necessary and bring up interesting new themes that might come up.

3.3.2 Selection of Informants

When selecting the informants, I kept in mind if what I want to research, could be researched with the choice of informants (Ryen, 2002). To do so, it was essential to find music therapists that had experience working with individuals that have suffered violence and abuse. I wanted to have a varied selection that included music therapists with different backgrounds, methods, and approaches. I tried looking for variables relevant to my research questions and theories (Ryen, 2002). Since the target group of my study can be related to music therapy through

[3] See attachement 2: Interview Guide

different institutions and work fields, I first studied the different options to find music therapists with relevant experience for my study. This process was not easy as several music therapists may have worked with clients or patients with violence and abuse history only on particular occasions and not on a larger scale. Because of the limited number of informants due to the scoop of this study, I wanted to find information-rich participants, music therapists who could contribute to a great degree to answering my research questions (Ryen, 2002). Through my literature study, recommendations from music therapists, and exploring relevant institutions in connection to my target group, I ended up with a selection of four experienced music therapists. As soon as I got permission from NSD to conduct my interviews, I contacted the relevant informants. Due to practical reasons, two of the interviews were conducted digitally, and the other two in person, and the approximate duration of each interview was 45 minutes.

3.4 Data analysis

After conducting the interviews, I was left with a significant amount of data material. Individual interviews are often a time-consuming strategy that often leads to thorough work with transcription and analysis (Malterud, 2002). Because of that, I had to make decisions and be critical about the data material that was more useful and important in relation to the research questions I intend to answer. As Malterud (2017) points out, research is not only about developing knowledge but also organising it systematically. In the following part, I will explain how I transcribe and analyse the data material.

3.4.1 Transcriptions

I recorded my interviews using a portable Zoom recorder. The audio recording was played in the computer program VLC to easily reduce the speed of the audio for a better understanding of the conversation. This phase was challenging and time-consuming, partly due to the length of the interviews and other language-related difficulties. Three of the interviews were conducted in Norwegian and one in English. I have chosen to keep the original language in the transcriptions to maintain the nuances of the language, and I have used bokmål when transcribing the Norwegian interviews. Later on, I translated the categories and codes to English when doing the analysis. I have excluded sounds such as: “hmm” “aha” “emm” as well as repeated or uncompleted words.

Moreover, I have edited some sentences in order to keep the original meaning and give more clarity to the written transcription. To preserve the anonymity of the informants, I changed some words like the name of institutions or places, or other information that could help identify their identity. Kvale and Brinkman (2015) state that transcribing is a transformative process in which the data is changed from one form to another, from spoken to written form. I have been as precise as possible when transcribing the material, seeking to be faithful to the interviewees' words without losing the data's original meaning in the process.

3.4.2 Method for Analysis

I have used thematic analysis as the method to analyse the data material. "*Thematic analysis involves the searching across a data set to find repeated patterns of meaning"* (Braun & Clarke, 2006, s.86). It is also an accessible form of analysis for those who do not have much research experience. According to Braun & Clarke (2006), thematic analysis can be beneficial when looking for a method that gives flexibility and provides a rich and detailed data input. This type of data analysis is not strictly connected to any pre-existing theoretical framework and thus can be used within different theoretical frameworks (Braun & Clarke, 2006). This type of data analysis was especially relevant to my study as I wanted to be open to the analysis without a predetermined theoretical framework.

Throughout the whole analysis process, I have used an abductive approach. Abduction uses a combination of a data-driven (inductive) approach and a theory-driven (deductive) approach. This combination considers empirical and theoretical facts, keeping in mind the possible preconceptions the researcher may have (Malterud, 2017). I have been open to the themes that came up in the interviews, and thus respecting the empirical facts. I have been aware of my preconceptions and interests in answering the research questions, which go hand in hand with my hermeneutical approach. Braun & Clarke (2006) noted that researchers can not completely free themselves from their previous knowledge of the subject when analysing data material, and I have read a considerable amount of literature about music therapy and trauma. Therefore, to avoid bias, it has been essential to maintain a reflective position when sorting out the most relevant information from the participants, acknowledging that the data is not coded "*in an epistemological vacuum*" (Braun & Clarke, 2006, p. 84). Nevertheless, as Malterud (2017) explains, theories can be used as a premise or reference framework for our interpretations, contributing to further knowledge development.

Another decision to be made in the thematic analysis is about the level at which the themes are identified. I have based my analysis on the semantic level of the themes, which

refers to the explicit or surface meaning. The research is not looking for any other meaning beyond what has been said by the informants (Braun & Clarke, 2006). With that being said, the analytical process of the data material has developed from organising the content by its semantic meaning to interpreting the significance of the content and its implications within a broader context.

According to Malterud (2002), a step-by-step approach can prevent the researcher from being left with an unmanageable amount of data material. I have conducted my analysis following Braun & Clarke's (2006) six phases of thematic analysis. However, as analysis is not linear but more of a *recursive process* (Braun & Clarke, 2006, p. 86*)*, I have moved forth and back throughout the phases as needed. I will describe my process through the different phases in the following section.

I initially transcribed the data material in the first phase, *familiari*sing myself with the data. By transcribing the data myself, I got the chance to familiarise myself with the material more than if I had not done it. Later, I immersed myself in the data through active reading and re-reading the transcriptions while taking notes about my initial thoughts and ideas. This part of the process helped me remember the thoughts I had at the beginning when re-reading it later. After reading the transcriptions several times, I underlined what seemed more interesting concerning my research question.

In the second phase, *generating initial codes*, I started to code and identify relevant features for my research. This phase was done manually by using colour coding to group the different potential categories and patterns and by doing so, organise the data into meaningful groups (Braun & Clarke, 2006). The research questions and theoretical framework influenced the categories, but I was open for the new categories that arose.

Later, I worked systematically across the entire data material to code all the relevant data extracts. This part of the process was very demanding and required a a considerable amount of time.

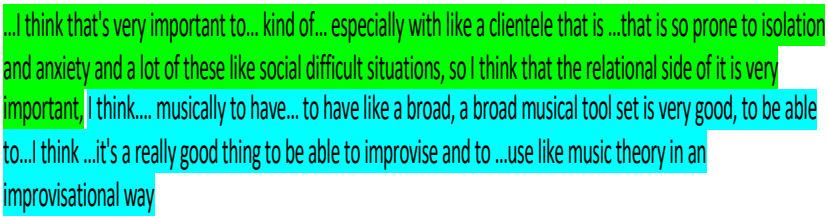

Figure 2: Example of the use of colour codes.

On the one hand, I tried to give equal attention to the entire data material, coding for as many potential patterns as possible (Braun & Clarke, 2006). On the other hand, due to this paper scoop and time limitations, I had to remind myself about my research questions when choosing the categories and sorting out the data material that was more relevant to my study.

The data extracts that did not fit into any existing categories were put into a separate category. Some data extracts belonged to more than one category, some to one category and others to none (Braun & Clarke, 2006).

After having coded all the data sets, I began to collate the codes that belonged to the same category together, both within each interview and, later, across the four interviews. To get a better overview of the data material and ensure that data extracts are collated together with each code (Braun & Clarke, 2006), I used a chart as the following example shows.

Data extract	Codes	Category
Jeg tror man må tenke på trygghet da som et sånn eksistensialistisk fenomen sant, altså hva er trygghet? og for barn sånn som bor på barnevernsinstitusjon hjemme sånn i første fasen av det oppholdet så er det veldig kaotisk, altså hvem er hvem? hvem kan du stole på? hvor kan jeg gå? Hva skjer med deg, ikke sant? Sånn at tryggheten her vil jo være å bygge inn noen strukturer i hverdagen som er fastere sant ...	Safety as an existentialist phenomenon Chaotic first phase Providing structure. Stability and predictability	Safety/ Sense of safety

Figure 3: Chart example collating codes.

In the third phase, *searching for themes,* I examined all the collated codes and organised them into potential themes and subthemes. In order to do so, it was crucial to have a clear overview of the similar categories and their respective codes across the different interviews. By analysing and comparing the codes across the interviews, I got a clearer idea about the overall themes they could form and their relevancy in a broader context. Based on my abductive approach, I moved forth and back between the empirical material and the theoretical framework of this study. I avoided merely using the questions of my interview guide as the identified themes, which Braun & Clarke (2006) point out as bad examples of thematic analysis. Visual representations, as conceptual maps, were helpful at this stage and gave me a better overview of the *relationships between codes, themes, and different levels of themes (*Braun & Clarke, 2006, p. 89).

Interview 1	Interview 2	Interview 3	Interview 4
Music for coming in contact with memories, traumas or difficulties. Help of the music to process it in different ways Get calm first to feel the heavy, difficult	Singing can anchor in the body More contact with themselves and their feelings Not actively working on traumas Use breaks	Antidote to what trauma does Potential to keep the person inside a window of tolerance Repetition of something that builds communication and regulation	Regulating as a musical frame Improvisation between reading and giving feedback Sensitive and clear Room for regulating needs clear frames

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Figure 4: Chart example with codes across the interviews.

I have oscillated between the fourth and fifth phases, *reviewing themes & defining and naming themes,* since both phases influenced each other in the process. After evaluating and refining the potential themes, five at first, I finally redefined the five main themes into four themes with subthemes. The fifth theme could be broken down into the other existing themes and thus avoid too much overlap. In addition, having subthemes contributed to give more structure to the larger and more complex themes (Braun & Clarke, 2006). When giving the definitive names to the themes, I kept in mind the overall story of the data as well as the particular aspects that each theme brings to the study.

The sixth phase, *producing the report,* consists of writing the final report where I present my findings and arguments concerning my research question. This phase will be further presented in the results and discussion chapters.

3.5. Ethical Considerations

There are several ethical considerations that I, as a researcher, have faced during the process of carrying out this research project. As Mohlin (2008) mentioned, ethical awareness and reflection must be present in all the phases of the research, including preparations, investigations and writing a report. Some of these can be of a general nature, and others more specific to the research questions and method (Mohlin, 2008). I will next present my reflections, decisions, and examples of the ethical aspects of this study, as well as explain my methodology critique.

At the start of the project, I sent an application to NSD (Norsk Senter for forskningsdata) where I informed them about my project and applied for permission to interview the informants. By doing so, I ensured that all the data and personal information was treated following the national ethical guidelines. I asked for guidance from my supervisor during the process to ensure that, and I got helpful feedback about the best way to store the data and maintain the informants' anonymity and confidentiality. When my application got approved by NSD[4]. I could contact the potential interview participants and send them the informed consent forms[5]. There, I provided written information about the purpose of my study and a clear description of how the personal information would be handled during and after the project's end. I underlined that participation in this study was voluntary, and they could at all times withdraw their participation with no further consequences. Because my informants are music therapists, they were familiarised with this part of the process. However, I reminded them before the interviews about their duty of confidentiality when disclosing information and examples about their clients, something that NSD pointed out to me.

The informed consent form states that the participants have the right to confidentiality. That means that they cannot be identified by the reports or citations, and identifiable data will not be revealed (Mohlin, 2008). I thus ensured that none the music therapists nor their clients could be tracked back. During the whole process, the data was handled in a way that preserved the informant's anonymity. This process was done by storing the data in an encrypted hard disk and creating a connection key (*koblingsnøkkel*) that was kept separated from the data material. Some ethical dilemmas arose during the process. Norway has a relatively small music therapy network, and the target group of my study is also quite specific. In addition, one of the informants uses a pretty specific approach, GIM therapy, which involves some ethical considerations in the anonymisation process. Because of that, and to avoid some of the music therapists could be identified, I altered some details such as gender, nationality, workplace, or institution's name.

3.5.1 Methodological Critique

One of the main critiques on this study revolves around my choice of interviewing music therapists. On the one hand, this allowed me to understand better the music therapist's

[4] See attachement 1: NSD approval.
[5] See attachement 3: Informed consent forms.

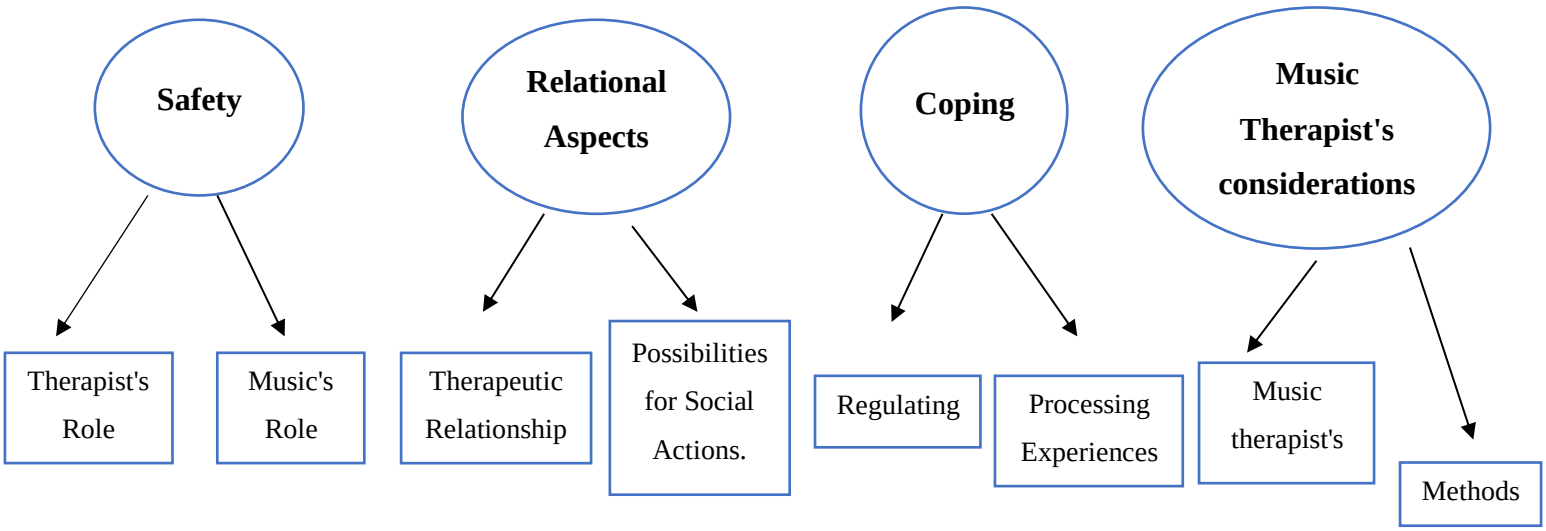
perspective and experiences when working with individuals who have experienced violence and abuse. There needs to be more research that examines how music therapists work with this clientele within a Norwegian society context. This has been particularly useful in getting a deeper insight into the music therapeutical approaches, methods, and skills that can be beneficial in that type of work, which will be further explained in the results chapter. On the other hand, it is impossible to know exactly how others have experienced a phenomenon, in this case, music therapy, because *"på seg selv kjenner man ingen andre"* (Ihlen & Ihlen 2003, cited in Trondalen, 2008, p.34*).* In my research questions, I try to answer if music therapy can promote health, and a sense of safety, and help with self-regulation for individuals who have experienced violence and abuse. With my choice of method and informants, I can only answer those questions based on the perceptions and experiences that the music therapists have had with their clients. The informants have occasionally answered in my interviews that it is difficult to answer on behalf of their clients. That is something I have been aware of during the whole process, and therefore I have made use of the hermeneutical circle in going back and forth between how I interpret the music therapists' experiences based on how the music therapists previously interpreted their clients' experiences.

Even though I have selected a varied and information-rich choice of informants, I have kept in mind that interview results cannot be generalised with as few as four interviews. In qualitative interviews, the social relationship between the interviewer and the interviewee influences the information (Kvale & Brinkmann, 2015). Since I did not know the informants in advance, I considered it relevant as part of my researcher's role to create a comfortable atmosphere where the interviewees could talk freely and safely. The structure flexibility of semi-structured interviews allowed the informants to express their experiences freely. I also was aware of my preconceptions about the subject and hence tried to avoid leading questions during the interview process. All in all, I looked for a balance between collecting interesting information and respecting the interviewee's integrity (Kvale & Brinkmann, 2015).

By explaining my methodological procedures with transparency and clarity and using active ethical reflexivity about the study and its possible weaknesses, I intend to prove the credibility and validity of the following results.

4. RESULTS

This chapter will present this study's main findings and outcomes. The results are based on the analysis of the data collected from the interviews, and my research objectives and theoretical framework guide the interpretation of the findings. I will describe the four main categories I ended up with from analysing the empirical data to address my research questions and reflect shortly on each category. These categories will be presented in the following order: Safety, Relational Aspects, Coping and Music Therapist's Considerations. It is important to note that all these categories are largely interrelated and will therefore share some common elements. The conceptual map below shows how the themes and subthemes from the data material have been divided and organised.



I will present each category and explain their reasoning by providing relevant citations from the interviews, always contextualising and interpreting them (Svend & Brinkmann, 2013). I have chosen to present the data material thematically across the four interviews I have carried out due to several topics being discussed in all the interviews. To anonymise the informants, I will refer them as *Andrea, Tom, Peter,* and *George* and to me as "R" for researcher.

4.1 Safety

The first category, safety, has been very present across all the interviews, and it has been considered a prerequisite to work further with relations or coping. Therefore, it will be presented first. The two subthemes that appeared more relevant in this category were related to the therapist's role and music's role in providing safety and will be presented in that order.

4.1.1 Therapist's Role in Providing Safety.

Andrea states how important it is to feel safe in life and how that should come first. Also, she moves specifically to safety in the therapy room and feeling safe with the music therapist and explains:

> *De klientene har jo kjent seg trygge på meg om jeg har hatt en relasjon, da er de sikre på at jeg gjør det jeg gjør for å hjelpe, jeg vil bare alles beste. At de tingene der er veldig tydelig etablert da. Fordi da tør de å gå inn i egne prosesser, gå inn i å undersøke hva som finnes inne her av gamle traumer og vanskelige ting.*

It seems crucial for the therapy process that the client feels safe with the therapist. It cannot be taken for granted, and I am curious to know more about how music therapists can promote safety for their clients. When asking Peter about how the music therapist can facilitate safety in the therapy room, he highlights the central role of experiencing safety and safe relationships repeatedly, and he answers:

> *So, I think that starts with the relationship or having that therapeutic relationship that kind of… that well, that starts off with the seed of safety, which will grow in the experience of coming back and being able to be honest and getting acknowledgement for what you are feeling, what you are experiencing and why you are experiencing it.*

Tom talks about how safety is also about the music therapist daring to go into the unknown first and showing that to the clients.

> *Også tror jeg at trygghet også handler mye om å sette et eksempel som musikkterapeut, at man tør å gå litt foran, at man ikke selv er anspent eller stresset. [...] at man tør å by på seg selv da og tør å være den første som hoppe litt ut i det ukjente.*

Following that, Andrea – who mainly uses GIM [6] method in therapy– shows her concern about the therapist exposing herself to her therapy process and emphasises the importance of that as a part of GIM training.

> *[...] vi som skal jobbe som terapeuter må våge eller ville utsette oss selv for egen terapi, og for å bli troverdig, og for at det skal være sånn og ekte relasjon, at vi også har vært gjennom den terapeutiske prosessen.*

When talking with George about providing safety as a therapist – in the context of working with children and youths – he is clear about the subjectivity of the individual's experience of safety as a phenomenon. However, he is certain about how the music therapist should be a safe creator and not contribute to more chaos in the life of the clients. In order to do that, he emphasises giving structure, stability and predictability in a quite certainly chaotic every day.

> *[...]Denne voksne personen her kommer jeg til å. … eller jeg kan stole på fordi at jeg treffer han igjen, og jeg vet hvordan han eller hun oppfører seg, og dette musikkrommet kan jeg besøke og det vet jeg er der for meg uke etter uke sant, at man liksom lager en form for struktur i en kaotisk tilværelse tenker jeg er veldig viktig for en trygghetsskapende...*

In addition to clarity and avoiding unclear communication as a therapist.

> *Jeg tror veldig på tydelighet, jeg tror barn som opplever voksne som ikke er tydelig, blir veldig usikre sant, at hvis du ikke er helt supertydelig på det vanlige og hvorfor du gjør det du gjør, og hva du står for, så kan barn bli usikre.*

Other elements George considers safety-creators are being activity-oriented and being careful with asking too direct questions about the client's upbringing or problems.

> […] *Jeg tenker at det er lurt å være litt sånn aktivitetsorientert da, for det er ikke nødvendig ... altså denne trygghetsskapningen er ikke nødvendigvis at du går i gang*

[6] See chapter 2.3.2 on GIM method

med å spørre veldig sånn direkte og får de til å beskrive oppveksten sin, eller liksom har satt ord på problemene sine, det kan være litt sånn invaderende.

Tom mentions the importance of being sensitive as a therapist and constantly checking how the client feels during musical activities, always prioritising that the clients feel safe over the music or the musical activity.

Og på en måte hele tiden setter nesten tryggheten først, så hvis det er et behov som dukker opp. Hvis det er en person i gruppa som viser at her var det mye følelser eller et eller annet sånn, så er det det viktigste. [...] da stopper jeg eller tar en pause i gruppa.

Regarding being sensitive with the clients and perceiving how safe they might feel, George points out reading their body language and checking the potential safety development.

[...] Når du liksom leser kroppsspråket til barna da sant, så kommer de gjerne inn første gangen med det ser vi ned i gulvet og sånt og så holder de armene sine litt sånn bak ryggen ... og de er ikke helt tilstede sant, [...] Og så når det går en stund, når du får dette til å fungere, så kom neste gang de kommer, så kommer de mer sånn rett inn i rommet her, ikke sant, og altså du kan jobbe litt sånn utifra sånn kroppsspråk.

4.1.2 Music's Role in Providing Safety.

If we move now to music in connection to safety, Andrea talks about the fundamental role of music and its necessary and supportive function for providing safety. In the context of GIM therapy and the processes that it involves, Andrea mentions:

Så det er jo liksom, jeg hadde sagt så mange ganger at jeg hadde aldri turt å drive med (GIM terapi?) hvis jeg ikke hadde hatt musikken, sant.

Moreover, she goes deeper into the subject by explaining the central role of music as a facilitator within the triangle of therapist-client-music.

Du har musikken som en underliggende både fasilitator, underliggende, den støtter og holder og bærer, er liksom den som og, som viser mange fasetter. [...] og på en måte og blir en sånn trygg underliggende støtte, når de skal gå inn og bearbeide og se på det som har vært vanskelig.

Nevertheless, she is clear about the complexity and the individual experience of music's role and describes its potential duality concerning safety/unsafety.

For noen så blir musikken det som ligger under og støtte og holde og bærer. Mens i andre settinger så blir musikk det som utløser, ikke sant.

Andrea also explains how she usually is very careful at the beginning stage of GIM sessions not to use music that might be too overwhelming since the clients already have challenging and possibly overwhelming emotions.

Når det er så mye ... så mye stort, sterkt, krevende som er der inne, og så kommer musikk som liksom enda større som de som skal [...] Så min erfaring er egentlig å gå helt motsatt vei. [...] Altså man trenger ikke å bli utfordret av musikken i tillegg når det er så mye annet inne dem som er utfordrende.

Tom talks about being careful with the content of songs' lyrics since they can have a powerful meaning and potentially trigger bad experiences and shares an example of how he handled a delicate situation.

Men da var det en som sa: «det her kan vi jo ikke synge ... jeg kan ikke synge om mamma ... mamma er overgriper». Men da var vi kommet på et punkt i gruppa hvor det var greit å si og greit å snakke om og fortsette å synge låta likevel. Det synes jeg var en veldig fin ting, og at det vi anerkjenner at dette her er kanskje litt på kanten, men går det an å tenke at det bare er én sang likevel?... at det ikke trenger å handle om traumene da.

In relation to lyrics and the powerful messages they can convey, Peter shares the story of a strong song written by one client in which the client's abuse history was expressed. Playing

that song for others who had also suffered abuse could be too overwhelming for some of them.

> *[…] when she came to play it, we played it a little bit, but it was too much for some of the users, so we had to stop. If we are going to play it again nowadays it is only if we are like a small group and everybody like complies and it can be through the texts first, the lyrics and stuff.*

If we bear in mind what George has previously said about how structure can be a safe-creating element, we can see his opinion about music when I asked him about the role of music in his work.

> *[…] sånn som det blir i et sånt sosiokulturelle perspektiv så kan du si at musikken blir en sånn strukturerende ressurs.*

In this section, we have seen how music therapists and music play an essential role in providing safety to the client. Later in the discussion chapter[7], I will discuss further other topics, such as unsafety in the therapy room, and the client's role in experiencing safety and emotional regulation. All the informants agreed on how safety comes first and how essential it is for the client to feel safe with the therapist to establish a relationship and go into the therapeutic process. In addition, repetition is considered crucial for the client's experience of safety, and that repetition of a safe therapeutical relationship can allow growth and development. The therapist needs to be sensitive, careful, and aware of the client's body language concerning safety. Safety is also perceived in the form of structure and predictability, especially for those with a chaotic every day, and music can be thus used as a structuring resource. The music itself is regarded as an underlying facilitator and the necessary support, with a duality of roles as the one that holds and contains, but also potentially the one that triggers.

4.2 Relational Aspects

In the next section, I will present the relational aspects that occur in the music therapy room. Due to the informant's variety in working both individually and in groups, aspects regarding

[7] See chapter 5.1 & 5.3

the relationship with the music therapist as well as the relationships between group members, will be emphasised. Therefore, the findings of this section will be divided into two groups: Therapeutic relationship and Possibilities for Social Actions. The latter is based on Even Ruud's (1990) definition of music therapy as using music to give people new possibilities for action, and I link it specifically to the social arena.

4.2.1 Therapeutic Relationship

As Andrea mentions, the therapeutic relationship is the most essential part of the therapeutic process, something that goes across the different therapeutic approaches and forms.

> *[...] som all forskning viser at det er jo kanskje primært, det alle viktigste er forholdet til terapeuten, altså det relasjonelle forholdet til terapeuten, og kommer over alle ulike terapiformer med det da. Ut fra det som klienten eller brukeren meldt tilbake at det som faktisk ... eller har vært det viktigste i prosessen, ikke sant.*

Furthermore, she continues explaining how crucial it is for the client to trust the therapist.

> *Det handler om, selvsagt, om at klienten må ha tillit til meg. Det kommer og det relasjonelle inn, ikke sant. Som på en måte er før musikk.*

Peter explains how he can often end up talking with his clients more than making music and highlights the central role of the relational side.

> *[…] I think that is very important to kind of… especially with a clientele that is so prone to isolation and anxiety and a lot of these like social difficult situations, so I think that the relational side of it is very important.*

Individuals who have experienced violence and abuse have difficulties establishing relationships and trusting others. George emphasises the importance of being aware of it and how music work can be a way of doing that.

> *[...] hvis vi snakker veldig generelt da så er jo den målgruppen vi snakker om her, målgruppe der nettopp dette med relasjoner til andre mennesker er vanskelig da og*

det å tørre å knyte bånd til andre og kjenne på trygghet og tillit, det er akkurat der det er vanskelig for de [...]og musikkarbeidet blir en måte å gjøre akkurat det da.

When establishing a relationship, music is of tremendous help. In the Norwegian child welfare system context, George describes how music can be a shared interest and a common project to work with.

[...] det er det som gjør at man har noe å snakke om, det som gjør at man kan dele en interesse, ikke sant. Det at man kan ha det gøy sammen, men at barnet kan oppleve voksne som viser følelser og liksom ordentlig engasjerer i noe [...] det er det musikken bidrar med, ikke sant, at du har en ... rett og slett et felles prosjekt å jobbe med.

Once safety and contact are established with the therapist, the clients often open up and show a big need for conversation, according to George.

[...] og så viser det seg ofte at de har egentlig veldig mye på hjertet og sånt, de har behov for det .... som en psykolog kalt det «den endeløse samtalen», at de har lyst til å snakke ut og inn og alt mulig, og de har jo behov for sant, og det er akkurat det de mangler.

4.2.2 Possibilities for Social Actions

When I talk with Tom about the group dynamics between the clients in the music group, he emphasises the interpersonal relationships between the clients and their supportive attitude toward each other despite their vulnerabilities. Moreover, they also took care of each other, and Tom tried to foster that, giving them space to do so.

[...] men det var et veldig som sterkt miljø der mellom, og de fant ... var flinke til å gi støtte til hverandre. [...] Så det jeg gjorde mye var det egentlig bare å gi rom til at de kunne støtte hverandre, fordi jeg synes at det var egentlig noe av det fineste med gruppa, at de tok vare på hverandre.

Tom explains how the group members he was working with knew each other from before and how the relationships and atmosphere of the group showed it, something that promoted safety and participation.

Så på en annen måte klarte vi å bruke hverandre litt, tror jeg, til å skape litt trygt rom for å delta i en gruppe.

When discussing the role of music, Tom wants to focus on what music can lead to. He describes how he perceived the social effects of making music together or musicking[8].

[...] Hvorfor er det lettere å snakke sammen etter at man har sunget sammen. Det synes jeg er et eksempel på noe sånn en sosial effekt som kommer av at man har sunget eller spilt sammen som jeg synes er vel så interessant ... for det er bare at ... ja, det smører på en måte litt den gruppen da, det å være sammen i musikken da.

[...] Det at man jobber med å bruke musikken skaper kanskje noen andre muligheter i en gruppe, altså andre muligheter å være sammen på, og da for eksempel det å le sammen, det å leke sammen, alle de tingene der er jo ting man lettere får tilgang på i musikken, i hvert fall etter min erfaring.

Tom emphasises having breaks and mentions how the atmosphere positively changed during the breaks.

Jeg synes det å ha en gruppe først, og så har jeg en god pause, og så fortsetter etter pausen, da var det et eller annet veldig spennende der, fordi i disse pausene så fløt praten så lett, og det var så god stemning.

Peter has similar thoughts about musicking together and how that serves as a social and musical common ground.

[…] but there is something about coming to a place where you are together with ten other people that have experienced like massive trauma, and coming and feeling like we are all here for the same reason, but we are actually… but we are here to make music, and we are here to experience this social and musical thing.

[8] Christopher Small refers to the term "musicking" in his book Musicking (1998) and defines it as a verb that encompasses all music-related activities from composing to performing to listening music to dancing.

In this section, the informants have shared their views on the essential role of the therapeutic relationship in establishing safety and contact with the client. As George describes, people with a trauma history struggle particularly with forming bonds with or trusting others. Music can be a common project to work on relationships and trust and promote the client's openness to conversation. Peter mentions that musicking provides a common social ground between the group members beyond their past traumatic experiences. Tom explains how trusting and caring relationships can also happen between the group members and how the music therapist must handle that. Tom emphasises social effects – such as talking to each other easily– that arose after making music together and the way it influences the group atmosphere also in the breaks.

4.3 Coping

In the following section, I will present the findings regarding the clients' coping experiences. Coping here is understood in the form of both regulating and processing experiences and emotions. These two subthemes have been very present in the informants' interviews and will be presented in that order. Regulation refers to self-regulation and co-regulation, meaning that the client's regulation is happening with the external help of others.
By processing experiences, I mean processing traumatic experiences and other emotional experiences not necessarily connected with trauma.

4.3.1 Regulating

When talking with Andrea about handling situations where a GIM session might eventually get too overwhelming for the client, she gives a clear example of co-regulation between the therapist and the client.

> *[…] hovedregel eller intensjon er jo at man ikke kommer dit der det blir for sterkt, at det blir akkurat passe utfordrende sterkt, og hvis det skulle skje at det blir for overveldende på en måte så er det flere veier å gå. En mate er å guide, veilede […] altså hjelper klienten å finne måten å allikevel manøvrere i det som er overveldende. […] og det er jo et helt klart mål å hjelpe klienten til å nettopp kunne regulere seg selv i dette.*

Andrea continues talking about helping clients to regulate themselves and tells a specific example from her GIM sessions with a client to illustrate that. Andrea helps the client by stepping herself into the client´s imagery –where the client has "met" his abuser- and protects the client by stopping and sending the abuser away from the client´s imagery.

> […] *han møtte igjen overgriperen i en sesjon. Så ba ham om hjelp… hjelp meg, hjelp meg...Da gikk jeg faktisk inn da jeg hørte om følelsene sine og kicked inn på en mate, inn i hans bildet nå og sa: "stop", altså til overgriperen. "Du har ikke lov til å legge din hånd på ham, du har ingenting her å gjøre, gå ut". […] for klienten var veldig viktig fordi at han hadde prøvd å be om hjelp i alle år, ikke sant. […] Ingen trodde på ham eller ville høre på ham når han prøvde å gi beskjed, så jeg hørte på ham og hjalp ham, og neste gang som det var en sesjon etterpå eller der igjen, når han møtte igjen overgriperen da, så klarte ham å sette grenser selv.*

Andrea uses a door metaphor that represents the difficulties or traumas and explains how the client regulates himself in processing those difficult emotions. It is up to the client how far they will go if they want to open the door, take a quick look inside, or not go inside that door.

> *Altså hvor dypt man går, hvor langt man går, når man gjøre det er helt opp til… opp til klienten.*

Tom and I talk about self-regulation, and he shares his opinion about how self-regulation involves more than the self.

> *[…] selvregulering er jo ikke bare noe du kan gjøre selv nødvendigvis selv om det heter selvregulering, du må av og til også få anledning til å gjøre det. Og derfor i den gruppa så var det viktig for meg å si at man kunne ta pauser når man ville. […] Så det vil absolutt si at det er en form for selvregulering, at man selv forholder seg til hvor mye man ønsker å ta del da i en gruppe, og hvor mye...eller når blir det for mye da.*

Peter shares a similar opinion about helping the clients with regulation and taking breaks.

[…] a lot of the clients they need help with regulation when they are in the music therapy group, and they are going to need to take a break, and like to go out and talk, and land, and like help getting back into the window of tolerance.

Tom continues talking about regulating in the group he was leading and mentions that it is difficult to answer on behalf of his clients since they know best about their regulating experiences. He emphasises how music plays a fundamental role in the regulating process.

[…] det at i det hele tatt folk ble stående kanskje i det vanskelige av og til, å fortsette å synge, får i hvert fall meg til å tenke at de finner måter å takle det på ,og kanskje da at musikken hjelper med å flytte fokuset over på noe annet eller... at det finnes noe selvregulering der og.

Tom mentions how the group constantly worked on regulating without necessarily talking directly about doing it and how music can facilitate that.

[…] den gruppa individuelt og som gruppa måtte finne måter å regulere samspillet, at man orker å stå i det. Men da vil jeg kanskje si at musikken gjorde at vi kunne jobbe med det litt indirekte da, musikken gjør at man kunne stå i det lengre ofte tror jeg.

Peter explains how music is regulatory in itself because it activates all the brain parts and involves using the body, thus doing the opposite of what trauma does.

[...] all five parts, major parts of the brain need to be in activation to be active in music, and so that in itself is something that builds to regulation, when the brain parts are in communication with each other because it is basically the antidote to what trauma does. […]it (music) can keep you in this window of tolerance and as you are doing it, your brain is building this communication and you are also being physical, you are using your body, extremely important thing. […] the more we can use our body and experience contact between the body parts that is exactly what you need to strengthen your brain, to create these regulatory pathways.

4.3.2 Processing Experiences

When I talk with Peter about processing trauma in the music therapy room, he mentions that the clients are not necessarily there to talk about their traumas; they are there for the music.

> *You are not there to talk about trauma. You are not there to talk about difficulties or to hear about other people's problems that are going to trigger you. You are there for the music.*

Tom has a similar view about not explicitly focusing on processing traumas but on the music and shares how the clients experienced that.

> *[...] den gruppa hadde jo ikke egentlig noe fokus på verken traumer eller overgrep eller vold. Den var på en måte bare noe helt annet. Og det var jo det deltagerne satt og setter mer pris på ...at de jobber så mye med seg selv ellers. [...] der var det bare på en måte musikken som var i fokus.* […]*Jeg gikk ikke inn der med tanke på at at vi skulle bearbeide traumer sammen eller sånt, men hvis det var et biprodukt av at de var med på gruppa det vet jeg ikke.*

Furthermore, he mentions how being together in the difficulties might make it easier for the clients.

> *Kanskje det gjorde det lettere for de som var med å forholde seg til de egne traumer hvert fall kanskje i et fellesskap da. Det vil jeg tro … kanskje, at den åpenheten som de gruppene viste hverandre gjorde at det hvert fall var lettere å stå i det vanskelig sammen da.*

At the same time, the clients can indirectly work on their traumas through music. Peter shares stories of a few clients who wrote songs about their abuse.

> *I think to be able to talk about and kind of own what happened to you and to be able to put it into a song and deliver it and try and help other people by writing a song and delivering that song on a stage about … there are so many elements of health*.

Peter mentions that daring to share a song about the traumas experienced comes with the safety, relationship, and repeated regulation experiences that clients can experience coming to music therapy.

> *[…] getting to a place where you can just express and talk about what has happened and just kind of like leave it like that, this is my song, and this is what it is about, and experience in that mastering.*

Andrea tells the story of a client who "met" the people who had hurt her and heard them apologising in a GIM session and describes how important that experience was for the client.

> *[...] de hadde jo aldri sagt det til henne sånn i real life, ikke sant. Så, men det skjedde i musikkterapien, i sesjoner. Det ble veldig, veldig viktig for henne.*

Andrea explains how important it is to combine the cognitive and emotional with the bodily reactions in processing trauma.

> *[…] traumer og erfaring sitter i kroppen. Vi må finne en form å bli forandret, transformert eller altså å bli bearbeidet, ikke sant. At man har med seg både minner og det kognitive sammen med de kroppslige reaksjonene.*

In this section, the informants have shared their views on their client's regulation and how this not only happens within the self but with the help of the therapist or other group members (co-regulation). Thus, the therapist can help the clients regulate themselves, and taking breaks is very helpful. Music can serve as a facilitator that allows the clients to stay longer in the difficulties. Music activities involve and connect all the brain parts and the body, which is the opposite of what trauma does. Therefore, it is necessary to combine the cognitive, emotional, and memories with the bodily reactions to process trauma, a combination that happens during music activities, according to the informants. This topic will be discussed further in the discussion chapter. Many informants agreed on not focusing on the traumas but on the music, something the clients seemed to appreciate. However, trauma-related experiences were sometimes processed through music and songwriting. Experiences

where the clients shared their traumatic past, were only possible after the safety, relationship, and repetition of regulation were firmly established.

4.4. Music Therapist's Considerations

In the next section, I will present the findings concerning the informants' considerations as music therapists who work with people who have experienced violence and abuse. These findings intend to illuminate the most relevant aspects of the music therapist's way of working with this population. Considerations are divided into two subthemes: Methods which refer to the music therapeutic approaches and techniques, and music therapist's competences which involve the music therapist's professional and personal skills, working experience, and knowledge.

4.4.1 Music Therapist's Competences

Working as a music therapist with this study's target group can be challenging. George emphasises how crucial it is to work in a team, search for help when needed, and take care of oneself to avoid burnout.

> *[...] det er veldig viktig at man jobber med dette i et tverrfaglig team, med andre yrkesutøvere* […] *noe av dette her handler jo om egenomsorg, og det å ta vare på seg selv, fordi at man kan bli ganske utbrent og tomt da, sånn her er det ikke bra å stå i sånt alene, så det å bruke andre å være i team, det har jeg alltid sagt er veldig viktig.*

George highlights the importance of tolerating and containing whatever might come up in the therapy room.

> *[…] at du skal tåle ganske mye... og å hjelpe til med at andre skal regulere seg sånn, så du må tåle gråt, du må tåle raseri, du må tåle forferdelige historier […] å romme barnets følelser sant, eller contain, at du tåler det, det er vanskelig, du kjenner at det er skikkelig vanskelig men du tåler det.*

Peter has a very similar opinion and states that the music therapist must:

[…] being able to contain and acknowledge difficult themes that can come up, and to be able to acknowledge them and to kind of move on and strengthen the process…

George explains how the therapist must be calm, clear, warm, sensible, reflective, understanding, and self-aware.

[…] og også være i stand til å forstå eget indre kaos da, dette med barn som har opplevd traumer. Så jeg tror det det er mye der altså at man ønsker å ha en selvinnsikt og selvrefleksjon

Tom underlines essential music therapeutic aspects such as flexibility, collaboration, and openness, always giving room for improvisation.

[…] *og bare som hele tilnærming til gruppa handlet for meg veldig mye om improvisasjon. [...] så prøvde jeg å forsterke det … ta taket i det som oppsto naturlig litt i gruppa da.*

4.4.2 Methods

Tom explains that the group members had a particular interest in singing and that some members had read theories about how singing helps anchor the body and get more in touch with yourself and your feelings. He also names some members' difficulties with breathing exercises.

Og mange opplevde sånn at akkurat det å synge i gruppe gjorde at de på en eller annen måte fikk kontakt med den siden av seg selv da. Så jeg tror at absolutt at sang og generelt alt som har med litt sånn indirekte kanskje å ta kontroll på pust, fordi som jeg nevnte så var det enkelte som opplevde at det var vanskelig med pust […]men når man først begynner å synge så tenke man kanskje ikke så mye over at man puster.

Peter emphasises improvisation as a method, adapting to what is needed in the moment and having a broad musical toolkit that allows you to play with anybody. He also talks about balance and mentions:

[…] having focus on like finding the balance between the social part and the challenges, obstacles, and finding like this social cohesiveness through for example things like humor…

Peter shares his view on how using songwriting is very individual and describes this method's potential benefits.

t's very individual but yes, I write a lot of songs myself, and I use it a lot, […] it's a wonderful way of connecting and helping patients and clients discover this wonderful skill set that is available to everybody basically, and something you can build your identity on later in life.

Andrea explains how GIM therapy combines cognitive, memories, feelings, and bodily reactions, thus being holistic.

[...] det er så veldig fint å få mulighet å jobbe med den metoden som kombinerer alt ... alt dette er på en måte her for hele menneske, potensielt sett for hele menneske.

Moreover, the clients often have some intuition about wanting to use that method before contacting the GIM therapist.

[...] de tenker intuitiv at dette kan være en måte for meg å jobbe på. Sånn at de går å oppsøke meg og ikke oppsøke en psykolog eller en altså noen som bare jobber kognitivt, men at de gjerne vil jobbe med et mer helhetlig uttrykk da.

In this section, the informants have shared their views on relevant music therapists´ competences, such as working on an interdisciplinary team, asking for help when needed, and ensuring self-care. The music therapist must contain all that can come up in the therapy room, which might be challenging. Therefore, the therapist needs to have good self-awareness and self-reflection abilities. The informants use approaches and methods individually depending on the client or situation. Tom highlighted his group members´ preferences for singing as a method and their sometimes-difficult relationship with breathing. Andrea describes GIM as a holistic approach that combines cognitive, emotions, memories, and bodily reactions. The

importance of combining all those aspects when working with individuals who have experienced trauma will be discussed further in the next chapter[9].

[9] See chapter 5.3 & 5.4

5. DISCUSSION

In this chapter, I will discuss the study's findings in the context of the theories and literature presented in the theory chapter and theories that came forth from the data material when necessary. The discussion is based on the four central themes the data analysis led to: Safety, Relational Aspects, Coping, and Music Therapist's Considerations. I will systematically go through all four categories while relating them to existing theories. In this chapter, I will also draw the reflections presented in the results section. As my research question states, the intention here is to see if music therapy can promote health for those who have experienced violence and abuse. Finally, I will conclude by seeing this study in light of existing literature, the study's implications, and future directions that acknowledge the need for further research on this topic.

5.1 Safety

I was already interested in the topic of safety when formulating my research questions. The interest arose after reading recent trauma theories that consider safety a core developmental need (Bath & Seita, 2018) and a crucial prerequisite for normal development and establishing a therapeutic relationship (Bath, 2015; Maslow, 1954). Therefore, one of my research sub-questions intends to find out more about music therapy's potential ability to promote a sense of safety for those who have experienced violence and abuse. In addition, looking closer to promoting a sense of safety seemed relevant to answer the overall research question about promoting health. According to Bath's three pillars [10](2015), safety –the first pillar– is crucial when creating an environment that promotes healing and resilience for individuals who have experienced trauma. Safety is decisive during the first life phase, but it is also a prerequisite for optimal development later in life. Without safety and stable caregiving, the child cannot reduce his alarm reaction, and the survival brain will win over the learning brain (Braarud & Nordanger, 2017). In the same way, the clients cannot learn new skills or explore their resources without first feeling safe in the music therapy room (Rolvsjord, 2007).

Even though I had my theory-based preconceptions on the essential role of safety, all the informants clearly expressed the same vision. The informants spoke honestly about how difficult it is to speak on their clients' behalf regarding safety, when it was felt and why.

[10] See chapter 2.2.1

George explained safety as an existentialist phenomenon perceived differently by each individual and hence difficult to describe. Therefore, the results and discussion are seen through the lenses of music therapists and will focus on a larger extent on what music therapists can do to promote safety rather than the safety experiences of clients. The informants always put safety first, correlating with Bath's three pillars[11] (2015).

Andrea mentioned how safety must be well established before clients dare to go into their processes and investigate difficulties and older traumas. As van der Kolk (2014) claims, you need to revisit the trauma and confront what has happened to you sooner or later, but only after feeling safe. In the context of GIM, Andrea described how her clients trusted her after establishing a therapeutic relationship and understood that she does what she does to help them. As Peter mentioned, repeatedly experiencing a safe therapeutic relationship can foster a sense of safety. It is the experience of coming back to the music therapy room and being able to be honest and accepted for what you are experiencing that gives a solid ground for the clients to develop, learn, and challenge one's borders (Krüger et al., 2018; Smith, 2017).

George talked about promoting safety by providing stability and predictability, especially in the context of child welfare systems. The music therapy room and the music therapist can offer a stable place where the child knows he/she can come week after week (Kleive, 2009). Experiencing stability over time in music therapy can have future benefits in helping the child or adolescent to master a school setting or a job situation (Krüger et al., 2018). Safety can also be seen as getting help or guidance when experiences or emotions are too overwhelming.

Van der Kolk (2014) states that first in the agenda of trauma treatment is to find ways to cope with overwhelming emotions associated with the past. Andrea shared an example of how she helped a client to handle an overwhelming situation in a GIM session by being there and giving regulation support to the client. According to recent trauma theories[12], individuals who have experienced developmental trauma might not have gotten the regulatory support needed early in life. Therefore, they have challenges regulating their emotions and exploring the limits of their tolerance window (Braarud & Nordanger, 2017). The informants shared how they, as music therapists, are present for the client, prepared to contain whatever the client might express. They are there in order to help the client manage challenging situations

[11] See chapter 2.2.1
[12] See chapter 2.2.2

on their own. As Braarud & Nordanger (2017) claim, trusting that the caregiver can help the child manage overwhelming situations is crucial for developing safe attachments. The informants described how music therapy could be a way to do so, thus promoting the development of safe attachments.

The informants explained how the music therapist must be cautious and sensitive to make their clients feel as safe as possible, especially during the first therapy phase. Contact establishment and safety-creating activities are more present at the beginning of a music therapy course (Krüger et al., 2018). The informants described different ways of working in the first safe-creating phase. George talked about being activity-oriented and not asking too direct questions about the client's upbringing or problems. Andrea mentioned how GIM therapy usually starts with supportive music, music of low intensity. Clients who have experienced trauma may already have strong and overwhelming emotions. According to Andrea, the music should not even add more powerful and challenging emotions but be a container.

Braarud & Nordanger (2017) talk about how individuals who have experienced developmental trauma usually have a narrower tolerance window and, therefore, may quickly be overwhelmed by experiences or emotions. Tom explains how he always puts safety first and is ready to take breaks whenever the client's feelings might be too overwhelming. Focussing on safety and stress reduction can significantly affect the traumatised client's development (Braarud & Nordagner, 2017). Peter discusses working individually with his clients before joining the music group in order to anchor safety and the therapeutic relationship. Krüger (et al., 2018) mention that establishing safety through music therapy often starts with one-to-one sessions, which prepare for group participation. In the individual sessions, the clients can acquire skills they can use later in the group.

Braarud & Nordanger (2017) explain that individuals who have experienced trauma can have their alarm system easily activated. They sometimes experience as threatening situations that normally would be perceived as safe. The informants exemplified and explained how to handle such situations to avoid causing stress to their clients. Tom described how a client did not want to sing a song about mothers since her mother had abused her. Because safety had been previously established and Tom acknowledged the client's feelings, he dared to ask the client if it would be acceptable to sing it and think it was only a song unrelated to her trauma.

The informants have described how music can be a facilitator, a common ground in which therapist and client can work on establishing safety and relationships. Rolvsjord (2007) claims that songs can be a less threatening way of communicating and expressing. However,

Andrea talked about how songs can be an underlying facilitator that supports, holds, and contains, but at the same time, music can also be a trigger in some situations. This view goes hand in hand with Beer & Birnbaum's (2023) critique of assuming that music is an inherently good medium that promotes safety and containment. Peter shared an example in which a song about one client's abuse was too overwhelming for the rest of the group to hear. Therefore, it is crucial to have a trained music therapist who can handle those kinds of situations.

When discussing safety thoroughly, the opposite phenomenon, unsafety, should be considered as well. As the informants mentioned, music can also trigger negative emotions, memories, or overwhelming reactions. As Beer & Birnbaum (2023, p. 42) claim: *"Music cannot automatically guarantee safety, and therapists do not embrace inclusivity and empowerment simply by employing the therapeutic benefits of music".* Nevertheless, music therapy offers a wide range of opportunities for the negotiation of consent, where clients can make choices and exercise control. As the informants described, music therapy allowed the clients to exercise negotiation and control over the situation.

A resource-oriented music therapy approach can be particularly relevant when gaining awareness about power unbalances between the therapist and client (Rolvsjord, 2010). The clients could actively choose how far they wanted to go in the therapeutic process or to what extent they wished to participate in the musical activities. These examples correspond well with developing the client's psychological safety[13], which involves showing self-control and self-protection. Unsafe situations can also refer to the music therapist's uncertainty in handling challenging situations. Tom explained how he experienced a client's dissociative episode in one of his first music therapy sessions. Because of his lack of experience and training on how to handle dissociation, Tom experienced the situation as challenging. I will come back to this concerning future implications and directions in music therapy's education and profession later in this chapter.

5.2 Relational Aspects

The informants had different experiences in their music therapy work with individuals who have experienced violence and abuse. Tom had mostly worked with groups, Peter and George both individually and in groups, and Andrea mostly in one-to-one GIM sessions. Those differences did not affect their common opinion on how crucial the therapeutic relationship client is. Andrea described the therapeutic relationship as the most essential part of the

[13] See chapter 2.2.1

therapeutic process, something that goes across the therapeutic approaches and techniques. According to Trondalen (2016), It has been proved that the therapist's education and professional qualities did not play such an important role in the therapy's outcome. However, the therapist's personal qualities had a more significant impact on the outcome. The intersubjective meeting between the therapist and the client very much influences the effect of therapy.

George talked about how the therapist's personal qualities consist of a combination of experience and training but also some innate personal aptitudes for relationships that some people possess to a larger degree than others. Peter described how music therapists, regardless of relational competences, will learn a lot about relationships and approach different clients and their personalities. There are many things that a music therapist needs to be able to talk about to create that kind of safe environment for the clients.

When dialoguing about the music therapist's necessary qualities to foster a beneficial therapeutic relationship, some informants underlined the common factors in therapy. Therapists need to be sympathetic, warm, empathetic, helpful, and caring for the patient for therapy to work. These factors can enable a therapeutic alliance and a positive bond between therapist and client as they trust and care for each other (Trondalen, 2016). Once more, we can correlate this with Bath's (2005) three pillars, where safety and trust must first be there to start forming a therapeutic alliance or bond that can lead to the client's coping experiences.

Moreover, many informants agreed on how vital it is for the clients to establish safe relationships with caring adults and acquire good relational experiences. George emphasised how this study's target group struggle precisely with establishing relationships, daring to trust others, and daring to feel safe with people. Peter highlighted how this clientele is prone to isolation, anxiety, and many difficult social situations. In the same line of thought, individuals who have experienced developmental trauma often do not trust adults. This lack of trust is caused by having experienced insufficient protection from their caregivers. In some cases, even the caregivers might be the source of the harm themselves (Bath, 2015; Braarud & Nordanger, 2017). Therefore, and as Braarud & Nordanger (2017) claim, they will need an overdose of good relational experiences to compensate for what they have missed. According to George, music therapy can offer positive and good relational experiences.

In the context of child welfare institutions, George explained children being in need of contact with adults, commenting that there are not enough adults there, and he criticised the lack of resources and activities. George spoke about how music – from a socio-cultural perspective- can be a “magical binder that holds things together”, a structuring resource; it

gives the therapist and client something to talk about and share an interest. Music allows children in child welfare institutions to experience adults who show emotions and are engaged in something, in addition to having a joint project to work with.

According to the informants in Krüger (et al., 2018) study, music therapy facilitated relationships where the youth could unfold in the music and show new sides of themselves. The latter corresponds well with George's opinion about how music can facilitate starting a non-threatening conversation with the client. Music therapy was also an arena where adults could get perspective on children and youth resources. Moreover, "*music therapy creates a framework for adult contact through relations experienced as stable and predictable, for example, by organising music therapy on a weekly basis"* (Krüger, et al., 2018, p. 6).

Tom and I discussed music's possible roles for the group members he worked with. He referred to an interesting topic concerning music in therapy as opposed to music as therapy. In the context of Tom's music therapy work, he considered it relevant describing what music led to in the group and not focus so much on what the music itself meant for the group. After being together in the music or musicking (Small,1998), the group members could easily relate to each other and talk, which Tom described as a social effect of singing together. During the break in between the first and second part of the session, Tom experienced how the atmosphere had positively changed and how the conversations flowed.

The previous example shows how the use of music-making in a group setting could facilitate relationships and conversations between individuals, thus giving them new possibilities for action (Ruud, 1990). Following Ruud's definition[14], I understand new possibilities for action as new possibilities for social interaction and connection with others, crucial in trauma-informed music therapy (Bath, 2015; Braarud & Nordanger, 2017; Krüger et al., 2018).

Another relational aspect Tom highlighted was the existing relationships between the group members. According to Tom, these relationships were caring, helpful, and supportive, fostering safety and participation within the group. As Krüger (et al., 2018) claim, the clients can help each other and create belonging to a community through music therapy.

Furthermore, maintaining those relationships over time can contribute to mastering experiences. Herman (1992) sees a trusting client-therapist relationship and supported relationships between group members as strategies for creating safety for survivors.

[14] See chapter 1.3

Peter spoke about how the music therapy group offered its members a place to be together with other people who have also experienced trauma but changed the focus from their trauma background to making music together. Smith (2017) explains how performing music together helped people who have experienced sexual abuse step out of the stigmatisation of being a victim. Performing a different role than the stigmatised role in society, in this case, an abuse victim can generate change in the context of stigma (Krüger et al., 2017; Smith, 2017).

Following the same argument as recent trauma theories (Bath, 2015; Braarud & Nordanger, 2017; van der Kolk, 2014), George discussed the differences between old and modern trauma perspectives. He explained how the old trauma theory views experiencing a traumatic upbringing as permanent damage, which would impair coping abilities, whereas modern trauma psychology is more interested in compensating for the damage with the help of caring experiences and supportive situations.

5.3 Coping

Working on regulation is essential in trauma treatment because trauma disrupts the ability of the nervous system to regulate itself. Traumatic experiences can trigger a fight, flight or freeze response in the body, which can become stuck in the brain and body and lead to chronic dysregulation[15] (Braarud & Nordanger, 2017; van der Kolk, 2014). Learning and developing regulating abilities can help individuals with trauma manage trauma symptoms better, thus contributing to healing and resilience (Bath, 2015). When researching if music therapy can promote health for those who have experienced violence and abuse, I considered it crucial to investigate if music therapy can help this population to self-regulate and eventually how.

All the informants agreed on regulation's central role in their music therapy work with this population. Tom mentioned the complexity of self-regulation and how self-regulation might imply more than the individual's ability to regulate himself. To be able to self-regulate may require external help or guidance. Individuals who have experienced developmental trauma usually have an underdeveloped regulating system and can become quickly overwhelmed by emotions (Braarud & Nordanger, 2017). The music therapist must be aware of this, carefully adapting the session to the client's needs. Tom explained how he included regular breaks and stressed that the group members could take breaks when needed. He

[15] See chapter 2.2.3 & 2.2.4

considers a form of self-regulation that the clients deal with how much they want to participate in the group and acknowledge when it becomes too much.

Following a similar reasoning, Andrea described a door metaphor to refer to the client's own choices in deciding how far they want to go in processing emotions or difficulties. This approach goes hand in hand with the resource-oriented perspective, emphasising the client's participation and collaboration in the therapeutic process (Rolvsjord, 2004, 2010). Tom explained how many of his clients showed a good ability in mastering challenging situations themselves that could happen during music activities like dissociation episodes. This description corresponds well with Rolvsjord's (2010, p. 204) essential therapeutic principles for working resource-oriented, "*Recognising the client's competence related to her or his therapeutic process".*

Peter also mentioned many clients needing help with regulation in the music therapy room. Moreover, he explained that the clients may need help getting back into the *window of tolerance*. [16]As Braarud & Nordanger (2017) claim, individuals who have experienced chronic trauma often will have a narrower window of tolerance and easily come out of the optimal activating zone. Peter spoke about the initial forming phase of the music group he worked at and stressed how crucial it was to give the opportunity for the clients to come and go as they wished. This opportunity gave them space to be aware of their personal needs, thus involving their self-regulating abilities. The group members' capacity to self-regulate by deciding when to stay or leave the group is, in many ways, the contrary to the chronic traumatic experiences they had suffered. The group members could not decide for themselves what to do or when to leave when they were in violent or abusive earlier situations (Smith, 2017).

According to Smith (2017), these open activities can contribute to containing the group while encouraging the group to keep playing. Repeating this kind of activity over time can contribute to the brain's regulation-learning and enable the participants to broaden their window of tolerance (Braardu & Nordanger, 2017; Smith, 2017).

Regulation also may occur in terms of co-regulation or regulation with external help. The informants shared examples of how the music therapist, group members, or the music itself could serve as co-regulation support. In the context of GIM therapy, Andrea described how she consciously stepped into the client's imagery as the client asked for help and helped the client by stopping and sending the abuser away from the client's imagery. Tom spoke

[16] See chapter 2.2.3

about how the group -both in terms of each individual and as a group– had to find ways to regulate the interaction to bear tolerating the situation. According to Tom, music enabled the group members indirectly to work with regulation and possibly stay longer in the regulation process. Smith (2017, p. 63) argues that playfulness "*develops the social-engagement system to bear more activation and to regulate the level of activation through social contact".* Engaging in play and creativeness only may occur in the optimal activation zone, not when being in a freeze response. That means playfulness can be a powerful way to prevent such dysfunctional reactions (Smith, 2017). As van der Kolk states (2014), recovering from trauma requires the restoration of the capacity for playfulness and creativity.

When discussing with the informants how present processing trauma was in the music therapy room, the majority shared a common vision in which trauma was not the focus. Tom mentioned that the music group members did not focus on the traumatic experiences the members had suffered, and neither did Tom actively. Moreover, Tom explained that his clients expressed how they deeply appreciated not having to focus on their traumas – something they already did repeatedly in other therapeutic settings– when participating in the music therapy group. The latter can be connected to what I previously mentioned about moving away from the stigmatisation of being a victim (Smith, 2017).

Both Tom and Peter spoke about how music therapy could help move the focus from trauma-related experiences to music. They emphasised musical and social interactions, creating something together, and being there for the music rather than being there for the trauma. As Smith (2017) states, interacting in a music group or being present while others play music can move the focus from the trauma-related elements to the musical interaction. As Freud claimed in the 1890s, focusing on and talking about the trauma will not necessarily resolve it. Talking about trauma will not always stop flashbacks or improve concentration (van der Kolk, 2014). However, all the informants were clear that resource-oriented music therapy should not exclude working on traumas. As George claimed, it often implies working with both the strong positive and challenging aspects like a difficult upbringing or traumatic experiences.

Nevertheless, the informants illustrated how the clients could work on their traumas indirectly through music. Songwriting is an example here. Peter talked about how some of his clients wrote their own songs in which they conveyed the abusive situations they had experienced. Peter named the elements of health and mastering involved in *owning* what happened to you, putting it into a song and delivering it. In connection with the last-

mentioned, Rolvsjord (2007) writes about songwriting as a helpful method to connect with and express emotions and experiences in a less threatening way than verbal communication.

At last, Peter stressed how music-making activates and connects all the brain parts in addition to using your body. Such an integrating process may strengthen your brain and create regulatory pathways. Andrea underlined the importance of combining cognition, emotions, and memories and bodily reactions in processing trauma. As van der Kolk (2014) claims, trauma treatment must engage the whole organism, body, mind, and brain. Music has the capacity to stimulate multiple regions of the brain simultaneously, including cognition, emotions, memories, and motor functions (Brean & Skeie, 2021).

5.4 Music Therapist's Considerations

As the informants previously mentioned, music therapists must be able to tolerate and contain whatever might arise in the therapy room. George explains how that implies tolerating very challenging situations like the client crying, rage, and heartbreaking stories. When working with individuals who have suffered violence and abuse, the music therapist must be prepared to be exposed to the client's terrible traumatic past. This exposition can cause fatigue, stress, burnout, and even secondary traumatisation[17]. To prevent that, George stresses how crucial it is for the music therapist to foster self-care and self-awareness, including awareness of inner chaos. The music therapist must have good coping and regulating skills to be able to help clients regulate themselves. As George stated, it is not helpful for the traumatised child if the music therapist loses control and has a meltdown. Trondalen (2016, p. 100) defines self-care as "c*aring for oneself as a music therapist so that one can care for others"*.

Moreover, George highlighted the importance of teamwork and searching for help when needed inside and outside the workplace. According to George, it is pointless to deal alone with such difficult and heavy situations that may arise when working with traumatised clients. In connection to the latter, Trondalen (2016) points out that self-care is not only about giving to oneself but also receiving help, care, and support from others.

Moving to another topic, Tom described focusing more on singing in the music group he was working with, and underlined his clients' interest in singing and forming a small choir. He also mentioned that some clients had difficulty controlling their breathing and connected

[17] Secondary traumatisation refers to situations where individuals are traumatised by hearing another's traumatic events. Such indirect trauma exposure can occur in professional, familiar, and social relationships. Source: https://sykepleien.no/forskning/2017/10/ogsa-hjelperne-kan-bli-traumatisert

singing as an indirect way of controlling their breath. According to Tom, singing can enable breathing control without explicitly thinking of it. Many of Tom's clients had read theories about how singing can help connecting your mind, your body, and your emotions. As Brekke (2019) claims, the voice is our most bodily instrument. The voice and its expressive qualities can be used to influence the psyche. Our voice is strongly connected to our personal history and how we relate to others and ourselves (Kleive, 2009). As we have seen, breathing and singing are closely interrelated. Breathing can help us focus on the present moment and gain body awareness. According to van der Kolk (2014), slow and rhythmic breathing can increase the coherence between different brain regions, leading to improved cognitive function and emotional regulation.

Concerning the music therapeutic techniques or methods more suitable for working with this population, the informants made clear that it is very individual and depends on the situation and person. However, the informants find it important having a broad musical kit of various activities in order to engage all their clients and being flexible enough to improvise along the way. Because of that, the informants emphasized how improvisation also might be applied to the choice of method and intervention. Songwriting was seen as a central music therapeutic method to many music therapists with trauma survivors (Brekke, 2019; Krüger, et al., 2018; Rolvsjord, 2007). In the result chapter, Peter named having used songwriting very often and explained some of its potential benefits. However, George shared a more critical view of songwriting as a tool. He claimed that songwriting might be appropriate only after establishing a safe therapeutic relationship for those interested and underlined that it is not a miracle cure.

At last, one of the informants mainly used GIM therapy in her work with this study's population and pointed out this specific method when seeking to work holistically. GIM therapy combines emotions, memories, cognitive, and bodily reactions, an effective approach for trauma treatment as it addresses the complex effects of trauma on an individual's physical, emotional, and psychological health and well-being (van der Kolk, 2014).

5.5 Implications and future directions

In this study, I have investigated existing literature on music therapy with individuals who have experienced violence and abuse. I have interviewed four experienced music therapists working with this population. Despite the growing interest in using music therapy with individuals who have suffered traumas, a limited amount of research has been conducted in

this area, and even more limited when it comes to GIM therapy. There are still not many music therapists specialising in working with this population, even though statistics [18]show the severity and impact of violence and abuse globally, not least in Norway (NKVTS; WHO, 2022).

The informants in this study have shared their experiences and views on using music therapy with this population and emphasised its immense potential. Many of their sharings correlate with central aspects discussed in the existing literature that connects recent trauma theories with music therapy (Brekke, 2019; Krüger, et al., 2018; Smith, 2017). Both literature and the informants showed the relationship between music therapy and Bath's (2015) three pillars in trauma wise care: Safety, connections, and coping. However, as I previously discussed, safety in music therapy seems to be underresearched (Lai et al., 2021). Considerations regarding music as potentially unsafe or a trigger for traumatised individuals need further research.

Although music therapists may also promote physical and social safety (Bath, 2015; Lai et al., 2021), there is still a gap in what music therapists or other therapists can do regarding cultural safety – referring to structural and systemic injustices. Traumatic experiences such as violence and abuse should not be seen as an individual problem but through the lens of a wider political, social, and cultural problem. Following this line of argument Beer & Birnbaum (2023) claim that the future of music therapy trauma practice must go beyond treating the individual's problems and take action to change the conditions that enable violence and abuse. A music therapy practice that is truly trauma-informed "*needs to challenge the depoliticisation of safety and remain committed to approaches that are political and community-oriented"* (Beer & Birnbaum, 2023, p. 39). I wish to raise awareness on this topic and encourage more research about it.

As one of the informants exemplified, working as a music therapist with individuals who have experienced violence and abuse may imply facing challenging trauma-related situations like the client's dissociative episodes. I believe that music therapy education needs to better address trauma-informed music therapy according to society's demands. The complexity of trauma-related symptoms and mental disorders may support the ongoing music therapy discussion on the need for specialisation in the field of mental health care.

Concerning music therapeutic approaches and perspectives, existing literature and this study's informants have shown the predominance of psychodynamic music therapy when

[18] See chapter 1.1

researching and working with individuals who have experienced violence and abuse internationally. However, Norwegian music therapy is strongly rooted in a resource-oriented perspective, and music therapists working with this population have mainly used that perspective in their work. Therefore, I wish to encourage more research in resource-oriented music therapy with this population. At the same time, I encourage Norwegian music therapists working with this population also to consider psychodynamic[19] insights relevant to their work. More research is also needed to understand better the possibilities and limitations of the GIM method for working with this population.

[19] See chapter 2.3.1

6. CONCLUSION

In this study, I have investigated if music therapy can promote health and a sense of safety for individuals who have experienced violence and abuse and help them to self-regulate. In order to fully answer that question, it was necessary to investigate how it can be done. This was achieved by conducting interviews with four experienced music therapists working with this population and reviewing existing literature on the topic. The findings –resulting from my interpretation of the music therapists' experiences– were divided into the categories safety, relational aspects, coping, and music therapist's considerations. The first three showed how music therapy gave clients the opportunity to experience and work with safety, relational aspects, and coping – something that corresponds with Bath's (2015) three pillars of trauma wise care: *safety*, *relations,* and *coping*. These three aspects have been presented earlier in the thesis as necessary for a therapeutic environment that promotes healing and growth. The last category aims to better understand the music therapist's way of working with this population, including competences, methods, and approaches.

This study has described many potential benefits of using music therapy –individually and in groups– with individuals who have experienced violence and abuse. Next, I will name some of the most significant aspects when answering my research questions. Music therapy can offer a safe environment with a structured and predictable framework. It can also provide a safe setting where clients can dare to explore emotions, new relationships, and process experiences. Through music therapy, clients can experience positive and good relational experiences, which is essential to compensate for the imprints of developmental trauma and prevent this population's risk of isolation. The music therapy room can be a place where the clients can move their focus from trauma to music, thus fostering being in the present moment and not in the traumatic past. Music therapy gives clients new possibilities for social actions. By engaging in music-making activities with others, clients can build trust and develop social skills.

Moreover, music therapy groups can promote a sense of belonging to a community and their participation in the community. Music therapy can enable clients to exercise and regain self-control by giving them room to actively decide on their participation and involvement in the music activities and letting them develop their self-regulation abilities. Participating in music therapy sessions can provide the clients with regulatory experiences – both self-and co-regulation. Music activities can be a less threatening way of exploring and

challenging the limits of their window of tolerance and consequently help broaden it. As previously mentioned, developing regulating abilities can help people with trauma manage trauma symptoms better, thus contributing to healing and resilience. Last but not least, music-making capacity to engage an individual's body, emotional, cognitive, and social aspects simultaneously makes music therapy a holistic approach that can potentially address the physical, emotional, cognitive, and social repercussions of having experienced trauma in the form of violence and abuse.

As previously mentioned, further research is required to fully understand the potential benefits of using music therapy in the treatment of individuals who have experienced violence and abuse. In the next years, I hope to see several music therapists working with this population and more research showing how music therapy can be a relevant approach in trauma treatment. These facts can support its continued use and further implementation in the field.

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ATTACHEMENT 1: NSD EVALUATION

Vurdering

Referansenummer
677879

Type
Standard

Dato
27.06.2022

Prosjekttittel
Musikkterapi med mennesker som har opplevd vold og overgrep.

Behandlingsansvarlig institusjon
Norges musikkhøgskole / CREMAH - Senter for forskning i musikk og helse

Prosjektansvarlig
Ruth Eckhoff

Student
Maria Quevedo

Prosjektperiode
01.09.2022 - 15.06.2024

Kategorier personopplysninger
Alminnelige

Rettslig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)

Behandlingen av personopplysningene kan starte så fremt den gjennomføres som oppgitt i meldeskjemaet. Det rettslige grunnlaget gjelder til 15.06.2024.

Meldeskjema

Kommentar
OM VURDERINGEN
Personverntjenester har en avtale med institusjonen du forsker eller studerer ved. Denne avtalen innebærer at vi skal gi deg råd slik at behandlingen av personopplysninger i prosjektet ditt er lovlig etter personvernregelverket.

Personverntjenester har nå vurdert den planlagte behandlingen av personopplysninger. Vår vurdering er at behandlingen er lovlig, hvis den gjennomføres slik den er beskrevet i meldeskjemaet med dialog og vedlegg.

VIKTIG INFORMASJON TIL DEG
Du må lagre, sende og sikre dataene i tråd med retningslinjene til din institusjon. Dette betyr at du må bruke leverandører for spørreskjema, skylagring, videosamtale o.l. som institusjonen din har avtale med. Vi gir generelle råd rundt dette, men det er institusjonens egne retningslinjer for informasjonssikkerhet som gjelder.

TAUSHETSPLIKT
Intervjuene må gjennomføres slik at det ikke fremkommer opplysninger som kan identifisere enkeltpersoner eller avsløre annen taushetsbelagt informasjon. Vær spesielt oppmerksom på at ikke bare navn, men også identifiserende bakgrunnsopplysninger må utelates. Slike opplysninger kan være kombinasjon av for eksempel stedsnavn, alder, kjønn, tidspunkt, diagnoser og eventuelle spesielle hendelser. Dere må derfor være forsiktig ved bruk av eksempler under intervjuene. Vi anbefaler at du minner deltagerne på deres taushetsplikt i forkant av intervjuet.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til den datoen som er oppgitt i meldeskjemaet.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a.

PERSONVERNPRINSIPPER
Personverntjenester vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:
· lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
· formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke behandles til nye, uforenlige formål
· dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
· lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), og dataportabilitet (art. 20).

Personverntjenester vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
Personverntjenester legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Ved bruk av databehandler (spørreskjemaleverandør, skylagring eller videosamtale) må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29. Bruk leverandører som din institusjon har avtale med.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og/eller rådføre dere med behandlingsansvarlig institusjon.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til oss ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: https://www.nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema
Du må vente på svar fra oss før endringen gjennomføres.

OPPFØLGING AV PROSJEKTET
Personverntjenester vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

ATTACHEMENT 2: INTERVJUGUIDE.
SEMISTRUKTURERT INTERVJU.

- **Innledende spørsmål:**

1- Hvordan vil du beskrive musikkterapi for deg?
2- Hvilke tanker har du om musikkterapi i arbeid med mennesker som har opplevd vold og overgrep?
3- Hvilken rolle har musikk hatt i din erfaring med mennesker som har opplevd vold og overgrep?
4- Hvilke kompetanser/egenskaper tenker du er viktige/relevante som musikkterapeut i arbeid med mennesker som har opplevd vold og overgrep?

- **Forskningsspesifikke spørsmål:**

5- Hvilke musikkterapeutiske tilnærminger eller metoder pleier du å bruke i arbeid med den aktuelle målgruppen?
6- Hvordan tenker du at musikkterapi kan bidra til å fremme helse og livskvalitet hos mennesker som har opplevd vold og overgrep?
7- Hvilken rolle har trygghet hatt i ditt musikkterapeutiske arbeid med den aktuelle målgruppen?
8- Hvordan kan du legge til rette for trygghet i musikkterapirommet?
9- Hvordan tenker du at musikkterapi kan oppleves som en trygg arena for de som har opplevd vold og overgrep? Har du eksempler fra din praksis?
10- Har du noen tanker rundt dine erfaringer med musikkterapi og selvregulering hos mennesker som har opplevd vold og overgrep? Hva med bearbeiding av emosjoner og eventuelt traumer? Har dette spilt en stor rolle i terapirommet?
11- I hvilken grad har de traumatiske hendelsene målgruppen har opplevd vært til stede i musikkterapirommet? Eventuelt hvordan har du forholdet deg til det?
12- Hvilke rolle tenker du at selve musikken har hatt for den aktuelle målgruppen i selvregulering og håndtering av emosjoner?

- **Avslutning:**

13- Er det noe mer du vil kommentere eller legge til som du ikke har fått sagt?

ATTACHEMENT 3: INFORMED CONSENT FORM

Vil du delta i forskningsprosjektet *" Musikkterapi med mennesker som har opplevd vold og overgrep"*?

Bakgrunn og formål

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å bidra til ny kunnskap om musikkterapi med mennesker som har opplevd vold og overgrep. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg. Problemstillingene for oppgaven er:

• *Kan musikkterapi fremme helse og livskvalitet hos mennesker som har opplevd vold og overgrep, og eventuelt på hvilke måter?*
• *Kan musikkterapi være en trygg arena for de som har opplevd vold og overgrep, i så fall under hvilke betingelser?*
• *Kan musikkterapi bidra til å håndtere emosjoner og selvregulering hos mennesker som har opplevd vold og overgrep, i så fall på hvilke måter?*

Prosjektet er en masteroppgave i musikkterapi ved Norges Musikkhøgskole.

Hvem er ansvarlig for forskningsprosjektet?

Norges Musikkhøgskole er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?

Utvalget av informantene har blitt trukket etter veiledning med min masterveileder, Ruth Eckhoff. Utvalgskriteriene tar utgangspunktet i musikkterapeuter med relevant erfaring med målgruppen jeg ønsker å forske på.

Hva innebærer det for deg å delta?

Deltakelse i studien innebærer et personlig semistrukturerte intervju. Intervjuet vil vare ca. 45-60 minutter og vil gjennomføres i løpet av høst 2022. Spørsmålene i intervjuet vil handle om praksisrelatert erfaring og refleksjoner rundt det valgte temaet og målgruppen.
Dataene vil registreres via lydopptak under intervjuet

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt. Det vil kun være veileder og studenten som har tilgang til datamaterialet mens studien pågår. I masteroppgaven vil opplysninger være anonymiserte.

Alle opplysninger vil bli behandlet uten navn eller andre direkte gjenkjennende opplysninger. Det vil bli opprettet en kode som vil knytte deg til opplysningene dine gjennom en navneliste. Dette for å sikre din anonymitet. Listen vil være passord-beskyttet, samt lagres atskilt fra datamaterialet.

Det skal ikke være mulig å identifisere deg eller tredjepersoner (dine klienter) under behandlingen av dataene. Det blir lagt vekt på omskrivninger for å anonymisere klienter.

Prosjektet vil etter planen avsluttes 15. juni 2024. Ved prosjektetslutt vil alt datamateriale anonymiseres. Lydopptak og datamateriale som inneholder personopplysninger vil ikke lenger oppbevares.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra *Norges Musikkhøgskole* har Personverntjenester vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

Maria Quevedo Meloni (mquevedomeloni@gmail.com) eller masterveileder Ruth Eckhoff (ruth.eckhoff@nmh.no).

- Personvernombudet ved NMH: Rolf Haavik (pvo@nmh.no) eller telefon: 90733760

Hvis du har spørsmål knyttet til Personverntjenester sin vurdering av prosjektet, kan du ta kontakt med:

- Personverntjenester på epost (personverntjenester@sikt.no) eller på telefon: 53 21 15 00.

Med vennlig hilsen

Ruth Eckhoff (veileder)	Maria Quevedo (Forsker og masterstudent)

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet «*Musikkterapi med mennesker som har opplevd vold og overgrep»,* og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ å delta i intervju

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

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(Signert av prosjektdeltaker, dato)