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Being a person who plays in a band rather than being a person with a mental illness playing in a band: A qualitative study of stigma in the context of music therapy in mental health aftercare

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ABSTRACT

Introduction: The study explores the theme “stigma” and how it was experienced by participants in MOT82, a music therapy project in the field of mental health aftercare in Norway. The theme is explored through the research questions: How is stigmatisation experienced by participants in a music therapy project in the field of mental health in aftercare? And: Which strategies can be used to prevent stigma in the context of music therapy in mental health aftercare?

Method: The method for the study is based on User Interviewing User, a method for evaluation of health services, where the service users are actively involved in the entire research process. The analyses were qualitative processes within a hermeneutic abductive approach highlighting reflexivity as an important part of the research process.

Results: The participants in the study expressed MOT82 to be a positive arena that fostered experiences of mastery, personal development, inclusion, and a strong collaborative community. However, the participants also highlighted the theme of stigma, expressed through stories about mechanisms of exclusion; negative processes of labelling; and how stigma could be related to issues concerning illness, health, and treatment.

Discussion: Findings related to the theme of stigma are discussed and illuminated by theory from sociology, music therapy, stigma research and recovery; emphasising the concepts of social capital, performance and the importance of a user perspective. With regards to the matter of destabilising stigma, the message from the participants in MOT82 is clear: Tone down the focus on mental illness, turn up the volume regarding the importance of doing music.

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KEYWORDS Stigma; User Interviewing User; reflexivity; community music therapy; resource-oriented music therapy; user perspective

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Introduction

The word *stigma* originates from Greek and originally referred to marks that were cut or burned into the skin of slaves or criminals in order to make them easy to recognise and identify (Goffman, 1963). The horrific custom made it clear whether you were to be included or excluded in the ancient society and set a standard for whom it was socially accepted to bother, harass, and harm. Unfortunately, in modern time, stigma is still a comprehensive problem, although its mechanisms of labelling have become much more subtle. Today, stigma can be seen as a process in which people who deviate from the normative standards of society are marked as “different” and somehow “inferior.” Such unjust practice could be related to visible “marks” – e.g. visible physical “abnormalities,” skin colour, tattoos, or wearing a hijab; or related to invisible “marks” – e.g. sexual orientation, or certain physical or mental health conditions (Buechter et al., 2013).

For the authors of this article, the topic of stigma emerged as a result of an evaluation report of MOT82 (Tuastad et al., 2018), a music therapy project in the field of mental health aftercare in Norway. MOT82 is organised under the culture sector in the municipality located in a local community centre. Various musical activities take place in MOT82, like playing in bands, individual sessions, song writing, studio sessions, choir, informal low threshold “jam”-meetings in “music café,” concerts and open music workshops of different kinds. Some of the musical activities are led by music therapists, while others are organised by the participants themselves. Aims for MOT82 are to provide support for participants’ process of gaining access to musical resources in the local community and of making music as a self-led activity in everyday life. The theoretical frame for MOT82 emphasises recovery-oriented (Solli, 2014), resource-oriented (Rolvsjord, 2010), and community music therapy approaches (Stige & Aarø, 2011).

In a User Interviewing User (UIU) evaluation report, participants’ experiences of being part of MOT82 were examined. UIU is a method for evaluation of health services, where an overall principle is that service users are actively involved in the entire research process (Rise et al., 2014). The participants being interviewed for the MOT82 evaluation report expressed how the project had been an arena for mastery, personal development, inclusion, and a strong collaborative community (Tuastad et al., 2018). These positive responses correlated well with what the authors of the report expected to find, as well as with similar music therapy evaluation reports within the fields of mental health and substance use disorder in Norway (see e.g. Bjotveit et al., 2016; Dale et al., 2019; Kielland, 2015; Kielland & Selbekk, 2019; Kielland & Taihaugen, 2017). However, during the interviews, the topic of stigma also emerged. The participants shared stories about their experiences of feeling stigmatised in society, and eagerly discussed the topic of stigma in relation to mental illness and health, as well as mechanisms of exclusion. They also talked about how stigma was related to identity issues and processes of being labelled negatively by others. This article seeks to elaborate upon these findings regarding the topic of stigma in the field of mental health aftercare, and to explore possible strategies for stigma prevention within the context of music therapy. The research questions are:

1. How is stigmatisation experienced by participants in a music therapy project in the field of mental health in after care?
2. Which strategies can be used to prevent stigma in the context of music therapy in mental health aftercare?

Stigma as a concept

The concept of stigma is probably best known through the Canadian sociologist, Erving Goffman (1963), who describes stigma as “an attribute that extensively discredits an individual by reducing him or her from a ‘whole person’ to a ‘tainted, discounted one’” (Goffman, 1963, p. 3). Goffman distinguishes between three “types” of stigma, articulated as “abominations of the body” (e.g. physical “abnormalities”); “blemishes of individual character,” where perceived traits, such as selfishness or laziness, are inferred from known “blemishes” (e.g. mental illness); and “tribal identities” (ethnicity, nationality, gender, religion).

Since Goffman’s seminal work on stigma, research on this topic has grown steadily (Mehta et al., 2015). The ‘new’ literature has challenged and developed Goffman’s concept separating stigma into three interactive levels (Livingston & Boyd, 2010): (a) structural stigma (also known as institutional stigma) exists at the system level and refers to the rules, policies, and procedures of private and public entities in positions of power that restrict the rights and opportunities of people being stigmatised; (b) social stigma (also known as public or enacted stigma) exists at the group level and relates to the mechanisms of large social groups endorsing stereotypes and acting against a stigmatised group or individual; and (c) internalised stigma (also known as self- or felt stigma) exists at an individual level and describes the process in which affected individuals endorse stereotypes, anticipate social rejection, consider stereotypes to be self-relevant, and believe that they are devalued members of society (Corrigan et al., 2005).

Stigma related to mental health

In the field of mental health, stigma corresponds with issues such as prejudice, discrimination and stereotyping (Corrigan, 2016). For many individuals experiencing mental illness, stigma is a problem that interferes with recovery efforts (Corrigan et al., 2001) and general worsened life conditions (Elstad & Norvoll, 2013). The impact of these factors leads many individuals experiencing mental health problems to reject help and treatment, it increases the risk of relapse, and can contribute to long-term mental illness (Link & Phelan, 2013). Research emphasises that individuals experience discrimination from others who associate mental illness with character deficiency, unpredictability, laziness, and the inability to care for one’s self (Jorm & Griffiths, 2008), whereas others may internalize these beliefs (Link et al., 2001), thereby exacerbating low self-esteem, low self-efficacy, and decreasing quality of life (Markowitz, 1998; West et al., 2011). In a meta-analysis about internalised stigma for people living with mental illness, the main finding indicates that internalised stigma is negatively associated with psychosocial factors, including hope, self-esteem, empowerment/mastery, self-efficacy, quality of life, and social support/integration (Livingston & Boyd, 2010). Problems related to stigma can also negatively effect family circumstances, involving issues such as stereotyping, lack of openness about mental illness, stories of harassment, and lack of recognition for experienced difficulties (Elstad & Norvoll, 2013). Public responses to descriptions of people with mental illness are also often associated with stigma. In a mental health module of the US General Social Survey, participants responded that they were unwilling to make friends with, have as a neighbor, socialize with,

work closely with, or marry a person with schizophrenia (Buechter et al., 2013, p. 3). More surprising perhaps, healthcare providers also hold negative stereotypes about people with mental illness and their families (Knaak et al., 2017).

The most common strategies for preventing stigma related to mental illness are education, contact, and protest (Buechter et al., 2013). Through *education*, the goal is to replace myths about mental illness with facts and information, for instance, in the forms of documentary films or seminars about the subject. *Contact* relates to people who have a history of mental illness publicly talking about their experiences. *Protest* is an approach that aims to challenge inaccurate and negative representation of mental illness through public demonstrations and marches, writing letters to the editor, sit-ins, and boycotts.

Stigma related to music therapy

In the field of music therapy, the research on stigma is sparse. In the North American context, Silverman (2013) explored the effect of music therapy on self- and experienced stigma in an acute care psychiatric unit. Findings from Silverman's (2013) randomised group study indicate that music therapy methods, such as group song writing, may be engaging and effective when it comes to addressing self- and experienced stigma. In Norway, stigma emerged as a theme in Solli's PhD study of music therapy in an acute psychiatric unit (Solli, 2014). Using a recovery perspective, one of his findings highlighted how music therapy afforded a sense of freedom from being stigmatised. In music therapy, the participants could break free from their stigmatic role of being a "psychiatric patient" using music as a resource for rebalancing self-perception and for positive identity building. Having few "illness-free zones" in their lives, music therapy in this context could afford a sense of freedom from illness, stigma, and treatment (Solli & Rolvsjord, 2015, p. 18).

The first author of this article was also introduced to the topic of stigma through his PhD work which was a participatory action research study of a rock band of ex-inmates (Tuastad, 2014; Tuastad & Stige, 2015, 2018). The rock band was found to be a strong community of practice essential in forming the bandmembers' identities, personal mastery, and musical skills. However, the study also revealed stories about how the bandmembers experienced different levels of stigma. This experience of stigma could be manifested through people's general scepticism related to ex-criminals; the feeling of being stared at in public; and negative attitudes among public service professionals who were meant to help but instead created a lot of frustrations through their disempowered attitudes.

Even though there is only a small amount of research within music therapy in the mental health field that explicitly addresses stigma, several approaches explore related themes. This includes a resource-oriented approach emphasising empowerment and making a clear political stand for the destabilisation of oppression, inequality, and social stigmatisation in the field of mental health (Rolvsjord, 2010, p. 2). A congruent approach can be seen in a person-centred and socially oriented recovery perspective in music therapy (see e.g. Ansdell et al., 2016; Eyre, 2013; Hense & McFerran, 2017; McCaffrey et al., 2018; Rolvsjord, 2018; Solli et al., 2013; Solli, 2014; Solli & Rolvsjord, 2015). Studies underpinned by this recovery approach in music therapy highlight "users' experiences of music therapy as being distinctively different from other 'treatments,' in terms of being musical and offering a space where illness is not in focus"

(Rolvsgjord, 2018, p. 208). This correlates well with the overall emphasis within the recovery perspective on creating “recovery-nurturing environments” – that is, environments that provide opportunities for participation in supportive, accepting, and non-stigmatising arenas (Glover, 2005).

Many of the values described in the resource- and recovery-oriented perspectives are also present within a community music therapy approach (Stige & Aarø, 2011), which emphasises the importance of user-involvement and empowerment, and identifies equality, solidarity, and social justice as important values. Inspired by critical theory, these perspectives aim to challenge hierarchical ideologies that oppress minority groups and privilege those with power (Hense, 2015). Also common to these perspectives is the inherent critique of the bio-medical model and its individual-oriented focus. Health is seen as more than just absence of illness and diagnoses, and these music therapy approaches in the mental health setting therefore go beyond an individual-oriented focus by highlighting the importance of psychosocial factors such as social welfare, social participation, and liveable life conditions. Such critical perspectives posit that although health is an individual construction based upon personal values and meaning, these subjective ideas are inherently shaped by the societal forces of macro systems (Ruud, 2010, p. 120). Health then becomes a relational concept dealing with the interactions between the person and their surroundings.

Method

The method for this article is based on “User Interviewing User” (UIU); a fairly new method that has been under development in Norwegian health services since 1998 (Rise et al., 2014). UIU is a method for evaluation of health services, where persons with service user experience interview participants and are actively involved in the entire research process. Similar methods have been used in the British National Health Service (Rose, 2001). Furthermore, resemblance is found in user-involved approaches highlighting principles of co-researching or co-production in mental health service improvement research (see e.g. Trivedi & Wykes, 2002; Veseth et al., 2017). Studies incorporating UIU methods indicate that being interviewed by someone with similar experiences creates opportunities for more honest and critical answers than traditional “expert-driven” research interviews (Clark et al., 1999). Supportive factors of UIU include trust in the interviewer with similar experience; acceptance of life competence; equality and power relations; and a “free-speech” environment without conscious or unconscious expectations from the researcher and their affiliated health services.

In our adapted version of UIU, a research group consisting of a music therapist/researcher, a service user representative and a music therapy student collaborated through the whole research period, but also had responsibility for specific parts of the research. The research group were involved in the music therapy project MOT82 in various ways: Lars Tuastad was the project leader, Bjarte Johansen was the user representative, and Astrid Østerholt was the music therapy student completing her internship. The service user representative conducted one focus group interview and three individual interviews. In this process, the service user representative reformulated some of the interview questions into a more common everyday language that felt natural to him and the context. All interviews were audio recorded. The music therapy student transcribed all the interviews verbatim. After reading the transcribed interviews separately, the full research group met to discuss and brainstorm different ways

of organising the data material. The process of analysing the data material was followed by writing the MOT82 evaluation report. This phase was led by Lars Tuastad, the music therapist/researcher, with contributions from the rest of the research group through conversations and email communication. Themes from the evaluation report related to stigma were then retrospectively elaborated for use in this article.

The focus group interview consisted of four persons, and an additional three persons were individually interviewed. The interview participants included four men and three women ranging from 20 years old to 60 years old. Participants were purposively selected (Patton, 2015) to ensure representation of the diversity of roles, health issues, and experiences present in the project. An interview guide was used in both the individual interviews and the focus group interview. The interview guide was intended to foster conversations about how music therapy was experienced by the participants in the aftercare project. For example, pros and cons of the project were examined, including questions about aims and framework, organisation, access and information, potentials for improvement, and challenges related to be regular participants of the “normal” culture community.

Analyses

The qualitative analysis was informed by a hermeneutic abductive approach (Alvesson & Sköldberg, 2009), undertaken as a mixture of individual and collective work in the research group. A hermeneutic abductive approach acknowledges the researcher as an active part of the whole research process, and recognises abduction as an applicable strategy that “allows zigzag movements between experience, interpreted empirical material, and theoretical reflections” (Stige, 2003, p. 39). Such “zigzag movements” led to different choices and paths where meanings and theoretical understandings evolved in a continual process, through examination and re-examinations of the empirical material.

The collective work of analysis took place within joint research meetings. The research group had six joint research meetings, each with a scope of three hours. A central component of the research group’s work was to strengthen the research competence, and the meetings therefore involved informative conversations about the use of qualitative methods, practical analysing strategies of the data material, and reflections on the findings. Throughout the different phases of analysis, the hermeneutic abductive approach emphasised ongoing processes of interpretation. The analysis process was also inspired by Braun and Clarke (2006) thematic analyses: First, we went through the data material individually, before meeting and discussing initial impressions of findings and identifying a preliminary list of codes from all three researchers. In the next phase, group discussions led to recoding and articulation of tentative codes. Here, we ended up with 10 codes, including topics such as “*participants’ personal experiences*”, “*cultural participation*”, “*need for safety*”, “*network*”, “*need for information, facilitation, aims and framework*”, “*potential for improvement*”, “*inclusion and exclusion*”, “*stigma*”, “*names*” and “*labelling*”. By systematising the data carefully and looking at statements and codes that were repeated the most in the various interviews, we reformulated the codes into final themes included in the published evaluation report of MOT82 (Tuastad et al., 2018): Cultural participation, Aims and framework... Inclusion, Exclusion and, Stigma.

After the evaluation report of MOT82 was published, we wanted to explore in more depth the theme of stigma because we found it to be an unexpected finding, but nevertheless a highly important and relevant subject to elaborate upon. The original themes of *Inclusion*, *Exclusion* and *Stigma* were adjusted as follows: *Stigma as exclusion*, *Stigma through labelling* and *Stigma related to illness, health, and treatment*. All quotes used in this article originate from the MOT82 evaluation report (Tuastad et al., 2018), after a process of being translated from the Norwegian language to English.

We acknowledge that the empirical data for this study contains few quotes from the participants in the finding section. This issue reflects the problem of turning some of the findings from an evaluation report into an article exploring one specific theme. However, we hope we still managed to convey a picture of MOT82 through the participants' descriptions of their experiences followed by our reflexive considerations. The topic of stigma in the context of music therapy in mental health was viewed as too important and in need of elaboration.

Ethical considerations

The study was approved by the Norwegian Centre of Research Data, and all participants were given written and verbal information about the study. Additionally, a letter of informed consent was signed by all participants. All names and identifiable details of the participants are anonymised.

Service user-involved research approaches involves a lot of benefits emphasising marginalised groups to be heard (Freire, 2000). However, there are also some ethical challenges and dilemmas to be mentioned. First, questions of imbalance in power structures need to be addressed. Was the research group simply consisting of an expert in research (the music therapist/researcher), an expert in experience (the service user representative) and an expert in studying (the music therapy student)? The research group were well aware of the challenges of imbalanced power structures and reflected on this throughout the research process. A strategy in this concern was to organise dividing roles and responsibilities connected to different parts of the research project: The music therapist/researcher led the research project and had the responsibility of organising the research meetings and writing up the final texts for the evaluation report and article. The service user representative had the responsibility for accomplishing all interviews, and the music therapy student transcribed the interviews verbatim. The research meetings had a collaborative ethos of equality aiming to focus on the research process including reflections about different ethical challenges and dilemmas.

Second, the three researchers were all closely involved in the project MOT82. This closeness to the field has some clear benefits connected to, for instance, the possibility of getting insight in some of the lived experiences going on for the participants in MOT82. However, such insider-positions (Geertz, 2000) also involve some challenges. One dilemma in this context is that you might come too close to the field, and get too involved. In such a scenario, there is a danger of missing some of the things that are actually going on, and in response also being unable to see alternative views and solutions. Accommodating such challenges calls for a process of self-inquiry and meta-positional reflection of our roles in the research field.

Reflexivity has been described as the process by which the researcher turns a critical gaze toward themselves (Finlay & Gough, 2003). According to Alvesson and Sköldberg (2009), reflexive methodology means that the researcher draws attention to how different types of linguistic, social, political and theoretical elements are intertwined in the development of knowledge, where the empirical material is constructed, interpreted and then written. In practice, this means to be critical, clear and reflective when it comes to the use of theories and approaches. Furthermore, it means to strive for transparency and openness regarding theoretical references, preconceptions, values, beliefs and attitudes. Reflexivity is thus about reflecting on one's own positions and perceptions, and that one has critical lenses on one's own role and how this influences the research process. The music therapist/researcher, the service user representative, and the music therapy student have worked together as a collaborative research group that has strived for reflexivity throughout the research process. The research group's work included discussions and reflections on e.g. challenges of proximity and distance, being compromised as an "insider," power imbalances, ethical dilemmas, theory use, pre-understanding, roles and our own influence on the research field.

Findings

In the following section, we will elaborate on the themes of: stigma as exclusion; stigma as a process of labelling; and how stigma was experienced in relation to illness, health and treatment.

Stigma as exclusion

The User Interviewing User report outlined that MOT82 had a strong climate of inclusion and a strong supportive community. Paradoxically, the findings also indicated that processes of *exclusion* were part of the group's culture as well. In particular, the music café seemed to be an arena in which it was difficult for new people to integrate. The music café is a low-threshold meeting place where 8–15 persons join in once a week for two hours in an acoustic jam session setting. In the focus group interview, some participants expressed how they thought it could be difficult for new participants to partake in the music café, due to its already well-established settings. The example below shows how this issue was experienced by those who had been part of the music café over a longer period of time:

Participant 1: *I've noticed that, when new people come into the music café (...) it gets a little quiet. And that's understandable: We play songs, have a break; and they stand a little to the side. Also, they may not come back the next time ... And I think much of it could be solved through for instance, having games like music quiz and playful music jams. But it is also that we communicate through more than just ... just music.*

The excerpt indicates how the music café seems to have a sort of silent group ethos build up over time. Such group ethos could include certain undefined ways of behaving or informal social rules (for instance, the expected songs to be played, musical genres, instruments being used, places you should sit or not, etc.). In this landscape, it could take some time for newcomers to get to know the group ethos and form an understanding of how to become a member of the group. Being a newcomer to the group

could easily lead to a feeling of being excluded and not accepted. In the next excerpt, a participant who showed up at the music café only once describes how she didn't feel included in the group:

Participant 6: *I once tried to join in at this music cafe, but it wasn't . . .*

Moderator: *It wasn't for you?*

Participant 6: *No, I felt (. . .) it was like there was already a group there and . . .*

Moderator: *It was a closed or you felt like it was a closed group?*

Participant 6: *Didn't feel it was . . .*

Moderator: *Inclusive?*

Participant 6: *Yes, it was not inclusive.*

Stigma through labelling

Stigma through labelling was articulated as a theme in the focus group interview. This theme was initially connected to the way concert events were advertised. During an annual event for music therapy in the field of mental health, the music therapists who managed the event tried to avoid stigmatisation by using a song title from a Norwegian songwriter as the title for the event. The song title, "Psykisk kan du være sjøl," directly translates into "Mentally ill you can be yourself," and the song's theme seeks to normalise issues related mental health.

However, as a title for the event, it was perceived as uncomfortable and stigmatising by the participants in the focus group interview:

Participant 1: *Once you label the concert "Psykisk kan du være sjøl" (mentally ill you can be yourself), then you do exactly what they say . . . And then . . . you stigmatise. Then no one would come (to the concert).*

Participant 3: *I wouldn't have invited any of my friends . . .*

Participant 1: *Inviting people to "Psykisk kan du være sjøl" is no fun.*

Participant 3: *No, no, I would never have done it.*

The participants also discussed how labelling something as a *music therapy* event could cause a division between the participants as well as create a gap between them and the ordinary music scene:

Participant 2: *I remember being part of a concert this spring, then I noticed a few things. At this event there was a large attendance, and it seemed to be an ordinary concert. And even though mental health was part of the event, I didn't feel like it affected the performances. It was more like witnessing a concert performed by ordinary musicians. And that's when I think people can associate it to stigma. When you put the label mental health on it . . . you associate it with unfamiliar things; sort of.*

Participant 3: *Then people think it's amateurs; that it's bad (music).*

Participant 2: *Yes, exactly. Or people get the feeling of "they only do it to become healed." And that's a little sad, I think.*

Participant 3: *We are not doing it to become healed. We do it because we want to share music with the world; like anybody else . . . I really think it's a pity to have the label (mental health) on us.*

The participants talked about how they felt like they were stigmatised through labeling due to the name of the event (mentally ill you can be yourself), and how connecting the labels of music therapy and mental health to events made a barrier that disconnected the participants from the ordinary music scene.

Stigma related to illness, health and treatment

The participants in the focus group interview eagerly discussed stigma related to illness, health, and treatment. This discussion revealed concerns related to the transition from being part of an institutional mental health hospital to being part of an aftercare program in a cultural setting:

Participant 3: *I have always been sceptical, because you get associated with being ill and you don't want to be associated with that . . . In fact, that's an important point.*

Moderator: *Yes, and especially when it's music in aftercare. In fact, it is really for people who have finished treatment with a psychologist or . . .*

Participant 3: *Exactly, that's true.*

Moderator: *We're not in treatment, so we're really not sick anymore.*

Participant 2: *It creates certain associations, doesn't it?*

Participant 3: *That's exactly what it does . . . Especially for other people, for the rest of the world it creates an undesirable picture.*

The participants were critical of being associated with mental illness and wanted to be fronted as musicians rather than being “portrayed” as sick or in treatment.

Discussion

In this article, we explore the topic of stigma and how it was experienced by the participants in MOT82, a music therapy project in mental health in aftercare. The next section will discuss the findings using theory from different fields – i.e. sociology, music therapy, stigma research, and the recovery perspective.

Stigma as exclusion

Inclusion is one of the great advantages of being part of a group setting, where belongingness and relatedness are suggested to be basic psychological and social needs (Stige & Aarø, 2011, p. 87). It is like a glue that connects people into an “us” feeling. The feeling of being included clearly emerged as one of the great benefits of being part of MOT82. The members expressed how MOT82 felt like a safe and well-organised arena for musical and social activity, offering affiliation and a strong sense of community that prevented social isolation. However, several of the participants stated that one could also experience different degrees of exclusion. In relation to the low-threshold meeting place called ‘music café’, the most well-established participants of MOT82 mentioned that it could be difficult for newcomers to integrate into

the group. This was also confirmed by one participant who once tried to be part of the group. This finding indicates that the strong “us”—feeling in the group can make it difficult for new members to enter the group. It seems that there are strong ties within the group, and that this makes it difficult to welcome other individuals and groups.

Also, it takes time to be admitted in a group. There are certain dynamics, codes and rules to be learned. You need to get known to the group, and the group needs to get to know you. Related to the field of community music therapy, participation is one of the defining characteristics (Stige & Aarø, 2011). An understanding of participation is linked to sociocultural theories (Vygotskij et al., 1978), emphasising situated learning (Lave & Wenger, 1991), learning as participation in a community of practice (Wenger, 1998), and an ecological understanding echoed in Bronfenbrenner's ecological model (1979) as well as Small's musicking concept (Small, 1998). Informed by these theories, participation can be viewed as a collaborative activity (Stige, 2006), and includes processes of negotiating meaning, situated learning, exploring of identity issues, and acknowledging different forms of participation (Stige, 2010, pp.125–147). Moreover, participation has an ecological component insisting “upon both individual and communal change, the use of and development of inclusive settings, and an interest in the broad application of music as an ecology of performed relationships” (Stige, 2006, p. 124).

The duality between the strong bonds within the group on the one hand and the difficulty for others to enter the group on the other hand can be described through Putnam's (2000) concept of social capital, understood as our social connectedness or how well we are integrated into the community. *Bonding social capital* can give a group a sense of identity and common purpose. It helps to strengthen the bonds between the members and creates a close unity. The positive outcomes of such close unity are described in a recent book chapter arguing that “homogenous music groups which foster a shared lived experience can ‘shelter’ people with mental illness from social stigma and social exclusion often experienced in the wider community” (McFerran et al., 2021). Despite these positive aspects, the ties could also promote a too strong inward-focused behaviour, an “us against them” mentality, which enables the exclusion of those who are not “inside” the group. In such a context, there will be a need for *bridging social capital*; understood as networks that cross social boundaries. The members who belong to such networks are more likely to come into contact with a multitude of different people, which can have a preventive effect when it comes to the development of isolated trust and exclusion mechanisms (Paxton, 2002, p. 259). Bridging social capital will have a greater capacity to produce a sense of identity and reciprocity across differences between individuals (Putnam, 2000).

In MOT82, participants' responses show that there was a strong bonding social capital that could trigger exclusionary patterns. In the future, this bonding social capital should be supplemented by a greater emphasis on bridging social capital that can assist in the creation of a more inclusive environment in which new members in the project can gain a better sense of belonging. Inclusion then “involves supportive relationships, well functioning social networks, and welcoming attitudes and actions” (Stige & Aarø, 2011, p. 148).

Stigma through labelling

Although performance has long been part of the music therapy landscape, community music therapy's entrance in the 2000s really put the concept on the theoretical map. According to Ansdell (2005), "Giving performance' can have positive, healthy connotations that relate to a fundamental and natural mode of musicing, and to a fundamental psychological and social reality – that 'performing' ourselves in the world is natural and necessary" (p. 4). Within community music therapy performance is seen as a resource for networking and community building, and as a political tool with an aim of destabilising stigma, discrimination, and injustice. Despite community music therapy's embracing of performance, the need for active reflections is emphasised by several music therapy theorists (see e.g. Ansdell, 2005, 2010; O'Grady & McFerran, 2012; Stige & Aarø, 2011; Stige et al., 2010), highlighting potential pitfalls of performances (Maratos, 2004), such as the client's capacity and vulnerability (Jampel, 2011; Turry, 2005) and wider ethical considerations (Aigen, 2004). In relation to our project, performance in music therapy can be problematised by looking at how the MOT82 performance generated the possibility of unintentionally labelling participants.

When discussing the title for a concert event in the field of mental health, the participants in the UIU interview were quite honest in stating that this title – "Psykisk kan du være sjøl" ("Mentally ill you can be yourself") – felt uncomfortable and stigmatising. Their message was clear: They would not invite their friends to an event with such a name. In their view, it felt like wearing a banner stating: 'we are mentally ill'. Paradoxically, the music therapists who came up with the title did it with the good intention of normalising and destigmatising mental illness. How could they get it so wrong? We will argue that context is of relevance in this matter. First, the title for the event is adapted from the song "Psykisk kan du være sjøl" ("mentally ill you can be yourself") which is probably well-known amongst music therapists and health workers in Norway, but not for the participants in MOT82. The artist behind the song is acknowledged for articulating difficult feelings, especially related to 'silent men'. In the lyrics of the specific song, "Psykisk kan du vera sjøl," the artist addresses issues like sorrow, loneliness, and inadequacy. At the same time, the song could be seen as an attempt to normalise mental illness and may afford comfort and strength through its lyrics. In this sense, it could almost serve as an anthem for mental health stating that "we all have mental health."

The participants' responses to the concert title hence illustrate how performance in music therapy can be problematised in relation to unintentional and potentially stigmatising processes of labelling. For instance, do these concerts need to have a music therapy label? A mental health label? Or should the performances be labelled as "ordinary" concerts? If we begin by examining the last question; is it ethically right for a performance that is led by music therapists in the field of mental health to be called an "ordinary" concert? When discussing attempts to destabilise stigma, the literature introduces the dilemma of normalisation versus solidarity. In an editorial comment in *The British Journal of Psychiatry*, Corrigan (2016) asks: "should we seek normalcy or solidarity?" (p. 314). In relation to the stigma associated with mental illness, one approach is to seek normalcy, where people who have a mental illness are framed as being "just like everybody else." In contrast, the other approach involves working toward solidarity, where the public supports those who have a mental illness regardless of their symptoms. Corrigan (2016) compares pros and cons related to both

approaches. Several countries (e.g. Australia, New Zealand, and Britain) have relied on the normalcy approach in their social marketing campaigns addressing stigma. Aiming to replace notions of the “abnormal” with “normal,” these campaigns seek to contrast myths of mental illness with facts, hence framing mental illness as “normal.” As a result, this approach can create better recognition and understanding of mental illness and a greater understanding of the benefits of treatment. However, this approach can also generate unintended effects related to identity issues. Some people with mental illness describe themselves in a negative way, often related to their distress, failures, or symptoms. Research suggests that those who identify with their mental illness, but also embrace the stigma of their disorder, report less hope and diminished self-esteem (Corrigan, 2016). However, not everyone who identifies with their mental illness will experience these negative consequences. It is also possible that a mental illness identity can be accompanied by a sense of pride when facing and overcoming challenges related to mental illness and that the person can more easily withstand societal stigma through demonstrating a sense of resilience. Taking a solidarity approach could promote this individual sense of pride, contribute to a greater communal awareness, and promote social justice, that in turn could assist toward the destabilisation of stigma.

Related to the ‘*Psykisk kan du være sjøl*’ (‘mentally ill you can be yourself’) concert, this could be viewed as an attempt to seek a solidarity ethos through the misunderstood use of normalisation. Although the music therapists had good intentions, the concert as well as its title were decided by the music therapists in a top-down fashion, when instead it should have been decided in close collaboration with the participants. In a position paper, Fairchild and Bibb (2016) critically reflect upon how participants are represented in music therapy practice and research. They disclose “a tendency within music therapy practice and research to talk and write about people with illness or disadvantage at the expense of strengths and resilience” (Fairchild & Bibb, 2016, p. 2), creating a potential risk for ignoring “all that makes a person human” (Slade, 2012) – both their strengths as well as their weaknesses. In relation to this risk associated with depicting participants, Slade (2012) suggests the use of “self-knowledge,” which values the lived experience that the participants bring to the research. Examples of identified self-knowledge include: Lola, “student and animal-lover with complex physical and mental health problems,” Sam, “Ex-music theatre artist with chronic mental illness”; and Milly, “Creative arts student with bipolar disorder” (Bibb & McFerran, 2018; Fairchild & Bibb, 2016). As previously discussed, the evaluation report of MOT82 revealed that the participant felt stigmatised by the name that was chosen for the concert. As a result of this evaluation, a participant-led name poll was arranged for the next year’s concert, with “Gjenklang” being the winning name. This can be translated into “Reverberation.” Perhaps this could be the main message for this section: The need for reverberation – musical, relational, and social – with the participants being the gatekeepers in order to “combat” stigma.

Stigma related to illness, health, and treatment issues

In the focus group, the discussion of illness, health, and treatment created a lot of temper and engagement. The participants argued that they did not feel ‘sick’ and therefore should not be associated with a mental health system, seeing as they were

now part of a communal aftercare program in a cultural setting. In many ways, the discussions reflect different ideologies and values within society that influence these different context settings. A majority of the participants in MOT82 are recruited from community mental health clinics organised as part of the overall specialised mental health care system in Norway, called DPS (District Psychiatric Centres). They have been either inpatients or outpatients in DPS and have received different levels of treatment and assistance based on their mental health issues. DPS is associated with a medical model way of thinking: You are a patient with a diagnosis (or being assessed for a possible diagnosis) receiving treatment related to your mental illness. In other words, even if the music therapists working at the DPS have the best intentions, you are still regarded as a “person with a mental illness playing in a band” when going to music therapy in this context/setting. In contrast, MOT82 is not part of the mental health care system, but rather, it is an aftercare program situated within the mainstream community. It is organised under the culture sector in the municipality, seeks to promote inclusion, and views the participants as culture consumers. Hence, in this cultural setting, you are a “person playing in a band” rather than a “person with a mental illness playing in a band.” As Bibb and McFerran (2018) point out in an article about music recovery, such reflections also should refer timing and pacing related to where a person or group are in their recovery process and where they are in a health-illness continuum. Their study indicates that participants in an inpatient setting seem to have increased need for therapeutic input focusing on health facilitated by a therapeutically trained music therapist. However, when moving to outpatient and community setting, the primary focus “may move to building musical skills” best facilitated by community musicians (p. 247), or in the context of MOT82 a music therapist facilitating processes corresponding to an ecological and community music therapy way of thinking.

Many critics of the medical model are also critical to the diagnostic system in mental health care. People in recovery explicitly point out that using pathological terms when describing their experiences feels disempowering and stigmatising (Stanton, 2001). Citing Rolvsjord (2018), “the recovery perspective in music therapy draws upon perspectives that are critical toward the adaptation of the medical model in music therapy, and instead emphasises user involvement, the fostering of strengths and recourses, and community orientation” (p. 191). In an article about the ‘competent client’, Rolvsjord (2014) points out two main critical points linked to the interdisciplinary field of mental health: “First, there is a tendency to locate mental health problems in the individual” (p. 2) and to individualise societal issues. As the Norwegian culture psychologist, Madsen (2014), explains: “problems are being understood as psychological, when the problems should actually be viewed in light of systems of meaning other than the mental aspect: the social, the political, the structural, etc.” (p. 198). Furthermore, Rolvsjord (2014) problematises how there seems to be a tendency to “depict the therapist as an expert with power, and the client as weak and pathological” (p. 2). ‘The competent client’ indicates a shift away from a strong focus on pathology and problems to a focus on strengths and resources. In light of this, ‘the competent client’ has competence, craft, and agency in their own life and therefore also in relation to therapeutic processes. Moreover, and in line with the recovery perspective, there is a need for valuing the knowledge that comes from the experiences of people who are in recovery. A user perspective acknowledges the need for competence and knowledge that users have from first-hand experience of living with illness in a complex health care system.

Conclusion

This article elaborates upon findings of how stigma was experienced by participants in MOT82, a music therapy project in the field of mental health aftercare in Norway. Illuminated by theory from the fields of sociology, stigma research, music therapy and the recovery perspective, strategies combating stigma can be summed up in three main points. First, to counteract exclusion in MOT82, bonding social capital should be supplemented by a greater emphasis on bridging social capital that can assist in the creation of a more inclusive environment in which new members in the project can gain a better sense of belonging. In this regard, fostering inclusion could be linked to the participatory and ecological approach of community music therapy. Second, labelling can be counteracted through reflection and consciousness-raising on language use, better collaboration with participants, and a solidarity approach that contributes to a greater communal awareness, and promote social justice for the participants. Third, stigma related to illness, health and treatment issues states a focus on ‘the competent client’ and the need for a user perspective.

In this regard, the study of MOT82 in this article is an example of research that values the user perspective and invites ‘silent voices’ to be heard (Freire, 2000). These voices argued that although there are many positive qualities associated with MOT82, there are also some aspects that were critiqued. Participants expressed experiences of stigma related to exclusion; stigma related to labelling of concerts; and stigma related to illness, health, and treatment. With regards to the matter of destabilising stigma, their message is clear: Tone down the focus on mental illness, turn up the volume regarding the importance of doing music. And although it should be obvious, it might still be necessary to point out: People are not their diagnosis – people are people. They are persons with strengths and weaknesses; ups and downs; hope and despair; success and failure; dreams and nightmares; faith and disbelief. And when someone in the setting of MOT82 is playing in a band, they want to be a person who plays in a band rather than being a person with a mental illness playing in a band.

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