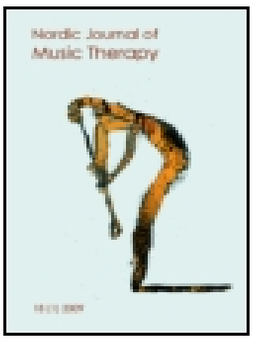

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Health care workers' perspectives on the challenges and possibilities of music therapy within medication-free treatment services

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ABSTRACT

Introduction: In 2015, the Norwegian Regional Health Authorities introduced the possibility for people with psychotic disorders to choose medication-free services, with music therapy as a treatment option. This study aimed to explore the health care workers' perspectives on challenges and possibilities of music therapy within these services.

Method: This is a qualitative study by an interdisciplinary research team, including experts by experience. Ethnographic notes provide data from participant observation with one patient using music therapy, describing what music therapy can be "a case of". Focus group discussions (FGDs) with health care workers, including music therapists, explore their experiences with music therapy and medication-free treatment. These were transcribed and analyzed using systematic text condensation in a stepwise, iterative process involving co-authors to ensure reflexivity.

Results: The summary from the participant observation provides the reader with background information on how music therapy can unfold in mental health care. The informants from the FGDs described music therapy as having a high degree of treatment flexibility providing a continuous process of choices. The collaborative choices both among staff members as well as between patient and staff were experienced as important for treatment outcome. Patients worsening or stagnating increased the significance of contingent choices.

Discussion: The strengths of music therapy, such as its acceptability and flexibility, also represent challenges, including dilemmas of prioritization, challenges when ending therapy, and the need for close collaboration when assessing a patient's worsening. There is a potential for improving the implementation of music therapy into the existing health care teams.

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KEYWORDS Music therapy; mental illness; recovery; choice; medication-free

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Background

Schizophrenia, though a disputed diagnosis, is one of the most burdensome and costly illnesses with psychosis as a core symptom worldwide, accounting for 1.1% of the total disability adjusted life years (DALY's; Hjorthoj et al., 2017; Kahn et al., 2015; Os, 2016; Theodoridou & Rössler, 2010). In a recent study from Denmark, people diagnosed with schizophrenia missed the equivalent of 73% of healthy life per year (HeLP) because of their mental illness and substance use disorders (Weye et al., 2021). Guidelines for treatment of psychosis recommend the use of anti-psychotic medication (Helsedirektoratet, 2013; Keepers et al., 2020). Discontinuation of such medication occurs in collaboration with therapists but is more often described in the literature as non-adherence (Tessier et al., 2017). Non-adherence is often considered a major challenge and cause of relapse and hospitalization. Studies have shown that anti-psychotic medication non-adherence among patients living with schizophrenia is high, and influenced by complex factors related to illness, treatment, and level of social support. Studies recommend to address these factors to enhance treatment stability and adherence (Semahegn et al., 2020).

In 2015, the Norwegian Regional Health Authorities introduced the possibility for people with psychotic disorders, including schizophrenia, to choose medication-free services, within the constraint of the law defining responsible treatment (Helse- og omsorgsdepartementet et al., 2015). The aim was to generate more psychosocial treatment options for people experiencing psychotic disorders, and to give patients choosing to discontinue medication a safe and supportive environment to do so. This treatment option would provide an alternative to self-induced non-adherence, when patients stop using anti-psychotic medication on their own. All the district psychiatric centers in the Bergen region, Norway, provide optional medication-free treatment. This is the context of this study of therapist experiences of the reform instigated by the health authorities, although the participants in this study also worked with patients outside of the medication-free treatment regime.

This change of approach towards a higher acceptance of discontinuation of medication within mental health care was spurred by advocacy work by user organizations (Fellesaksjonen, 2011). There is research suggesting that absence of anti-psychotic medication predicts a higher probability of recovery in the long term (Harrow et al., 2021). Medication-free services are considered to be a step towards a more recovery-oriented treatment practice, advocating for person-centered care and greater self-determination for those with severe mental illness (Davidson, 2016; Davidson et al., 2007). Greater self-determination implicates a greater choice of treatment, which was the intention of adding more psychosocial treatment options within medication-free services. Research has shown how patients with mental health diagnoses receiving their preferred treatment demonstrate a lower dropout rate and improved therapeutic alliance (Windle et al., 2020). Hence, more treatment options should reduce the costs of premature dropout and disengagement.

Music therapy has been recommended since 2013 in the official Norwegian guidelines for treating people experiencing psychosis (Helsedirektoratet, 2013). All district psychiatric centers in the Bergen region have gradually implemented music therapy between 2013 and 2020, some as part of the medication-free treatment project (Oevernes, 2019; Tuastad & Myrhaug, 2020). Music therapy provides recognized benefits of a recovery-oriented practice (Solli et al., 2013), and Norwegian music

therapy practices focus on relational and resource-oriented work aimed at building identity, coping strategies, and capacities and possibilities for community participation (Ruud, 2010). Flexible practices highlighting human rights, user involvement, and citizenship are typical (Stige & Aarø, 2012).

A report from the Norwegian Institute of Public Health (Bjerkan & Leiknes, 2016) summarized five different systematic reviews (Gold et al., 2006, 2005, 2009; Lee & Thyer, 2013; Mössler et al., 2011) on the therapeutic effect of music therapy. They concluded that music therapy as addition to treatment as usual for patients with schizophrenia possibly has a better effect than standard care on general health, mental health and social functioning. However, there was a lack of long-term studies to prove the effect over time. This is similar to a Cochrane systematic review from 2017 and a meta-analysis from 2020, where authors found moderate- to low-quality evidence suggesting that adjunct music therapy improves the global state, social functioning, and quality of life of people with schizophrenia or schizophrenia-like disorders (Geretsegger et al., 2017; Jia et al., 2020). A Danish RCT from 2021 compared the effect of music-listening groups with the effect of music therapy groups on negative symptoms for patients with schizophrenia. They found no difference between the two groups, however, both groups experienced significant reduction in PANSS negative subscale score (Pedersen et al., 2021). A review from 2019 concluded that music therapy is a valuable and undervalued method of non-pharmacological support for patients with various psychiatric disorders (Witusik & Pietras, 2019).

There are many ways of conducting music therapy. Factors suggested to be of particular importance to succeed when working with acute adult psychiatric in-patients are the frequency of therapy, structure of the session, consistency of contact and the therapeutic relationship (Carr et al., 2013). Factors such as musical–social engagement and shared decision-making (participatory and music-centered practice) are highlighted in the literature on more community-oriented music therapy (Stige & Aarø, 2012). Hence, music therapy is a treatment with a high degree of flexibility in both form and content. This creates an opportunity for music therapists to provide an individualized and flexible treatment option based on patients' choices and preferences in mental health care.

As outlined above, this study is situated in a clinical context where music therapy is offered as treatment for people with psychosis who can choose to discontinue medication. To our knowledge, there is no previous research published on how music therapists are involved in and experience the politically instigated implementation of medication-free services for patients with psychosis. We believe this provides an opportunity to explore therapist experiences with patients choosing to use music therapy as a part of their discontinuation process, as well as with those who chose to use music therapy as concomitant treatment with medication.

We aim to reveal both possibilities and challenges for music therapy within this setting, and the focus of this study is to explore music therapists' and other health care workers' perspectives on professional work with mental health patients who choose music therapy within the context of medication-free treatment options.

Method

Study context

The Norwegian health system is largely public, and organized into four regional health authorities. These entities chose different approaches for the implementation of the medication-free treatment program. The Western Norway Regional Health Authority comprising the Bergen region aimed to improve health care for all patients with psychosis by integrating more psychosocial interventions into existing services in district psychiatric centers. The treatment options offered were among others individual psychotherapy, Illness Management and Recovery groups (IMR), individual job support (IPS), occupational therapy, music therapy, and physiotherapy. The focus was on supporting patients' choice and increasing users' involvement and sense of ownership of therapy. All patients who are above 18 years old, not restricted by coercive measurements, and within the admission area are eligible for these medication-free services.

Study design and data collection

This study was part of a larger qualitative PhD project exploring patient and therapist perspectives on medication-free treatment of psychosis. The full study consisted of in-depth interviews with patients (Oedegaard et al., 2020), focus group discussions (FGDs) with therapists (Oedegaard et al., 2022), and participant observation with a patient in music therapy. For this study, information was gathered from the participant observation and the part of the FGDs specifically relevant for the aim of revealing possibilities and challenges for music therapy within medication-free services. The participants for FGD number 3 were purposely selected to reach the necessary strength of information for this aim, which therefore constitutes the main source of information for this study. The participant observation served as a learning experience providing the first author with a deeper knowledge of how music therapy unfolds within mental health care, thus informing in particular the facilitating of FGD number 3. We believe that a condensed summary of this experience will give the reader a similar insight and understanding for what music therapy within mental health care can be "a case of", and further a deeper understanding of the following analysis and discussion of the FGDs.

Participant observation

Participant observation means the researcher participates in the context to be studied, with the aim of describing the problem from an insider perspective (Malterud, 2017). This requires "to make a certain personal as well as intellectual commitment" by the researcher, and further, "to exploit one's full range of capacities in order to make sense of a given social world". This includes to be observant, to take the role of the other, to listen, to learn and to imitate, according to Atkinson (Atkinson, 2015). For the participant observation, we asked a music therapist to suggest a suitable patient, meaning above 18, able to give an informed consent, and living with a psychotic disorder. The patient also needed to be willing to accept having a stranger in the room during therapy. The first author was invited to participate in one music therapy session, to gain trust with the chosen patient. We obtained a written, informed consent

before the next session. The first author participated in and took observational ethnographic notes from seven individual music therapy sessions with this particular patient. This participant observation took place at one district psychiatric center in the Bergen region. It lasted over a period of about three months, at a rate of approximately one session every week except when sessions were canceled. Each session lasted for about one hour. The first author wrote down the experience in as much detail as possible immediately after each session. A condensed summary of these experiences provides an introduction to the findings.

We chose an ethnographic method, inspired by Atkinson's (2015) broad analytic and presentational approach, to be able to learn more and possibly make sense of the interaction patterns and relational matters of music therapy. Ethnography provides the tool to demonstrate how these are means of social work getting done, of social order being constructed, and of social experience being shared. We aimed to do this through encounters with people familiar with this treatment, and the sharing of this social experience (Atkinson, 2015; Emerson, 1995).

Focus groups

We gathered information from three focus group discussions with altogether 17 participants. FGD number 1 and FGD number 2 lasted for about 60 minutes. FGD number 3 lasted for about 90 minutes, as we had additional questions specifically regarding the role of the music therapists. Demographic and professional details on the participants can be studied in Table 1.

The focus group discussions were performed following Malterud's recommendations (Malterud, 2012a), including the use of a topic guide asking for concrete stories, provided as supplementary material. The main author was moderator and a co-author secretary for the FGD, facilitating the discussion and sharing of experiences. In this

Table 1. Focus group participants.

Focus group discussion 1 (FGD1), December 2017 District Psychiatric Clinic Psychiatrists and psychologists	Focus group discussion 2 (FGD2), June 2018 District Psychiatric Clinic Bachelor-level education	Focus group discussion 3 (FGD3), June 2018 University of Bergen Music therapists
Moderator: CHO	Moderator: CHO	Moderator: CHO
Secretary: MV	Secretary: MV	Secretary: BS
P*1: Man 60–70**	P1: Man, 40–50**	P1: Man, 30–40**
Psychiatrist	Mental health nurse	Master of music therapy
P2: Man, 40–50	P2: Woman, 30–40	P2: Man, 50–60
Psychologist	Physiotherapist	PhD in music therapy
P3: Woman, 50–60	P3: Woman, 50–60	P3: Woman, 20–30
Psychologist	Occupational therapist	Master of music therapy
P4: Woman, 40–50	P4: Woman, 40–50	P4: Man, 20–30
Psychiatrist	Social educator	Master of music therapy
P5: Woman, 40–50	P5: Man, 40–50	P5: Man, 30–40
Psychologist	Occupational therapist	Master of music therapy
P6: Woman, 40–50		P6: Man, 30–40
Psychiatrist		Master of music therapy

*P: Participant **Age range. We chose to provide an age range rather than the correct age of each participant to increase confidentiality.

way, the moderator and secretary could act as each other's control to make sure all participants were heard.

Relevant information regarding music therapy from all the FGDs was included.

Analysis of participant observation

Field observations might yield analytic ideas of "what this is a case of". From such ideas "sensitizing concepts" might emerge to inform further data collection (Atkinson, 2015). We aimed for a process of analysis that would take into account the complexity of the research field. The analysis of the ethnographic notes from the music therapy sessions was initiated by a summary of the notes written by the first author. The last author read the original notes, and commented on the summary. As we agreed on necessary changes, the first author rewrote it accordingly. This was done as an iterative process until the summary contained the required information and essential descriptions of the first author's observation of music therapy within medication-free services.

Analysis of focus groups

For analysis purposes, we used Systematic Text Condensation (STC), a method described by Malterud, inspired by Giorgi's psychological phenomenological analysis (Giorgi, 2009; Malterud, 2012b). This is a thematic, cross-case strategy suited for exploratory analysis, consisting of five steps. The first author and the last author read the transcripts, and each found between five and eight preliminary themes relevant across the focus groups. The teamwork then yielded five main themes after a thorough discussion of all the suggested themes. The first author sorted the meaning units, identifying those related to the chosen themes and subthemes, using NVivo as a sorting tool, yielding one code group for each theme. In this process, the names and keywords for each code group were changed and elaborated to enhance the understanding of the topic. The first author wrote the text condensates based on each code group, reducing the content of the meaning units into a condensed text retaining most of the participants' original wording. Meaning units that could not be incorporated in the condensate were left out based on lack of relevance for the chosen theme or study question, or reorganized into a different theme or subtheme. The first author discussed the condensates and themes with the last author and the second author, and finally reorganized the information into three main themes with corresponding synthesized accounts of the main concerns for the therapists, as we agreed on an improved understanding of the data. These synthesized accounts constitute the key findings presented within the findings section below Music therapy as a flexible process: continuous choices; Music therapy and medication-free treatment: collaborative choices; and Music therapy in complex situations: contingent choices.

Ethical considerations

The Regional Ethics Committee for Medical Health Research (REK sør-øst 2017/736) defined this study as health service research and hence according to the Norwegian Health Research legislation, the study was approved by the local data protection officer

for Bergen Health Trust in July 2017 (2017/8692). All participants signed forms providing informed consent to participate.

Findings

Participant observation: What music therapy can "be a case of"

We have provided the summary of the ethnographic notes from the participant observation as a case example in italics below for readers who would like to have a deeper insight into what a music therapy session can "be a case of". We believe mental health care staff would find this useful in their understanding of what music therapy can entail, and hence helpful for their understanding of this study and for presentation of this therapy to their patients.

I was looking forward to meet the patient, Tom, and finally start the planned participant observation. The music therapist and I met Tom at the reception at the district psychiatric center. I was told he got there in a taxi every time to attend the sessions, some of which his psychologist would join, playing the bass guitar.

He seemed a bit shy, but smiled. When asked, he expressed that he had nothing against me being there. We went down in the basement, where the music therapy room was. Tom chatted a little with the music therapist and seemed comfortable. In the beginning of the session, Tom and the music therapist talked about what they had done the last time and if he had done anything in particular regarding music in between the sessions. Then they planned the activity for the next hour together.

Usually, Tom started by approaching an instrument, normally the electric guitar and once the piano, and then he began improvising. The music therapist sat behind the drums, and, adapting to the patient, gave rhythms and a frame to the music. It was clear that they were used to the setting, and knew each other well. They would exchange glances and little nods and smiles to change the music – increasing or decreasing the tempo, for instance, and sometimes they would just laugh at their own performance.

I sat in a chair watching, enjoying the music. I was impressed with Tom's musical competence, he seemed quite lost at arrival, but now he was really at ease, performing with skill. It seemed they could go on and on forever improvising music, and I was later told they sometimes could play for 15–20 minutes in one go. I applauded when they stopped, and told Tom how impressed I was. I really tried to show how much I enjoyed being part of this, and I got the impression that he enjoyed having an audience.

Tom had a severe schizophrenia diagnosis, lived in an apartment in a house owned by his parents, and had a very low level of functioning with no school or work on a daily basis. The only time he got out was to attend the music therapy sessions once a week. The music therapist gave me some background information about Tom's process, which helped me understand the session:

The music therapist told me that he tried to encourage Tom to play together with other patients, and hopefully form a band. I got the impression that this had been a regular topic over time. Tom just kept saying he liked it as it was, and had no interest in playing with other people than the therapist(s). I wanted to do an interview with him to gain a deeper understanding of his views on his health and the music therapy, but he did not want that. I participated in seven similar sessions, and I tried to ask some questions at the end of a couple of sessions, as I wanted to learn what the music therapy

meant to him, and how he reflected around the effect of it. I asked if he enjoyed the sessions, which he confirmed.

The music therapist said it was the only therapy Tom would attend and he was always on time. I asked Tom if the therapy had an effect on his state of mind somehow, and he described it to be the peak of the week. However, it was like a similar low line all the week, a short peak, and then it would drop to the same level just after the session. The music therapist confirmed how the therapy had lasted over a couple of years, but the patient had not changed much in his personal recovery process.

The impression was that Tom's level of functioning had not improved, and that for him music therapy was not helping in a process of recovery aiming for a more active and self-supporting life. The music therapist was a bit frustrated about this, and unsure of how to go forward. On the other hand, music therapy seemed to be important, as this was the only time of the week Tom got out and was engaged in some sort of activity. The prioritizing forward seemed unclear and difficult, as there were waiting lists to attend to. The therapist considered it to be a certain risk for Tom, however, to end music therapy, as he would lose his only activity outside of his home.

This is a description of individual music therapy with one particular patient. The weekly session was an important part of his life, and appeared to be therapeutic regarding level of functioning and negative symptoms during the session. On the other hand, there were no clear improvements of functioning transferrable to other domains in his life, such as practical and social arenas, even though the therapy had lasted for a long time, which the therapist interpreted as stagnation for the patient's recovery process. Thus, this particular narrative illustrates a tension where the aim of the therapy – namely improved social and practical functioning – and the reality did not correspond. The therapist was hence experiencing frustration and dilemmas in prioritizing his resources.

Focus group discussions: The role of music therapy within services providing medication-free treatment for patients experiencing psychosis

In the focus group interviews, we asked the therapists to describe their experience with providing medication-free treatment. The music therapists were asked to describe more detail in the characteristics of music therapy within mental health care. The following findings emphasize the information from the focus group with music therapists, but include information from all the groups.

The key findings involve how the process-oriented nature of music therapy is described, including its flexible and personalized treatment characteristics. This is followed by how processes related to the choice of using music therapy unfold within a new frame of medication-free treatment, from the perspectives of both music therapists as well as other care staff. Finally, key challenges are discussed related to the complexity of therapeutic relationships, treatment needs, and discontinuation of therapy.

Music therapy as a flexible process: Continuous choices

One important issue raised by both music therapists and other therapists was that many patients who did not want to attend any other treatment still wanted music therapy.

> "In my experience this is a form of treatment that reaches those patients who are not capable of using or want to use the other types of therapy we offer. Some patients experiencing severe withdrawal and negative symptoms, who are passive and lack insight into their illness might still be interested in trying this therapy. It seems to strengthen the alliance. Additionally, the patients seem more available both emotionally and cognitively during and sometimes after music therapy. The problem is actually the availability of this therapy, as few patients get it during their admission." (FGD2, P1, psychiatrist)

According to the music therapists, the patients' positive attitude towards music therapy was often instigated by the flexibility of this treatment:

> "The user participation is strong in music therapy. So, the fact that I had the space to let her take control was important to her. And then it was another person who told me that it was (because it was) so flexible in music therapy, because I asked him, should we have an aim, work with something specific, and he didn't want that, he just wanted to come and see how he felt that day, and go along with that in the session. If he wanted to play music, or if that would be too difficult that day, if we should rather listen to music, and talk about . . . yes. So that flexibility was highly appreciated." (FGD3, P4, music therapist)

The patient pathway was said to be paved with many different choices. For instance, patients had to choose the profile of their own therapy process, regarding type of music and expression mode. According to the music therapists, the patients had different needs and wishes for choosing the content of their music therapy sessions. Some wanted to explore the period in time when they first experienced psychotic symptoms, by playing the music they listened to at that time and talk about what happened to them. Others wanted to work with their current difficulties, like psychotic symptoms. Many patients did not want to focus on the illness at all; they just wanted to focus on the music.

Music therapists described the therapy provided also to be flexible in format. Music therapy groups were described to afford positive possibilities in several aspects, providing a sense of connection, where patients helped and supported each other. These groups could be very different from each other in size, content and threshold for entering. When starting certain band-like groups, the therapists attempted to find patients who could fit together both regarding levels of musicality and choices of expression. Other groups had a lower musical threshold for participating, similar to musical gatherings. Listening groups could work for almost all patients, as participation only required choosing a song. Some groups were open, meaning people could choose to stay or leave during the time the group lasted.

Music therapists in the inpatient department described how patients who were too sick to join kept their door open and chose to listen to the music from inside their room. It was described as helpful to have music therapy activities in common areas, with concerts performed by patients or the therapist, for instance. This could provide an uplifting ambiance for the rest of the day, for both staff and patients, and facilitated a nice activation and new relationships between patients. Some departments also used music actively when the music therapist was not present, by singing or listening to music together with the patients:

> "We use music in the ward when we gather the patients; they can sing along or just listen. We use music listening as a way to reach patients, and see how this can be a way to build relations with those who are hard to reach otherwise." (FGD2, P1, mental health nurse)

In the outpatient department, therapists described that many patients were too sick to be able to join a group, or were unable to be in the same group. Some patients found it socially demanding to join a group. For the music therapists, it could be challenging to introduce new members particularly to smaller groups, if the dynamics felt excluding to the new member. In such groups, fixed patterns and social codes could be difficult to overcome, when the original group members did not include new members in conversations, or otherwise displayed behaviors of social exclusion.

When patients were not eligible to participate in a group for reasons like level of symptoms or lack of groups that matched the particular needs of the patient, individual therapy was suggested. Some patients stayed in therapy for two to three years. Music therapy students and/or colleagues of the music therapist, such as a psychologist, could sometimes join these sessions. The music therapists described how this provided variation, musically and socially, but there was no further elaboration on this in the focus group discussions.

Music therapy and medication-free treatment: Collaborative choices

We asked the participants about the processes regarding patient choices of therapy within the new clinical setting that includes medication-free treatment. One music therapist wanted to share the experience he had with a patient wishing to discontinue his medication:

> "I would like to tell you a success story about a very ill patient, with great interest in music. He wanted to discontinue his medication, but every time he tried, he got sicker. I started to have one therapy session a week with him, and then we increased it to two because we saw he benefitted from it. When he seemed ready to start in a group, I went outside the clinic and found a suitable candidate through other music therapists. He was very nervous about it, but we went to see the other patient together. We worked a few months to establish them as a band, and now they play without me." (FGD3, P2, music therapist)

The informants described several different scenarios on how choices regarding music therapy were made with increased focus on and acceptance for discontinuation of medication. Some patients would ask for music therapy themselves, because they considered intuitively that music therapy would be useful for them. When referenced or upon admission, the staff would typically suggest available options based on what was considered beneficial for the patient. Then it was the patient's decision to accept or decline the suggestion. Information regarding the treatment options was considered dependent on the knowledge of the referring staff. According to the music therapists, both patients and staff members other than music therapists often had little knowledge about music therapy. These therapists' knowledge and assessment of the patient's need could affect the presentation of choices, and therefore patient choices and treatment decisions.

The music therapists described how they had the impression of psychiatrists being disconcerted facing patients choosing medication-free treatment. To ensure that the patient would have some therapeutic support in the process of discontinuing their medication, psychiatrists sometimes referred patients to music therapy, even when they had not expressed any interest. In this way, the psychiatrists pushed patients a bit around in the treatment "menu" in an effort to keep the patient in treatment in a possibly troublesome phase of the illness during discontinuation of medication, propelling the patient choice. This could lead to music therapists experiencing treatment processes as demanding:

> "I feel that when they come and ask me, this is a medication-free treatment course, I need some help here, we are stuck, then I feel I need to prioritize that patient. And those patients I have that have been referred to me in that way are perhaps those with the least turn-up, because they don't have that burning passion for music. I will not say they do not have any outcome from the therapy, but it is far more demanding for me, it takes more planning, it is more challenging to see it through, at least for me. And then, I'm thinking, should I really prioritize those who might not get that much out of it, who are not passionate about it, but are kind of pushed into it because they are in a medication-free treatment course?" (FGD3, P3, music therapist)

Music therapists described how they often played an important role in the beginning of a treatment course, especially when the health care team were not able to get into a position to treat otherwise. Many patients who struggled with negative symptoms could be interested in choosing music therapy, even though they did not make use of other treatment options. In these situations, the music therapist could start building a relationship, and other treatment options could be suggested and accepted as the patient felt safer.

> "They use me a lot in the beginning, they can't get into a position to treat, and he is interested in music therapy, can he get an appointment, and if I have time, he will. Then we start building the relationship, and eventually we succeed in adding other treatment options. That works." (FGD3, P1, music therapist)

Patients could also appear more emotionally and cognitively available during music therapy and sometimes afterwards, which could open for a better alliance and dialogue regarding further choices of treatment.

The alliance formed during music therapy was said to be transferable in many cases, and highlighted as important for the rest of the health care team to recognize and use as a resource. It was perceived challenging for the music therapists when other therapists in the care team, like the psychologist or psychiatrist, were replaced . This could be due to staff finding new jobs, pregnancy leaves, or similar reasons. With a new person taking over the responsibility for the treatment, it could be time-consuming to build a new relationship. The quality of the collaboration both among staff members as well as between patient and staff was considered important for treatment outcome. Also, collaboration constituted the basis for the therapists' safety, as being alone with patients experiencing a high level of paranoid symptoms had to be carefully considered, as it could constitute a risk for the therapist.

Patients often needed extended support to take the step to participate in activities or groups outside of the clinic. The music therapists described how they used their personal and work-related network to find patients that matched criteria like musical interest and personality. They spent time outside of the clinic with the patients to consolidate the relationship before they could manage without the support of the therapist.

Music therapy in complex situations: Contingent choices

The informants were asked to share how they experienced challenges regarding music therapy within the frame of medication-free treatment.

The music therapists expressed a perceived increase in the general level of symptoms and illness after the introduction of medication-free treatment. The symptom load was experienced as a bit higher for the patients not using anti-psychotic medication than for those who did. It could be more demanding for the patients to focus on the music therapy sessions if they were struggling with symptoms like anxiety and

restlessness. At times very sick people were referred to music therapy, which made the therapy harder to carry out, with less attendance and participation in the sessions. Less anxiety and paranoid thoughts made it easier to keep a good relationship. On the other hand, increased use of medication could result in less engagement in the music.

Some therapists had positive experiences with patients who used medication on a regular basis and music therapy at the same time, as they appeared more stable regarding attendance, and less challenging relationally with less paranoid thoughts. However, when patients attended therapy over a long period, the recovery process seemed quite similar for both patient groups, those using medication as well as for those who had discontinued. This was depending on whether they managed to stay in therapy or dropped out. Therapists worried about the latter, as absence of treatment could have adverse effects on the patient's life in their opinion.

The music therapists described themselves to be among those in the health care team who respected the users' decisions more than other team members, for instance, in discussions about discontinuation of medication. Also, the music therapists described themselves as professionals who mediated the recovery perspective more than other team members. When other team members disagreed, the argument often evolved around the topic of what constitutes "responsible treatment." Music therapists expressed a need to be humble in such discussions, considering the possibility of the patient worsening.

There was an experienced need to prioritize medication-free patients ahead of other more stable patients, especially if they were without other treatment options. If a patient's condition worsened, music therapists considered it to be a heavy responsibility to decide when to take action. The music therapists did not feel competent to consider illness progress on their own if they were the only one having regular contact with the patient. Hence, it was perceived very important to have a health care team to ask for support and help to observe or add measures if there were reasons to worry about a patient.

The music therapists described how therapy sessions could become a negative experience for some patients if it got too emotional. Sometimes the patient could express feelings of being afraid of or reluctant towards stopping the therapy, if the roles had become unclear and the relationship too close, as this quote illustrates:

> " I have also stopped treating patients when I have felt it did not work out, and they have been very hurt. This is no fun for either of us, but it is no good to keep on doing something that does not work." (-FGD3, P3, music therapist)

The therapist conveyed how it could be stressful to end therapy, when people are expressing hurt feelings. However, ending therapy needed to be done if criteria of progress were not reached, or the therapist considered the therapy not to be useful for the patient. Losing an important social meeting and regular activity could be negative and experienced as a personal rejection. Therefore, preparing the patient on boundaries for the music therapy was perceived very important.

Patients could develop patterns in individual therapy that were difficult to deviate from, and hence it could be difficult to promote a connection with other patients with the aim to form a group or band. However, the relationship between patient and therapist was often described as supportive and strong. For some patients, this relationship could be sufficient, and a group or band too difficult to relate to.

The music therapists expressed how they felt it was important to challenge patients and work with social skills and problems through music therapy, even though the patients would not have chosen to dare to do so with no pressure. This could, for instance, be to participate in a band, hold a concert, or otherwise take steps towards aims they had agreed on. It could be difficult to consider the balance between the freedom to choose and to challenge a patient's limits:

> " . . . a challenge can be how they sometimes need to be challenged, I believe. If they are allowed to always decline every suggestion, they might need that too, but to simply accept that every time means they can keep up that kind of defense even when it could have been useful for them. When I have taken the chance, ok, but try anyway, you know, it surpasses that free choice by making it harder to turn down the suggestion, but afterwards (. . .) they seemed to be happy about it." (FGD3, P5, music therapist)

The music therapist expressed a need to evaluate the therapeutic effectiveness for each patient, as they saw how not all patients had as much use of music therapy in their struggle for progress in personal and clinical recovery. Considering each patient's personal outcome of music therapy had to be held up against to which degree it was responsible treatment to put pressure on that person's limits, for instance, regarding social participation. On the other hand, it could be considered poor treatment not to put some pressure on the patient if this challenge would improve the therapeutic outcome.

Discussion

In this study exploring health care workers' perspectives on music therapy within the context of medication-free treatment, music therapy was said to provide flexibility and continuous choices for patients. Medication-free treatment presented new contexts for collaborative choices and experiences for music therapists as part of the interdisciplinary health care teams. Participants explained how lack of knowledge among coworkers regarding music therapy as treatment could be challenging, as well as increased referrals of people with more severe symptoms. Music therapists explained how they often took the role of promoting the recovery philosophy in the team, and the role as a relationship builder that the rest of the team could lean on. Choices were explained to be contingent on situations, available resources, professional competences and the patient's level of symptoms, presenting both challenges as well as possible solutions. In the following, we will elaborate on the three themes presented in the findings section, and relate them to the existing literature.

Continuous choices

The music therapists expressed many different angles of approach, regarding both format and content of the therapy. This is in line with other research showing that this therapy has no conclusive models (Carr et al., 2013). This variation and freedom to shape the therapy to the needs of the individual is both positive regarding the level of flexibility, but also potentially negative regarding the possible variation of therapeutic quality. To optimize the use of music therapy, the academic and clinical training and careful selection of intervention techniques are essential to correspond with the particular needs of the patient group (Stegemann et al., 2019). The flexibility was

said to instigate a positive attitude towards the therapy from patients otherwise reluctant regarding treatment, providing a pathway of individual choices. This is in line with research showing how patients enjoy music therapy, as it is not experienced as traditional therapy (Solli & Rolvsjord, 2014). Music therapy could then open the door for patients into other treatment options, as the patient over time would feel more safe and familiar with the health care team. Previous research indicates that music therapy is a feasible and effective treatment for patients with low motivation for therapy (Gold et al., 2013). Also, low drop-out rate is believed to be a positive side of music therapy (Hannibal et al., 2012).

Collaborative choices

As music therapy has been increasingly implemented into treatment as usual for patients with psychosis, there is a need for increased knowledge among music therapists' coworkers to understand the nature of this treatment. Specifically, regarding changes due to medication-free treatment, participants raised three important issues in this study. First, patients off medication could appear more affected by their symptoms, and hence more difficult to reach during music therapy sessions. Second, increased use of medication could affect patients' level of effort and participation during the music therapy sessions. Third, therapists noticed increasing numbers of referrals to music therapy of more ill people with limited musical interest, due to the need for keeping those wishing to discontinue medication in some treatment for safety reasons.

Psychiatrists and psychologists are often gatekeepers to available treatment, and lack of knowledge may infer inadequately based referrals, or no referrals, based on the gatekeeper's recommendations to the patients. This could result in patients not being referred to music therapy even though they could have found it useful, but also referring patients to music therapy when they are somehow unable to cope with the demands of the therapy. Patients with interest in music are more likely to find it useful, but this should be interpreted very broadly, and is not necessarily linked to musical skills (Ansdell et al., 2010).

This expressed concern for referrals was said to be due to lack of information provided for the gatekeepers. However, studies have suggested how resistance towards change, staff attitudes and lack of user involvement can be reasons for poor implementation of recovery-oriented services (Lorien et al., 2020), such as music therapy.

To create conditions that can nurture the patient's passion for music seems to be key when the music therapists in this study talk about how and why they adjust their practices to circumstances and requests. This is in line with previous theorization of how music works in music therapy (Ansdell, 2016; Stige & Aarø, 2012). The health care team also need to know how and when to take advantage and make use of the positive relational, emotional and cognitive impact music therapy can have on a patient experiencing negative symptoms. The quality of the patient–therapist alliance is well known to be of importance for the outcome of treating severe mental illness (Ljungberg et al., 2015).

Contingent choices

One challenge mentioned by the music therapists was difficulties with ending the therapy. Issues regarding termination of therapy are well known from psychotherapy,

where unmet expectations and unresolved alliance ruptures are described (Curran et al., 2019). Music therapists need to be aware of and have competence with problems with ending therapy in general, as well as regulating emotions after certain sessions. Music therapy emphasizes the importance of the relational quality between the therapist and the patient; hence it should be equally important to find good ways to end a relationship that most likely is experienced as more than a purely professional one.

One therapist mentioned how ending therapy was "no fun for either of us." Even though music therapy not necessarily is "fun" work for the therapist, we believe this indicates a level of personal stress as the relationship gets too close. The mutual similarities between psychotherapy and music therapy indicate the importance of taking into account the sometimes challenging relational dynamics, and to focus on interpersonal sensitivity and reflexivity (Witusik & Pietras, 2019). The findings suggest that sensitivity to context is essential too. Consider, for instance, the case example with Tom's music therapy process presented initially in the findings section. Dilemmas concerning discontinuation of music therapy go beyond narrowly considering the effects of the intervention or the relational complexities of the collaboration, because music therapy within the context of medication-free treatment options sometimes is the only therapy on offer that the patient chooses to use.

Also, it was challenging for the music therapists to observe and assess which actions were needed when a patient was worsening. In these situations, it was important to be part of a health care team to find adequate solutions. There is a risk of relapse or worsening for patients who choose to discontinue their anti-psychotic medication, with potentially negative impact on several parameters for the individual (Hor & Taylor, 2010; Schooler, 2006; Strømme et al., 2021). This risk needs to be closely monitored, and assessed on a regular basis by the team, including the medically responsible psychiatrist.

Strengths, limitations and future research

Implementing medication-free treatment for people with psychosis, including the use of music therapy, is an innovative approach in mental health care. To our knowledge, this is the first research project about music therapy within a setting of medication-free treatment, exploring available data that could inform future collaborative processes between therapists and patients. In this study, we could have asked more explicitly about and probed for music therapy in focus group one and two, to further illuminate various health care personnel's perspectives on the use of music therapy in this context. Future research should look into the intricacies of the relationships between musical possibilities and various challenges in person, system, and situation, including the user perspective in mental health care, and the experienced usefulness of music therapy. There is a need to look further into the relationship between the music therapist and the patient as a dyad over time, to improve the understanding of how choices are made in various situations. Given that the results of this study revealed that access to information about music therapy sometimes was very limited, further research on the use of tools for shared decision making would be very relevant, when such tools include music therapy as one treatment option.

Conclusion

Music therapy within medication-free treatment represents the recovery philosophy, with a high degree of flexibility and individual freedom of choice. We found three main themes on how these therapeutic choices are made; continuously through the entire process, in collaboration with the therapist, but also contingent on circumstances such as level of sickness and available resources. There is a potential to improve the implementation of music therapy in health care teams. Increased knowledge on the potential and limits of music therapy among co-workers is needed, including the role as a relationship builder that the rest of the team could lean on. A continuous quality assurance of their therapeutic work is required. Finally, the music therapists need support in assessing stagnation and potential worsening of the patient's condition.

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Availability of data and materials

The transcribed focus groups are not publicly available for confidentiality reasons, but anonymized Norwegian transcripts can be made available from the corresponding author on reasonable request.

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