

Expectations in music therapy

A sociocultural perspective

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Master thesis

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Fall 2017

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Acknowledgments

I will like to thank my supervisor, Brynjulf, for helping me disentangle my thoughts, and for believing in me.

Thanks to Rikke and Magnus, for helping me with language and structure.

Thanks to friends and family for your encouragement.

And thanks to Astrid, for your infinite patience and support. Your motivation helped me through this.

Abstract

This thesis is a theoretical exploration of the nature and influence of expectation in music therapy in mental health care. By reviewing music therapy and psychotherapy literature, as well as various learning theories, expectation is suggested as a fundamental factor that influences both actions and experiences in music therapy. A rationale for a sociocultural perspective on expectation is articulated, and the concept is considered in relation to discourses regarding the user-perspective in music therapy and culture-centered music therapy. I argue that expectations concerning music therapy is mainly based upon one's understanding of music, health and therapy. The literature suggests that expectation influences both process and outcomes in therapy, and that a focus on promoting positive expectations is important. Based on a sociocultural perspective, I reflect on ethical considerations concerning changing clients' expectancies. Finally, implications for the practice of music therapy is considered.

Forventninger i musikkterapi: et sosiokulturelt perspektiv

Denne oppgaven er en teoretisk utforsking av hva forventning er og hvilken påvirkning den har i musikkterapi i psykisk helsevern. Ved å utforske musikkterapilitteratur, psykoterapilitteratur og ulike læringsteorier, er det foreslått at forventning er en fundamental faktor i musikkterapi, som påvirker både handlinger og opplevelser. Et rasjonale for en sosiokulturell forståelse av forventninger blir beskrevet, og konseptet knyttes opp til diskurser angående brukerperspektivet i musikkterapi og kultur-sentrert musikkterapi. Forventninger til musikkterapi tenkes å hovedsakelig være basert på ens forståelse av musikk, helse og terapi. Litteraturen som gjennomgås foreslår at forventninger påvirker både prosessen og utfallet av terapi, og det anbefales å aktivt styrke klientens positive forventninger til terapien. Basert på et sosiokulturelt perspektiv, reflekteres det i oppgaven rundt etiske hensyn knyttet til å endre klienters forventninger. Til slutt beskrives implikasjoner for musikkterapipraksis.

1.0 Introduction

What are expectations, and do they influence the process of music therapy in mental health care? These are questions I want to explore in my master thesis. In psychotherapy, expectations have long been considered an important factor for the benefits of therapy (e.g. Frank, 1961; Goldstein, 1962). Some have even argued that the change of clients' expectancies is at the essence of all psychotherapy approaches (Greenberg, Constantino, & Bruce, 2006). In music therapy, Katharina Stahr and Thomas Stegemann (2014, 2016) have studied the role of music therapist's expectancies in therapy, and are currently studying clients' expectancies in music therapy. They argued that expectation is probably an important factor influencing the process of music therapy, but that there is a need for more research. With this master thesis, I wish to contribute to the exploration of expectation in music therapy.

1.1 Purpose

The purpose for my master thesis is to explore the role of client's and therapist's expectations in music therapy in mental health care. By reviewing both music therapy and psychotherapy literature that consider expectation as a factor in therapy, I will synthesize a working definition of expectation and consider its possible influence in music therapy. After reviewing the literature, I will elaborate on the nature of expectation by exploring cognitive and sociocultural perspectives on learning, before I finally consider implications for the practice of music therapy. My research questions will be articulated in section 1.3.

1.2 Background

One of the main tenets in my exploration of expectations and understanding is that our world-views are developed in relation to the social and natural world we participate in; as we grow up, and throughout our lives (Wenger, 1998). My own world-view is of course no exception. I will start this text by describing the relevant academic context of my study program, and the present status of music therapy in mental health care in Norway. Then I will describe in more detail my personal academic trajectory towards an interest in expectations in music therapy. By doing this, I hope to communicate the relevance of my enquiries based on the present

status of music therapy in mental health care, and also make my values and presumptions more transparent for the reader.

Norwegian context

For me, what characterises the Norwegian discipline of music therapy is its critical tradition. Even Ruud could in many ways be considered the father of Norwegian music therapy, as he contributed in shaping the discipline with his theoretical development of a humanistic perspective in music therapy (Ruud, 2010), his critical enquiries concerning epistemology, ontology and values in music therapy (e.g. Ruud, 1980, 1998; see also Ruud, 2015a, 2015b for a collection of his articles published between 1973 and 2014), and of course his essential role in establishing the first music therapy study in Oslo, Norway in 1978. Ruud emphasised human's agency and active meaning-making, and considered the relationship between individual and community when trying to understand health and the role of music therapy. In Bergen, Norway, where I have studied music therapy, professors such as Brynjulf Stige and Randi Rolvsjord have followed in Ruud's critical footsteps. They are both acclaimed contributors to the international discourse of music therapy, and my own theoretical reflections are highly inspired by their work. Stige (2002) has articulated a culture-centered perspective of music therapy, exploring the interdependency of individuals and collectives, and how culture is embedded in biological, psychological and social processes. His work is challenging music therapists to look beyond the music therapy room, and look to the myriad of relationships that promote or challenge health as experienced by the client. Rolvsjord's (2010) main focus is mental health care in her articulation of a resource-oriented music therapy. With grounding in positive psychology, feminist perspectives, and empowerment philosophy, she criticized disempowering ideologies and political conditions that contribute to the construction of mental illness, and she promoted a view of the client as a competent contributor to the processes in music therapy (e.g. Rolvsjord, 2004, 2006, 2014a). Congruent with these three professors' perspectives is also community music therapy (Stige & Aarø, 2012; Stige, Ansdell, Elefant, & Pavlicevic, 2010) and the recovery perspective as integrated in music therapy (Solli, 2012; Solli, Rolvsjord, & Borg, 2013); two traditions which are well established in contemporary practices of music therapy in Norway. Shared by all these orientations, is a view of music therapy as a collaborative enterprise where the user perspective is recognized and respected.

These well-articulated theoretical orientations, coupled with high grade quantitative research (Geretsegger et al., 2017; Gold et al., 2013; Gold, Solli, Krüger, & Lie, 2009;

Mössler, Chen, Heldal, & Gold, 2011), and research on clients' experiences of music therapy (e.g. Solli & Rolvsjord, 2014; Solli et al., 2013) has contributed to the growing interest and acknowledgment of music therapy in mental health care we find in Norway today. In 2013, music therapy was recommended in the national guidelines for the treatment of people experiencing psychosis (Helsedirektoratet, 2013), and in 2016, when Norwegian politicians responded to the user organizations' demand for medication-free treatments in mental health care, music therapy was promoted as one of four medication-free approaches (Helsedirektoratet.no, 2016). This last decision is interesting, as the government directly intervened with mental health care policies to strengthen clients' rights; here the right to choose one's own treatment. Robert Whitaker (2017), a recognized critic of psychiatry and the pharmaceutical industry, congratulated Norway as the first country in the world to systematically open up for medication-free treatment as part of standard mental health care. He argued that psychiatry is driven by a grand narrative where medications are seen as essential and necessary for client recovery. Respecting clients' own judgments in mental health care, and acknowledging that medications are not essential, but rather one of many approaches, challenges the conventional narrative and opens up for new understandings of mental health and the processes in therapy.

It thus seems as there is an atmosphere in Norwegian mental health care where the clients are given more responsibility and acknowledgement; where client knowledge is respected as a valid 'truth' when it comes to mental health care. Adherents to the traditional narrative, what has been conceptualized as 'the medical model' of mental health care (see below), who mainly depend on empirically supported treatments, will naturally be critical to the introduction of the client's perspective as a 'second truth'. As mental health care traditionally has been conceptualized as the cure of people with mental disorders who by definition do not know what is best for themselves, a transition towards respecting the client as an 'expert-by-experience' is indeed a paradigm shift. I then find it natural to ask *how* the client's perspective contributes to the processes in mental health care, and it is with this question I will argue that a focus on expectations becomes even more relevant than before. Expectations have been argued to be fundamental for the benefits of therapy (Wampold & Imel, 2015), and an exploration of the nature and influence of expectations might provide a scientific rationale for why the client's perspective should be acknowledged in mental health care, as a supplement to the ethical rationale guided by universal human rights.

Music therapy in Norway has long seen the value of the client's perspective. When music therapy is now recommended as a medication-free treatment that clients can decide to

use, I see the profession as a key representative of this ‘new narrative’ that Whitaker (2017) saw emerging in Norwegian mental health care. It is with this background I study expectations in music therapy. I hope to contribute to the discourse about ‘how music therapy works’ and to encourage a practice that is open for several ‘truths’.

Personal academic trajectory

At the time of writing, it is five years since I started studying at the five-year music therapy program in Bergen, Norway. Early on, I was drawn to the context of adult mental health care, for at least three reasons; 1) I was fascinated about how people experienced the world differently, 2) I found a pulsating debate in the music therapy and psychotherapy literature about how clients in mental health care should be treated, based on differing perspectives on the nature of mental health, the purpose of therapy, and what the working ‘mechanisms’ of therapy were, and 3) I found it meaningful and inspiring to work with the people I met in therapy, as they taught me a lot about life, and as I felt I could make a difference in theirs. My interest in mental health led to an interest in philosophy and critical perspectives. After three years of study I wrote an assignment where I explored the rise of psychotherapy as a scientific discipline, critically discussing diagnosis systems, power structures in therapy, and a medicalised view of the processes in psychotherapy and music therapy in mental health care. My starting point for this discussion was mainly Rolvsjord’s (2010) articulation of resource-oriented music therapy. Rolvsjord promoted an awareness of the client’s active role in therapy; argued that discourse is not only representing the nature of mental health and music therapy, but also influencing or even constitutive to these; argued that the focus of therapy should ultimately be empowerment, instead of primarily symptom reduction, viewing the client’s health in a contextual perspective; and she introduced me to the notion of ‘common factors’ and ‘the contextual model’. I was easily persuaded by Rolvsjord’s resource-oriented approach which promoted an egalitarian vision for mental health care, where collaboration was fundamental to health promotion, which necessitated a respect for the client’s world-view in music therapy. I had these egalitarian values in mind when studying for my next assignment, exploring common factors and the contextual model in psychotherapy and their presence in the music therapy literature.

Exploring the notion of common factors, I encountered a debate in the literature concerning the processes in therapy. I will shortly describe this debate here, as it is an important background for the rest of the text. What is described as ‘the medical model’ in mental health care is a conceptual framework for understanding mental illness and the

processes in therapy borrowed from the discipline of medicine. The medical model has five components; it is believed that 1) the client has a disorder or an illness that can be diagnosed by a skilled psychotherapist, 2) the psychotherapist can provide a psychological explanation for the cause of the illness, 3) it is possible to determine a mechanism of change, 4) it is therefore possible to design a procedure for alleviating the illness, and 5) the procedure is argued to be the vehicle that alleviates the illness (Wampold & Imel, 2015). Based on this conceptualisation of therapy, two clients with the same diagnosis, who tries two different therapy approaches, should not experience the same rate of recovery, since one of the two approaches will better target the core of the illness. While this conceptual scheme has been criticized from several orientations in mental health care (see Rolvsjord & Stige, 2015), the common factors hypothesis specifically targets its claims concerning how therapy works. Meta-analyses of psychotherapy outcome research suggests that all approaches in psychotherapy are close to equally effective (Lambert, 2013). Based on these findings, the common factor hypothesis held that (psycho)therapy works through common elements shared by all or most therapy approaches, while the specific activities promoted by the different schools of therapy have little or no effect in themselves (Duncan, Miller, Wampold, & Hubble, 2010; Rosenzweig, 1936). Based on the common factors, and a cultural conception of psychotherapy, Bruce E. Wampold and Zac E. Imel (2015; Wampold, 2001b) have articulated a ‘contextual model’ as an alternative to the medical model in mental health care. This model suggests that psychotherapy works through three pathways; 1) a real relationship, 2) expectations, and 3) activities based on a sound rationale which is expected to be helpful (Wampold & Imel, 2015). They argued that what is important for therapy to be effective is that the client and therapist believe in the approach, and expects that engaging in the therapeutic activities will help the client deal with her troubles. The scientific validity of the approach is irrelevant, as long as the activities are expected to lead to benefits (Wampold, 2007; Wampold & Imel, 2015).

In music therapy, I found there was support for the importance of a good therapeutic relationship and for the use of various musical activities (e.g. Bruscia, 2014), but I did not know of many music therapists who discussed the role of expectancies and belief in therapy. Based on the emphasis on expectation in the contextual model of mental health care, I wanted to explore the nature and influence of expectations in music therapy. Did any music therapists discuss expectations as an essential factor for the benefits of music therapy? If so, how did they explain expectations’ influence on the process or outcome of music therapy? And importantly, could the role of expectations in therapy be a rationale for respecting the client’s

perspective in music therapy? These were questions that lead me to exploring expectation as a topic for my master thesis.

1.3 Research questions

The primary aim of this theoretical enquiry is to explore the nature and influence of expectation in music therapy. I will explore literature from both music therapy and psychotherapy, and conceptualize a working definition of expectations. This will further be explored in relation to theories on learning, and discussed in relation to music therapy.

The following research questions will be explored:

1. *How have expectations been considered in the music therapy and psychotherapy literature?*
2. *How can expectations be understood from a sociocultural perspective?*
3. *What are the areas of understanding that expectations towards music therapy are based upon, and how can these be considered from a sociocultural perspective?*
4. *What are the implications of a sociocultural notion of expectation for the practice of music therapy?*

The results from the first research question will be the basis for the articulation of a working definition of expectation in music therapy, presented in chapter 2. This definition suggests that expectation is partly based on understanding, and chapter 3 will address the second research question by exploring a sociocultural perspective on understanding. Based on these enquiries, the two final research questions will be explored in chapter 4. Finally, chapter 5 presents a summary of the findings.

1.4 Method

As the purpose of my study is to explore a sociocultural understanding of expectation, I have chosen a theoretical approach to the phenomenon of study. By using a theoretical approach, the main ‘data’ of the enquiry is literature, and the main method is critical reflections communicated through chains of arguments. As expectation is an abstract concept, empirical studies will only provide the ‘fragments’ of its consequences, which necessarily needs to be

interpreted by using a theoretical framework. There is therefore a need for both empirical research and theoretical enquiries as they complement each other in the constructive process of understanding the phenomenon.

In research, it is required that the researcher describes her epistemological preconceptions as part of her method; that is, her assumptions about the nature of knowledge, and what it is possible to know. As my focus of study is expectation as linked to understanding, my study is in essence an epistemological enquiry. This implies that a description of my epistemological point of view becomes more than a reflexive consideration of what I am able to 'find' through my enquiries, as this epistemology will be fundamental to all of my arguments as I explore the nature and influence of expectation. The following description of epistemology therefore has two purposes; 1) being a reflection of the research process, and 2) presenting the epistemological assumptions that govern my enquiries. I will present three philosophical orientations that inform my point of view; hermeneutics, social constructionism and critical theory.

The philosophers of *existential hermeneutics* held that hermeneutics was not just a method to be used in research, but a process which is fundamental to the experience of being (Alvesson & Sköldbäck, 2009). Heidegger and Gadamer held that we, as human beings, are 'always already' situated in a concrete and historical context; a context from where we understand and experience the world. This spatio-temporal field from where we experience the world was pictured as a *horizon*; a horizon that were the sum of our conscious and unconscious assumptions (Svendsen & Säätelä, 2007, p. 93). *Preunderstanding* was therefore seen as a necessity to all understanding, as everything is interpreted based on preconceived assumptions. 'Understanding' could therefore be seen as not only knowing the 'right answer' to something, but an ability to experience the world as meaningful. It is therefore not possible to detach oneself from one's horizon of understanding, as it is the fundament from which the world is understandable. In research, this implies that I as researcher have preconceptions which permeates the whole of the research process; as a necessity to understand that which I am studying, by directing my attention to what I deem as important, including what literature I choose to read, and finally by filtering information and structure it in the process of writing. The best I can do is to be aware of my preconceptions and values; something I tried to communicate by presenting my background in section 1.2.

All people have their own horizons of understanding from where they understand and experience the world. Gadamer held that it is possible to 'visit' other people's horizons through *empathy*, and through this process revise and/or enrich one's own horizon through a

fusion of horizons (Alvesson & Sköldberg, 2009). This process also goes for literature. Gadamer held that texts also represented a horizon of understanding, and for a person to learn what the text is communicating the reader must seek to fuse her own horizon with the text's (Svendsen & Säätelä, 2007). As the primary data for my research is literature, this is relevant for my research process; by engaging in a dialogue with the texts, I have tried to understand expectation by 'seeing' the world from the texts' point of view, which has resulted in a revising or enriching of my preunderstanding. Our horizon is therefore dynamic and amenable, as it changes when we explore the world from the perspectives of others.

In terms of *social constructionism*, I consider our horizon of understanding as socially constructed. Peter Berger and Thomas Luckmann held that people adopt the social norms and knowledges of their society through *socialization* (Alvesson & Sköldberg, 2009). By using the terms above, we might say that the people (and texts) we encounter as we grow up, and throughout our lives, are those who represent the knowledges and values of the society. As we engage in a fusion of horizon with these people (and texts), we are socialized into seeing the world as they do. Our experience of the world is thus socially co-constructed (I will refer to this in section 3.5 as a process of negotiation). Social norms and knowledge is argued to be passed on through generations, where *language* is considered an essential mediator. For my research process, this implies that my exploration of expectation rests on the constructions of others. The notion of expectation as an essential factor in therapy (Wampold & Imel, 2015), as an example, is a discourse which I can extend and explore by matching these claims to my own experiences, and by relating it to other scientific discourses. By doing this, I take part in the social construction that constitutes our understanding of music therapy.

This leads me to the final concept which has influenced my epistemology; *critical theory*. The tradition of critical theory is based on the notion that societal conditions are not natural and inevitable, but rather "historically created and heavily influenced by the asymmetries of power and special interests, and that they can be made the subject of radical change" (Alvesson & Sköldberg, 2009, p. 144). Critical theory thus aims at critically disputing the social constructions that serve to maintain repressive power relationships as they are accepted as 'just the way things are'. The traditional medical model of mental health care (see section 1.2) can be seen as such a social construction, or *ideology*, that serves as a rationale for a mental health care where the therapist is the powerful expert and the client is seen as subordinate (Maddux, 2005, 2008). By exploring the role of the client's perspective in music therapy through studying expectation, I hope to contribute to a change of ideology in mental health care; combatting inequality, by providing a rationale for an egalitarian

approach. Critical theory acknowledges the ethics of research and theory development; we are not only describing a social reality, but either conforming to and reproducing the social order, or challenging that social order by questioning its fundamental ideologies (Alvesson & Sköldberg, 2009; Rolvsjord & Hadley, 2016). This implies that I am allowed to have an agenda in my research, as long as I am aware of multiple perspectives and as I am transparent in my values. That said, if my research is to be acknowledged, it is not my agenda that will lead to change in practices, but the coherency of my arguments.

Kenneth Aigen's (2005b) description of a *philosophical enquiry* has been a resource in my research process. I have not kept to this method as a framework for my enquiry, but used it as a guide for my theoretical approach. Aigen described philosophical enquiry as having four procedures; 1) clarifying terms, 2) exposing and evaluating underlying assumptions, 3) relating ideas as a systematic theory, and 4) using arguments as the primary mode of enquiry. Throughout chapter 2, I will try to clarify a working definition of expectation by reviewing how the concept is used in both the psychotherapy and the music therapy literature. In chapter 3, I will explore underlying assumptions in the cognitive and sociocultural perspectives on understanding. In terms of relating ideas as a systematic theory, I will synthesize various conceptions of expectation from the psychotherapy and the music therapy literature into a coherent working definition of expectation. This definition will further be related to sociocultural learning theories and to the ideas from culture-centered music therapy (Stige, 2002). Finally, arguments will indeed be the main mode of enquiry, complemented by referring to the work of others which in many ways constitute the fundament on which my arguments may be experienced as plausible.

2.0 Towards a working definition of expectations

This chapter will explore how expectations have been considered in the psychotherapy and music therapy literature. Section 2.1 considers placebo trials, various conceptualizations of expectations used in psychotherapy research, expectations as a common factor, a sociocultural perspective on expectations in psychotherapy, and outcome expectancies. Section 2.2 presents a summary of my literature review on common factors in music therapy, before presenting an original literature review on the presence of expectations in the music therapy literature. Section 2.3 will present a working definition of expectation based on insights from both the psychotherapy and music therapy literature, and in section 2.4 I reflect on the ethics of changing clients' expectancies.

2.1 Expectation in psychotherapy

As an introduction, it serves to present a definition of expectation. Warren Tryon (1994, as cited in Stahr & Stegeman, 2014, p. 276) defined expectation as “the anticipation of future consequences based on prior experience, current circumstances, or other sources of information”. I will explore this definition in more detail in section 2.2.

Placebo

Expectations have generally been treated as an unwanted and disturbing factor in medicine and psychotherapy research. What has been credited as one of the first exemplary demonstrations of the scientific method to expose charlatanism and pseudoscience in medicine, was the discrediting of Franz Anton Mesmer's medical practice in the late 18th century (Wampold & Imel, 2015, p. 5). Mesmer's cures by the use of ‘animal magnetism’ showed remarkable effects, but through a placebo trial, researchers found that the effects of the cure were not caused by the purported physical mechanisms (here, animal magnetism), but were merely a result of the patient's expectations and beliefs. Interestingly, the researchers did not consider this a demonstration of the power of expectations, but rather celebrated the exposure as a progression towards a scientifically based medicine; what is today called evidence-based medicine.

By using placebos in medicine research, researchers have experimentally controlled for the psychological effects of expectations on treatment outcomes in order to determine the specific effects of the physical intervention. Placebos are ‘sham’ medications or treatments which should be identical to the original intervention but lack the remedial properties.

Placebo treatments in medicine could for example be the administration of inert pills, tonics, or salves, or carrying out a simulated surgery (as was the case in Moseley et al. (2002)), in the same contexts as usual treatment. Interestingly, compared to no treatment conditions in research, placebos have shown to have a robust effect in itself (Wampold, Imel, & Minami, 2007), which suggests that psychological effects are indeed important contributors to the remedial (and sometimes detrimental) effects in medicine (Harrington, 1997b). Today, most theorists explaining placebo effects emphasise the role of expectations (Wampold & Imel, 2015, p. 205). Classical conditioning (see section 3.1) has also been proposed as a mechanism through which placebos trigger bodily responses, but also here, expectancies have been suggested as a mediating factor (Kirsch, 1997). Interestingly, it is not only the patient's expectancies which are experimentally controlled for in medicine research. The double-blind design, where neither the patient nor the doctor knows whether the medication is a placebo or contains the active physiochemicals, is used to make sure that the doctor's expectations are not influencing the patient's expectations, and consequently influencing the effects of the medication (Wampold & Imel, 2015). In psychotherapy, even the researcher's allegiance to the psychotherapy approach has been shown to influence the outcomes of comparative psychotherapy research; suggesting that the researcher's expectations influence the effects of the therapy (Luborsky et al., 1999). This shows that expectation has long been a recognized phenomenon, but that it has mostly been treated with negative connotations. As Anne Harrington observed;

On the one hand, we acknowledge the power and ubiquity of placebo responses by our requirement that all new drugs be tested in double-blind placebo-controlled situations; however, we then define those same responses as the “non-specific noise” in the treatment to be subtracted out of the picture.

Harrington, 1997a, p. 1.

Psychotherapy

One would think that the focus on reducing the powerful ‘self-healing’ effect of expectation in medicine research would naturally lead to an exploration of the role of expectations in psychotherapy. But this has not always been the case. While some psychotherapists were interested in expectation as a contributing factor to psychotherapy already in the mid-20th century (e.g. Frank, 1961; Goldstein, 1962), the interest in expectation as an important element in psychotherapy has waxed and waned (Greenberg et al., 2006). Today, there seems

to be a renewed interest in the concept (Constantino, 2012).

Generally, expectation has been linked to the common factor perspective, which holds that the effects of psychotherapy are more or less a result of the factors in psychotherapy which is shared by all or most approaches; such as a therapeutic relationship, a cogent explanation for the mental illness, activities which is meant to be helpful, and expectations (Duncan et al., 2010; Frank & Frank, 1991; Lambert, 2013; Rosenzweig, 1936; Wampold & Imel, 2015). The common factors hypothesis is a proposed explanation to the results from comparative psychotherapy research which suggests that there is little to no difference in effects between different psychotherapy approaches (Lambert, 2013).

In psychotherapy research, expectations have been conceptualised as *outcome expectancies* and *treatment expectancies*; the former referring to the belief in the therapy to be helpful, while the latter refers to expectations concerning client and therapist roles in therapy, therapy activities, and duration of therapy (Constantino, 2012). *Efficacy expectancies* have also been discussed in psychotherapy, and refers to the belief in one's ability to perform the activities proposed by the therapy approach (Greenberg et al., 2006). Concepts such as *hope*, *motivation* and *therapy preferences* are viewed as related concepts to the above, but either viewed as different in nature or as larger overarching concepts; outcome expectation, as an example, is viewed as an underlying element of hope. Further, expectancies are viewed as amenable, and thus likely to change throughout the course of therapy (Constantino, 2012). A review of the literature on client expectations suggests that client treatment and outcome expectancies contribute to the effectiveness of psychotherapy (Greenberg et al., 2006). And a meta-analysis of the influence of client outcome expectancies on therapy outcomes supports the notion that expectations influence client change (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011).

Theoretical estimations of the role of expectations in psychotherapy have been proposed prior to these studies; both Marvin R. Goldfried in 1980, and Joel Weinberger and Andrew Eig in 1999, argued that expectation was one of five common elements of all psychotherapy models contributing to their effectiveness (as cited in Greenberg et al., 2006, pp. 658-659). Michael J. Lambert's well cited pie chart presented expectations as representing 15% of the effects in psychotherapy, sided with 40% client/extra-therapeutic factors, 30% common factors, and 15% specific techniques (Lambert, 1992). Note that Lambert's estimation of expectation's effect has been argued to be an underestimation (Greenberg et al., 2006). Further, Lambert's estimation of the common factors (I include expectation in my use of the common factor concept) has been argued to depict the common

factors as separate, independent entities. Importantly, the common factors, including expectations, are interdependent, dynamic factors that influence and are influenced by each other throughout the course of therapy (Hubble, Duncan, Miller, & Wampold, 2010).

Indeed, other perspectives of expectations in psychotherapy, linking expectation to client and therapist's understanding of therapy, argues that expectation has a more permeating influence on psychotherapy. Jerome D. Frank is recognized as a pioneer in his sociocultural take on psychotherapy. He and his daughter, Julia B. Frank (1991) viewed expectation as part of a person's *assumptive world*, which were thought to be a person's understanding of herself and the world. By comparing psychotherapy with 'healing practices' of other cultures, they argued that psychotherapy was a practice that included 1) an emotionally charged, confiding *relationship* with a helping person, 2) a healing *setting* that provided safety and strengthened the patient's belief in the competence of the helper, 3) a *theory*, or '*myth*', that both client and therapist believed in, and that worked as an explanation for the client's symptoms and prescribed a *ritual* or procedure for resolving them, and 4) that the ritual required active *participation* by both therapist and patient (Frank & Frank, 1991). Most relevant for the discussion of expectations, is their emphasis on the client's 'assumptive world', and their questioning of the necessity (or even possibility) for a therapeutic theory to be 'objectively valid'. What matters in therapy, they argued, is that the client and therapist believe in the theories and procedures proposed by the therapeutic model and collaborate toward better health based on this therapeutic rationale. Here, expectation is argued to be based upon the person's assumptions and beliefs. In this text, I will simply use the word 'understanding' to capture both assumptions and beliefs.

Frank and Frank's sociocultural perspective on psychotherapy is acknowledged by psychotherapists today (e.g. Anderson, Lunnen, & Ogles, 2010; Wampold, 2001a, 2007), and the contextual model described in section 1.2 builds on their perspective, whilst being updated to match the present body of research (Wampold & Imel, 2015). The contextual model positions expectation at its centre; "If the client believes the explanation and that engaging in therapeutic actions will improve the quality of their life or help them overcome or cope with their problems, expectations will be created and will produce benefits" (Wampold & Imel, 2015, p. 59). Instead of holding that it is the therapeutic techniques that lead to change, as is the conventional notion of the medical model, the contextual model directs the focus towards the therapeutic relationship and the assumptive worlds of the client and therapist. Importantly, it is not just the client but also the therapist that needs to believe in the approach and its theoretical rationale;

Owing to these findings, we conclude that what happens [in therapy] [...] is less important than the degree to which any particular activity is consistent with the therapist's beliefs and values (allegiances) while concurrently fostering the client's hope (expectations). Allegiance and expectancy are two sides of the same coin: the faith of both the therapist and the client in the restorative power and credibility of the therapy's rationale and related rituals. Though rarely viewed in this way, models and techniques work best when they engage and inspire the participants.

Hubble, Duncan, Miller, & Wampold, 2010, p. 37.

The notion of response expectancies has been proposed as part of the explanation to how expectations lead to the benefits of psychotherapy (Wampold & Imel, 2015, p. 205).

Response expectancies

Response expectancies are anticipations of automatic subjective reactions to stimuli, and are often self-confirming (Kirsch, 1985, 1999). Expecting that coffee makes you more alert, or that drinking alcohol makes you feel intoxicated, for example, can make you feel more alert or intoxicated even if the coffee is caffeine-free and the drink, alcohol-free. This same mechanism has been argued to be the cause of placebo responses (Kirsch, 1997); the body reacts, despite the absence of the potent stimuli. Irving Kirsch (1985) argued that response expectancies are not only influencing bodily reactions, but are integral to our experience of the world. He exemplified this with the experience of fear and sadness; “fear is an immediate consequence of the expectation of an aversive or harmful event, and sadness is an immediate consequence of the belief that one has irretrievably lost something of great consequence” (Kirsch, 1997, p. 178). Independent of how the world actually is, our subjective experience of the world is influenced by what we expect to experience. This also goes for perceptual experiences. In perceiving something ambiguous, we often perceive what we expect to perceive (Kirsch, 1999). Consider as an example the picture in figure 1;



Figure 1: demonstration of a perceptual set.

What one sees in this picture is influenced by what one expects to see. From a cognitive perspective, our readiness to perceive something based on our expectations is referred to as a ‘perceptual set’ (Passer & Smith, 2011). Figure 1 could be seen as either a woman’s face, or a saxophone player. Even though the picture itself does not change based on our expectations, our experience of it will. Indeed, Kirsch has argued that “what we experience at any given time is a joint function of the stimuli to which we are exposed and our beliefs and expectations about those stimuli” (Kirsch & Low, 2013, as cited in Wampold & Imel, 2015, p. 205). I see this as linked to the notion proposed by the philosophers of existential hermeneutics, that every experience necessitates a preunderstanding (Alvesson & Sköldbberg, 2009); we always experience something as *something*.

Furthermore, Kirsch argued that our perception of internal states actually changes that which is perceived;

When people introspect, however, the distinction between percept and that which is perceived breaks down. The perception is not just *of* the experience, it *is* the experience. Therefore, changing people’s perception of pain, anxiety, depression, and other psychobiological states is equivalent to changing these experiential states.

If expectations are influencing our experiences, of the world and ourselves, they may indeed have a central influence on the process and outcome of therapy.

In the following, I will review the music therapy literature considering expectations in music therapy, before I articulate a working definition of expectation based on the insights from both disciplines.

2.2 Expectation in music therapy

I first encountered a discussion of expectations in the music therapy literature when exploring the common factors discussion in music therapy (Bjotveit, 2015). I will shortly summarize the relevant findings from this review, as well as the studies from Stahr and Stegemann, before I present the findings from an original literature review conducted for the purpose of this thesis.

Expectation as a common factor

In my review of the appearance of the common factor discussion in the music therapy literature (Bjotveit, 2015), not all authors considered expectations specifically. Out of the 26 texts discussing common factors, 13 texts elaborated on the role of expectations. Five of these mentioned expectation as part of Lambert's (1992) estimation of the common factors (see section 2.1 this text), but the authors did not consider expectation in detail. These texts were (Clavier, 2014; Hillecke, Koenig, Warth, & Wilker, 2012; Hillecke, Nickel, & Bolay, 2005; Rolvsjord, 2006). Rolvsjord (2010) compared Lambert's estimations to other estimations of the common factors, and also considered the sociocultural perspective of therapy as proposed by Frank and Frank (1991; see section 2.1). Concerning expectations, she stressed the role of therapist's belief in the approach (i.e. allegiance). Interestingly, based on her exploration of clients' competencies and theories of change, Rolvsjord argued that a music therapist that works resource-oriented must "believe in the client even more than in her or his techniques" (2010, p. 202). Other texts considering the role of therapist allegiance in music therapy practice were (Hallan, 2004; Rolvsjord, 2014a), while a focus on hope was promoted by (Solli, 2014). In terms of music therapy research, expectations were considered by discussing the role of therapist's allegiance to the therapy approach (Bradt, 2012; Silverman, 2015b), researcher's allegiance (Gold, 2015), and placebo controls in music therapy research (Bradt, 2012; Gold, 2015; Gold et al., 2013; Gold et al., 2005).

I observed two different trends in the discussion of common factors in music therapy (Bjotveit, 2015). Several authors recognized the influence of common factors on the effects of music therapy, and considered this a challenge to establishing specificity in music therapy; i.e. determining what effects are due to specific music therapy interventions (e.g. Hillecke et al., 2005; Silverman, 2015a). The other trend I observed consisted of authors that used the research on common factors to deemphasise the role of specific techniques; rather promoting a therapy that focussed on factors such as the therapeutic relationship, hope, and on the contributions of the clients in therapy (e.g Rolvsjord, 2010; Solli, 2014). My own contention is congruent with this second trend. Based on a sociocultural perspective of therapy (Frank & Frank, 1991; Wampold & Imel, 2015), I believe the primary role of techniques in music therapy in mental health care is to serve as rituals through which clients can work on their troubles together with a therapist. The effectiveness of a technique mainly depends on the client's and therapist's belief in its utility. This notion will be discussed in chapter 4, as I consider implications for a music therapy practice that acknowledges the role of client's and therapist's expectations.

Thirteen texts from my literature review on common factors in music therapy considered expectation in either practice or research. As expectations were discussed as one of several common factors, none of the authors considered the nature and influence of expectations in much detail. Two texts that did not show up in the search results on common factors were the texts by Stahr and Stegemann.

Based on the notion of expectation as a common factor in music therapy, Katharina Stahr and Thomas Stegemann interviewed music therapists about their expectations in therapy (2014), and are currently conducting a survey study of clients' expectations in music therapy (2016). In their interviews with music therapists, Stahr and Stegemann (2014) distinguished between *implicit* expectations, which could be both conscious and unconscious, but were not expressed in therapy, and *explicit* expectations that were communicated to the clients. Most of the music therapists that were interviewed considered their implicit expectations as having a negative influence on therapy; exemplified by the expectation that one ought to always play music in music therapy. Explicit expectations were mostly seen as positive, as the music therapists could express their expectations in order to build trust and establish a working alliance. On the other hand, such an expression of expectations was also seen as a risk, as the music therapist could promise too much to the client, and/or she might be perceived as being too overruling. Further, the music therapists said they managed their expectations through supervision, journalizing the sessions, and by being self-reflective.

Stahr and Stegemann (2014, 2016) held that there is a need for more research on the influence of expectation in music therapy, as it is probably an important and underestimated factor contributing to music therapy effects.

The studies of Stahr and Stegemann are important contributions to our understanding of the influence of expectations in music therapy. I look forward to seeing the results from their survey study of clients' expectations. I will now present an original literature review on expectations in music therapy.

Literature review

The term 'expectation' is not often found as an entry in the index of music therapy books. A stop at the library looking through the indexes of various music therapy books showed that 'expectation' was not an entry in the indexes of books like *The Oxford Handbook of Music Therapy* (Edwards, 2016), *International dictionary of music therapy* (Kirkland, 2013), *Music, Health, & Wellbeing* (MacDonald, Kreutz, & Mitchell, 2012), *The Handbook of Music Therapy* (Bunt & Hoskyns, 2013), *Guidelines for Music Therapy Practice in Mental Health* (Eyre, 2013), *Handbook of Neurologic Music Therapy* (Thaut & Hoemberg, 2014), *Music-Centered Music Therapy* (Aigen, 2005a) or in the second edition of *Music therapy research* (Wheeler, 2005). Looking at subject indexes is not necessarily representative of whether the authors discuss expectations, but it can nonetheless serve as an indicator of the presence of expectations in the music therapy literature.

To get a better sense of how music therapists had discussed the concept, I did a literature review on expectation in music therapy in mental health care. I first used 'full text' searches, but this resulted in a lot of varied literature where the authors seldom considered the concept itself. I then limited my search to 'title', 'keywords' and 'abstract', which resulted in a feasible amount of texts. Interestingly, none of the texts from my common factor review showed up when searching exclusively for expectations. The texts discussing expectation as a common factor had not referred to the concept as a keyword or used it in title or abstract. My review is therefore not considered as a comprehensive review. As the main purpose of the review is to be a resource in my exploration of the nature and influence of expectations, I do not find it necessary to conduct a comprehensive review of everything that is written about expectation. Together with the literature presented above, where expectation was considered as a common factor, the literature from this review can still serve as a theoretical background for my further exploration of the expectancy concept.

Method

The literature review included texts concerning music therapy in mental health care that explicitly considered expectation. Texts that used the word expectation, or any other form of the expecta* truncation, by ‘chance’ were not included. To limit the amount of texts using the concept without explicitly considering its role in therapy, the search was limited to ‘title’, ‘abstract’ and/or ‘keywords’. These results were evaluated, and I excluded texts that a) did not focus on the concept of expectation, b) did not consider mental health care contexts, or c) I were not able to retrieve (this last criterion was only relevant for Saroyan (1990)).

Keywords selected were (Music therap*) AND (Expecta*) AND (Mental OR Psychiatr*). The following databases were used: PubMed, ProQuest, PsycInfo (OvidSP), Cochrane Library, Social Science Index. The following electronic music therapy sources were searched: Oxford Handbook of Music Therapy (Oxford Handbooks online), British Journal of Music Therapy, Nordic Journal of Music Therapy, and Voices. Keywords for the searches in the music therapy sources were Abstract: Expecta*, Keywords: Expecta*, Title: Expecta*. The literature review was limited to the English language.

Results

The literature review resulted in six texts that met my inclusion criteria; Curreri (2013), Auf der Heyde et al. (2012), Quiroga (2015), Pavlicevic (1987), Choi (1997), and Edwards (2011). In the following, I will shortly present each text and their use of the expectation concept.

Enrico Curreri (2013) studied a chance-centred music therapy method called ‘aesthetic perturbation’, and its effect on rigidity in adult mental health care clients. Curreri, as both therapist and researcher, composed a piece of music using chance procedures, which resulted in an unconventional composition meant to challenge the clients’ musical expectations. The music was conducted by the therapist and performed by the clients, and followed by verbal reflections concerning the piece of music and the themes that emerged. The qualitative analysis suggested a decrease in rigidity for the participants, and the clients said they found the activity a positive experience and a catalyst for change.

Similarly, Tanja Auf der Heyde and colleagues (2012) studied music therapy methods and their effects on client expectations. They studied rhythmic interactions within musical improvisations with a client with a history of cumulative trauma. They argued that musical improvisations with planned and spontaneous disruptions in rhythmic interaction allowed for reconstruction of “a disrupted expectation system, [...] finding agency in the playful

thwarting of expectations, and for exploring the continuum of separation and connectedness in a musical relationship” (Auf der Heyde et al., 2012, p. v).

Rodrigo Quiroga (2015) studied challenging moments in music therapy and how these were experienced by music therapists. He drew from the psychotherapy literature where challenging moments had been defined as an expression of a disparity between the therapist and the client’s expectations of the treatment process (p. 20). A disparity which is best expressed in the client’s behaviour, he argued (p. 25). This link between challenging moments and a disparity of expectations resonated with the experiences of the music therapists he interviewed. Quiroga thus proposed this to be a generalizable finding, and an ‘essence’ of the nature of challenging moments in therapy (p. 23). He suggested two ways of dissolving challenging moments in music therapy; first, always try to understand the client’s expectations, and then choose between two approaches, a) either allow and accept the client’s expectations without trying to change the client’s or one’s own expectations, or alternatively, b) try to re-direct one’s own or the client’s expectations and to meet in a shared space. Quiroga visualised this second notion by suggesting a ‘proximity of expectations’ continuum, where the discrepancy between the client and therapist’s expectations was conceptualized on a continuum.

Mercedes Pavlicevic (1987) considered the first meeting between client and music therapist in the first session of music therapy. She reflected upon the challenges of meeting clients and their various expectations to what music therapy might be. In her experience, some clients were excited while others became anxious after being referred to music therapy. The client’s past experiences with music, music therapy as something new or unfamiliar, and the client’s present troubles were all factors that influenced the client’s openness to music therapy, she argued. She stressed that the first pre-musical meeting should be focused on establishing a safe and trusting relationship, and the client and therapist should come to a mutual agreement to whether they should try music therapy.

Byung-Chuel Choi (1997) assessed clients’, music therapists’, and other mental health care professionals’ expectations concerning the perceived efficacy of music therapy. Generally, most health care professionals reported a positive perception of music therapy, but there were some differences between the different disciplines. One of his findings suggested that clients generally perceived music therapy to be less efficacious than music therapists rated it themselves. Choi thus recommended more research on what the clients expect and find most helpful in therapy.

In the last text from my literature review, Jane Edwards (2011) discussed the cultural

trend of expecting music to be an effective means for social gain, and expecting music participation and listening to be exclusively good and helpful. She cautioned about the pitfalls of viewing music as a stimulus or as an innately good commodity, and advocated for more research on human relating and human experience to understand the benefits of music. She also reflected upon how beliefs and expectations concerning music's role in individual and social transformation are reflected in individual and collective actions; exemplifying this with community choirs which are established to address therapeutic and social needs.

Analysis

In the process of analysing the six texts from my literature review, I reviewed the texts by asking five questions. The questions were “*whose* expectations are the authors focusing on?”, “what *kind* of expectations are they writing about?”, “do they reflect around what the expectations are *based upon*?”, “are they writing about possible *change* in expectations?”, and lastly, “what are the *consequences* of these expectations according to the authors?”. In asking these questions I read and re-read the articles while looking for explicit or implicit answers.

Whose expectations, and what kind of expectations?

Curreri (2013) and Auf der Heyde with colleagues (2012) both addressed client's expectations. They both focused on expectations *in* music, or musical expectations. Pavlicevic (1987) and Quiroga (2015) focused on the interaction between the client's and the music therapist's expectations. Pavlicevic focused on expectations to music therapy in general and to the processes in music therapy. Quiroga considered expectations to the music therapy process, to the relationship between client and therapist, and to the specific music therapy session. Choi (1997) assessed the expectations of clients, music therapists, and other mental health care professionals. Here he assessed expectations toward music therapy's relevance and place in the multidisciplinary team. Lastly, Edwards (2011) reflected on a general trend she found in western culture, which can be conceptualised as expectations at a cultural level. Specifically, she criticised or questioned expectations towards the health benefits of music and music therapy. See table 1 for a summary.

	Client's expectations	Music therapist's expectations	Colleagues' expectations	Cultural expectations
Music therapy	Pavlicevic, 1987	Pavlicevic, 1987		Edwards, 2011
Music	Pavlicevic, 1987			Edwards, 2011
The process in music therapy	Pavlicevic, 1987; Quiroga, 2015	Pavlicevic, 1987; Quiroga, 2015		
The relationship in music therapy	Quiroga, 2015	Quiroga, 2015		
The specific music therapy session	Quiroga, 2015	Quiroga, 2015		
Music therapy efficacy	Choi, 1997	Choi, 1997	Choi, 1997	
Musical parameters	Curreri, 2013; Auf der Heyde et al., 2012	Auf der Heyde et al., 2012		

Table 1: Horizontal columns show whose expectations the authors considered. Vertical columns show the direction of the expectations.

What are the expectations based upon, and do they change?

The authors were more or less explicit with their reflections concerning what the expectations were based upon. Client's past musical experiences were argued to be the fundament for musical expectations, or expectations *in* music (Curreri, 2013; Auf der Heyde et al., 2012). Client's past experiences with music may also influence their expectations towards music in general and music therapy, Pavlicevic (1987) argued, while also including the novelty of music therapy and the client's illness as factors possibly influencing expectations. Quiroga (2015) linked client's and therapist's expectations to their beliefs about the specific session, the therapeutic process in general and the relationship in music therapy. Choi (1997) argued that expectations at institutional level was influenced by whether the staff had observed music therapy sessions, if they had an awareness and knowledge about music therapy theory and research, and what the status of music therapy was; i.e. if music therapy was a certified profession or not. Choi also found group differences between the professions, which might indicate that there could be in-group similarities and between-group differences in expectations based on the professionals' background and education. Finally, Edwards (2011) argued that research focus, theoretical discourse, and the media had an influence on cultural expectations to music and music therapy.

Only some of the authors reflected around possible changes in expectations. For both

Curreri (2013) and Auf der Heyde et al. (2012) change in expectations was one of the main goals in therapy. Curreri argued that playing and experiencing unusual music might result in a decrease in rigidity and an openness to new experiences, while Auf der Heyde and colleagues argued that rhythmical explorations and challenges to musical expectations might build agency and help reconstruct a fragile expectation system. Quiroga (2015) found that music may or may not reduce the disparity of expectations between client and music therapist. Further, he proposed that trying to understand the client's perspective might help the music therapist in either adjusting her or his own expectations to better match those of the client, or try to influence the client's expectations to match those of the music therapist's.

What are the consequences of these expectations?

In the six texts from my literature review it was suggested that expectations could influence action, collaboration, emotions, listening experience, cognition and musical communication. Edwards (2011, p. 94) held that expectations, or beliefs, concerning music's potentials are linked to collective and/or individual action. Quiroga (2015, p. 25) stated that behaviour was the strongest expression of the client's expectations. Further, he argued that a disparity of expectations between client and therapist could lead to 'challenging moments' as experienced by the music therapist, which suggests that expectation could influence the collaborative relationship in music therapy. Pavlicevic (1987) wrote that some clients reported feelings of anxiousness or excitement when being referred to music therapy, which she argued was connected to the client's expectations towards music therapy. After the clients in Curreri's (2013) study had performed music that challenged their musical expectations, they reported to become more open for new and unfamiliar experiences, and they said they had learned to listen to music differently; i.e. the musicking changed their listening experience of music. Auf der Heyde and colleagues (2012, p. 86) linked expectations to cognition and argued that a healthy expectation system that manages to predict coming events helps facilitate attention and allows for an optimisation of arousal levels and so a minimization of energy expenditure. They also viewed musical expectations, here related to rhythm, as a shared ability facilitating dialogue and shared musicking between client and music therapist. Additionally, they referred to a 'prediction effect' which they described as the positive feeling that one might experience when one accurately predicts the rhythm in music (p. 87).

Discussion

The literature review resulted in six texts where expectation was a central theme. Two studies of music centred techniques where change in client expectation were part of the agenda (Curreri, 2013; Auf der Heyde et al., 2012); an article where the music therapist reflected on expectations and the first session with a new client (Pavlicevic, 1987); an interview study where the author found expectation as a central theme when considering challenging moments in music therapy (Quiroga, 2015); a survey study of clients', music therapists' and colleagues' expectations toward the efficacy of music therapy (Choi, 1997); and finally, a critical theoretical enquiry of cultural expectations concerning the benefits of music (Edwards, 2011). This diversity of texts offers insights from various perspectives concerning the nature and influence of expectations in music therapy. Interestingly, none of the authors referred to the common factors discussion when considering expectations. The six texts can therefore be seen as belonging to other discourses than the thirteen music therapy texts presented prior to this review. I find this diversity fruitful for my exploration. I will not elaborate on the six texts in more detail, but rather synthesize the author's reflections into a coherent conceptualization of expectations.

The common factor discussion in psychotherapy and music therapy, builds on the notion that expectation is based on assumptions and beliefs (e.g. Frank & Frank, 1991). In this text, I use the word 'understanding' to represent assumptions and beliefs. This conceptualization can be compared to the definition of expectation suggested by Tryon, above; expectation is "the anticipation of future consequences based on *prior experience, current circumstances, or other sources of information*" (1994, as cited in Stahr & Stegeman, 2014, p. 276). This definition is congruent with the notion proposed by Frank and Frank, if we consider 'prior experience' and 'other sources of information' to represent what constitutes a person's understanding. Based on a sociocultural notion of understanding (see section 3.5), I will argue that 'other sources of information' is mainly *discourse*; i.e. stories, theories, conceptualizations, etc., which are learned through language. In addition to understanding, Tryon highlighted the influence of 'current circumstances' on expectations. In sum, we can then argue that expectations are based on understanding (own experiences and what is learned through discourse) and an evaluation of current circumstances. The findings from the literature review can then be categorized into these three themes; prior experiences, discourse, and current experiences:

- Prior experiences
 - Prior musical experiences (Curreri, 2013; Auf der Heyde et al., 2012; Pavlicevic, 1987).
 - Having participated in or observed a music therapy session (Choi, 1997; Pavlicevic, 1987).
- Discourse
 - Novelty of music therapy (Pavlicevic, 1987).
 - The status of music therapy (Choi, 1997; Edwards, 2011).
 - Knowledge about music therapy theory and research (Choi, 1997; Edwards, 2011).
 - Media's representation of the benefits of music (Edwards, 2011).
 - Music therapy education (Quiroga, 2015).
 - Other education (Choi, 1997).
- Present experiences
 - Challenging experiences (Curreri, 2013; Auf der Heyde et al., 2012; Quiroga, 2015).
 - Confirming experiences (Auf der Heyde et al., 2012).
 - Client's mental illness (Pavlicevic, 1987).

I find that the considerations made by the authors from my literature review fits well into the three overarching themes.

An example can serve; based on this notion of expectation, a client's expectancy concerning the benefits of music therapy (i.e. outcome expectancies) is based on her prior experiences with the benefits of music therapy (having participated in music therapy before, or having personal experiences with music and/or other therapies), having read or heard about the helpfulness of music therapy (e.g. having read about it in the media, or heard about music therapy from a friend who has tried it), and her evaluation of the current circumstances (e.g. both 1) if what she experiences in music therapy are challenging or confirming her understanding, and 2) as she evaluates the trustworthiness and genuineness of the music therapist, the perceived competence of the therapist, and the cogency of the therapeutic rationale).

Another aspect of the nature of expectations that can be synthesized from the literature review, is that expectations change. Several authors considered how music therapists could change the client's expectations (Curreri, 2013; Auf der Heyde et al., 2012;

Quiroga, 2015) or redirect one's own expectations as a therapist (Quiroga, 2015). This is congruent with the psychotherapy literature (e.g. Constantino, 2012), and also with the notion that expectations are based on prior experiences and discourse. With new experiences, expectations might change.

Additionally, the authors considered expectations held by clients (Curreri, 2013; Auf der Heyde et al., 2012), therapists (Pavlicevic, 1987; Quiroga, 2015), other mental health care professionals (Choi, 1997), as well as expectations found as trends in western culture (Edwards, 2011). As therapist and researcher allegiance have been shown to influence the outcomes in psychotherapy (Luborsky et al., 1999; Wampold & Imel, 2015), it is possible that other agents' expectancies influence the process and outcome of music therapy. Indeed, a conceptualization of therapy as a cultural healing practice holds that therapy works because it is coherent with the assumptions and expectancies concerning healing practices held in their culture (Frank & Frank, 1991; Wampold, 2001a, 2007).

Finally, we can consider the influence of expectation in music therapy. The literature considering expectation as a common factor focussed on expectation as a factor that influenced the process and outcome of therapy, while the notion of response expectancies suggested that expectations influence experience and bodily reactions. The authors from the literature review suggested that people *act* based on their expectations (Curreri, 2013; Edwards, 2011; Quiroga, 2015), that both *emotions* (Auf der Heyde et al., 2012; Pavlicevic, 1987) and *cognition* (Auf der Heyde et al., 2012) are influenced by expectations; that *collaboration* in music therapy is influenced by expectations (Pavlicevic, 1987; Quiroga, 2015); that *musical communication* is based on musical expectations (Auf der Heyde et al., 2012); and finally, that *musical experiences* can change when introduced to unconventional and challenging music (Curreri, 2013). In other words, we could say that expectation might influence actions and experience (i.e. emotions, cognition and musical experience), which might influence collaboration in therapy, and are necessary for musical communication.

2.3 A working definition

Based on the synthesis from the psychotherapy and music therapy literature, a working definition of expectation can be articulated;

Expectation is the anticipation of future consequences, based on understanding (prior experiences and what is learned through discourse) and an evaluation of current

circumstances. Expectations can change, and they can influence the process and outcome of music therapy through their influence on actions and experience.

The definition is meant as a tool for exploring the concept in relation to music therapy. It is not meant as a universal definition of expectation, but as a resource throughout this text.

2.4 Reflections

Expectations seems to have a permeating influence on the process of therapy, as it influences both experience and actions. The notion of response expectancies (Kirsch, 1985) suggests that expectations might be integral to the experience of mental illness. This notion was echoed by the authors of the literature review on client's expectations in psychotherapy; "most psychotherapy approaches are inextricably linked with the manipulation and revision of patient expectations" (Greenberg et al., 2006, p. 671). If we see mental illness as essentially a subjective experience (e.g. Slade, 2009), this might indeed be the case.

I find the role of expectations in music therapy fascinating, but I also sense a wariness concerning how our knowledge of expectations' potency in therapy may be applied in practice. There is a danger that a focus on clients' expectations in music therapy may motivate therapists to act manipulatively in order to persuade clients into changing their perspective. If we look at the wordings in Greenberg and colleagues' citation above, they described psychotherapy as a "manipulation and revision" of patient expectancies. Based on this notion, psychotherapists have later constructed an 'expectancy enhancement' manual, meant to be a guideline for enhancing client's treatment and outcome expectancies (Constantino, 2012). I find such an approach as balancing on a precarious line. I acknowledge that what is taking place in mental health care is the change of expectations and a change of experience, but I find it pivotal to reflect on whose experience of the world we consider to be 'legitimate'. Mental health care has a history of not acknowledging the clients' perspective (e.g. Bracken & Thomas, 2005; Slade, 2009), and by changing clients' expectations one is ultimately trying to change the clients' understanding and experience of the world and themselves. This is ultimately an ethical agenda. Well, I guess this is a question of epistemology; if one considers understanding as a direct representation of how the world is, this can be used as a rationale for persuading clients to see the world detached from their 'illusions'. Alternatively, one might consider the understanding of the world as socially constructed, where the experience of the world is as much defined by people as it is by the

characteristics of the world. Personally, my epistemological view resonates with this latter notion. This implies that the therapist must be reflexive concerning whose truth she is advocating, and be aware of how truth is constructed. How then should we as music therapists understand and act on expectations in music therapy?

This line of thought tells me that we need to look closer at the nature of understanding to better understand the nature of expectation, and consequently how we can apply this knowledge in an ethical manner in music therapy. I will therefore explore theories of learning in chapter 3, before I consider implications for the practice of music therapy in chapter 4.

3.0 Expectations and understanding

In chapter 2, I have presented literature from both music therapy and psychotherapy where expectation is considered as a factor in therapy. It is argued that expectations influence both process and outcome in therapy (Constantino et al., 2011; Greenberg et al., 2006; Stahr & Stegemann, 2014, 2016), based on their influence on actions and experience. To better understand how expectations develop, how they become part of a person's experience of the world, and how we as therapists should act on our own and clients' expectations, I have chosen to explore theories of learning.

The study of learning is the study of the processes that lead to change in behaviour and/or experience. I therefore find the discipline of learning highly relevant for my exploration of the nature of expectancies. Throughout the 20th century, various theories and perspectives on learning have been developed, and today, the debate about the nature of learning is mainly between fundamentally cognitive and fundamentally social perspectives (Bråten, 2002b). Based on my perspective on epistemology, inspired by existential hermeneutics and social constructionism (see section 1.4), in addition to my grounding in the orientations of culture-centered music therapy (Stige, 2002) and resource-oriented music therapy (Rolvjord, 2010), I am myself a supporter of the social perspectives on learning. I will therefore dedicate most of chapter 3 to a presentation of sociocultural perspectives on learning. That said, I have found that expectation has been a central concept in learning theory and research, but mostly based on cognitive and social-cognitive perspectives. A review of these perspectives and their exploration of expectation will therefore be fruitful for my exploration of the nature of expectation. A comparison of the fundamentally cognitive and social perspectives, and the rationale for why I adhere to the social tradition, will be presented in section 3.4. I will start with a short presentation of a behaviourist perspective on learning, as it set the stage for modern theories of learning, and is an important backdrop for the development of cognitive perspectives.

3.1 Behaviourist perspective

In the first half of the 20th century, behaviourism was the dominating view of learning. For behaviourists, only observable behaviours were of interest when studying learning. Claims about subjective experiences such as thoughts, emotions, attitudes, etc. were regarded as unscientific (Säljö, 2001, p. 51). Learning was thus defined by behaviourists as an

establishment and strengthening of associations between observable stimuli and responses (Bråten, 2002b, p. 11). These responses were mainly bodily reactions and behaviour. Classical and operant conditioning were, and still are, two key concepts in the behaviourist perspectives on learning.

Ivan Pavlov's *classical conditioning* showed how organisms (including human beings) that responded naturally to a stimulus could be thought, or conditioned, to respond similarly to another stimulus if the new stimulus was associated with the original stimulus (Passer & Smith, 2011). Pavlov originally studied dogs' salivary response, but a musical example can serve here. Have you ever heard a song that 'takes you back' to a specific event, and triggers an emotion you felt at that event; say, at a funeral? As you associate the song with the event the song elicits a bodily response (e.g. sadness) that naturally was elicited by the event. Importantly, this conditioning is argued to be an automatically formation of a bond between the original unconditioned stimulus (the funeral) and the conditioned stimulus (the song), that elicits a bodily *reflex*, and should therefore be explained without referring to mental concepts, such as expectation.

Later, *operant conditioning* was coined by B. F. Skinner as a term representing how organisms learn and adapt their behaviour according to associated consequences. Here, 'reinforcements' and 'punishments' that follows a response is argued to either increase or weaken the frequency of the response/behaviour (Passer & Smith, 2011). Early music therapy practices were based on such a behaviourist perspective, where music was often used as a reinforcement for 'appropriate behaviours'. Ruud (1980) described a study by Jorgensen that can serve as an example;

Jorgenson (1971) reports the effects of contingent preferred music in reducing two stereotyped behaviors of a profoundly retarded [sic] child. The usual stereotyped hand movement consisted of placing the third finger of the left hand over the second finger; the child turned the wrist and hand in a side to side motion against the bridge of her nose. Preferred music was presented for the duration of no stereotyped hand movement. Whenever the stereotyped movement occurred the experimenter interrupted the music immediately and said, "Quiet hands." The tape recorder was turned on as soon as hand movements had stopped. Results showed that stereotyped behavior decreased radically under these conditions of contingent use of music.

Ruud, 1980, p. 34.

Skinner's theories of learning were meant to highlight how social influences shape human behaviour through reinforcements and punishments (Passer & Smith, 2011, p. 234), and Skinner held that cognitive processes were unnecessary to consider when explaining behaviours (p. 240). Proponents of another fundamental perspective on learning, *cognitivism*, criticised the behaviourist view of learning for being a reductionist perspective, representing human beings as passive organisms manipulated by external forces. Cognitive learning theorists emphasised human's mental world in explaining learning and behaviour, and I will briefly present some of cognitivism's characteristics in the following.

3.2 Cognitive perspective

Where behaviourists understood learning as conditioned reflexes or associated contingencies between action and consequences, cognitive learning theorists argued that the organism's cognition, or 'mental operations', formed a link between stimulus and response (Passer & Smith, 2011, p. 240). Cognitive learning theorists argued that classical conditioning elicits a conditioned response because the organism predicts (or expects) the presence of the unconditioned stimulus. This has been coined 'the expectancy model' of classical conditioning (Passer & Smith, 2011, p. 242), and is more in line with Kirsch's response expectancies (see section 2.1). Similarly, operant conditioning is explained to motivate actions because of the perceived relationship between the action and the probable consequence. As the cognitive pioneer Edward Tolman argued, "[...] learning does not merely 'stamp in' stimulus-response connections. Rather, learning provides knowledge, and based on their knowledge, organisms develop an *expectancy*, a cognitive representation, of 'what leads to what'" (Passer & Smith, 2011, p. 241 [emphasis added]). Just as with response expectancies, it is argued that it is the *perceived* contingency between actions and consequences that influences behaviour, not the *actual* contingency (Passer & Smith, 2011, p. 242). This shows that expectancy has been a key concept for cognitive learning theorists in explaining both classical and operant conditioning, in other words, in explaining both bodily reactions and behaviour.

A characteristic of the cognitive perspective is its representation of human beings as information processors, often by using the computer as a metaphor for cognitive processes. Cognitive theorist Helstrup (2002) argued that cognitive processes such as attention and memory are central parts of learning. From a cognitive perspective, learning involves an encoding of perceptual stimuli which is processed in the working memory, stored in long

term memory, and retrieved and applied as factual knowledge or skills across contexts (Helstrup, 2002). This process of learning is seen as an active process where the individual not just receives information, but actively constructs their understanding of the world, by filtering out stimuli, and linking new information to other information stored in memory (Helstrup, 2002); a cognitive perspective called *constructivism* (Säljö, 2001, p. 57). This constructivist view of understanding has been used to explain why people understand the world differently. In psychotherapy, such a perspective can be linked to George Kelly's concept of *personal constructs*, which are cognitive categories that people use to sort their understanding of the world; what is true or false, good or bad, etc. (Passer & Smith, 2011, p. 470).

A representative of the cognitive perspective, and a pioneer in explaining children's cognitive development was Jean Piaget (Säljö, 2001, p. 60). Piaget argued that children learn by their spontaneous exploration in the world, constructing *cognitive schemas* while organizing their understanding of the world. New experiences were either incorporated into existing schemas, a process called *assimilation*, or challenged the child's cognitive schemas, causing them to change; a process called *accommodation* (Passer & Smith, 2011). Example; Imagine a child who has a cognitive schema of birds, thinking that all birds can fly. When this child travels to a new country she sees several birds that fits with her 'bird schema', and she can easily assimilate the new birds into her schema. But one day she encounters a penguin. As penguins are birds that cannot fly, the child must force her 'bird schema' to include species that are birds, but cannot fly, through accommodation. As the cognitive perspective on learning views learning as an individual process, where the person explores the world through her own activities and observations, making her own constructive interpretations, the perspective can be characterized as *egocentric* (Säljö, 2001, p. 67). It is held that we are individually constructing cognitive schemas of the world, and everyone are born with the same 'cognitive apparatus' as a capacity making this constructive process possible (Säljö, 2001, p. 57).

Where behaviourism was criticized for its representation of learning as a passive process conditioned by the environment, a purely cognitive perspective can be criticized for having a too strong emphasis on learning as an individual process without considering social and cultural influences. A third perspective on learning emerging in the second half of the 20th century, the *social-cognitive* perspective, sought to combine behaviourist theories with cognitive theories; viewing the person as an active agent in social contexts (Passer & Smith, 2011, p. 483).

3.3 Social-cognitive perspective

The social-cognitive perspective is based upon the theory of *reciprocal determinism*, where the person (including cognitive, affective and biological processes), the person's behaviour, and the environment is viewed as mutually influencing each other (Bråten, 2002a; Passer & Smith, 2011). The person's learning is thought to be an active process within a social environment; a process which is influenced by, and adapted to, the environment, but also that changes the environment. The social-cognitive perspective therefore integrates behaviourist theories of social influences (such as reinforcements and punishments) with cognitive theories of the person as an active information processor and interpreter (Passer & Smith, 2011). The social-cognitive perspective is similar to the cognitive perspective as it builds on an individualist constructivist perspective, but it differs from cognitive perspectives in its emphasis on social factors and its focus on the role of motivation in learning (Bråten, 2002a, p. 186). Theories on motivation has been central in the social-cognitive perspective, and expectation is often an essential component of these.

Pioneers within the social-cognitive perspective articulated theories on what motivated people's actions. Julian Rotter argued that the two components that motivate action are 1) expectations concerning the probability that an action will lead to certain consequences within a specific situation, and 2) the 'reinforcement value' of the consequences, that is, how much the consequences are desired or dreaded (Passer & Smith, 2011, p. 484). The *expectancy-value model of achievement* builds on this notion, and research suggests that a person's achievement expectancy predicts *performance*, while the perceived value of the task better predicts *choice* (Reeve, 2015). In other words, our choices are often influenced by what we want, while our performances are influenced by whether we believe we can accomplish the task or not. Self-efficacy is argued to be essential to a person's achievement expectancy, and will be described in the following.

Another pioneer contributing to the social-cognitive perspective was Albert Bandura. Bandura coined the term *self-efficacy* which is a person's expectancy that she will be able to perform a certain action given the skills she possesses and the circumstances she faces (Reeve, 2015). Bandura argued that self-efficacy was influenced by four factors: 1) previous performance experiences with similar tasks in similar situations, 2) observing other's actions and outcomes, also called *vicarious experiences*, 3) verbal persuasion, and 4) emotional arousal. These four factors could either increase or decrease a person's perceived self-efficacy. Interestingly, researchers have found that people with high self-efficacy for a task often outperform people with low self-efficacy at the same task. It is argued that the person

with high self-efficacy puts more effort into the activity and persists longer when facing difficulties (Reeve, 2015, p. 276). This suggests that self-efficacy can be a kind of self-fulfilling prophecy; believing you can do something, enhances your chances to accomplish it.

3.4 Learning as acquisition and participation

The cognitive and social-cognitive perspectives on learning has provided valuable research concerning the influence of expectations. Expectation is argued to elicit automatic bodily responses, and to guide behaviour and alter performances. As I now proceed to a sociocultural perspective on learning, and use this as I discuss implications for music therapy, it is not because I dismiss the cognitive and social-cognitive theories referred to above, but because I disagree with the fundamental epistemological assumptions about the process of learning.

The cognitivist perspective views learning as a constructivist process, where information is encoded and processed actively by the person (Helstrup, 2002, pp. 110). This can be argued to implicitly reflect a view of the world as ‘simple’ or easily interpretable. Furthermore, one might argue that we do not ‘discover’ or learn about the world in isolation from people and things around us (e.g. the cognitivist, egocentric view mentioned above), but rather learn in relation to other people, where the world in many ways are interpreted *for us*, or in collaboration with, the people around us and the generations before us (Säljö, 2001, p. 67). This is more in line with a social constructionist view of understanding (Alvesson & Sköldberg, 2009).

The metaphor that is used to depict the learning process in cognitive learning theories (including the social-cognitive) is the *acquisition* metaphor (Bråten, 2002b). Learning is seen as an individual process where the person discovers the world, or where knowledge is ‘transmitted’ from another person, and the knowledge becomes *internalized* into the information processing brain (Lave & Wenger, 1991, p. 47). With this perspective, the mind is seen as an independent entity residing in the brain and the nervous system, detached from the external world. The social-cognitive perspective holds that we are influenced by the social environment, but it still holds this divide between mind and the world (Bråten, 2002a, p. 186). Sociocultural perspectives are based on a fundamentally different conception of the learning process, as they build on a *participation* metaphor (Bråten, 2002b). These perspectives hold that learning is increasing possibility to participate in social communities (Lave & Wenger, 1991; Säljö, 2001; Wenger, 1998). This is a shift in focus, from the

individual as an information processor, to the individual as an integral part of social practices. The dualistic distinction between context and cognition, body and mind, or external and internal, is rejected, rather viewing people as co-constitutive of their experiences and social world in their use of intellectual tools and artefacts. “There is nothing from the ‘outside’ that comes into the ‘inside’” (Säljö, 2001, p. 155).

It is not in the scope of this thesis to try to merge the two fundamentally different perspectives on learning. It is argued that the two are incommensurable, but that the perspectives can complement and enrich each other, and coincide as two approaches to the understanding of learning (Bråten, 2002b). I will use the sociocultural perspective, as I find it to better explain how people experience the world differently, as well as the great variations in how people expect music to be used therapeutically.

3.5 Sociocultural perspective

The proponents of sociocultural perspectives on learning argue that individuals cannot be understood in isolation from their social and cultural environment. It is therefore the relationship between the collective and the individual that is the starting point of enquiry for a sociocultural perspective (Säljö, 2001). In this section, I will start with presenting what is argued to be a fundamental capacity for cultural learning, namely ‘communicative musicality’, before presenting theories on how the language and artefacts we learn to use through socialization influences how we experience the world. Then I will present theories on identity development through participation in communities of practice, and how people take part in a negotiation of social norms and meanings, before I finally suggest an answer to the second research question; how can expectation be understood from a sociocultural perspective?

Communicative musicality

Research on infant-caregiver interaction suggests that babies are born with a motivation to engage in nonverbal dialogues with their caregivers, suggesting that babies take part in cultural learning from day one (Malloch & Trevarthen, 2009). Contrary to the belief that infants only needed protection and nourishment the first months of their lives, infant research from the 1960’s and onwards have suggested that babies are born with an innate capacity to communicate nonverbally through gestures, expressions and vocalizations. Stephen Malloch and Colwyn Trevarthen (2009) coined this innate capacity *communicative musicality*, and

they argued that people of all ages communicate on the basis of this fundamental capacity. Referring to an earlier research of Malloch, they held that communicative musicality was characterized by three parameters; pulse, quality and narrative. *Pulse* is the regular and predictable succession of vocal or gestural events through time, where the production and perception of these are fundamental for shared coordinated communication. *Quality* is the contours of the expression of sounds and/or gestures moving through time; i.e. pitch and volume of sound, and direction and intensity of gestures. And finally, *narrative* is the combination of pulse and quality in sequences that communicates a shared sense of situated meaning in a shared sense of passing time with the caregiver (Malloch & Trevarthen, 2009, p. 4). Interestingly, expectation is arguably a vital aspect of communicative musicality, as it is foundational for a perception of a coherent and meaningful narrative in communication, as part of the perception of pulse. This suggests that we are born with an innate capacity to recognize patterns of behaviours and events in the world in order to perceive the world as predictable, and to be able to communicate with others.

Socialization, language and artefacts

Recall the sociocultural notion of socialization described briefly in section 1.4. Roger Säljö (2002) used the notion of socialization to describe the process through which people learn to become participants in social communities. Based on the innate capacity of communicative musicality, children learn the language, social norms and knowledges of their ‘significant others’ (family, close friends, etc.) in the process of *primary socialization*. *Secondary socialization* is the learning of ‘sub worlds’ from more peripheral communities (e.g. school, neighbourhood, etc.), often involving more abstract knowledge, and is more prone to change through new experiences (Alvesson & Sköldberg, 2009, p. 28). This notion is congruent with Frank and Frank’s (1991) description of the development of assumptive worlds. Through socialization people learn to use the intellectual and physical tools of their communities. This notion is essential to Säljö’s (2001) sociocultural perspective. Intellectual and physical tools, first proposed by the psychologist Lev Vygotsky¹, are resources people use when they understand the world and act within it.

Intellectual tools are codified in linguistic forms, and includes language, numeric systems, classification systems, etc. (Säljö, 2002). Through intellectual tools, and most notably *language*, human beings form knowledge and construct their understanding of the

¹ Vygotsky’s term ‘psychological tools’ is here replaced with Säljö’s ‘intellectual tools’ (see Säljö, 2002, p. 35)

world. We can talk of distances, characteristics, similarities and differences, and take part in dialogues where we express our feelings, discuss politics, tell histories, and share experiences etc. Language directs attention, divide the world into meaningful entities, and affords a shared sense of co-existence. Importantly, these intellectual tools have a social and cultural origin; produced and passed on from generations, through communication in socialization processes. They are produced and maintained in collective human practices, and a person must learn to use the language according to the social norm to be able to participate in the community. This goes for children learning their first language, and for people that want to participate in new communities, such as a rock band, a study program, or the family of a new boy/girlfriend. Variations in language use can be subtle or pronounced. As the learning of a new language is the ability to *participate* in language, and not internalization of language rules (i.e. cognitive perspective), what determines a competent communicator in a sociocultural perspective is her ability to *use* language according to the norms of the community (Lave & Wenger, 1991, p. 109; Säljö, 2002, p. 47).

Indeed, some theorists argue that it is the use of language in social contexts that makes the words meaningful. The philosopher Wittgenstein, for example, suggested the notion of *language games*, where the meaning of words and concepts are created and maintained through social use (Bracken & Thomas, 2005, p. 150). The word ‘sweeping’ as an example, has a totally different meaning in a rock band for a guitarist than for a person cleaning the living room, or for a person at a tall building who is scared of heights; sweeping could refer to a guitar technique, a method to clean the floor, or as an adjective for overwhelming heights. The meaning of the word is not in the word itself, but it is present in the use of the word in specific situations. This notion is acknowledged by the philosopher Alva Noë who argued that “I am not myself, individually, responsible for making my words meaningful. They have their meaning thanks to the existence of a social practice in which I am allowed to participate” (2009, p. 90).

Language is thus seen as a tool ‘borrowed’ from the collective and used to communicate with other people in speech and writing, and importantly, also to communicate with ourselves in thought. Vygotsky thus proposed that intellectual tools have both an *interpsychological* function in communication with others, as well as an *intrapsychological* function as we communicate with ourselves (Säljö, 2002). This perspective dissolves the divide between ‘outside’ and ‘inside’, as our ‘inner dialogue’ makes use of intellectual tools ‘borrowed’ from the social practices we participate in. “Language is *simultaneously* a collective, an interactive, *and* an individual sociocultural tool. That is why it can work as a

link between culture, interaction and the individual's thoughts" (Säljö, 2001, p. 89 [my translation]).

Physical tools, or artefacts, are the things in the world that people make use of in their every-day practices. Through the construction of artefacts, such as cars and planes, hearing aids, the smartphone, money, etc., human beings have radically changed their ways of living, as the artefacts shape both practices and thinking. In a sociocultural perspective, artefacts are not seen as something separate from the human being because they are integral to human practices (Säljö, 2001). People use physical artefacts to help perform activities, to remember, resonate, communicate, to perceive, and so on. Artefacts are therefore not seen as things which are separate from the individual spectator, but they are rather seen as an integral part of what constitutes a human being, as they are active resources for thinking and acting (Säljö, 2002, p. 39).

By emphasising the *use* of artefacts, it is fruitful to conceptualise them as *technologies*. And these technologies *afford* ways of acting or perceiving (DeNora, 2007). In this perspective, a radio, as an example, is an artefact, or technology, in which a person can listen to music. The radio affords the possibility to listen to music. But an artefact can afford various things. A radio could also afford being used as a table, or used as a decorative object representing a fashion style from the 1960's, or being used as an object to break through the window if you want to get out and the window is sealed. When an artefact's affordances are used, the affordances are *appropriated* (DeNora, 2007). It is in the appropriation of artefacts that people establish norms for practices; and people must be creative to perceive affordances of an artefact which is not usually appropriated. Additionally, artefacts naturally afford certain things; a ball affords to be rolled more naturally than a triangle. The perceived affordances of an artefact thus motivate certain kinds of actions. This is important in a sociocultural perspective, because it shows the intimate link between artefacts and human practices; artefacts are produced by people to work as resources for action and experience, and in turn, the use of these artefacts and their inherent properties form the perceived affordances of the artefact which motivate action and form social practices (DeNora, 2000, p. 36). In other words, artefacts can constitute practices based on their perceived affordances.

Importantly, Säljö (2002) also viewed intellectual tools as having affordances. Like artefacts, intellectual tools have limited affordances. Some might, as an example, argue that language is sometimes an insufficient tool when it comes to describing experiences; whereas other mediums such as dance, visual arts and music provide other affordances for expression. Although extensively rich, the use of language filters experiences and transforms them into

words that conform to the structure of language. If language has both an *interpsychological* as well as an *intrapsychological* function, it could be argued that people communicate and think about the world through the ‘filtering’ concepts they have learned through language (Säljö, 2001, p. 68). This suggests that the use of language influence, or even constitute, our own and others’ experiences (Säljö 2001, p. 92).

Indeed, the sociocultural perspective views intellectual tools and artefacts as integral to the experience of being. One might call it a view of a human being as ‘person-in-the-world’ (Lave & Wenger, 1991, p. 52), where a dualistic conception of persons as separate from their social and natural world is viewed as reductionist. As Noë argued, exploring experience² and tools, “language, tools, and collective practices makes us what we are” (2009, p. 67). Noë continued, arguing that

Parts of me – tools – can be spatially discontinuous with me: What makes them me, what makes them part of my body, is the way my actions take them up. And insofar as I act in and feel with my extended body, my mind is extended too.

Alva Noë, 2009, p. 80.

There is an intimate reciprocal link between our experience of the world, as mediated through language and the perceived affordances of artefacts, and the natural and artificial world (i.e. nature and the constructed artefacts in the world). Etienne Wenger described this relationship with the metaphor of the river and the mountain;

...our experience and our world shape each other through a reciprocal relation that goes to the very essence of who we are. The world as we shape it, and our experience as the world shapes it, are like the mountain and the river. [...] The river only carves and the mountain only guides, yet in their interaction, the carving becomes the guiding and the guiding becomes the carving.

Wenger, 1998, p. 71.

As we take part in various discourses and practices with various artefacts, we change our experience of the world and develop a unique identity.

An example from my own studies of music therapy can highlight this point. One of

² Noë’s main focus is exploring consciousness, but he does not distinguish between the two concepts consciousness and experience (2009, p. 8)

the first concepts we were introduced to in the music therapy program here in Bergen, Norway, was the notion of *musicking*. I will shortly describe this concept here as I will make use of it in the discussion below. Musicking is a notion proposed by Christopher Small, who argued that “there is no such thing as music” (1998, p. 2). He argued that music is an activity, not a thing; it is something people do. His definition of musicking was “to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practicing, by providing material for performance (what is called composing), or by dancing” (1998, p. 9 [emphasis removed]), and he even included any activity that contributes to the performance (such as selling tickets for a show) as part of musicking. The view of music as something separate from the activity is a *reification*, he argued; that is, making an abstraction of an activity and treat the abstraction as something real and autonomous. This new conception of musicking was an intellectual tool appropriated in the music therapy program in Bergen, and a way of experiencing music that I had never imagined before. By ‘borrowing’ this tool, it changed my perception or experience of what it means to music. Looking back, the concept of musicking probably influenced my experience of more than music, as it widened the focus of enquiries to always consider the role of context when trying to understand something. In addition, this new experience of music, a thing or activity that I was familiar with, showed me how my understanding of the world is amenable, suggesting for me that we indeed live in socially constructed realities.

Another example from my studies, is the discussion of what music therapists should call the persons that they work with. Are they clients, patients, participants, or users? What our professors hold is that the words (or intellectual tools) we use when talking about the people we work with is not neutral, but rather influence how we perceive them (e.g. Rolvsjord, 2010, p. 36). This is in line with the sociocultural perspective proposed here.

Community of practice and identity

The notion of communities of practice (Lave & Wenger, 1991; Wenger, 1998) can be viewed as social ‘spheres’ where socialization takes place. As Wenger (1998) argued, communities of practice are everywhere, and they are recognized by their joint social enterprise where the participants negotiate their practice towards a common ‘goal’. The communities mentioned above can be viewed as communities of practice; i.e. a rock band, a study program, and families. In these communities of practice, the participants are appropriating language and artefacts in certain ways. This local norm of appropriation of tools is the community of practice’s *competence* (Wenger, 1998). For a person to become a legitimate participant within

a community of practice, the person must first be given *access* to the community by the other participants. Then she must learn to appropriate the tools in the same way as the participants within the community of practice; in other words, the person needs to learn their competence. Recalling the way tools mediate experience as discussed above, this implies that various communities of practice afford different ways of experiencing one self and the world. The communities of practice we are born into, and those we choose and are allowed to participate in, are determinants for how we experience the world.

Wenger (2013) has suggested a metaphor where individuals are walking through a *landscape* of communities of practice throughout their lifetime. As a person learns to participate with various languages and tools, her trajectory within and across communities of practice constitutes that person's *identity*. This identity is characterised by her developed skills, attitudes and resources in terms of using the languages and artefacts according to the rules of the communities of practice she participates in. Her identity also includes what affordances she has learned to perceive (Stige & Aarø, 2012³, p. 124). Identity is thus both capability and legitimacy; it is both personal skill and social recognition.

Negotiation of meaning

The process of socialization, where a person develops an identity through gradually learning to appropriate the tools of the communities of practice she participates in, is not a process that only influences the individual. The individual's own perspective is also influencing the competence of the collective. Jean Lave and Etienne Wenger pictured the participation in a new community as "both absorbing and being absorbed in – the 'culture of practice'" (1991, p. 95). Wenger (1998) proposed the notion of *negotiation of meaning* to represent this same process, and this is a key concept in his articulation of the theory of community of practice. When a new participant is included into a community, the person starts taking part in the negotiation of meaning. That is, she starts taking part in the discourse of the community and in the appropriation of its tools. As a newcomer, she mainly needs to learn the community's way of talking, thinking and seeing the world by getting familiar with their discourse, and learn their ways of appropriating artefacts. As she becomes acknowledged as a legitimate participant by the 'old-timers', her own perspective (based on her accumulated identity) becomes more respected. She can then suggest changes to the discourse and the practices based on her own experiences (Lave & Wenger, 1991; Wenger, 1998, p. 138).

³ Stige and Aarø described musical identity (i.e. musicianship). This is my adaptation to identities in general.

Note that this mutual engagement in the negotiation of meaning is within and across the various communities of practice that people are participating in, and also influenced by larger discourses tying communities of practice into broader constellations; discourses such as science, religion and law. The negotiation thus involves a complex interaction between the local and the global (Wenger, 1998, p. 131).

I will use music therapy as an example. What is music therapy? When I was included to the study program in Bergen, I had to learn the discourse about music therapy from my professors, which included concepts such as musicking. I also needed to learn how to use the artefact 'music' as a music therapist. I needed to learn to see, think, hear, and communicate as a music therapist. The discourses and practices of my study program was also influenced by the larger international discourse of music therapy, and other interacting discourses. As I am now done with five years of training, my own perspective is more acknowledged, and I am allowed to communicate this through a master thesis. My voice is more acknowledged than before, and my practices are perceived as more exemplary of the profession.

What I consider music therapy to be is thus a combination of the discourses I participate in and my own experiences of music therapy; two factors that do not have any clear boundary, as the discourse is influencing my experiences. To cite Wenger (1998) ones more, our experience and the world is like the river and the mountain, they influence each other in a reciprocal relationship.

Expectation in a sociocultural perspective

The sociocultural perspective provides an alternative rationale for the nature of knowledge and understanding than what is assumed in the cognitive perspectives. Knowledge is seen as more or less local to a specific community of practice depending on its similarities to other communities of practice and its embeddedness in the grand narratives of science, religion, politics, etc. Knowledge is not only validated by its correspondence with the world, but very much through its legitimacy as judged by the expert participants of the community.

The sociocultural perspective also addresses the relation between discourse and experience, and adds artefacts as having an influence on experience. Even if people are living in the same world, their participation in various discourses and use of various artefacts will result in various experiences of that same world; implying that people live in the same world, but in different realities. I see this notion as a possible explanation to response expectancies' (Kirsch, 1985) influence on experience. Through our trajectory of learning within and across various communities of practice, we learn to perceive the world as the other participants do

by using their language and appropriating their artefacts. As we learn to experience the world, we develop response expectancies to how the world operates and to how the world looks, sounds, smells, tastes, and feels like.

As argued in section 3.4, I do not see the sociocultural perspective as incongruent with the research on expectations in cognitive and social-cognitive perspectives. The research that suggests that expectation influences bodily responses and experiences (e.g. Kirsch, 1985), guides actions (cognitive model of operant conditioning, and value-expectancy model in motivation theory), and enhances performances and persistence (self-efficacy) are all congruent with a sociocultural perspective. What the sociocultural perspective stresses is that the understanding that our expectations are based upon is *socially negotiated*. This implies that therapists must recognize their own understanding and expectancies as socially constructed; as based on one of many truths. It also implies that the experiences of the clients must be recognized as real for them. A neglect of the clients' perspective becomes more than saying their perspective is illogical or incorrect; it becomes a dismissal of their experienced reality. This could indeed, in some cases, cause more harm than help.

A person's expectations can be linked to the notion of identity, as proposed in the sociocultural perspectives. Through our trajectory within and across various communities of practice, we develop expectancies to how artefacts can be used. As will be discussed below, the affordances we have learned to perceive in music and musicking are the fundament for our expectancies concerning how it is possible to use music to promote health.

4.0 Central areas of understanding in music therapy

Expectations are influencing both process and outcome of therapy (Constantino et al., 2011; Greenberg et al., 2006). In chapter 2 we reviewed the literature in music therapy and psychotherapy, and argued that expectations are based on understanding and an evaluation of current circumstances. The notion that expectancies influence actions was supported in chapter 3, where we considered how expectation had been linked to theories on motivation and classical and operant conditioning. The sociocultural perspective stressed the socially negotiated nature of understanding and expectations, and our sociocultural embeddedness can be seen as a rationale for how response expectancies influence experience.

Based on the notion that expectations are based on understanding, we can ask which areas of understanding that constitutes our understanding of music therapy. That is, what concepts are fundamental to our understanding of music therapy as a therapeutic practice? Before I consider this question, I will present a conceptualization of the process of music therapy. The chapter will end with implications for music therapy practice.

4.1 Culture-centered music therapy

Culture-centered music therapy, as articulated by Brynjulf Stige (2002), is a metatheory that builds on a sociocultural conception of humankind. Stige's description of *enculturation* is similar to the notion of socialization as described in section 3.5, and he uses the notions of negotiation of meaning, and legitimate participation in communities of practice, and sees experience as co-constructed through the use of symbolic tools and artefacts. This makes culture-centered music therapy a conceptualization of music therapy which is highly congruent with the perspective I want to communicate in this text.

Stige's use of the concept *culture* includes a person's assumptive world and her conscious and nonconscious actions, such as routines, rituals, and other practices. Culture is also symbolic tools such as language and music, and artefacts, and these are seen as constitutive to a person's experience of self and the world. Culture is, in other words, in all we are, and in all we do. Culture is the customs and worldviews we learn through socialization, and human co-existence is enabled by our cultural capacity for communication through use of symbols and artefacts.

As a metatheory, culture-centered music therapy can be seen as a 'theory about theories'. With his enquiries Stige wanted to encourage cultural awareness and cultural

sensitivity in all approaches of music therapy; be they humanistic, psychodynamic, transpersonal or behaviouristic oriented. To be culture-sensitive is to be open for diversity, as every client we meet as music therapists will have different worldviews based on their unique trajectory of learning. A culture-centered approach is thus a client-centered approach with awareness of the client in social and cultural context (Stige, 2011).

Based on this sociocultural perspective, Stige proposed a definition of music therapy:

Music therapy as professional practice is situated health musicking in a planned process of collaboration between client and therapist.

Stige, 2002, p. 200.

Music therapy is a *professional practice* as the music therapist has a professional responsibility, and must have completed the necessary training to become a certified music therapist. The process in music therapy is conceptualized as situated health musicking, and will be described in detail below. Describing music therapy as a *collaborative* process highlights the shared responsibility of client and therapist in their mutual engagement towards their goals, and promotes an approach where the therapist is open and respecting of the client's worldview. Stige (2002, p. 202) suggested a universal description of the client's process in music therapy as an "engagement in health-promoting cultural learning". This notion is based on his sociocultural conception of *health*;

Health is then understood as the mutual and general interest and care for each person's possibility for participation. Individual aspects of health, as personal conditions and qualifications for *participation in sociocultural life*, are then acknowledged, while *mutual care* to ensure the development of the conditions and qualifications of each person is also underlined. Health is therefore not understood as an either-or state, but as a quality of the *interactions and activities* that humans engage in.

Stige, 2002, p. 200.

To use the concepts from chapter 3, health is related to the person's possibility for legitimate participation in communities of practice. It is both based on the individual's capabilities, and the *mutual care* of the other participants in the community of practice. "The planned direction of the process is increased possibilities for participation, in the context of therapy and in the context of a larger community" (Stige, 2002, p. 214). Health promotion can be understood as

a planned process of increasing participation in therapy, and in other communities of practice where the client wants to participate. And music is argued to be a powerful tool for social integration.

Health musicking

Health musicking is the collaborative process in music therapy, as articulated by Stige (2002). Health musicking is “the musicking of a client and a therapist in relation to a health concern” (p. 210). The notion of music as a situated activity (Small, 1998; see section 3.5 this text), is thus used here. Stige actually balanced the view of music as activity and music as things, or artefacts. Musical artefacts are considered as *musics*, which includes songs, melodies, lyrics, as well as instruments, cd’s, songbooks, etc., which are developed as resources for musicking throughout cultural history. When we take part in musicking we appropriate the affordances of musics. Further, this activity is made possible by the innate capacity of communicative musicality. The relation between these concepts is illustrated in figure 2.

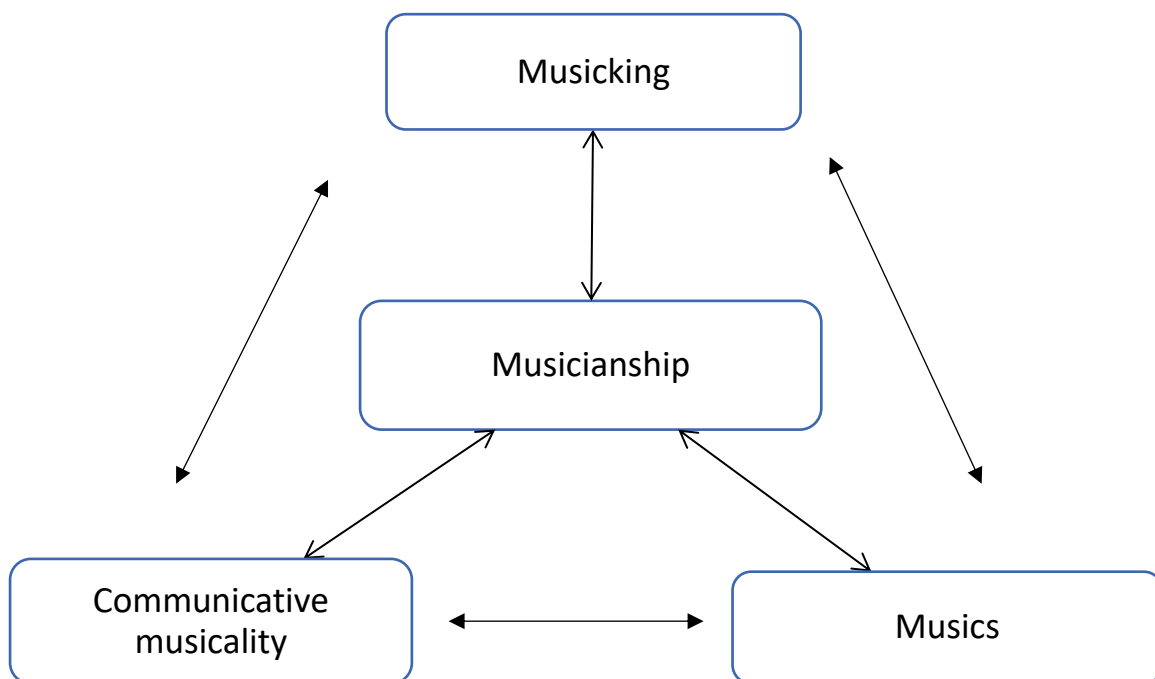


Figure 2: Relationship between communicative musicality⁴, musics, musicianship and musicking (Stige & Aarø, 2012, p. 126).

⁴ This model has been presented with a variation of terms referring to the person’s innate capacity for nonverbal communication and participation in cultural learning. Stige & Aarø (2012) used ‘musicality’, while the original model from Stige (2002, p. 83) used ‘protomusicality’. I use ‘communicative musicality’ as it is a term already introduced in this text.

A person's musical identity is conceptualized as *musicianship*; a notion introduced by Mercedes Pavlicevic and Gary Ansdell (2009). Musicianship is the learned skills and attitudes developed through the person's encounters with musics in her trajectory of learning (see section 3.5 above on identity).

Stige's (2002) articulation of health musicking involves more than the use of musics; health musicking as the process of music therapy is "characterized by careful assessment and application of the health affordances of arena, agenda, agents, activities, and artifacts" (Stige, 2002, p. 211). He argued that different arenas (a music therapy room at a clinic, a concert venue, etc.), agendas (goals, themes to explore, symptom reduction, etc.), agents (therapists, family members, friends, etc.), activities (improvisation, listening, reflecting, etc.), and artefacts (i.e. musics) all afford different possibilities in terms of promoting health; i.e. promoting possibilities for legitimate participation.

What affordances one perceives is learned and influenced by social norms and personal experiences with the five components. A social norm of practicing music therapy in my home town, for example, is to play with clients in a band format, often collaborating towards a concert. Norms of appropriating the components of music therapy are often derived from theoretical orientations that propose a rationale for a specific approach. Playing in bands and performing at concerts is an approach derived from the orientation of community music therapy, where increased participation in the local community often is a main agenda (e.g. Stige & Aarø, 2012). These norms of practice influences expectancies toward music therapy, as it is such practices people experience and hear about through discourses. I remember the leader of a psychiatric hospital here in Bergen ones said he did not think music therapy could afford anything for the hospital, as he found the patients too ill to participate in bands and to play concerts. He was not aware of the myriad of possibilities of using music in a collaborative relationship to promote health.

Areas of understanding in music therapy

As the leader of the hospital, music therapists and clients also have expectancies towards the health affordances of the components in music therapy. For theoretical purposes, it is possible to consider prior experiences and discourses of delimited concepts, that combined constitutes a person's understanding of music therapy. I call these concepts 'areas of understanding'. Even Ruud (1998, p. 19) suggested that the fundamental areas of understanding which concerns music therapy, are the areas of *music, science, health, therapy, society* and *the individual*. As expectations are based on understanding, we can argue that a person's

understanding of these areas will be governing for that person's expectancies towards how music therapy can promote health. As expectations influence both actions and experience, these expectations can ultimately be governing for how music therapy is practiced.

It is not in the scope of this text to consider all of Ruud's concepts, but I will focus on three of them; namely music, health and therapy. The following sections will present sociocultural perspectives on the experiences of these concepts. As an understanding of music therapy can be argued to be more than a combination of various areas of understanding, section 4.5 presents sociocultural reflections concerning music therapy as a whole.

4.2 Music

The first area of understanding I want to consider is music. Our understanding of music will be governing for how we expect music to be used as a health resource in therapy.

Based on the sociocultural perspective articulated in this text, our understanding of music develops through experiencing music ourselves and by participating in the discourses of the communities of practice we participate in (Säljö, 2001; Wenger, 1998). As language mediates experience of the things we experience, there is no clear line between discourse and own experiences. Indeed, referring to Wittgenstein, Ruud held that discourse is constitutive to our experience of music;

To master a language, according to Wittgenstein, means to master a reality. To master the use of language in aesthetic contexts implies mastering manifold attitudes, skills, and presuppositions that together create an aesthetic reality. It is also important to grasp that the very formation of the concepts that constitute this aesthetic reality constitutes the aesthetic experience. In other words, there is a relationship between the use of language and the aesthetic experience.

Ruud, 1998, p. 81.

What music is, and how it can be used, is therefore conditioned by social conventions even more than its physical properties.

What do we experience when we experience music? If we use Stige's (2002) conceptualization, there are both musics, and the appropriation of musics in musicking. On our personal learning trajectory, within and across various communities of practice, we

therefore experience musical artefacts and the use of these in musicking. Through discourse we learn about how musics have been appropriated in cultural history, as well as values and attitudes towards aesthetic quality. Through this trajectory, we develop a unique musicianship (i.e. musical identity), that includes skills and attitudes concerning musics, as well as the perceived affordances we have learned to see (Stige & Aarø, 2012). Our expectancies will be based on the affordances we perceive in musics; we cannot expect musics to be used in ways that we cannot first imagine.

Randi Rolvsjord (2010) has suggested a notion that refers specifically to the *health affordances* we perceive in music (i.e. how musics can be used to promote health). *Musical experience skills* are suggested as the “competencies that people draw on when they use music to regulate their emotions, as motivation for working, as a device for social ordering, or as a means of communication in music therapy sessions” (Rolvsjord, 2010, p. 72). Such a skill is thus referring to clients’ and therapists’ experience with using music as a health resource in everyday life and in therapy.

Expectations towards how musics can be used to promote health is intimately linked with the health affordances we have learned to perceive. Indeed, I will argue that the health affordances we experience in a specific situation with a client is *the same as* what we expect to be health promoting in that situation.

Clients’ expectancies toward *playing* music will also depend on the musical culture in the communities of practice she participates in. That said, western culture is characterised by a sense of ‘elitism’ concerning the performance of music, where only a few people deemed as ‘talented’ have the ‘right’ to perform music. Small (1998, p. 8) argued that the right to music has been ‘hijacked’ by some “few stars, and their handlers, [who] grow rich and famous through selling us what we have been led to believe we lack”. Rolvsjord (2006) argued that there could be personal, social, economic or cultural constraints that influenced a client’s access to music in everyday life. I believe a client’s personal experience with the performance of music may influence her openness to trying an active music therapy approach.

4.3 Health

Health is the second area of understanding I wish to consider. I believe one’s conception of health is fundamental to how clients and therapists expect how artefacts and activities can be used at a specific arena by the agents in their work towards their agenda.

The medical model, as described in section 1.2, builds on a medical understanding of mental health, where health is considered an either-or state. In this perspective clients are either healthy or unhealthy, normal or abnormal. Therapy based on this notion could be related to what is considered *clinical recovery*, which is recovery from mental illness based on observable measures (e.g. symptom reduction, social functioning) (Slade, 2009). Alternatively, one could conceive of health on a continuum, where there are no discrete differences between the people that are ‘healthy’ and ‘unhealthy’. Variations along the continuum between health and illness can be shifting from day to day, and be more or less stable over time. This view is similar to a dialectic approach to health, which holds that health and well-being cannot be experienced without its relation to illness (Rolvsjord, 2010, p. 29). Similarly, diversity models suggest that mental illness is not wholly negative, as mental illness can sometimes be a resource in life; be it in work, social relationships, music, etc. Some have even expressed that their life is experienced as deeper, stronger or richer after their experience with mental illness (Slade, 2009, p. 32). *Personal recovery* in mental illness is suggested as a personally defined experience of better health, and does not necessarily include symptom reduction. Personal recovery is experienced by the client, and can be conceptualised as well-being despite the troubles from mental illness (Slade, 2009).

Cultural conceptions of health, and discourses that maintain a specific view of health, will have influence on how clients experience their mental illness, as well as decisions concerning the agenda, artefacts and activities and the agents’ roles in therapy. Building on the notion that our understanding and experience of health is related to discourses about health, James E. Maddux (2005, 2008) criticized what he observed as an *illness ideology* in mental health care. He argued that the leading discourse in mental health care had an excessive focus on psychopathology and that psychotherapy’s primary focus was the ‘curing’ of illnesses, rather than the promotion of health. He argued that this ideology is partially a result of the growth and influence of diagnostic manuals which builds on assumptions about mental illnesses as discrete entities within the individual, often neglecting social influences on disability, as well as a language adapted from medicine bearing negative connotations; terms such as “*symptom, disorder, pathology, illness, diagnosis, co-morbidity, treatment, doctor, patient, clinic, clinical, and clinician*” (Maddux, 2008, p. 56). His solution for a rejection of the illness ideology and a move towards a *positive clinical psychology* was first and foremost to start using the language of positive psychology (Maddux, 2005, p. 22).

Tia DeNora (2007) suggested that health as experienced by the individual can be

conceived of as *health status*, and it is intimately linked to cultural assumptions and the practices and artefacts we consider as related to health care;

[...] health is performed in social settings and in relation to performance conventions and materials. For example, in some countries today, when we visit a health professional – for a medical check-up, let us say – we submit ourselves to a battery of tests (blood pressure, heart rate, cholesterol, and so on). We then receive an assessment (like a report card) of how ‘healthy’ we are in relation to established measures. Our ‘bad’ cholesterol is low, our blood pressure ‘perfect’, our short-term memory is failing, we are experiencing ‘mild depression’. When we repeatedly ‘pass’ or ‘fail’ the tests designed to ascertain these things, we are deemed, by medical practitioners, to be healthy or ill. Health, in other words, is indicated by the passing of some tests or trials that accord with cultural conceptions of what it means to be healthy. When we have achieved a good ‘report card’ time and time again, we accumulate an identity – we are ‘healthy’. Health, in other words, is health-status. We are apportioned degrees of this status according to how we repeatedly perform in the various trials and tests that are set for health-assessment.

DeNora, 2007, p. 272.

DeNora sees health as *performed*, and her conceptualization is congruent with the perspective of Stige (2002) outlined in section 4.1, where health is a quality of interaction and activities in social enterprises. Understandings and experiences of health can then be considered socially constructed, and be a result of “complex interactions between biological, psychological, social, and cultural factors” (Stige, 2003, p. 203).

4.4 Therapy

Understandings of therapy can also be argued as being developed through discourses and prior experiences. In section 2.1, I described Frank and Frank’s (1991) conceptualization of psychotherapy as a healing practice based on a cultural narrative concerning the nature of mental illness and the role of therapists as culturally sanctioned healers. They argued that the helpfulness of a therapy rests on the client’s acceptance of the therapeutic rationale and belief that the activities promoted by the therapy can lead to positive change. The effect of therapy rests on the worldview of the client, not the potency of the activities. The therapeutic

rationale and activities should therefore be close to the clients' own 'folk psychology' and theories of change (Wampold, 2001, 2007; see also Bohart & Wade, 2013, p. 235).

Some people have experienced how therapy is practiced themselves, while others learn about therapy through discourse, the media, etc. The traditional Freudian representation of therapy, where the client lies at a couch while talking about her problems to an interpreting therapist, is perhaps an image many westerners imagine when thinking about psychotherapy. For therapists, and some clients, literature is perhaps the main source to take part in the discourse of therapy. We can read about how therapy has been practiced, and about rationales that explain why a certain way to do therapy is better than an alternative way. We adopt concepts such as 'defence mechanisms', 'the unconscious', 'projection', and 'the ego', from psychoanalysis, and concepts such as 'self-actualization', 'unconditional positive regard' and 'self-determination' from humanistic therapy; all which can be seen as intellectual tools used to communicate about what we consider the focus of mental health care. Additionally, we might expect a therapist to use or think with such terms when practicing therapy competently. The discourses we learn to use about therapy through our trajectory via universities towards becoming a certified therapist is, in a sociocultural perspective, constitutive to how we understand and approach mental illness, and, as I argue in this text, also part of what makes therapy work. Even antidepressants, which is thought to mainly work through altering physiochemistry in the brain, is argued to mainly work because of expectations based on cultural beliefs (Bracken & Thomas, 2005). This notion is supported by research on placebo effects and antidepressants (Kirsch, 2014). It is argued that "the drug industry has worked with (and 'on') the medical profession *and the public* to generate a set of background cultural assumptions and orientations through which we as individuals experience and understand our different states of distress" (Bracken & Thomas, 2005, p. 169). Considering the harmful 'side-effects' of medications, this implies that although our discourses and expectations might be the basis for change in mental health care, some discourses have better consequences than others.

4.5 Music therapy

We have now considered three of Ruud's (1998) six areas of understanding that a conception of music therapy is suggested to be based upon. I have referred to various authors who considered music, health and therapy from a sociocultural perspective. Discourse and personal experiences with the respective phenomenon is thought to influence the person's

expectancies towards it, and ultimately expectancies towards how arena, agenda, agents, activities, and artefacts in music therapy can be appropriated to promote health.

One might argue though, that an understanding of music therapy is not merely a combination of understandings of music, health, and therapy. On the one hand, music therapy as a profession itself has a (relative) long history of enactment, constructing its own norms of practices, knowledges and values, and on the other hand, even if people can explicitly communicate their understandings of music, health and therapy, for many, music therapy is still a new concept lacking a ‘definition’. This status is interesting, as clients might not know what to expect from music therapy; even thirty years after Pavlicevic (1987) observed just that (see the literature review above). Before considering implications for music therapy practice, I will explore some sociocultural discussions concerning music therapy.

When Kenneth Bruscia (2014, pp. 272-276) sought to articulate a definition of music therapy in the third edition of his seminal book, he discussed the role of discourse in the process of defining. He too recognized the power of discourse, and he argued that any definition or understanding of music therapy is ‘co-constructed’. The notion of basing our understanding of music therapy on own personal experiences as well as the discourse of others is supported in his reflections (2014, p. 275). He proposed a ‘hierarchy of constructs’ where a definition could be evaluated based on its congruence on several levels; we could compare and evaluate our own discourse (a) with our personal experiences in music therapy (b) and with the discourse of others (c), and compare and evaluate other’s discourses (c) with our own experiences (b) and with the discourses of others (d). I understand Bruscia’s agenda to be concerned with finding a universal definition that can serve as a negotiated global definition, useful to describe as many music therapist’s experiences as possible. In terms of expectancies, and how our understanding is part of our experienced reality, I find local knowledge to be more relevant for the practice of music therapy. The hierarchy of constructs Bruscia proposed can be seen as the competence of the global community of practice which is music therapy, and will therefore have an influence on the individual, but it is the therapist’s (and client’s) personal understanding that will govern expectancies and influence the process of music therapy.

This local knowledge is more present in Brynjulf Stige and Karolyn Kenny’s (2007) reflections concerning the stories we tell about how music therapy work. Drawing from studies of musical healing in different cultural contexts (e.g. Gouk, 2000), they argued that music therapists needed to acknowledge “the possibility that the way we imagine music therapy working is part of how it works”. Further, they cautioned that if this is the case,

music therapists needed to be reflexive concerning who they consider ‘we’ to be, because what the music therapist believes is not necessarily what the client believes;

[...] every case of music therapy practice represents the possibility that the music therapist encounters clients or participants who think differently. In other words; there may be a mismatch between the music therapist and the client participant in terms of how music therapy works. If music therapy works the way we think it works, this kind of mismatch may make it not work. Or our misconceptions, at least, may inhibit music therapy from working in the best ways.

Stige and Kenny, 2007.

If our expectancies influence process and outcome of therapy, then music therapy may indeed work because we believe it does. This is also in agreement with Quiroga’s (2015) reflections, linking a mismatch of expectations between client and therapist to difficult moments in music therapy (see literature review).

What then, if the client’s beliefs are different from the therapist’s? Should the therapist abandon her own perspective and try to match the client’s expectancies? Stige (2002, p. 41) suggested that *interest* in and *respect* for the client’s beliefs is a good starting point. We must also remember the importance of the therapist’s allegiance to the therapeutic approach. The music therapist’s allegiance and belief in her approach is necessary for her to be recognized as a competent person, and to be convincing enough to ‘spark’ hope and positive expectations for the future. Also, one of the main reasons clients come to therapy is because they cannot find a solution to their problems themselves⁵ (Frank & Frank, 1991; Wampold & Imel, 2015). Music therapy, as a culturally respected ‘healing practice’ represented by a competent music therapist, can therefore offer an explanation and a solution for the client’s illness which motivate the client and inspire hope for the future. As Ruud argued;

We should be aware that our ways of describing, interpreting, or “proving the effects of” music therapy are a kind of discourse that creates the reality we believe in – and that we want other people to believe in. In therapy, this discourse must be felt as

⁵ Frank and Frank (1991) called this an experience of *demoralization*.

“true”, lest we encounter both grave ethical and serious practical problems in dealing with clients.

Ruud, 1998, p. 116.

As a socially constructed reality is not a relative reality, music therapists should indeed believe in their discourses. But recognizing that the discourses *are* social constructions that could sometimes not match the worldview of the clients, allows for a flexibility where the approach could be tailored to each client

Gary Ansdell (2003) also reflected on ‘the stories we tell’ in music therapy. He argued that “the question we should ask of the theoretical stories we tell about our practice as music therapists is not *Are they True?* but rather *What do they allow us to do?*” (Ansdell, 2003, p. 157). He then proposed a focus on *pluralism*, respecting a diversity of approaches, complemented by *pragmatism*, where theories and approaches are adapted to what is needed by the client at the specific time and place. He saw theories in music therapy as a ‘useful fiction’, where their values are ultimately judged by what they afford in the situation, and what they allow the client and therapist to do.

4.6 Implications for practice

The sociocultural perspectives presented in this text sees experience as negotiated in social practices and mediated through discourse and artefacts. Even though we live in the same world, we live in different realities. For clients in mental health care, where meaning, experience and relationships are a central concern, the notion of socially constructed realities has a permeating influence on therapy.

I will highlight six areas where music therapists should be aware of the role of expectancies and the influence of our cultural embeddedness.

The client’s worldview

The user perspective has been a theme throughout this whole text. We started with considering the growing support of the user perspective in Norwegian mental health care, exemplified with the right to choose a medication-free alternative (Helsedirektoratet.no, 2016). In Norway, user involvement is a legal right in mental health care, grounded in a fundamental respect for human beings’ right to make choices about themselves. The Norwegian Directorate of Health also refers to user involvement as having a therapeutic

effect through increased autonomy and generation of hope (Helsedirektoratet, 2013). The notion of understanding as being socially constructed, and the influence of expectations on process and outcome of therapy, suggests that there are more reasons for acknowledging the user perspective in mental health care.

A sociocultural perspective on music therapy in mental health care suggests that belief in the health affordances of music therapy and expecting that music therapy will be health promoting is essential to the benefits of therapy (based on notions from Ansdell, 2003; Frank & Frank, 1991; Gouk, 2000; Ruud, 1998; Stige & Kenny, 2007; Wampold, 2007; Wampold & Imel, 2015). If music therapy works because we think, or *expect*, that it works (Stige & Kenny, 2007), and clients develop their expectancies through their unique trajectory of cultural learning, then music therapy will work differently for every individual client. What artefacts and activities in music therapy afford therefore depends on the relation between client and therapist, and their relation to the agenda and the arena where they participate (Stige, 2007, 2012). A respect of the user-perspective should therefore be elementary to any practice that aims for health promotion and empowerment.

Another argument for respecting the user perspective becomes apparent if we see the clients as active agents in therapy, who themselves makes use of music therapy in their process towards better health (see definition of health in section 4.1). We could argue that therapy does not work *on* clients; clients make therapy work by their use of its health affordances. Indeed, this has been suggested as an explanation to the minimal variations in effect between various psychotherapy approaches; clients are able to use a myriad of approaches when dealing with their troubles (Bohart & Tallman, 1999). In music therapy, Rolvsjord (2013, 2014b, 2015) has studied clients' contributions in therapy, and clients' use of musics as a health resource in everyday-life. Her research supports the notion that it is the clients that make therapy work, through their active participation, contributions and use of music and music therapy. Based on the enquiries in this thesis, we can argue that clients will not make music therapy work if they do not believe in its health affordances.

Evidence-based practice

The sociocultural perspectives I have presented, suggests that theories in music therapy are not necessarily corresponding with how the world is, but can be viewed as a 'useful fiction' facilitating a working relationship and positive expectancies for recovery (Ansdell, 2003). This opens up for a tailoring of the approach to the individual client. How does this notion relate to the 'evidence-based' trend in current health care policies?

Evidence-based practice, originating from evidence-based medicine, has been contested by music therapists who have argued that an exclusive focus on approaches that has been empirically supported, is incompatible to the spontaneous and creative nature of music therapy; and treatments based on diagnoses only, is not helpful in practice as clients' individual differences and preferences are argued to be more important than the diagnosis (e.g. Aigen, 2015; Rolvsjord, Gold, & Stige, 2005). Based on this same critique, the American Psychological Association (APA) articulated an alternative framework, more suited for psychotherapy. They defined *evidence-based practice in psychology* (EBPP) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006). Clinical expertise included an “awareness of the individual, social, and cultural context of the patient” and allowed “psychologists to adapt interventions and construct a therapeutic milieu that respects the patient’s worldview, values, preferences, capacities, and other characteristics” (APA, 2006, p. 277). Moreover, APA wrote that “psychological services are most effective when responsive to the patient’s specific problems, strengths, personality, sociocultural context, and preferences” (2006, p. 284). Here, the best evidence available should be balanced by tailoring the approach to the unique client, in a collaborative working relationship between client and therapist (p. 280). I find the notion of EBPP as a fruitful framework for music therapy in mental health care. The implications from the research on expectations, and a sociocultural view of therapy, is that client’s worldview and clinical expertise should be given primacy, while evidence and theory should be considered helpful resources, or a ‘useful fiction’, whose value must be determined in every individual case.

The power of discourse

The sociocultural perspective holds that language are constitutive to our experience of the world and ourselves. Music therapists should be aware that their dialogues with clients is a negotiation of how the world should be experienced. We discussed this in section 3.5, here I want to highlight the experience of music. Talking about music is difficult, as the musical experience is translated into the concepts and structures of language. As music is a rich and polysemous medium, its translation into language can result in depriving it from what makes it meaningful. Ruud (1998) saw this as an act of power, where the music therapist could, by imposing her own experience of the music, prevent the client of deeply exploring her musical experiences through her own language. If music therapists do not have a deep respect for the client’s unique understanding and representation of music, “they reduce themselves to

suppliers of a new language or new model through which the client may rewrite her experiences” (Ruud, 1998, p. 24). I acknowledge this point, but I can also imagine settings where music therapists can help clients towards a deeper, and more meaningful experience of music. As with the experience of the world, the power of language in colouring experience is a two-edged sword; it can change our experience to the better, but it also challenges us to consider whose reality we deem is better. I will argue that a respect for diversity and for a plurality of realities is a healthy attitude, in therapy and in society at large. The implication for practice is to be aware of the power of language, and to be reflexive concerning one’s own values and how these might not be shared by the client.

The power of musicking

The sociocultural perspective presented in this text sees intellectual tools and artefacts as constitutive to our experience of the world and ourselves (Säljö, 2001). Music is here a special medium, as it can be seen as both an intellectual tool through which we can communicate and express ourselves, as well as an artefact developed as resources for musicking in cultural history. Through musicking (i.e. the use of musics; melodies, rhythms, etc.) we can learn to experience the world differently. Two very different examples can illuminate this. In the literature review, we saw that the clients in Curreri’s (2013) study reported to experience music differently after playing and talking about unconventional music. One of the clients said she started to hear the traffic noise outside the window as part of the music. In a more encompassing notion, we might see the act of musicking as actively participating in a social space, letting one’s voice (metaphorically and perhaps literally) be heard in the community of practice (Stige, 2002). Such an act of participation will then be part of the negotiation of meaning, as the person engages in negotiating how she wants the world to be. She also performs herself for the other participants in the community, making a stand of who she is, or who she wants to be. This line of thought is congruent with Small’s original use of the concept musicking;

Musicking is about relationships, not so much about those which actually exist in our lives as about those that we desire to exist and long to experience: relationships among people, as well as those between people and the rest of cosmos, and also perhaps with ourselves and with our bodies and even with the supernatural, if our conceptual world has room for the supernatural. During a musical performance, any musical performance anywhere at any time, desired relationships are brought into virtual existence so that those taking part are enabled to experience them as if they really exist.

Musicking can therefore be seen as affording identity development and increased (and sometimes decreased) participation in communities of practice.

A view of music as cultural artefacts necessitates an awareness of the cultural history of the artefacts. Based on the artefact's history of use, it embodies a meaning which is present for the people who know of that history. These meanings could be shared by societies as 'common-knowledge' or idiosyncratic based on an individual's personal history with the artefact. The electric guitar, as an example, has been argued to have a cultural history of use dominated by male players (Halstead & Rolvsjord, 2015). Jill Halstead and Randi Rolvsjord considered this male gender stereotype to have consequences for the practice of music therapy. One of the suggested implications was to be aware of implicit gendering in music therapy; do music therapists offer the electric guitar to female clients as often as male clients? They also saw a therapeutic potential in using the guitar for either affirming or disrupting gender stereotypes.

Hope

The fifth implication for practice, is the importance of promoting hope and optimism. Research suggests that optimism is positively related to happiness, and psychological and physical well-being, and negatively related to anxiety and depression, whilst hope is positively related to happiness, and negatively related to stress and depression (Alarcon, Bowling, & Khazon, 2012). Adding that positive outcome expectancies is related to good outcomes in therapy (Constantino, et al., 2011), a promotion of hope, optimism and positive expectations is important. That said, this must be approached on the client's terms. We should be aware of the possible disempowering effects of the way we talk about approaches directed towards promoting hope, positivism and positive expectations. In some situations, terms like 'expectancy enhancement' or 'manipulation' of hope and expectancies (e.g. Greenberg et al., 2006; Constantino, 2012), could contribute to a discourse that presents the therapist as powerful and intelligent, while the client is perceived as weak and delusional (see Rolvsjord, 2014a). I believe a respect of the client's worldview, and a genuine interest in the client's perspective, may be a better approach, and still promote hope and optimism.

Mutual care

The final implication I want to highlight is the shared responsibility which is necessary for the clients to become legitimate participants in their social world. If the client is to become a

legitimate participant in her family, sphere of friends, work, at her institution, with her therapist, etc. the communities must first of all allow the client to participate, and consequently let the client's voice be heard and influential to how they see the world through their discourse and activities (Lave & Wenger, 1991). A focus in music therapy on the individual client alone, could result in a limited focus on conforming the client to social norms, and thus fail to notice the potentials in preparing the social communities for accepting the client. Music therapy has the potential for both social integration and social critique (Stige, 2002; Stige et al., 2010); and both is necessary if society is to accept a diversity of world-views, and to stop producing mental illness by narrowing what is considered normal.

5.0 Conclusion

This thesis has presented a theoretical exploration of the nature and influence of expectation in music therapy in mental health care. I have argued that clients' and music therapists' expectations towards how music therapy can promote health influences both the process and the outcomes of music therapy.

I will summarise my reflections by considering each of the four research questions.

1. *How have expectations been considered in the music therapy and psychotherapy literature?*

By reviewing music therapy and psychotherapy literature concerning placebo trials in research and the common factors discussion, and by conducting a literature review on the presence of expectations in the music therapy literature, I synthesized a working definition of expectations in music therapy;

Expectation is the anticipation of future consequences, based on understanding (prior experiences and what is learned through discourse) and an evaluation of current circumstances. Expectations can change, and they can influence the process and outcome of music therapy through their influence on actions and experience.

This working definition was used as a tool enabling further exploration of the concept.

2. *How can expectations be understood from a sociocultural perspective?*

A sociocultural perspective on expectations sees expectations as part of a person's accumulated identity. Clients and music therapists will have different expectations to music therapy based on their personal trajectory of cultural learning. Expectations are part of a person's experienced reality, and they are based on a socially negotiated understanding. This implies that music therapists must recognize their expectations concerning music therapy as based on one of many 'truths', as well as respecting the clients' expectancies as part of their experienced reality. Music therapists should be reflexive concerning whose reality they are advocating, and be open for idiosyncratic expectations towards how music therapy could promote health.

3. *What are the areas of understanding that expectations towards music therapy are based upon, and how can these be considered from a sociocultural perspective?*

I have argued that expectations towards music therapy is mainly based on the areas of *music*, *health*, and *therapy*. Based on a sociocultural perspective, I have argued that clients and music therapists develop an understanding of these through experiencing the concepts themselves and learning about them through discourse.

4. *What are the implications of a sociocultural notion of expectation for the practice of music therapy?*

Music therapists should respect the client's worldview; if the client does not believe in the benefits of music therapy, then participation in music therapy will probably not lead to positive change. This implies that the music therapist and the client should collaboratively decide what *artefacts* to use, what *activities* to engage in, which *agents* should be included, on what *arena* music therapy should be practiced, and what *agenda* they should work towards.

Theory or therapy manuals should be seen as resources for the practice of music therapy, while clinical expertise and the client's worldview should be given highest priority. Music therapists should be open for several approaches and theoretical rationales. As therapist's allegiance to the therapeutic method is important, music therapists should believe in the health affordances of their approach.

Music therapists should promote hope, optimism and positive outcome expectancies. This should be part of the collaborative process of music therapy, and should not be practiced at the expense of respecting the client's troubles and experiences.

A view of health as related to both individual capability and collective responsibility suggests that health promotion can be achieved through both social integration and social critique. A possible agenda for music therapy could therefore be to take part in the community's negotiation of what is expected to be normal in terms of mental health.

Contributions to the discourse of music therapy

I consider this thesis as contributing to the discourse of music therapy by;

- Presenting a review of expectations in the music therapy literature.

- Charting relevant discourses in psychotherapy and learning theories.
- Considering ethical concerns related to a focus on expectations in music therapy.
- Linking theories of expectations to established sociocultural perspectives in music therapy.
- Linking theories of expectations to the user-perspective in music therapy.

Study limitations

The scope of this text has mainly been on a meta-level, where expectation as a universal factor in music therapy and psychotherapy has been explored. A more focussed exploration of expectations in music therapy could have provided a more nuanced picture of the interaction between client and therapist's expectations. My study could also have elaborated in more detail on the articles from the literature review, but I chose to use these articles, combined with the psychotherapy literature, as a background for exploring expectation in a sociocultural perspective. My preunderstanding of expectation as possibly a concept that could support an acknowledgement of the user-perspective, could also be seen as a limitation of this study. That said, my grounding in critical theory tells me that a use of research for emancipatory purposes, by criticizing socially constructed hegemonies, should be the purpose of all research.

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