# The importance of fun

Perceptions of music therapy for children at an inpatient unit in mental health care

Guro Parr Klyve

Thesis for the degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
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UNIVERSITY OF BERGEN

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## Scientific environment

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Guro Parr Klyve

# Introduction

The field of topic for this dissertation is music therapy with children in mental health care. In exploring my perspective as a researcher in this field through the lens of memories, a patchwork of moments emerges.

> I am standing in the choir among hundreds of others. The orchestra is ready and the church is full. “Sing so that the audience forgets their uncomfortable chairs!” The director smiles and makes a face, and we laugh. I sing as loud and clear and well as I can. I am thirteen, and I can hear my sister, my brother and father, I can hear the one I’m in love with, and my friends. I can see my mother forgetting her chair. I can sense that we are all part of the music.
>
> It's summer, and I’m working at a mental health clinic. We’re the same age and we listen to music. She talks about the life that once was, and the life that became too challenging. She talks about all the things she wants to do. I talk about my life as a student and future work, and we have many similar wishes and plans. But the doors are locked, and I’m the only one who has a key.
>
> Shaking, striving to keep his hands still, barely able to talk, shaking. He is at his weekly social visit to the school where I study outdoor life. He sits down, lays his shaking hands at the piano keys, starts to play. The fingers flies over the piano and beautiful music flows into the room. He shakes no more.
>
> I am standing in the choir again. It is the second time in just a year, and my body shivers. A friend from childhood and a friend from later on. Both of them died by suicide. I sing with grief and I sing with anger. And trying to understand.
>
> Small feet on our living room floor. Six of them altogether, steps in rhythm with the music, in rhythm with their father, and in rhythm with me. Small steps. And the largest there is.

Some moments are more formative than others. The glimpses of memories described above have been important both for my choice of profession and for my research in the field of children in mental health care. Various experiences of music through the many different phases of life have been formative and important. Also, experiences with mental health challenges both in my peripheral family and friends, as well as work experience during summers at mental health clinics as a student, have motivated me to work as a music therapist in mental health care for adults. But, I gradually became more concerned with the initiation of interventions earlier in life and the importance of this and, after having worked as a music therapist in this field for a short period, my focus and motivation changed. The experience of the loss of two close friends who had just started their adult lives may also have played a part in this change. Thus, my motivation to work with early intervention led me to start working as a music therapist at the hospital with children in mental health care.

Working as a music therapist in an inpatient unit for children in mental health care felt important and meaningful, with interprofessional collaboration and significant moments with the children.

> Tones from the piano and drums fill the hospital's music room. The boy has challenges expressing himself, and his daily life at home is currently difficult. He looks down and drums at his own pace, without saying a word. I start singing a song with a sudden pause in it and he looks up at me in surprise. We continue to play the song, and after a few more choruses, the boy stops at the same time as me. He looks at me surprised and proud, and smiles. We continue to play together, and slowly get to know each other through the musical interaction.

During the years of working as a music therapist at the hospital, I had many experiences of sharing something important with the children through musical communication. Also, having the opportunity to observe the children through musical interplay, both alone and with their parents, seemed to offer something new in the interprofessional health service and collaboration. However, I started to become

curious about how the children experienced playing, listening to, or making music during their stay at the hospital, and what significance music therapy could have in the interprofessional collaboration. I became aware of the limited research in the field, and the motivation for this PhD study started to grow.

The field of mental health care for children started to feel even more important when I became a mother. Being a mother of three children has taught me even more the importance of listening to children's perspectives on things, and I believe this has helped strengthen me as both a music therapist and a researcher. However, the focus on children's perspectives has also been present in various ways throughout earlier phases of my life, such as exploring the children's perspectives in literature in my special topic at high school, as well as when working in kindergartens in my early twenties in Norway and Tanzania.

As a girl, I sometimes experienced being treated differently from the boys around me, and thus a feminist awareness appeared early. These experiences were also present in the world of music, such as different expectations for girls and boys, and playing rhythmic piano with a lack of female pianist role models. As a student, these experiences became even clearer to me, and I started to be concerned about questions around gender, especially in an international perspective. When I studied women's and gender research as a part of my bachelor's degree, my commitment to these questions was reinforced. This feminist awareness and commitment through the years underpinned feminist epistemology and theories as a natural starting point for me when I started this PhD. I found feminist epistemology especially relevant when reflecting on interviewing children.

Through the years of working on this dissertation, I have had opportunities to share my work with colleagues at national and international conferences. This has both inspired and challenged my further work, and it has been fruitful for its progress. However, during the COVID-19 pandemic, conferences and opportunities for making international acquaintances have unfortunately been curtailed. The pandemic has affected the PhD process in several ways, including through working from home and

strict infection control measures at the hospital. Fortunately, data collection was performed before the outbreak, but the pandemic still separated me from the unit in the analysis and writing process. Although this made the process somewhat more challenging, it also provided an important lesson on the fragility of real-world research. The serious consequences that the pandemic appears to have had on children's mental health have also strongly motivated me to focus on and contribute to this field.

This dissertation addresses perceptions of music therapy in mental health care for children through an exploration of the multiple perspectives of the children, their parents and the interprofessional staff. The study was a qualitative study and it was situated in an inpatient unit for children in a Norwegian hospital. The participating children were between eight and 12 years old, and the staff were part of interprofessional teams that were assigned to each child. The dissertation is article-based and consists of three articles and a synopsis. Two of the articles have been published and the third has been submitted for publication. The three articles are listed on page 17 and are referred to in the text as the first, second and third articles respectively. In this synopsis, I position myself and the dissertation in this field of research, I elaborate further on the theoretical framework of the study, and I discuss the different parts of the dissertation as a whole.

# Abstract in English

Children's mental health and their well-being are largely influenced by their surroundings. This is particularly relevant now as the COVID-19 pandemic is proving to have had major consequences for children's mental health. Children's mental health problems are complex and involve life challenges for both the child and their families. A variety of interprofessional services are provided for children in mental health care, including, at some hospitals, music therapy, which is a relatively recent proposition in this context.

This qualitative study explores perceptions of music therapy for children in an inpatient unit in mental health care through a feministic epistemological approach, with a primary aim of obtaining a better understanding of music therapy in this setting. Through the multiple perspectives of the children, their parents and the interprofessional staff, these various perceptions are explored in a multiple case study design. Participant observation, in combination with the interviews with the parents, provided important contextual information. As a foundation for the interviews with the children, a thorough theoretical reflection and discussion concerning power relations in research with children was done. Three articles are included in this dissertation, concerning the theoretical discussion, the children's perspectives and the interprofessional staff's perspectives.

In the first article, power relations in research with children were highlighted through a theoretical reflection and discussion. An awareness of epistemic justice, epistemic ignorance and epistemic injustice was emphasised as important when working and researching with children and patients in mental health care. It was also highlighted that knowledge about epistemic injustice, and how to avoid it, reveals the importance of including children in mental health care and their knowledge in research.

The second article focused on the children's perspectives and, through semi-structured interviews, the children conveyed their experiences of music therapy in various ways. Multiple modalities were used by the children to express themselves, such as through music, drawings, movements, silence and words. In the analysis

process, a narrative approach informed by “portraiture” was used, highlighting non-dominant experiences. This narrative method allowed for multiple modalities in the analysis as well as in the presentation of the findings. In the children’s own perspectives, fun appeared to be an essential part of music therapy in mental health care for the children, not understood as entertainment, but as something of existential importance and with great therapeutic potential.

In the third article, the focus was on the interprofessional staff’s perceptions of music therapy. Through these perceptions, the possible significances and potentials of music therapy in this setting were explored, both concerning the children and the interprofessional collaboration. This revealed various potentials in music therapy, such as emotion regulation, as well as experience of identity and freedom for the children.

The multiple perspectives of the children and the interprofessional staff contribute new insights and understanding to this field. When linking and discussing these various perspectives, new questions arise: how to be attentive to, and curate children’s perspectives? Are the children’s and the staff’s perspectives in conflict or are they complementary? What can music therapy contribute to an inpatient unit for children in mental health care? Is a resource-oriented approach in a medical setting contradictory? These questions are discussed and reflected upon in this dissertation, and offer a new understanding of the significance that music therapy can have and what it can contribute to children in mental health care.

# Abstract in Norwegian

Barns psykiske helse, trivsel og livskvalitet er i stor grad påvirket av deres omgivelser. Dette er spesielt aktuelt nå da covid-19 pandemien viser seg å ha hatt store konsekvenser for barnas psykiske helse. Barns helseutfordringer er sammensatt og involverer livsutfordringer for både barnet og deres familie. Det gis et variert interprofesjonelt helsetilbud for barn i psykisk helsevern, og i noen tilfeller inkluderer dette musikkterapi, som er et relativt nytt tilbud i denne konteksten.

Denne kvalitative studien utforsker opplevelsen av musikkterapi for barn på sengepost i psykisk helsevern gjennom en feministisk epistemologisk tilnærming, med et mål om å få en bedre forståelse av musikkterapi i denne konteksten. Gjennom de mange perspektivene til barna, foreldre og det tverrfaglige personalet blir disse ulike opplevelsene utforsket i en multiple case studie. Deltakerobservasjon, i kombinasjon med intervjuene med foreldre, ga viktig kontekstuell informasjon. Som et grunnlag for å intervjue barna ble det gjort en grundig teoretisk refleksjon og diskusjon om maktrelasjoner i forskning med barn. Tre artikler er inkludert i denne avhandlingen, og disse omfatter den teoretiske diskusjonen, barnas perspektiv og personalets perspektiv.

I første artikkelen blir maktrelasjoner i forskning med barn belyst gjennom en teoretisk refleksjon og diskusjon. En bevissthet rundt epistemisk rettferdighet, epistemisk ignoranse og epistemisk urettferdighet framstod som viktig når en jobber og forsker med barn og pasienter i psykisk helsevern. Det ble også framhevet at kunnskap om epistemisk urettferdighet, og hvordan en kan unngå dette, viser hvor viktig det er å inkludere barn i psykisk helsevern og deres kunnskap i forskning.

Den andre artikkelen fokuserte på barnas perspektiv, og gjennom semistrukturerte intervju formidlet barna sine opplevelser av musikkterapi på ulike måter. Barna brukte mange ulike modaliteter for å uttrykke seg selv, som blant annet gjennom musikk, tegning, bevegelser, stillhet og ord. I analyseprosessen ble det brukt en narrativ tilnærming informert av «portraiture», som belyser ikke-dominante opplevelser. Denne narrative metoden ga rom for de ulike modalitetene i analysen, så

vel som i presentasjonen av funnene. Gjennom å gi oppmerksomhet til barnas egne perspektiv ble det tydelig at gøy var en essensiell del av musikkterapi i psykisk helsevern for barna, ikke forstått som underholdning, men som noe av eksistensiell betydning og med et stort terapeutisk potensial.

I den tredje artikkelen var fokuset på det tverrfaglige personalets oppfattelser av musikkterapi. Gjennom deres perspektiv ble mulige betydninger og potensial ved musikkterapi i denne konteksten utforsket, både i forhold til barna og i forhold til det tverrfaglige samarbeidet. Dette viste flere ulike potensial i musikkterapi, som blant annet emosjonsregulering så vel som opplevelse av identitet og frihet for barna.

De mange ulike perspektivene til barna og personalet bidrar med ny innsikt og forståelse inn i dette feltet. I en sammenkobling og diskusjon av disse perspektivene oppstår nye spørsmål: Hvordan kan vi ivareta barnas perspektiv? Er barnas og de ansattes perspektiv motstridende eller utfyllende? Hva kan musikkterapi bidra med i en sengepost for barn i psykisk helsevern? Er en ressursorientert tilnærming i en medisinsk setting en motsetning? Disse spørsmålene blir diskutert og reflektert over i denne avhandlingen, og bidrar med ny forståelse for hvilken betydning musikkterapi kan ha og hva det kan bidra med for barn i psykisk helsevern.

# List of Publications

Klyve, G. P. (2019). Whose knowledge? Epistemic injustice and challenges in hearing children's voices. *Voices: A World Forum for Music Therapy, 19*(3), 1–10. https://doi.org/10.15845/voices.v19i3.2834

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Klyve, G. P., Rolvsjord, R., & Elgen, I. B. (Submitted). Polyphonic perspectives. A focus group study of interprofessional staff's perceptions of music therapy at an inpatient unit for children in mental health care.

# Contents

# 1. Background

As described in the introduction, this study grew out of an interest in and a motivation to work on early intervention in mental health care, and my point of departure as a researcher is founded on my experiences of music as well as certain significant life experiences.

## 1.1 Children in mental health care

Childhood is a critical stage for mental health. Rapid development and growth occur during this period, and the environment in which the child grows up has a major role in its development and well-being (World Health Organization, 2021). One in ten children and adolescents worldwide experience a mental health disorder, and suicide is one of the major causes of death for adolescents between 15 and 19 years old (World Health Organization, 2021). It has also been shown that most mental health disorders start to develop during adolescence (Jones, 2013; Patel et al., 2007), and the onset of such development indicates that early intervention services must be targeted at younger age groups in order to prevent mental health disorders later in life (Jones, 2013). Considering the great consequences of children's and adolescents' well-being on their future lives, it is essential to address early intervention in respect of their psychosocial development and mental health (Jones, 2013; World Health Organization, 2021). Children's mental health has recently become a field of increasing concern, as one of the many consequences of the COVID-19 pandemic (United Nations Children's Fund, 2021). When focusing on children's mental health, it is crucial to also involve their families and life circumstances, which always provide a context to their well-being.

In Norway, the increased focus on children's mental health as a consequence of COVID-19 has led to some strengthening of relevant services and increased attention from the Norwegian Government (Ministry of Health and Care Services, 2021).

Current services for children with mental health challenges and issues are subject to great variation in communications and interactions, and in some cases and contexts they include music therapy. However, there remains a great need for increased focus and reinforcement in this field, notably taking account of children's own perspectives.

## 1.2 Children's perspectives

Children's voices and perspectives in mental health care have traditionally not been included in research (Liegghio et al., 2010), but, over the last decade, many processes have contributed to a repositioning of children, both in respect of their agency within society, as well as in research. The UN Convention on the Rights of the Child (CRC), (UN General Assembly, 1989), Article 12 in particular, has had a profound effect on these processes. Furthermore, changes in how children are perceived in society, understanding them as competent social actors, have contributed to the inclusion of children in mental health care in research (Liegghio et al., 2010; Powell & Smith, 2009; Sinclair, 2004; Sommer et al., 2010). Children now participate more actively in the research process and are not merely objects of inquiry. Ethical and methodological choices impact the children's participation, and this requires certain skills on the part of the researcher, both in terms of specific abilities and attention (Powell & Smith, 2009).

As Sommer et al. (2010) argue, in Scandinavia, children's rights, child-centredness and an interest in children's worlds have historically been more prominent than elsewhere, and the centrality of child perspectives and children's perspectives reflects the profound impact of culture on the participation and perception of children in society. This also implies that child perspectives and children's perspectives are not neutral; they are always in some way influenced by the values on which "children" and "childhood" are built. The distinction made here between the "child perspectives"

and "children's perspectives" is based on a notion of the child's role in the various situations. Sommer et al. (2010) define them as follows:

> "**Child perspectives** *direct adult's attention towards an understanding of children's perception, experiences, and actions in the world"* (p. 22, emphasis in original).

> "**Children's perspectives** *represent children's experiences, perceptions, and understanding in their life world"* (p. 23, emphasis in original).

Hence, the focus on children's perspectives stands in contrast to child perspectives by viewing children as subjects in their own world. In attempting to understand the children's statements and actions, adults adopt a child-focused interpretation in their child perspective (Sommer et al., 2010). Children's perspectives are an overall topic for this dissertation. In the second article the children's perspectives are displayed through our child perspectives as researchers and adults, aiming to understand and interpret the children's perspectives. In the third article, the child perspectives are more prominent. I perceive these as complementary perspectives and not as opposites.

Although there is a growing awareness of children's perspectives, research focusing on children's and adolescents' experiences in mental health care in general is limited (Persson et al., 2017). Children should be included as participants regardless of their age, and considered as subjects with their own opinions. This entails certain requirements, such as getting thoroughly involved in the children's ways of communicating (Skivenes & Strandbu, 2006).

How children experience their own treatment in mental health care and what kind of help they receive has been in increasing focus, as exemplified in the guidelines for children and youth mental health treatment by the Norwegian Directorate of Health (2018). In mental health care for adults, such focus has been even greater in the last decade, highlighting the importance of client and first-person perspectives for recovery (Anthony, 1993; Slade, 2009). Demonstrating the importance and potentials

of client-based approaches, this has contributed to a change in practice and research in adult mental health care. However, in mental health care for children and youth, such approaches have not yet been so extensively explored (Naughton et al., 2018; Naughton et al., 2020; Simonds et al., 2014).

Children in mental health care appear to be in a position where they are at risk of knowledge exclusion. Exclusion from knowledge is one of the primary harms of epistemic injustice, a concept that will be thoroughly discussed and reflected upon later. Children in mental health care are particularly susceptible to this kind of injustice (Klyve, 2019).

## 1.3 Recent developments in music therapy

There is increasing acceptance in the Norwegian health care system and in society in general of music therapy as a therapeutic approach. In recent decades, there has been a change in music therapy practice in Norway, from focusing primarily on pedagogical contexts to a greater focus on medical contexts (Ruud, 2022). Music therapy with children in medical contexts includes both somatic units and mental health care units. Through its inclusion in the Norwegian national treatment guidelines for psychosis (Norwegian Directorate of Health, 2013), it has expanded and developed in the field of mental health, especially with adults (Rolvsjord, 2010, 2018; Solli, 2014), but also with children and young people (Johns, 2018b; Trondalen, 2004). Another field undergoing particular growth is music therapy for children and young people in child welfare (Fuhr, 2022; Krüger, 2012). Perspectives on trauma and music therapy have also been a subject of increasing research with children in Norway (Enge & Stige, 2022; Johns, 2017; Krüger et al., 2018), particularly with a focus on developmental traumatization (Nordanger & Braarud, 2017).

Perspectives critical of the traditional medical model have been developed in music therapy. These new perspectives have had a major impact within the field, and build

upon various traditions such as recovery, feminism, community orientation and human rights perspectives. Three approaches of particular relevance for my study are the focus on user involvement (Baines, 2003; Procter, 2001, 2004; Solli, 2014), the focus on contextual and community orientation (Ansdell, 2002; Rolvsjord, 2006a; Rolvsjord & Stige, 2013; Ruud, 2010; Stige, 2002, 2012; Stige & Aarø, 2012) and the focus on resources (Rolvsjord, 2004, 2010, 2014). In the present study, which is situated in a medical setting, I consider such critical perspectives to be highly relevant. Although they are mainly focused on adults in mental health care, they provide a useful basis for reviewing previous research in the field of music therapy with children in mental health care.

## 1.4 Previous research and literature in the field of music therapy with children in mental health care

Research and literature in the field of music therapy with children in mental health care are limited, but growing. Through a literature search, the aim was to explore research and literature in the field of children in mental health care, with a view to investigating how children are represented and how their own perspectives are represented in the literature. There is some variability in the ages that define childhood, with the CRC's definition of a child as an individual between birth and 18 years (UN General Assembly, 1989), and the UN's definition of adolescence as between 10 and 19 years (United Nations Children's Fund, 2022). However, this second definition is not universally accepted as regards either its start or its end (Sawyer et al., 2018). Due to the context of this study, i.e. an inpatient unit with services for children between 0 and 12 years old, 'children' will be understood as individuals up to 12 years of age. The literature search is thus mainly limited to this age group. However, significantly more research has been undertaken on music therapy with adolescents in mental health care, some of which has been considered relevant here, in addition to which, some of the literature concerns both children and adolescents.

Three meta-analyses have been carried out in music therapy with children and adolescents in mental health care in general (Geipel et al., 2018; Gold et al., 2004) and with internalizing symptoms in particular (Gitman, 2010). These studies showed promising effects, revealing its effectiveness for some children and adolescents, while also highlighting a need for further research. In their quasi-experimental study, Gold et al. (2007) emphasized that music therapy in outpatient services for children and youth with mental health issues might require more time to show positive effects when there are manifold and complex issues. Porter et al.'s (2017) RCT on music therapy in clinical settings pointed out that such therapy might be effective for children with comorbid conditions.

Some research in the field focuses on specific challenges or diagnosis. In Helle-Valle's (2016) doctoral dissertation, children's restlessness was explored in the context of a community music therapy project with children in a kindergarten, through a case study (Helle-Valle et al., 2017) and a cooperative inquiry group (Helle-Valle et al., 2015). Among other findings from this project, Helle-Valle et al. (2017) argued that community music therapy can be a good approach to children with restlessness when focusing on improved mutual relationships between the child and their ecology. Other studies focusing on restlessness and ADHD in music therapy with children and youth are Jackson (2003), who performed a survey which found that music therapists use multiple methods in their work with children with ADHD. Rickson and Watkins (2003) investigated music therapy with aggressive boys and its effect on prosocial behaviours, and their results suggested that music therapy might help to develop positive relationships with others. Rickson (2006) investigated music therapy with boys with ADHD and its effect on motor impulsivity, comparing improvisational and instructional music therapy. Although no definite conclusions were made, the findings indicated that instructional music therapy may help to reduce motor impulsivity. Through a case study, Aigen (1991) illustrated a therapeutic process with a boy who was referred to music therapy because of aggressive behaviour. The process showed how music contributed to empowerment and change for the boy. Herman's (1991) case study described the process of recovery in music

therapy of a boy with severe emotional challenges. Hiben (1991) presented a music therapy process with a group of children with ADHD and learning disabilities, and explored the children's interpersonal development in this process.

Through an RCT, Goldbeck and Ellerkamp (2012) investigated the efficacy of music therapy for children with anxiety disorders. The results indicated that music therapy, despite methodological limitations, was a good intervention for children with anxiety disorders. Gooding's (2010) multiple-part PhD examined music therapy with children and adolescents with social challenges and its effect on improving social skills competence, for which it proved to be effective.

In Hakomäki's (2012) case study, music therapy and traumatic loss was explored in a collaborative study with a 14-year-old co-researcher. Storycomposing was investigated as a method through the co-researcher, and appeared to be a suitable approach to children's processing of traumatic experiences. Sannes (2012) explored music therapists' experiences with emotion regulation in music therapy, and the findings showed that the nonverbal interaction appeared to be a basis for emotion regulation. Through a musical frame in child psychotherapy in her doctoral dissertation, Johns (2018b) explored the influence of non-symbolic microprocesses in therapeutic interplay. In the findings, musical dynamics, suggested as "description of the dynamics of lived relationship experiences over time" (Johns, 2018a, p. 198), proved to have potentials for facilitating emotion regulation. Emotion regulation was also focus in Uhlig et al.'s (2018) RCT study on music therapy with children and adolescents, focusing primarily on rap and singing in a school setting. Kirkerud (2016) focused on what experiences music therapists had with self-esteem in promoting children's mental health. The findings suggested that music therapy can enhance children's self-esteem. In Bartram's (1991) case study, a music therapy process with a boy with interpersonal problems was explored, and Montello and Coons (1998) investigated music therapy for children with emotional, learning and behavioural disorders through comparing active versus passive music therapy.

Interprofessional perceptions of music therapy with children and adolescents in mental health care were explored through focus group interviews (Thorgersen, 2015) and surveys (Hense, 2018). The findings of these two studies emphasised both the various potentials of music therapy as part of the interprofessional collaboration, as well as the importance of increasing the staff's understanding of these potentials of music therapy.

Assessment processes in music therapy with children and youth in mental health care have been a topic for several studies (Jacobsen, 2012; Layman et al., 2002; Loewy, 2000; Wells, 1988). Jacobsen (2012) tested the validity and reliability of a music therapy assessment tool with parents with emotionally neglected children, and the results indicated that this was a good assessment tool for families at risk. Layman et al. (2002), Loewy (2000) and Wells (1988) explored, described and investigated assessment in music therapy for emotionally disturbed children and adolescents, with promising results.

A great deal of research has been done on music therapy with children and autism spectrum disorders. This can largely be considered as a field in itself and it is beyond the scope of this dissertation to provide a complete overview of this research. However, it is still relevant to the field of music therapy with children in mental health care, and the recently published Cochrane review of music therapy with autistic people is thus included (Geretsegger et al., 2022).

The anthology *Music in mental health work with children and young people* (Ruud, 2009, my translation of title) provides an insight into a Norwegian context with children and young people, and two chapters are of particular relevance to this study. Kleive (2009) explored how structured play with voice and movement can contribute to a therapy process for children and youth with trauma-related dissociative disorders, and Fugle (2009) presented music therapy as a relevant method at an outpatient clinic in mental health care for children and youth.

Oldfield (2006, 2011, 2017) provided a thorough insight into clinical work through case studies with children and families in a mental health context. Jacobsen (2017a,

2017b) also described music therapy with families, focusing on the work with families at risk and emotionally neglected children. Music therapy with children and their families was further described through case studies in Oldfield et al. (2012) with a focus on short-term music therapy processes. Molyneux (2005) also wrote about short-term music therapy with children and adolescents in mental health care and the powerful potentials this offered, as well as multidisciplinary family assessment processes with families in this setting (Molyneux, 2008). Soshensky (2007) provided case studies with children in mental health care, and Twyford et al. (2008) described a relevant case study from transdisciplinary assessment. Doak (2012) suggested some guidelines for music therapeutic work with children and adolescents, while Rogers (2012) presented ways to work with children and adolescents with post-traumatic stress disorder (PTSD). In her book, Fugle (2012) focused on the use of music in varied work with children and youth, and on music's impact on mental health, and in her article of 2015 she provided an insight into music and imagery with a child with complex trauma and the potentials therein. Complex trauma and music were also discussed and displayed through case studies in Johns (2017) and Fugle and Johns (2021). Rickson (2003) shared a music therapy process with a boy who had experienced severe neglect and violence. Songwriting processes with children in mental health care were described in Baker and Wigram (2005), both as improvisational processes (Oldfield & Franke, 2005) and song-creation processes (Davies, 2005). Johns (2012) described meetings with children in psychotherapy, focusing on forms of vitality and musical dynamics.

The majority of the research in the field of music therapy with children in mental health care turns out to be quantitative studies in which the children are represented through a largely diagnostic focus. This is also the focus of much of the qualitative study research, although some of these studies are more diagnostically independent. However, there is a clear absence of the children's perspectives in the literature. A child perspective is occasionally provided where we get a sense of who the children are through case studies and descriptions, and their voices are sometimes visible through presented song creations. But the children's own perspectives of music therapy are rarely found. In Hakomäki's (2012) case study, a good attempt has been

made to include children's perspectives. However, I consider that this is rather a question of an adolescent's perspective due to the boy's age. Although the boy shared experiences from the music therapy process from the time he was 7-9 years old, he was 14 years old at the time of the research project. The representations of young people's perspectives in research in the field of music therapy in mental health care turn out to be more prevalent, and I have therefore chosen to include some research that is considered relevant for this dissertation (which does not offer a complete overview of this field of research).

Young people's own perspectives are present in several studies which explored connections between young people's musical identity and their recovery (Hense, 2015, 2019; Hense & McFerran, 2017; Hense et al., 2014), their intentional use of music (McFerran et al., 2018), as well as in relation to ADHD (McFerran, 2009), anorexia (Trondalen, 2004), bereaved adolescents (Skewes, 2004), and child welfare (Fuhr, 2022; Krüger, 2012). Hense et al. (2018) explored how young people experienced music therapy sessions based on the Healthy-Unhealthy Uses of Music Scale (HUMS), and Aitchison and McFerran (2022a) explored young people's perception of assessment in mental health care settings. This led to further research on young people's lived experiences of multidisciplinary mental health assessment (Aitchison & McFerran, 2022b).

Other studies that are relevant to children's perspectives of music therapy, but which are not part of the field of mental health care, include research with children with a history of family violence that shared their experiences of music therapy in special care (Fairchild & McFerran, 2019; Fairchild & Mraz, 2018), and refugee children's experiences of music therapy (Enge & Stige, 2022; Roaldsnes, 2017). Vestad (2013) explored small children's experiences of everyday use of music and its potential to promote good health in the moment and the future. Although these studies are not in the field of music therapy, I consider them relevant to the field under study here.

The participants in Hense (2019) and McFerran (2009) were aged from 12 years and up. Although they are defined as adolescents by the authors, one can argue that they

are on the border between childhood and adolescence. McFerran's (2009) study is situated in a school context and not in a mental health care one, but I find it a relevant perspective on the field of mental health care for children.

Through this review, I have discovered that both the research and the more descriptive literature in the field of music therapy with children in mental health care are mainly presented from the perspectives of an adult researcher and/or music therapist. Perspectives of interprofessional staff are present in the literature, but limited. I did not find any perspectives of music therapy from children under 12 years old in the context of mental health care. The children who participated in the research are thus represented through an adult perspective, and much of the research was quantitative and with a diagnostic focus. The case descriptions in the field give a better insight into children's experiences, such as through song lyrics, and are important contributions that complement the research. Also, the research offering young people's perspectives in mental health care, as well as the research involving children's perspectives in other, but adjacent fields, provide an understanding of the possibilities and the significances of including the participants' perspectives. Based on the previous research in the field of music therapy with children in mental health care, I identified a need for more qualitative research in this field in general, and on children's perspectives in particular.

## 1.5 Research team

The research team was an interprofessional one, with me as the project leader, my main supervisor Randi Rolvsjord, professor of music therapy, and my co-supervisor Irene Bircow Elgen, professor of child and adolescent psychiatry. Although there are some limitations in terms of our intersectional diversity, as three highly educated, white, adult women, our varied professional backgrounds were of great value. During the study, the research team also had close collaboration with the unit staff at the hospital. I had the role as both researcher and music therapist in the study. The unit's

other music therapist, Anita Barsnes, and I were responsible for the music therapy with the children in the study, and conducting the participant observation in each session. Barsnes was present at the interviews in the cases where she had been the music therapist.

Rolvsjord had the role of moderator in the focus group interviews, and she was co-author of the second article. In the third article, both Rolvsjord and Elgen were co-authors.

I use first-person singular pronouns in this synopsis to avoid depersonalizing the text, and to refrain from speaking for others (Rolvsjord & Hadley, 2016). Plural pronouns in the first person accordingly refer to me and my supervisors.

# 2. Theoretical Framework

The theoretical framework for this study is influenced by various theories in addition to the perspectives already presented in the background chapter. As previously described, feminist epistemology and theories were a natural starting point for me, and it provides a rationale that I found especially relevant in relation to children's perspectives. My approach to knowledge is influenced by a feminist epistemological stance. From this perspective, I emphasise in particular aspects of how knowledge is perceived as something "produced, not simply found" (Ackerly & True, 2010, p. 27). Perspectives of children's communication and development, particularly theories about communicative musicality (Trevarthen & Malloch, 2000), have been central in approaching children's musical interaction in music therapy in mental health care. Resource-oriented music therapy (Rolvsjord, 2010), as well as relational perspectives (Johns, 2018b; Trondalen, 2016), have been influential both for the music therapeutical work in the study, as well as for the framework for the interpretation of the various interviews.

## 2.1 Feminist perspectives

The field of feminist theories is a complex one, incorporating many theories and approaches. The perspectives are however largely consistent in their various emphases on "the need to challenge sexism, racism, colonialism, class, and other forms of inequalities in the research process" (Naples, 2003, p. 13). The self-reflexive, political, and critical elements of feminist-informed research "enable the researcher to "see" those people and processes lost in gaps, silences, margins, and peripheries" (Ackerly & True, 2010, p. 22). Within this feminist-informed theoretical framework, a diverse corpus of feminist theories have been of influence in the shaping of this research project. This is reflected in all parts of the study – the ontological, the epistemological, the axiological, and the methodological – as it is in the choice of topic for the study, the approach to knowledge, the reflexivity practised

along the way, as well as the methodology and the methods chosen (Hesse-Biber, 2014). In the choice of topic – *perceptions of music therapy with children in mental health care* – I acknowledge that my own emotions have played a role and motivated these choices (Jaggar, 1997). Furthermore, informed by feminist theories, a desire to challenge the silent, marginalized position that children and patients in mental health care traditionally occupy in research motivated me to explore the children's own perspectives as a crucial part of this research project.

### 2.1.1 Feminist epistemology

Feminist epistemology identifies how women and other subordinated groups have been systematically disadvantaged by "dominant conceptions and practices of knowledge attribution, acquisition, and justification" (Anderson, 2017). Power relations are emphasized and challenged by feminist researchers, centralizing "the relationship between the researcher and researched to balance differing levels of power and authority" (Hesse-Biber, 2014, p. 3). This is of particular relevance in this research project with children, and will be further elaborated in the section below on epistemic injustice. Also, intersectionality is a central concept here, as various sociocultural categorizations, such as age, gender, class, ethnicity and dis/ability, are interwoven and interact, "and in so doing produce different kinds of societal inequalities and unjust social relations" (Lykke, 2010, p. 50).

The questions asked in this study are unavoidably tied to particular epistemological understandings of how knowledge is produced (Naples, 2003). This also requires a reflection of my own situatedness as a researcher, considering how diverse feminist researchers, such as Sandra Harding and Donna Haraway, transformed the principle of objectivity into "feminist objectivity" (Hesse-Biber, 2014, p. 5). Feminist research usually has a transformative agenda, supporting social transformation and justice (Hesse-Biber, 2014; Rolvsjord & Hadley, 2016).

In music therapy, feminist perspectives are limited but increasing (Edwards & Hadley, 2007; Hadley & Edwards, 2004; Rolvsjord & Hadley, 2016; Wheeler, 2006).

Feminist perspectives are often used in terms of a feminist approach to music therapy (Curtis, 1996, 2006, 2015; McFerran & O'Grady, 2006). However, in this study, I think of feminist perspectives primarily as an epistemology. There is limited research that "explicitly links up with feminist epistemology and methodology" (Rolvsjord & Hadley, 2016, p. 482), but this is also growing (Curtis, 1990, 1996, 2015; Hense, 2015; Hense et al., 2014; O'Grady, 2009, 2011; Rolvsjord, 2006a, 2015; Veltre & Hadley, 2012).

### 2.1.2 The situated knower

"Feminist objectivity means quite simply *situated knowledges"* (Haraway, 1988, p. 581, emphasis in original). Objectivity in feminism is thus not about a division of object and subject and transcendence, but the observer's perspective is, according to Haraway, always limited. This limited perspective determines what can be seen, and the observer is hence responsible for what we see. According to Harding (1986), a feminist standpoint is "a morally and scientifically preferable grounding for our interpretations and explanations of nature and social life" (p. 26), and Haraway argues that seeing from the perspective of the subjugated is a preferred standpoint of situated and embodied knowledge. However, it is important to be aware of the risks of "romanticizing and/or appropriating the vision of the less powerful". It is "neither easily learned nor unproblematic" to see from below, and "[t]he standpoints of the subjugated are not "innocent" positions" (Haraway, 1988, p. 584). They are nevertheless preferred standpoints because of their apparently more persistent, objective, and adequate descriptions of the world, holding more epistemic authority than knowledge developed in dominant groups (Haraway, 1988; Naples & Gurr, 2014). This requires a high degree of language and body skills and conveyance of vision (Haraway, 1988). In this, it is important to keep in mind that vision is "*always* a question of the power to see – and perhaps of the violence implicit in our visualizing practices" (Haraway, 1988, p. 585, emphasis in original). Also, it is important to keep in mind that our identity as researchers is not something predetermined and set, and it is thus crucial to "take special care to adequately

understand and transparently analyze" our own "(multiple) locations" (Naples & Gurr, 2014, p. 27).

Although many of the standpoint themes are agreed upon, there are different conceptualizations of standpoint among the various standpoint theorists, and critics point at the risk of essentialism (Naples & Gurr, 2014). This is important to take into account when adopting this approach.

### *Queer epistemology*

Queer epistemology seems to share some of the aspects of feminist standpoint theory, concerning the "critique of dominant epistemic paradigms and the entanglement of knowledge and power" (Hall, 2017, p. 163). When exploring epistemic injustice in relation to children in mental health care in the first article, I link this to queer epistemology, perceiving both queer theories and feminist theories as "part of a broad discourse on gender" (Klyve, 2019, p. 2). In this discussion, the focus is on children and patients in mental health care which are "two identity markers which seldom are discussed in the intersectionality debate on gender" (Klyve, 2019, p. 2). Despite the aspects that queer theories share with feminist standpoint theory, there are also important differences. In queer epistemology, identity is not perceived as "a point of departure for shared consciousness" (Hall, 2017, p. 163). Instead there is a focus on "affectively attuned knowing", an embodied involvement "of something other than shared understanding" (Hall, 2017, p. 163). "Queer listening" (Bonenfant, 2010; Hadley & Gumble, 2019) is suggested as a redefinition of how one perceives and listens to voices, involving a development of "a certain virtuosity" (Bonenfant, 2010, p. 78). In the first article, this concept became an important part of the theoretical discussion.

### 2.1.3 Reflexivity

"Identity alone does not ensure that a critical standpoint will be achieved" (Hall, 2017, p. 162), but it is a "point of departure" (Hall, 2017, p. 162). My point of departure as a feminist informed researcher is based on my identity, defining myself as a white cisgender heterosexual woman, using she/her/hers pronouns, and my previous life experiences, as partially presented and discussed in the introduction, are important parts of this identity. I am the mother of three children, I am a music therapist, and I am a PhD researcher. This "embodied perspective" (Naples, 2003, p. 197) has influenced the research questions that were chosen, it has influenced the choice of participants, the methodology and methods that were used, as well as how the findings were approached, analysed, and displayed (Naples, 2003).

Self-reflexivity has been an important part of the research process, acknowledging that feminist researchers are neither "immune to internalized oppression nor to the hegemonic constructions of research practice that insist on a distanced and objectifying angle of vision" (Naples, 2003, p. 197). In this process, a consideration of power differences has been crucial, however, recognizing that "we cannot eliminate all power imbalances" (Naples, 2003, p. 197). This is further discussed in the following section on epistemic injustice.

Epistemic injustice is defined by the feminist and philosopher, Miranda Fricker, as "a wrong done to someone specifically in their capacity as a knower" (Fricker, 2007, p. 1). An awareness of this and how it influences us is important in research, particularly when doing research with children and patients in mental health care. Fricker divided epistemic injustice into two forms: testimonial injustice and hermeneutical injustice, and in both sorts it is the subject that "suffers from one or another sort of prejudice against them *qua* social type" (Fricker, 2007, p. 155). In testimonial injustice, "a hearer wrongs a speaker in his capacity as a giver of knowledge, as an informant" (Fricker, 2007, p. 5). Hermeneutical injustice is about "having some significant area of one's social experience obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource" (Fricker, 2007, p. 155). Both of the sorts affect two of the "most basic everyday epistemic practices"

(Fricker, 2007, p. 1) which are: “conveying knowledge to others by telling them, and making sense of our own social experiences” (Fricker, 2007, p. 1).

It has thus been of special importance during the research process to be reflexively and critically aware of my possible prejudices as researcher towards the participants, as well as trying to disrupt identity prejudices through a deconstruction of binary oppositions (Klyve, 2019).

## 2.2 Music therapy perspectives

Music therapy can be defined as “an effort to increase people’s possibilities for action” (Ruud, 1998, p. 3). This definition includes both the individual and the structural barriers to participation, understanding music therapy as something that meets both the individual and the cultural and sociological needs of the clients (Ruud, 1998). Norwegian music therapy has its foundation in humanistic music therapy (Ruud, 2010; Trondalen, 2008). At the core of music therapy practice, there is a non-judgmental perspective of music (Rolvsjord, 2010; Bruscia 1998). This implies that the clients do not need any musical abilities or skills to play instruments to participate in music therapy. The music therapist facilitates for the client the capability to quickly participate in an interaction in music, regardless of skills and abilities.

However, there might also be a risk inherent in bringing music into therapy, blending something healthy with the illness, and thereby associating music with the illness or subsequent challenges (Rolvsjord, 2010). There may nevertheless be an ethical consideration in including music therapy in an illness-dominated situation at the hospital, for instance, with the intention of bringing something “normal” into such a situation (Aasgaard, 2002; Rolvsjord, 2010). These considerations were highly relevant for this study, situated as it was at a hospital.

Given my feminist epistemological stance, one option for theoretical approaches to therapy could be a feminist music therapy approach (Curtis, 1996, 2006, 2015;

McFerran & O'Grady, 2006). Although the emphasis on empowerment and anti-oppression which is central to feminist therapy is interesting for this study, I found the relevance of relational perspectives and a resource-oriented perspective more pertinent for the therapeutic work with children with mental health challenges. I consider the focus on empowerment in combination with the focus on the resources in the clients as a more appropriate way to adopt a feminist epistemological stance in this study (Rolvsjord, 2014). In a resource-oriented approach, deconstructing binaries and establishing equal relationships with the competent clients is crucial (Rolvsjord, 2014), and this, I argue, is highly relevant in the mental health context with children.

### 2.2.1 Relational perspectives

Relational music therapy is closely related to the relational turn in psychodynamic theories. Research in the 1970s and 1980s on infants' abilities to communicate and engage in an interaction revealed the competent child, and this played a major role in this turn. Shifting from a one-person model of human development to a two-person model, the development is seen as fundamentally relational, and the feelings and affects are understood as the primary agent for this development (Trondalen, 2008, 2016).

In music therapy, a relational turn involves an intersubjective perspective (Trondalen, 2016) in which the theories of Daniel Stern have been important influences (Stern, 1985). Therapeutic involvement is acquired to enable intersubjective sharing, adjusting to the children's needs and signals (Johns, 2018b). This includes both non-verbal and verbal knowledge, and an affective communication is central. Emotional availability and musical codes enable intersubjectivity, sharing feelings through musical gestures and actions (Trondalen, 2016). Trondalen (2008) and Ruud (2010) build on the concept of "thirdness" (Benjamin, 2004), as something new that arises in the intersubjective sharing in the musical interplay, something that is more than what each can create by themselves. The therapeutic relationship in relational music therapy is based on the notion of client and therapist as "fellow travellers" (Yalom,

2002), understood as a therapeutic attitude of being in the process together (Trondalen, 2016). In this, an affective awareness in the therapist is crucial. Being in the here-and-now together in the music enables intersubjectivity, and this involves a non-verbal regulation of emotions and affects (Johns, 2018; Trondalen, 2016). In such a therapy process, experiencing shared time is of importance; it does not need to be a large amount of time, but enough to experience the qualitative experiences of being in a relationship (Johns, 2008).

### 2.2.2 Resource-oriented music therapy

In resource-oriented music therapy, the processes are described by terms such as negotiations, interactions and collaborations, instead of "intervention", and in this way a mutuality and equality in the relationship between the client and the therapist is emphasized (Rolvsjord, 2010). This understanding of the therapeutic relationship contrasts with the power relations that can arise between the client and the therapist in music therapy. This is of particular importance if music therapy is linked to both an elitist culture and an illness ideology. In such cases, the music therapist may end up possessing "a double position of expertise" (Rolvsjord, 2010, p. 35), as both an expert on the client's illness as well as on music (Rolvsjord, 2014). This imbalance, if not solved, may create more vulnerability for the client (Rolvsjord, 2010).

A resource-oriented approach to music therapy is rooted in theories that critique traditional psychiatry, such as theories from empowerment philosophy, positive psychology, and the common factors approach. In addition to these theories, various perspectives in current musicology are important parts of the theoretical framework, informing the role and concept of music within resource-oriented music therapy. Although resource-oriented music therapy initially focused on adults in mental health care (Rolvsjord, 2010), I consider this to be a highly relevant approach with children too. A resource-oriented approach to music therapy has previously been examined in various research fields with children and young people, such as with premature

infants (Gaden et al., 2022), paediatric oncology (Brault, 2019), and young people in mental health care (Aitchison & McFerran, 2022a; Trondalen, 2004).

The resources of the clients are at "the center of attention" (Rolvsjord, 2010, p. 74) in a resource-oriented approach to music therapy. This may concern the client's musical resources, such as knowledge of songs and artists, instrumental skills, song producing skills on the computer, as well as everyday use of music. However, music therapy may also be an arena where resources other than the musical ones are displayed, and it is thus important to not just focus on the musical resources in music therapy (Rolvsjord, 2010). Viewing the client within their context is of importance in a resource-oriented approach, in contrast to the traditional medical model of psychiatry and psychology which is "founded on a concept of pathology as something that resides solely in the individual" (Rolvsjord, 2010, p. 80). Diagnosis is an individualization of the client's challenges, and it may involve a risk of pathologizing structural and social problems (Rolvsjord, 2010). Empowerment philosophy seem to "bridge the gap between therapy and society" (Rolvsjord 2010, p. 81), when perceiving health as something linked to both power and resources. Empowerment has the basic idea of "power to" instead of "power over", and it is something that "cannot be seen in isolation from the interaction between individual and society" (Rolvsjord, 2010, p. 81). This involves transferring power to the client from the expert therapist, and crucial to this is active participation and involvement on the part of the client (Rolvsjord, 2004, 2014, 2015). Aiming for empowerment in music therapy also involves contextualizing the therapy. Taking an interest in the client's musical identities and use of music in other places than in the situation of the therapy allows the client to take some of the experiences from music therapy back into their everyday life (Rolvsjord, 2010). Access to music both at the individual and at the structural and social levels is crucial in resource-oriented music therapy, as music is seen as a health resource.

### 2.2.3 Music in the context of children's music therapy

How we understand music affects how we perceive music in music therapy (Rolvsjord, 2010). The concept of music in music therapy is not a fixed one. It varies depending on the therapist's theoretical approaches, individual musical traditions and previous experiences (Trondalen, 2016). The individual's culture and context are also aspects of great importance for the music in music therapy (Rolvsjord, 2010; Ruud, 1990, 1998; Stige, 2002, 2012). Musicking (Small, 1998) is a concept which is widely used in music therapy (Ansdell, 2014; Rolvsjord, 2010; Ruud, 2010; Stige, 2002). This is an inclusive concept that encompasses all types of participation in the music and the surroundings. In resource-oriented music therapy, the client's conscious use of music is highlighted, linked to their musical experiences and the knowledge these have produced (Rolvsjord, 2010, 2015). What music affords and how it is appropriated are key in this process (DeNora, 2000). Some music therapists perceive music as a means of symbolic actions or emotions, while others perceive it as a relational force in itself (Trondalen, 2016). The concept of communicative musicality (Trevarthen & Malloch, 2000) has both influenced and illustrated music's various communicative potentials in music therapy.

In the research on early communication between infants and their caregivers in the 1970s, by Colwyn Trevarthen and a network of international researchers, creative non-verbal conversations were revealed (Ansdell, 2014). These conversations were later listened to musically by Stephen Malloch, and the concept of communicative musicality (Trevarthen & Malloch, 2000) was developed to describe the proto-musical features in these duets (Ansdell, 2014). The parameters that define this ability are pulse, quality and narrative, and these are crucial for our common musicality (Malloch, 1999; Trevarthen & Malloch, 2000). Communicative musicality is an innate ability to communicate, and it supports intersubjectivity throughout life. A communicative musicality, in combination with an affective communication, is central in a relational approach to music therapy (Trondalen, 2016). Forms of vitality (Stern, 2010) facilitate communication through an affective dialogue, and lay the foundation for the experience of being understood, or lack thereof (Johns, 2018). A specific strength of music therapy is how communicative musicality is supported and

mobilized (Ansdell, 2014) through forms of vitality in musical interaction with individuals of all ages.

The various elements of intersubjectivity, as in music, are also present in children's everyday play (Johns & Svendsen, 2016). Play is considered to be an important part of children's development, and key to therapy for children (Johns & Svendsen, 2016; Winnicott, 1971). Play can be experienced by children as something that lessens anxiety in therapy due to a more indirect addressing of the children's emotions, on the children's own terms. Play can thus facilitate an exploration of the full range of emotions, helping to make children's feelings clearer and contribute to building a bridge between the verbal and the non-verbal (Johns, 2021; Johns & Svendsen, 2016). Addressing children's emotions indirectly is, as previously mentioned, something that also may happen in the intersubjective sharing in a musical interplay (Trondalen, 2016). This also makes it possible for children to express themselves in a way that does not require words. Aasgaard (2002) highlights how play can be a major part of music therapy with children in the context of paediatric oncology, and the importance and therapeutic potentials of this. Children's use of music is often associated with joy, and music seems to be an important part of a meaningful life for children. When it is self-initiated and meaningful in itself, it may also be a great health resource for children in their everyday life (Vestad, 2013).

# 3. Empirical context

## 3.1 The children's unit in mental health care at Haukeland University Hospital

The context of the study was the unit for children at the Department of Child and Adolescent Psychiatry, Division of Mental Health, at Haukeland University Hospital in Bergen, Norway. This is a unit that provides care for children from birth to 12 years old.

In Norway, the health care system is divided into primary and specialist health care services. Children that struggle with mental health challenges are cared for by the primary health service, and referred to the specialist health service if they show symptoms of more serious mental illness. In the specialist health care service, it is the outpatient clinics that have the primary responsibility for the care of the children. If there is a need for a more intensive and closer follow-up, the children are referred to the inpatient clinics (Norwegian Directorate of Health, 2018).

Children that are referred to the children's unit at Haukeland University Hospital have serious and extensive challenges, and several of them have a variety of developmental disorders. Reasons for referrals from the outpatient clinics may include complex and challenging issues, including difficulties in communication, elevated need for care, challenges in collaboration with parents, non-attendance at the outpatient clinic, a need for more intensive observation or treatment, a need to be shielded, starting out with new and complicated medication, as well as a need for faster clarifications. The unit has room for six children, and all the children are accompanied by one of their parents during their stay at the hospital.

Each child has their own interprofessional team that takes care of them and follows them through the process at the unit. The interprofessional staff at the unit include 18 social workers, one music therapist, two psychiatrists and two psychologists. Also, the teachers at the hospital school are closely connected to the unit, providing one-to-one teaching for the children, and the teachers are included in the interprofessional

teams. The stay at the unit is usually between 4 and 8 weeks, depending on the children's needs and the reasons for referral.

The unit has a relational therapy approach, and the main method used among the staff is emotion regulation, as described by Campos et al. (2004), Nordanger and Braarud (2017), and Nyklíček et al. (2011). The Circle of Security (COS) therapeutic model (Coyne et al., 2019) lays the foundation for the shared perspectives and the common language among the staff at the unit. This therapeutic model is based on attachment psychology, focusing on relational abilities, and the unit offers a guidance course for the parents during their stay at the unit. The staff also uses this method in their everyday interaction in the department, modelling for the children and their parents.

At a few hospitals in Norway, music therapy is part of the interprofessional service offered, but its inclusion at the different hospitals appears to be random. There may be varied reasons for this, but they probably include the limited research and knowledge available in this field, in addition to the fact that music therapy is a relatively recent proposition. However, when it comes to the positive effects of music therapy with adults in mental health care, the knowledge and evidence base are larger. This has led to music therapy being recommended in national treatment guidelines for psychosis (Norwegian Directorate of Health, 2013), which also affects the development of music therapy services in mental healthcare for children and young people.

## 3.2 Music therapy at the children's unit in mental health care at Haukeland University Hospital

The children's unit in mental health care at Haukeland University Hospital is one of the inpatient units in Norway where music therapy is an integrated part of the health service. In 2011, I started as the first music therapist at this unit, in a 30% temporary position. This was a service that was also shared with the adolescents' units. After a while, the position was expanded to a 50% position, before becoming a full-time

permanent position shared between the children's and adolescents' units in 2016. There have been many good interprofessional collaborations during this period, and the staff have shown curiosity and interest in music therapy along the way. Due to good experiences with clients and to research in the field, the department has now invested in a further development of the music therapy service. In the autumn of 2022, when I return to the hospital as music therapist after this PhD study, the music therapy service at the Department of Child and Adolescent Psychiatry will consist of 2 full-time permanent positions.

The work of the music therapist in this setting is influenced by resource-oriented (Rolvsjord, 2010) and relational perspectives (Johns, 2018b; Trondalen, 2016). In music therapy at the children's unit, a non-verbal and affective communication through music is often used, enabling the children to express themselves through music. But this does not preclude verbal communication in the sessions, as this also might form an important part of the music therapy process. In the music room, there is a varied selection of instruments, such as drums, pianos, guitars, digital music programs on the computer, xylophones, microphones, various rhythm instruments and ukuleles. With a resource-oriented approach to music therapy, mutuality and equality in the relationship between the child and the therapist is emphasized. In this, the music therapist aims to facilitate a collaboration and negotiation during the music therapy process, with focus on the child's preferences and agency. The sessions are set up according to what the children want to do, within the framework of the music room. The children often take the initiative in what to do in the sessions, but just as often it is the music therapist who suggests alternatives, and the children who choose between them. The sessions can then consist of playing music together, listening to music, making music together at the computer, dancing to some music, as well as writing songs together. The songs are often brought into the sessions by the children themselves, or else the music therapist suggests songs that the children might recognize or that they can learn.

Children are referred to music therapy by the psychologist/psychiatrist when this is considered to be relevant for the child. Such referrals are not linked to any specific

diagnoses, but the various cases and challenges are often discussed with the music therapist. Issues relevant for music therapy include, but are not limited to, challenges with attachment, with self-esteem, with restlessness, with emotions, with verbal expressions and with social interaction. The music therapist writes notes from the sessions in the health record, describing their understanding and interpretation of what the child and the therapist did during the sessions. The focus of the music therapist often depends on the therapeutic focus for the child elsewhere in the unit, as well as whether the stay is planned to be for observation and assessment or for treatment. The music therapist participates in the weekly interprofessional team meetings in the cases where music therapy is a part of the service offered to the child.

# 4. Aims and Research Questions

The literature review above identified gaps in knowledge concerning children's perspectives of music therapy in mental health care. It also revealed limited knowledge of how interprofessional staff perceived music therapy in this setting. The research gap points to a need for more research in this field. Based on this knowledge, the main aim of this PhD study was to gain more knowledge about music therapy with children in mental health care at the hospital. This was explored through the multiple perspectives of the children, the parents and the staff, as well as through participant observation. This study contributes new insights and understanding to the existing literature, addressing the following research questions:

*What are the perceptions of music therapy at an inpatient unit for children in mental health care?*

The sub-questions explored in the articles were:

1. *How do the children experience music therapy in this context?*
2. *How do the children express these experiences?*
3. *What are the interprofessional staff's perceptions of music therapy?*

As previously mentioned, feminist research usually has a transformative agenda, and through this study I aim to bring children's perspectives of music therapy in mental health care to the table, as equal perspectives to the others. Also, I want to contribute to, and highlight the importance of, an increased focus on children in mental health care in general.

The methodological strategies and the methods chosen to include the various perspectives are presented and discussed in the following chapter.

# 5. Methodology

The focus of this chapter is on the methodological strategies and choices that were made in the project, the ethical considerations and reflexivity, as well as the overall methods and reflections on the connections between these. A more detailed description of the methods used in each of the study parts is presented in the individual articles.

## 5.1 Methodological strategies

The feminist epistemological stance taken in this project identifies practices of knowledge production and dominant conceptions to "systematically disadvantage women and other subordinated groups" (Anderson, 2017). Children in mental health care are regarded in this thesis as such a subordinated group, and their points of view are of importance in this knowledge production (Naples, 2003; Rolvsjord & Hadley, 2016). This influenced the choice of both the focus of this study and the methods chosen. The feminist epistemological stance relates to a set of methodological strategies that are used in this project (Rolvsjord & Hadley, 2016). The strategies, described in more detail below, have included embracing multiple perspectives, reflexivity, an awareness of power relations, allowing the researcher's voice and emotions, as well as a focus on discourse.

Embracing multiple perspectives is central in the feminist approach to research (Rolvsjord & Hadley, 2016) and this has been crucial for the overall method in this study. The focus of the study was chosen with an aim of exploring the marginalized perspectives that children and patients in mental health care have traditionally had, as well as the parents' and the interprofessional staff's perspectives. Through these multiple perspectives, the main focus has been to explore what music therapy can contribute to mental health care for children. In order to provide knowledge from these multiple perspectives, the study methods varied in accordance with the persons and situations involved (Rolvsjord & Hadley, 2016).

Reflexivity is another central process in feminist research, scrutinizing the researcher's background and location in an attempt to understand how this may influence the research (Hesse-Biber, 2014). Reflexivity has been central to all stages of the project. In this context, an awareness of power relations has required a particularly high degree of reflexivity, since, by its nature, the mental health care of children comprises many power relation challenges. In feminist research, it is crucial to be aware of power relations (Rolvsjord & Hadley, 2016), and in this study this concerned particularly the power relations between children and adults, patient and therapist, researcher and participant, as well as psychiatrist/psychologist and social worker. An awareness of this, and of the risk of epistemic injustice in relation to power relations (Fricker, 2007), was essential in the interview processes, particularly in the interviews with the children.

By allowing researcher's voice and emotions (Jaggar, 1997), my own feelings have, as previously acknowledged, played a role in the research process and have motivated the choice of topic and methods. This is particularly influenced by the fact that I strongly believe that an increased focus on children in mental health care and their experiences with music therapy is of great value. As previously mentioned, the choice to write in the first person rather than the third person was made to avoid depersonalization of the text, and so as not to speak for others (Rolvsjord & Hadley, 2016). When "we" is used, this refers to me and my supervisors.

A focus on discourse was key to this project. Discursive reflexivity concerned a respect for the varied voices in the project and the participants' different discourses, possible power relations in the discourse, as well as my own text production. The representation of the children in the study was performed with the aim of understanding their perspectives, and, through an emphasis on both resources as well as challenges, the focus has been to *study up* (Harding, 2009), "rather than study down" (Rolvsjord & Hadley, 2016, p.483) in this process of exploring the marginalized perspectives.

## 5.2 Development of research design

The choice of qualitative research methods was made to address the main aim of this research project in the best possible way, exploring "meanings of social phenomena as experienced by individuals themselves, in their natural context" (Malterud, 2001, p. 483). The overall design of the study can be described in terms of a multiple case study (Stake, 1995). In a case study, the quest is to understand the participants through their own stories and "to preserve the *multiple realities*, the different and even contradictory views of what is happening" (Stake, 1995, p. 12, emphasis in original). In a feminist approach to research, exploring varied voices and multiple perspectives is central (Rolvsjord & Hadley, 2016). We chose a multiple case study design to facilitate an exploration of the various voices and perspectives of music therapy at this particular unit. This made it possible to explore the "situated knowledges" (Haraway, 1988) of the children, their parents and the staff, and the resources these perspectives bring. The methods for data collection that we used were semi-structured individual interviews with the children and focus group interviews with the staff in interprofessional teams, as well as participant observation in the music therapy sessions to strengthen the analyses. This was done in each case, centred on the music therapy process with each child. Semi-structured interviews were also conducted with the parents and were initially planned to be included in one of the articles.

In the more practical and pragmatic development of the study, some decisions were taken regarding the content and distribution of empirical material across the articles, which may have led to some case-features becoming less prominent. Through reflection and discussion with my supervisors, we considered that further attention to the children's perspectives would be essential in order to understand their perspectives in the best possible way. We thus decided that it would be more constructive to have a closer analysis of the interviews with the children, including more space for the children's perspectives to be presented. Also, a more thorough focus on children's perspectives in general was considered to be essential, since this is a field with particular ethical issues and a topic which needs more focus. As

previously highlighted, children's perspectives in mental health care are limited, and children's perspectives in music therapy in mental health care are seemingly non-existent. As a result, the first two articles concentrated on children's perspectives, while we decided that the focus of the third article should be on the interprofessional staff's perspectives. Consequently, two interrelated smaller studies emerged in the development of the study, as represented in the two empirical articles. The interprofessional staff's perspectives contributed both a child perspective concerning what music therapy offered the children in each case, and aspects of what music therapy contributed to the interprofessional collaboration and the health service in general. The multiple perspectives of the children and the interprofessional staff thus illuminated different questions in the same cases. As a consequence, the parents' perspectives were not included in any of the articles as originally planned. However, although we did not perform any systematic analysis of these data, they contributed significant contextual information for the analysis process. Our perception of this choice of articles was that it provided crucial space for the children's perspectives and enabled an important discussion of these perspectives. It also facilitated a discussion of the various perspectives of the children and the staff concerning both what music therapy can offer the children as well as of the overall process at an inpatient unit in mental health care. Consequently, a presentation of parents' perspectives was saved for a possible future article.

### 5.2.1 Participants

Participants in the study were eight children between eight and 12 years old, their parents, as well as the staff in interprofessional teams that were linked to each child. The inclusion criteria for the children were their age as well as an ability to engage in an interview. Based on the referral to the unit, an assessment was also made together with the psychiatrist/psychologist to consider whether music therapy was relevant for the child. This process was typical for the unit. The inclusion criteria for the parents were to be a parent of one of the children included in the study, and the inclusion criteria for the staff were to be a member of an interprofessional team that was linked

to a child included in the study. One of the children chose not to participate in the interview. The focus group interview with the child's team was nevertheless carried out.

A small pilot with two children at the unit, not included in the study, facilitated some user involvement (Bird et al., 2013; Jørgensen, 2019). The children gave feedback on the questions as part of the development of the interview guide. Otherwise, the children in the study participated actively in the interviews where they played music, drew drawings and expressed themselves non-verbally and verbally. However, we considered that a deeper involvement of the children, such as through participatory research, would include too high a potential risk in this specific context (Bird et al., 2013). The children were in a particularly vulnerable situation at the hospital, with the possible involvement of a family crisis, and the risk of imposing unreasonable burdens on the children was real (Bird et al., 2013). In this context, a requirement of a specific participatory commitment could possibly have limited the children's possibilities for action (Gallacher & Gallagher, 2008).

## 5.3 Methods for data collection

Given the multiple case study design, an array of methods for data collection was used. It is usual in feminist epistemological approach to facilitate expression of the various voices in the best possible way (Munday, 2014). Semi-structured interviews, in combination with participant observation, offered a good way for the children to express themselves. The interviews were held in the music room, and this provided a safe and natural context for the interview, which is highlighted as one of the most important considerations in interviews with children (Eder & Fingerson, 2001). Semi-structured interviews were also chosen as a good way to explore the parents' voices. Focus groups are perceived as "naturalistic" (Munday, 2014, p. 239), and were chosen as a method for data collection to resemble the usual situation in the interprofessional team. This facilitated natural conversations among the staff, as well

as between the staff and the researchers, and to provide space to each of the voices in the group.

### 5.3.1 Semi-structured interviews

Semi-structured interviews were decided on as particularly suitable for the children, as well as for their parents. A semi-structured interview aims to gain an insight into the participants' world. It is similar to a normal conversation, but has an interview guide (appendices 10.5 and 10.6) which leads the conversation into specific topics and possible questions (Kvale & Brinkmann, 2015). Thus, this method enabled conversations that resembled the natural interactions in the music therapy sessions, as well as those between the sessions. However, in the interviews with the children there were many particular ethical and practical concerns we had to consider both before and during the interviews.

When interviewing children, it is important to consider the child's age to know what to expect. We chose to include children between eight and 12 years old because of an expectation that children in this age range are able to answer suitably adapted questions (Vogl, 2015). This age range was also determined by the age of the children at the unit. However, it proved difficult to elicit comprehensive answers in the interviews, both because of the children's vulnerable situation, where verbal expression was itself a challenge, and because of the specific challenges they had with social interaction, expressing emotions and attachment.

As recommended in the literature, the questions in the interviews were adapted to the capacities and competencies of each child, through a sensitive approach (Carter & Ford, 2013; Eide & Winger, 2003). Children communicate through many modalities, and not just through words (Clark, 2005; Ilje-Lien, 2019). Various modalities were included in the interview setting, aided by the music room being the context for the interaction. This offered the children multiple ways to express themselves, through music, movement, drawings, and showing things through music and words. The music room was a setting which the children already knew and where they felt safe,

and the variety of modalities of expression facilitated a fun and engaging research situation (Carter & Ford, 2013).

It is important to build a strong rapport when interviewing children in general (Eder & Fingerson, 2001; Irwin & Johnson, 2005; Powell et al., 2018), and in this particular setting at the hospital this proved crucial. Communication and interplay through music with the music therapist in the music therapy sessions provided a good foundation for building a rapport with the children. I was both the interviewer and the music therapist in half of the cases, and in the other cases my fellow music therapist, Barsnes, was present to give the children a sense of familiarity.

After considering filming the interviews, we came to the conclusion that this could affect the interaction and that, due to ethical concerns, it would be best to audio-record them.

### 5.3.2 Participant observation

We made participant observations during the music therapy sessions, which is a method commonly used in music therapy (Keith, 2016). It is recommended to combine several methods to fully capture people's experiences, and this is of particular importance in relation to children (Eder & Fingerson, 2001). Such a combination is useful as a means of strengthening the analysis as well as to elicit more valid answers (Eder & Fingerson, 2001). Participant observations were made in each music therapy session as part of the data collection, and the music therapists were the participant observers in each case. This served both the purpose of building rapport with the children as well as providing contextual understanding of the children. A contextual understanding was important both for the interviews and for the analysis. As previously mentioned, a strong rapport with the children is essential for their sense of safety and thus also for their communication during the interview, (Eder & Fingerson, 2001; Irwin & Johnson, 2005; Powell et al., 2018). A good contextual understanding of the music therapy setting at the hospital was crucial for the analysis process (Eder & Fingerson, 2001).

### 5.3.3 Focus group interviews

Focus group interviews with the interprofessional teams were chosen to allow a multiplicity of perspectives to emerge and an integration of the varying voices (Malterud, 2012; Wilkinson, 2008). For this reason, the focus group is a commonly used method in feminist research (Munday, 2014). A shared interview guide (appendix 10.7) was used in the eight focus group interviews with the eight different interprofessional teams, and semi-structured interviews were performed (Kvale & Brinkman, 2015). In a focus group study, it is crucial to have a common understanding among the participants and the researcher of which questions the discussion is supposed to answer (Malterud, 2012). It is also important in focus group interviews to be open to other relevant questions that might emerge from the participants' experiences and responses. The most important strength of focus group interviews is that many voices are heard, and their internal validity is strengthened by identifying and comparing variations on the specific theme (Malterud, 2012).

## 5.4 Methods for data analysis

Multiplicity in voices requires different strategies for analysis. The aforementioned discursive reflections during the process highlighted the importance of a respect for the various voices and the participants' representations, and this became central in both the analysis process as well as in the presentation of the findings. Thus, in order to make space for the children's own expressions and as a way to destabilize the power inequalities present in the research context, we made a choice to analyse and present the children's own expressions through narrative episodes informed by the portraiture method. In the analysis of the focus group interviews, we were informed by constructivist grounded theory, which we considered a good approach for including the various perspectives. In the analysis process, the focus was primarily across the cases rather than the exploration of individual cases. The pragmatic

solution for how the empirical material was distributed in the articles played a role in why this became the major focus. Through the analysis, two levels of perspectives were in focus: the children's perspectives and the staff's child perspectives. In addition, the researchers' perspectives were present and constituted a third perspective level.

### 5.4.1 Analysis of the interviews with the children

When analysing the interviews with the children, it was crucial to be flexible in the approach, following the impulses of the children (Irwin & Johnson, 2005). Children's way of communicating is through multiple modalities, and not just through words. This implies that it was important to also pay attention to what the children showed and did during the interviews (Clark, 2005; Ilje-Lien, 2019). To include these different modalities, we chose a narrative approach to the analysis of the interviews (Kvale & Brinkman, 2015). In this, we were informed by portraiture (Lawrence-Lightfoot & Davis, 1997).

Portraiture is a method that strives to "combine systematic, empirical description with aesthetic expression" and the aim is to convey the perspectives of people by capturing the "richness, complexity, and dimensionality of human experience in social and cultural context" (Lawrence-Lightfoot & Davis, 1997, p. 3). It is a method that allows for multiple modalities, which is crucial when exploring children's perspectives, and it seeks to illuminate non-dominant experiences and narratives. In portraiture, the researcher's voice is everywhere, the voice "is the research instrument" (Lawrence-Lightfoot & Davis, 1997, p. 85). This is reflected in the framework of the inquiry, the choices that are made, the questions that are asked, the stories that are told, and the language that is used. A portraitist listens for a story, actively searching, and is central in the creation of the story.

The five features of portraiture consist of context, voice, relationship, emergent themes and aesthetic whole. In our analysis, these features served as a scaffolding in our portrait-like displays of episodes.

### 5.4.2 Analysis of the interviews with the staff

There were some specific concerns and challenges when analysing focus group interviews, concerning the complexity of the voices of the participants across each interview and between the groups (Barbour, 2014). The various voices in the focus groups were a combination of both dominating and more careful voices. This reflected sometimes the participants' professional background in a hierarchical hospital system, but not in every case. It was important to recognize and be aware of these unique dynamics in the interviews during the analysis process (Charmaz & Belgrave, 2012). Also, it was central to balance the similarities and variations between the groups. The focus group interviews were analysed through an inductive analysis, informed by constructivist grounded theory (Charmaz, 2014; Charmaz & Belgrave, 2012; Thornberg & Charmaz, 2014).

Constructivist grounded theory is based upon Glaser and Strauss's (1967) original grounded theory statement, adopting the comparative, inductive, open-ended and emergent approach which is central in this statement. The iterative logic and the emphasis on meaning and action is also included in the constructivist turn of grounded theory (Charmaz, 2014). Constructivist grounded theory "highlights the flexibility of the method" (Charmaz, 2014, p. 13), and in this, "the subjectivity and the researcher's involvement in the construction and interpretation of data" (Charmaz, 2014, p. 14) is acknowledged. In Charmaz's view, "subjectivity is inseparable from social existence" (p. 14) and the findings are perceived as "an interpretive portrayal of the studied world, not an exact picture of it" (Charmaz, 2014, p. 17). In this analytical method, the raw data was processed through a thorough process of coding at different levels, emerging into codes and categories. The focus of the analysis was not to construct a theory, but rather to explore the data through an analysis informed by this constructivist grounded theory approach.

### 5.4.3 The use of data from participant observation and the interviews with the parents

Although the participant observation and the interviews with the parents were not systematically analysed, they contributed an important contextual understanding. The data were used as a backdrop for both the interviews as well as the analysis process. The participant observations provided particularly crucial information and understanding for the interviews with the children and in the creation of the narratives. They also contributed an important understanding of the analysis and interviews with the parents and the staff. The interviews with the parents, which were conducted after the interviews with the children, gave important contextual information for the analysis of the interviews with the children and in the creation of the narratives. They also contributed to an important understanding prior to the focus group interviews with the staff and the analysis of these. As emphasised above, a combination of several methods in research with children is of great importance to strengthen the analysis (Eder & Fingerson, 2001).

## 5.5 Ethical considerations

The PhD study was approved by REK – Regional Committees for Medical and Health Research, 29.03.2017, 2017/52/REK vest (appendix 10.1). Different ethical considerations were made depending on the interview in question, whether with the children, the parents or the staff.

As previously emphasized, a reflexivity concerning decisions and actions throughout the research process has been particularly important. In my feminist epistemological approach, research is perceived as "constructed rather than discovered" (Charmaz, 2014, p. 13), and a questioning of my own role in this research process has been crucial. Reflexivity is also considered to be one of the criteria for meeting overall standards for qualitative inquiry (Malterud, 2001), concerning "articulating questions tacitly underlying and motivating research" as well as "evaluating their legitimacy and relevance" (Stige et al., 2009, p. 1508).

There are many complexities in involving children in research, but to not involve them in research concerning them might be unethical (Neill, 2005). It requires a particularly high degree of reflexivity when including children in research. Concerning consent, we designed a specific information sheet to be easier for the children to understand (appendix 10.2). In addition, we designed information sheets aimed more directly at their parents who signed on their behalf (appendix 10.3). Further actions were taken to ensure the safety and protection of the children. This included confidentiality and conducting the interviews in ways that would feel safe for the children, with careful choice of context, as well as the choice of me being both researcher and music therapist (Eder & Fingerson, 2001; Irwin & Johnson, 2005; Powell et al., 2018). As mentioned, building rapport and trust with the children is central in research processes with children, and this was an important part of making the children feel safe in this situation. This is especially important when the topic or context is considered to be sensitive (Powell et al., 2018). Between the music therapy sessions and the interview, the children were cared for by their caregivers and the staff at the unit.

As previously mentioned, it was essential to reflect upon and be critically aware of the power relations between the researcher and the children. In the interviews where Barsnes (the other music therapist involved) participated, it was of particular importance to be aware of the power relations in the constellation of one child and two adults. The double role of being both researcher and music therapist required careful consideration, and a self-reflexiveness of personal and potentially unconscious reactions was crucial (Finlay, 2002).

Prior to the interviews with the parents and the staff, information sheets were provided and informed consents were signed (appendices 10.3 and 10.4). In the interviews with the parents, it was important to be aware of the possible power relation between the parent and the researcher, due to intersectional aspects such as sociocultural differences and positions.

In focus group interviews, there is a risk of peer pressure. This might involve statements from one or more of the participants which are perceived as more important than those of the other participants (Malterud, 2012). The moderator must be aware of their role and action in such cases, how they might appear to support some statements more than others, and the moderator thus has a crucial role in which stories are told by the participants (Malterud, 2012; Munday, 2014). Recognizing the diversity as well as tensions within the group, utilizing it in the best possible way, is something that characterizes a good moderator (Malterud, 2012). Focus groups have the potential to be empowering and non-hierarchical, although some element of power always will remain among the participants, as well as between the participants and the researcher (Munday, 2014). It is essential to carefully consider the context of the interview as this has a great impact on the communication in the focus groups (Malterud, 2012).

It was important to be critically aware of my multiple roles as therapist, researcher, facilitator and secretary in the focus group setting (Finlay, 2002). With a constructivist approach to the analysis of the focus group interviews, the notion of the researcher as a value-free, neutral observer is torn apart. This meant that it was crucial for the researchers to examine, and not ignore, how preconceptions and privileges could shape the analysis (Charmaz, 13). Also, a reflexivity concerning the intersectional diversity in the group was important. An awareness of how the various sociocultural categories, such as gender, ethnicity, professional background and age could contribute to unjust power relations between the researchers and the participants, as well as among the participants, was important (Munday, 2014).

# 6. Findings

In this chapter I will present a summary of the findings from article 1, 2, and 3.

## 6.1 Summary of article 1

The first article in this dissertation is called "Whose knowledge? Epistemic injustice and challenges in attending[1] to children's voices". This is a theoretical discussion of the importance of an awareness of epistemic justice, epistemic ignorance and epistemic injustice when working and researching with children and patients in mental health care. As described earlier, the concept of epistemic injustice is defined by Miranda Fricker (2007) as "a wrong done to someone specifically in their capacity as a knower" (p. 1). In this discussion, I identified prejudices in society against both children and patients in mental health care, as well as an exclusion from meaning making. This, I argued, has implications for their vulnerability to experience epistemic injustice.

During the discussion, the concept of "queer listening" (Bonenfant, 2010; Hadley & Gumble, 2019) was introduced (as previously defined in the theoretical framework in chapter 2). I proposed that the development of "a certain virtuosity" (Bonenfant, 2010, p. 78) is a "way for adults to hear the knowledge offered by the child" (Klyve, 2019, p. 5). An awareness of other modalities than words was highlighted in the discussion, as a way to avoid epistemic injustice when researching with children. Also, it was emphasized that knowledge about epistemic injustice in relation to children and patients in mental health care, as well as how to avoid it, point to the importance of including children in mental health care and their knowledge in research. The article was published in *Voices: A World Forum for Music Therapy*.

[1] The word "attending" was used as a translation for the Norwegian word "ivareta". However, since writing this title, I have gained insight of the challenge in translating "ivareta", and that the word "attending" may not comprise what I want to convey. Thus, through this synopsis, I have used words such as "being attentive to", "curating" and "caring for".

This thorough theoretical discussion laid the foundation for the interviews with the children and for the second article.

## 6.2 Summary of article 2

The second article is called “Moments of fun. Narratives of children’s experiences of music therapy in mental health care”, written with Randi Rolvsjord as co-author. The article explored the children’s own experiences of music therapy in this setting and their way of expressing themselves through multiple modalities. “Kristin”, “Kato”, “Kristian”, “Tone”, “Fredrik”, “Ellen”, and “Dina” participated in semi-structured interviews in their last week at the unit, and participant observations were made by the music therapist in the sessions during the music therapy process.

Since children express themselves through play and actions as much as words, it was crucial to not just pay attention to what the children said, but also to what they did and showed during the interview. In the analysis, we took a narrative approach, informed by portraiture (Lawrence-Lightfoot & Davis, 1997), and the findings were displayed in four selected narratives. These were selected to show a great variation and rich nuances across the cases. Throughout the analysis process, the word *fun* became a prominent theme, used in different ways by all the children except for one.

In the discussion of the findings, we focused on the word fun as a common thread across the cases and as a word with various dimensions. Focusing on the multidimensional meaning of fun, we considered the expressions of fun to be a valuable and significant contribution. However, we also emphasised that the use of the word fun should not be understood as an experience of music therapy as being mere “entertainment”, but rather as something existential with great therapeutic potential. In the article, we argued that the multidimensional meaning of fun is essential in music therapy with children in mental health care. The article was published in *Nordic Journal of Music Therapy*.

## 6.3 Summary of article 3

The third article is not yet published, but is titled “Polyphonic perspectives. A focus group study of interprofessional staff’s perceptions of music therapy at an inpatient unit for children in mental health care”. This is written with Randi Rolvsjord and Irene Bircow Elgen as co-authors. The article deals with the interprofessional perceptions of music therapy in this context and the various implications thereof.

The staff in the interprofessional teams participated in focus group interviews, one for each team linked to each child that participated in the study. In our inductive analysis process, we were informed by constructivist grounded theory (Charmaz, 2014; Charmaz & Belgrave, 2012; Thornberg & Charmaz, 2014).

In the analysis process, two main categories were identified, being “The staff’s perceptions of what music therapy offers the children” and “The staff’s perceptions of what music therapy contributes to the interprofessional understanding of the children”. The categories then consisted of eight dimensions that were linked to one of the categories. In the first category, which focuses on what music therapy offers the children, the dimensions were “Music therapy as a place to be free”, “Music therapy as motivation and opportunity for music”, “Music therapy as an arena for identity”, “Music therapy as an arena for feelings and expressions”, and “Music therapy as an opportunity for relationship”. In the second category, which focuses on what music therapy contributes to the interprofessional understanding, the dimensions were “Music therapy as part of the assessment process”, “Music therapy as an integrated part of the treatment context”, and “Music therapy as potential for continued treatment”.

In the findings, the three prominent topics of *emotion regulation in music therapy*, *experience of freedom in music therapy*, and *the music therapist as a part of the interprofessional team* emerged and were elaborated on in the discussion. The article

has been submitted to *International Journal of Qualitative Studies on Health and Well-being*.

# 7. Discussion

In the preceding chapters, I have elaborated on my theoretical framework, previous research in the field, the empirical context, the aims and research questions, the methodology and methods used in the study, as well as ethical considerations. In the previous chapter, I presented summaries of the findings of each of the three articles, and these will now be discussed and reflected upon in relation to each other, in relation to the theoretical framework, and in relation to the research questions presented earlier:

*What are the perceptions of music therapy at an inpatient unit for children in mental health care?*

1. *How do the children experience music therapy in this context?*
2. *How do the children express these experiences?*
3. *What are the interprofessional staff's perceptions of music therapy?*

The overall findings of the study presented in the three articles contribute to an understanding of how music therapy is perceived at an inpatient unit for children in mental health care, as well as of the importance of paying attention to the children's perspectives in this. The children's perspectives contribute first-person insight and bring new understanding of the therapeutic processes into this complex field of knowledge. The staff's perspectives add more child perspectives to the current body of research as well as insights into the significance of music therapy as part of an interprofessional collaboration in this setting. The multiple perspectives of the children and the staff together provide a better understanding of what music therapy can contribute to this context.

When reviewing the overall findings, questions emerge that actualize four themes that will be the subject of the further discussion: How to be attentive to, and curate children's perspectives? Are the children's and the staff's perspectives conflicting or complementary? What can music therapy contribute to an inpatient unit for children in mental health care? Is a resource-oriented approach in a medical setting a

contradiction? All four of these questions will be individually discussed and reflected upon through this chapter, in this order. The discussion of the first two questions concerns the overall findings, while the discussion of the next two is more focused on how the findings have implications for practice.

## 7.1 How to be attentive to, and curate children's perspectives?

When researching with children, it is important to keep in mind that 'children' is not a fixed category or a unified group. This is reflected upon in the first article, highlighting that there are nevertheless certain characteristics that form children as a group. Referring to Jones (2001) in this article, I reflect upon how children are defined as the negative of adults, as the binary opposite, in their newness, youngness and "lack of accumulative experience and knowledge which make adults adults" (Jones, 2001, p. 175). Jones emphasises at the same time that children "are *not less than adult; they are different to adults*" (p. 175, emphasis in original). With this in mind, and given that the concepts of 'children' and 'childhood' always will be affected by the values that underpin them in the culture in question (Sommer et al., 2010), children must be understood as a varied, non-unified group of individuals. Such reflexivity and critical awareness toward these concepts was a key issue in an attempt to avoid epistemic injustice. Since the children were also patients in mental health care, it was equally important to be reflexive and critically aware of the term 'patients in mental health care'. With the knowledge of the risks of epistemic injustice when starting the interview process with the children, I was aware of how my credibility judgments might be shaped by my prejudices, despite my beliefs. This implied that I had to be alert to how I perceived the children's social identity, as well as my own social identity in this context, and how this might impact my credibility judgement (Fricker, 2007; Klyve, 2019). Such vigilance also applied to the representation of the *children's perspectives* through our *child perspectives* (Sommer et al., 2010).

How then to be attentive to, and curate children's perspectives? Children communicate in several ways, through actions and through showing things as much as conveying through words. This is a central topic in both the first article and the second, emphasising the multiple dimensions of children's perspectives. Being attentive to, and curating children's perspectives in research is thus a complex and challenging task. Nevertheless, this is a crucial ambition, embodying a culture that increasingly views children as independent individuals who are equal in their own rights (Sommer et al., 2010).

In the second article, we chose to present children's perspectives through narratives informed by portraiture (Lawrence-Lightfoot & Davis, 1997). We found that the narratives provided the opportunity to contain the various expressions of the children, which made it possible to display these in all their varieties as valuable expressions in themselves. These did also provide space for the silence in the interviews, attuning to what was not said, as has been emphasized as important in avoiding epistemic injustice (Fricker, 2007). This is especially important to take into account in interviews with children, as emphasized in the first and second article. The children's multiple dimensions of fun came to the foreground through the narratives, and were thoroughly discussed after the presentation of the narratives, in relation to each other and to theoretical perspectives (Klyve & Rolvsjord, 2022). We do however acknowledge the challenges in interpreting the children's perspectives into our child perspectives, knowing that we cannot know whether the children actually felt what they expressed bodily or verbally (Sommer et al., 2010). Through our choice of analysis and in our display of the children's perspectives, we have communicated the children's perspectives with great respect for their form of expression. In this, we wanted to give as much space as possible to the children's own expressions. However, we do not claim that this was the only approach, acknowledging that there are multiple ways of addressing children's perspectives.

As previously described, the children's perspectives are an overall topic for this dissertation, with the staff's, the parents' and the researchers' child perspectives as complementary perspectives alongside. While the first two articles mainly focused on

the children's perspectives, the third article provided child perspectives. In the process of the focus group interviews and in the presentations of the staff's perspectives, it was as important as in the interviews with the children to maintain an awareness of the representation of the children. An awareness of the representation of participants in the music therapy literature in general is of great importance (Fairchild & Bibb, 2016). This meant highlighting both resources and challenges, using specifically selected words to describe the children and patients in mental health care (Fairchild & Bibb, 2016). Through all three articles, we have made conscious choices in this regard, with a specific aim of highlighting the strengths of the children alongside their challenges.

Another topic for discussion is how we should relate to the perspectives that the children have contributed. The children's emphasis of music therapy as something fun is explored in the second article. The multidimensional meaning of the word – "as a joy to play, as a sense of capability, as expressions through music, as the creation of music, as a bridge between home and hospital and as a relational phenomenon" (Klyve & Rolvsjord, 2022, p. 15) – became essential to pay attention to, and was explored through thorough attention to the children's multimodal expressions. This indicates the importance of including the many modalities in children's expressions, as well as of an awareness of the multiple dimensions, when addressing children's perspectives.

When I expanded my perspective regarding previous research with children's and young people's perspectives relevant to this study, I found that the concept of fun in music therapy also was expressed by adolescents in two of McFerran's studies. In McFerran's (2009) exploration of the role of music therapy in a school setting, music therapy was expressed to be fun by a 12-year-old boy with ADHD. In McFerran's doctoral thesis (Skewes, 2004), fun was central among the multiple perspectives of the bereaved adolescents who participated. I find the acknowledgement of the importance of fun in music therapy for adolescents to be very interesting and it corresponds to the findings of my study. Skewes (2004) also acknowledged the multiple meanings of the word fun, and highlighted that it is a complimentary term

often used by the adolescents. The adolescents' experiences of music therapy as something fun takes on an extra dimension considering the context of the bereaved adolescents – the loss of their loved ones. This was also an aspect in my study, where the context of "the unfamiliar hospital environments and complex challenges" (Klyve & Rolvsjord, 2022, p. 15) added another dimension to the children's experiences of fun. As Skewes (2004) argued, fun should not be underestimated in music therapy with young people, and it is neither, as we argue, "something that can be ignored in therapy work with children" (Klyve & Rolvsjord, 2022, p. 14).

## 7.2 Are the children's and the staff's perspectives conflicting or complementary?

The multiple perspectives of the children and the staff tell us something about how music therapy is perceived at an inpatient unit in mental health care. To what degree are the perspectives complementary? Are they also in conflict? The differences in expression between the children and the staff are striking. On the one hand we have the children's embodied expressions, and on the other the staff's sophisticated professional language, formed by their education and sociocultural background. But this may also raise a new question: are they talking about the same thing? The level of perception is obviously different, as the children have experienced music therapy through participation while the staff's perceptions of music therapy are through the children, the music therapist and the medical record during the process. These different perceptions nevertheless add useful understanding from the point of view from which it is conveyed. The children's embodied expressions tell us something about what the children have experienced. The staff's perceptions tell us something about what they think the children have experienced, as well as how music therapy fits into and interacts with the other services at the unit. One might claim that these different viewpoints provide a realistic representation of the actual situation at the unit.

Another question that arises concerns what is possible to communicate. Since music is an essential part of communication in music therapy, providing many non-verbal experiences – is it even possible for the children to express these experiences verbally? It has been crucial through the process to keep in mind this possible contradiction the children may have experienced in the interviews when asked to verbalize the non-verbal. As previously mentioned, the possibility to express oneself through modalities other than words in the interviews became significant, both because of this contradiction and also to include the various ways children naturally express themselves. Fredrik, one of the children who participated in the study, played various instruments during the interview. He alternated between sound and silence, and occasionally he seemed to emphasize what he expressed verbally with certain sounds or by being completely silent.

> Fredrik has found a ukulele and plays three notes in a row over and over again, a slow triad that after a while goes a little faster. “Do you think it is different to play music than to talk?” I raise my voice so Fredrik can hear me through the music. “Yes, it... is very different” he says and continues to play the three notes. “Is it possible to say something about how it is different?” I ask and barely hear Fredrik’s answer through the ukulele tones. “Eeh... it’s not possible to say.” “But it was very different?” I ask again. “Yes,” he says as he continues to play the same notes. A fourth note has gradually also been added to the pattern. “Do you think it is possible that music sounds like different things?” I ask, and Fredrik quickly answers “yes” through the ukulele notes. I ask if Fredrik can remember when he and I played the piano and improvised together. “Mhm” Fredrik answers and goes from playing the quartet to striking all the strings on the ukulele. “And then you said you thought it sounded sad? Do you think that if you are sad one day it will be possible to make a melody, for example, that sounds sad?” I ask, and Fredrik stops playing. “Yes, we can... speak emotions too”, he says and starts to play again (Klyve & Rolvsjord, 2022, p. 10).

Fredrik's use of music through the interview and his emphasis on music's ability to "speak emotions" illuminate, in our child perspective, his experience of being able to express himself through music. His way of using sound and silence throughout the interview also showed this ability. However, this seems to be in conflict with the staff's perception of Fredrik, where there was an agreement that Fredrik's ability to communicate emotions was limited: "emotions there and then he isn't […] very good at… communicating" (Klyve, Rolvsjord & Elgen, submitted, p. 13). The staff talked about how Fredrik had challenges in putting emotions into words, and we may wonder if such a focus on verbalisation of the emotions could limit the understanding of the child. By not taking into account the child's natural way of expressing their emotions through other modalities, such as music, some information offered by the child may be missed.

Our prejudices as adults, as well as inattention to children's various ways of expressing themselves, can cause us to not hear and "miss out on knowledge offered by the child" (Murris, 2013, p. 246), and thus epistemic injustice happens (Fricker, 2007). As discussed in the first article, children and patients in mental health care are vulnerable to epistemic injustice. It is of particular importance to pay attention to children's own perspectives in health care, due to how health care involves children and due to how the children's views are crucial for their own well-being (Carela & Györffyb, 2014).

An awareness of epistemic injustice is also crucial when looking at the perspectives of the children and the perspectives of the staff as a whole. There might be a 'power of definition' in this, considering a possible perceived hierarchy between the children's expressions in contrast to the medical discourse, as well as between the children as patients in mental health care and the professionals (Lorke et al., 2021). The intersectionality in this, such as age, professions, positions, gender and challenges, is important to reflect upon and to be aware of in relation to how it can affect us. How do we perceive the difference in conveyance – do we value the children's statements of fun equally to the staff's more theoretical subject-specific statements? Or do we experience the staff's statements as something that ultimately

defines the significance of music therapy in this context? Alongside the children's possible difficulties in expressing their non-verbal experiences in music, it is worth noting that the staff also may experience a difficulty in expressing what happens in music therapy and in describing the music in medical terms. A consequence may be that the music is distanced from the actual experience and some of its intrinsic value.

The children's expressions are verbally limited, but their emphasis on fun and its dimensions resemble to some extent the staff's perspectives of what music therapy offers the children. The staff's perceptions of music therapy as a place to be free, as motivation and opportunity for music, as an arena for identity, as an arena for feelings and expressions, and as an opportunity for relationship (Klyve, Rolvsjord & Elgen, submitted) – all of these dimensions may be argued to also be comprised in the children's perception of music therapy as fun. As emphasised above, there might be a power of definition in the difference of expressions, but the resemblance between these perspectives is also important to recognize and significant for our understanding of music therapy in this context.

How we value the various voices and expressions of the children in relation to the staff's expressions may be affected by our prejudices. It is important to keep in mind that the children's emphasis on music therapy as fun might also stand in great contrast to, for instance, the staff's perception of music therapy as a possible place to achieve treatment goals, such as emotion regulation. Music therapists' language may also largely contrast with the children's expressions, using professional language and terms to describe and make themselves understood in an interprofessional team, as well as possibly positioning themselves and seeking to gain more acceptance in the medical context. Although the importance of the children's perspectives is emphasized throughout the study, this does not mean that the staff's perspectives are not important. Quite the contrary.

The interprofessional staff also express their perception of music therapy as a place for the children to be free (Klyve, Rolvsjord & Elgen, submitted), and this may to a greater extent resemble the children's expressions of music therapy as fun. However,

as discussed in the third article, there is a possible contradiction in these perceptions, between music therapy as emotion regulation and music therapy as a “space of freedom”.

The possible contradiction between these perceptions consists of the perception of music therapy as, on the one hand, a place for the children to be free, and on the other, as a place where treatment goals can be achieved – which can further lead to an experience that this freedom is restricted. Emotion regulation is, however, not something that in itself restricts freedom, as it is something that is continuously present in a musical companionship and naturally a part of intersubjectivity, as a “‘musical’ phenomenon” (Ansdell, 2014). Rather, the restrictions can arise when the non-verbally expressed feelings are perceived as inadequate and it is required that the musical expressions be translated into words. As exemplified in the third article, this might have been the experience in the case of the boy Kato who participated in the study. He stopped attending music therapy after a session with a complex emotional reaction, concerning a specific focus on verbalising emotions, which was the overall focus in the interprofessional team. The staff’s perception of this was that it offered useful observations in the process. Kato’s perception may have been that this episode restricted his freedom in the music. He did not comment on this episode in the interview, but neither did he express that music therapy was fun, and was the only one of the children not to do so. Both his non-attendance of music therapy and his limited expressions in the interview may reflect his experience of this episode. However, it may also indicate that Kato did not like music therapy, and it is important to acknowledge that music therapy may not be for everyone.

The children’s and the staff’s perspectives appear to be both conflicting to some degrees and complementary. In our understanding of this, the risk of epistemic injustice is central. It is thus of particular importance to be aware of our own prejudices, the various ways of expressions, the differences in conveyance, and the possible power relations that are in play, when addressing the children’s and the staff’s perspectives as a whole.

## 7.3 What can music therapy contribute to an inpatient unit for children in mental health care?

The children's perspectives, as well as the staff's perspectives, contribute new insights and understanding to the field of music therapy with children in mental health care at the hospital. The children's own expressions of music therapy as something fun, as well as the staff's perception of music therapy as a place for the children to be free, tell us something about what music therapy may offer the children in this context. The opportunity for the children to take a break from their challenging everyday life appears to be needed and desired. "Engagement with something that is not related to illness or treatment can […] play an important role in the total health situation" (Rolvsjord, 2010, p. 76). In this, music therapy is not to be taken as a way to avoid challenges, but rather as a different approach to the challenges. The children may experience meaningful interactions with another safe adult, and the experiences can be stored and become important aspects of self-esteem and of further life outside the music room (Trondalen, 2008, 2016).

The findings indicate that music therapy facilitates emotion regulation in this context, as stated by the staff both concretely as well as through their highlighting of "space of freedom" (Klyve, Rolvsjord & Elgen, submitted). The staff's perception of the potentials of music therapy to facilitate emotion regulation corresponds to the treatment process at the unit, and may thus contribute to the overall therapy goals. However, it appears to be crucial to pay attention to the children's perspectives in this, facilitating opportunities to express emotions non-verbally – on their own terms. Thus, in the third article, we argue that further discussion is needed of what is considered therapeutic, and we pose the question whether the "space of freedom" in music therapy in itself can offer levels of emotion regulation for the children in such a context?

The staff also pointed to how music therapy contributed to the assessment process, bringing in new perspectives to the cases and complementing the whole. This was exemplified in the third article, with the case of Dina where there were questions about ADHD. In this case, the staff discovered another, more focused side of Dina through descriptions from music therapy, as well as resources that they had not seen her use before. At home, Dina had a turbulent situation. Through her own expressions, she used the term 'fun' in multiple ways, with different meanings. She focused on the joy of playing and the sense of capability, as well as on the relationship with the music therapist in the music. Her emphasis on fun in the relationship with the music therapist was of particular importance considering her unstable situation at home. In Dina's case, the staff highlighted music therapy's contribution to a better relationship to the health service.

In Dina's case in particular, but also in the other music therapy processes in general, the music therapist acted as a bridge between the music therapy and the interprofessional team. The music therapist conveyed observations from the sessions, focusing on the interactions and the children's being in the music. A translation of the music-therapy-specific terms into terms that the other disciplines easily can understand is needed in this process (Twyford, 2008). However, as discussed in the third article, representing the non-verbal processes verbally to an interprofessional team is a complex process which includes various challenges and implications (Ansdell, 1999). Despite these challenges, the findings in the study indicated that music therapy contributed to a more holistic view of the children. This was stated by the staff in the case of Ellen, and they also highlighted how the health service at the unit would have been poorer without music therapy. The music therapists emphasised the importance of the interprofessional collaboration and how this also contributed to a better understanding of the children and thus also to better music therapy (Klyve, Rolvsjord & Elgen, submitted).

However, the staff accentuated a wish for better collaborations within the team, with the aim of getting the music therapist even more closely linked to the service and to the interprofessional team (Klyve, Rolvsjord & Elgen, submitted). The staff also

highlighted a need for more knowledge about music therapy and its potential in order to make the collaboration even better, something that has also been highlighted in previous research (Choi, 1997; Hense, 2018; Ledger et al., 2013; O'Kelly & Koffman, 2007; Thorgersen, 2015).

The children's focus on music therapy as fun – the multidimensional meaning of the word – gives us an important perception of what music therapy can contribute to the children in this setting. Considering children's multimodal expressions, as well as potential challenges in expressing themselves verbally, one of the aspects of why the children experienced music therapy as fun may be the opportunity to express themselves through music. Also, the fun and normalcy of playing music at the hospital may contribute to a continuum between home and the hospital (Vernisie, 2015). As emphasised in the second article, the children's experiences of music therapy as fun "should not be taken to mean that music therapy is experienced as mere "entertainment"" (Klyve & Rolvsjord, 2022, p. 14), but as something with therapeutic potentials. Fun can be of existential importance (Aasgaard, 2002), and facilitating fun in music therapy may be a crucial contribution to this context.

In an environment that includes a number of professions and approaches, the various contributions of music therapy in this setting can be perceived differently depending on which approach one takes in this context. Thus, in the next section I will discuss and reflect upon if a resource-oriented approach can contribute something to this medical setting – or whether it is a contradiction?

## 7.4 A resource-oriented approach in a medical setting – a contradiction?

The possible contrast between the children's and the staff's perspectives also highlights a possible contrast between the discourses of resource-oriented and medical perspectives. A question of relevance might thus be to what extent the

children's experiences of fun make sense in this medical context? And whether having a resource-oriented approach in this medical setting is coherent?

A resource-oriented approach to music therapy implies levels of critique of the medical model. Of specific relevance here is a contextual understanding of the individual (Rolvsjord, 2004, 2010, 2014). Rolvsjord contends that by destabilizing the binary traditional medical perception of the therapist as an expert and the client as weak the *competent client* is put in focus (Rolvsjord, 2014).

A resource-oriented approach to music therapy does not imply that the children's challenges are ignored, but rather an understanding of therapy as something that is "as much about nurturing resources and strengths as it is about fixing pathology and solving problems" (Rolvsjord, 2010, p. 5). With this approach to music therapy in the mental health care unit for children, the perception of what therapy is at this particular unit for the children may thus be challenged. However, it can be questioned whether this unit is a "medical" unit, as their approach to therapy may differ from more traditional medical practices. Several approaches with an awareness of the children's contexts and resources are part of the therapy processes, and the parents are included in close collaboration with the interprofessional teams. The unit is nevertheless located in a medical hospital, with the medical discourse and perspectives as its baseline.

In a medical context, where clients traditionally have been defined by their weakness through a pathological focus, a perspective of the client as an active agent of change contributes potentially conflicting, but important perspectives (Brault, 2019, Rolvsjord, 2014). In this study, the children contributed a great effort themselves to the experiences of fun in music therapy, in an equal collaboration with the music therapist (Klyve & Rolvsjord, 2022; Rolvsjord, 2010, 2014; Stige, 2002). The children's expressions of music therapy as fun tell us something about how they experienced participating in this collaborative interaction in this setting. Fun can be a serious matter (Aasgaard, 2002), and I would argue that the children's experiences of

fun do make sense – and take on additional significance – especially in a medical context.

However, taking a resource-oriented approach in a medical setting may present certain challenges. Bringing music into the hospital setting may, as previously mentioned, include a risk of mixing the illness with something healthy, and this may cause an association between the music and the illness later (Rolvsjord, 2010). This imposes ethical considerations, and the opportunity of playing music and normalization of the situation at the hospital may be considered more important than the risk of this mix (Aasgaard, 2002).

Other challenges may be present in cases where resource-oriented music therapy is used as part of the diagnostic assessment processes. Having a resource-oriented approach in this process is not inherently contradictory, but neither it is entirely unproblematic. Diagnosing the children may be an individualizing of the challenges, placing the problems in the child (Helle-Valle, 2016), and this is not consistent with a resource-oriented approach. The resource-oriented music therapy approach is nevertheless used as assessment in mental health care settings (Aitchison & McFerran, 2022a), and as emphasised by the staff in this study, music therapy may contribute valuable observations to this process (Klyve, Rolvsjord & Elgen, submitted).

Having a resource-oriented approach as a music therapist in a medical setting is not, I would argue, necessarily a contradiction. But it requires the therapist to be particularly conscious and clear about their own approach when meeting other professional groups with different approaches or agendas. The discourse and focus of a resource-oriented approach may contrast with the traditionally medical perspective, focusing more on the strengths and resources in the child than on the problems. A resource-oriented approach can thus specifically contribute to a different understanding of the children. As described above, this seemed to be the case with Dina, where there was a question of ADHD, and where observations from music therapy described resources that Dina showed that seemed to contradict this. The staff

thus gained the opportunity to see other sides of Dina which contributed to a more holistic view of the child.

Despite the conflicts between the children's and staff's perspectives, as well as between a resource-oriented approach and a medical perspective, there are also clear complements. The opportunities for fun and the significance of these experiences in this particular setting, as well as the contribution to a holistic view of the child, show how a resource-oriented approach also largely complements the medical perspective rather than merely being a contradiction.

# 8. Implications and critique

## 8.1 Implications for practice and research

As described in the third article, this study has implications for practice concerning the importance of a close collaboration between the team and the music therapist. The findings indicate that inclusive teamwork with close dialogue between the music therapist and the other team members can provide a purposeful use of music therapy in the therapy process. Observation by the interprofessional staff in the music therapy sessions may also be an important part of this.

Viewing the overall findings of the study, the children's experiences of music therapy as fun are at the centre. The multidimensional meanings of fun have implications for how both music therapists and other professionals embrace these experiences in the various therapy processes. Also, in the interprofessional collaborations, these experiences can point towards the use of music therapy in assessment processes to illuminate children's resources and motivation. The children's expressions through various modalities have implications for how we are attentive to the children in communication in this context, and how we provide spaces for the children to express themselves – on their own terms. The findings indicate that facilitating such spaces for expression and experiences can contribute something of great value to the overall therapy processes for the children.

The findings of this study contribute a first-person insight of music therapy in an inpatient unit in mental health care and a better understanding of music therapy as a part of the interprofessional collaboration at this unit. In further research in this field, even more focus and inclusion of the children's perspectives and experiences is needed. In this, other methods should also be explored with the intention of including the children's perspectives.

The findings indicate that it could be useful to compare and explore how different therapeutic approaches at the clinic interact with music therapy to obtain an even better understanding of the significance of music therapy in such a setting. In such a

comparative and exploratory study, the use of video could be relevant. The findings also identified a need among the staff for more knowledge about music therapy and its potentials in order to improve the collaboration. This indicates that action research related to music therapy in interprofessional teams could be a useful way forward.

If quantitative methods were to be used in further research in this field, the findings of this study indicate the importance of having relational and positive aspects for the children as part of the outcome measures for the study.

## 8.2 Strengths and limitations

This thesis has illuminated children's perspectives of music therapy in mental health care, and a particular strength of this study is the first-person insight of music therapy in this specific context. The context is challenging for research, due to the complex challenges which are the reasons for referrals to the unit, and which can make it difficult for the children to participate in research. The children's perspectives thus contribute new understanding to a limited field of research.

In combination with the multiple perspectives of the interprofessional staff, this study has contributed an understanding of what significance music therapy can have in this context.

Research with children may involve the children actively in the research process (Bird et al., 2013; Jørgensen, 2019). In this study, some user involvement was facilitated in the small pilot with two children, and the children participated actively in the interviews. We considered that a deeper involvement, such as participatory research, included too high a risk in this particular setting (Bird et al., 2013). It was important to take into account the children's vulnerable situations at the hospital, including possible personal and familial crises, and not impose unreasonable burdens (Bird et al., 2013). Also, as previously mentioned, a crucial part of the decision to not include deeper involvement in this particular context was made due to the risk that a

requirement of a specific participatory commitment could limit children's possibilities to act (Gallacher & Gallagher, 2008). However, the user perspectives were carefully included throughout the entire process, both in the music therapy sessions and in the interviews.

As previously mentioned, some of the case features may have been less prominent as a consequence of the omission of the parent's perspectives in the articles. However, this provided more space for the children's perspectives, and in the end this strengthened an important exploration and presentation of these.

Video recordings could possibly have offered more accuracy when analysing micro-levels of the children's "showing". This could thus have provided the opportunity for microanalysis of the music therapy sessions, a level this study does not address. Also, the staff's understanding of music therapy could possibly have been strengthened by watching a recording from music therapy sessions, or by participating in a session. But our main ethical concerns considered how the act of video recording and participation in the sessions could affect the interaction between the child and the therapist.

This dissertation contributes multiple voices and multiple perspectives of music therapy in an inpatient unit in mental health care. This included the diverse perspectives of the children, girls and boys equally, the various perspectives of the parents and the staff, which included both men and women, and with diverse socio- and multicultural backgrounds. However, there could have been an even greater intersectional diversity among the participants, particularly in respect of greater variation in both multi- and socio-cultural backgrounds.

Another strength of this dissertation is the exploration of the various ways of both being attentive to and curating the children's perspectives in research. Although interviews with children are challenging, the need for children's perspectives, and caring and attending to them, are of great importance in this limited field of research.

# 9. In conclusion

The aim of this study was to gain a better understanding of music therapy at an inpatient unit for children in mental health care. The children's perspectives contribute new first-person insights into this field. The children highlighted the word 'fun' in their experience of music therapy, through their various modalities. Each of the children offered various meanings of fun which are displayed through the narrative episodes informed by portraiture.

The staff's complementing child perspectives contribute a better understanding of what music therapy can contribute to the interprofessional collaboration. In the staff's perception of music therapy, emotion regulation is highlighted as a particularly valuable contribution to the unit. The staff emphasized that music therapy facilitated both specific opportunities for emotion regulation, as well as a place for the children to be free. The multiple perspectives of the children and the staff provide a better understanding of what music therapy can contribute to a mental health care unit for children.

In discussing the children's perspectives in relation to the staff's child perspectives, we found a corresponding theme in the staff's perception of music therapy as a place to be free. Other dimensions were also complementary, concerning what music therapy offered the children in this context. However, the staff also highlighted themes that were more in conflict with the children's perspectives, such as achieving specific treatment goals through music therapy. The various richnesses in expression of the children and the staff are discussed in relation to these perceptions, and the concept of epistemic injustice is central in this respect. An awareness of our own prejudices is crucial in order to avoid epistemic injustice and to not miss out on the knowledge which is offered by the children.

The findings of this study indicate that music therapy may contribute to a better understanding of the child, a potentially better relationship between the health service and the child, as well as help achieve therapeutic goals, such as through emotion regulation. The findings also show that music therapy contributes something

unrelated to the children's challenges, stated as fun and as a "space for freedom", not as a way to avoid the challenges, but rather as a different approach to them. Fun appears to be an essential part of music therapy for children, and the children's multidimensional meaning of the word 'fun' is understood as: a sense of capability, as the creation of music, as expressions through music, as a relational phenomenon, as a bridge between home and hospital and as joy in playing. In this, fun should not be understood as entertainment, but as something of existential importance with great therapeutic potentials, and something which cannot be ignored in therapy with children.

Children's perspectives are crucial to include in health care services that concern them. Through attending equally to the children's and the staff's perspectives at an inpatient unit in mental health care, a new insight into music therapy in this field is elicited. A better understanding of what music therapy can contribute to this context, and how children experience music therapy, can facilitate more experiences of fun and freedom – of existential value – for children in mental health care.

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# 10. Appendices

## 10.1 Ethical approval by Regional Ethics Committee

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

| Region: | Saksbehandler: | Telefon: | Vår dato: | Vår referanse: |
|---|---|---|---|---|
| REK vest | Camilla Gjerstad | 55978499 | 29.03.2017 | 2017/52/REK vest |
| | | | Deres dato: | |
| | | | 21.03.2017 | |

Vår referanse må oppgis ved alle henvendelser

Guro Parr Klyve
Griegakademiet - Institutt for musikk

**2017/52 Musikkterapi med barn på sykehus i psykisk helsevern**

**Forskningsansvarlig:** Universitetet i Bergen
**Prosjektleder:** Guro Parr Klyve

Vi viser til din tilbakemelding om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Tilbakemeldingen ble behandlet av leder av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) på fullmakt. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

**Prosjektomtale**
*Formålet med denne studien er å få mer kunnskap om musikkterapi i utredning og behandling av barn på sengepost i psykisk helsevern. Tidligere studier har vist at musikkterapi i psykisk helsevern har positiv effekt, og musikkterapi er nå anbefalt i faglige retningslinjer for psykosebehandling. Det viser seg samtidig at det er stor bruk for både mer praksis og mer forskning på musikkterapi med barn i psykisk helsevern. Hovedproblemstillingen er: Hvilken betydning har musikkterapi på sykehus med barn i psykisk helsevern? Dette vil utforskes gjennom barnas, foresattes og helsearbeidernes perspektiv på musikkterapi og deres opplevelse av tilbudet på Barneposten på Klinikk psykisk helsevern for barn og unge, Haukeland universitetssjukehus. Denne kvalitative studien vil ta i bruk en multiple casestudiedesign, med 6-10 case. Datainnsamlingen omfatter intervju med barna og deres foresatte, fokusgruppeintervju med miljøterapeuter, lærere og behandlere, samt deltakende observasjon.*

*Komiteen ba om tilbakemelding fra prosjektleder*
- REK ber prosjektleder om å innsnevre problemstillingen.
- REK vest ber om nærmere forklaring av hvordan virkning på tilstandsbilde skal måles.
- Komiteen ber om prosjektlederen sin vurdering av om det kunne være hensiktsmessig å ha en gruppe med samme diagnose.

*Tilbakemelding fra prosjektleder*

- Studiens problemstillingen er endret for å tydeliggjøre forskningsformålet. Prosjektleder understreker at studien vil utforskes gjennom barnas, foresattes og helsearbeidernes perspektiv på musikkterapi og deres opplevelse av musikkterapitilbudet. Effekten av musikkterapitilbudet skal ikke måles. Forskningsspørsmålet er derfor endret til: Hvordan oppleves musikkterapi på sykehus i psykisk helsevern for barn?

- Det er ikke et ønske å undersøke utfallet av terapien, men i stedet utforske erfaringer fra terapiforløpet. Å spisse problemstillingen mot en bestemt diagnose vil derfor ikke være

Besøksadresse:
Armauer Hansens Hus (AHH), Tverrfløy Nord, 2 etasje. Rom 281. Haukelandsveien 28

Telefon: 55975000
E-post: rek-vest@uib.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK vest og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK vest, not to individual staff

hensiktsmessig, da ulike diagnoser eller problemstillinger vil være styrkende og utgjøre et mangfold i studien.

- Forsker- og behandlerrollen. Søker viser forståelse for problemene med sammenblanding av roller, men mener at det er en fordel at forskeren også er musikkterapeuten for barna i studien.

- Utlevering av journalopplysninger til forskning. Som musikkterapeut har prosjektleder allerede tilgang til journalen. I studien ønsker man opplysninger om henvisningsgrunn og evt. diagnose, men prosjektleder avviser ikke at dette er mulig å hente fra foreldre.

*Vurdering av tilbakemeldingen*
REK vest ved leder har vurdert tilbakemeldingen. Tilbakemeldingen besvarer komiteens spørsmål og merknader på en utfyllende måte, og REK vest har ingen merknader til den presiserte problemstillingen. Prosjektleder er bevisst på det problematiske ved et uklart skille mellom forsker- og behandlerrollen. For komiteen handler dette først og fremst om at forskning har et annet formål enn behandling og at deltakernes frivillighet ikke må være under press.

Når det gjelder utlevering av journalopplysninger til forskning ber REK vest om at opplysninger om henvisningsgrunn og diagnose innhentes direkte av foreldrene slik at de kan velge om de ønsker å oppgi slike opplysninger til forskningsprosjektet. Vi har ingen øvrige merknader.

**Vilkår**
Opplysninger om henvisningsgrunn og diagnose må innhentes fra foreldrene, ikke fra journalen.

**Vedtak**
*REK vest godkjenner prosjektet på betingelse av at ovennevnte vilkår tas til følge.*

*Sluttmelding og søknad om prosjektendring*
Prosjektleder skal sende sluttmelding til REK vest på eget skjema senest 30.04.2021, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK vest dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

*Klageadgang*
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Marit Grønning
Prof. dr.med
Komiteleder

Camilla Gjerstad
rådgiver

**Kopi til:** postmottak@uib.no

## 10.2 Information Sheet – Children

# Musikkterapi på Barneposten

### HVORFOR BLIR DU SPURT OM Å VÆRE MED?

Vi ønsker å få vite mer om hvordan det er å ha musikkterapi mens en er på Barneposten. Du blir spurt om å hjelpe oss med dette fordi du er henvist til musikkterapi, og vi ønsker å høre hvordan du opplever å ha musikkterapi mens du er her.

### HVA VIL SKJE DERSOM DU DELTAR?

Du vil få musikkterapitimer 1-2 ganger i uken. Når det nærmer seg slutten av oppholdet ditt på posten vil du få mulighet til å dele dine erfaringer fra musikkterapitimene i et intervju der vi kommer til å stille deg noen spørsmål om hvordan det har vært å ha musikkterapi mens du har vært her på Barneposten. Musikkterapeuten du har hatt i timene og en av miljøkontaktene dine kommer til å være med i intervjuet.

### HVA VIL SKJE DERSOM DU IKKE DELTAR

Det er helt frivillig å delta i studien, og du kan når som helst trekke deg fra å delta om du ikke ønsker å være med lenger.

Du er allerede henvist til musikkterapi og du vil kunne motta musikkterapitilbudet uavhengig av om du blir med i studien eller ikke.

## 10.3 Informed Consent Sheet – Parents

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET (TIL FORESATTE)

# MUSIKKTERAPI MED BARN PÅ SYKEHUS I PSYKISK HELSEVERN

Dette er et spørsmål til dere om å delta i et forskningsprosjekt som handler om å få mer kunnskap om opplevelsen av musikkterapi på sykehus i psykisk helsevern for barn. Du blir spurt om å delta i studien fordi ditt barn er henvist til musikkterapi, og vi ønsker å høre hvordan dere og barnet deres opplever musikkterapi under innleggelse på Barneposten, Klinikk psykisk helsevern for barn og unge på Haukeland universitetssjukehus.

Dette er en doktorgradsstudie ved Universitet i Bergen, i samarbeid med Haukeland Universitetssjukehus.

## HVA INNEBÆRER PROSJEKTET?

Ved deltakelse i studien vil barnet deres motta musikkterapitilbud 1-2 ganger i uken mens dere er på Barneposten. Mot slutten av oppholdet på posten vil det bli gjennomført ett intervju med dere og ett intervju med barnet deres. I intervjuet med barnet vil musikkterapeuten være tilstede, i noen tilfeller også en av miljøkontaktene. En av musikkterapeutene på posten er også prosjektleder for studien, og det er hun som kommer til å gjennomføre intervjuene. Intervjuene og musikkterapitimene vil bli tatt opp på lydopptaker, og musikkterapeuten kommer til å skrive logg fra musikkterapitimene. Intervjuene varer i 30 – 45. min.

I prosjektet vil vi innhente og registrere opplysninger om ditt barn. Dette innebærer journalopplysninger om henvisningsgrunn til Barneposten og om barnets evt. diagnoser.

## MULIGE FORDELER OG ULEMPER

Mulige fordeler med å delta i studien er at barnet deres får delta i musikkterapi under oppholdet på Barneposten, og at dere i etterkant får dele opplevelser og erfaringer fra dette. For dere kan dette bidra til en større forståelse for musikkterapi og for hvilken betydning musikkterapi kan ha hatt for barnet deres under oppholdet på posten. For barnet kan det å dele egne erfaringer og opplevelser i en studie gi følelsen av å være aktive deltakere i forskningsprosessen.

Mulige ulemper med å delta i forskningsprosjektet for dere kan handle om fokus- og tidsbruk. Dere skal være med på mye i løpet av oppholdet på posten, og intervjuet komme slik i tillegg til dette.

For barna kan intervjusituasjonen være fremmed og de kan føle seg usikre. Det vil i den sammenheng skapes trygge rammer for intervjuet, og intervjuene kommer til å bli gjennomført på musikkrommet, som på det tidspunktet vil være kjent for barnet. Forskeren som skal gjennomføre intervjuet vil bruke tid i forkant av intervjuet på å bli kjent med barnet slik at hun ikke er en helt fremmed person når intervjusituasjonen kommer. Forskeren er også musikkterapeut på posten, og i noen tilfeller vil derfor musikkterapeuten som har hatt timene med barnet også være den som stiller spørsmålene i intervjuet. I disse tilfellene vil en av barnets miljøkontakter være tilstede. I andre tilfeller vil den musikkterapeuten som har hatt timene med barnet være med i intervjuet.

Barnet er henvist til musikkterapi og vil få tilbud om musikkterapi uavhengig om dere samtykker til deltakelse i studien eller ikke.

## FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom dere ønsker å delta, undertegner dere samtykkeerklæringen på siste side. Dere kan når som helst og uten å oppgi noen grunn trekke deres samtykke. Dette vil ikke få konsekvenser for deres videre behandling. Dersom dere trekker dere fra prosjektet, kan dere kreve å få slettet innsamlede prøver og opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom dere senere ønsker å trekke dere eller har spørsmål til prosjektet, kan dere kontakte Guro Parr Klyve, tlf: 911 17 671, e-post: guro.klyve@uib.no.

## HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om dere og barnet deres skal kun brukes slik som beskrevet i hensikten med studien. Dere har rett til innsyn i hvilke opplysninger som er registrert om dere og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter dere til deres opplysninger gjennom en navneliste.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om dere blir behandlet på en sikker måte. Informasjon om dere vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

**GODKJENNING**

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk, 2017/52/REK vest.

## SAMTYKKE TIL DELTAKELSE I PROSJEKTET

### JEG ER VILLIG TIL Å DELTA I PROSJEKTET

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Som foresatte til_____(Fullt navn) samtykker vi til at hun/han kan delta i prosjektet

Sted og dato

Foresattes signatur

Foresattes navn med trykte bokstaver

Sted og dato

Foresattes signatur

Foresattes navn med trykte bokstaver

Jeg bekrefter å ha gitt informasjon om prosjektet .

---

Sted og dato

Signatur

---

Rolle i prosjektet

## 10.4 Informed Consent Sheet – Staff

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

# MUSIKKTERAPI MED BARN PÅ SYKEHUS I PSYKISK HELSEVERN

Dette er et spørsmål til dere om å delta i et forskningsprosjekt som handler om å få mer kunnskap om opplevelsen av musikkterapi på sykehus i psykisk helsevern for barn. Du blir spurt om å delta i studien fordi vi ønsker å høre hvordan du opplever musikkterapi på Barneposten, Klinikk psykisk helsevern for barn og unge på Haukeland universitetssjukehus.

Dette er en doktorgradsstudie ved Universitet i Bergen, i samarbeid med Haukeland Universitetssjukehus. Prosjektet er forankret i et samarbeid med Psykisk helsevern for barn og unge (PBU) v/ klinikkdirektør Liv Kleve og seksjonsleder på Barneposten, Sture Larsen. Det siste året er det gjennomført flere informasjonsmøter i PBU om prosjektet.

### HVA INNEBÆRER PROSJEKTET?

Ved å delta i studien samtykker dere til å bli med på fokusgruppeintervju sammen med andre ansatte på posten, der tema vil være musikkterapi og hvilken betydning dette kan ha hatt for enkelte barn som dere har hatt kontakt med på Barneposten. Dere vil måtte kunne sette av 1 time. Intervjuene vil bli tatt opp på lydopptaker.

### MULIGE FORDELER OG ULEMPER

Mulige fordeler med å delta i forskningsprosjektet er at du vil få en større mulighet enn ellers til å reflektere rundt hvilken betydning musikkterapi kan ha hatt for de ulike barna. Deltakelse vil også kunne bidra til økt bevissthet rundt bruk av musikkterapi generelt på posten.

Mulige ulemper ved deltakelse i studien er tidsbruk da du forplikter deg til å delta på 1 times fokusgruppeintervju.

## FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede prøver og opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte Guro Parr Klyve, tlf: 911 17 671, e-post: guro.klyve@uib.no.

## HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

## GODKJENNING

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk, 2017/52/REK vest.

## SAMTYKKE TIL DELTAKELSE I PROSJEKTET

### JEG ER VILLIG TIL Å DELTA I PROSJEKTET

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Jeg bekrefter å ha gitt informasjon om prosjektet

Sted og dato

Signatur

Rolle i prosjektet

## 10.5 Interview Guide – Children

# Intervjuguide med forskningsspørsmål

*Musikkterapi med barn på sykehus i psykisk helsevern*

Barna

**Hovedproblemstilling**

*Hvordan oppleves musikkterapi på sykehus i psykisk helsevern for barn?*

Delproblemstillinger

1. *Hvordan opplever barna musikkterapitilbudet i denne sykehussituasjonen?*
2. *Hvordan opplever foreldre / foresatte musikkterapitilbudet?*
3. *Hvilken relevans har musikkterapi for utredning og behandling i psykisk helsevern?*

**Forskningsspørsmål til delproblemstilling 1: Barna**

1. Hvordan opplever barna å ha musikkterapi mens de er innlagt på sykehuset?
2. Har forkunnskaper eller sterkt forhold til musikk noe å si for opplevelsen av musikkterapi?
3. Hvilken betydning kan musikkterapi ha for barna mens de er på sykehuset?
4. Har barna opplevd å kunne bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi?
5. Opplever barna at musikkterapi skiller seg fra andre ting de er med på i løpet av sykehusoppholdet?
6. Ser barna en sammenheng mellom musikkterapi og tilbudet ellers på posten?
7. Har barna et behov for oppfølging i musikkterapi etter utskrivelse?

| **Forskningsspørsmål** | **Spørsmål til barna** |
|---|---|
| Hvordan opplever barna å ha musikkterapi mens de er innlagt på sykehuset? | • Husker du hva dere har gjort sammen i musikkterapi? Har du spilt noe instrument? Eller har du sunget? Hva synes du om det? |
| Har forkunnskaper eller sterkt forhold til musikk noe å si for opplevelsen av musikkterapi? | • Hører du på musikk på telefonen/youtube/spotify hjemme? Når da?<br>• Spiller du noe instrument, eller synger du, hjemme eller på skolen? |

| | |
|---|---|
| Hvilken betydning kan musikkterapi ha for barna mens de er på sykehuset? | • Er det noe du vil fortelle fra musikkterapi?<br>• Hvordan syns du det var å spille mens du var her på Barneposten? Hvorfor synes du det?<br>• Er det noen spesiell opplevelse / situasjon du vil dele? Husker du da vi [konkret situasjon]? Hva syntes du om det?<br>• Er det noe du ikke har likt så godt i timene, eller er det noe du har opplevd som vanskelig?<br>• Hva skjer ellers mens du er her på sykehuset? |
| Har barna opplevd å kunne bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi? | • Når du spiller musikk, er det annerledes enn å snakke? |
| Opplever barna at musikkterapi skiller seg fra andre ting de er med på i løpet av sykehusoppholdet? | • Hvordan synes du det er å ha musikkterapi mens du er her på sykehuset? Synes du det er annerledes å spille her enn om du hadde vært hjemme? |
| Ser barna en sammenheng mellom musikkterapi og tilbudet ellers på posten? | • Hvorfor tror du at Barneposten har tilbud om musikkterapi? |
| Har barna et behov for oppfølging i musikkterapi etter utskrivelse? | • Hvis det hadde vært mulig, ville du deltatt i musikkterapi etter utskrivelse fra Barneposten? Hvorfor / hvorfor ikke? |

| | |
|---|---|
| *Avsluttende spørsmål* | • Er det ellers noe du har lyst til å fortelle fra musikkterapi?<br>• Er det noe du har lyst til å spørre meg om?<br>• *Tilbakemelding til barnet* |

## 10.6 Interview Guide – Parents

# Intervjuguide med forskningsspørsmål

*Musikkterapi med barn på sykehus i psykisk helsevern*

Foreldre/foresatte

**Hovedproblemstilling**

*Hvordan oppleves musikkterapi på sykehus i psykisk helsevern for barn?*

Delproblemstillinger

1. *Hvordan opplever barna musikkterapitilbudet i denne sykehussituasjonen?*
2. *Hvordan opplever foreldre / foresatte musikkterapitilbudet?*
3. *Hvilken relevans har musikkterapi for utredning og behandling i psykisk helsevern?*

**Forskningsspørsmål til delproblemstilling 2: Foreldre/foresatte**

1. Hvordan har foreldrene opplevd musikkterapi?
2. Hvilket inntrykk har foreldrene av barnet sin opplevelse av musikkterapi?
3. Kan forkunnskaper eller sterkt forhold til musikk ha noe å si for barnets opplevelse av musikkterapi?
4. Hvilken betydning kan musikkterapi ha hatt for barnet mens han/hun har vært innlagt på sykehuset?
5. Dersom foreldre har hatt timer med barnet: Hvordan opplever de musikkterapi som arena for kommunikasjon og samspill med barnet sitt?
6. Ser foreldrene en sammenheng mellom musikkterapi og tilbudet ellers på posten?
7. Opplever foreldrene at musikkterapi skiller seg fra andre ting som barnet er med på i løpet av sykehusoppholdet?
8. Hvilke potensialer ser foreldrene i musikkterapi i en slik kontekst?
9. Opplever foreldrene at barna har behov for videre oppfølging i musikkterapi etter utskrivelse?

| **Forskningsspørsmål** | **Spørsmål til foreldre/foresatte** |
|---|---|
| Hvordan har foreldrene opplevd musikkterapi? | • Hvilket inntrykk har dere av musikkterapi? |
| Hvilket inntrykk har foreldrene av barnet sin opplevelse av musikkterapi? | • Hvordan tror dere at [barnet] har opplevd musikkterapi? |
| Kan forkunnskaper eller sterkt forhold til musikk ha noe å si for barnets opplevelse av musikkterapi? | • Hører [barnet] på musikk hjemme? Når da?<br>• Spiller [barnet] noe instrument, eller synger han/hun, hjemme eller på skolen? |

| | |
|---|---|
| | • Opplever dere at dette har noe å si for [barnet] sin opplevelse av musikkterapi? |
| Hvilken betydning kan musikkterapi ha hatt for barnet mens han/hun har vært innlagt på sykehuset? | • Hvilken betydning tenker dere at musikkterapi kan ha hatt for [barnet] mens han/hun har vært her på sykehuset? |
| Dersom foreldre har hatt timer med barnet: Hvordan opplever de musikkterapi som arena for kommunikasjon og samspill med barnet sitt? | • Hvordan opplevde dere samspillet og kommunikasjonen med [barnet] i musikkterapitimene?<br>• Hvordan opplever dere musikkterapi som arena for kommunikasjon- og samspill?<br>a. For [barnet]?<br>b. For dere?<br>• Andre ting disse timene har bidratt til?<br>• Har dere gjort dere noen tanker om hva som gjorde at dere opplevde det slik? |
| Opplever foreldrene at barnet har kunnet bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi? | • Har dere inntrykk av at [barnet] har kunnet uttrykke seg annerledes i musikkterapi enn ellers? |
| Ser foreldrene en sammenheng mellom musikkterapi og tilbudet ellers på posten? | • Opplever dere musikkterapi som en del av tilbudet ellers på posten? |
| Opplever foreldrene at musikkterapi skiller seg fra andre ting som barnet er med på i løpet av sykehusoppholdet? | • Skiller musikkterapi seg fra andre ting [barnet] er med på i løpet av sykehusoppholdet? |
| Hvilke potensialer ser foreldrene i musikkterapi i en slik kontekst? | • Ser dere potensialer i musikkterapi for denne konteksten? |

| | |
|---|---|
| Opplever foreldrene at barna har behov for videre oppfølging i musikkterapi etter utskrivelse? | • Dersom det hadde vært mulig, tror dere [barnet] hadde hatt nytte av videre oppfølging av musikkterapi etter utskrivelse? |
| *Avsluttende spørsmål* | • Er det ellers noe dere ønsker å fortelle fra deres opplevelse av musikkterapi? |

## 10.7 Interview Guide – Staff

# Intervjuguide med forskningsspørsmål

*Musikkterapi med barn på sykehus i psykisk helsevern*

Fokusgruppe

**Hovedproblemstilling**

*Hvordan oppleves musikkterapi på sykehus i psykisk helsevern for barn?*

Delproblemstillinger

1. *Hvordan opplever barna musikkterapitilbudet i denne sykehussituasjonen?*
2. *Hvordan opplever foreldre / foresatte musikkterapitilbudet?*
3. *Hvilken relevans har musikkterapi for utredning og behandling i psykisk helsevern?*

**Forskningsspørsmål til delproblemstilling 3: Fokusgruppe**

1. Hvordan har gruppa opplevd musikkterapi med barna?
2. Hvordan tror de barna har opplevd musikkterapi?
3. Kan forkunnskaper eller sterkt forhold til musikk ha noe å si for barnets opplevelse av musikkterapi?
4. Hvilken betydning kan musikkterapi ha hatt for barna mens de har vært innlagt på sykehuset?
5. Opplever gruppa at barna har kunnet bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi?
6. Dersom barna har hatt timer med foreldre: Hvordan opplever gruppa at musikkterapi har fungert som kommunikasjons- og samspillsarena?
7. Opplever gruppa at det er god koherens mellom musikkterapi og tilbudet ellers på posten?
8. Hvilken relevans har musikkterapi i denne spesifikke saken?
9. Opplever gruppa at barna har behov for videre oppfølging i musikkterapi etter utskrivelse?
10. Hvilke potensialer ser gruppa i musikkterapi i en slik kontekst?

| **Forskningsspørsmål** | **Spørsmål til fokusgruppa** |
|---|---|
| Hvordan har gruppa opplevd musikkterapi med barna? | • Hvordan har dere opplevd musikkterapi med [barnet]? |
| Hvilket inntrykk har gruppa av barna sin opplevelse av musikkterapi? | • Hva er deres inntrykk av [barnet] sin opplevelse av musikkterapi? |

| | |
|---|---|
| Kan forkunnskaper eller sterkt forhold til musikk ha noe å si for barnets opplevelse av musikkterapi? | • Vet dere om [barnet] spilte noe instrument eller om hun/han har et sterkt forhold til musikk?<br>• Opplever dere at dette har noe å si for [barnet] sin opplevelse av musikkterapi? |
| Hvilken betydning kan musikkterapi ha hatt for barna mens de har vært innlagt på sykehuset? | • Hvilken betydning mener dere musikkterapi kan ha hatt for [barnet] mens det har vært her på posten? |
| Opplever gruppa at barna har kunnet bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi? | • Har dere inntrykk av at [barnet] har kunnet uttrykke seg annerledes i musikkterapi enn ellers? |
| Dersom barna har hatt timer med foresatte: Hvordan opplever gruppa at musikkterapi har fungert som kommunikasjons- og samspillsarena? | • Hvordan opplever dere at musikkterapi fungerer som kommunikasjons- og samspillsarena?<br>a. For [barnet]?<br>b. For foreldrene?<br>• Andre ting disse timene har bidratt til? |
| Opplever gruppa at det er god koherens mellom musikkterapi og tilbudet ellers på posten? | • Opplever dere at det er en helhet mellom musikkterapi og tilbudet ellers på posten?<br>a. God informasjonsflyt?<br>b. Årsaker til hvorfor / hvorfor ikke? |
| Hvilken relevans har musikkterapi i denne spesifikke saken? | • Hvilken relevans ser dere i musikkterapi med [barnet]? |
| Opplever gruppa at barna har behov for videre oppfølging i musikkterapi etter utskrivelse? | • Dersom det hadde vært mulig, opplever dere at [barnet] hadde hatt nytte av videre oppfølging av musikkterapi etter utskrivelse? |

| | |
|---|---|
| Kan forkunnskaper eller sterkt forhold til musikk ha noe å si for barnets opplevelse av musikkterapi? | • Vet dere om [barnet] spilte noe instrument eller om hun/han har et sterkt forhold til musikk?<br>• Opplever dere at dette har noe å si for [barnet] sin opplevelse av musikkterapi? |
| Hvilken betydning kan musikkterapi ha hatt for barna mens de har vært innlagt på sykehuset? | • Hvilken betydning mener dere musikkterapi kan ha hatt for [barnet] mens det har vært her på posten? |
| Opplever gruppa at barna har kunnet bruke musikken til å uttrykke seg eller bearbeide ting i musikkterapi? | • Har dere inntrykk av at [barnet] har kunnet uttrykke seg annerledes i musikkterapi enn ellers? |
| Dersom barna har hatt timer med foresatte: Hvordan opplever gruppa at musikkterapi har fungert som kommunikasjons- og samspillsarena? | • Hvordan opplever dere at musikkterapi fungerer som kommunikasjons- og samspillsarena?<br>a. For [barnet]?<br>b. For foreldrene?<br>• Andre ting disse timene har bidratt til? |
| Opplever gruppa at det er god koherens mellom musikkterapi og tilbudet ellers på posten? | • Opplever dere at det er en helhet mellom musikkterapi og tilbudet ellers på posten?<br>a. God informasjonsflyt?<br>b. Årsaker til hvorfor / hvorfor ikke? |
| Hvilken relevans har musikkterapi i denne spesifikke saken? | • Hvilken relevans ser dere i musikkterapi med [barnet]? |
| Opplever gruppa at barna har behov for videre oppfølging i musikkterapi etter utskrivelse? | • Dersom det hadde vært mulig, opplever dere at [barnet] hadde hatt nytte av videre oppfølging av musikkterapi etter utskrivelse? |

# Article 1

Voices
A WORLD FORUM FOR MUSIC THERAPY

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ESSAY | PEER REVIEWED

# Whose Knowledge?

## Epistemic Injustice and Challenges in Attending to Children's Voices

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## Abstract

In this essay, I will discuss the importance of having an awareness about epistemic justice, epistemic ignorance and epistemic injustice, and why this awareness is important in connection to children and patients in mental health care. I also suggest ways to avoid epistemic injustice when working with, and doing research with, children in mental health care. In doing so, I tie this to feminist epistemology where conceptions such as knowledge, knowers and objectivity are questioned, and dominant conceptions and practices of knowledge production are perceived as a systematic disadvantage of women and other subordinated groups (Anderson, 2017). I am as well linking this to queer epistemology which differs from feminist standpoint epistemology in the idea of the identity being "a point of departure for shared consciousness" (Hall, 2017, p. 163).

Keywords: *epistemic injustice, children, mental health, feminist perspective, queer perspective*

## Introduction

Drawing on both queer theory and feminist theory in this essay, I will explore epistemic injustice and the challenges faced when attending to children's voices in mental health care.

Philosopher and feminist, Miranda Fricker (2007), defined "epistemic injustice" as "a wrong done to someone specifically in their capacity as a knower" (p. 1). Informed by this understanding, I am discussing how both children and patients in mental health care have been subjected to epistemic injustice, and how children in mental health care in this sense might experience a double epistemic injustice.

What are the challenges when considering epistemic justice in interviewing children in mental health care?

Fricker`s (2007) perspectives on epistemic injustice and ignorance are framed in a feministic epistemology. Discussions about objectivity in feminist epistemology are concerned with "limited location and situated knowledge" (Haraway, 1988, p. 583)



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and focused on how the knowers` social location affects "what and how she[/he/they][1] knows" (Anderson, 2017). In relation to these discussions, Fricker (2007) argues that people should be conceived "as operating as social types who stand in relations of power to one another" (p. 3).

In queer epistemology, one is instead focusing on an affectively attuned knowing, "a sensibility of something other than shared understanding" (Hall, 2017, p. 163). Queer theorists acknowledge other forms of epistemic injustices, such as epistemic violence (Hall, 2017) and "willful hermeneutical ignorance" (Pohlhaus, 2012), focusing on "the dialectical relation between interdependence and situatedness" (p. 720).

I perceive both feminism and queer theory as part of a broad discourse on gender. Through a discussion on epistemic injustice and ignorance, I will connect these two perspectives, focusing on two identity markers which seldom are discussed in the intersectionality debate on gender, namely children and patients in mental health care.

I am currently working on a Ph.D. project where the purpose is to gain more knowledge about how children experience music therapy during hospital admission in mental health care. The project is a qualitative study, and the problem statement is explored through a multiple case study design with 8 cases. I am conducting separate interviews with the children, as well as their parents, and several of the staff at the hospital will participate in focus group interviews. What is explored in this essay will be of importance when arguing for interviewing children in mental health care despite the challenges and critical issues this might imply (Einarsdóttir, 2007). It will also be important in interpreting and understanding the children's voices.

Even though my focus in this text is on children in mental health care, I do think there are examples that will be transferable to other identity markers.

## The child as a social competent actor

What is a child? When working and doing research with children, this is an important question to ask. One could argue that it is an easy question to answer, emphasising age and development. It is, however, as much a question about how we (adults) perceive children, what their role and impact are in our society. All interaction with others is "predicated on the categories in which we spontaneously place them" (Gilbert, 2009, p. 93), and the binary opposition child/adult places children linguistically less valued than adults and dependent on them. Fixed categories, such as children and adults, gender and sex, are strongly criticized and questioned in queer theory, and binary oppositions such as feminine/masculine, woman/man, female/male are under constant deconstruction (Butler, 2006).

The "otherness" of children "somehow represents the very things which make children children" (Jones, 2001, p. 173). How we perceive this "otherness" and deal with it is a key issue in the relations between adulthood and childhood, as well as in research related to childhood. From an adult's position, the child seems to be more "other" the younger they are, Jones suggested, acknowledging how the inner worlds of young children are mysterious and distant to adults. At the same time, Jones referred to the infant research conducted by the biologist Trevarthen (1993), among others, which showed infants` capabilities for emotionality and communicating. This "communicative musicality" (Trevarthen & Malloch, 2000) provides a basis for mutual understanding between people.

To communicate about "children" as a fixed category and a unified group of people might, however, simplify the complexity of the group. There is, nevertheless, something that apparently forms them as a group, including their youngness, newness, and "lack of accumulative experience and knowledge which make adults adults" (Jones, 2001, p. 175). This implies that children are defined as the binary opposite, the negative of adult, but, as Jones emphasises, it is important to realise that children "are *not less than adult; they are different to adults*" (p. 175, emphasis in original).

The children`s rights, defined by the UN Child Convention (UN, 2006), and a growing influence of the consumer have had a great influence on how childhood is viewed

in society. What has changed has been an increasing understanding of the child as a competent social actor and children`s involvement in research (Powell & Smith, 2009; Sinclair, 2004). Children are now not merely objects of inquiry but can be active participants in the research process. This development demands specific attention and capabilities in the researcher, as their methodological and ethical choices impact children`s participation in research (Powell & Smith, 2009). Given the diversity of contexts and research problems, a child-centred perspective is suggested (Grover, 2004).

## Epistemic injustice

Two of our most basic everyday epistemic practices are "conveying knowledge to others by telling them" and "making sense of our own social experiences" (Fricker, 2007, p. 1). Fricker brought to light certain ethical aspects of these practices by defining a distinctively epistemic kind of injustice, dividing it into two forms: *testimonial injustice* and *hermeneutical injustice*. In both, it is the subject that "suffers from one or another sort of prejudice against them *qua* social type" (p. 155). In *testimonial injustice*, "a hearer wrongs a speaker in his[/her/their] capacity as a giver of knowledge, as an informant" (p. 5), while in *hermeneutical injustice* it is "some significant area of one´s social experience" that is "obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource" (p. 155).

### Testimonial injustice

When the speaker is wronged in their capacity as a subject of knowledge, they are wronged in a capacity which is essential to human value (Fricker, 2007). This is a matter of credibility deficit, where someone receives lower credibility than they deserve. Fricker argued that various degrees of this happen all the time, referring to Shklar (1990) who pointed at injustice as something that is not a surprising abnormality, but rather a normal social baseline.

Social power is central in testimonial injustice, especially the particular kind of social power called *identity power*. Identity power is at work where there is an operation of power depending upon "shared imaginative conceptions of social identity" (Fricker, 2007, p. 14), and one example of this is gender. For example, gender identity power is active when a cis man influences a cis woman`s action by making use of the identity as a cis man. One of Fricker's main example was from Minghella`s (2000) movie, *The Talented Mr. Ripley*, where Herbert Greenleaf wrongs Marge Sherwood's capacity as a knower in relation to the disappearance of their fiancé, Dickie Greenleaf. Marge is convinced (rightly) that Dickie´s friend, Tom Ripley, has killed Dickie, but Herbert Greenleaf disregards Marge`s beliefs. "Marge, there´s female intuition, and then there are facts" (Minghella, 2000, in Fricker, 2007, p. 88). Herbert Greenleaf thus fails to see Marge as a source of knowledge, and one might claim that there is a clear identity prejudice at work in this situation.

The primary harm of testimonial injustice is about exclusion from knowledge owing to "identity prejudice on the part of the hearer" (Fricker, 2007 p. 162). Identity prejudice is related to social identity, and the influence of this prejudice in the credibility judgement of a hearer is an "operation of identity power" (p. 28). Identity power can control our actions even despite our beliefs, as it is at "the level of the collective social imagination" (p. 15). Our responses to the testimony of others are learned through epistemic socialization and "our normal unreflective reception of what people tell us is conditioned by a great range of collateral experience" (Fricker, 2003, p. 161).

### Hermeneutical injustice

The primary harm of hermeneutical injustice is about exclusion from knowledge owing to "structural identity prejudice in the collective hermeneutical resource" (Fricker, 2007, p. 162). This harm is in deep connection with the primary harm of testimonial injustice, but, according to Fricker, in hermeneutical injustice and in contrast to tes-

timonial injustice, there is no culprit ? it is purely structural. Hermeneutical injustice happens when an individual is unable to understand their own experience because of a cognitive disadvantage stemming from a "gap in collective hermeneutical resources" (p. 6).

Fricker (2007) exemplified hermeneutical injustice with the story of Carmita Wood, a woman in the late 1960s, who experienced sexual harassment at the workplace. At that time, there were no words in the hermeneutical resources that could explain what happened, to neither Wood nor the male professor at work who sexually approached Wood. Wood developed chronic back pain and quit their job. Applying for unemployment insurance, Wood had a hard time explaining what had happened, and their application was denied. Wood joined a feminist group discovering that everyone in the group had had similar experiences, and they started to speak out about this "sexual intimidation," and "sexual coercion" (Brownmiller, 1990, in Fricker, 2007, p. 150), coming up with the word "sexual harassment."

When some groups are excluded from practices where social meaning is generated, "collective hermeneutical resources" (p. 6) inadequate to the experiences of marginalized social groups are produced. Collective impoverishment becomes unjustly and particularly disadvantageous to some groups of people, but not others, in concrete social situations, such as in the example of Carmita Wood. Hence, according to Fricker (2007), hermeneutical injustice is fundamentally "a kind of structural discrimination" (p. 161).

## Epistemic violence, epistemic ignorance and willful hermeneutic ignorance

Queer epistemology brings another form of testimonial injustice into focus, namely "the epistemic violence" (Hall, 2017, p. 158) of mandatory testimony about one`s gender and sexuality. Testimonial injustice in queer epistemology is thus not only about the silencing of those who are marginally situated, but also about the epistemic violence maintained by the pressure to inhabit an identity category, "to understand oneself as a certain kind of person because of one's desires and actions" (p. 159).

Mason (2011) was critical of Fricker`s central argument of hermeneutical injustice, claiming that Fricker`s analysis might contribute to the disempowerment and marginalization of non-dominant subjects. Mason argued that Fricker failed to see the possibility that subjects in marginalized groups might possess "non-dominant interpretive resources from which they can draw to understand and describe their experiences" (p. 295). According to Mason, marginalized subjects will hence not necessarily experience hermeneutical injustice, and even though Fricker (2007) emphasized that hermeneutical injustice is "not a subjective failing" (p. 169), I do, to a certain degree, agree with Mason. For instance, in Wood`s example, Mason argued that the women understood that their experiences of sexual harassment were wrong even though they didn't have any name for it. It is not the socially recognized name that prevents groups from understanding. Mason (2011) suggested an "alternative kind of unknowing" (p. 298), which is at play when hermeneutical resources are insufficient with the experiences of someone in the community. This is hermeneutical injustice and "epistemically and ethically blameworthy ignorance" (p. 301). Mason here referred to Mills (1997) who focused on ignorance rather than knowledge, reflecting on how those with power can fail to understand, rather than marginalized groups, due to "epistemically irresponsible and ethically reprehensible practices of misinterpretation, misrepresentation evasion, and self-deception" (p. 303). In the context of epistemic ignorance, the comprehensibility of marginalized groups to dominant groups is prevented by "epistemic practices infected by ignorance, not by their own inability to understand their experiences" (Mason, 2011, p. 304).

Following up on Mills` notion of epistemic ignorance, Pohlhaus (2012) paid attention to the relationship between interdependence and situatedness as an account of how it is possible to actively maintain such systemic ignorance. Pohlhaus critiqued

Fricker (2007) and the limitations of hermeneutical injustice, pointing to the argument regarding willful hermeneutical ignorance. Marginally situated knowers may be epistemically disadvantaged, Pohlhaus (2012) argued, but those who are dominantly situated are also situated to know that their dominant epistemic resources are not very suitable in whole parts of the world. Willful hermeneutic ignorance describes how marginally situated knowers resist epistemic dominance actively through interacting with other marginally situated groups. At the same time, dominantly situated knowers continue to misinterpret and misunderstand the world. A dominantly situated group may maintain their ignorance "by refusing to recognize and by actively undermining any newly generated epistemic resource that attends to those parts of the world that they are vested in ignoring" (p. 728). One way this kind of ignorance appears might be through the maintenance of binary pronouns. I find these perspectives both relevant and interesting, and I will discuss them further in relation to children.

## Epistemic injustice and children

Considering my above discussion of children`s "otherness" in society, prejudices against children and childhood are clearly present. The epistemic prejudices are related to the prejudices and assumptions adults have, implicitly and explicitly, about children (Murris, 2013). Do these prejudices make children more vulnerable to epistemic injustice (Carela & Györffyb, 2014)? Fricker (2007) claimed that "wherever there are identity prejudices in the discursive environment, there is a risk of testimonial injustice" (p. 86). Identity prejudice, which is produced by binary discourses, operates as a "widely held disparaging association between a social group and one or more attributes" (p. 35), and talking about children as a fixed category might emphasize prejudices in this context. As earlier mentioned, it might be insufficient, and also wrong, to talk about children as a fixed category, and I argue that it also underpins children`s vulnerability to epistemic injustice.

Carela and Györffyb (2014) claimed that the question of epistemic injustice in relation to children is of particular importance in health care. This is because children have important information about their own well-being, and Carela and Györffyb emphasized how one can easily disregard what children actually tell us. Murris (2013) acknowledged this as well, proposing that "hearers` prejudices cause adults to miss out on knowledge offered by the child, but not heard by the adult" (p. 246). Despite these important perspectives on children`s prone position in relation to epistemic injustice, the literature is remarkably silent on children in this context, and it is further silent on what influences adults when hearing children`s voices and what we regard as "real" knowledge (Murris, 2013). "Queer listening" (Bonenfant, 2010; Hadley & Gumble, 2019), which involves "developing a certain virtuosity" (Bonenfant, 2010, p. 78) might be one way for adults to hear the knowledge offered by the child, and I will consider this further when examining different virtues for epistemic injustice.

In relation to hermeneutical injustice, I argue that children often experience exclusion from meaning making. This might create a "gap in collective hermeneutical resources" (Fricker, 2007, p. 6), and thus possibly prevent children from making sense of their own social experiences. In some social contexts, hermeneutical injustice happens when someone is "socially constituted as something they are not" (p. 168). Fricker exemplifies this with Edmund White`s (1983) book *A Boy`s Own Story*, where a boy growing up in 1950s America has a strong sense of dissonance around their own feelings for other men and the authoritative hermeneutical constructions of the social identity of being gay. The boy`s young self is, in this context, formed through all of these different constructions about homosexuality around them, exemplifying how some might thus "be prevented from becoming who they are" (Fricker, 2007, p. 168). Connecting this with queer epistemology and the previously mentioned mandatory testimony of one`s gender and sexuality, hermeneutical injustice might also contain epistemic violence.

I understand hermeneutical constructions as the primary harm of hermeneutical injustice in relation to children, as well as the epistemic violence that occurs when facing

pressure to inhabit an identity category. Considering the different aspects that predispose children to epistemic injustice, it is crucial to find ways to prevent epistemic injustice when working and doing research with children.

## Epistemic injustice and patients in mental health care

One might also ask, is epistemic injustice relevant when communicating about patients in mental health care? I argue that it certainly is, considering the many identity prejudices against patients in mental health care that are clearly present in society (Johnstone, 2001). Central to mental health legislation, "some people lack the capacity to make decisions" (Lakeman, 2010, p. 151). The implication of this is that the words, preferences, and choices of "some people" (i.e., patients in mental health care) and their interpretations of their problems, "lack coherence, logic or credibility" (p. 151). Considering how Fricker (2007) identified the primary harm of testimonial injustice, patients in mental health care seem to be vulnerable to testimonial injustice. Lakeman (2010) argued that testimonial injustice is foundational for other forms of injustice, such as social and procedural justice, exemplifying how decisions in mental health services are based on assessment of the credibility of the person`s testimony.

Patients in mental health care might also experience hermeneutical injustice in that they might be deprived of their means of understanding and communicating their own social experience (Wardrope, 2015). This is central to the critique of medicalization. Wardrope (2015) claimed that "medicine`s epistemic authority eclipses all other understandings in our collective hermeneutical resources" (p. 342). Patients in these concrete social situations might suffer an unjust disadvantage and hence a sort of "structural discrimination" (Fricker, 2007, p. 161). Wardrope, however, does not agree with the critique of medicalization, referring to the risk of committing the other kind of epistemic injustice, testimonial injustice. Wardrope (2015), here referred to how the critiques ascribe insufficient credibility to the testimonies of, for instance, children with ADHD diagnosis, where the majority of the children who were asked "rejected the medicalization critique`s analysis" (p. 348).

The main disabling barrier in mental health care is considered to be social stigma (Beresford, Nettle, & Perring, 2010; Rolvsjord, 2014). An epistemically and ethically blameworthy ignorance might occur where lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals in mental health care experience pervasive stigma in mental health care (Bain et al., 2016; Hadley & Gumble, 2019). This stigma might affect how LGBTQ individuals are heard as mental health patients and willful hermeneutical ignorance (Pohlhaus, 2012) happens.

## The virtue of epistemic justice

Fricker (2007) suggested different virtues for the two different kinds of epistemic injustice. In order to avoid testimonial injustice, Fricker claimed that the hearer has to have a "corrective anti-prejudicial virtue that is distinctively reflexive in structure" (p. 91). The ideal is to neutralize impacts of prejudices, and one should overcompensate to increase the level of credibility that would have been there without prejudices. "The virtuous hearer neutralizes the impact of prejudice in her[/his/their] credibility judgements" (p. 92) Fricker claimed. The virtue of hermeneutical justice is also corrective in structure, and it involves a more "socially aware kind of listening" (p. 171). In order to avoid hermeneutical injustice, one has to possess a sensitivity or alertness to the possibility that our interlocutors' difficulties in trying to make something intelligible in the communication is not because they're not intelligent, but rather because there is a gap in collective hermeneutical resources. One has to realize that the speaker might struggle with an "objective difficulty, and not a subjective failing" (p. 169). Fricker, however, does not meet Mason`s (2011) nor Pohlhaus' (2012) critique in these virtues, failing to recognize the non-dominant interpretive resources which subjects in marginalized groups might possess, as well as the willful hermeneutic ignorance in dominant situated groups.

The previous mentioned "queer listener" (Bonenfant, 2010) might be related to Fricker`s term the "virtuous hearer" (2007). Bonenfant (2010) suggested that the voice is a "form of social touch" (p. 77) and that this touch can "activate reactions in bodies, literally, by vibrating them" (p. 77). "Queer is a doing, not a being" (p. 78), and the queer listener "listens out for, reaches toward, the disoriented or differently oriented other" (p. 78), as well as finding appreciation of the other. Connecting this to music therapy, Hadley and Gumble (2019) claimed that when engaging in queer listening, "music therapy can be transformed into a space" (p. 226) where this appreciation can happen. As Fricker (2007) was also emphasizing, when "listening out for queer desires and needs" (Bonenfant, 2010, p. 78) a sensitivity is required.

## Hearing the competent and credible child and embracing epistemic humility

As I have advocated earlier, children and patients in mental health care seem to be vulnerable to epistemic injustice. In my Ph.D. project, the children who are participants in the study are both "children" and "patients in mental health care." What kind of precaution is needed in order to avoid epistemic injustice in this context?

Exclusion from knowledge is, as earlier mentioned, the primary harm of testimonial injustice, and one might also argue that this is the primary harm in research. According to Fricker (2007), prejudices can shape our credibility judgements despite our own beliefs, and testimonial injustice thus might happen without us being aware of it. To avoid the injustice, then, the hearer has to be critically aware and identify the impact of identity power in their credibility judgement. The hearer has to be alert not only to the speaker´s social identity, but also to the impact of their *own* social identity on their credibility judgement. Being reflexive and critically aware to how we perceive "children" and "patients in mental health care" is hence a key issue to avoiding testimonial injustice in the interaction with those children in mental health care that are participating in this study, as well as how we perceive ourselves ("adults"/"researchers") in this context. Another important aspect is a critical awareness regarding the *difference* as structured discursively in the binary oppositions between "children" and "adults" and "researchers" and "patients in mental health care." There is further importance to how this might impact relationships, and thus the interaction, between the researcher and the children participating in the study. The "otherness" of the fixed categories of children and of patients in mental health care, and the prejudices one might have connected to this "otherness", implicit or explicit, are crucial and important to interrogate and be aware of in efforts of avoiding testimonial injustice in the research process.

Fricker (2007) argued that a more socially aware kind of listening, as in the virtue of hermeneutical justice, involves "listening as much to what is *not* said, as to what is said" (p. 171–172). When searching for these other voices, the queer listener has to possess a virtuosity and a "certain kind of attunement to hearing beyond syntax" (Bonenfant, 2010, p. 78). Listening to what is *not* said is particularly interesting in relation to children, considering, for instance, the previously suggested child-centred perspective and the plentiful advice for implementing varied techniques when interviewing children (Einarsdóttir, 2007). Children often communicate and express themselves through different modalities and not just through words. As earlier mentioned, even infants communicate and actively take part in communication through an inborn "communicative musicality" (Trevarthen & Malloch, 2000), and the knowledge about this non-verbal communication gives us an idea about what adults might miss if they ignore what is *not* said. Important information and relational initiatives from children can be missed, resulting in an exclusion of children`s knowledge and ways of expressing themselves from hermeneutical resources. Hermeneutical injustice seems to affect children more strongly than other groups, and to avoid this injustice requires, according to Fricker (2007), a reflexive and critical awareness, but also, I argue, a more general analysis of structurally embedded power in the different social situations.

If we consider this alongside the work of Mason (2011), the case of hermeneutical injustice might also relate to another kind of unknowing, which is not a hermeneutical injustice but rather an epistemically and ethically blameworthy ignorance. Children might possess "non-dominant interpretive resources" (p. 295) which can be used to "understand and describe their experiences" (p. 295), and according to Mills (1997), it is not always the marginalized that fails to understand their experiences but, just as often those in power, those in the dominant group. Pohlhaus (2012) argued that hermeneutical injustice, as Fricker (2007) has defined it, happens when "a marginally situated knower has no community with which to develop adequate epistemic resources" (Pohlhaus (2012, p. 731) to make sense of their own experiences. However, willful hermeneutical ignorance occurs where marginally situated knowers *have* a community where adequate epistemic resources are developed, but dominantly situated knowers do not want to acquire this knowledge.

If adults then systematically ignore what children communicate, what implications might this have in research? Will it, in light of this question, even be possible for adults to understand what children communicate about their experiences?

When our interlocutors have difficulties in trying to make something intelligible in communication, Fricker (2007) emphasizes that it is not because the interlocutor is not intelligent but rather because there is a gap in collective hermeneutical resources. Because of this gap, we have to possess a sensitivity or alertness to this possibility. But is this sensitivity and alertness enough? Do we have the right tools in our epistemic capacities to go beyond the gaps developed through a systemic ignorance of children`s different experiences and expressions? Wardrope (2015) critiques Fricker`s suggestion to not engage with "the root causes of epistemic injustice" (p. 350). Wardrope`s (2015) alternative is "epistemic humility" (p. 350), an awareness of one`s own epistemic capacities and the limitations of these, as well as an active searching for contrasting and complementary perspectives outside oneself to go beyond these shortcomings. Wardrope argued that it is important to not just involve personal awareness but also to involve public expressions of the epistemic limitations one has. This might be a useful perspective to bring into research with children and patients in mental health care.

## Conclusion

Who has the right to knowledge? And whose knowledge are we seeking? Doing research with children in mental health care involves many different challenges. One of these includes the risk of epistemic injustice, and this risk is a central issue within this specific context. Children and patients in mental health care seem to be vulnerable to epistemic injustice – both testimonial and hermeneutical injustice, as well as willful hermeneutical ignorance. In order to avoid this, it is of special importance to be critically and reflexively aware of the prejudices one might have as a researcher towards the fixed categories of "children" and "patients in mental health care" and also to deconstruct binary oppositions in an attempt to disrupt identity prejudices. It is also crucial to maintain a sensitivity and an alertness, a "queer listening" (Bonenfant, 2010; Hadley & Gumble, 2019), to the difficulties that children in mental health care might have when trying to express themselves to the researcher in a way that is clearly understood.

It is of special importance to be aware of modalities other than words when interacting with children in efforts to avoid epistemic injustice. It also seems to be crucial to go beyond one's own shortcomings and involve public expressions of the epistemic limitations one has. Knowledge about how epistemic injustice exists in relation to children and patients in mental health care, and how to avoid it, gives us an awareness about why it is important to include children in mental health care and their knowledge in research and to explore the different complex challenges.

## About the author

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## Notes

1. Throughout this text, I use they/them/their pronouns instead of only his/her in efforts to include those who do not use binary pronouns.

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# Article 2

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# Moments of fun: Narratives of children's experiences of music therapy in mental health care

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# Moments of fun: Narratives of children's experiences of music therapy in mental health care

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**ABSTRACT**

**Introduction:** Mental health issues in children involve complexities and life challenges for the child and their families. Music therapy as part of treatment in mental health care focuses on interaction and communication through music, with emphasis on the children's resources. There is a small, but growing amount of research in the field of music therapy with children in mental health care.

**Method:** This qualitative study explored children's own experiences of music therapy in mental health care at the hospital. This was done through a multiple case study design, including semi- structured interviews with seven children and participant observations. A narrative approach informed by "portraiture" was used in the analysis process in order to highlight non-dominant experiences and allow for multiple modalities in the analysis and in the presentation of findings.

**Findings:** The children's experiences were expressed through various modalities. These were displayed through narratives representing the core of the interview with each particular child. The word fun became a prominent emerging theme across the cases.

**Discussion:** In the children's expressions, the word fun seemed to be a container of experiences, with rich variations and multiple meanings. Through a thorough attention to this word and the children's actions before, after and while they spoke, multi-dimensional meanings of the word emerged. Through listening to the children's own experiences, fun proved to be an essential part of music therapy in mental health care with children, not as mere entertainment, but as something of existential importance and with great therapeutic potentials.

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## Introduction

Mental health problems for children involve complexities and life challenges for both the child and their families in everyday lives. Between 10% and 20% of children and youth in the world have a mental disorder, and about half of these start before the age of 14 (World Health Organization, 2021). The Covid-19 pandemic has led to major concerns for the mental health of children and youth, and for the first time, UNICEF's biannual report, "The State of the World's Children", investigates mental health

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(United Nations Children's Fund, 2021). Help directed towards children and their families involves a broad range of interactions and communication. As part of treatment in mental health care music therapy focuses on interaction and communication through music, with a distinct emphasis on the children's resources (Johns, 2018; Trondalen, 2004).

This article focuses on children's perspectives in music therapy in mental health care. Traditionally, children's perspectives have been excluded from the mainstream perspectives on child mental health and development (Liegghio et al., 2010), but there have been many processes in the last decade contributing to the repositioning of children in research and their agency within society. The importance of the inclusion of children with mental health issues in research is recognized through the UN Convention on the rights of the child (CRC; UN General Assembly, 1989), and Article 12 in particular, as well as through changes in how children are viewed in society (Liegghio et al., 2010; Powell & Smith, 2009; Sinclair, 2004; Sommer et al., 2010). Children should be considered as subjects with their own opinions, recognized as participants regardless of their age, and this requires serious involvement in tuning in to children's communication (Skivenes & Strandbu, 2006). The children's own opinions about treatment decisions and what type of help they receive is increasingly taken into account as exemplified in the guidelines for children and youth mental health treatment by the Norwegian Directorate of Health (2020). Nonetheless there are still a relatively small number of studies that investigate young people's experiences in mental health care (Persson et al., 2017). First-person and client perspectives have increasingly gained importance in adult mental health care in recent years as highlighted by the recovery movement (Anthony, 1993; Slade, 2009). Such approaches have contributed to a fundamental change in both research and practice demonstrating the potentials of a client-based approach in adult mental health care, but have to a much lesser extent been explored in mental health for children and youth (Naughton et al., 2018; Naughton et al., 2020; Simonds et al., 2014).

### *Previous research on music therapy with children in mental health care*

The small but growing amount of research in music therapy with children in mental health care contributes to an increasing awareness in regard to the importance of early intervention. There is a larger amount of research done in music therapy with youth in mental health care than with children under 13 years old. Some of these youth studies can be considered relevant also in relation to children, and are therefore included in the brief literature review which follows.

Promising, but inconclusive effects of music therapy with children and youth in mental health care in general are documented both in meta-analyses (Geipel et al., 2018; Gitman, 2010; Gold et al., 2004), RCT (Porter et al., 2017) and quasi-experimental study (Gold et al., 2007). The greater part of the research focuses on children and autism spectrum disorder (Bieleninik et al., 2017; Edgerton, 1994; Gattino et al., 2011; Geretsegger et al., 2012; Geretsegger et al., 2014; Kern & Aldridge, 2006; Kim et al., 2009; Mössler et al., 2019; Pasiali, 2004; Walworth, 2007; Wigram, 2000; Wigram & Gold, 2006). Some of the research focuses on music therapy with children and youth in relation to restlessness and ADHD (Helle-Valle et al., 2017, 2015; Jackson, 2003; Rickson, 2006; Rickson & Watkins, 2003), children and youth with social challenges (Gooding, 2010) and children with anxiety (Goldbeck & Ellerkamp,

2012). Emotional interactions in music are explored by Sannes (2012) and Johns (2018), as well as music therapy as part of the assessment process with children in mental health care (Jacobsen, 2012) and interdisciplinary experiences (Hense, 2018; Thorgersen, 2015).

Young people's experiences of music therapy are included in several studies, in relation to anorexia (Trondalen, 2004) and in exploring connections between youths' musical identity and their recovery (Hense, 2015, 2019; Hense & McFerran, 2017; Hense et al., 2014; McFerran et al., 2018). Other research of relevance in connection with children and youth's experiences is the research on music therapy with refugee children (Enge & Stige, 2022; Roaldsnes, 2017), children under special care due to history of family violence (Fairchild & McFerran, 2019; Fairchild & Mraz, 2018) and with youth in child welfare (Krüger, 2012).

The diverse research portrayed in this short review gives us a better understanding of music therapy as a useful approach with children in mental health care, but leaves us at the same time with questions regarding the children's experiences of this form of care. As presented, youth's experiences are represented in this field, but research specifically focusing on children under 13 years old and their own experiences of music therapy in mental health care is not found.

Drawing on these perspectives and gaps in knowledge, this article contributes to existing literature by focusing on the personal experiences of children between 8 and 12 years of age who participated in music therapy in an inpatient hospital unit in mental health care. The children's perspectives were explored through a narrative approach, and the following research questions were addressed:

(1) How do children experience music therapy in mental health care at the hospital?
(2) How do they express these experiences?

## Methodology

### *Study context*

The study was situated at the unit for children at the Department of child and adolescent psychiatry, Division of mental health, at Haukeland University Hospital in Bergen, Norway. The unit provides care for children from birth to 13 years old, and the children are always admitted together with one of their parents. At the unit there is room for six children with parents, and the interprofessional team working there is made up of 18 social workers, two psychologists, two psychiatrists and one music therapist. The unit is also closely connected to the hospital school with one-to-one teaching. The children stay at the hospital for between 4 and 8 weeks, and the cause of referrals from the outpatient clinics are always complex and challenging. Reasons for this include for example, non-attendance at the outpatient clinic, difficulties in communication with the children, challenges in collaboration with parents, the need for a more intensive observation or treatment, starting out with new and complicated medication, the need for faster clarifications, shielding the child and high need for care.

The unit follows a relational therapy approach and uses emotion regulation as their main method (Campos et al., 2004; Nordanger & Braarud, 2017; Nyklíček et al., 2011). The therapeutic model, Circle of Security (COS; Coyne et al., 2019), which is based on

attachment psychology, lays the foundation for the common language and shared perspectives at the unit. Music therapy is an integrated element of the total service provision at the unit. Children are referred to music therapy by the psychologist/psychiatrists and the music therapist participates in treatment teams for each child. Music therapy can be defined as "an effort to increase people's possibilities for action" (Ruud, 1990, 1998, p. 3) and the work of the music therapist is influenced by resource-oriented perspectives (Rolvsjord, 2010), as well as more relational perspectives (Johns, 2018; Trondalen, 2016). In music therapy, a non-verbal and affective communication through music is used.

## *Design*

To address the main aim of this study which was part of the first author's PhD-study,[1] the authors conducted a qualitative study with a multiple case study design (Stake, 1995), consisting of semi-structured interviews with children (Eide & Winger, 2003; Kvale & Brinkmann, 2015), participant observation (Fangen, 2004) and a narrative approach to analysis (Kvale & Brinkmann, 2015) informed by "portraiture" (Lawrence-Lightfoot & Davis, 1997).

The research team consisted of the two authors, in close collaboration with the unit staff at the hospital. The first author[2] was also one of the two music therapists responsible for the music therapy with the children in the study. The other music therapist, Anita Barsnes, did the participant observation in her sessions and was present in the interviews in the cases where she had been the music therapist. User involvement (Bird et al., 2013; Jørgensen, 2019) in the study included a small pilot where two children at the unit gave feedback on the questions as part of the development of the interview guide (the interview guide can be found in the supplemental material).

When designing the study the authors have been informed by feminist and queer-theories, especially the concept of "epistemic injustice" (Fricker, 2007; Klyve, 2019). Epistemic injustice is defined as, "a wrong done to someone specifically in their capacity as a knower" (Fricker, 2007, p. 1). An awareness of children and patients in mental health's vulnerability to epistemic injustice is of special importance when doing research in this field (Klyve, 2019).[3] This implies that it is especially important to be reflexively and critically aware of the prejudices one might have as researchers toward the fixed categories of "patients in mental health care" and "children". Children are born with a communicative musicality, and this plays a great part in communication also later in life (Erickson, 2009; Ilje-Lien, 2018; Trevarthen & Malloch, 2000). This implies that one must not only pay attention to the children's verbal form of expression, but also include other varieties of communication (Clark, 2005; Ilje-Lien, 2019). To avoid epistemic injustice when doing research with children in mental health care an awareness of children's multi-modal communication is crucial. That was a concern both in the data collection and the analysis.

The music therapy service in the study was typical for the unit. All participants participated in individual 1-hour music therapy sessions in a soundproof music room at the unit. This room contained various instruments, such as band instruments and

[1]This PhD-study as a whole contains several parts, consisting of interviews with the children, interviews with the parents, focus group interviews with the staff and participant observation. This article is based on the interviews with the children and the participant observation.

[2]The first author has worked for several years as a music therapist at this particular unit.

[3]This is previously discussed thoroughly in Klyve (2019) as a part of this PhD-study.

digital music programs at the computer, as well as various rhythm instruments, drums, ukuleles and xylophones. The music therapy sessions consisted of playing music together, and the songs were often chosen by the children themselves or improvised. Some sessions also consisted of collaborative song making on a computer. The children were offered two music therapy sessions every week, but due to their motivation and condition which could vary from day to day, the number of sessions varied. Some of the children participated in every session, some participated in just a few. In those cases where attachment and interaction within the family were described as specific challenges the parents were included in one or two sessions.

### *Participants*

During the recruitment period, between 1st of September 2017 and 31st of December 2017, there were 18 children at the unit. The children were electively admitted to the hospital and all of them stayed at the unit for four weeks. The children were referred to the children's unit for assessment due to complex challenges, some of these consisting of difficulties in attachment, social interaction and verbalizing thoughts and feelings. The criteria for inclusion in the study were age eight to 12 years and sufficient abilities to participate in an interview. Also, as typical for the unit, an assessment was made together with the psychologist/psychiatrist as to whether music therapy could be relevant for the child, based on the referral to the unit. Eight children, four girls and four boys were included in the study. There were diagnostic variations among the children, often in a combination of several diagnoses. Six of the children were diagnosed with neurobiological behavioral disorders, including ADHD, autism spectrum disorder, severe depression, language disorder, obsessive-compulsive disorder, generalized anxiety disorder, developmental disorder within motor skills, learning difficulties and Tourette syndrome. Two of the children were diagnosed with attachment disorder due to neglect.

### *Ethical considerations*

The PhD-study that this study was part of was approved by REK – Regional Committees for Medical and Health Research, 29.03.2017, 2017/52/REK vest. Involving children in research has many ethical complexities but it may at the same time be unethical to not involve them in research concerning them (Neill, 2005). Hence, research with children requires a particularly high degree of reflexivity. Specific considerations were taken regarding consent, including the provision of a specific information form addressing the children in addition to information directed to the parents. Safety and protection of the children were carefully considered throughout the study. This included measures taken to ensure confidentiality, as well as to provide a safe interview situation for the children. The double role as therapist and researcher held by the first author required careful considerations and to be self-reflexive of personal and potentially unconscious reactions (Finlay, 2002). It was also essential to be critically aware and reflexive in regard to the power relations in the interview setting and the researcher's own perceptions and prejudices (Klyve, 2019). This was particularly important in the situations where Barsnes participated in the interview and the constellation became one child and two adults.

### *Data collection*

The data collection consisted of separate semi-structured interviews with the children in their last week at the unit (Kvale & Brinkmann, 2015) and participant observation in the music therapy sessions (Fangen, 2004). It is of special importance to combine interviews with other methods when researching with children, both to strengthen the analysis and to elicit more valid answers (Eder & Fingerson, 2001). Therefore, participant observation, where the music therapists were the participant observers, was included as a part of the data collection in each music therapy session. This type of participant observation is commonly used in music therapy case studies (Keith, 2016). In our study this served the double purpose of building rapport with the children, essential for their sense of safety and hence their communication in the interview (Eder & Fingerson, 2001; Irwin & Johnson, 2005; Powell et al., 2018), as well as providing the researchers with contextual understanding for the purpose of the analysis (Eder & Fingerson, 2001). A log was written from every session, and the two music therapists met regularly during the different therapy processes. The sessions were audio-recorded in case something of special interest occurred during the sessions and had to be listened through repeatedly. The focus on interplay and communication through music in the music therapy sessions facilitated a good way of building rapport with the children. A strong rapport with the children was especially important in this particular setting at the hospital where the children were in a vulnerable situation with complex challenges and had difficulties in verbally expressing themselves. Also, since some of the children had challenges with attachment, expressing emotions and social interaction, there were challenges in eliciting comprehensive answers in the interviews. Hence, it was especially important to include the various modalities through which the children expressed themselves. The music room as the context of the interview was considered to be a space which was well-known to the children and where they felt safe (Carter & Ford, 2013). It was also a place which facilitated the possibility for the children to use both words and other modalities, such as expressing themselves through music, exploring and showing things through music or drawing with crayons and paper presented in the room. The possibility to play music or to draw during the interview also facilitated a more engaging and fun research situation (Carter & Ford, 2013). The interviews were audio-recorded.

Through a dialogue with the children, their parents, the psychologist/psychiatrist, and the music therapist, the preferred option was to have only the music therapist (the first author) present with the child during the interview, as this resembled the familiar situation of music therapy. Thus, no parents or caregivers from the unit were present in any interview with the children. Barsnes participated in the interview along with the first author in the cases where she had been the music therapist to make the situation more familiar and relationally safer for the children. When facilitating participation for the children in the interviews, it was particularly important to have a sensitive approach to each child, adapting the questions to their capacities and competencies (Carter & Ford, 2013; Eide & Winger, 2003). One of the children chose not to come to the interview and in the end, seven of the eight children participated in interviews.

### *Data analysis*

A large dose of flexibility is needed when analyzing interviews with children because of the fragmentary nature of this kind of interviews in following the children and their impulses (Irwin & Johnson, 2005). As previously emphasized, it is important to not only listen to what the children say, but equally important to pay attention to what they do and show (Clark, 2005; Ilje-Lien, 2019). With this in mind, the authors chose a narrative approach to the analyses of the interviews informed by portraiture. The analysis was conducted collaboratively by the authors, the constellation referred to below as "we".

Portraiture is a method that seeks to illuminate non-dominant experiences and narratives (Lawrence-Lightfoot & Davis, 1997), allowing for multiple modalities which is crucial when exploring children's perspectives. It is a method of documentation and inquiry used in qualitative research, where "systematic, empirical description" is combined with "aesthetic expression" (Lawrence-Lightfoot & Davis, 1997, p. 3), and where the researcher's voice is everywhere, the voice "is the research instrument" (Lawrence-Lightfoot & Davis, 1997, p. 85). A portraitist listens for a story, actively searching, and is central in the creation of the story. There are five features of portraiture, consisting of context, voice, relationship, emergent themes and aesthetic whole. These features served as a scaffolding in our analysis which took a narrative approach and our narratives are portrait-like displays of episodes. This involved levels of selection, in which we purposively searched for both the typical aspects of each case, but at the same time maximum variations between cases, thus offering cross-cases representation (Coyne, 1997; Patton, 2002; Stake, 2006). The focus in the narratives was on conveying the children's own expressions through thick descriptions (Freeman, 2014; Geertz, 1973).

Following the interviews and the transcription, six steps were completed as part of the analysis process. In the first step we did a thorough exploration of the written data material, with a focus on highlighting emergent themes which appeared through words or actions in the material. In the second step, we returned to the audio material, focusing on the emergent themes found in the first step, listening to the children's voices – their way of expressing the words, what they showed and the music they played, the relationship between the child, the music therapist and the researcher and the context in the different situations. The third step included writing the narratives of the seven different interviews, focusing on the details of the particular situations, and by this, including the whole child with all the various ways they expressed themselves. In this process, the voices of the children and the researchers were blended in a dialogue. In the fourth step the written material went through a thorough process of compaction, with a focus on compiling the various parts together to create a narrative containing the essence of the interview. At this point of the analysis an external person, a poet, was consulted to give feedback on the aesthetic whole of the narratives. The fifth step was a translation from Norwegian to English, focusing on trying to preserve the various literary qualities of the narratives. In the sixth step we made a selection of four of the seven narratives to be displayed in this article, focusing on rich nuances and variation in content across the cases that were selected. This selection of cases offered the opportunity to go more into depth of the particular cases, but still represent the variations and the whole of the seven different interviews.

## Findings

The findings are displayed through the four narratives presented below. Through these narratives, children's experiences of music therapy in mental health care at the hospital are portrayed, showing a varied picture of experiences expressed through modalities such as drawing, words, music, silence, movements and gestures. The children's opportunities to express themselves through different modalities in the context of the interview, as well as the narrative approach informed by portraiture in the analyzing process, provided a good foundation for the children to express themselves and to let their expressions be visible and heard. In the verbal display of these episodes, we chose to use "I" to make visible the first author's personal participation and to give these narratives an identifiable narrator. By using our own voice in composing these narratives, the story came to life. The children's perspectives and expressions were seen and interpreted through the researchers' point of view, as music therapists, adults and researchers, and this will always be important to keep in mind.

The four narratives that will be presented are based on the four interviews with "Kristin", "Tone", "Fredrik" and "Dina". The children's names were changed to protect their identities. When listening to the children we observed, through what they did and through what they said, their experiences of being at the hospital and participating in music therapy. The children's repertoire of ways of expressing themselves helped us to understand their experiences, by observing not only their words in the interviews, but also how they told us what they told us – the volume and dynamics of how they talked and how they breathed. Furthermore, they communicated to us through playing songs they had made, through how they played the instruments, through their improvisations, their drawings and their engagement or lack thereof. All of these parts of the repertoire, and much more, were important parts of the perception of the children's experiences, and this repertoire also clearly showed a great deal of strength and resource in the children. Throughout the process of analysis, the children's use of the word fun became a prominent emergent theme across the cases. The word fun was used in various ways by nearly all the children except for one. It is however not just the vocal utterance that gave meaning to this word, as emphasized above, but just as much what the children did when using this word. The word fun seemed to be a natural way for the children to express their experiences of music therapy, but captured a variety of dimensions.

### *Kristin*

> Kristin calls out into the microphone when she arrives at the music room, "Hello! Hello!". The sound lingers for a while, then it becomes silent. "Whoa, there are two microphones!" she suddenly shouts, discovering an additional microphone in the room. "Yes", I say, sitting down. "Why?" Kristin asks. I suggest it might be because someone else has been in the room. But Kristin is of another opinion, suggesting that it is because she is supposed to sit one way with one of the microphones, and I with the other one, and then she sits down with her back to me. I ask if Kristin remembers anything of what she and I have done together in the music therapy sessions. "Mmm", Kristin says cautiously. Then there is a long moment of silence between us. "We have played music", Kristin says. "Yes", I answer, following up asking her if she has played any instruments. Kristin responds with a quick and clear "yes". "Yes, we have. And we have also played a particular song quite a bit, haven't we?" I ask. Kristin gets up, heading for the computer. She clicks and writes a while before she finds a song from a film from which we have played many songs together. Kristin puts on the song and we watch the music video together. "I wonder,

how do you think it was to play instruments and sing while you were here at the unit?" Kristin continues clicking and writing on the computer. It's quiet again. "Fun" Kristin says after a little while. I point at the crayons, and say that Kristin may draw, if she wants to. Kristin says, "Yes", and starts to draw immediately. She is concentrated on drawing for a long time. I occasionally ask some questions, but it is completely silent while she draws. She sometimes goes back and forth to the computer where the photo of a girl from the music video is displayed. The girl is the one who sings the song that Kristin and I have played a lot together during the sessions.

Kristin is an active child. She was engaged throughout the music therapy process singing and dancing, and one of the focuses throughout these sessions was to build a relationship in a safe environment, and observe this process. In the narrative above Kristin showed creativity and curiosity when meeting unexpected things, and she answered enthusiastically when asked if she had played any instruments. It seemed that Kristin sometimes let the silence speak for itself, and sometimes it looked like the silence gave her time to think through the answers. When drawing, the silence seemed to occur because she was occupied drawing, and the drawing itself could be interpreted as an answer of her experiences of music therapy. Kristin expressed that music therapy is fun, and then she turned over to the drawing, staying silent for a long time, drawing the girl from the songs she and the music therapist had played together. Our experience is that Kristin's expression of fun pointed to the relational aspect of what she and the music therapist had done together in these sessions.

### *Tone*

Tone, Anita and I sit together in the music room. The rain is hammering down outside the narrow window, like a gap in the wall. "I'm wondering, do you remember what you did in these sessions?" I ask, and Tone answers right away. "I have eeh. . . played some drums. . . and the piano, and I have also made some songs on Garage band." "Yes. Cool! Did you like it then?" I ask. "Yes" Tone answers quickly. "Mmm. Is there something you have liked best?" I ask curiously. "That", she says, pointing at the computer. "Garage band?" I ask. "Yes", Tone answers. "Mmm. Have you made the songs then?" "Yeees, I'm making my fourth song now" Tone says, alittle proud. "Fourth song?!" I say impressed. "Whoa! And then it's like. . . have you brought the music with you too?" "Yes, I got two songs on a CD, but I was not happy with just two songs, so then I will get these two songs, plus some others that I will make, all of them, on a new CD" she says enthusiastically. "Aaa, how cool! Sounds really cool" I say, smiling.

"Is there anything special you would like to talk about from these sessions?" I look at Tone. "Mmm . . . no" she answers. Then it is quiet between us. "But how did you think it was then, to play while you were here at the unit?" I ask. "Mmm, fun" says Tone, with a smile in her voice. I ask why she thinks it was fun. "Because there are a lot of instruments here and then . . . show those songs on that and . . . " Tone answers softly and points at the piano. "Yes, which you knew from before?" I ask. "Yes" Tone answers loud and clear.

"Would you show Guro how you do it? How you find different sounds in the program?" Anita looks at Tone who is working at the music program on the computer. "Yes, it's like that: here you can choose an instrument like, for example, now it's on bass . . . And then you can put it on so that you can hear them". Tone turns on the sound and continues to show how she puts together the different sounds in the program. "And then you make a song like that" she says and puts on the song once more.

Before starting with music therapy, there was an insecurity about how Tone would cope with so many new things and impressions, as she needed predictability and safe environments to be in. However, throughout the music therapy process she was engaged playing music together with Anita in a safe setting, spending a lot of time

making songs at the computer. In the narrative above, Tone showed a lot of joy and pride when she enthusiastically told us about the songs she had made and let us listen to them. She also showed great self-confidence and seemed to feel capable when she showed how she made the songs. Tone answered fun when asked how she thought it was to play instruments at the hospital, elaborating this with "because there are a lot of instruments here and then . . . ", pointing at the piano, "show those songs on that". We experience that Tone's expression of fun both pointed to a joy of having the opportunity to try out different instruments and making new songs at the computer, as well as the opportunity to show what she knew from before and what she had learned at the hospital, connecting the two worlds at and outside of the hospital.

### *Fredrik*

Fredrik plays a fragile melody on the piano. "Do you remember which instruments you have played in these sessions?" I ask while he continues to play. "I have . . . played ukulele" he says after a while, and emphasizes the answer with two hard notes on the piano [bambam!]. "Electric guitar" [bambam!], "two electric pianos" [bambam!]. "What do you think about playing these different instruments?" I almost shout through the music. "It was fun", Fredrik answers.

Fredrik strikes the strings on the guitar a couple of times and the notes linger. "Is there anything from these sessions that you would like to talk about?" I ask as the sound from the guitar fades out. Fredrik strikes the guitar again, a little rhythm on all the strings, while I send a new question through the notes "and which you remember particularly well?" The music from the guitar lingers, and Fredrik says "no" and starts to play again. "Nothing I remember particularly well" he says and starts to explore playing fingerstyle on the guitar. "Wasn't there anything you thought was extra nice?" I ask, and the flimsy notes sing next to it. "No" Fredrik answers quickly, but as I take a breath to ask the next question, he exclaims: "Well, yes, the first day you were here." "The first day?" I say, and for a moment it is completely silent. "What was the nicest, or what made it nice?" I ask. "Eeh . . . because that was when I actually . . . by the way, today I actually want to *learn* music!" Fredrik says enthusiastically and starts playing the guitar again. "Mhm. I can show you a little" I answer. "But, what was it you said, in the first session it was the first time you . . . ?" "I started to actually *know music*" Fredrik emphasizes the last two words. "Yes? To actually know music?" I ask. Fredrik answers "yes", and strikes his fingers over the guitar several times. "I actually want a guitar. I have always wanted to play guitar", he says as he explores the sounds on the guitar further. "Yes," I say curiously. Fredrik plays louder and louder on the guitar. "But how did you think it was to play while you were here then, while you were in the hospital?" I ask through the loud sound. "It was the only time I've ever played," he says, putting down his guitar. Fredrik hangs up the guitar and starts looking for other instruments in the room.

Fredrik has found a ukulele and plays three notes in a row over and over again, a slow triad that after a while goes a little faster. "Do you think it is different to play music than to talk?" I raise my voice so Fredrik can hear me through the music. "Yes, it . . . is very different" he says and continues to play the three notes. "Is it possible to say something about how it is different?" I ask and barely hear Fredrik's answer through the ukulele tones. "Eeh . . . it's not possible to say." "But it was very different?" I ask again. "Yes," he says as he continues to play the same notes. A fourth note has gradually also been added to the pattern. "Do you think it is possible that music sounds like different things?" I ask, and Fredrik quickly answers "yes" through the ukulele notes. I ask if Fredrik can remember when he and I played the piano and improvised together. "Mhm" Fredrik answers and goes from playing the quartet to striking all the strings on the ukulele. "And then you said you thought it sounded sad? Do you think that if you are sad one day it will be possible to make a melody, for example, that sounds sad?" I ask, and Fredrik stops playing. "Yes, we can . . . speak emotions too" he says and starts to play again.

Fredrik participated enthusiastically throughout the music therapy process, and he expressed a great joy when presented with the opportunity to play music. Fredrik showed a sense of capability when he said he started "to actually know music", as well as expressing this through the words "it was the only time I've ever played". This also showed Fredrik's experience of taking part in the music, and he seemed motivated to continue this experience in his desire for a new guitar. Fredrik demonstrated that music can be another way of expressing himself when he played music throughout the entire interview, emphasizing words with music and exploring various musical sounds. He also demonstrated this when talking about how playing music was very different from talking, and that music could "speak emotions". Fredrik used the dynamics of the music, and the silence in the music highlighted some answers that seemed to be of particular importance. Fredrik said "it was fun" when asked how he thought it was to play the various instruments. Our experience is that Fredrik's expression of fun pointed to the opportunity to play music and the experience of expressing oneself through music.

### *Dina*

> Dina and I play together. Both of us play guitar, and I sing. It's a song Dina and I have played together a lot. "I am wondering if you remember what we have done in these sessions?" I ask when we've finished playing the song. Dina's guitar is still in her lap, and I hang it up while I wait for an answer. "Drum, guitar and piano". Dina lists the three instruments. "What did you like best? Or did you like any of it?" "The guitar" Dina answers firmly, and I repeat. "The guitar. Why?" "I don't know, it was just fun", Dina says smiling. "Yes" I say, and Dina adds that "it was a little too much with all those grips". "Yes. But you learned it very fast" I respond. "Yes" Dina says proud. "Did you like some songs better than others?" I ask, and Dina laughs a little. "That one eeh . . . which we just played." "Yes. "Beat it"?" I ask. "Because it was . . . there were so few chords." Dina says laughing.
>
> "How do you think it was, then, to play while you were here, at the unit?" It's quiet for a while before Dina carefully answers. "It was fun." Then it's quiet again. "Why did you think it was fun then? What was fun?" I ask, and Dina takes a deep breath. "A bit of everything" she says. "Yes." It's quiet for a while. "If it was possible, would you like to continue with music therapy? With a different music therapist, not me, after . . . " "Yes", Dina says quickly as I talk " . . . you come home from the unit?" I continue. "Yes" she says again. "Yes? Why would you want to continue then?" I ask further. "I don't know, it's so fun playing" Dina says with laughter in her voice, striking a blow on the cymbal.
>
> "Is there anything else you want to talk about from these sessions, or anything you have thought of that you want to say?" It's a silence between us. Dina takes a deep breath. "I just want to say that it has been fun h . . . having you" she says quickly.

Dina had a very turbulent situation back home, and during the music therapy process, she started to learn the guitar and showed a great motivation for this. Dina also seemed to develop a good relationship with the music therapist where she felt safe. In the narrative above, Dina showed and expressed a great sense of capability at the guitar when she was met at her level and needs. She also showed a joy in several of her answers. In the many silent moments, Dina seemed to carefully consider her response, and she seemed to be confident in the silence. Dina used the term fun several times during the interview. On the question why she liked to play the guitar, Dina answered "I don't know, it was just fun", explaining afterward that she liked best to play the songs with few chords. When asked how she thought it was to play at the hospital, she answered "it was fun", and on the follow-up question about what she thought was fun,

she answered "a bit of everything". Dina also answered "it's so fun playing" as the reason why she would like to continue with music therapy after leaving the hospital. When asked if there was anything else she wanted to talk about, Dina said "it has been fun h . . . having you". The silence and the way she took a deep breath just before she said this, made it seem that it was difficult for her to express these words. And with her unstable situation back home in mind this also implies a lot more than just the words she said. We experience that Dina used the term fun in various ways, every time with a slightly different meaning, pointing to the sense of capability to play, to the feeling of merely being in the music, the feeling of playing instruments, as well as the feeling of playing together with the music therapist.

As previously mentioned, in the interview with six of the seven children, the word fun was used repeatedly when talking about what they did and experienced in music therapy. Kato, not presented above, was the only one of the children that didn't use this word. Also, he did not participate in all of the music therapy sessions, and he was not sure if he wanted to participate in the interview. According to his mother, Kato often faced challenges this way, cutting out activities, and this might also have been the case here. However, it is important to keep in mind that Kato's choice not to participate in music therapy may alternatively reflect that he did just not like music therapy. Kristian and Ellen, not presented above either, used the word fun. Kristian's expression of fun pointed to, and was emphasized by, the joy he also showed in playing music during the interview. Our experience is that Ellen's expression of fun pointed to a great joy in participating through music, expressing inner movements, and sense of capability through playing and dancing.

## Discussion

In this study, we explored young children's experiences of music therapy offered as part of their treatment in a mental health care unit. Through the narratives presented we have displayed diverse experiences communicated in the interviews through actions and play as much as words. It was a great motivation for this research to bring children's perspectives to the table when exploring the meaning and usefulness of music therapy in the context of children's mental health care. Furthermore, to regain children's epistemic justice in such a context of research. In the discussion of our findings, we focus on the dimensions of fun as an emergent theme, a common thread across the interviews. On a critical note, the children's repeated use of the word fun might be taken to point toward a lack of lingual nuances in the interview material, and thus in the children's ability to convey their experiences. This may call into question the value and competence of the statements in terms of epistemic value. Hence, our discussion will focus on the multidimensional meaning of fun expressed by the children, as a significant and valuable contribution.

### *Dimensions of fun*

Some of the children connected the term fun to a description, "it's fun because . . . ", others used the word fun without further explanation. However, more importantly, their showing might help us entangle various dimensions of the meaning of fun. In this context of exploring children's experiences of music therapy in mental health care at the hospital, the term fun seems to contain various dimensions, yet all of them situated

in a range of positive emotions. One reason for this might be that children's vocabulary is not fully developed, depending on their age and level of development (Vogl, 2015), and that fun is a word which children use with ease due to a difficulty in putting things into words. This, however, does not imply we should not pay attention to the word fun, but rather the opposite. The children seemed to use the word as a container of experiences, with rich variations and multiple meanings. Also, when giving thorough attention to this word and what the children did before, after and while they spoke, we can discover dimensions that they may not be able to express through words. This again emphasizes the importance of including the different modalities in children's expression and see the whole picture when listening to the children.

## The significance of fun

Experiences of *fun* in the context of a children's hospital could be of great importance. *Fun* as in a joy to play, as something relational, as the creation of music, as a bridge between home and hospital, as a sense of capability, as expressions through music – all of these dimensions tell us something about how music therapy might be experienced as a place to be free for the children in this context. It also demonstrates how it can be an important motivation in the treatment process, as well as the importance of it being a *fun* part of this process. Thus, when music therapy is *fun* it might involve experiences of enablement, communication through other modalities than words, relations, experiences that are therapeutically useful in a treatment context. The main feature of music therapy for these children seems to be that music therapy is *fun*. Moments of *fun* for children in the hospital may resemble more normal aspects of everyday life, such as play. Play has been considered as central in children's development (Johns & Svendsen, 2012; Winnicott, 1971), and Article 31 in the CRC (UN General Assembly, 1989) highlights the right to engage in play. In a comment to that article, the Committee on the Rights of the Child (2013) emphasizes how essential play is for children's wellbeing and health. The committee also underlines how play promotes imagination, self-efficacy, self-confidence, the development of creativity, as well as cognitive, physical, emotional and social skills and strength. It is natural for children to express, regulate, integrate, reconstruct and recreate emotions through play (Johns & Svendsen, 2012), and it is recommended in guidelines for psychotherapy with children to use play as an approach to get the children involved in conversation (Lund & Sørbye, 2019). Play is the child's language, and the therapist's ability to engage in children's play, and help them to regulate and express emotions, affects the therapeutic aspect of play (Johns & Svendsen, 2012). Depending on the therapist's theoretical approach, the significance of play in therapeutic processes is emphasized differently (Johns & Svendsen, 2012). However, the strong emphasis on *fun* in the children's expressions points toward the developmental and therapeutic importance of play for children regardless of the therapeutic approach.

*Fun* is not something that just suddenly happens in music therapy, but arises due to the great efforts of both the child and the music therapist. Music therapists have a unique ability to engage in children's play, attuning to each other through music (Stern et al., 1985; Trevarthen & Malloch, 2000), using other modalities than words, as previously emphasized as crucial in communication with children, such as sound and gestures to

build relationship (Trevarthen & Malloch, 2000). This provides a good foundation for the therapeutic relationship between the music therapist and the child, and it is clear that both the child and the music therapist are active participants in the music therapy process (Rolvsjord, 2015; Stige, 2006a). This participation strengthens an equal collaboration between the two, and such a collaboration is of great importance in making the therapy work (Rolvsjord, 2010). Given the children's positive experiences of music therapy as something *fun*, we may suggest that music therapy might help children grasping with the situation of being in a hospital by bringing normalcy and play (Vernisie, 2015). Also, they may have appreciated and been more at ease with expressing emotions through music, in contrast to children's potential difficulties in conveying feelings through words. Further, that these experiences of *fun* imply therapeutic useful experiences that provides relational competency, learning, motivation and interest. Thus, in our understanding of children's experiences of music therapy of something *fun* should not be taken to mean that music therapy is experienced as mere "entertainment". Rather, it represents therapeutic potential that aligns with children's natural potentials for development (Aasgard, 2002; Turry, 1999). Having *fun* can be of existential importance (Aasgard, 2002), and is not something that can be ignored in therapy work with children. With reference to positive psychology, Vestad (2013) explores how positive emotions in music with children might be important in the moment as well as in contributing to good health in the future. Joy and pleasure have traditionally been treated ambivalently in music therapy literature (Rolvsjord, 2010; Stige, 2006b), and a way to deal with "the problem of pleasure" is to "take an interest in how pleasure is expressed or experienced by each client" (Stige, 2006b, p. 50). Through perceiving the experiences of each of the children participating in this study, focusing on the various ways of expressions, multidimensional meaning of *fun* emerged. The nuances beyond the lingual in addition to the verbal words prove to be important in perceiving what the children convey, and thus in regaining children's epistemic justice in the context of research. The children expressed themselves through gestures, music, words, drawing, silence and movements, and based on their experiences, we argue that *fun* – the multi-dimensional meaning of the word – is an essential part of music therapy in mental health care with children.

### *Strengths and limitations*

Interviews with children are challenging, yet the research area of music therapy with children in mental health care needs the perspectives of the children. Thus, doing interviews with children highlights the strengths and the limitations of this research article. As previously discussed, children show as much as they say, which complicates the very idea of interviews with children. Perhaps an even greater awareness ahead of the interviews about how children communicate through other modalities could have added more scope to the data collection. Video recordings could also have offered more possibilities for accuracy regarding micro-levels of "showing". At the outset of the study our main ethical concerns considered how the act of video recording the sessions could affect the interaction. However, our choice of interviews was specifically chosen with the intention of making the children's perspectives visible, and we argue that there are a lot of important statements from the children in the interviews, both verbally, bodily, creatively and musically, that become visible through the narratives.

### *In conclusion*

This study contributes to the body of research a qualitative exploration of children's own experiences whereby previous research in the field of music therapy with children in mental health care has mainly been quantitative studies. In this article, the children's own expressions and perspectives have been displayed in narratives informed by portraiture. When interpreting the children's expressions, it has been crucial to include the various modalities children use when expressing themselves. In the narratives the word fun became significant across the different cases and used as a container of experiences with multiple meanings. When exploring the dimensions of fun in the children's various expressions, fun is understood as a joy to play, as a sense of capability, as expressions through music, as the creation of music, as a bridge between home and hospital and as a relational phenomenon. The context of the children's experiences – the unfamiliar hospital surroundings and complex challenges – is important to keep in mind and adds even another dimension to their experiences of music therapy as fun. We argue that fun is an essential part of music therapy in mental health care with children, not as mere entertainment, but as something of existential importance with great therapeutic potentials. Children's stories are important and through listening to and interpreting the children's own perspectives, we expand our knowledge in the field of music therapy in mental health care.

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