The groove of recovery

A qualitative study of how people diagnosed with psychosis experience music therapy

Hans Petter Solli

Dissertation for the degree of philosophiae doctor (PhD)
at the University of Bergen

2014

Dissertation date: 25.11.2014

Scientific environment

This PhD-project is a shared enterprise between Lovisenberg Diakonale Hospital and The Grieg Academy Music Therapy Research Centre (GAMUT) at The Grieg Academy-Department of Music at the University of Bergen. The project has been financially supported by the Norwegian ExtraFoundation for Health and Rehabilitation through EXTRA funds, administrated through the Norwegian Council for Mental Health. In addition, Lovisenberg Diakonale Hospital funded the first five months of the project.

Acknowledgments

First of all I want to thank all the participants who said yes to share their experiences and stories with me in this study - I hope I have treated your contributions with the respect that they deserve. Then I want to express my deepest thanks to my supervisor Randi Rolvsjord who has guided me steadily through all the phases of this project. Your enthusiasm, positivism, generosity, wisdom and kindness have been of invaluable help on this long and winding road of completing my thesis. I also want to thank Brynjulf Stige for longstanding support and for helping me with the project proposal. I want to thank all the great people at GAMUT for collegial support and helpful feedback on my texts - in particular Lars Tuastad and Viggo Krüger for being my PhD-buddies and Rune Rolvsjord for graphical assistance. I want to thank Marit Borg for sharing your knowledge about recovery and for arranging the reference group meeting at HiBU. I also want to thank Lars Ole Bonde for valuable feedback on the preliminary Viva Voce Examination. At Lovisenberg Diakonale Hospital many people have supported me and contributed in making this PhD project come real. I especially want to thank Bjørn Holm, Kirsten Bugge Bjørnå, John E. Berg, Anne-Mari Bakøy and Trond Noddeland for their genuine support and practical organization all these years; Aina Rytterseveen Johansen for clinical supervision, ethical advices and an always open door; Kristin Østlie for clinical supervision and uplifting PhD lunches; my very dear colleagues at the FEM-gruppa and all the rest of the beautiful people working there. At the Norwegian Council of Mental Health I want to thank Charlotte Elvedal for keeping track of the project finances. I also want to thank the Melbourne group who generously hosted my research stay: Denise Grocke, Katarina McFerran, Emma O'Brian, and the rest at NaMTRU. I owe lots of thanks to the people who have helped me with the English language: Alison Ledger, Kenneth Hognestad, Martin Cavanagh, Maury Saslaff, Simon Procter and Simon Gilbertson. Warm thanks to my my mother and father for your unconditional love and support. Finally, I want to give love and lots of thanks to my dear wife Elin and my two wonderful children Ella Marie and Øyvind for contributing to making this project possible in your own unique ways.

Abstract

An understanding of recovery as a personal and social process has emerged within mental health systems, and is increasingly shaping international mental health policy and practice. In this critical and user-oriented perspective, recovery is understood as a way of living a meaningful, hopeful and contributory life, despite the limitations caused by illness, with the primary job of mental health professionals being to support these processes of change. The recovery perspective has to a small degree been explored in relation to music therapy, and implications for practice have only been vaguely described.

The primary aim of this study was to explore the user perspective of people diagnosed with psychosis in order to understand how music and music therapy can contribute to the processes of recovery. A qualitative case study methodology was chosen as a framework, and a hermeneutical-phenomenological approach was utilized in order to understand participants' experiences of music therapy. In addition, a qualitative meta-synthesis of previous studies containing first-person accounts was conducted. The findings in this thesis are presented in three articles.

The first article presents the meta-synthesis, and discusses the results in relation to the theory of mental health recovery. Through a systematic literature review, 14 studies containing first-hand accounts of participants' experiences with music therapy were identified. From the synthesis, a taxonomy of four areas of users' experiences was identified: (1) Having a good time, (2) Being together, (3) Feeling, and (4) Being someone. Music therapy's possible role in supporting the recovery processes of the person, and as part of recovery-oriented mental health services, were discussed.

The second article is a multiple case study based on participatory observation and qualitative interviews of nine inpatients diagnosed and hospitalized at a psychiatric intensive care unit. The data were analysed using IPA (interpretative phenomenological analysis), and resulted in the development of a taxonomy of four super-ordinate themes: (1) Freedom, (2) Contact, (3) Well-being, and (4) Symptom relief. Mental health recovery, positive mental health and agency were proposed to constitute an appropriate framework for music therapy in mental health care.

The third article is a single case study of a young man's experiences of music therapy and the progressing processes of recovery. This was achieved by means of a qualitative case study that featured a description of the music therapeutic process based on participatory observation, alongside first-hand accounts of the participant's subjective experiences gathered from interviews. The data were analysed using interpretative phenomenological analysis (IPA), and the presentation has a narrative form. The discussion highlights music therapy's possibilities to afford agency and empowerment, promote a positive identity, develop positive relationships and expand social networks.

The findings of the three articles are discussed in relation to established theory research and practice. Primary findings include that: music therapy was primarily experienced in relation to aspects of positive mental health and well-being and only occasionally in terms of symptom remission, music therapy supported the processes of recovery by affording a therapeutic and social arena that promoted participants' agency and music therapy supported processes of recovery across multiple contexts in the participants' lives.

List of publications

Paper 1:

Solli, H. P., Rolvsjord, R., & Borg, M. (2013). Toward understanding music therapy as a recovery-oriented practice within mental health care: a meta-synthesis of service users' experiences. *Journal of Music Therapy, 50*(4), 244–273. doi: 10.1093/jmt/50.4.244

Paper 2:

Solli, H. P., & Rolvsjord, R. (2014). "The opposite of treatment": a qualitative study of how patients diagnosed with psychosis experience music therapy. *Nordic Journal of Music Therapy*. Advance online publication. doi: 10.1080/08098131.2014.890639

Paper 3:

Solli, H. P. (2014). Battling illness with wellness: a qualitative case study of a young rapper's experiences with music therapy. *Nordic Journal of Music Therapy*. Advance online publication. doi:10.1080/08098131.2014.907334

Table of contents

1. Introduction

1.1 Personal context

My first encounter with a "mad" person took place when I was about nine years old. I was travelling into town with my mother when a woman with an intense coloured lip stick entered the bus and started chatting loudly with herself as if she was talking to an imaginary friend. She was the most unusual person I had ever seen, odd and peculiar, and a little scary for a nine year old. But I also remember being fascinated by how she brought life and laughter into the sleepy morning bus. Later, I heard that she was "one of the mad", one of those who were locked inside the huge hospital building where the bus always stopped. Later, in the schoolyard, I even heard a song about how crazy patients like her sometimes escaped through a hole in the fence.

The summer I turned 20 I was offered a summer job as a nurse assistant at that very same hospital. I got to meet and know the patients from the inside of the buildings, though at first I was a little frightened by this strange and unknown world. However, I soon discovered how these people were not as different from me as they seemed, and when I got to know their life stories it was easier to understand their often strange behaviour and why their life had become so troublesome. I remember that I was particularly fascinated by how conversations about music often broke the ice and how many of the patients became more relaxed, open and sharing during such music discussions. Listening to music, playing guitar and singing together with the patients became my favourite activity. These musical encounters made the work so meaningful and rewarding that for the next six years I continued to work summer- and weekend jobs at different psychiatric hospitals.

Nonetheless, during these years, the positive encounters stood in strong contrast to how I experienced the focus of the psychiatric treatment as a whole. Although we all had good intentions and wanted to help the patients, the heavy focus on the diagnosis, symptoms, problems and treatment did not seem to serve all the patients well, leaving little time for getting to know and support the healthier sides of the persons. The worst part was the forceful treatment procedures I had to assist, as

overpowering angry or chaotic patients, forcing them into the isolation room or the locking bed, or holding them down as forced medication was given. Even though these actions could most often be justified as necessary in order to avoid the person or someone else getting seriously injured (and it was probably sometimes a lifesaving act) these episodes were extremely challenging from an ethical point of view, and often devastating for the alliance.

This mix of both meaningful musical and non-musical encounters on the one side, and a growing recognition of psychiatry's limitations regarding possibilities for promoting a better life for its patients on the other, woke a political and social engagement in me, which was an important motivational factor for becoming a music therapist. After I completed my training in 2001, I started working as a music therapist at Lovisenberg Diakonale Hospital in a psychiatric intensive care unit, which is the context of the present study. As a music therapist with my own music room and loads of instruments available, my presumption of music's positive connections to health and well-being was further confirmed. I also continued to experience how many persons with severe mental illness were able to talk about their experiences in surprisingly coherent and meaningful ways. These two insights from the practice field of music therapy conceived the ideas of the present PhD thesis.

1.2 Academic context

The study builds on current developments in mental health care, and aims to contribute to current requests for knowledge in this field. In international literature, concerns have been expressed about the quality of mental health services (Antoniou, 2007; Bentall, 2003; Deegan, 1996a; Healthcare commission, 2005; Slade, 2009; Williams, 2012). Hence, there was a request for new, more humane and more effective approaches to treatment, as well as care and support for people with severe mental illness (Bentall, 2009; Bracken & Thomas, 2005; Fledderus, Bohlmeijer, Smit, & Westerhof, 2010; Sarris, Glick, Hoenders, Duffy, & Lake, 2014; Wilken, 2007). In particular, there was a request for practices that are resource-oriented, convey hope, and that promote well-being and social inclusion (Herrman, Saxena, & Moodie, 2005;

Priebe, Omer, Giacco, & Slade, 2014; Repper & Perkins, 2003; Slade, 2009, 2010). This can be understood as an invitation to new or current peripheral approaches to treatment, therapy or service into a field of practice previously dominated by representatives from a medical and deficit-oriented perspective.

Music therapy can be seen as one response to this invitation, with the positive effects of music therapy having been documented in relation to diagnostic conditions such as schizophrenia and psychosis (Mössler, Chen, Heldal, & Gold, 2012), the wider group of people with serious mental disorders (Gold, Solli, Krüger, & Lie, 2009; Grocke et al., 2013) and mental health care clients with a low therapy motivation (Gold et al., 2013). This growing base of evidence has been noted by committees of national clinical guidelines, both in Norway and the UK, where music therapy is now recommended as an evidence-based treatment for patients with schizophrenia and psychosis (Directorate of Health, 2012; National Collaborating Centre for Mental Health, 2010).

While quantitative trials in music therapy have grown in number and size (although much more of this type of research is required), few qualitative research studies exploring first-hand accounts of people with psychosis have been conducted (Solli, Rolvsjord, & Borg, 2013). This seems to reflect a missing research focus in mental health in general, in which subjective experiences of treatment and therapy have received a limited amount of attention (Jenkins & Barrett, 2004; Messari & Hallam, 2003; Rennie, 1994; Strauss, 1989, 2008). Additionally, McLeod (2001a) alerts about a growing gap between research and therapy practice, making it difficult for practitioners to utilize research findings in their practical work. More specifically, there has been a lack of studies illuminating various ways of supporting the processes of empowerment and agency. Hence, McLeod calls for more critical research in the form of small-scale practitioner studies and experiential studies in which the researcher is present as a witness to the therapeutic process.

In summary, the present study should be seen as a response to the request for knowledge about how mental health care practices can contribute to helping people diagnosed with psychosis to lead a better life (what will later be described as recovery). Closely related to this, it is a response to the lack of exploration of the user-perspective

in mental health care in general, and in music therapy in particular. Lastly, this study can be seen as a response to the request for critical and practice-relevant research. This situates this study in an interdisciplinary discourse of the fields of psychiatry, mental health care, psychology, sociology and music therapy.

2. Theoretical background

2.1. Psychosis

The areas of human experience that will be the centre of attention in this study have been referred to by different terms such as *madness*, *schizophrenia* and *psychosis*. These terms refer to a state in which people start to have unusual perceptions, ideas and experiences that are neither shared nor endorsed by other people. This often includes phenomena such as hearing and seeing things that no one else does, in addition to holding beliefs that are not based in common reason or sound evidence (Geekie & Read, 2009). Schizophrenia and psychosis are both medical terms, and are often used interchangeably to describe the same phenomena.

The term *schizophrenia*[1] is a rather clearly defined term that has traditionally been preferred by clinicians for diagnostic work. Today, the most used operational definition of schizophrenia can be found in the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013). Here, schizophrenia is defined as the presence of two or more of the following symptoms: delusions, hallucinations, disorganized speech and behaviour, and other symptoms that cause social or occupational dysfunction. Furthermore, the symptoms must have been present for at least six months in order to fulfil the criteria of the diagnosis. Similar criteria, although with some significant differences[2], are presented in the WHO's diagnostic manual, ICD-10 (International Classification of Diseases World Health

[1] The term was first used by Swiss psychiatrist Eugene Bleuer (1857-1939) in 1908, building on Emil Kraepelin's (1856-1926) work with the diagnosis dementia praecox (Bentall, 2003).
[2] These differences are related to duration of symptoms, requirement of social/occupational dysfunction and subtypes and course specifiers (Tandon et al,, 2013).

Organization, 1992), which is the official classification system in Norway. Here, the diagnosis of schizophrenia is built on clusters of symptoms related to deteriorating and impaired functioning, as well as to persistent psychotic symptoms.

The term *psychosis* is a more loosely defined term than schizophrenia, with no single clear-cut operational definition. It has traditionally been used to refer to states of being out of touch with reality and being non-understandable. This looseness of the use of the term "psychosis" is a quality that has been embraced by researchers and clinicians who are sceptical of a diagnostic approach to treatment (Geekie & Read, 2009). It has been argued that the use of the term psychosis it less pejorative and stigmatizing than the term schizophrenia (British Psychological Society, 2000).

However, I am aware that using the (professionally defined) term psychosis in a research project that aims to explore users' own experiences, and which is grounded in a humanistic and resource-oriented context, can be regarded as being contradictory. In accordance with Geekie (2007), I will claim that this is a tension that is impossible to completely avoid in a project such as this. A common criticism of a pathological discourse is that it fails to include the person's life circumstances, and because symptoms are identified as qualities of the individual person, this leads to increased stigmatization and exclusion (Read, 2004; Repper & Perkins, 2003). In contrast, in the context in which this study was conducted, a psychiatric hospital, the professionals use diagnostic categories as a way of communicating and structuring the work, and many of the participants in this study were also familiar with the use of such categories. Thus, by choosing the term, psychosis, I am aware of the danger of adopting such an individualistic and deficit-oriented focus. Nevertheless, I will use psychosis as an umbrella term in this thesis, understood as unusual perceptions and unusual beliefs, which are often perceived by other people as being out of touch with reality.

The lifetime prevalence of all psychotic disorders has been found to be up to 3.5%, and between 0.7-1% for schizophrenia (Perälä et al., 2007; Tandon, Keshavan, & Nasrallah, 2008a), with these conditions being connected to huge expenses for health services worldwide (Johannessen, 2002). There is no overall agreement of the etiology and pathophysiology of schizophrenia, and available treatments are only modestly effective (Bentall, 2009; Tandon, Keshavan, & Nasrallah, 2008b).The closest thing to

a consensus of what causes schizophrenia is an attempt to integrate psychological, social and biological factors in what has been called the *stress-vulnerability model* (British Psychological Society, 2000). This model was first described by Meehl (1962), who proposed that contributions from both vulnerability and stress factors are important. Recent findings that illuminate the social determinants of psychosis indicate that childhood adversity and trauma are substantially associated with this condition (Varese et al., 2012). There is some, though more uncertain, evidence, which show positive associations between adult life events at the onset of psychotic disorder and psychotic experiences (Beards et al., 2013). Further risk factors associated with the development of schizophrenia are an upbringing in urbanized areas (Pedersen & Mortensen, 2001), a family history of migration (Cantor-Graae & Selten, 2005) and the use of cannabis (Arseneault, Cannon, Witton, & Murray, 2007).

A growing body of evidence shows that psychotic experiences are on a continuum with normality, meaning that unusual experiences are not necessarily noxious, and that such experiences can also be adaptive and life-enhancing (British Psychological Society, 2000). This knowledge contributes to normalizing some aspects of psychosis, while also disposing of some of the beliefs and myths connected to severe mental illness. However, albeit with the reservations and critique connected to this phenomenon, it is important not to lose sight of the fact that psychosis is a serious and highly distressing condition that causes suffering for many people (Geekie, 2007); therefore, the people affected also need access to the best of what health services can offer.

As there is a lack of evidence for any particular theory of schizophrenia, and there is an absence of consensus among researchers, I find Geekie and Reed's (2009) notion of psychosis as an *essentially contested concept* to be especially fruitful. Their idea of essential contestedness builds on the philosophical work of W. B. Gallie, grounded on the argument that the usage of a term determines its meaning (in Geekie & Reed, 2009, p. 142). They argue that "the disputed nature of the concept [psychosis] is neither accidental, nor transitional, but rather a central component of the very meaning of the concept" (p. 143). A positive implication of this view is that it provides a possibility to meet service users with an open, sensitive and respectful attitude, one that allows both

the person affected and the professional helper to accept the plurality of explanations, and to give the subjective experiences a high value. I will argue that such an open and wondering attitude towards the concept of psychosis was favourable when investigating the first-person perspective, and it also fits well with the theoretical discourse of recovery.[3]

2.2 Recovery

The term "recovery" is a multifaceted concept that has increasingly been used to describe and define goals and purposes for mental health services worldwide (Slade, Amering, & Oades, 2008; Slade, Adams, & O'Hagan, 2012). However, there is a lack of consensus on what recovery means in relation to mental illness and an inconsistency in how the term is used in different countries and settings (Davidson & Roe, 2007; Slade et al., 2012). This is evident, as recovery has been described by the use of a wide range of terms, including an approach, a model, a philosophy, a paradigm, a movement, a vision, a myth (Roberts & Wolfson, 2004), and a perspective (Anthony, 1996). I will mainly refer to recovery as a perspective in this thesis, except when referring to a particular aspect of the term and when referring others work.

The historical roots of recovery can be traced back to humanistic values practiced as a form of psychosocial care in Europe during the period between 1790-1890, which was called moral treatment (originally *traitement morale*) (Davidson, Rakfeldt, & Strauss, 2010). As we see it today, the recovery perspective can be seen as a response to the implementation of the deinstitutionalization policy in the US in the 1950s and 1960s, and the subsequent transformation to community-based mental health services in the 1980s (Adeponle, Whitley, & Kirmayer, 2012). It is important to note that recovery differs radically from earlier anti-psychiatric trends in psychiatry. Recovery started as a movement among users with the aim of improving the collaboration between users and services, while anti-psychiatry emerged as an academic debate critical to the very idea of psychiatric care (Slade, 2009). Against this

[3] The literature about psychosis as an *essentially contested concept* was discovered by the current researcher after the articles had been published, and is therefore not cited therein.

background, Deegan (1996a) speaks of the recovery-movement as a *conspiracy of hope.*[4] She points to a growing development in which case managers, policymakers, health professionals and service users began to join interests and voices, "pressing back against the strong tide of oppression which for centuries has been the legacy of those of us who are labelled with mental illness" (p. 2).

From a sociological and ethnographic viewpoint, Pilgrim (2009) describes recovery as a *polyvalent concept,* proposing that a different usage of the term comes from three main interest groups: traditional bio-medical psychiatrists, social psychiatrists emphasizing social skills training and dissenting service users. These three positions represent differing ontological positions. For the first group, the traditional bio-medical tradition, the term recovery has been used in professionally led research and practice to describe observable and measurable improvement in a patient's condition (Liberman, Kopelowicz, Ventura, & Gutkind, 2002). This understanding of recovery is located within an illness frame of understanding, in which recovery from biologically determined illnesses is a result of treatment, and is expected to be invariant across individuals. The ontological position here is that mental disease exists "out there", and is embodied in the person who is ill (Pilgrim, 2009, p. 484).

In the second group, often found in community-oriented social psychiatry, a diagnosis is regarded as less important. Instead, rehabilitation is focused around limiting psycho-social impairments that are assumed to arise from a range of biological, psychological and social factors. This is done by applying supportive and personally tailored skills training to enable patients to live their life in the community, and to promote the ability to socially integrate. Here, recovery (from impairment) is an outcome of successful rehabilitation.

A problem with the first two understandings of recovery, with their focus on symptoms and normal functioning, is that they represent a mismatch as to how people with mental illness themselves experience living and coping with mental illness (Deegan, 1996a, b; Lauveng, 2012; Read & Reynolds, 1996; Slade, 2009; Topor et al.,

[4] Here, Deegan (1996a) refers to the original meaning of the term *conspiracy*: "breathe the spirit together".

2006). They also lack a contextual understanding of how societal structures serve to promote or impede processes of recovery equal to the critique represented by the social model of disability (Pilgrim, 2013, p. 56). The problem with this individualized view focusing on deficits and functioning is that it leaves patients and users as passive recipients of expert care, something that contributes to stigmatization, disempowerment, social exclusion and hopelessness (Repper & Perkins, 2003; Slade, 2009). Moreover, in relation to research, such a focus causes a limited progress in the development of more effective services for people with severe mental illness (Bentall, 2003, 2009; Priebe, Burns, & Craig, 2013).

The third notion of recovery originates from service users who have demanded freedom from authoritative and coercive services that have conveyed hopelessness, and who have possibly made a claim for self-determination and social inclusion. This understanding of recovery can be framed as a social-existential state in which the users are regarded as "experts by experience", and who are seen as active agents in their own life and recovery process (Pilgrim, 2009). Key factors to recovery (such as respect, freedom, meaning and hope) strongly relate- and contribute to human dignity, and can therefore best be understood in humanistic and existential terms and contexts (Kogstad, Ekeland, & Hummelvoll, 2011). According to Pilgrim (2008), this survival and citizenship understanding of recovery is questionable in relation to the professional accounts to recovery for several reasons:

> An emphasis on diagnosis (a categorical or nomothetic approach to human functioning) is inimical to social-existential formulations (an idiographic or biographical approach). The user emphasis on choice is incompatible with the willingness of psychiatric professionals to continue to defend or even embrace their role as rule enforcers or agents of social control. "Mental health law" and biological psychiatry are seen as opposing this expectation about freedom and biographical sensitivity; they are viewed as an impediment to, not vehicle for, recovery. (p. 300)

To part this last notion of recovery from the two previous, Slade (2009) applies the terms *clinical recovery* versus *personal recovery*, while Davidson and Roe (2007) suggest the notion of recovery *from* mental illness versus recovery *in* mental illness. This way of framing recovery – as *personal* recovery *in* mental illness, and as a social-existential state, includes distinct values, beliefs, practices and terminology, and can

therefore be regarded as a new paradigm of how mental illness and mental health are understood (Onken, Craig, Ridgway, Ralph, & Cook, 2007). It is this third understanding of recovery that is referred to as *recovery* or the *recovery perspective* in this text.

A much cited definition of recovery is the one by Anthony (1993):

> Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness; recovery involves the development of new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness. (p. 7)

In regard to music therapy, it is of special interest to note how this definition focuses upon the person's own strengths and competencies in order to build a positive identity, as well as recovering social roles and relationships that give life a value and meaning. This implies that being engaged in recovery as a process means to pursue and participate actively in meaningful and enjoyable everyday life activities despite the limitations imposed by the disability (Davidson, 2012; Davidson & Roe, 2007).

Personal, structural and social levels of recovery are treated differently by different authors and researchers. In addition to understanding recovery as a personal journey, it is also regarded as being a social process with contextual implications (Repper & Perkins, 2003; Tew et al., 2012; Topor, Borg, Di Girolamo, & Davidson, 2011). From a dimensional analysis of the recovery literature, Onken et al. (2007) argue that recovery must be understood within an ecological framework: "Recovery relies not only on the individual's emerging sense of integrity and purpose (first-order change), but also on society's increasing ability to acknowledge and support that integrity and purpose (second-order change)" (p. 19). Such an ecological understanding of recovery has been searched and applied in this study.

Furthermore, recovery has been linked to- and elaborated upon in relation to a rather large group of related theories and terms, such as empowerment, resilience, quality of life (Amering & Schmolke, 2009; Slade, 2009), well-being, positive psychology and salutogenesis (Clarke, Oades, & Crowe, 2012; Provencher & Keyes, 2013; Resnick & Rosenheck, 2006; Slade, 2010), common factor approach (Davidson & Chan, 2014), and social capital (Repper & Perkins, 2003; Tew, 2013; Tew et al.,

2012). In this regard, recovery and music therapy already have many common theoretical links and similarities.

Although there is no overall consensus as to how recovery should be understood, a systematic review and narrative synthesis conducted by Leamy, Bird, Le Boutillier, Williams and Slade (2011) is much cited, and has also been influential for other work (e.g. Slade et al., 2014; Tew et al., 2012). Leamy et al. (2011) found that recovery processes comprise the following five categories: connectedness, hope and optimism about the future, identity, meaning in life and empowerment (yielding the acronym, CHIME). These categories are suggested as potential "clinical end-points for interventions" (p. 451) that should be interchanged with current clinical end-points such as symptomatology and hospitalization rates.

This overview of the history, various meanings and applications of recovery brings us over to the very source of this term – the first-person perspective.

2.3 The first-person perspective

The various conceptualizations of recovery can be linked to philosophical discussions of an objectivist outsider perspective versus a subjectivist insider perspective[5] (Brown, Rempfer, & Hamera, 2008). It has been claimed that mental health systems generally value knowledge from a biomedical paradigm in psychiatric research and practice, in which a preoccupation with quantitative data in natural science is traditionally preferred against the cost of qualitative inquiries (Bracken & Thomas, 2005; Strauss, 2011). Thus, the first-person perspective of people with mental illness has long been an under-researched field and an undervalued source of knowledge (Bracken & Thomas, 2005; Geekie, Randal, Read, & Lampshire, 2012; Jenkins & Barrett, 2004; Slade, 2009; Strauss, 1989, 2008).

To provide a meta-perspective on the various forms of knowledge, I will now turn to two Norwegian philosophers, Hans Skjervheim and Dag Østerberg. In his critique of positivistic approaches in psychology, Skjervheim (2001) refers to two

[5] This theme has previously been discussed in the candidate's theory of science essay, which was further developed in Solli (2012).

forms of approaching and understanding another person: *participating* and *observing*. He argues that when we have difficulties in understanding another person, or when it is hard to take a person's statements seriously, we tend to take the role of the *observer*. This is an objectivist position, in which we reduce the other person into a fact, a thing in itself that is observed from the outside. Skjervheim argues that this approach alienates the other person and ourselves in relation to her or her or him, so as a consequence we fail to take the other person seriously (2001).

A different position is taken as we start engaging in the other person's opinions and assessments of a case. This is the role of a *participant*, a subjectivist position in which the actions of the other are regarded as intentional, and the approacher and the person in question take part in a threefold relation within the case (Skjervheim, 2001). As I understand Skjervheim, giving some attention to subjectivity in a research study means that a researcher must be participatory, show personal engagement and seek a mutual relationship with the participant. To show genuine interest and respect toward the other person's experiences is an act of empowerment (Malterud, 2010). In relation to the recovery perspective, a participatory approach to research and clinical work is therefore warranted. We will see later how participants experienced the interviews in this study as an empowering situation.

Østerberg (1982) supplements Skjervheim's philosophy by offering the terms *externalist* (utvendighet in Norwegian) and *internalist* (innvendighet in Norwegian) to help understand and gain knowledge about another being.[6] An externalist relationship is characterized by beings who are restricted from each other, and who are looked at separately and independent from each other and independent of their world context. Østerberg exemplifies this with a hypothetic-deductive reasoning, in which a hypothesis is formed and then tested through observation, thereby leading to the development of a rule. On the other hand, in an internalist relationship, the two parts are mutual and inform each other through a dialectic relationship, and cannot be understood independently of their context. Here, the parts are understood through themselves and through the whole, as in a hermeneutic circle. From Østerberg's (1982)

[6] Østerberg also describes a third form of understanding, "identity", which refers to the identical parts in an external relationship.

reasoning, we can derive that studying people diagnosed with psychosis from an externalist perspective alone can provide important but always limited knowledge. Hence, the internalist perspective is necessary in order to capture the contextual and dialectic aspects and nuances of the person being studied. This is also transferable to clinical practice, in which professional helpers with a predominantly externalist perspective will contribute to putting the patient in a role characterized by helplessness, hopelessness and dependence (Norvoll, 2002; Slade, 2009).

Skjervheim's and Østerberg's attention to the intentional, relational and contextual perspective mirrors the recovery perspective, in which first-person accounts of individuals and their life context are seen as vital sources of knowledge. Slade (2009) grounds the epistemological rationale of recovery on the notion of *nomothetic* knowledge (generalized knowledge coming from investigations of a large number of objects, with efforts to derive natural laws) and *idiographic* knowledge (knowledge coming from investigation of the particular, with efforts to understand the meaning of a subjective phenomenon). Psychiatric practice has been criticized for uncritically applying nomothetic knowledge about mental illness (in the form of diagnostic categories or manuals of evidence-based treatment) on individuals without taking into account the individual variations and contextual dependency that characterize mental health problems and processes of recovery (Davidson, 2012, p. 254). Implicit in the recovery perspective is a critique of the dominant scientific paradigms emphasizing the outcomes from studies of larger groups and biomedical parameters, while neglecting the role played by the individual person (Lysaker & Leonhardt, 2012).

It can be argued that the first-person perspective and idiographic knowledge are particularly important for acquiring knowledge about severe mental illness due to their ontological nature. Geekie et al. (2012) argue that psychotic experiences, such as hearing or seeing things that others do not, are phenomena only directly accessible to the person who experiences them, and that first-person accounts of such experiences are the only direct source for knowledge. For this reason, service users' personal narratives are the only way we can access some of the complexity, meaning and depth of peoples' experiences of mental illness and recovery (Bellack & Drapalski, 2012; Jenkins & Barrett, 2004; Messari & Hallam, 2003).

There are also ethical reasons for giving primacy to the first-person perspective. Geekie et al. (2012, p. 2) argue that the historical domination of the outsider perspective has silenced the entire social group of people with severe mental illness, hence being subjected to the perspective of others. Because this group of people has been shielded from the public, with few possibilities of communicating their opinions and experiences, this has negatively contributed to processes of alienation, stigmatization and social exclusion (Repper & Perkins, 2003). Thus, meeting service users with a dominant outsider perspective can be a violation of one of the most important goals of the recovery perspective – to promote a positive identity other than being a person with mental illness (Slade, 2009, p. 83). On the other hand, an increased attention to the first-person perspective contributes to giving a human voice to the people struggling with mental illness, nurturing processes of normalization, social inclusion and empowerment (Malterud, 2010; Slade, 2009).

2.4 Music therapy

The interest for recovery perspectives in music therapy is new, but growing (Chhina, 2004; Grocke, Bloch, & Castle, 2008; Jensen, 2008; Kaser, 2011; Kooij, 2009; Maguire & Merrick, 2013; McCaffrey, Edwards, & Fannon, 2011; Solli, 2009, 2012; Solli & Rolvsjord, 2008). Since the literature review on music therapy and recovery was completed for the first two articles of this thesis, two more texts have been published. Eyre (2013) has written a chapter called "For adults in a recovery model setting", in which she focuses on assessment, methods, procedures and guidelines rather inconsistently linked to certain aspects of mental health recovery. In an effect study of recreational music therapy interventions on mood, Silverman and Rosenow (2013) discuss parts of their findings in relation to the recovery model. The "Recovery model of music therapy" has also been included as an entry in the recent International Dictionary of Music Therapy (Kirkland, 2013), though with reference to a different tradition of recovery than in the current thesis.[7] These various applications of the term

[7] This entry links to Borczon's (1997) work about recovery for people with substance abuse problems.

"recovery" show that the recovery is also used in music therapy to describe different traditions and approaches.

Although the recovery perspective has been peripheral in the theory and research of music therapy, a rather large amount of the theoretical underpinnings of recovery has been elaborated upon in previous music therapy texts. This includes empowerment (Procter, 2002; Rolvsjord, 2004), well-being (Ansdell, 2014; Ansdell & DeNora, 2012; DeNora, 2013), social capital (Procter, 2004, 2011), anti-oppressive practice (Baines, 2013), resource orientation (Rolvsjord, 2010; Ruud, 2010), agency (Ruud, 1998, 2010; Rolvsjord, 2013; Stige & Aarø, 2012), and last but not at least, community orientation and community music therapy (Ansdell, 2002, 2005, 2014; Jampel, 2007; Stige, 2002, 2012a; Stige & Aarø, 2012).

The above list of themes and theories underpinning both the recovery perspective and parts of music therapy illustrates that they largely share a common meta-theoretical understanding of what illness, health and treatment means. It is evident that a humanistic approach to music therapy as described by Ruud (2010) fits particularly well with the perspective of mental health recovery, as he highlights musicking as a source for a better life by being a "provider of vitality; (…) a tool for developing agency and empowerment; a resource or social capital in building social networks; a way of providing meaning and coherence in life" (p. 111). Furthermore, Ruud suggests that music therapy should "not only depart from explanations of illness and treatment based upon dysfunction of the clients, but builds upon and cooperates with the client in broadening his or her resources" (p. 16). Such a resource-oriented approach to therapy and care, further elaborated upon by Rolvsjord (2007, 2010), is a central element in a recovery-oriented practice (Tondora, Lawless, O'Connell, & Rowe, 2009a). It is also important here to refer to the work of Nordoff and Robbins (1977), and theory and practice inspired by their philosophy and method. I will argue that their approach to music therapy is also close to a recovery-oriented practice, as it has a strong focus on musical resources, motivation, capacity for human experience and the authenticity of the relationship between client and therapist (Aigen, 2005a, b; Ansdell, 1995, 2014; Ness & Ruud, 2007).

If we take a look at some central definitions of music therapy, it becomes clear that there are also discrepancies between music therapy and a recovery-oriented framework. A much cited definition of music therapy is the one developed by Bruscia (1998, p. 20): “Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.” In this definition, the focus on health promotion (rather than a cure) and the emphasis on relationship is in accordance with the central components of a recovery-oriented practice (Slade, 2009). However, the emphasis on music therapy as a systematic process of intervention points in the direction of a more mechanistic and expert-initiated process, which conflicts with the emphasis on the therapeutic relationship being based on reciprocity, with the service user as an active agent.

Another influential definition is given by Stige (2012a), who defines community music therapy practice as:

> …situated health musicking in a community, as a planned process of collaboration between client and therapist with a specific focus on promotion of sociocultural and communal change through a participatory approach where music as ecology of performed relationships is used in a nonclinical and inclusive setting. (p. 426)

Most parts of this definition resonate well within the framework of recovery, particularly the focus on collaboration and participation, the promotion of change and the communal and ecological focus. Even so, the restriction of practice to non-clinical settings is not in accordance with a recovery-oriented practice which acknowledges that recovery is a process that needs to be attended to in any phase and context of a person’s life (Slade, 2009).

A definition that grasps one of the most essential features of recovery is Ruud’s (1980) sociologically informed definition of music therapy as an effort to “increase the possibilities for action" (Ruud, 1998, p. 52). This short and rather open definition targets the important aspect of the service-user being an active agent in music therapy and in his/her own life, and how the mental health service’s (hereunder music therapy) role is to recognize, support and help develop such an agency (Slade, 2009). This definition also targets an understanding of mental health difficulties as something not

situated inside the individual patient, but instead one that springs out of the interplay between biological, psychological, social and economic factors. For the same reason, this is also a definition that resonates well with psychosis as an essentially contested concept (Geekie & Read, 2009).

My understanding of music is grounded in Stige's (2002, 2012a, b) notion of *health musicking*. Stige (2002) originally developed this concept in a discussion of a contextual understanding of music and health, in which he drew on theory from music sociology and musicology (among others). One source was the work of DeNora (2000, 2007), who argues that music is not a cause or stimulus with a given response or effect. Rather, musical pieces or activities *afford* certain things (such as social contact, well-being or health effects), but the possible effects depend on peoples' *appropriations* of these possibilities in a given setting.[8]

Another source of Stige's conceptualization of health musicking is the notion of *musicking* (Small, 1998). Small states that "there is no such thing as music" (p. 9), arguing that instead of being a noun, music is a verb, an activity: "To music is to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practicing, by providing material for performance (what is called composing), or by dancing" (p. 9). By this concept, Small opens up the arena of music participation to include roles such as being a roadie, ticket seller or sound engineer, as they all contribute to musical performances. Hence, Small understands musicking as a relational and social term.

Health musicking is then defined as an "appraisal and appropriation of the health affordances of arena, agenda, agents, activities and artefacts of a music practice" (Stige & Aarø, 2012, p.132). Music is framed here as a human action and a performance of relationships, in which the health effects of music are not given, but created by the way music is used by involved participants in given situations (Stige, 2012a). The notion of health musicking matches well with this study's framing of mental health recovery as an active process in which the person is the true agent. Health musicking highlights the fundamental relational, participatory and social

[8] DeNora uses the terms appropriations and affordances with reference to the work of Gibson (1986).

aspects of music in a way that fits well, both with my personal experiences as a music therapist and with the user-perspective as being investigated in this study.

3. Empirical context

3.1 Psychiatric intensive care unit

Lovisenberg Diakonale Hospital is Norway's largest private hospital, serving as a local hospital with a responsibility for medical and psychiatric services to approximately one-fourth of Oslo's population. The hospital operates within the framework of Public Health, but is based on charitable values with non-commercial purposes. The music therapy practice described in this study took place in the hospital's psychiatric intensive care unit, consisting of three wards all situated in one building, each with 12-15 beds. All three wards had locked entrance doors as many of the patients were coercive admitted. The average length of hospitalization was four-six months, although some of the patients were returning to the hospital more or less regularly when in need of hospitalization. In that regard, the inpatient setting becomes a part of many service users' everyday life (Borg, 2007). A majority of the people hospitalized at the time of the study were diagnosed with psychosis, including many with additional substance abuse.

3.2 The music therapy practice

Music therapy at LDS was an integrated part of the multi-professional service provision, including individual sessions, open groups, music in the milieu and community-oriented work (Solli, 2009). *Individual sessions* were offered a music therapy room, a 25 ^{m2} room inside the hospital equipped with the following instruments: a drum kit, a bass guitar, an electric guitar with amplifier, acoustic guitars, an electric piano, different hand drums and percussion, a xylophone, a PA-system with microphones, a Hi-Fi system with a CD player, a small CD library, various notebooks

and a small recording studio. All participants attended weekly 45-60-minute individual sessions. The applied approaches to musicking were chosen in collaboration with the patient, but typically included: free and structured improvisations on various instruments, singing and playing familiar songs, learning to play an instrument, songwriting, recording and programming music, music listening and verbal conversations (Solli, 2008).

The weekly open *music therapy group*[9] was held in each of the three wards once a week. The group was situated in the living room/TV room, lasting for 45 minutes and having an open door so that the patients could regulate their attendance themselves. The physical structure of the group consisted of seven-eight chairs standing in a circle, with instruments (hand drums, percussion instruments, and one-two xylophones) placed in front of- or on the chairs. The session was based on the improvisational use of popular music, either played from free memory or by using texts collected in a loose-leaf binder. Each session was closed with a short session of physical stretching exercises, listening to a relaxing tune from the CD player and a verbal summary, in which everybody had the chance to give a brief summary about how they had experienced the session. The goals of the group included engagement, well-being, communication and the building of relationships.

Music in the milieu included activities such as a sing-along session every Friday before the weekend, in addition to a big social arrangement for all three wards four times a year called the Season Party. In both activities, the music therapist administered the musical happenings, and the patients were encouraged to perform music or play together with the music therapist. At the season parties, a professional band or artist was booked to perform a concert, and the evening always ended with a disco where the music therapist (often in collaboration with a patient) was/were DJ(s). Lastly, *community-oriented work* was a part of the music therapy practice that included helping patients to find music or culture activities in the community to attend, both during and after hospitalization. These places and activities included music schools, choirs and day centres with music groups.

[9] For more information about this music therapy group setting, see Solli (2006).

In general, the approach to music therapy at LDS was aligned with the principles of resource-oriented music therapy. Rolvsjord, Gold and Stige (2005, p. 24) describe six essential therapeutic principles for music therapy: 1) To focus on the client's strengths and potential, 2) Recognizing the client's competence related to his or her therapeutic process, 3) Collaborating with the client concerning the goals of therapy and the methods of working, 4) Acknowledging the client's musical identity, 5) Being emotionally involved in the music, and 6) Fostering positive emotions. However, this did not mean that emerging problems or negative emotions were neglected or avoided, but rather that this was responded to within a frame of his or her resources. Common to these principles was that they were also understood in the frame of a mutual relationship between the client and the therapist (Rolvsjord, 2010). A search for such a shift of power towards mutuality in the relationship was fundamental in the therapy described in this study, although the severity of the patients' conditions sometimes required more of a leading and structuring role. In this context, I recognize my role as a therapist with what Slade (2009) describes as a "partnership relationship". This refers to a basic orientation in which the therapist is "actively seeking to be led by the individual and their own wishes, goals and dreams (p. 116, with reference to Bracken & Thomas, 2005).

Although I primarily see myself as a music therapist, I also hold an identity as a musician. As a former professional drummer, I am used to having the role of supporting other musicians by affording a steady beat, while adjusting the tempo and rhythm so that the music flows more smoothly and the music starts to groove (Solli, 2008). By using this competence, and taking a musician role in the musical interplay, I often experience that the relationship between my patients and me naturally moves in the direction of a more reciprocal and collaborative relationship. Another consequence of my background as a musician is that I find it natural to take the musicking out of the therapy room and into other contexts, such as recording and producing CDs so that other people can hear the patients' music, or by providing possibilities to perform music. I like to follow the music where it wants to go. Such sliding transitions between different roles and contexts of musicking characterized the music therapy provided in this study.

4. The aim of the study

The overall aim of the study was to explore and understand how music therapy can contribute to processes of recovery for people with severe mental illness. Since recovery is about the person's everyday life in whatever clinical- or non-context exists, I aimed to study how music and music therapy were experienced in both the clinical setting of a psychiatric intensive care unit and how it affected the participants' everyday life during the course of music therapy.

The research questions were:

1. How do people diagnosed with psychosis experience music therapy?

2. How can music therapy support the recovery process of people diagnosed with psychosis?

3. How can music therapy contribute to a more recovery-oriented mental health service?

5. Methodology

5.1 Methodological approach

Because the aim of the present study was to investigate how inpatients with psychosis experienced music therapy in the social context of a psychiatric intensive care unit, a qualitative methodology was chosen. Qualitative methods can be defined as a "systematic collection, organization and interpretation of textual material derived from talk or observation (…) used in the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context" (Malterud, 2001, p. 483). Qualitative approaches to research are regarded as being particularly appropriate for investigating the processes of recovery in mental illness since they deal with the interpretation of human experience in context (Davidson, 2003, Davidson, Ridgway, Kidd, Toor, & Borg, 2008 ; Ralph & Corrigan, 2005). Furthermore, music therapy has a well-established tradition of applying a qualitative methodology to help investigate

matters of meaning and process in musical interaction (Aigen, 2008a, b; Wheeler, 2005).

The study was informed by a constructivist paradigm, building on the assumption that truth is a local, specific and co-constructed reality, and hence that knowledge is a process of co-creation that is best available through a subjectivist position (Guba & Lincoln, 2008). This implies that it is impossible for me as a researcher to completely remove myself from the process of meaning making. Instead, I form an active part of the interpersonal context, in which meaning is constructed and investigated together with the participants. Slade (2009, pp. 54-56) proposes such a constructivist position as being helpful in order to understand the processes of recovery, as identity is understood as an embodied and emerging process embedded in social contexts and developed within relationships. The co-creative approach to knowledge construction is also a good fit with this study, since both music therapy and the recovery fundamentally reflect co-creative and collaborative processes. This also represents an important epistemological consideration when exploring first-person accounts, because it provides a consciousness of the interpretative and constructive aspects of the results.

In the process of selecting the most appropriate methodological approach within qualitative research, phenomenology was first approached. Phenomenology offers a philosophical framework for examining the personal perception of an object or event and to "go back to the thing itself" (Ashworth, 2008). As the exploration of the individual's *experiences* of music and music therapy were the primary focus, phenomenology seemed to capture the individual and experiential focus appropriate for this study. Moreover, phenomenology is described as a favourable methodology for gaining knowledge about the personal and social processes of recovery (Davidson, 2003; Gill, 2012). However, I found that a phenomenological approach gave little room for reflecting on my own position as a researcher and how this influenced the research process and the findings. Particularly since the present study included an investigation of patients from my own clinical practice, I needed a methodology that captured the interpretative and interactive sides of the knowledge construction.

Such an attention and reflexivity towards the dynamic processes of pre-understanding or preconceptions within a phenomenological position were found in the work on hermeneutics offered by Heidegger and Gadamer (as described in Alvesson & Skjöldberg, 2000; Mulhall, 1996; Smith, Flowers, & Larkin, 2009). This led to a choice of a hermeneutical-phenomenological approach, which can be described as being "phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognizes that this inevitably becomes an interpretative endeavour for both participant and researcher" (Smith et al., 2009, p. 37). With such an approach, new understandings emerge from a fusion of the horizons of the participant and the researcher, which resonated well with my experiences of my encounters with participants through interviews and participatory observation.

5.2. Reflexivity

Reflexivity is regarded a central component of the overall standard of qualitative research (Abrams, 2005; Malterud, 2001). Nonetheless, various aspects of reflexivity apply to various research studies (Stige, Malterud, & Midtgarden, 2009), so here I will highlight some of the aspects that I regard as being central to my study. Alvesson and Sköldberg (2000) understand reflection in qualitative research as "thinking about the conditions for what one is doing, investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched" (p. 245). I do not regard reflexivity as belonging to a particular stage of the research process, but rather as an attitude permeating the entire study (Georgaca, 2003). An important arena for raising the awareness on matters of reflexivity was regular conversations with my academic supervisor. Another arena was the individual clinical supervision that I received from a psychologist at the hospital during the data collection, and I also attended a weekly supervision group with members of the multi-professional team.

Because this study is framed within a constructivist ontology and epistemology, in which knowledge is regarded as being a co-constituted product of the participants, the researcher and their relationship, I have been mindful of approaching the

participants as human beings with a capacity to be reflective themselves, and to be experts by experience. This can be regarded a type of *mutual* and *collaborative reflexivity* (Finlay, 2003a), in which the participants and I joined together in reflexive dialogue about the experiences and meaning of musicking and the value of music therapy.

The hermeneutic methodology in this study calls for a reflexivity about the interpretative nature of the findings. In relation to this, reflexivity can be understood as

> …the process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes. (Finlay, 2003b, p.108)

In this study, I have been personally involved on many levels, and my subjective experiences and subjectivity have been an important part of the study. The purpose of opening this comprehensive summary with a personal narrative about my way into the landscapes of mental health care and music therapy was to make transparent any contribution this has made to the research project, so that these can be taken into critical reflection of the project (McLeod, 2001, p. 202). Moreover, in accordance with a hermeneutic epistemology, I have embraced transparency regarding the critical ideological position that has informed the project.

This critical ideological position requires a high level of discursive reflexivity, as the use of language is regarded as being crucial to the process of changing the mental health system towards a recovery-oriented care, thereby implying that traditional terms found in the illness paradigm (such as diagnostic terms) have to be reconsidered (Coleman, 2004). One consequence of this is the use of the term *psychosis* rather than the term *schizophrenia,* since the former is considered to be less pejorative and stigmatizing than the last.

When writing this thesis, I have been conscious of doing it in a *person first language* to avoid depersonalization and contributing to the stigmatization of the participants (Deegan, 1996a). Thus, I am referring to research participants and others people with mental illness as "*people* with a mental illness" or similar, rather than "psychiatric patients", "schizophrenics" or "the mentally ill". The term "patient" is

used when referring to somebody who has been admitted to a hospital, as in my understanding this is a normalizing term that is used both in relation to physical and mental health care. The term service user is applied when referring to people who receive treatment or care in mental health services in general.

5.3 Methodological strategies

Different qualitative methods were chosen for each of the three research articles in order to explore the first-person perspective of music therapy. The first article reports a qualitative meta-synthesis that searches to give an overview and an interpretation of the current body of knowledge coming from first-person perspectives of music therapy in mental health care. The second and the third articles, respectively, report a multiple and single case study, with both reporting findings from the project's empirical data. The order of the articles reflects a movement in the research, from exploring a greater spectrum of diagnosis, practice arenas, music therapy approaches and the number of participants (Paper 1) towards a restriction of these factors, to nine participants diagnosed with psychosis at the same clinical practice (Paper 2), ending with one participant in a single case study (Paper 3).

5.3.1 Meta-synthesis

A meta-synthesis was not intended in the original project description. The initial plan was to write a theoretical article about specific therapeutic factors in music therapy for patients with psychosis, based on the two case studies. As I became more familiar with the recovery literature, I found the notion of *therapeutic factors,* with their focus on agency and mutual empowerment, did not work well together. The idea of instead doing a meta-synthesis was then developed, as I conducted a review of the existing music therapy literature and the user perspective. While searching for literature containing first-person accounts of service users' experiences with music therapy, I simultaneously discovered the methodology of a qualitative meta-synthesis (Finfgeld, 2003; Sandelowski & Barroso, 2003), and found this to be a more suitable way of

carrying out a literature review. Since a qualitative meta-synthesis refers to both "an interpretive product and to the analytic processes by which the findings of studies are integrated, compared, or otherwise put together" (Sandelowski & Barroso, 2003, p. 154), there was an initial fit with the hermeneutic-phenomenological framework of the study as a whole. It also turned out to be a good fit with the recovery perspective, with its emphasis on the first-person perspective.

Doing a meta-synthesis provided a way of analysing and reporting the status quo of knowledge about service-users' experience of music therapy in a way that I believe was true to the data material, and in a way that constructed new knowledge from already existing data material. However, doing a meta-synthesis is linked to methodological and epistemological challenges that must be taken into account when searching to understand this study, including: the reliability of data retrieval, sampling bias; a loss of detailed information; heterogeneity and quality of method; the differing levels of the analysis; and an exaggeration of the descriptions and interpretations (Jensen & Allen, 1996, p. 556).

After the meta-synthesis was completed two new texts, which include rich first-person accounts about music therapy, were published. The first is Hooper and Procter's (2013) chapter, which refers to a conversation between a former service user and his music therapist some years after their collaboration. The other text is Ansdell's (2014) book "How music helps in music therapy and everyday life", which is also rich in first-person accounts from service users. It should also be mentioned that one text escaped the literature search, which was Jensen's (2011) user survey from his practice in social psychiatry in Denmark. This text cites the evaluation comments of 35 service users, and provides a structured overview of the most important themes accounted for. However, all three texts did not meet the inclusion criteria of the meta-synthesis due to a lack of methodological descriptions.

5.3.2 Case studies

To explore how patients diagnosed with psychosis experienced participation in music therapy at a psychiatric intensive care unit, a case study design was chosen. Stake (1995, p. 2) refers to a case as "a specific, a complex, functioning thing (…) [that] has a boundary and working parts". In the present study, the cases included nine specific participants and their experiences of music and music therapy. The study of these nine cases had boundaries in both space and time, as it all took place inside a hospital within the time of the data collection. This PhD project includes both a multiple case study[10], in which all nine participants were studied (Paper 2), and a single case study, in which one participant from the multiple case studies was purposely selected for a more detailed exploration (Paper 3).

Both studies can be described as instrumental, as the cases were chosen in order to understand something other than the particular patient (how music therapy was experienced and how it could promote recovery) (Stake, 1995). On the other side, the participants in the study were given to the study to a large degree, because they were those particular patients who were hospitalized and attending music therapy at the time of the data collection. As I had such an intrinsic interest in these specific cases, this study also had the qualities of being an intrinsic case study.

The recovery perspective invites a high degree of user involvement. Consequently, I arranged a meeting with the Norwegian Council for Mental Health in 2010 to talk about the possibilities of organizing a reference group of service users that could provide feedback on the study. They responded positively but had little experience with such work, so due to various practical aspects the plan of establishing such a group was postponed. In the meantime, I came into contact with Buskerud University College, which appeared to have experience with reference groups, and even had a training programme for co-researchers. They organized a meeting with an initial reference group of four service users with previous experience as co-researchers. The purpose of the meeting was to obtain feedback on the research project from people

[10] The term "multiple case study" is not used in Article 2. The reason for this is that the IPA was the primary methodological approach, and due to the length of the article a case study design was not elaborated upon.

with first-hand experience with mental illness and hospitalization in order to ground the study in a user-perspective, as well as to optimize factors regarding the participants' health and well-being (Veseth, Binder, Borg, & Davidson, 2012). I had one meeting with this group in the autumn of 2012, in which the intentions and aims of the study were presented and where I received some initial feedback. The group were generally very positive to the project, and supported the methodological approach and ethical considerations presented. Their primary considerations were connected to the possibilities of user-involvement and the well-being of the patients involved in the study. We made plans for a further collaboration, but due to trivial conditions (a childbirth) followed by a time pressure in relation to the deadline for the data collection, no further meetings were arranged.

One way of increasing user-involvement in research is to let participants read and provide feedback on the researcher's interpretations of their statements, referred to as a member check (McLeod, 2001b) or a member validation (Kvale & Brinkmann, 2009). In the present study, this was difficult to implement for two main reasons. First, due to the severity of the participants' condition, I considered that a member check would be a stress factor. Second, many of the participants were discharged before the paper was written so they would therefore be difficult to locate and meet, and if a meeting could take place I would have no possibility to follow up on any negative reactions. However, I will argue that some degree of the member check was applied during the interviews, as I often repeated parts of what the participant said to see if I had understood them correctly, as in the following example:

HP:	So what you say is that there is no psychosis in this room?
Marco:	That's right! It's something…It's not in the same way
HP:	Yes….
Marco:	It's not that way. It's because…It's not that kind of negative psychosis, then. It's definitely not…it's kind of a good spirit here, you know.

In this way, I had the possibility of validating my understandings and interpretations of the participants' narratives.

5.3.3 Data collection

In many ways, the choice of context for the data collection was a pragmatic choice. There are few hospitals in Norway where music therapy is offered to patients with psychosis. The Lovisenberg Diakonale Hospital (LDS) has had music therapy as part of their treatment programme since 2001, and was one of the few institutions where music therapy was fully integrated as a part of standard treatment. These premises made LDS an attractive context for conducting research, while an established relationship with the hospital management, along with their willingness to support the project economically in the initial phase, was decisive.

During the two first years of the project, I had a 50% engagement as a music therapist, while the other 50% was a research position. These two roles were distributed so that music therapy was provided as usual without giving any priority to patients who were relevant to the research project. According to the project plan, 8-12 cases were to be included, which is within the recommended amount of cases suggested in order to capture a manageable interactivity between cases (Smith et al., 2009; Stake, 2006). The anticipated number of participants was initially determined by a calculation of how many patients within the inclusion criteria would normally attend music therapy within the given period of data collection. The recruitment of participants was time consuming, and the scheduled time limit had to be extended by three months in order to obtain the required number. The cases were selected according to the criteria of inclusion and exclusion described in Article 2.

Participants for the research project were selected from among patients who had already attended music therapy.[11] As a routine procedure, patients were given information about the study and the conditions, and were asked to consider the request for a couple of days before responding. Someone from the staff, most often the primary contact, was then informed about the request and instructed to discuss the matter with the patient after the meeting. In this way, I searched to prevent patients from feeling obligated to participate simply to please their therapist. Most of the time

[11] For detailed information about the participants, see Paper 2, p. 5.

this procedure was followed, but some of the patients refused to take time to think it over and immediately agreed to participate. In these cases, staff members were asked to follow up the patient after a couple of days to check if the decision was maintained.

My experience was that the inclusion criteria (as described in Article 2) were clear and well defined in order to select which participants to include. All but one of the patients who were asked responded positively to the request for participation, and there were no dropouts. This can be understood as a result of a careful targeting of patients who were in stable phases of their condition and of patients who we considered to be capable of accomplishing the interviews. In this regard, the double role of therapist and researcher was optimal, as this provided possibility for establishing a relationship with the patients prior to recruitment, as well as providing access to evaluations of the patient's condition from the multi-professional team. Morse (2010) refers to professional health workers who study their own practice as "insiders" since they have an occupational closeness to the participants and a care provider role.

The most challenging aspect of the data collection was the rapid patient turnover (an average stay was approximately four months). A typical progression was that patients started to receive music therapy during a period in which they were in a too acute psychotic phase to be included in the study, and after some months, as we considered the person to be ready for inclusion, they were discharged from the hospital. However, this trend did not mean that the participants included were those who were the least ill or the most well-functioning group of patients. Instead, a typical characteristic of the participants was that they were the people with the most severe, long-lasting and complicated illnesses and difficulties, and who were evaluated as having limited possibilities for managing themselves outside the hospital, and hence needed to stay for longer than four months.

The empirical material for each participant included recorded and transcribed interviews, both clinical- and reflexive notes from participatory observation, recordings of improvisations and songs. In addition, I had access to electronic hospital notes of each patient's clinical history and daily reports from the hospital's multi-professional team. According to the initial project plan, the recorded music was

collected with the intention of letting participants describe their experience of musical interaction while listening to the recordings. Also, the choice of collecting such a variety of data was built on a calculated risk that the participants may not have been in good enough shape to accomplish the interviews, or that the quality of the interview data would be distorted due to the nature of the psychotic conditions. In that case, the observations, the log and the musical material would have played a more central role in the project. Still, as the data collection began, I found that the interviews went particularly well. They provided a rich amount of data, with detailed descriptions that only contained insignificant amounts of chaotic talk.

The question of credibility because of a lack of insight associated with delusions raised the question of the value of the data collected through the interviews. In this study, the interest in the patient's narratives was based on the assumption that a story will always express something true about the life of the patient, even when the story is not evidently coherent (Lorem, 2005). In a perspective such as this, statements from patients with psychosis can always be interpreted as containing layers of meaning, and can therefore be subjects for analysis.

5.3.4 Interviews and participatory observation

Qualitative interviews were used in order to elicit descriptions of first-person subjective experiences of music therapy. The main focus of the interviews was the participants' experiences with all four areas of music therapy (as previously described), but most of the interviews circulated around the experiences of individual sessions. Due to the participants' mental condition and the research context, I expected that conducting interviews would prove to be a challenge. Kvale and Brinkmann's (2009, p. 164) criteria for a high-quality interview includes getting rich, specific and relevant answers from the participants, as well as possibilities to clarify the meaning of relevant aspects during the interview.

As developed by Kirkevold and Bergsland (2007), in order to prevent getting a poor quality of data from the interviews, a set of strategies for conducting qualitative

interviews, with persons with difficulties providing detailed accounts of their experiences, was applied. These strategies included: 1) a focus on doing the interview situation as safely as possible, 2) to do repeated interviews, 3) to spend time in establishing a rapport with the interviewee, and 4) to combine the interview with participatory observation. By adjusting the interviews to these strategies, and having a flexible attitude towards the interview procedures, I experienced that the quality of the interviews were excellent. Further, none of the participants reported negative experiences with their contribution to the project. On the contrary, several of the patients expressed gratitude for being given the opportunity to tell their story and be valued as an "expert of experience". Some also found the interviews amusing, as expressed by P1: "This is much cooler than those boring …boring statistics on the phone from those statistical….you know what I mean."

Research interviews always involve a power asymmetry, as the interviewer holds a scientific competence, asks one-directional questions with the instrumental purpose of acquiring knowledge, and has a monopoly of interpretation over participants' accounts (Kvale & Brinkmann, 2009, p. 33). I acknowledge that such an asymmetry was present in the interviews. However, because the present study identifies music therapy as an arena for mutual partnership relationships and rich possibilities for agency, I most often felt that some of the qualities of this empowering position were carried forward into the interview situation. Indications of such empowerment was passages in which participants forcefully interrupted the researcher in order to complete their reasoning, and passages in which the researcher's question or comment upon a statement was refused or contradicted, like in this example:

HP: We call this music therapy, then. Do you think that is has any therapeutic impact, or? That it can help in any way…like in relation to illness and in relation to health?
P7: No, not in relation to illness. In fact I don't think that.
HP: No?
P7: It depends, I guess, what bothers you. Say depression for example, but…not psychosis. If I…am struggling with something emotional, then maybe, because that is so closely connected. But I don't think it affects psychosis.

One challenge in asking my own patients to be participants was to secure that they felt comfortable with answering questions as sincerely as possible. The double role of therapist and interviewer may have resulted in some patients holding back negative experiences or exaggerating the positive aspects of the therapy (McLeod, 2001b). However, I will argue that this is less decisive, as the study was not about the quality of the music therapy, but instead about how the patients experienced the music and the interplay. Nevertheless, it was of great importance to be observant of this problem in the planning of the interviews, and to create an open and safe frame in the interview situation, so that the patients were able to share their genuine experiences.

Even though the participants were going through an extremely vulnerable period in their life, many in an acute crisis, in addition to confronting the overwhelming and distracting features of psychotic experiences, I never felt that including them in the research project inflicted any additional burden. I believe this was related the fact that the research was conducted within an already established relationship between the participant and the music therapist. This resembles Davidson's (2003 p. 27) concern that doing qualitative inquiries with people in crisis requires the building of emphatic bridges.

Yet, the double relationship of being therapist and researcher was also a methodological challenge that demanded reflexivity on both positions and roles. An example of this was when the final interview with P3 was conducted on the same day that she was discharged from the hospital. Several of her accounts were characterized by an urge to express gratitude to the music therapist before she had to say good-bye.

HP: So, if you were to conclude – how has it been to have music therapy as a part of your treatment here at the hospital?
P3: Very good! I am very satisfied. Thank you for the help.

Passages such as this, which I interpreted as being affected by factors that diffused the message, were paid less attention to in the process of data analysis.

5.3.5 Analysis

In the early phase of the project, there was a process of selecting an approach for the analysis. Grounded theory in its constructivist format (Charmaz, 2006) was considered as a possible choice of methodology, but it was my impression that this method's high conceptual level was in danger of fracturing the data so that the experience became distanced to the experiencing subject, which is also a common critique of grounded theory (Charmaz, 2003, p. 269).

In my initial search for literature I discovered Ansdell and Meehan's (2010) study, which investigated music therapy in mental health care from a user-based, idiographic perspective. In this study, the data material were analysed using an Interpretative Phenomenological Analysis (IPA), which immediately seemed to be a relevant approach for my study. The suitability of IAP was strengthened by the results of an unstructured literature search on combinations of keywords such as IPA, psychosis and music therapy in Google scholar. I identified several IPA studies, investigating individual's experiences published in peer-reviewed journals (e.g. Bailey & Davidson, 2003; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007; Richards, 2008), which led to an investigation into the theoretical foundations, methodological implications and practical application of the IPA, as described by Smith et al. (2009).

IPA was originally developed by Jonathan A. Smith in the mid-1990s as a qualitative and hermeneutical-phenomenological approach centred on psychology. This approach integrates phenomenology in that "it involves detailed examination of the participant's lived experience; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event" (Smith & Osborn, 2008, p. 53). By taking this position, it was possible to explore the participant's experiences through a dialogical engagement, using participatory observation, interviews and the transcribed texts. In accordance with hermeneutic phenomenology, IPA emphasizes the active role of the researcher as an interpretative agent, accentuating how access to the insider perspective depends on the researcher's conceptions of the data through a hermeneutic process (Smith et al., 2009).

A detailed description of the analytic steps of IPA is described in Paper 2 (p. 6) and in Paper 3 (pp. 7-8). IPA's character is that of being a flexible guideline that can be adapted by researchers to fit particular research aims (Smith et al., 2009). Due to the high quality of the data from the interviews, in combination with my increasing awareness of the importance of the first-person perspective in recovery literature, the interviews received the primary focus in the analysis for Paper 1. Observation is an approach to data collection not commonly found in IPA studies, but can be incorporated if a high degree of reflexivity is applied (Larkin & Griffiths, 2002). In Paper 3, participatory observation was the basis of a narrative presentation of the case, together with data from the interviews.

Although the recordings of musical interactions and notes from participatory observation were not the subject of analysis in Article 2, they worked as a way of documenting happenings and the process of creating musical artefacts that were later discussed in the interviews. During the data analysis, they functioned as a contextual background that was accessible for listening or reading back to. In that way, the observations and recordings contributed to a triangulation that contributed to my own understanding and construction of meaning in the interviews, which again afforded possibilities for exploring more nuances of the first-person accounts while providing thicker descriptions (Kvale, 2001).

From a constructive perspective, access to the participant's experiences is always partial and complex, and an analysis will always be short of achieving a genuinely first-person account because the narratives are constructed by the participant and the researcher. What I have done is provide a description that is as close to the participant's experience as possible, while being mindful of the interpretational aspects of the knowledge construction (Larkin, Watts, & Clifton, 2006). Hence, at all stages of this analytic process, the themes and families were the subject of the reflection, re-examination and reflexivity of how my own pre-understanding collared the analysis. There was a constant alternation in focus, moving back and forth between details in the text, the wholeness of each interview, the sum of all the interviews and the project as a whole, often referred to as the hermeneutic circle (Alvesson & Sjöldberg, 2000).

5.4 Ethical considerations

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK Vest), and was reported to the local Health and Social Services Ombudsman. All participants were given written and verbal information about the study, which included information about their right to withdraw at any time without giving any reason, and that such a decision would not have any negative consequences for their music therapy (see Appendix). A letter of informed consent was also signed by all the participants before the first interview (see Appendix). All names, locations and other details that were regarded as a threat to the anonymity of the participants were omitted or distorted in order to remove any trace of the participants' identity, but with care in not changing the meaning (Kvale & Brinkmann, 2009). However, it is a well-known challenge that reporting rich qualitative data from therapy settings may compromise confidentiality (Christians, 2008; McLeod, 2001b). Matters of ethics and confidentiality were therefore consecutively discussed with the main supervisor and a senior nurse in an administrative and academic post at the hospital. A primacy was given here to not disclose private knowledge that would harm or embarrass the participants involved in the study (Christians, 2008).

According to the ethical guidelines that regulate research activity in Norway (National Committee for Research Ethics in Norway, 2006), researchers are obligated to respect human dignity and prevent harm and suffering. Although the level of risk connected with participation in the present study was considered to be low by the ethical committee, the matter of ethics was closely monitored throughout the project. The participants were all in an extremely vulnerable situation, so careful considerations were made to reduce any stress factors. Both in the phase of inclusion, and in the later process of the research, the mental condition of the participants was discussed with the responsible psychiatrist or psychologist and/or the multi-professional team. Moreover, participants were asked both during and after each interview how they felt about being interviewed to help reduce any eventual stressors. Also, any sign of stress unpleasantness in the interview situation was followed up, as the following excerpt from one of the interviews illustrates:

HP: Just stop for a moment, "George". Are you OK?
P6: Yeah, it's OK to sit down and talk like this.
HP: Cause, sometimes you become a bit staring, and then I'm wondering if I am losing you a bit?
P6: Yes, yes…
HP: You want to say something about that, or?
P6: No… no…
HP: Cause, if you want us to end the talk now, just tell me so.
P6: No, I think it's all right.
HP: You think it's all right?
P6: Yes.
HP: Yes? That's good. Let's go back to the interview then.

The positive experiences with participation in the project could be related to my double role as the therapist and researcher. A consequence of this was that the data collection was conducted within an already established relationship, and took place within a well-known context (talking to their music therapist in the music therapy room). Hem, Heggen and Ruyter (2007, p. 41) argue that successful research on vulnerable patient groups requires knowledge of research ethics, research experience and a familiarity with the therapeutic arena where the research takes place. I would argue that my clinical familiarity and careful considerations of the ethical aspects were clear strengths that provided a secure frame for the participants in this study.

Along with the principle of avoiding stress and harm, the prediction and evaluation of possible benefits for the participants is also part of ethical considerations (National Committee for Research Ethics in Norway, 2006; Oeye, Bjelland, & Skorpen, 2007). Since the perspective of people with severe mental illness have been neglected to a large degree in research literature, it can be argued that not involving this group of people in research projects due to a fear of conducting harm is also ethically problematic. Geekie and Read (2008, p. 194) refer to what they call "The basic human right of 'authoring' experience", arguing that by broadening our understanding of psychotic experiences by attending to first-hand lived experiences we also allow users to participate in a dialogue. My experience from this project was that many of the participants were honoured and proud to be asked to contribute, because they felt useful and that their story was regarded as being important. At the end of each interview, the participants were asked how they felt about the interview session. None

of the participants reported any negative experiences, although most of the participants expressed positive experiences and gratitude for being asked to contribute:

> Of course I want that [to be interviewed]. I want to share it, you know…the thoughts I have, then. Of course! I like to talk. That's why I'm a rapper. (P1)

> It was fun being interviewed! (P3)

> Difficult questions that I haven't considered before. So I…But I got answers to some questions I've never thought of before. Like what music means to me. (P7)

In a wider perspective, a benefit from this study is that the first-person account of the participants is shedding light on a field that has had a limited focus in music therapy, which may contribute to help enhance the quality of the practice for other patients.

6. Findings

6.1 Summary of Paper 1

The first article is called "Toward understanding music therapy as a recovery-oriented practice within mental health care: A meta-synthesis of service users' experiences." The aim of this article was to explore service users' experiences of music therapy as they are reported in the existing research literature. Through a systematic literature review, 14 texts were identified to match the inclusion criteria, on which a qualitative meta-synthesis was conducted. The synthesis was processed as an interpretative translation between users' statements and the respective authors representation of these, and from this analysis a taxonomy of four areas of experience was identified: (1) *Having a good time* through an engagement in music, contributing to various aspects of well-being and promoting meaning in current life and the hope for a future life, (2) *Being together* with other people, in the clinic, in the community and in everyday life, providing arenas for engaging in interpersonal relationships, teamwork and social participation in ways that facilitated the processes of social inclusion, (3) *Feeling* – experiencing, expressing and regulating emotions through music in ways that facilitated well-being and emotional life, and (4) Strengthening the experience of *being*

someone through offering an arena where strengths, interests and talents could be explored, used and flourished, thus promoting experiences of mastery and a stronger and more healthy identity. The findings were discussed in relation to how music therapy can support personal and social recovery processes, and how music therapy can be a contribution to recovery-oriented services in mental health care. The paper has been published in the *Journal of Music Therapy*.

6.2 Summary of Paper 2

The second paper is called "The opposite of treatment": A qualitative study of how patients diagnosed with psychosis experience music therapy." The aim of this article was to explore how mental health patients diagnosed with psychosis experience participation in music therapy in general, and particularly in relation to the current mental condition and life situation. The study reports data from semi-structured interviews with nine participants, and was analysed using an interpretative phenomenological analysis (IPA). The findings were structured into a taxonomy of four super-ordinate themes: (1) freedom, (2) contact, (3) well-being and (4) symptom reduction. The results are considered in relation to the theory of mental health recovery, and include both personal and social processes recovery. From this discussion, it is suggested that a focus upon recovery, positive mental health and (personal and social) agency constitutes a more adequate framework for music therapy than a primary focus upon symptom remission and functional improvement. The paper has been published online ahead of print in the *Nordic Journal of Music Therapy*.

6.3 Summary of Paper 3

The third and last paper is called "Battling illness with wellness: A qualitative case study of a young rapper's experiences with music therapy." The object of this article is to explore how music therapy situated inside a psychiatric intensive care unit might afford possibilities for social recovery. One of the participants from the second article was selected, and a single case study with data from qualitative interviews and

participatory observation was the basis for an in-depth exploration of interpersonal and social processes in music therapy. Data were analysed using interpretative phenomenological analysis (IPA), and presented in a narrative form structured by the various musical engagements from the therapy process: the individual sessions, the making of a CD, a concert performance and the distribution of music on the Internet. The medical construct of "negative symptoms" is explored from a user-perspective, and the musical and therapeutic processes from the case are considered in relation to the theory of social recovery, including aspects such as agency, identity, positive relationships and social networks. The article was published online ahead of print in the *Nordic Journal of Music Therapy.*

7. Discussion

This chapter is a discussion of the findings presented in the three research articles in relation to the overall research questions:

1. How do people diagnosed with psychosis experience music therapy?
2. How can music therapy support the recovery process of people diagnosed with psychosis?
3. How can music therapy contribute to a more recovery-oriented mental health service?

The discussion will be organized in six parts. First, I will start by looking at the relationship between the papers: How do they supplement and challenge each other? Second, I will discuss what we have learned from approaching first-person accounts in this study. Third, I will discuss the inter-relatedness of some of the central themes identified in the three articles and propose a model for how to understand processes of recovery in music therapy. Forth, I will discuss the cross-contextual and flexible features of music therapy found in this study. Lastly, the strengths, limitations and implications for research and practice will be discussed.

7.1 Relationship between the papers

All three papers explored how music and music therapy were experienced by people with severe mental health difficulties, and how such musical engagements supported the processes of personal and social recovery. The most apparent difference in the premises of the papers is that Paper 1 was based on data material from already existing studies, in which the data constituted a heterogeneity of clinical contexts, diagnosis and music therapy approaches. On the other hand, Papers 2 and 3, were based on a homogeneity of the same factors: inpatients at one psychiatric intensive care unit, all diagnosed with psychosis and receiving music therapy from the same music therapist. It is also important to note that Papers 1 and 2 are a study of a music therapy practice that is strongly influenced by the recovery perspective.

The data material in Paper 1 also included a variety of research questions and methodological approaches, whereas Papers 2 and 3 were both designed according to one set of research questions and a similar design. Paper 3 differs from the other two previous articles, as it includes observation in its data material, thereby allowing for a narrative presentation from the perspective of the music therapist and researcher. However, I will argue that all three papers complement each other insofar as they collectively provide a broad investigation into the first-person perspective of individuals with different diagnoses and mental health challenges from various mental health contexts, thus attending to various approaches to music therapy provided by different music therapists.

Despite the differences in music therapy approaches, user populations, contexts, and research design, the major findings from the meta-synthesis were supported in the case studies to a large degree. Across the three papers, music therapy was experienced as supporting and promoting processes crucial for mental health recovery, especially main themes such as subjective well-being, social engagement and positive identity/self-awareness.

Although the two case studies confirmed many of the findings from the meta-synthesis, they contributed toward illuminating two specific aspects not reported in the meta-synthesis, namely *symptom alleviation* and *freedom*. Even though some studies

included in the meta-synthesis did contain some narratives related to symptom alleviation, this was a theme that was sufficiently accounted for in the data material; hence, it was not included as one of the categories or sub-categories. Another contribution of the case studies was the notion of music therapy as "the opposite of treatment", which was reflected in the main category of "freedom". This theme was also identified in some of the studies included in the meta-synthesis, but not to such an extent and depth that it was regarded as being essential.

7.2 Learning from first-hand experiences

To the best of my knowledge, this study is the first within the field of music therapy that has conducted in-depth interviews specific to inpatients diagnosed with psychosis. Consequently, the study has contributed new knowledge about how music therapy is experienced for people with the most severe mental illness (psychosis) in an acute intensive phase of their illness, as well as in a potentially stressful milieu.

A central epistemological presumption in this study has been that people's first-person accounts are a significant and valid source of knowledge about the processes of recovery. Such a stance implies that I look at the research participants as fellow citizens who have an important role in informing others, which contributes to a better understanding of what helps and hinders mental health recovery (Borg, 2007). Dreier (2008, p. 8) argues that a lack of comprehensive research on client's perspectives leaves it up to therapists to create a culture of interpretation. This is problematic, as it has been properly illustrated that the perspective of a client can be quite different from that of the therapist (O'Hagen, 1996; Sands, 2000; Yalom & Elkin, 1974). The present study can be seen as a contribution to help hinder the development of music therapy built solely on a professional perspective by highlighting the first-person perspective.

When investigating how music therapy was experienced in relation to the participants' health, illness and recovery process, it became evident as early as in the first interviews that there were some discrepancies between my preconception of how music therapy "worked" or "helped" and the participants' ways of thinking about music and music therapy. For several different reasons, most of the participants did not

think in terms of illness or recovery at all. For some individuals, their current life situation and mental distress meant that reflecting on the processes of their recovery was not something they were capable of at the moment. Some did not think of themselves as ill, so what should they recover from? Others were unsure of their given diagnosis – neither understanding nor accepting it, because what was referred to as psychosis (e.g. delusions and hallucinations) by the professionals was a real experience to them. One man had positive experiences related to being ill (P6: "The psychosis may become pleasurable").

Despite these various perspectives on the ontology of psychosis and different evaluations of their own need for help, all nine participants in the case studies seemed to agree that music and music therapy were a source to a better everyday life. This resonates with Davidson, Tondora, Lawless, O'Connell, & Rowe's (2009, p. 75) observation that "While few people express a desire to 'work on their recovery', many people express a desire to get their lives back." Instead of talking about recovery, my participants talked about things such as having fun, connecting with other people and feeling alive. These findings are significant, since they provide new idiographic knowledge about how music therapy is experienced by patients with psychosis. They reveal a radically different view – that music therapy in this context is not (or should not be) primarily a treatment of an illness, but rather an arena where patients can become active agents in personal processes of recovery. This new knowledge points to the importance of doing research that captures first-hand accounts of people with psychosis.

Although many of the participants repelled the psychiatric diagnosis they were given, and refused to let music be mixed with the medical discourse, other participants showed a high level of reflexivity about how music was important for their mental illness and their treatment. This heterogeneity of ways of reflecting on their mental health problems and its relationship to music and music therapy is significant, because it shows how a group of people with the same diagnosis are not homogeneous, but instead consists of individuals with unique ways of understanding their life challenges. This shows how idiographic knowledge is important for bringing attention to

individual differences, and can contribute with significant knowledge needed for the development of the best possible music therapy services for individuals with psychosis.

One last aspect of the participants' unexpected notion of music therapy as "the opposite of treatment" is linked to the trustworthiness of the study. My double role as a therapist and researcher was something that could potentially cause participants to shape their answers in order to please their therapist. The fact that several of the participants rejected the premises of my questions and argued against my preconceptions of music therapy and recovery can be interpreted as a sign of autonomous thinking and free expressions of opinion in the interviews. This strengthens the impression that the participants' reflections were honest and unreservedly spoken to a large extent, without being dramatically shaped or modified in order to please or obtain goodwill. Such indications strengthen the overall trustworthiness of the study.

7.3 Inter-related processes of recovery in music therapy

The overall objective of the study was to learn about whether and how people diagnosed with psychosis found music and music therapy to be helpful for them in their lives. In relation to Research Question 1, all of the participants provided rich and colourful narratives about their experiences with music. These experiences were further developed into two sets of main categories through an interpretative analytic process: Having a good time, Being together, Feeling and Being someone (Paper 1), and Freedom, Contact, Well-being and Symptom reduction (Paper 2).

In order to address how music therapy can help in supporting the recovery process of people diagnosed with psychosis (Research Question 2), I will now discuss how some of the themes from the three studies relate to each other. The selection of these themes is the result of an interpretative and constructive synthesis of the findings from all three articles, in combination with central findings from other research literature within the field of mental health recovery. I regard the triangulation of my own empirical material with other research literature to be especially important in this study, as most of the participants did not include reflections on such an overall

research question. Five themes will be illuminated and discussed in the following: well-being, personal and social agency, sense of self and identity, symptom alleviation and hope.

An overall finding in the present research project was that music therapy was primary described in relation to *well-being*[12]. Descriptions of how musicking was related to mental illness and difficulties were given less of a focus, and were often not addressed before it was brought up by the interviewer. A particularly interesting finding was how some participants resisted the very idea of music being a treatment because they regarded music as belonging to the healthy parts of their life and not their illness. Therefore, one can say the participants' experiences of music and music therapy reflected a salutogenic understanding of music's help, rather than a pathogenic one (Antonovsky, 1996). Furthermore, the experiences of music therapy as an approach primarily targeting the resources, rather than deficits, harmonize with what is described as resource-oriented therapeutic models in psychiatry (Priebe et al., 2014).

Experiences of subjective well-being are found to be central to the processes of personal and social recovery (Davidson, Tondora, et al., 2009, 2005; Onken et al., 2007; Slade, 2010). Well-being is also found to be inter-related with other aspects of recovery, such as providing a sense of meaning and purpose, hope and commitment, social agency, value as a human being and a positive identity and sense of self (Davidson, Shahar, Lawless, Sells, & Tondora, 2006, p. 155). In my study, similarly interlinked processes were discussed in Paper 1 (Solli, Rolvsjord, & Borg, 2013, pp. 263-264), and were further elaborated upon in Papers 2 and 3.

This study supports previous studies that have identified music therapy in mental health care as a source of subjective well-being (Ansdell, 2014; Ansdell & Meehan, 2010; Rolvsjord, 2010). However, this study adds to the literature by reporting first-person accounts of such strong experiences of subjective well-being from individuals diagnosed with psychosis in an intensive care setting. The topic of well-being seems to be under-researched in music therapy for people with severe mental illness and is not reported as a common clinical aim or considerations for music

[12] Well-being is here understood as a broad concept that includes emotional, psychological and social sides, as described by Provencher and Keyes (2013).

therapists in psychiatric inpatient settings (Carr, Odell-Miller, & Priebe, 2013). The present study calls for a greater awareness of the importance of addressing well-being as a central goal for music therapy for people with a severe mental illness.

A second major finding was that music therapy was experienced as an arena for participants to regain and develop *personal and social agency*.[13] In particular, it seemed that together with the enjoyable features of musicking, the active, interactive and collaborative aspects of music therapy were connected to a high degree of motivation for an active engagement in music. The personal aspects of agency were connected to participants experiencing mastery in music therapy, which again led to experiences of having the ability to get out of a withdrawn and passive position and beginning to see themselves as creative human beings who could produce and perform music. In particular, the physical, bodily and concrete engagement with music, such as singing or rapping meaningful lyrics or playing loudly on drums, were found to be empowering experiences that provided participants with a perceived ability to affect their lives. The social aspect of agency was compromised of how participants used various approaches to musicking to connect and reconnect with other people, often starting with the one-to-one relationship with the music therapist and gradually moving towards other social relationships both inside and outside the hospital. This ability to engage meaningfully with others was reported to be transferable to contexts other than music therapy.

The development of agency is at the core of what the movement and perspective of recovery is all about, as it asserts that service users are not passive receivers of biological and social forces, but rather active participants in forming their lives (Lysaker & Leonhardt, 2012). Agency is therefore vital for counteracting the processes of stigma, social exclusion and disempowerment (Repper & Perkins, 2003). The finding of music therapy as a promoter of personal and social agency, as well as the utter importance of agency reported in the research literature, suggests agency as a primary goal for music therapy for people with severe mental health difficulties.

---

[13] Agency was understood here as "the perceived ability to affect one's own destiny and to engage meaningfully with others, and reflects the dimensions of mastery and positive relationships with others" (Provencher & Keyes, 2013, p. 285).

Thirdly, related to the aspects of well-being and agency was the finding that music therapy seemed to promote a *positive identity* and a strengthened *sense of self*. Participants reported that music therapy provided possibilities for adjusting and broadening their perception and understanding of themselves as being more than their illness, and helped in developing a self-image of being a creative, active and productive individual valued by others. Such developments of a more positive identity are described as vital for the processes of overcoming stigma (Leamy et al., 2010; Repper & Perkins, 2003). In music therapy, this seemed to be closely connected to mastery and the achievement of goals (such as mastering an instrument or producing a CD) and the connected experiences of well-being. Music was also reported to be a source of identification and belonging with other social groups (such as other rappers, musicians, or artists), and was therefore also used as an approach to develop social belonging and social identity. Additionally, an engagement in music activities, especially improvisations on instruments together with the therapist, was experienced as helping participants recapture a bodily sense of self, a sense of aliveness and of being in the world.

A fourth aspect I will highlight here is how enlarged experiences of *hope*[14] were explicitly connected to musicking, both in the meta-synthesis and in the case studies. The hope for a better life is often described as an overall goal in recovery-oriented practice (Deegan, 1996a; Slade, 2009; Schrank, Stanghellini, & Slade, 2008), yet few strategies or interventions have been found to be successful in increasing hope (Schrank, Bird, Rudnick, & Slade, 2012). Although hope is most commonly understood as a future-oriented expectation,[15] it also involves the person's experiences in the past and the present (Schrank, Wally, & Schmidt, 2012). This correlates with the temporal phenomenology of music, which can also be said to be a "dynamic interpenetration of past/present/future" (Ansdell & Meehan, 2010, pp. 34-35). Hope in the "here and now" *present* moment can be related to participants' experiences of enjoyment and pleasure, a sense of aliveness, flow and emotional awareness. It may

[15] From positive psychology, valued subjective experiences are understood as well-being (in the past), flow and happiness (in the present) and hope and optimism (for the future) (Seligman & Csikszentmihalyi, 2000).

also be related to the sudden experience of symptom alleviation while being in a musical interplay. *Past* experiences can be linked to hope when positive memories of past experiences grow to become a part of the person's narrative and identity, becoming a source of expectancy for similar positive experiences to come. Common experiences here were various aspects of feeling well, experiences of freedom from illness and stigma, experiences of having managed and fulfilled something to be proud of and musical encounters with other people. Past and present experiences seemed to shape the hopes for the *future,* which was reported in general terms as looking forward in relation to hoping for the illness to cease, hoping for new social contacts and valued roles, as well as dreams of becoming a professional musician or a star.

Although hope is seen as a common factor shared by most treatment approaches (Frank & Frank, 1993), the finding from the present study suggests that music therapy may be a particularly promising approach to promoting hope for individuals with severe mental illness. My finding is supported by Ansdell and Meehan's (2010, p. 34) study, which also found music therapy to increase motivation, encouragement and hope for a group of people with acute mental health problems – what they called "music's hope". Because hope is found to be one of the core aspects in the processes of personal and social recovery, and few hope-promoting approaches are known in mental health care, this finding must be regarded as being particularly important, pointing to hope as one of music therapy's most profound contributions to people with severe mental health problems.

A fifth and final aspect of how music therapy was found to promote recovery was by alleviating symptoms. Not all the participants wanted to talk about their psychosis and mental health problems in the interviews, but the accounts of those who felt comfortable in sharing their experiences provided insight into a previously little explored field of knowledge. Music therapy was linked here to the temporary alleviation of the symptoms of psychosis such as hearing voices that nobody else could hear and images or people that nobody else could see (commonly referred to as hallucinations), disturbing and destructive thoughts, annoying sounds and a psychotic state in general. Participants related these effects to a shift in focus, the urge to let the music be at the centre of attention and a perceived empowerment and agency to battle

these undesirable experiences. It has previously been reported that listening to music can reduce the phenomena of the hearing of voices (Kalhovde, Elstad, & Talseth, 2014), though the detailed first-hand accounts of subjectively experienced symptom alleviation connected to active musical interaction have not previously been described as far as I am concerned.

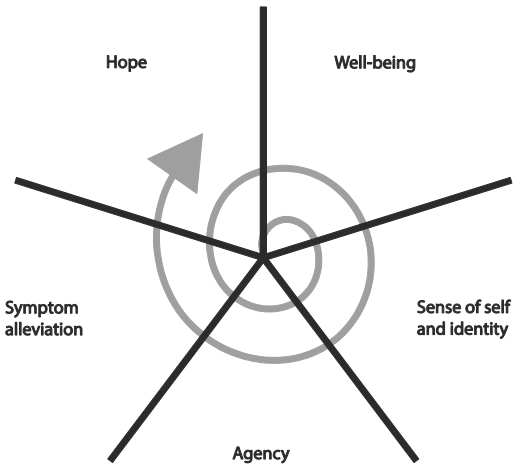
Clinical recovery is regarded a subset of personal recovery (Slade, 2009, p. 43), since the processes of entering and being in recovery appear to be connected to a reduction in the illness (Davidson, Tondora, et al., 2009). The symptom alleviation reported in the current study can therefore be understood more as a result of the previously described recovery processes in music therapy, rather than as the result of skilful diagnosis-specific interventions by the music therapist. According to Priebe et al. (2014), a typical aspect of resource-oriented therapeutic models in psychiatry, such as music therapy, is exactly how a primary targeting of patients' resources, instead of deficits, may indirectly affect the symptoms of a defined disease. In the present study, some of the participant's seemed to more or less deliberately own this knowledge, as they insisted that musicking should be about wellness rather than about illness.

The above-described processes of recovery in music therapy (well-being, agency, sense of self and identity, hope and symptom alleviation) are all regarded as important in the processes of personal and social recovery (Leamy et al., 2011; Onken et al., 2007; Slade, 2009). Hence, a major finding of the present study is that music therapy can be an important support in the recovery processes of people with severe mental illness. To sum up, we can formulate music therapy as recovery oriented-practice as *the affordance of a therapeutic and social arena where people with mental health difficulties can work on their process of recovery through musicking.* Such an understanding defocuses the expert role of the music therapist. Instead, we must ask how music therapy can support the recovery processes of the person. Such an approach to music therapy puts agency in the centre of attention, reflecting the perspective that "recovery is primarily the responsibility of the person with a serious mental illness" (Davidson, Tondora, et al., 2009, p. 33). Furthermore, it highlights music therapy as a process of collaboration, redefining the music therapist's role and power relation in the

direction of becoming a partner (Bracken & Thomas, 2005; Slade, 2009), a fellow traveller (Yalom, 2002) or in a musical context as a fellow musician (Solli, 2008).

It has been claimed that stigma is the primary obstacle to a better life for the many people suffering from mental illness and its consequences (Sartorius, 2002). Psychiatry has been blamed for catalysing a downward spiral in which the passivity, dependency, stigma and experiences of hopelessness lead to a reduced self-esteem and confidence followed by social withdrawal, which again leads to further experiences of hopelessness, thereby progressively increasing emotional, psychological and social distress (Frank & Frank, 1993; Repper & Perkins, 2003; Spaniol, Gagne, & Koehler, 1999; Williams, 2012). According to the findings in this study, music therapy seems to contribute towards counteracting such a downward development, instead promoting an oppositely directed spiral (see Figure 3).

Figure 3 - An upward spiral of recovery processes in music therapy[16]



[16] The graphical layout of this model is inspired by Boehm's (1988) spiral model of software processes in computer science.

In Paper 1, I proposed possible links between positive experiences of joy and mastery, hope, agency and social participation in music therapy, but the methodology of the meta-synthesis provided limited possibilities for studying how the various recovery factors were interlinked. Given the additional findings of recovery processes in music therapy from the two case studies, in which more details and a thicker description of the cases, alongside possibilities to follow participants' processes over time, the inter-relations of the various aspects were further illuminated.

However, a complete overview of how these different processes were connected is not possible to achieve in this study, as this was not the main focus of attention in the interviews. Additionally, recovery processes are found to be non-linear and unique to each individual person, and are therefore difficult to describe in general terms or step-by-step processes (Slade, 2009). With these precautions in mind, I nevertheless suggest that, based on this inquiry, music therapy can be understood as an upward spiral of well-being, agency, sense of self and identity, symptom alleviation and hope. These processes seem to be inter-related and to affect each other positively, not in a mechanistic way or a set order, but as a non-linear and an individual process.

7.4. Music therapy as a flexible and cross-contextual practice

Regarding both Research Question 2 and 3, I now want to address the cross-contextual and flexible features of music therapy found in my study. A common theme across the papers was how music and music therapy transgressed the traditional understanding of therapy as a dyadic process between the therapist and the patient or as a psychotherapeutic group process. Music therapy was experienced to promote the processes of recovery: 1) in a variety of clinical or non-clinical contexts, 2) by facilitating relationships between the patient/user and other people outside music therapy, and 3) by affecting the patient/user's everyday life in a number of ways.

First, Paper 1 is comprised of a variety of music therapy practices, from psychiatric inpatient settings to psychiatric outpatient settings and community practices. An interesting finding here was that music therapy supported the processes of personal and social recovery across all these different contexts. Recovery-oriented

practice has primarily been described in relation to community mental health care settings (Davidson, Tondora, et al., 2009), and to a lesser degree been aimed and scientifically studied in relation to inpatient practices (Buckle, 2005). Acute and intensive wards are built around rigid structures with high focus on risk management, premises not easily combined with the processes of empowerment, agency and social inclusion (Chen, Krupa, Lysaght, McCay, & Piat, 2013). It could therefore be expected that music therapy in inpatient settings had less possibilities to support such recovery-related processes. Despite these premises, music therapy was reported to facilitate recovery in the entire range of treatment contexts. The finding of music therapy as a recovery-oriented practice in inpatient settings was strongly confirmed by the following two case studies in Papers 2 and 3. What can be the reasons for this? It seemed that despite being situated in individual settings in the context of acute wards, music therapy offered possibilities to connect with other life contexts.

Second, a main finding in all three papers (but most widely explored in Article 3) was how music therapy facilitated contact with other people a variety of contexts. In the two case studies, in which the music therapy practice took place inside the walls of a locked hospital, the musicking seemed to "migrate" out of the therapy room in the shape of musical artefacts (such as audio recordings and CDs), performances and music that were uploaded to social platforms on the Internet. First, music therapy facilitated relationships between the patient and staff members and fellow patients at the hospital, or peers in community settings. Second, songwriting and the making of CDs were reported to be important for the patient's relationships to family and friends. Third and last, music was used by the patients/users to establish contact with other people in the community, particularly people from various parts of the cultural life, such as other musicians, a DJ from a local pub or people on the Internet. A music therapy practice that includes all these different participants and sites, with the aim of supporting change on both an individual and relational level, operates with complex interventions within a complex system (Rolvsjord & Stige, 2013).

The third aspect was that the study provided knowledge about how music therapy affected the use of music in the participant's everyday life. The narratives described how participants were motivated by the music therapy sessions to start to

play by themselves or together with friends in their spare time, to join a choir or to attend dance gatherings in the community. One participant even invested in an electronic drum kit so that she could play to regulate her symptoms in her own apartment. In contrast, music from the participant's everyday life was also brought into music therapy in the form of songs they wanted to sing, songs they had written and wanted to record, music on iPods and CDs they wanted to listen to. This point toward music therapy as a form of therapy with inherent characteristics to incorporate the musical life history and current musical interests of users into the therapy process, as well as to inspire patients for further musical and cultural participation.

The processes of social change through music and music therapy have been elaborated upon within the field of community music therapy, though limited to community contexts, as community music therapy by definition takes place in non-clinical settings (Stige, 2003, p. 454) and is "usually not oriented towards treatment" (Stige & Aarø, 2012, p. 23). What can be regarded as a contribution of the present study is that it illuminates how music therapy can bridge processes of personal and social recovery between different contexts. That is how music and music therapy can support recovery in clinical practice, social arenas in connection to clinical practice and communal services, and not least in participants' everyday lives as lived in all of those contexts. This means that music therapists needs to recognize that processes of recovery happens on a personal, social, organizational and community level (Prilleltensky & Prilleltensky, 2006; Slade, 2009).

Seen from a recovery perspective, music therapy's cross-contextual and flexible characteristics are enormously valuable. Recovery is a process that first takes place in a person's everyday life; therefore it is important to remember that the contributions from mental health services (such as music therapy) only play a limited part in the overall process (Borg, 2007; Borg & Davidson, 2008). Furthermore, Tew et al. (2012) argue that recovery "involves a shift from the individualizing focus that has become more dominant in recent years towards a twin-track approach that involves not just direct work with service users, but also developmental work with families, social systems and communities" (p. 456). Hence, an important aspect of how music therapy can support recovery for people with a severe mental illness is by cultivating the

possibilities to work with the person's social network and to motivate people to continue to use music in their everyday lives. Borg and Davidson (2007) argue that, "Everyday life tasks and skills need to be addressed as part of the practitioners' agenda, as well as if not more than such issues as insight or medication compliance" (p. 11). For music therapy, this would especially imply paying attention to the person's interests, hobbies and activities, and linking and integrating these into the music therapy process.

In the recovery literature, scepticism has been expressed towards the establishment of therapeutic or cultural practices that substitute for activities that can be found in the community. It has been argued that such services provide "inward-looking safe havens" (Tew, 2012, p. 455) which may only lead to a "program citizenship" inside mental health systems rather than true social inclusion (Davidson, Tondora, et al., 2009, p. 168). Such services will potentially keep people away from real life in the community and contribute to further stigma and discrimination. Music therapy is hence a practice that can be accused of offering an artificial version of something that is already present in the community, such as music schools, choirs and the possibility for playing in a band. My experiences from almost 15 years in practice are that it is not easy for all people with severe mental health difficulties to join community (musical) activities, especially not in certain phases of the illness. In order to promote the processes of personal and social recovery, it is important for the music therapist to work with complex systems, continuing to engage in the patient's everyday life situation and working to promote the various relationships that link people together.

7.5 Strengths and limitations

Qualitative studies are creative and interpretative, and the interpretations are constructed (Denzin & Lincoln, 2008). Thus, the present study is an interpretative document containing my attempts to make sense of what I have learned. Since I as a researcher have used myself as an instrument, self-critique is seen as particularly relevant in a qualitative study such as this (Stige et al., 2009). I have tried my best to

take such a critical attitude, and I have attended to matters of reflexivity throughout this project. Since reflexivity is a process and not an end point, it can never be completely achieved. To what degree I have succeeded at adapting a proper critical and self-reflective stance is not up to me to judge. However, I will argue that by being open about my motives, background and perspectives, and by attempting to have a high level of consciousness of various levels of reflexivity, this serves to strengthen the trustworthiness of this study.

A major strength of this study is its closeness to practice and the access to data from a group of patients who have previously been rendered a limited amount of attention in the research literature. The clinical context of the study was well-established with music therapy integrated as a central part of the hospital's treatment services, with the current researcher being employed as a music therapist since 2001. Moreover, the hospital management and the general staff exhibited a positive and engaged attitude towards the study. The project therefore did not interfere with the practice, and made it possible to study "treatment as usual". All of these factors contributed to the possibility to access rich and detailed first-person accounts and the possibilities for a close and active participatory observation, so hence the ability to approach and study processes of recovery. This closeness to practice provides possibilities for clinicians to utilize the research in their own practice (McLeod, 2001b), also referred to as pragmatic validity (Kvale & Brinkmann, 2009, p. 256).

Although the first-person perspective contributes to valuable knowledge, it is important to remember that it does not represent some ultimate truth. Here, I agree with Smail (as cited in Geekie et al., 2012, p. 3), who states that, "The subjective perspective needs to be evaluated intersubjectively (which brings it as near as possible to being objective) but there is still, ultimately, no authority beyond it." In the present thesis, such intersubjective evaluations took place, both in conversations with the interviewees and through discussions between my supervisor and present author.

Another strength of this study is the diversity of participants included in the case studies. Literature regarding first-hand accounts of recovery in mental illness has been accused of being predominantly white middle-class, well-educated writers, and thus being less relevant for the recovery process of the average service user (Geller,

2014). The present study included five men and four women, including two participants with a multicultural background, participants with a generally low level of education and income, and with limited social support. However, they also represented a homogeneous group, as they all were aged between 21–41 years, lived in a capital city, were located at the same hospital and received music therapy from the same therapist. Additionally, the strategic selection of participants prioritized individuals capable of expressing themselves well verbally, and who had a motivation for music therapy. In that regard, it can be argued that the study included a group of patients with an above average level of verbal and musical resources, as well as motivation. Nonetheless, the meta-synthesis strengthens these limitations, since it included a plurality of approaches to music therapy, contexts, music therapists and participants.

A weakness of the study is the limited degree of user involvement in the planning and accomplishment of the study. According to the strong focus on user involvement in recovery, it would have been warranted to establish a reference group at an earlier stage of the process. However, this was compensated for by studying, and letting the study be informed by, literature reflecting service users' experiences and values in relation to mental health services. Furthermore, the user- perspective was carefully attended to as I sought to have an awareness of the participants' wishes, needs, perspectives and values throughout the study.

Lastly, I aimed to study how music and music therapy were experienced in both the clinical setting of a psychiatric intensive care unit, and how it affected the participants' everyday lives during the course of music therapy. Although the everyday perspective was illuminated through the participants' narratives in the interviews, the study's clinical context resulted in a limited access to knowledge about the everyday use of music outside music therapy settings. To study such dimensions more directly, a design that allowed for investigations in both contexts would have been necessary.

7.6 Implications for research and practice

This study supports earlier findings of music therapy as a meaningful, motivating, vitalizing and positively experienced approach to therapy for people diagnosed with a

severe mental illness (e.g. Ansdell & Meehan, 2010; Jampel, 2006; Rolvsjord, 2010). In this way, it confirms and complements results from outcome studies with regard to the significant effects of music therapy on negative symptoms (Gold et al., 2009, 2013; Mössler et al., 2011). Hence, this study adds to- and supports the body of knowledge, thereby indicating that music therapy should be offered as part of standard treatment for service users with severe mental illnesses, as suggested in current guidelines (Directorate of Health, 2012; National Collaborating Centre for Mental Health, 2010).

An understanding of recovery as a personal and social process is increasingly underpinning the policy of mental health systems. It is important for music therapists to be aware of this ongoing development and adjust or practice in accordance with these policies. This study contributes to raising the awareness of recovery within our field of practice. Even more important, however, is it that an increased amount of attention to the recovery perspective will contribute towards raising awareness of the user-perspective, thus ensuring that music therapists provide a best possible practice for our users. The most central practical implication of the recovery perspective is that we need to acknowledge that recovery is something people who experience severe mental health illness must to do themselves, and that professionals' job is to follow and support this process (Davidson, Tondora, et al., 2009; Rudnick, 2012). The present study illustrates how service users can be such an active agent, in addition to being capable of actively *using* music in ways that promote recovery. As a result, I suggest that music therapy as recovery oriented-practice can best be understood as the affordance of a therapeutic and social arena in which people with mental health difficulties can work on their process of recovery through musicking, rather than a process of systematic diagnosis-specific interventions.

This study have identified several ways that music therapy can promote the processes of recovery for people with a severe mental illness, which includes the potential to support and strengthen a positive identity and sense of self, facilitate well-being and emotional expression, support the processes of social inclusion and promote hope. Many music therapists are already working in ways that incorporate many of these aspects. However, according to a recent systematic review of music therapy practices in adult psychiatric care, neither well-being, hope, positive identity or agency

were identified as common goals (Carr et al., 2013). Music therapy as recovery-oriented practice implies that we need to raise our awareness of current knowledge about what fosters and hinders recovery, thus implying that we need to start inviting service users into the driver's seat of music therapy (Solli, 2012).

Lastly, some of the participants in this study strongly resisted a blending of music and psychiatric treatment, as music aligned with a precious area and resource in their life that they wanted to keep apart from the realm of illness and treatment. This finding calls for caution as far as what type of approach to music therapy is offered, demanding an openness to the case that for some persons, perhaps especially those who are actively using music as a health resource, music therapy may not always be appropriate. Even so, I would argue that if a music therapy practice is based on recovery values and oriented towards supporting the agency of the user, it should be possible to tailor a way of collaborating musically and supporting the personal journey of recovery for most service users.

The findings of this thesis contribute to the ongoing reflection and dialogue about using music therapy in mental health care. As a recovery-oriented practice, music therapy has received little attention in research and theory thus far, although the interest seems to be growing. The increasing prominence of the notion of recovery and recovery-oriented practices has called forth a request for more research in this field (Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009). This study has identified music therapy as a practice that is highly aligned with the perspective of recovery. More qualitative research is required to further explore service users' experiences of music therapy, and how music therapy can best support the processes of recovery. In particular, studies of service users' attendance in music therapy in relation to their appropriations of music in their everyday life would be valuable knowledge. Furthermore, because current mental health services are oriented towards social inclusion to an increasing degree, knowledge about how music therapy can promote such processes is warranted. Here, it would be of particular interest to gain more knowledge about the interplay and collaboration between various areas of music therapy practice: acute units, intensive care units, community services and non-medical settings.

8. Conclusion

The aim of this study was to explore the user-perspective of people diagnosed with psychosis in order to understand how music therapy can contribute to processes of recovery. The collection of data included interviews and participatory observations of nine participants admitted to a psychiatric intensive care unit. A hermeneutic-phenomenological approach was applied in the design of the study and in the analysis of data. In addition, a qualitative meta-synthesis of service users' experiences with music therapy was conducted. The conclusions from this study follow the research questions and therefore address three areas: the experiences of music therapy, the processes of recovery in music therapy and music therapy's contributions to a recovery-oriented mental health service.

The first major finding of this research is that service users primarily described their experiences of music and music therapy in relation to aspects of positive mental health and well-being. The experiences of symptom alleviation were described by some participants, but had the character of being of secondary importance. Instead, music therapy was found to support inter-related processes of recovery, an upward spiral of well-being, agency, a sense of self and identity, symptom alleviation and hope. A conclusion to be drawn from this is that music therapy was found to support elements regarded as being central to the processes of recovery for people with severe mental illness.

The second major finding was that the positive experiences reported were connected to music therapy as an arena for the performance of agency. Music therapy was primarily described as different from most other treatment approaches insofar as it afforded possibilities for the person to be an active agent-, rather than a passive receiver, of treatment. Furthermore, participants described social aspects of agency in that musicking afforded possibilities for social connectedness and social participation. A conclusion to be drawn from this is that music therapy was found to promote recovery by affecting the person's perceived ability to affect his or her situation and the ability to engage with other people in a meaningful and rewarding way.

The third major finding was that music therapy supported processes of recovery across multiple contexts in the participant's life – in the clinical hospital setting, in social settings, both inside and outside the hospital, and in the participant's everyday life. The cross-contextual and flexible characteristics must be regarded as a key aspect, since recovery is a personal and social process mainly taking place outside professional mental health-care settings. A conclusion to be drawn from this is that music therapy can be an important contribution to a recovery-oriented mental health care, both in inpatient-, outpatient- and community settings.

Lastly, I want to link these findings to the title of this thesis. As we have seen, *recovery* is about getting one's life onto a new and better track. It is a way of seeing, approaching, grasping and appreciating life's possibilities despite limitations caused by illness. *Groove* is a term that refers to aspects of music that make it swing, flow, feel good and feel alive. Groove is about motion and emotion, participation, reciprocity, communication and community and it is characterized by discrepancies, irregularity and nonlinearity (Keil & Feld, 2005). One could therefore say that recovery *in* mental illness is a process of getting (back) into the groove of life. This groove is not about making everything perfect, linear or normal, but rather about finding one's own personal groove and, not least, finding ways and places to groove together with other people. That is the groove of recovery. This thesis suggests that music therapy affords an arena that can help people with severe mental illness to get into such a groove.

9. References

Aasgaard, T. (2002). *Song creations by children with cancer. Process and meaning*. (Unpublished doctoral dissertation). Department of Music and Music Therapy, Aalborg University, Aalborg.

Aasgaard, T. (2004). A pied piper among white coats and infusion pumps: Community music therapy in a pediatric hospital setting. In M. Pavlicevic & G. Ansdell (Eds.), *Community music therapy* (pp. 147–163). London: Jessica Kingsley.

Abrams, B. (2005). Evaluating qualitative music therapy research. In B. Wheeler (Ed.) *Music therapy research* (2nd ed., pp. 247-258). Gilsum, NH: Barcelona.

Abrams, B. (2012). A relationship-based theory of music therapy: Understanding processes and goals as being-together-musically. In K. E. Bruscia (Ed.), *Readings on music therapy theory* (pp. 87–119). Gilsum, NH: Barcelona.

Adams, S. M., & Partee, D. J. (1998). Hope: The critical factor in recovery. *Journal of Psychosocial Nursing and Mental Health Services, 36*(4), 29–32.

Adeponle, A., Whitley, R., & Kirmayer, L. J. (2012). Cultural contexts and constructions of recovery. In A. Rudnick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives.* Croydon: Oxford University Press.

Aigen, K. (2002). *Playin' in the band. A qualitative study of popular music styles as clinical improvisation.* New York: New York University.

Aigen, K. (2005a). *Being in music: Foundations of Nordoff-Robbins music therapy*. The Nordoff-Robins music therapy monograph series (Volume 1). Gilsum, NH: Barcelona.

Aigen, K. (2005b). *Music-centered music therapy*. Gilsum, NH: Barcelona

Aigen, K. (2008a). An analysis of qualitative music therapy research reports 1987-2006: Articles and book chapters. *The Arts in Psychotherapy, 35*, 251–261.

Aigen, K. (2008b). An analysis of qualitative music therapy research Reports 1987-2006: Doctoral studies. *The Arts in Psychotherapy, 35*, 307–319.

Aigen, K. (2013). Social interaction in jazz: Implications for music therapy. *Nordic Journal of Music Therapy, 22*, 180–209. doi:10.1080/08098131.2012.736878

Allen, J. G., Munich, R. L., & Rogan, A. (2004). *Agency in illness and recovery.* Unpublished manuscript. The Menninger Clinic and the Menninger Department of Psychiatry and Behavioral Science at the Baylor College of Medicine. Retrieved from http://www.menningerclinic.com.

Alvesson, M., & Sköldberg, K. (2000). *Reflexive methodology. New vistas for qualitative research*. London: Sage.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Amering, M., & Schmolke, M. (2009). *Recovery in mental health. Reshaping scientific and clinical responsibilities.* Chichester, WS: Wiley-Blackwell.

Anderson, E. (2012). *Feminist epistemology and philosophy of science*. The Stanford Encyclopedia of Philosophy (Fall 2012 Edition). Retrieved from http://plato.stanford.edu/archives/fall2012/entries/feminism-epistemology

Ansdell, G. (1995). *Music for life. Aspects of creative music therapy with adult clients.* London: Jessica Kingsley.

Ansdell, G. (2002). Community music therapy and the winds of change. A discussion paper. *Voices: A World Forum for Music Therapy, 2*(2). Retrieved from https://voices.no/index.php/voices/article/viewArticle/83/65

Ansdell, G. (2003). The stories we tell: Some meta-theoretical reflections on music therapy. *Nordic Journal of Music Therapy, 12*(2), 192–159. doi:10.1080/ 08098130309478085

Ansdell, G. (2005). Being who you aren't; Doing what you can't: Community music therapy & the paradoxes of performance. *Voices: A World Forum for Music Therapy, 5*(3). Retrieved from https://voices.no/index.php/voices/article/view/229/173

Ansdell, G. (2010a). Music on the edge: Musical minds in east London, England. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps. Community music therapy in action and reflection* (pp. 33–40). Farnham: Ashgate.

Ansdell, G. (2010b). Belonging through musicing. Explorations of musical community. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps. Community music therapy in action and reflection* (pp. 42–62). Farnham: Ashgate.

Ansdell, G. (2014). *How music helps in music therapy and everyday life*. Farnham: Ashgate.

Ansdell, G., & DeNora, T. (2012). Musical flourishing: Community music therapy, controversy, and the cultivation of wellbeing. In R. McDonald, G. Kreutz, & L. Mitchell (Eds.), *Music, health & wellbeing* (pp. 97–112). Croydon: Oxford University Press.

Ansdell, G., & Meehan, J. (2010). "Some light at the end of the tunnel": Exploring users' evidence for the effectiveness of music therapy in adult mental health settings. *Music and Medicine, 2*(1), 29–40. doi:10.1177/1943862109352482

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11–23. doi:10.1037/h0095655

Antoniou, J. (2007). Bored on the ward. In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin. (Eds.), *Experiences of mental health in-patient care. Narratives from service users, carers and professionals* (pp. 33–40). London: Routledge.

Antonovsky, A. (1996). The Salutogenic modell as a theory to guide health promotion. *Health Promotion International, 11*, 11-18.

Arseneault, L., Cannon, M., Witton, J., & Murray, R. M. (2007). Causal association between cannabis and psychosis: Examination of the evidence. *FOCUS: The Journal of Lifelong Learning in Psychiatry, 5*(2), 270-278.

Ashworth, P. (2008). Conceptual foundations of qualitative psychology. In J. A. Smith (Ed.) *Qualitative psychology. A practical guide to research methods* (2nd ed., pp. 4-25). London: Sage.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*, 1-10. doi:10.1186/1471-2288-8-21

Baines, S. (2003). A consumer-directed and partnered community mental health music therapy program: Program development and evaluation. *Voices: A World Forum for Music Therapy, 3*(3). Retrieved from https://voices.no/index.php/voices/article/view/137/113

Baines, S. (2013). Music therapy as an anti-oppressive practice. *The Arts in Psychotherapy, 40*(1), 1–5. doi:10.1016/j.aip.2012.09.003

Baines, S., & Danko, G. (2010). Community mental health music therapy: A consumerinitiated song-based paradigm. *Canadian Journal of Music Therapy, 16*, 148–191.

Beards, S., Gayer-Anderson, C., Borges, S., Dewey, M. E., Fisher, H. L., & Morgan, C. (2013). Life Events and psychosis: A review and meta-analysis. *Schizophrenia Bulletin, 39*(4), 740-747.

Bellack A., & Drapalski, A. (2012). Issues and developments on the consumer recovery construct. *World Psychiatry ,11*(3), 156-60. doi: 10.1002/j.2051-5545.2012.tb00117.x

Bentall, R. P. (2003). *Madness explained. Psychosis and human nature*. London: Penguin.

Bentall, R. P (2009). *Doctoring the mind. Why psychiatric treatments fail.* London: Pinguin.

Boehm, B. W. (1988). A spiral model of software development and enhancement. *Computer*, *21*(5), 61-72.

Boevink, W. (2012). Life beyond psychiatry. In A. Rudnick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives* (pp. 15–29). Oxford: Oxford University Press.

Borczon, R.M. (1997). *Music therapy: Group vignettes*. Gilsum, NH: Barcelona Publishers.

Borg, M. (2007). *The nature of recovery as lived in everyday life: Perspectives of individuals recovering from severe mental health problems.* (Unpublished doctoral thesis). Norwegian University of Science and Technology, Trondheim.

Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*(2), 129-140. doi:10.1080/09638230701498382

Borg, M., Jensen, P., Topor, A., & Andersen, A. J. (2011). Recovery med nordisk blikk [A Nordic view on recovery]. *Tidsskrift for Psykisk Helsearbeid, 8*(4), 290–292.

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health, 13*, 493–505. doi:10.1080/09638230400006809

Borg, M., & Kristiansen, K. (2008). Working on the edge. Everyday life research from Norway on the meaning of work for people recovering in psychosis. *Disability & Society, 23*(5), 511–523.

Boydell, K., Gladstone, B., & Crawford, E. (2002). The dialectic of friendship for people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*, 123–131. doi:10.2975/26.2002.123.131

Bracken, P., & Thomas, P. (2005). *Postpsychiatry. Mental health in a postmodern world.* New York: Oxford University Press.

British Psychological Society (2000). *Recent advances in understanding mental illness and psychotic experiences.* Leicester: British Psychological Society.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta-ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy, 7*(4), 209–215.

Brown, C., Rempfer, M., & Hamera, E. (2008). Correlates of insider and outsider conceptualizations of recovery. *Psychiatric Rehabilitation Journal, 32*(1), 23-31. doi: 10.2975/32.1.2008.23.31

Bruscia, K. E. (1998). *Defining music therapy* (2nd ed.). Gilsum, NH: Barcelona.

Bruscia, K. E. (2012). *Case examples of music therapy for schizophrenia and other psychosis* [Adobe Digital Editions version]. Retrieved from http://www.barcelonapublishers.com/e-books

Buckle, D. (2005). Social work in a secure environment: Towards social inclusion. *Journal of Psychiatric Intensive Care, 1*(01), 37-43. doi:10.1017/S1742646405000075

Byrne, C. M., Woodside, H., Landeen, J., Kirkpatrick, H., Bernardo, A., & Pawlick, J. (1994). The importance of relationships in fostering hope. *Journal of Psychosocial Nursing and Mental Health Services, 32*(9), 31–34.

Cantor-Graae, E., & Selten, J. P. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry, 162*(1), 12-24.

Carr, C., d'Ardenne, P., Sloboda, A., Scott, C., Wang, D., & Priebe, S. (2011). Group music therapy for patients with persistent post-traumatic stress disorder – An exploratory randomized controlled trial with mixed methods evaluation. *Psychology and Psychotherapy: Theory, Research and Practice, 85*, 179–202. doi:10.1111/j.2044-8341.2011.02026.x

Carr, C., Odell-Miller, H., & Priebe, S. (2013). A systematic review of music therapy practice and outcomes with acute adult psychiatric in-patients. *PloS one, 8*(8), e70252. doi:10.1371/journal.pone.0070252

Charmaz, K. (2003). Grounded theory. Objectivist and constructivist methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry*. (2nd ed., pp. 249-291). London: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage

Chen, S. P., Krupa, T., Lysaght, R., McCay, E., & Piat, M. (2013). The development of recovery competencies for in-patient mental health providers working with people with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(2), 96–116. doi:10.1007/s10488-011-0380-x

Chhina, C. (2004). Music therapy and psychosocial rehabilitation: Towards a person-centred music therapy model. *Canadian Journal of Music Therapy, 11*(1), 8–30.

Choi, B. C. (1997). Professional and patient attitudes about the relevance of music therapy as a treatment modality in NAMT approved psychiatric hospitals. *Journal of Music Therapy, 34*(4), 277–292. doi:10.1093/jmt/34.4.277

Christians, C. G. (2009). Ethics and politics in qualitative research. In N. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed.) (pp. 185-220). London: Sage.

Clarke, S., Oades, L. G., & Crowe, T. P. (2012). Recovery in mental health: A movement towards well-being and meaning in contrast to an avoidance of symptoms. *Psychiatric Rehabilitation Journal, 35*(4), 297-304. doi:10.2975/35.4.2012.297.304.

Clemencic-Jones, V. (1998). The benefits of group music therapy in an acute psychiatric setting. In R. R. Pratt & D. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and music therapy: Expanding horizons*. Saint Louis, MO: MMB Music.

Coleman, R. (2004). *Recovery: An alien concept.* Wormit Fife: P & P Press.

Crane-Ross, D., Lutz, W. J., & Roth, D. (2006). Consumer and case manager perspectives of service empowerment: Relationship to mental health recovery. *Journal of Behavioral Health Services & Research, 33*(2), 142–55.

Davidson, L. (2003). *Living outside mental illness. Qualitative studies of recovery in schizophrenia.* New York: New York University Press.

Davidson, L. (2012). Considering recovery as a process: Or, life is not an outcome. In A. Rudnick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives* (pp. 252-263). Croydon: Oxford University.

Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., & Sells, D. (2005). Processes of recovery in serious mental illness: Findings from a multinational study. *American Journal of Psychiatric Rehabilitation, 8*, 177–201. doi:10.1080/15487760500339360

Davidson, L., & Chan, K. K. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services, 65*(5), 675-677. doi:10.1176/appi.ps.201300274

Davidson, L., Drake, R. E., Schmutte, T., Dinzeo, & Andres-Hyman, R (2009). Oil and water or oil and vinegar? Evidence-based medicine meets recovery. *Community Ment Health J, 45*, 323–332. doi:10.1007/s10597-009-9228-1

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system

transformation. *Psychiatric Services, 57*, 640–645. doi:10.1176/appi.ps.57.5.640

Davidson, L., Rakfeldt, J., & Strauss, J. (2010). *The roots of the recovery movement in psychiatry. Lessons learned.* Chichester, WS: Wiley-Blackwell

Davidson, L., Ridgway, P., Kidd, S., Topor, A., & Borg, M. (2008). Using qualitative research to inform mental health policy. *Canadian Journal of Psychiatry, 53*(3), 137–144.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-470. doi:10.1080/09638230701482394

Davidson, L., Shahar, G., Lawless, M. S., Sells, D., & Tondora, J. (2006). Play, pleasure, and other positive life events: "Non-specific" factors in recovery from mental illness? *Psychiatry: Interpersonal and Biological Processes, 69*(2), 151–163. doi:10.1521/psyc.2006.69.2.151

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65*(2), 131–145. doi:10.1111/j.2044-8341.1992.tb01693.x

Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). *A practical guide to recovery-oriented practice. Tools for transforming mental health care.* New York, NY: Oxford University Press.

Davidson, L., Tondora, J., Staeheli, M., O'Connell, M., Frey, J., & Chinman, M. (2005). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community-based clinical practice* (pp. 476–501). London: Oxford University Press.

De Backer, J. (2004). *Music and Psychosis. The transition from sensorial play to musical form by psychotic patients in a music therapy process* (Unpublished doctoral dissertation). Department of communication and psychology, University of Aalborg, Aalborg.

Deegan, P. (1996a). *Recovery, rehabilitation and the conspiracy of hope*. Paper presented at the 6th annual mental health services conference of Australia and New Zealand, Brisbane. Retrieved from https://www.patdeegan.com/pat-deegan/lectures/conspiracyof-hope

Deegan, P. (1996b). Recovery as a journey of heart. *Psychiatric Rehabilitation Journal, 19*(3), 91–97.

Deegan, P. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care, 25*(3), 11–24. doi:10.1300/J010v25n03_02

de l'Etoile, S. K. (2002). The effectiveness of music therapy in group psychotherapy for adults with mental illness. *The Arts in Psychotherapy, 29*, 69–78. doi:10.1016/S0197-4556(02)00139-9

Dencin, N. K., & Lincoln, Y.S. (2008). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 1-44). London: Sage.

DeNora, T. (2000). *Music in everyday life*. Cambridge: Cambridge University Press.

DeNora, T. (2006). Evidence and effectiveness in music therapy: Problems, power, possibilities, and performances in health contexts (A discussion paper). *British Journal of Music Therapy, 20*(2), 81–93.

DeNora, T. (2007). Health and music in everyday life – A theory of practice. *Psyke & Logos, 28*(1), 271–287.

DeNora, T. (2013). *Music asylums. Wellbeing through music in everyday life*. Surrey: Ashgate.

Department of Health and Human Services. (2006). *National consensus statement on mental health recovery.* MD: Substance Abuse and Mental Health Services Administration. Center for Health Services.

Dix, R. (2005). Psychiatric intensive care and low secure units past, present and future introducing the journal of psychiatric intensive care. *Journal of Psychiatric Intensive Care, 1*, 1–2. doi:10.1017/S1742646405000014

Dreier, O. (2008). *Psychotherapy in everyday life. Learning in doing: Social, cognitive, & computational perspectives*. New York: Cambridge.

Edwards, J. (2006). Consideration of potential informants from feminist theory for music therapy practice. In S. Hadley (Ed.), *Feminist perspectives in music therapy* (pp. 367–388). Gilsum, NH: Barcelona.

Eyre, L. (2011). Therapeutic chorale for persons with chronic mental illness: A descriptive survey of participant experiences. *Journal of Music Therapy, 48*, 149–168. doi:10.1093/jmt/48.2.149

Eyre, L. (2013). Adults in a recovery model setting. In L. Eyre (Ed.), *Guidelines for music therapy practice in mental health care* (Chapter 4) [Adobe Digital Editions version]. Gilsum, NH: Barcelona. Retrieved from http://www.barcelonapublishers.com/e-books

Faerden, A., Friis, S., Agartz, I., Barrett, E. A., Nesvåg, R., Finset, A., & Melle, I. (2009). Apathy and functioning in first-episode psychosis. *Psychiatric Services, 60*, 1495–1503. doi:10.1176/appi.ps.60.11.1495

Fangen, K. (2004). *Deltakende observasjon* [Participatory observation]. Oslo: Fagbokforlaget.

Fingfeld, D. L. (2003). Metasynthesis: The state of the art—so far. *Qualitative Health Research, 13*(7), 893–904.

Finlay, L. (2003a). Reflexive journey: Mapping multiple routes. In L. Finlay & B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences* (pp. 3-20). Oxford: Blackwell.

Finlay, L. (2003b). Through the looking glass: Intersubjectivity and hermeneutic reflection. In L. Finlay & B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences (pp. 105-119)*. Oxford: Blackwell.

Finlay, L. & Gough, B. (Eds.) (2003). *Reflexivity. A practical guide for researchers in health and social sciences.* Oxford: Blackwell.

Fledderus, M., Bohlmeijer, E. T., Smit, F., & Westerhof, G. J. (2010). Mental health promotion as a new goal in public mental health care: A randomized controlled trial of an intervention enhancing psychological flexibility. *American Journal of Public Health*, *100*, 2372–2378. doi:10.2105/AJPH.2010.196196

Frank, J. D., & Frank, J. B. (1993). *Persuasion & healing. A comparative study of psychotherapy.* Third edition. Baltimore: The John Hopkins University Press.

Geekie, J. (2007). *The experience of psychosis: Fragmentation, invalidation and spirituality* (Unpublished doctoral thesis). The University of Auckland, Auckland, New Zealand.

Geekie, J., Randal, P., Read, J., & Lampshire, D. (2012). Introduction. In J. Geekie, P. Randal, D. Lampshire, & J. Read (Eds.), *Experiencing psychosis: Personal and professional perspectives* (pp. 1-5). London: Routledge.

Geekie, J., & Read, J. (2008). Fragmentation, invalidation and spirituality: Personal experiences of psychosis – ethical, research and clinical implications. In J. F. M Gleeson, E. Killackey, & H. Krstev (Eds.), *Psychotherapies for psychosis. Theoretical, cultural and clinical integration* (pp. 183-199). New York: Routledge.

Geekie, J., & Read, J. (2009). *Making sense of madness. Contesting the meaning of schizophrenia.* New York: Routledge.

Geller, J. L. (2014). First person accounts of mental illness and recovery (Book review). *Psychiatric Services, 65*(1), e4. Retrieved from http://journals.psychiatryonline.org/data/Journals/PSS/929507/e04.pdf

Georgaca, E. (2003). Analysing the interviewer: The joint construction of accounts of psychotic experience. In L. Finlay & B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences* (pp. 120-132). Oxford: Blackwell.

Gibson, J. J. (1986). *The ecological approach to visual perception*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Gill, K. (2012). Contrasting conceptualizations of recovery imply a distinct research methodology. In A. Rudnick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives* (pp. 95-108). Croydon: Oxford University Press.

Gold, C., Mössler, K., Grocke, D., Heldal, T. O., Tjemsland, L., Aarre, T., … Rolvsjord, R. (2013). Individual music therapy for mental health care clients with low therapy motivation: Multicentre randomised controlled trial. *Psychotherapy and Psychosomatics, 82*(5), 319–331. doi:10.1159/000348452

Gold, C., Solli, H. P., Krüger, V., & Lie, S. A. (2009). Dose-response relationship in music therapy for people with serious mental disorders: Systematic review and meta analysis. *Clinical Psychology Review, 29*, 193–207. doi:10.1016/j.cpr.2009.01.001

Grocke, D., Bloch, S., & Castle, D. (2008). Is there a role for music therapy in the care of the severely mentally ill? *Australasian Psychiatry, 16*, 442–445. doi:10.1080/10398560802366171

Grocke, D., Bloch, S., & Castle, D. (2009). The effect of group music therapy on quality of life for participants living with a severe and enduring mental illness. *Journal of Music Therapy, 46*(2), 90–104. doi:10.1093/jmt/46.2.90

Grocke, D., Bloch, S., Castle, D., Thompson, G., Newton, R., Stewart, S., & Gold, C. (2013). Group music therapy for severe mental illness: a randomized embedded experimental mixed methods study. *Acta Psychiatrica Scandinavica.* Advance online publication. *doi:10.1111/acps.12224*

Guba, E. G. & Lincoln, Y. S. (2008). Paradigmatic controversies, contradictions, and emergent confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research,* (pp. 255-286). London: Sage.

Gutiérrez, L. M. (1990). Working with women of color: An empowerment perspective. *Social Work, 35*(2), 149–153. doi:10.1093/sw/35.2.149

Hammel-Gormley, A. (1995). *Singing the songs: A qualitative study of music therapy with individuals having psychiatric illnesses as well as histories of childhood sexual abuse* (Unpublished doctoral dissertation). New York University, New York, NY. Retrieved form http://steinhardt.nyu.edu

Hansson, L. (2006). Determinants of quality of life in people with severe mental illness. *Acta Psychiatrica Scandinavica, 113*, 46–50. doi:10.1111/j.1600-0447.2005.00717.x

Healthcare Commission. (2005). *National Audit of Violence (2003–2005). Final report Healthcare Commission*. The Royal College of Psychiatrists. Retrieved from http://www.rcpsych.ac.uk/PDF/Final%20Report%20shortened%20for%20website.pdf

Hem, M. H., Heggen, K., & Ruyter, K. W. (2007). Questionable requirement for consent in observational research in psychiatry. *Nursing ethics, 14*(1), 41-53.

Herrman, H., Saxena, S., & Moodie, R. (Eds.). (2005). *Promoting mental health: Concepts; emerging evidence; practice* (A WHO Report in Collaboration with the Victorian Health Promotion Foundation and the University of Melbourne). Geneva: World Health Organization.

Hibben, J. (1999). *Inside Music Therapy: Client experiences*. Gilsum, NH: Barcelona.

Holt-Lunstad, J., Smith, T. B., Layton, J. B., & Brayne, C. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Med, 7*(7), e1000316. doi:10.1371/journal.pmed.1000316

Hooper, S., & Procter, S. (2013). Less comfortably numb, more meaningfully occupied. In L.O. Bonde, E. Ruud, M. S. Skånland, & G. Trondalen (2013). *Musical life histories. Narratives on health musicking* (pp. 221-240). Centre for music and health publications (Vol. 6). Oslo: NMH

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*, 482–485. doi:10.1176/appi.ps.52.4.482

Jampel, P. (2007). *Performance in music therapy with mentally ill adults* (Unpublished doctoral dissertation). New York University, New York, NY.

Jenkins, J. H., & Barrett, R. J. (2004). *Schizophrenia, culture, and subjectivity: The edge of experience.* Cambridge: Cambridge University Press.

Jensen, B. (1999). Music therapy with psychiatric in-patients: A case study with a young schizophrenic man. In T. Wigram & J. De Backer (Eds.), *Clinical applications of music therapy in psychiatry* (pp. 44–60). London: Jessica Kingsley.

Jensen, B. (2008). Musikterapi i socialpsykiatrien i Århus – musikterapeuten som socialarbeider [Music therapy in social psychiatry in Århus – the music therapist as social worker]. In U. Holck (Ed.), *Musikterapi i psykiatrien* [Music therapy in psychiatry]. Årsskrift 5. Aalborg: Musikterapiklinikken, Aalborg Psychiatric Hospital, & Aalborg University.

Jensen, B. (2011). Brugerundersøgelse om musikterapi i Socialpsykiatrien i Aarhus Kommune [User survey about music therapy in the Social psychiatry in Aarhus

municipality]. *Musikterapi i Psykiatrien Online, 6*(1). Retrieved from: http://www.mscand.dk/index.php/mip/article/viewFile/7157/6120

Jensen, L. A., & Allen, M. N. (1996). Meta-synthesis of qualitative findings. *Qualitative Health Research, 6*(4), 553–560.

Jetten, J., Haslam, C., Haslam, S. A., Dingle, G., & Jones, J. M. (2014). How groups affect our health and well-being: The path from theory to policy. *Social Issues and Policy Review, 8*(1), 103–130. doi:10.1111/sipr.12003

Johannessen, J. O. (2002). Schizofreni – omfang og betydning. [Schizophrenia – extent and consequence]. *Tidsskrift for den norske lægeforening, 122*, 2011-2014.

Kalhovde, A. M., Elstad, I., & Talseth, A. G. (2014). "Sometimes I walk and walk, hoping to get some peace." Dealing with hearing voices and sounds nobody else hears. *International Journal of Qualitative Studies on Health and Well-being, 9*, 1-12. doi: 10.3402/qhw.v9.23069

Kaser, V. (2011). Singing in the recovery model with a chronic mentally ill offender. In A. Meadows (Ed.), *Developments in music therapy practice: Case study perspectives* (pp. 400–415). Gilsum, NH: Barcelona.

Katschnig, H. (2000). Schizophrenia and quality of life. *Acta Psychiatrica Scandinavica, 102*(s407), 33–37. doi:10.1034/j.1600-0447.2000.00006.x

Kean, C. (2009). Silencing the self: Schizophrenia as a self-disturbance. *Schizophrenia Bulletin, 35*(6), 1034–1036. doi:10.1093/schbul/sbp043

Keil, C. & Feld, S. (2005). *Music grooves* (2nd ed.). Tucson: Fenestra books.

Kirkevold, M., & Bergland, Å. (2007). The quality of qualitative data: Issues to consider when interviewing participants who have difficulties providing detailed accounts of their experiences. *International Journal of Qualitative Studies on Health and Well-Being, 2*, 68–75. doi:10.1080/17482620701259273

Kirkland, K. (2012). *International dictionary of music therapy*. Hove, ES: Routledge.

Kirkpatrick, B., Fenton, W. S., Carpenter, W. T., & Marder, S. R. (2006). The NIMHMATRICS consensus statement on negative symptoms. *Schizophrenia Bulletin, 32*, 214–219. doi:10.1093/schbul/sbj053

Knight, M. T., Wykes, T., & Hayward, P. (2003). “People don’t understand”: An investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA). *Journal of Mental Health, 12*, 209–222. doi:10.1080/0963823031000118203

Kogstad, R. E., Ekeland, T. J., & Hummelvoll, J. K. (2011). In defence of a humanistic approach to mental health care: recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change. *Journal of Psychiatric and Mental Health Nursing, 18*(6), 479-486. doi: 10.1111/j.1365-2850.2011.01695.x

Kogstad, R. E., Mönness, E., & Sörensen, T. (2013). Social networks for mental health clients: Resources and solution. *Community Mental Health Journal, 49*(1), 95–100. doi:10.1007/s10597-012-9491-4

Kooij, C. V. (2009). Recovery themes in songs written by adults living with serious mental illnesses. *Canadian Journal of Music Therapy, 15*(1), 37–58.

Kristiansen, I. S., & Mooney, G. (2006). Evidence-based medicine. Method, collaboration, movement or crusade? In I. S. Kristiansen & G. Mooney (Eds.), *Evidence-based medicine. In its place* (pp. 1–19). New York: Routledge.

Krüger, V. (2011). *Musikk –Fortelling – Felleskap. En kvalitativ undersøkelse av ungdommers perspektiver på deltagelse i samfunnsmusikkterapeutisk praksis i barnevernsarbeid* [Music – Narrative – Community. A qualitative investigation of youth’s perspectives on participation in community music therapy practice in child welfare] (Unpublished doctoral dissertation). GAMUT, Dept. of Music - The Grieg Academy, University of Bergen, Bergen.

Kvale, S. (2001). *Det kvalitative forskningsintervju* [Qualitative research interview]. Oslo: Gyldendal Norsk Forlag.

Kvale, S., & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing*. London: Sage.

Larkin, M., & Griffiths, M. D. (2002). Experiences of addiction and recovery: The case for subjective accounts. *Addiction Research & Theory, 10*, 281–311. doi:10.1080/16066350211866

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120. doi:10.1191/1478088706qp062oa

Lauveng, A. (2012). *A road back from schizophrenia: a memoir*. New York: Skyhorse.

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services, 62*(12), 1470–1476. doi:10.1176/appi.ps.001312011

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*, 445–452. doi:10.1192/bjp.bp.110.083733

Liberman, R. P., & Kopelowic, A. (2002). Recovery from schizophrenia: A challenge for the 21st century. *International Review of Psychiatry, 14*(4), 245–25.

Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry, 14*(4), 256–272. doi:10.1080/0954026021000016905

Lorem (2005). *Withdrawal and exclusion - A study of the spoken word as means of understanding schizophrenic patients.* (Unpublished doctoral thesis). Institute of Community Medicine, University of Tromsø.

Lysaker, P. H., Buck, B., & Lysaker, J. T. (2012). Schizophrenia and alterations in the experience of self and agency: Comparisons of dialogical and phenomenological views. *Theory & Psychology, 22*(6), 738–755. doi:10.1177/0959354311435376

Lysaker, P. H., & Leonhardt, B. L. (2012). Agency: Its nature and role in recovery from severe mental illness. *World Psychiatry, 11*(3), 165–166. doi:10.1002/j.2051-5545.2012.tb00121.x

Maguire, A., & Merrick, I. (2013). Walking the line: Music therapy in the context of the recovery approach in a high security hospital. In S. Dickenson, H. Odell-Miller, & J. Adlam (Eds.), *Forensic music therapy. A treatment for men and women in secure hospital settings* (pp. 104–120). London: Jessica Kingsley.

Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet, 358*, 483-488.

Malterud, K. (2010). Power inequalities in health care–empowerment revisited. *Patient Education and Counselling, 79*(2), 139-140.

Mancini, M. A. (2007). The role of self-efficacy in recovery from serious psychiatric disabilities: A qualitative study with fifteen psychiatric survivors. *Qualitative Social Work, 6*(1), 49–74. doi:10.1177/1473325007074166

Maratos, A. S., Gold, C., Wang, X., & Crawford, M. J. (2008). Music therapy for depression. *Cochrane Database Syst Rev*, 1. doi:10.1002/14651858.CD004517.pub2.

Markowitz, F. E. (2005). Sociological models of recovery. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness* (pp. 85–99). Washington, DC: American Psychological Association.

McCaffrey, T., Edwards, J., & Fannon, D. (2011). Is there a role for music therapy in the recovery approach in mental health? *The Arts in Psychotherapy, 38*, 185–189. doi:10.1016/j.aip.2011.04.006

McDonald, R., Kreutz, G., & Mitchell, L. (Eds.). (2012). *Music, health & wellbeing*. Croydon: Oxford University Press.

McFerran, K. (2012). "Just so you know, I miss you so much." The expression of life and loss in the raps of two adolescents in music therapy. In S. Hadley & G. Yancy (Eds.), *Therapeutic use of rap and hip-hop* (pp. 173–189). New York, NY: Routledge.

McLeod, J. (2001a). Developing a research tradition consistent with the practices and values of counselling and psychotherapy: Why counselling and psychotherapy research is necessary. *Counselling and Psychotherapy Research, 1*(1), 3-11. doi:10.1080/14733140112331385188

McLeod, J. (2001b). *Qualitative research in counselling and psychotherapy*. London: Sage.

Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation, 10*(2), 29–37.

Meehl, P. E. (1962). Schizotaxia, schizotypy, schizophrenia. *American psychologist*, *17*(12), 827-838.

Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology, 42*, 171– 188.

Metzner, S. (2003). The significance of triadic structures in patients undergoing therapy for psychosis in a psychiatric ward. In S. Hadley (Ed.), *Psychodynamic music therapy case studies* (pp. 257–271). Philadelphia, PA: Barcelona.

Moe, T. (2000*). Restituerende faktorer i gruppemusikterapi med psykiatriske patienter ud fra en modifikation af GIM* [Restitutional factors in group music therapy with psychiatric patients based on a modification of guided imagery and music (GIM)] (Unpublished doctoral dissertation). Aalborg University, Aalborg. Retrieved from http://vbn.aau.dk/

Moe, T., Roesen, A., & Raben, H. (2000). Restitutional factors in group music therapy with psychiatric patients based on a modification of guided imagery and music (GIM). *Nordic Journal of Music Therapy, 9*(2), 36–50. doi:10.1080/08098130009478000

Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research, 20*(11) 1459–1468. doi: 10.1177/1049732310379116

Mössler, K., Chen, X., Heldal, T. O., & Gold, C. (2011). Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Reviews,* 12. doi:10.1002/14651858.CD004025.pub3

Mulhall, S. (2005). *Heidegger and Being and time* (2nd ed.). New York: Routledge.

Næss, T., & Ruud, E. (2007). Audible gestures: From clinical improvisation to community music therapy: Music therapy with an institutionalized woman diagnosed with paranoid schizophrenia. *Nordic Journal of Music Therapy, 16*(2), 160–171. doi:10.1080/08098130709478186

National Collaborating Centre for Mental Health. (2010). *The NICE guideline on core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* (Updated ed.). Leicester: The British Psychological Society and The Royal College of Psychiatrists.

National Committees for Research Ethics in Norway (2006). *Guidelines for research ethics in the social sciences, law and the humanities.* Retrieved from: http://www.etikkom.no/English/NESH/guidelines

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies.* Newbury Park Ca: Sage Publications.

Nordoff, P., & Robbins, C. (1977). *Creative music therapy.* New York: John Day & Company.

Norvoll, R. (2002). Makt og sosial kontroll innenfor psykisk helsevern [Power and social control within mental health care]. In R. Norvoll (Ed.), *Samfunn og psykiske lidelser. Samfunnsvitenskaplige perspektiver – en introduksjon* (pp. 121-144). Oslo: Gyldendal akademiske forlag.

Norwegian Directorate of Health. (2013). *Nasjonal faglig retningslinje for utredning, behandling og oppfølging av personer med psykoselidelser* [National guidelines for assessment, treatment, and follow-up of persons with psychotic illnesses]. Retrieved from http://helsedirektoratet.no/

O'Hagan, M. (1996). Two accounts of mental distress. In J. Read & J. Reynolds (Eds.), *Speaking our minds. An anthology of personal experiences of mental distress and its consequences* (pp. 44-50). London: Macmillan Press.

Odell-Miller, H. (1991). The experience of one man with schizophrenia. In K. Bruscia (Ed.), Case studies in music therapy (pp. 417–431). Phoenixville, PA: Barcelona.

Odell-Miller, H. (2007). *The practice of music therapy for adults with mental health problems: The relationship between diagnosis and clinical method* (Unpublished doctoral dissertation). Department of communication and psychology, Aalborg University, Aalborg. Retrieved from http://vbn.aau.dk/

Oeye, C., Bjelland, A. K., & Skorpen, A. (2007). Doing participant observation in a psychiatric hospital—Research ethics resumed. *Social Science & Medicine, 65*(11), 2296-2306.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9–22. doi:10.2975/31.1.2007.9.22

Pedersen, C. B., & Mortensen, P. B. (2001). Evidence of a dose-response relationship between urbanicity during upbringing and schizophrenia risk. *Archives of General Psychiatry, 58*(11), 1039-1046.

Pedersen, I. N. (2006). *Countertransference in music therapy. A phenomenological study on counter transference used as a clinical concept by music therapists working with musical improvisation in adult psychiatry* (Unpublished doctoral dissertation). Department of communication and psychology, Aalborg University, Aalborg. Retrieved from http://vbn.aau.dk/

Pedersen, I. N. (2013). Music therapy in psychiatry today-do we need specialization based on the reduction of diagnosis-specific symptoms or on the overall development of patients' resources? Or do we need both? *Nordic Journal of Music Therapy.* Advance online publication. doi:10.1080/08098131.2013.790917

Perälä, J., Suvisaari, J., Saarni, S. I., Kuoppasalmi, K., Isometsä, E., Pirkola, S., … Lönnqvist J. (2007). Lifetime prevalence of psychotic and bipolar I disorders in a general population. *Archives of General Psychiatry, 64*(1), 19–28. doi:10.1001/archpsyc.64.1.19

Pérez-Álvarez, M., García-Montes, J. M., Vallina-Fernández, O., Perona-Garcelán, S., & Cuevas-Yust, C. (2011). New life for schizophrenia psychotherapy in the light of phenomenology. *Clinical Psychology & Psychotherapy, 18*(3), 187–201. doi:10.1002/cpp.716

Pilgrim, D. (2008). Recovery and current mental health policy. *Chronic Illness, 4*(4), 295-304. doi: 10.1177/1742395308097863

Pilgrim, D. (2009). Recovery from mental health problems: Scratching the surface without ethnography. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community, 23*(4), 475-487. doi: 10.1080/02650530903375033

Pilgrim, D., & McCranie, A. (2013). *Recovery and mental health. A sociological account*. New York: Palgrave Macmillian.

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin, 31*(2), 55-60.

Ponde, M. P., Peireira, C. T. M., Leal, B., & Oliveira, S. C. (2009). The role of leisure in the lives of psychotic patients: A qualitative study. *Transcultural Psychiatry, 46,* 328–339. doi:10.1177/1363461509105822

Priebe, S., Burns, T., & Craig, T. K. (2013). The future of academic psychiatry may be social. *The British Journal of Psychiatry, 202*(5), 319-320.

Priebe, S., Omer, S., Giacco, D., & Slade, M. (2014). Resource-oriented therapeutic models in psychiatry: conceptual review. *The British Journal of Psychiatry, 204*(4), 256-261.

Prilleltensky, I., & Prilleltensky, O. (2006). *Promoting well-being: Linking personal, organisational and community change*. New Jersey: John Wiley & Sons.

Procter, S. (2002). Empowering and enabling – Music therapy in non-medical mental health provision. In C. Kenny & B. Stige (Eds.), *Contemporary voices in music therapy*. Oslo: Unipub Forlag.

Procter, S. (2004). Playing politics: Community music therapy and the therapeutic redistribution of musical capital for mental health. In M. Pavlicevic & G. Ansdell (Eds.), *Community music therapy* (pp. 214–232). London: Jessica Kingsley.

Procter, S. (2011). Reparative musicing: Thinking on the usefulness of social capital theory within music therapy. *Nordic Journal of Music Therapy, 20*, 242–262. doi:10.1080/08098131.2010.489998

Provencher, H. L., & Keyes, C. L. M. (2013). Recovery: A complete mental health perspective. In C. L. M. Keyes (Ed.), *Mental well-being. International contributions to the study of positive mental health*. New York, NY: Springer.

Putnam, R. D. (1996). The strange disappearance of Civic America. *The American Prospect, 24*, 24–48.

Ralph, T. O., & Corrigan, P. W. (2005). *Recovery in mental illness. Broadening our understanding of wellness.* Washington: The American Psychological Association.

Read, J. (2004). Does 'schizophrenia' exist? Reliability and validity. In J. Read, L. R. Mosher & R. P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia* (pp. 43-56). New York: Routledge.

Read, J., & Reynolds, J. (Eds.). (1996). *Speaking our minds. An anthology*. London: Macmillian.

Reker, T. (1991). *Musiktherapie im Urteil schizophrener Pasienten* [Music therapy: A rating by schizophrenic patients]. Psychiatrische Praxis, 18, 216–221.

Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology, 41*(4), 427-437.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery. A model for mental health practice.* Edinburgh: Baillière Tindall.

Resnick, S. G., & Rosenheck, R. A. (2006). Recovery and positive psychology: Parallel themes and potential synergies. *Psychiatric Services, 57*(1), 120-122. doi: 10.1176/appi.ps.57.1.120

Richards, S. L. (2008) *Positive aspects of the experience of psychosis: An interpretative phenomenological analysis* (Unpublished doctoral thesis). The University of Leeds. Retrieved from http://etheses.whiterose.ac.uk/397/

Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment, 10,* 37-48. doi: 10.1192/apt.10.1.37

Rolvsjord, R. (2004). Therapy as empowerment. Clinical and political implications of empowerment philosophy in mental health practises of music therapy. *Nordic Journal of Music Therapy, 13*, 99–111. doi:10.1080/08098130409478107

Rolvsjord, R. (2007). *"Blackbirds Singing": Explorations of resource-oriented music therapy in mental health care* (Unpublished doctoral disseration). Aalborg University, Institute for Psychology and Communication, Aalborg.

Rolvsjord, R. (2010*). Resource-oriented music therapy in mental health care*. Gilsum, NH: Barcelona.

Rolvsjord, R. (2013). Music therapy in everyday life: With the organ as the third therapist. In L. O. Bonde, E. Ruud, M. Skånland, & G. Trondalen (Eds.), *Musical life stories. Narratives on health and musicking*, Centre for Music and

Health Publication Series 6 (pp. 201–220). Oslo: Norwegian Academy of Music.

Rolvsjord, R., Gold, C., & Stige, B. (2005). Research rigour and therapeutic flexibility: Rationale for a therapy manual developed for a randomised controlled trial. *Nordic Journal of Music Therapy, 14*(1), 15-32. doi: 10.1080/08098130509478122

Rolvsjord, R., & Stige, B. (2013). Concepts of context in music therapy. *Nordic Journal of Music Therapy,* Advance online publication. doi: 10.1080/08098131.2013.861502

Rowland, C., & Read, B. (2011). Key changes music therapy: An extended pilot project in an adult mental health hospital setting. *British Journal of Music Therapy, 25*(1), 48–71.

Ruddy, R., & Milnes, D. (2005). Art therapy for schizophrenia or schizophrenia-like illnesses. *Cochrane Database of Systematic Reviews*, 2012(4), 1–22. doi:10.1002/14651858.CD003728.pub2

Rudnick, A. (2012). Introduction. In A. Rudnick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives.* Croydon: Oxford University Press.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529–539.

Rüsch, N., Lieb, K., Bohus, M., & Corrigan, P. (2006). Brief reports: Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services, 57*, 399–402. doi:10.1176/appi.ps.57.3.399

Ruud, E (1979). Musikkterapi [Music therapy]. *Musikk i skolen, 4*, 34-35.

Ruud, E. (1997). Music and the quality of life. *Nordic Journal of Music Therapy, 6*(2), 86–97. doi:10.1080/08098139709477902

Ruud, E. (1998). *Music therapy: Improvisation, communication and culture*. Gilsum, NH: Barcelona.

Ruud, E. (2010). *Music therapy: A perspective from the humanities*. Gilsum, NH: Barcelona.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM* (2nd ed.). Edinburgh: Churchill Livingstone.

Sandelowski, M., & Barroso, J. (2003). Toward a metasynthesis of qualitative findings on motherhood in HIV-positive women. *Research in Nursing & Health, 26*(2), 153–170.

Sandelowski, M., Docherty, S., & Emden, C. (1997). Qualitative metasynthesis: Issues and techniques. *Research in Nursing & Health, 20*, 365–371.

Sands, A. (2000). *Falling for therapy: Psychotherapy from s client's point of view*. London: Macmillian.

Sarris, J., Glick, R., Hoenders, R., Duffy, J., & Lake, J. (2014). Integrative mental healthcare White Paper: Establishing a new paradigm through research, education, and clinical guidelines. *Advances in Integrative Medicine, 1*(1), 9-16.

Sartorius, N. (2002). Iatrogenic stigma of mental illness - Begins with behaviour and attitudes of medical professionals, especially psychiatrists. *BMJ, 324*, 1470-1471.

Schiff, A. C. (2004). Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal, 27*, 212–218. doi:10.2975/27.2004.212.218

Schrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review. *Social Science & Medicine*, *74*(4), 554-564.

Schrank, B., Stanghellini, G., & Slade, M. (2008). Hope in psychiatry: A review of the literature. *Acta Psychiatrica Scandinavica, 118*(6), 421-433.

Schrank, B., Wally, J. &, Schmidt, B. (2012). Recovery and hope in relation to schizophrenia. In A. Rudinick (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives* (pp. 133-144). Croydon: Oxford University Press.

Schutz, A. (1971). *Collected papers*. Volume 1. The Hague, Martinus Nijhoff; 361.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5-14. doi: 10.1037/0003-066X.55.1.5

Silverman, M. J. (2003). Contingency songwriting to reduce combativeness and noncooperation in a client with schizophrenia: A case study. *The Arts in Psychotherapy, 30*, 25–33. doi:10.1016/S0197-4556(02)00231-9

Silverman, M. J. (2006). Psychiatric patients' perception of music therapy and other psychoeducational programming. *Journal of Music Therapy, 43*(2), 111–122. doi:10.1093/jmt/43.2.111

Silverman, M. J. (2010). Perceptions of music therapy interventions from inpatients with severe mental illness: A mixed-methods approach. *The Arts in Psychotherapy, 37*, 264–268. doi:10.1016/j.aip.2010.05.002

Silverman, M. J., & Rosenow, S. (2013). Immediate quantitative effects of recreational music therapy on mood and perceived helpfulness in acute psychiatric inpatients: An exploratory investigation. *The Arts in Psychotherapy, 40*, 269–274.

Skjervheim, H. (2001). *Deltakar og tilskodar* [Participant and observer]. Oslo: Universitetsforlaget.

Slade, M. (2009). *Personal recovery and mental illness. A guide for mental health professionals*. Cambridge: Cambridge University Press.

Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10*(1), 26. doi:10.1186/1472-6963-10-26

Slade, M. (2012). The epistemological basis of personal recovery. In A. Rudnic (Ed.), *Recovery of people with mental illness. Philosophical and related perspectives* (pp.78–94). Croydon: Oxford University Press.

Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: Past progress and future challenges. *International Review of Psychiatry, 24*(1), 1–4. doi:10.3109/09540261.2011.644847

Slade, M., Adams, N., & O'Hagan, M. (Eds.). (2012). Recovery around the globe [Special issue]. *International Review of Psychiatry, 24*(1), 1–78.

Slade, M., Amering, M., & Oades, L. (2008). Recovery: An international perspective. *Epidemiologia e Psychiatria Sociale*, *17*(2), 128-137.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery‐oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20. doi: 10.1002/wps.20084

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., & Bird, V. (2012). International differences in understanding recovery: systematic review. *Epidemiology and Psychiatric Sciences, 21*(04), 353-364.

Small, C. (1998). *Musicking. The meanings of performing and listening.* Middletown, CT: Wesleyan University Press.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J. A. & Osborn (2008*).* Interpretative phenomenological analysis*. In J. A. Smith (Ed.), Qualitative psychology. A practical guide to research methods*. (2nd ed., pp. 53-80). London: Sage.

Solli, H. P. (2006). Musikkgrupper på psykiatriske institusjoner [Music therapy groups in psychiatric institutions]. In T. Aasgaard (Ed.), Musikk og helse [Music and health] (pp.113-121). Oslo: Cappelen.

Solli, H. P. (2008). "Shut Up and Play!": Improvisational use of popular music for a man with schizophrenia. *Nordic Journal of Music Therapy, 17*(1), 67–77. doi:10.1080/08098130809478197

Solli, H. P. (2009). *Musikkterapi som integrert del av standard behandling i psykisk helsevern* [Music therapy as an integrated part of standard treatment in mental health care]. In E. Ruud (Ed.), Musikkterapi i psykisk helsearbeid for barn og unge [Music therapy in mental health care for children and adolescents]. Skriftserie fra Centre for Music and Health. Oslo: Norwegian Academy of Music.

Solli, H. P. (2012). Med pasienten i førersetet. Recovery-perspektivets implikasjoner for musikkterapi i psykisk helsearbeid [With the patient in the driver's seat. Implications of the recovery-perspective for music therapy in mental health

care]. *Musikterapi i Psykiatrien Online, 7*, 23–44. doi:10.5278/ojs/mipo/2edleel2. Retrieved from http://journals.aau.dk/index.php/MIPO/article/view/114/78

Solli, H. P., & Rolvsjord, R. (2008). Musikkterapi som behandlingstilbud for pasienter med psykose [Music therapy as treatment for patients with psychosis]. *Musikkterapi, 3*, 8–16.

Solli, H. P., & Rolvsjord, R. (2014). "The opposite of treatment": A qualitative study of how patients diagnosed with psychosis experience music therapy. *Nordic Journal of Music Therapy*. Advance online publication. doi:10.1080/08098131.2014.890639

Solli, H. P., Rolvsjord, R., & Borg, M. (2013). Toward understanding music therapy as a recovery-oriented practice within mental health care: A meta-synthesis of service users' experiences. *Journal of Music Therapy, 50*(4), 244–273. doi:10.1093/jmt/50.4.244

Spaniol, L., Gagne, C., & Koehler, M. (1999). Recovery for serious mental illness: What it is and how to support people in their recovery. In R. P. Marinelli & A. E. D. Orto (Eds.), *The psychological and social impact of disability* (pp. 409-422). New York: Springer.

Stake, R. E. (1995). *The art of case study research*. London: Sage.

Stake, R. E. (2006). *Multiple case study analysis.* New York: Guilford.

Stige, B. (1999). The meaning of music – From a client's perspective. In T. Wigram & J. DeBacker (Eds.), *Clinical applications of music therapy in psychiatry* (pp. 61–83). London: Jessica Kingsley.

Stige, B. (2002). *Culture-centred music therapy*. Gilsum, NH: Barcelona.

Stige, B. (2006). On a notion of participation in music therapy. *Nordic Journal of Music Therapy, 15*(2), 121–138. doi:10.1080/08098130609478159

Stige, B. (2012a). Elaborations towards a notion of community music therapy [Adobe Digital Editions version]. Retrieved from http://www.barcelonapublishers.com/ebooks/

Stige, B. (2012b). Health musicking: A perspective on music and health as action and performance. In R. McDonald, G. Kreutz, & L. Mitchell (Eds.*), Music, health & wellbeing* (pp. 183–195). Croydon: Oxford University Press.

Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward an agenda for evaluation of qualitative research. *Qualitative Health Research, 19*, 1504–1516. doi:10.1177/1049732309348501

Stige, B., & Aarø, L. E. (2012). *Invitation to community music therapy*. New York, NY: Routledge.

Strauss, J. S. (1989). Subjective experiences of schizophrenia: Toward a new dynamic psychiatry-II. *Schizophrenia Bulletin, 15*, 179–187. doi:10.1093/schbul/15.2.179

Strauss, J. S. (2008). Prognosis in schizophrenia and the role of subjectivity. *Schizophrenia Bulletin, 34*(2), 201–203. doi:10.1093/schbul/sbn001

Strauss, J. S. (2011). Subjectivity and severe psychiatric disorders. *Schizophrenia Bulletin, 37*(1), 8-13.

Tandon, R., Gaebel, W., Barch, D. M., Bustillo, J., Gur, R. E., Heckers, S., ... & Carpenter, W. (2013). Definition and description of schizophrenia in the DSM-5. *Schizophrenia research, 150*(1), 3-10.

Tandon, R., Keshavan, M. S., & Nasrallah, H. A. (2008a). Schizophrenia, "just the facts": What we know in 2008. 2. *Schizophrenia Research, 102*(1), 1-18.

Tandon, R., Keshavan, M. S., & Nasrallah, H. A. (2008b). Schizophrenia, "just the facts": What we know in 2008: Part 1: Overview. *Schizophrenia Research*, *100*(1), 4-19.

Tew, J. (2013). Recovery capital: What enables a sustainable recovery from mental health difficulties? *European Journal of Social Work, 16*, 360–374. doi:10.1080/13691457.2012.687713

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Boutillier, C. L. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work, 42*, 443–460. doi:10.1093/bjsw/bcr076

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation.

Epidemiologiae Psichiatria Sociale, 14(01), 1–3. doi:10.1017/S1121189X00001858

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry, 57*(1), 90–99. doi:10.1177/0020764010345062

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *Archives of Andrology, 9*(1), 17–37. doi:10.1080/15487760500339410

Travis, R., & Deepak, A. (2011). Empowerment in context: Lessons from hip-hop culture for social work practice. *Journal of Ethnic and Cultural Diversity in Social Work, 20*, 203–222. doi:10.1080/15313204.2011.594993.

Tyson, E. H. (2006). Rap-music attitude and perception scale: A validation study. *Research on Social Work Practice, 16*, 211–223. doi:10.1177/1049731505281447

Tyson, F. (1981). *Psychiatric music therapy: Origins and development*. New York, NY: Creative Arts Rehabilitation Center.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., ... & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661-671.

Veltre, V. J., & Hadley, S. (2012). It's bigger than hip-hop. A hip-hop feminist approach to music therapy with adolescent females. In S. Hadley & G. Yancy (Eds.), *Therapeutic use of rap and hip-hop* (pp. 79–98). New York, NY: Routledge.

Veseth, M., Binder, P. E., Borg, M., & Davidson, L. (2012). Toward caring for oneself in a life of intense ups and downs. A reflexive-collaborative exploration of recovery in bipolar disorder. *Qualitative Health Research, 22*, 119-133. doi: 10.1177/1049732311411487

Wallcraft, J., Amering, M., Freidin, J., Davar, B., Froggatt, D., Jafri, H., & Herrman, H. (2011). Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family

carers. *World Psychiatry, 10*(3), 229–236. doi:10.1002/j.2051-5545.2011.tb00062.x

Wheeler, B. (2005). Overview of music therapy research. In B. Wheeler (Ed.), *Music therapy research* (2nd ed., pp. 3-19). Gilsum, NH: Barcelona

WHO. (1973). *The international pilot study of schizophrenia*. Vol. 1. (pp. 427; Sw. Fr. 56.) Geneva: World Health Organization.

WHO. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

WHO. (2005). *Promoting mental health, concepts; emerging evidence; practice. A* Report of the World Health Organization. Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne. Retrieved from http://www.who.int/mental_health/evidence

Wilken, J. P. (2007). Understanding Recovery from Psychosis: A Growing Body of Knowledge. *Tidsskrift for Norsk Psykologforening*, *44* (5), 658-666.

Wilkinson, R. G., & Marmot, M. (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen: World Health Organization Regional Office for Europe.

Williams, P. (2012). *Rethinking madness. Towards a paradigm shift in our understanding and treatment of psychosis*. San Francisco: Sky's edge.

Yalom, I. D. (2002). *The gift of therapy. Reflections on being a therapist*. London: Judy Piatkus Ltd.

Yalom, I., & Elkin, G. (1974). *Every day gets a little closer: A twice-told therapy*. New York: Basic Books.

Zimmer, L. (2006). Qualitative meta-synthesis: A question of dialoguing with texts. *Journal of Advanced Nursing, 53*(3), 311–318.

Østerberg, D. (1982). *Sosialfilosofi* [Social philosophy]. Oslo: Gyldendal Norsk Forlag.