David J. Gamella, José Fernando Fernández, and María García (Eds.)

MUSIC THERAPY AND MUSIC AND HEALTH

EVEN RUUD

iDETEC Editorial

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FOREWORD

Music Therapy and Music and Health

With this book, I aim to provide an overview of the field of music therapy. The text is intended as an introductory resource for new students, as well as for anyone interested in the relationships between music, health, and therapy. At the same time, readers who are already familiar with music therapy may gain a broader understanding of the field, become acquainted with recent research, and discover new ways of articulating and advocating for the discipline.

Over the past fifty years, music therapy has gained a foothold in many countries, and music therapists continue to expand into new areas of practice. They work with children and young people requiring various forms of special educational support, within child welfare services, and in elder care with individuals experiencing memory-related challenges. In addition, music therapists are active in somatic hospitals, mental health services, correctional settings, and in the treatment and rehabilitation of people with substance use challenges.

Music therapy is established both as a professional field and as a research discipline concerned with the relationship between music and health. Research in this area explores how music shapes our emotions and sense of self, how it influences the brain and body, and how it contributes to the creation of community and belonging. As a field of practice, music therapy seeks to demonstrate the importance of music as a preventive and health-promoting resource—both within therapeutic contexts and in care work for individuals, groups, and communities, as well as at the level of public health.

With this book, I aim to provide an overview of the possibilities for using music to enhance health and well-being, and to improve quality of life for people who, for various reasons, require support in managing health-related challenges. At the

same time, I seek to highlight how listening to music, playing instruments, and participating in musical life can foster experiences of health and well-being.

This presentation emphasizes a broad introduction to the field while pointing to literature that offers more detailed knowledge and guidance for further study and professional practice.

The approach is grounded in a humanistic and interpretive research tradition. This involves clarifying key concepts, developing theory through the synthesis of existing knowledge, and engaging in critical reflection. The book draws on a review of current research, studies of professional practice, reflections on methods and forms of work, as well as an overview of areas of practice and therapeutic models. Particular attention is given to the concepts of music and health in an effort to establish a coherent conceptual foundation for the field of music therapy, with the aim of avoiding fragmentation and disintegration.

I have sought to provide a rationale for why music can be used therapeutically and how it may contribute to health promotion and prevention. At the same time, I aim to broaden the scope of music therapy to include a stronger focus on public health.

My point of departure is the Norwegian tradition of music therapy. Over the past fifty years, during which an organized music therapy field has developed in Norway, a range of practices, professional roles, and theoretical perspectives have emerged that give Norwegian music therapy its distinctive character. A broad and diverse field of practice has evolved, with music therapists working across multiple settings, including schools and kindergartens, community music schools, paediatric departments in somatic hospitals, district psychiatric centres, correctional services, and institutions supporting elder care.

Music therapy in Norway is characterized by a strong humanistic orientation, emphasizing care, experiences of mastery, the mobilization of individual resources, and the strengthening of resilience. In addition, a rights-based and socially oriented, community-focused approach to music therapy has developed, gaining international recognition and influencing the evolution of the field in other parts of the world.

The central elements of this theoretical synthesis involve integrating ecological and relational concepts of music. Within this perspective, music is understood as a fundamental form of expression whose primary function is to create relationships between people. This view has been developed by music therapists as well as leading music scholars. I connect this understanding of music with a concept of

health that encompasses multiple dimensions, ranging from the biological to the existential.

In developing this concept of health, I draw on sociologist Hartmut Rosa's theory of resonance, incorporating it into a broader notion of existential health. Through this sociological turn, I also aim to contribute to a more critically and sociologically oriented understanding of music therapy. At the same time, this framework provides a foundation for my theory of music as a "cultural immunogen," grounded in forms of musicking associated with vitality, agency, belonging, and meaning. On the basis of this conceptualization, I argue that music holds significant potential for contributing to public health.

The opening chapter offers a brief and general overview of the areas of practice, aims, and methods of music therapy, along with an outline of the historical relationship between music and health in Western culture. The chapter on music and public health demonstrates how music and musical activities—referred to here as "musicking"—can contribute to public health through health-promoting and preventive measures. It further elaborates the idea of musicking as a "cultural immunogen," understood as engaging with music in ways that strengthen resistance to ill health while enhancing opportunities for improved quality of life.

The second chapter offers a more detailed description of the user groups—pupils, patients, and clients—encountered by music therapists. It provides an overview of the needs individual users may have, the goals that guide therapeutic work, and a brief discussion of the activities and methods available to music therapists and other music-and-health practitioners. This is followed by a chapter outlining the main orientations, therapeutic theories, and models within the field of music therapy.

The fourth chapter focuses on what characterizes the understanding of music within music therapy. It examines how music is conceptualized within the discipline, emphasizing the importance of attending to users' musical preferences, genres, and identities in their encounters with the music therapist.

The subsequent chapter presents an overview of central working methods—the musical "toolbox" employed by music therapists and music-and-health practitioners. These include improvisation, performance, composition, songwriting, music production, and receptive approaches such as listening to music.

A following chapter addresses professional knowledge, illustrating how music therapy has developed as a profession encompassing a wide range of roles. Music therapists may work as musicians and educators, as therapists and caregivers, and

as project leaders, supervisors, and collaborators. This chapter outlines the distinctive competencies of music therapists, while also identifying skills and areas of expertise shared with musicians, educators, and healthcare professionals. It further explores how music therapists collaborate with other practitioners in the fields of music and health.

The final chapter focuses on music therapy as an academic discipline, including knowledge development and research. It describes the characteristics of the Norwegian music therapy tradition, with particular emphasis on humanistic values and an understanding of the significance of culture and society as a foundation for professional practice. The chapter also highlights the challenges involved in establishing a coherent knowledge base within the field's broad multidisciplinary scope. This includes integrating insights from neuropsychology and brain research, special education and clinical psychology, musicology, and philosophical disciplines such as ethics, philosophy of science, and the conceptualization of key terms such as health and music.

In a concluding afterword, I summarize how music can serve as a source of existential health and motivate us to maintain and strengthen our well-being. Music may contribute to the regulation of bodily processes associated with illness, for example by reducing stress levels. In this context, I discuss how music can assume the role of a cultural immunogen by offering, through a sensitive and responsive engagement, opportunities for emotional regulation, participation and community, as well as experiences of mastery and meaning.

At the same time, I point to ways of conceptualizing the field that may counteract fragmentation and support the continued development of music therapy as a discipline capable of evolving while embracing its diversity. This includes the cultivation of a professional language informed by postmodern perspectives.

For readers who wish to explore specific topics in greater depth, I provide a range of suggestions for further reading in an appendix. The body of research literature in music therapy has now grown so extensive that it offers support and evidence for a wide variety of interventions, and it continues to expand rapidly. Rather than attempting an exhaustive overview, I therefore direct readers to key sources and explain how and where relevant knowledge can be accessed. An additional overview of websites and portals offering up-to-date research syntheses across different areas of practice is also included.

Over the years, I have written a number of articles and books on music therapy, both in Norwegian and in English. In this volume, I have allowed myself to revisit and reuse some of this material, with appropriate revisions. Readers who

recognize similarities with my earlier work will likely do so for good reason. Where I draw most directly on previous publications, this is acknowledged in footnotes. Otherwise, references to relevant sources are provided through footnotes and in the bibliography.

A brief note on terminology is also warranted. Readers will encounter the neologism "musicking," which is now widely used among music therapists and music educators. I also use the term "health musicking" to refer to forms of musical engagement that may promote health. When referring to the individual's music therapists work with, I vary between terms such as user, client, patient, and pupil, depending on the context. Similarly, I alternate between expressions such as "disabled" and "people with disabilities" when discussing different forms of functional variation.

While emphasis is placed on literature and references grounded in research, I adopt a broad understanding of research and knowledge development. This includes drawing on qualitative as well as quantitative studies, meta-analyses, and other empirical approaches. In addition, I recognize the importance of experiential knowledge developed by music therapists through professional practice.

At a time when the increasing use of artificial intelligence offers new possibilities for accessing information and knowledge, it remains essential to engage with scholarly works that situate knowledge within context—historically, critically, and reflectively—and that provide guidance for translating knowledge into practice. It is my hope that this introduction to and overview of a diverse professional field may contribute to a more holistic understanding and help counteract the fragmentation of knowledge.

Producing a comprehensive account of the field of music therapy is an extensive undertaking, and there are many potential pitfalls in describing facts and developments within a constantly evolving interdisciplinary landscape. I therefore wish to extend my sincere thanks to Brynjulf Stige, who generously devoted time to a thorough review of the manuscript and offered numerous insightful, critical, and constructive comments. I am equally grateful to Gro Trondalen, whose careful reading led to important additions and valuable linguistic clarifications.

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Music and Anders Eggen for their support in facilitating the publication of the text, both as a Norwegian-language book and in the open-access version.

For this international edition, I have made several revisions, including reducing some of the Norwegian and locally specific references and incorporating recent literature and research. I would also like to extend special thanks to Tom Næss for his contributions to this edition. Particular gratitude goes to David J. Gamella, José Fernando Fernández and María García for their initiative in expanding this book into other languages — English, Spanish, and Portuguese — carrying forward the spirit of the original Norwegian project. Their skillful work in editing and translation has been essential in making this a reality. Finally, I would also like to express my sincere gratitude to the editorial project iDETEC (Institute of Creative Therapies) for its invaluable contribution to this edition.

Even Ruud

Oslo, April, 2026

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WHAT IS MUSIC THERAPY?

INTRODUCTION 0

What Is Music Therapy?

In this introductory chapter, I offer a brief introduction to music therapy for readers who are encountering the field for the first time. The topics addressed here will be explored in greater depth in the following chapters.

Music therapy is a complex field, in which therapists work in a variety of practice settings and occupy diverse professional roles and identities. At the same time, music therapy is a scientific discipline, grounded in research and knowledge development.

I provide an overview of the main practice settings and describe the principal aims of music therapy. I also briefly present what characterizes the field as an area of research and as a profession. Toward the end of the chapter, I shed light on how ideas about the relationship between music and health have deep historical roots in Western culture, and how these have been expressed through the ages.

The Subject of Music Therapy

When we hear about music therapy for the first time, it is usually through examples of where music therapists work and which users they work with. As we shall see in what follows, music therapy is also an academic field and a scientific discipline in which new knowledge is developed about the relationship between music and health. Furthermore, music therapy consists of a varied and extensive practice across a wide range of institutions and user groups. This work also entails many different occupational or professional roles in which music therapists need musical skills in addition to knowledge of the user groups they encounter and the aims and methods on which their work is to be based.

The Discipline

Music therapy is about using music to give people with health challenges or disabilities new opportunities for an increased quality of life through musical experiences and musical interaction. Through musical interplay and listening to music, music therapists seek to promote development and provide the joy of mastery, hope, and motivation for the best possible life. Music therapists facilitate musical activity that can create meeting places that give participants a social network, meaningful relationships, and a sense of recognition. Music therapists offer participation and enriching musical experiences that foster belonging, enrich emotional life, and create experiences of meaning and value in life.

From the mid-twentieth century onward, music therapy emerged as a new science, with research, education, and practice, primarily at North American universities. Over time, music therapy has gained a foothold in several countries around the world. Against this background, we now speak of music therapy as a scientific discipline, of different forms of practice, and as a profession—that is, a vocation for which one can receive training.

A Field of Research

As a field of knowledge, or scientific discipline, music therapy is to be understood as a multidisciplinary research field concerned with identifying and confirming relationships between music and health. There are many disciplines on which music therapy must rely in order to gain insight into the effects of music. These disciplines range from medicine, biology, and brain research to humanities disciplines such as

philosophy and musicology. Psychology and treatment theory, sociology, and cultural theory also make important contributions to all attempts to understand when, why, and how music can play a role in relation to health and quality of life.

When we research the relationship between music and health, the aim is not only to establish the effects of music therapy interventions. We also seek to understand when, where, and how music is used in everyday life by many people to reduce stress and regulate their emotions and energy so that they experience greater balance in life. This means that music therapy as a field also shows how music can serve as a health-promoting measure within public health.

A Practice

Music therapists use musical activities to stimulate development and improve participants' mental health. They work with people from the cradle to the grave. The areas in which they work today are many and wide-ranging, such as mental health, substance-use services, correctional services, somatic medicine, educational interventions, rehabilitation, and recovery. Music therapists use singing to stimulate children's language development and ability to communicate. In work with people with dementia and memory-related challenges, music is used to strengthen memory function and identity, reduce agitation, and improve social interaction. We find music therapists in somatic hospitals working with premature infants and their parents. Music therapists offer music to children with serious somatic illnesses who remain in hospital for long periods.

Music therapists also work with adult patients undergoing rehabilitation after a stroke or facing other neurological challenges. Within the field of mental health, music may be used to improve self-esteem, form new contacts and networks, support recovery processes, and help process emotions. Here, music therapists may provide instruction on instruments, form music groups, rock bands, and similar ensembles to motivate mastery and participation. For people with dementia or memory-related challenges, music therapy can help recall positive life experiences and strengthen the experience of identity. Music becomes an anchor in life and a "mirror of memories."

Music therapists work with individuals in one-to-one sessions and with groups. Often, individual therapy may serve as the starting point for creating optimal conditions for musical communication and the formation of relationships. In this work, the music therapist will often collaborate with other therapists and staff in interdisciplinary teams. They may also collaborate with parents and other close

persons who can continue the use of music in everyday life. We can see that music therapists often seek to engage the entire hospital ward or institution in a form of milieu-based work. They may create choirs in which doctors and nurses participate. With knowledge of the psychology of music, they may seek to improve the entire sound environment in an elder care institution in order to protect residents from noise.

The Profession

Music therapy is a profession, an occupation consisting of specific identities, roles, working methods, competencies, and ethical guidelines. In music therapy, there is always a music therapist present. The specific role the music therapist may take varies considerably depending on the different settings in which they work, or on the therapeutic or special educational models that provide the framework for practice. These may include roles involving educational work, a musician identity, that of a psychotherapist, or that of a project leader. Later, I will discuss in more detail some of the boundary lines between music therapists, music-and-health workers, and other professions that use music in milieu-based and health-related work.

Music therapists possess competencies as musicians, as well as in instructing and communicating music. They have knowledge of various client groups and master different forms of music therapy methods. Music therapists also possess knowledge of assessment, evaluation, and research in music therapy, philosophy of science and research methodology, as well as the many theoretical supporting disciplines on which the music therapist depends. Music therapy education is offered both as a bachelor's as well as a master's degree, depending on the country.

Goals, Forms and Areas of Practice

In order to provide an initial overview of the aims and forms of practice in music therapy, I will here give a general description of where music therapists work, what they seek to achieve, with which user groups, and with which methods or working forms they operate. All of these elements will be elaborated in the following chapters. It will also become clearer throughout the text why it is problematic to divide music therapy into different areas. This is because, in practice, music therapists draw on elements from various approaches, often taken from several disciplinary traditions and working methods. For the sake of overview, the

approaches referred to here are pedagogical music therapy, relational music therapy, community music therapy, music therapy in somatic hospitals, and music therapy as recreation and leisure provision.

Pedagogical Music Therapy

Many music therapists work in schools and kindergartens with interventions linked to individual adaptation in which learning goals are important. This may involve providing positive learning and mastery experiences through music that support children and young people in their linguistic, communicative, social, emotional, motor, and intellectual development. One example is when the music therapist writes songs for a child in order to practice language and pronunciation. Other children need help to feel safe and to experience support in social training. Musical activities, singing games, rhymes, and chants can provide a framework for learning how to wait one's turn, show consideration for others, or adapt to a group. Through improvisation, the music therapist creates a safe situation and a playful attitude that opens creativity and communication with children.

Relational Music Therapy

We may say that music therapy approaches the psychotherapeutic domain when identity, relationships, and experiences of self are part of the musical encounter with clients. This is recognizable in work across most practice settings, whether with children and young people in development, adolescents, adults, or older people. Through a therapeutic relationship, opportunities are created for empathy with and recognition of other people. Improvisation and interaction, for example in a band, create opportunities for new experiences of being with others—something that relational music therapy is concerned with.

In music therapy practice within mental health care, listening to music and songwriting are commonly used, such as writing music to one's own texts. Through these musical activities, one may work with the development of emotional awareness and emotional expression, strengthen identity and the capacity for mastery, and develop resources and resilience that keep illness and psychological imbalance at bay.

Music therapists work within the mental health field, with the treatment and rehabilitation of people with severe mental disorders or substance dependence. As I will discuss in more detail, theories of recovery, medication-free treatment, and user-oriented approaches are becoming central in music therapy in some

countries. Within elder care as well, music therapists work, among other things, to help older people preserve memories and identity, maintain personhood, and reduce anxiety and agitation.

Community Music Therapy

Music therapists work relationally with individuals and with groups. At the same time, they are concerned with the interface between what happens in the therapy session and the everyday life in which users spend most of their time. An important aim of the work is to build bridges between music therapy and the local community, to find opportunities for users to participate in musical life and in the local environment around schools and institutions, where relevant.

Music therapists work within healthcare teams with users who are referred for individual sessions. They may function as project leaders in systems that collaborate to create supportive communities and inclusive, socially sustaining environments. A socially engaged, rights-based, and systems-oriented approach to music therapy practice is found in what is called community music therapy. This is a form of practice based on the relationships among music therapy, the user, and the surrounding society. Music therapists are aware of such relationships and combine thinking from community music therapy with a necessary understanding of how to work with communication and the formation of relationships.

Music Therapy in Somatic Hospitals

Within somatic medicine, music therapy refers to the goal-directed use of music to affect the body and somatic illness, often within a biopsychosocial model that emphasizes a holistic approach to treatment. It may involve activating people physically and motorically. This can occur when people with brain injury need support from music's motivating functions in order to carry out and practice movements and motor skills. We also see this in work with older adults, where music and movement can stimulate muscles and breathing. Other areas within medical practice include the use of music to reduce the experience of pain, counteract sleep problems, provide experiences of deep bodily relaxation, and reduce stress.

In this work, a distinction is made between what is called *music medicine* and *medical music therapy*. When people speak of music medicine, this refers to the use of music in medical treatment without the involvement of a

music therapist. Medical music therapy, by contrast, is understood as a field of practice within music therapy in which the presence of the music therapist and the relationship with the client are important.

Within somatic medicine, or medical music therapy, music therapists work, for example, with patients with Parkinson's disease, in dementia care, with people with neurological disorders such as acquired language impairment (aphasia), in pain management, in connection with cancer treatment, or with premature infants, among other areas.

Music Therapy as Recreation

Sometimes music therapy is less directly aimed at the individual in order to address specific health challenges. We find that music therapists use music for diversion and recreation in institutions or for individuals in need of adapted services. In such cases, one may perhaps move out of therapy and into the sphere of leisure. As recreation, music therapy may have value where there is a need to break routines, create variety in everyday life, receive new stimuli, and meet people in new surroundings. Such measures can allow positive emotions to emerge and create a new cognitive orientation that may break down negative patterns of thought. New social impulses can also provide access to social networks.

Combinations of Working Methods and Goals

Music therapists will often combine working methods and goals drawn from different settings. If we imagine a music therapist working with older people with memory-related challenges, elements from different settings and forms of work will be present in practice. It will be natural to work with the body and physicality, for example through dance, singing, and movement with the aim of strengthening the body and breathing—in other words, the medical aspects.

But we know that whenever we work with people in general, it is impossible to avoid touching upon relational aspects. Relational work takes place within all the working methods music therapists use. When goals in which identity, communication, and social interaction are central, the relational aspect becomes especially clear. The pedagogical attitude appears not only when we work within special education or when we teach users band interaction and instruments. It is also present when we reconstruct memories and forgotten skills and work with reminiscence and reality orientation; in such cases, too, we must think pedagogically.

When we involve relatives in the work, engage an entire ward in shared activities, or collaborate with the musical life of the local community, we draw on the ecological thinking in music therapy, which is characteristic of community music therapy. As recreation and leisure activity, music may be used to distract, provide positive leisure experiences, and strengthen belonging and the sense of togetherness. When we use music to regulate states of mind, whether to counter tendencies toward agitation or to create readiness for relaxation and sleep, the music therapist is working with routines for musical self-care. Music therapy borrows language, or discourses, from many professional traditions when planning and carrying out its work. Such a holistic approach strengthens different aspects of work with people facing health challenges.

A Historical Retrospect

It is a familiar experience for most people that musical experiences affect us deeply and enduringly, that music leaves traces in body and mind and continues to work within us long after it has ceased to sound. This is no new experience in our culture but seems as old as the very story of music itself.

That these experiences are linked to medicine and to concepts such as health and therapy is likewise not foreign to history. In many cultures we know of, medicine and music are connected in one way or another. This may be in stories of music's power to drive away evil spirits (cf. the story of David and Saul), in rituals or religious forms of healing in which music is used to appease the gods or spirits, or in emerging medicine in antiquity, where music's power to harmonize body and mind was recognized.

In Western history and in many other cultures, music thus has been linked to illness and health. The starting point for music and health work in the West can be found in Greek antiquity. There, a philosophy of music was developed in which the so-called doctrine of ethos emerged as an attempt to explain how music could affect our state of mind, regulate our inner life, and influence our relationship to the cosmos. Throughout the history of music therapy, the idea of a connection between music and health was kept alive despite changing medical paradigms.[1]

[1] See Kümmel, 1977; Horden, 2000; Gouk, 2000; Ruud, 1980a, 2001a.

Medical Rules of Life in Antiquity

That music could become part of medicine in antiquity was connected to several factors. First, there existed a music-aesthetic worldview that attributed great power to music in influencing the mind. The ancient doctrine of ethos was precisely a philosophy of music according to which individual modes were thought to possess very special qualities. Some scales could calm; others could arouse. This theory was further grounded in a cosmology in which music was thought to be built upon the same numerical proportions that underlay the structure of the universe itself. Harmonious music reflected the harmony of the cosmos. When such music reached the human being, the mind could be tuned like a harp; disharmony could be transformed into harmony. Furthermore, it was believed that illness arose because of an imbalance among the various bodily fluids, the so-called humoral pathology.

Throughout history, a theory was further developed concerning how music could correct imbalances in the humoral equilibrium. Not least, there was a practice in which physicians were concerned with instructing people in the proper way of life to preserve health. The physician prescribed rules for a sensible relationship between work, sleep, rest, and nourishment. Preventive and health-promoting medicine already appears to have stood strongly in their practice. With the belief that music harmonized body and mind, music could become part of medical and cultural doctrines of living.

An example of how the relationship between culture and preventive health work was imagined in antiquity comes from an archaeological excavation of the medical center at Epidaurus (6th century BCE). This medical center did not consist only of buildings in which treatment itself took place. Spread over a large area, one still finds remains of temples, a library, a concert arena, a theatre, and athletic arenas.[2]

We know the disease theory from this time. It was believed that illness was caused by a mythical creature, a chimera, with the head of a lion, the body of a goat, and the tail of a serpent. This fantastical being could enter the body through the mind. To preserve health, it was therefore necessary to strengthen the mind's resistance against this monster. This could be done by engaging in cultural activities. The example is thought-provoking, not least because in recent times we have seen increased interest in the relationship between the immune system and psychological factors.[3]

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[2] Papadakis, 1971.

[3] Fancourt, 2026.

We see that this tradition contains an understanding of health-promoting and preventive work. Cultural activity was used to build up a defense against illness. In other words, what we notice is that already in antiquity, the idea began to take shape that there was an interaction between body and mind. It was not only by eating healthily—that is, by practicing moderation and not eating or drinking too much—that one could preserve a proper balance among the bodily fluids and thus avoid illness. By strengthening the mind's defenses, one could also prevent bodily disease.

Continuation within Islamic Culture

The idea of a well-functioning "two-way" system between body and soul was realized in Arabic medicine from the second half of the eighth century onward. It was Arab scholars from the Islamic Middle East who transferred the predominantly theoretical or philosophical discourse on the medical effects of music into a practical medical art. In this way, they brought sounding music right up to the patient's bedside.

An example of this way of thinking is found in a short introduction by Johannitius (Hunain ibn Ishaq), which, in Latin translation, circulated widely throughout Europe. In this text, a distinction is made between "natural" phenomena (that is, for example, the four humours and qualities such as moisture and warmth) and "contra-natural" phenomena (diseases and their causes). In addition, one operated with "non-natural" phenomena, and it was precisely these that were important for health. Such phenomena could include air and environment, food and drink, physical exercise and bathing, sleep, sexual intercourse, and not least "the passions of the soul." A central passage in Johannitius's text states:

> *Several states of mind create an effect in the body, for example those that bring the natural heat from the inner parts of the body to the outer parts or to the surface of the skin. Sometimes this happens suddenly, as in anger; at other times it happens gently and slowly, as in joy and pleasure (…) some affections disturb both the internal and external natural energy, as for example in sorrow.*[4]

The English historian of music therapy, Peregrine Horden, writes that these sentences became an entry point for bringing music into medicine, precisely under the heading of "joy and pleasure." Music—provided, of course, that it possessed

[4] Horden, 2000, p. 27.

the proper ethos—could manipulate "the passions of the soul" by soothing and alleviating states that caused illness. In this way, music could strengthen psychological states and prevent disease. Horden notes that it was on this basis that the Italian lecturer Gentile da Foligno, at the medical faculty in Perugia, in 1348 advised people to avoid emotions such as sadness, anger, and loneliness in order to prevent being attacked by the great plague. These emotions could disturb the body's composition and encourage disease. Instead, one should seek joy and pleasure through melodies, songs, and stories.

Thus, around the turn of the first millennium, through a synthesis of ancient music theory and its Arabic elaboration, an understanding had developed of the basic elements of preventive and health-promoting work. Central here were the highly natural "non-natural" phenomena: environment, ecology, diet, physical activity and bodily well-being, sexuality, and, not least for our purposes, "positive emotions." Music was given a clear rationale within this system. At the same time, musical thought remained rooted in general philosophy through the transmission of ancient musical thought, that is, the doctrine of ethos and the Pythagorean theory of the relationship between numbers and music.

Musica Humana

The transmission of this theory can be traced back to the Roman scholar Boethius, who in the sixth century, through the treatise De *Institutione Musica*, summarized the theory of the relationship between cosmic music and the music produced by human beings themselves. In brief, this understanding held that the harmonious music produced as the planets revolved around the earth (*musica mundana*) was reproduced by human beings through their own instrumental and vocal activity (*musica instrumentalis*). By playing and singing, the human being was harmonized (*musica humana*). As music historians write, Boethius refers to *musica humana* as "an inner human harmony, as symmetry between several of our limbs, as the relationship between body and soul; all this is a form of music—and as music based on the lawfulness of numbers."[5]

This theory, together with the anecdotes Boethius had added concerning the therapeutic effects of music, was reproduced in countless writings throughout the Middle Ages. It was especially important that this theory formed part of the "preliminary examinations" that physicians had to undergo throughout the medieval period.

[5] Benestad, 1976, p. 49.

Although the basic elements of this understanding remained in place for more than a thousand years, that is, until the end of the eighteenth century, new theories continually emerged concerning the medical or metaphysical basis for applying music in preventive and healing contexts. Close readings of texts from the Middle Ages show that, with the advent of scholasticism, Plato's understanding of the relationship between cosmic order and human order had to give way to purely logical arguments, in addition to the implausibility that could emerge from more empirical considerations. Even so, belief in the possibility of a musical cure could be maintained.

The Renaissance

There are many speculations throughout history concerning the relationship between culture and disease, music and health. Music philosophers seem to have kept pace with physicians. As soon as a new medical theory was proposed, music thinkers entered the scene and suggested a place for music. The Renaissance thinker Marsilio Ficino (1433–99) occupies a special place in this history. Ficino was a priest, theologian, astrologer, physician, magician, and, not least, a musician. During his work in fifteenth-century Florence, he fashioned a distinctive synthesis of ancient music theory, Christianity, and astrology. As an improvising musician, he had such a strong effect on his contemporaries that he was given the epithet "the second Orpheus." A contemporary eyewitness, Bishop Campano, wrote of Ficino's abilities as an improvising musician: "… his eyes then blaze, then he leaps forward, and he discovers music he has never practiced beforehand."[6] Ficino was said to appear "possessed," as if he were connected to "the source."

Descriptions such as this testify that, in the fifteenth century, there was concern with a certain rhetoric of authenticity. In other words, the point was to appear as an intimate mediator between cosmic music and what was being played in the moment. We may sense that for Ficino, music's harmonizing project was a matter that went beyond mere bodily well-being, involving instead a harmonization or joining together of cosmic and earthly conditions.

Doctrine of the Affections and Vitalism

When we move into the sixteenth century and the Baroque period, Descartes' mechanistic philosophy, together with the doctrine of the affections in music,

[6] Voss, 2000.

dominates the scene. Here it was thought that large or small intervals in music could expand or contract the body's *spiritus animal*e, a kind of life-breath flowing through the human being. If we were depressed, this vital air had contracted.

If we move further forward in history, we see that a vitalist conception emerged as a reaction against mechanistic and reductionist approaches in nineteenth-century science. It was now claimed that illness did not have a material basis but was caused by disturbances in the mind. And once again it was thought that music could be used in therapy because it could penetrate non-intellectual areas of the mind.

Throughout history, we see that the doctrine of the four bodily humours had to give way to other medical theories. These could be connected to such diverse conceptions as the mechanistic medical views of the sixteenth century, vitalist currents in the nineteenth century, or more exotic theories such as the doctrine of magnetism, to which Mozart alludes in the opera *Così fan tutte*.

Natural Science Takes Over

There is abundant documentation of how music was thought to be used in connection with medical treatment and therapies. The German historian Werner Friedrich Kümmel has described this thousand-year tradition in a broad survey. He nevertheless concludes that this tradition disappeared from history in the nineteenth century. The reason, he writes, is that the preventive tradition, in which the use of music formed part of broader rules of living, was eradicated.[7] With the breakthrough of scientific thinking and the rise of positivism, people became more concerned with studying the course of diseases than with prescribing rules of life. Within such a medicine, music seemed to become a marginal phenomenon.

An example showing that a decisive shift had indeed taken place can be found by reading the German music aesthete Eduard Hanslick, especially known for his book *Vom Musikalisch-Schönen*. I will not go into detail here about how Hanslick came to challenge Romantic musical aesthetics by claiming that the beautiful and meaningful in music was primarily connected to a kind of "play of forms" (*tönend bewegte Formen*) in music, rather than to music's ability to convey an extra-musical message. In his influential 1854 book, Hanslick writes, in good positivist spirit:

> *It may not be known to many lovers of music that we are in possession of an extensive literature dealing with the bodily effects of music and the medical*

[7] Kümmel, 1977.

> *application of these. This is a literature rich in interesting curiosities, but unreliable in its observations and unscientific in its explanations. Most of these medico-musical writings seek to elevate certain highly complex and accidental properties of music by granting them the status of powerful remedies.*[8]

As Peregrine Horden remarks, this quotation shows that we are in the process of leaving behind a way of thinking in which the doctrine of the "non-natural" phenomena and their importance for preventive and health-promoting medicine was disappearing from the horizon. Yet even though the understanding of music's therapeutic and preventive potential did not disappear entirely from history, from the nineteenth century onward there arose a need to place these ideas within an entirely new context.

Music Enters the Hospital

A good illustration of how music was thought to be useful as a means of treatment in the nineteenth century can be found in the German psychiatric hospital at Illenau, near Dresden. Historian Cheryce Kramer has studied archives, diaries, records, and medical reports from this hospital and is able to document how music played a prominent role in the treatment programme.[9] In the year 1875, for example, 140 concerts were organized at Illenau. The hospital had a choir, a marching band, and a chamber orchestra, all led by a full-time music instructor who worked closely with the physicians. All music that was to be performed first had to be approved by the doctors. If the music was considered too demanding, it had to be rearranged. The musical style was characterized by an effort to avoid chromaticism, overly complex harmonies, or excessively Romantic themes. The ideal was the music of Mendelssohn.

What, then, was the philosophy behind this arrangement? How could such an extensive use of music be justified, given that one could no longer rely on the cosmology and musical way of life inherited from antiquity? Kramer finds the justification in the belief that there existed a distinct faculty of the mind, *Gemüth*, which was especially receptive to aesthetic influences and which coordinated and united body and soul. *Gemüth* was a collective phenomenon, a condition that permeated the entire institution. The musical cure to which the patient was subjected depended on *Gemüth* as a precondition for aesthetic resonance and for

[8] Quoted after Horden, 2000, p. 30.

[9] Kramer, 2000.

collective alignment and attunement. Illness was regarded as a form of "arhythmicity," and music, together with synchronized gymnastic exercises, formed part of rituals intended to promote a shared social pulse.

This example is a reminder that all influence through music takes place within a cultural climate that sets certain parameters for how we interpret and experience music. The belief that there exists such a sensory faculty, *Gemüth*, becomes a prerequisite for this cure to work. *Gemüth* is to be understood as a collective interpretive framework, a set of shared expectations and conditioning emotional response patterns that make medical use possible. And when music is experienced as working in accordance with the way these cultural prescriptions are set up, our experienced relationship to music is reinforced, modified, and naturalized.

Indigenous medicine

In recent years, several music therapists have spoken out to criticize the dominant narrative about music and therapy shaped by music therapists within European and North American traditions. This criticism is directed at the colonial legacy and at theories and research within these traditions that contribute to suppressing and overlooking the medical and therapeutic traditions maintained by Indigenous peoples over generations. I have commented on this critique in the chapter on Music therapy theories and perspectives.[10]

It is beyond the scope of this account to trace the histories of various medical traditions as they exist in magical and religious contexts across a range of cultures. Nor have I made space to demonstrate connections between music, medicine, and health in major Indian, Chinese, or Muslim traditions.

It should be noted that there are multiple forms of rationality beyond those on which Western science is based. At the same time, it is important to acknowledge that scientific developments within Western medical thinking have led to many advances that benefit all people, regardless of cultural tradition. In addition, there are several illnesses or somatic conditions that may originate in psychosomatic factors, where the use of music and other cultural activities can have a tangible effect. The effects of such cultural practices are explained through local cosmologies and make sense within the rationalities on which those practices are based. When, for example, a musical ritual proves to have a curative effect, this can also be explained within a Western framework of rationality.

[10] See also CAMTI (red.) 2020.

An example may illustrate this. The anthropologist Tomas Maler studied medical practices among the Digo people in Kenya and Tanzania.[11] The medicine men there have a differentiated understanding of illness and treatment. They distinguish between accidents, poisonings, fractures, and snake bites, and "internal" illnesses. The former are treated with splints, ointments, and bandages and do not require medicine men or rituals. Certain chronic conditions and what we would describe as psychosomatic disorders—such as high blood pressure, digestive problems, depression, paranoia, psychogenic infertility, and more—are attributed to the influence of various spirits.

Treatment of these latter conditions is carried out in a strictly ritualized form by a medicine man specialized in particular illnesses. Healing rituals are divided into several phases. When a patient feels ill, they consult a medicine man, who may refer them to another after an initial conversation. An attempt is made to determine which spirit has caused the illness. The ritual aims to lure this spirit into the patient's body and carry the illness away when it departs. Each spirit has its own specific rhythm, closely connected to the patient's symptoms. For example, the rhythm used for fever is slow and calming to reduce the fever, while the spirit responsible for rheumatic conditions is invoked with hectic rhythms that raise body temperature. The effect is therefore not merely suggestive. After hours of rhythmic movement, the patient enters a hypnotic, seizure-like state. This indicates that the spirit is present, allowing the medicine man to communicate with it and negotiate the conditions under which it will withdraw. These conditions always involve material goods.

In the next phase, rhythm is used to guide the patient back to consciousness and regain control of the body. Finally, the rhythm intensifies again to expedite the expulsion of the spirit and demonstrate control over it. The conclusion involves reintegrating the patient into everyday village life. The names of relatives and neighbours are recited, and the patient must relearn and repeat them. Finally, the patient is instructed in various practical activities that structure daily life.

Anthropologist Maler followed a ritual in which a woman unable to conceive was treated. As infertile, she had lost status in the village and become socially isolated. The ritual followed the prescribed structure, and the rhythm was selected after diagnosis. Analysis of the music shows that the tempo increased from 72 beats per minute to 144, reaching a climax when the woman became possessed by the spirit and falls to the ground. The tempo then decreased back to 72.

[11] Maler, 1977.

A few weeks later, the woman becomes pregnant. The anthropologist rules out organic causes for her infertility and suggests that it was due to social pressure and stress. The medicine man also considers it a form of depression. The anthropologist argues that the therapy cannot be explained solely by the effects of music. He points out that the woman's self-esteem increased as she was accepted back into the community through the ritual after a long period of exclusion due to her infertility. During the ritual, she is made the centre of attention and even seated on the chair of a particularly fertile woman in the village—a demonstration of intimate contact affirming the community's desire to accept her again.

However, we should not overlook the carefully considered role of music, Maler writes. The medicine men have a highly conscious relationship to the music and rhythms they use. Tomas Maler recorded examples from various rituals and played them back to several medicine men. These samples showed that they could immediately identify specific rhythms and thereby know which spirit was associated with them.

This example illustrates how music therapists working in countries with Indigenous populations can collaborate with local medical traditions and cosmologies, opening possibilities for incorporating traditional healing practices. However, this requires a high degree of sensitivity and skill in navigating between different medical cultures without violating traditions or preventing patients from benefiting from modern medical advances.

Toward Modern Music Therapy

If we make a long leap in history to the present day, it has been argued that it is not only music that has disappeared from the field of vision of biomedical medicine. Criticism is often directed at a medicine that has lost a holistic perspective on the human being.

There are, however, several examples showing that a more holistic biopsychosocial perspective on illness has gained a foothold within contemporary medicine. Many people wish for a medical culture that takes care of the human being behind the illness—a medicine that does not forget the existential and humanistic perspectives that necessarily arise when illness and suffering occur. In recent times, we have also seen several reform movements within the field of mental health. As we shall read in later chapters, we encounter these reforms under themes such as recovery thinking, user participation, and medication-free treatment.

MUSIC AND PUBLIC HEALTH

1

Music and Public Health

In this chapter, I discuss theories, research, and interventions in which music forms part of preventive and health-promoting work, and how this can contribute to improved public health. I will describe key characteristics of public health work and provide examples of interventions in which music functions as a central resource.

Health and quality of life are core concepts throughout this book, and I will examine various definitions of these more closely. I also introduce the theory of music as a cultural immunogen and describe the musical "immunogens" related to vitality and emotions, mastery and agency, community and belonging, as well as meaning and aesthetic musical experiences.

I also consider how music may have positive effects in relation to health challenges such as stress and anxiety, pain, sleep difficulties, and depression. In addition, I draw on the self-help literature to show how we ourselves, through music and musical activities, can influence health and quality of life.

What Is Public Health?

Public health work is a broad concept that may be understood as the sum of preventive and health-promoting efforts, writes the sociologist and professor Olav Garsjø.[12] Garsjø also cites White Paper No. 26 (2002–2003), which states the following about health policy: "Public health work involves reducing what gives rise to health risks and strengthening what contributes to health (…) Public health work concerns investing in physical health, among other things through influencing lifestyle habits and living conditions. But it also concerns investing in mental health, by facilitating experiences of mastery, good self-esteem, human dignity, security, respect, and visibility."[13]

Public health studies concern the health status of the population or the country as a whole, and are concerned with how economic, physical, psychological, and environmental factors affect health status.[14] In this context, the question is to what extent music, or (health-)musicking, can influence health and quality of life in the population.[15]

Ever since music therapy in the 1980s defined this preventive and health-promoting aspect of the field, the discipline of music therapy has paid attention to how music is used in everyday life outside institutional settings. This tendency intensified around the turn of the millennium, when music was defined as a "cultural immunogen."[16] It became clear how many people in everyday life use music to give themselves new energy, process emotions, increase their sense of mastery, find community through participation in musical life, and create experiences of meaning.

We may think of three levels of preventive and health-promoting measures. One level involves interventions directed at groups facing a specific health challenge, while another refers to interventions aimed at groups that already show signs of ill health or problematic behavior and where one wishes to avoid deterioration. It is at these levels that music therapists often intervene. A third level encompasses

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[12] Garsjø, 2018, p. 36.

[13] Garsjø, 2018, p. 6

[14] Nylenna and Braut, 2023, p. 36.

[15] Music therapy and public health have been put on the map by professor emeritus in music and health, Lars Ole Bonde at Aalborg Universitet. Bonde has in collaboration with Karette Stensæth and CREMAH at the Norwegian Academy of Music initiated several Nordic seminars and a research collaboration with the Danish Institute of Public Health. See Bonde and Theorell (Ed.), 2018, as well as Saarikallio, Stensæth, Horwitz, Ekholm and Bonde, 2020. https://doi.org/10.18261/issn.2535-7913-2020-01-04

[16] Ruud, 2002, 2020a.

general interventions directed toward the health of the population as a whole. It is primarily this level that is the focus of this chapter.

Garsjø writes that preventive and health-promoting work is at once a political, professional, and private matter.[17] Public health studies will often concern the investigation of large populations in order to measure the effects of various interventions and their relationship to different life conditions. There are some such studies in which music is included, and these will be discussed below. For the most part, however, we shall take a closer look at how health musicking, as an everyday practice and a private matter, may help create life habits by drawing on the potential inherent in an active relationship with music.

Mental Health Rights

An understanding of the significance of music in health-promoting and preventive work resonates with theories and strategies proposed by the Norwegian professor of health psychology Arne Holte, who has also served as Deputy Director General of the Norwegian Institute of Public Health. He has proposed "seven mental health rights," understood in a human sense, as he writes.[18] Holte writes that we enjoy good subjective quality of life when we have:

- A sense of identity and self-respect – a feeling that one is someone and is worth something.
- A sense of meaning in life – a feeling of being part of something greater than oneself, that someone needs you.
- A sense of mastery – that there is something I am good at, something I can do, almost regardless of what it is, as long as it is something.
- A sense of belonging – that one belongs somewhere, belongs with someone.
- A sense of security – that one can, for the most part, think, feel, and express oneself without being afraid.
- A sense of participation – that what I do, or do not do, matters to others.

[17] Garsjø, 2018, p. 40.

[18] https://arneholte.no/de-syv-psykiske-helserettighetene/ Access date September 26.2025.

- A sense of community – that I have people with whom to share thoughts, feelings, and experiences, people who know me, care about me, and whom I trust will look after me when needed. I am not completely alone.

These points resonate strongly with the understanding of the relationship between music and quality of life presented below under the designation "cultural immunogens." When Holte, in a later article, updates a strategy for improving public health, the following points are worth noting: in order to reduce prevalence, disease burden, and the societal costs of mental disorders, one must invest in broad-based, systematically implemented prevention. As for strategy, he states that health and ill health are produced where people live their lives, including within cultural life. The main effort to improve mental health must take place outside the health services.

"It is easier and more effective to strengthen health than to prevent disease," Holte writes, citing the WHO. We may note that the government's escalation plan for mental health in the summer of 2023 includes efforts to prevent loneliness, strengthen competence in life mastery education in schools, and support mental health-promoting arenas.[19]

We shall see that the field of music therapy is able to respond to every point on Holte's list. It may be noted that when, in what follows, I devote considerable space to describing the health-promoting effects of music, this is because many of the processes that occur through health musicking outside an institutional context, and without the presence of music therapists, may also be health-promoting. The processes at work in independent musicking are often many of the same as those that occur in collaboration with music-and-health workers and music therapists. Many people in vulnerable situations, however, will need support in making use of the possibilities inherent in musical activity in order to improve their health and quality of life.

A Statistical Survey

A major Danish public health survey from 2013 included a number of questions about Danes' use of music. In this annual survey, in which 15,000 Danes respond to the general question "How are you?", respondents could now also answer the question "What do you use music for?" In this way, we see that Danes use music to

[19] Holte, 2024.

relax (60%), regulate mood (50%), gain energy (40%), improve concentration (20%), express feelings (20%), become wiser (10%)—or for nothing in particular (20%).[20]

When the relationship between perceived health and participation in music activities was examined more specifically, it turned out that amateur musicians had a significantly better health profile than professional musicians—even though the latter group also reported that their health was good or very good. This stands in contrast to more recent English and Danish studies, in which professional musicians are generally less satisfied with their health status. This applies especially to younger musicians and, not least, to women, when their responses are compared with those of the average adult Dane. A Norwegian study shows that very many musicians within different popular music genres have experienced periods of anxiety and depression. This implies weakened subjective health over the course of their musical careers. Women and younger musicians appear to be most vulnerable to negative mental health.[21] Serious concern for the health of these musicians is evident in the book *Can Music Make You Sick? Measuring the Price of Musical Ambition*.[22]

The American musician and neuroscientist Daniel Levitin discusses why so many professional musicians have poor health statistics. This concerns musicians in rock, heavy metal, and popular music who must live a life on tour. They often have marginal incomes and must live apart from their families for long periods. Substance and alcohol misuse hardly benefits health, and many are exposed to accidents. Levitin points to statistics showing that mortality among professional musicians is twice that of the population at large. These deaths often involve suicide, homicide, accidents, overdoses, and liver disease. This applies especially to country, metal, rock, and jazz musicians. The statistics also show that 71% of British musicians have experienced panic attacks and/or high levels of anxiety, while 69% report depressive disorders—three times higher than in the British population at large.

As for classical musicians, they are subjected to intense pressure to perform at a high musical and technical level every time they appear, with a correspondingly high level of stress for many. Fortunate are the amateurs, Levitin writes. They can play without pressure, performing music by the great masters together with the joy that comes from unburdened musical friendships. Or, as pianist Arthur Rubinstein put it: "I make mistakes. I don't practice much. I live life."[23]

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[20] Bonde, 2024.

[21] Nordgård, 2024.

[22] Gross and Musgave, 2020.

[23] Levitin, 2024.

Cultural Initiatives

Public health surveys in Denmark and Norway have shown that attending concerts, theatre performances, or museums as an audience member may be associated with longer life expectancy, fewer deaths from cardiovascular disease, and a lower prevalence of depression.[24]

Professor of Music and Health Lars Ole Bonde points out that in 2017, four Danish cities received state funding to carry out several projects under the shared title *Culture on Prescription*. In Aalborg, the initiative was called *Culture Vitamins*. The results of the projects were so positive that the municipality made the initiative permanent. At the same time, it established the interdisciplinary *North Jutland Centre for Culture and Health* (NOCKS).[25] Another project Bonde highlights is *SANS* (*Dance with a Song*), where more than 100 instructors now offer dance and singing in many different local associations.[26]

One initiative that must be mentioned is the project *Everyone Can Sing*, aimed at Danish schoolchildren. This is a project that offers communal singing in schools and is described in more detail in the chapter dealing with music therapy in the development of children and young people. Much research has now been conducted on the health effects of choir singing and communal singing. In general, this research shows that we form bonds with one another through singing together, regulate moods, and communicate across age, gender, social status, and health condition.

Singing is found in all cultures and creates lines of connection both within one's own culture and across cultures. Singing has a direct effect on our physical health, on breathing and heart rhythm, on gross and fine motor control of voice and breath, while also linking areas of the brain and influencing various executive functions. All in all, singing improves our individual quality of life, our vitality, and our emotional life, while social relationships are positively affected. Not least, through singing we can create an inclusive social community.[27]

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[24] Bonde, 2024, see also Fancourt, 2026.

[25] https://www.kommunikation.aau.dk/forskning/forskningsgrupper/forskningsgruppen-musikterapi/nocks

[26] https://danserpraksis.no

[27] See Bonde, 2024; Balsnes, 2010, 2022.

Music, Health, and Quality of Life

Music occupies a large place in the everyday lives of many people, and it is probably an under-communicated topic how music helps regulate health and strengthen several aspects of what contributes to quality of life and well-being. I ask whether this is an aspect of our public health that has received too little attention, for example within health psychology.

With the development of music technology, the internet, and the use of smartphones, a new practice has emerged related to emotional self-regulation through music.[28] This is a topic that is central to music therapy. Yet until recently, there has been relatively little transfer of knowledge from music therapy to the ways in which we use music in everyday life.

In a phase in which professional development has stood at the center, music therapy has insisted that music therapy is inseparably linked to a music therapist. When we speak of music therapy as a field or knowledge domain, however, it becomes important to study all forms of music use in relation to health and quality of life, even when they occur without the involvement of a music therapist.

That music is linked to health is an idea that resonates strongly among the public. We know that many people listen to music in everyday life to calm themselves and counteract unhelpful stress, to distract themselves from difficult thoughts and feelings, or to give themselves new energy and positive experiences. From musical life, we have many examples showing that participation in music activities has a health effect. Amateur musicians feel more refreshed after rehearsals, their mood is better, their backs are straighter, and their worries fewer. Perhaps the lurking headache disappeared, or the unsettled feeling of stress that arose at the end of a demanding working day.

From time to time, the media have taken up this theme through interviews and reports. In cultural policy, we have seen examples how central cultural authorities har attempted to develop new projects linking cultural activity and health. Pointing to the connection between active participation in musical life and the experience that this has a positive effect on our lives is not merely a cultural-political strategy for obtaining more funding for musical life. Music therapy can point to research showing the importance of amateur musical life for participants' quality of life and health through active engagement in music.[29]

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[28] Skånland, 2013.

[29] Pitts, 2018. See also https://www.marchnetwork.org

How we use concepts such as "health" and "quality of life" in music therapy may be seen in relation to the orientation that is taking place within health policy. Whereas health services were previously primarily concerned with curing disease, attention has now become more directed toward preventive work. These are familiar measures such as dental care, vaccination, or screening for possible illnesses. More recently, there has also been strong interest in health-promoting work—work directed toward our lifestyle and health habits—which implies a broader and more positive concept of health. And if we ask what is preventive and health-promoting for the population, it should not be only proper diet and physical exercise that appear on the agenda. There is much to suggest that the organizations and activities of musical life may themselves be regarded as health-promoting and may therefore be counted among our health institutions.

What Is Health?

In some countries, music therapy is strongly linked to a special educational practice in work with children. Many music therapists still work within this context. But music therapy has increasingly become more firmly rooted in broader health work. The same tendency can be seen in other areas of society, where *life mastery* has become an important topic, for example in schools.[30]

Health as the Absence of Disease

In many definitions of music therapy, working toward better health has become a central objective. If we turn to the literature on the concept of health, we quickly discover that there are many different understandings of what "health" may actually entail.[31] At first glance, we tend to think that health means the absence of disease—in other words, a kind of zero-state. There are several such variants of what we call biomedical theories of disease and health. Some emphasize that health is something we have when all parts of the body function according to what is considered "normal," whether biologically or statistically. Such theories usually rest on the basic assumption that the body is a mechanical system and that our vital functions may be understood as machinery. This is called a mechanistic understanding.[32]

[30] Eide and Ruud, 2023.

[31] For an overview, see Blaxter, 2004.

[32] See Medin and Alexanderson, 2000.

Health as Resource

Most people, as well as health researchers, understand health to mean something more than a medically normal state. Social medicine and the emerging field of health psychology offer accounts of how many people think of health as "that little surplus," the feeling of harmony and balance in life that gives one the energy to do what one most wants to do out of desire and joy.[33]

If we view the concept of health within a humanistic horizon, emphasis is placed on health as experience. This would mean that health is the same as experiencing well-being or a sense of meaning in life. A humanistic understanding opens for health to be perceived as a resource and to become a means for achieving the goals one has set in life. Such a goal might well be well-being itself, simply feeling good. Health becomes a resource alongside education, work, and housing. Health becomes an energy reserve, a strength from which we may draw to resist disease or recover more quickly. This view has consequences for how we organize health-promoting work. Such a concept of health shares features with what we call quality of life.

Health as Mutual Care

Professor of Music Therapy Brynjulf Stige has pointed out that health may be linked to caring both for oneself and for others. By taking as a point of departure how members of a senior choir experience singing together, it becomes clear that self-care may involve attending to physical needs, for example if one has problems with breathing and lung capacity. Or it may concern social needs being fulfilled, such as meeting regularly with fellow choir members.

Choir participants show care and support for one another, both musically and socially. This may involve everything from sharing transportation and looking after participants with memory-related challenges to including newcomers in the community. The choir leader, Stige notes, also plays a particularly important role in creating such a climate of trust and cooperation.

In this way, the concept of health includes what Stige calls "mutual care." This is a form of care that depends upon, and becomes visible through, shared responsibility for the running of the choir and an enhanced ability to respond to

[33] Ogden, 2000; Ruud, 2006.

one another's needs. In other words, this points to an ethical responsibility and an awareness of the importance of showing empathy and communicative ability.[34]

A Sociological Understanding of Health

Health may be understood as a state, an experience, a resource, and a process.[35] As for health as a state, we recognize this where health and illness are seen as two opposites on a continuum, and where one's health condition varies according to where on this continuum one is located. Health is something we "have"; we are either healthy or ill, and the two states do not exist simultaneously.

The concept of health is often understood pragmatically. It is regarded as a relative phenomenon and is related to what people expect based on age, disease burden, and social situation. Health is perceived as an individual and personal phenomenon, where the path to health differs from one individual to another. When people are asked what they mean by good health, they answer that health is well-being, functioning, nature, mood, mastery, and surplus/energy.[36] Sociologist Mildred Blaxter points to studies showing how people's understanding of health depends on their occupation and their belonging to different social classes.[37]

Sociologist Tia DeNora has outlined a complex and multifaceted concept of health, in which health is an identity and a condition ecologically constituted as an open system.[38] She describes three dimensions of health. (a) Health consists of *inscriptions*, that is, we are "marked" both by ourselves and by others when our condition is given a name. (b) Health status encompasses what we can *perform*, and (c) health consists of, and has meaning as, *lived experience*.

We may, for example, imagine a situation in which we have difficulty climbing stairs. The doctor tells us that we have a cardiopulmonary disease, arthritis, and so on. The doctor's diagnosis may lead me to become much more aware of my own condition. This inscription may cause me to stop using stairs and to fall increasingly out of shape. But I might also choose not to listen to the doctor, telling myself that

[34] Stige, 2010, Chapter 18.

[35] Medin and Alexanderson, 2000.

[36] Fugelli 199; Fugelli and Ingstad, 2001.

[37] Blaxter, 2004.

[38] DeNora, 2013.

I was only "temporarily out of condition." It might be that I always took the lift and therefore had never noticed the problem.

What DeNora wants to show us is that behaviour (*performance*) affects inscription, inscription affects behaviour, inscription affects experience, experience affects inscription, and experience affects behaviour. The way I act will influence the experience of how I am doing.

A health-sociological perspective seeks to say something about how these inscriptions, experiences, and performances are constituted. Central here is an understanding of how they emerge and are shaped within material cultures and social practices. As we saw in the example of the person who always took the lift, that person would not experience themself as disabled. In other words, experience, performance, and inscription depend on what my social world offers or does not offer.

To avoid a purely individualistic position, we must consider how culture and environment mediate illness/health. Within disability studies, anthropology, and constructivist studies of culture, there is concern with how health conditions are mediated by institutions and cultural practices.

There is also a temporal dimension to this understanding of health and illness. This means that symptoms and our ability to act may vary from day to day, moment to moment. This may be due to biological functions in the body, the effects of medication, psychosocial factors such as motivation, distraction, desire, and engagement. Or it may be due to external conditions that affect us, such as when, for example, the degree of air pollution creates respiratory illness. Variations in the experience of health and illness may be substantial. There is health experienced in illness and illness that manifests itself while health is experienced. When DeNora characterizes health-illness as an "open system," it is because the system takes shape in relation to factors outside the individual and outside the individual's internal physiological and biological composition. Since the system appears in relation to various external factors, it is inevitably also temporal, in flux, and potentially variable.

An Existential Dimension

We can see that there are many perspectives on health. The Swedish professor of theology and philosophy of religion, Ola Sigurdson, distinguishes between physical, mental, and existential health. In other words, to have full health is something more than bodily and mental well-being. Health involves an element of belief, in addition

to the way we relate to other people and to ourselves. Health thus becomes a cultural concept, something relational that forms part of the culture in which we live. In other words, health concerns the whole social and discursive network, with its norms, valuations, and ideals, that constitutes the very horizon of human meaning-making activity.[39]

Sigurdson writes that, within the modern medical project, the physical and psychological view of health has replaced the notion of existential health. The idea of existential health has not disappeared but has been incorporated into a biological view of health. It is medical science, and no longer theology—which is Sigurdson's concern—that has gained the power to define what is sick and what is healthy.

Sigurdson refers to the philosopher Fredrik Svenaeus, who distinguishes between three different dimensions of illness: that which can be established biologically, the experiential dimension, and the cultural dimension.[40] Here, the cultural dimension corresponds to existential health. Svenaeus observes that illnesses, diagnoses, and treatments may fulfil a cultural need, in that the diagnosis of an illness positions the person in society and relates us to the promises, hopes, and betrayals that make up the symbolic system of society. Our experience of illness takes place at the intersection of the biology of disease and its cultural meaning and context. Existential health thus becomes a form of cultural meaning that may be created by religious and existentially significant institutions, writes Sigurdson.

In other cultures, understandings of health and illness will appear differently. Biological processes are experienced by individuals and interpreted within a cultural context. The biological dimensions are metaphorically reinterpreted. Some notion of existential health exists in all cultures, because of what participants in that culture consider to constitute a good life and how it may be achieved, Sigurdson comments.

Sigurdson brings in the philosopher Gadamer when he defines health as an "existence," our "being-in-the-world," and our being with other people, in work and joy, fulfilled by the tasks of our own life. Health is therefore something that shows itself when it is not noticed. When we have health, we are primarily directed toward something else. Health is present as an unthematized horizon. In this way, health comes close to quality of life.

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[39] Sigurdson, 2008, p. 197.

[40] Sigurdson, 2008, p. 295.

Sigurdson refers to the psychologist of religion Valerie DeMarinis, who has pointed out that society suffers from an "existential dysfunction." This is because there are no longer given ideas, rituals, and institutions that offer a self-evident presentation of the meaning of life. When everyone must take responsibility for the meaning of life, this implies an existential loss. This loss represents a form of cultural epidemic that arises when cultural resources, symbolic systems, and ways of life no longer succeed in promoting health. Over time, such existential dysfunction results in experienced and diagnosable illnesses, something that may be understood by examining how the experience of health and illness is culturally constructed. DeMarinis calls for a public health strategy that can develop the existential imagination, for example through collective engagement with the arts.[41]

Later in the chapter, we shall see how the German sociologist Hartmut Rosa's theory of resonance sheds light on the significance of music for our existential health.

With this view of health as process, we see that health is not a static state, but something in constant change, something that can be influenced. Health is not something we have, but something that develops through a process. Health is created in movement and formed in the relationship between individual, action, and environment.[42] The humanistic concept of health is grounded in a view of the human being as active and capable of taking hold of one's own life, lifestyle, and health habits, and of adapting to the demands of life.

All these different understandings of the concept of health tell us that "health" evokes reflections in us about the quality of our physical, emotional, and social lives. Rather than believing it possible to find an objective definition of health, we see that health may be understood as a category of experience that reveals some of our unspoken assumptions about human and social realities. Indeed, talking about health is a way of expressing our culture's understanding of what is meant by "well-being" and "quality of life." Health thus becomes a keyword, a productive or generative concept, a value attached to other values that are central to us.

From this, and from a more general constructivist view of health, we may go one step further and say that health is linked to quality of life. And quality of life, in turn, may be understood as something connected to a good emotional life, good coping skills in life, good social contacts and relationships with others, and

[41] Sigurdson, 2008, p. 215–216.

[42] Medin and Alexanderson, 2000, p. 70.

experiences of meaning and coherence in existence.[43] These are precisely the kinds of experiences we associate with good public health.

From Health to Quality of Life

Health and quality of life must be seen in relation to one another, but they are not the same thing, writes sociologist Olav Garsjø. Good quality of life may exist independently of illness, even though good health and good living conditions form the most important basis for quality of life and subjective well-being.[44]

By thinking of music therapy as a way of giving people new possibilities for action, we create a point of departure for seeing connections between culture, quality of life, and health. The Swedish philosopher Lennart Nordenfelt writes that there is a tendency to equate quality of life with health. Most holistic theories have indeed been concerned with health as a feeling of well-being and as a capacity for action. In other words, there is a connection between a feeling of well-being and the ability to act. A person who cannot realize his or her individual goals may be said to be in a situation marked by lack of health. In this way, we may say that illness and health belong to two different categories. A person may objectively be defined as ill and may themself feel that they have some illness. But if this suffering does not affect the person's vital goals in life, writes Nordenfelt, the person has a certain degree of health.[45]

This way of thinking gives grounds for claiming that cultural workers contribute to strengthening public health. In turn, this understanding, because it acts back upon society, may create a culture in which people become more concerned with the positive sides of existence than with seeking a state free from discomfort or problems.

The link between action and quality of life is one of the keys to bringing culture and cultural activity into preventive health work. Action is the cultural factor that can help explain how active participation within the cultural sector—why or how engaging, for example, with music—can help sustain the feeling of being in good health.

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[43] See Ruud, 2001a.

[44] Garsjø, 2018, p. 32–33.

[45] Nordenfelt, 1991b:83. See also Nordenfelt 1991a, 1996.

If we see culture as a system of meaning that is maintained and transmitted through language and traditions, this may mean that many of the contexts that help give life meaning are threatened by powerful processes of social change. Children and young people who grow up in a close-knit, integrated society characterized by community and the transmission of traditions have greater resources of resistance against the feeling of loss of meaning, and more networks that can prevent social isolation. Since we also know that the degree of social integration matters for health and illness, we have here a strong argument for strengthening the cultural side of preventive health work.

We must abandon the idea of health as a kind of optimal and unattainable state of happiness and well-being. Life has its inherent difficulties. We must learn to live with life's hardships and a certain number of minor troubles. At the same time, from emerging health psychology and numerous health education campaigns, we know how we ourselves can help influence our own health[46]

Such campaigns are generally directed toward diet and exercise, and perhaps to a lesser extent toward quality of life more broadly. Nevertheless, it seems that these measures gradually have a more general effect in the population, often in connection with lifestyle choices. For there is a growing tendency among certain groups in society to mark their identity through allegiance to values related to health and increased quality of life. Health becomes a lifestyle marker, a way of showing the outside world that one takes the body and mental health seriously.[47]

In this way, we may say that health acquires a performative aspect. Health behaviour is something one performs by systematically influencing one's quality of life. Not only eating habits and maintenance of the body are drawn into lifestyle, but increasingly also cultural values, the way one manages and uses one's time in the broadest sense, connects with social communities, or seeks experiences of meaning through art. The challenge lies in facilitating such an expressive identity and lifestyle.[48]

Health Resources and Quality of Life

It is important to seek support in research and practice that have demonstrated connections between cultural factors and resistance to illness. An Israeli medical

[46] Taylor, 1996; Ogden, 2000.

[47] Aldridge, 1996.

[48] Hetherington, 1998.

sociologist, Aaron Antonovsky, has worked with models for understanding the relationship between health and life mastery. As the founder of so-called salutogenic research, he is concerned with understanding why we stay healthy. Whereas biomedical research is often concerned with pathogenesis—that is, with understanding why illness arises—Antonovsky seeks instead to understand what keeps us well. He is concerned with the general resistance resources (GRRs) that we can mobilize in the face of illness. He believes this resistance resources are found in people who experience a sense of coherence in life. This coherence arises when we experience life as manageable, comprehensible, and meaningful, as Antonovsky writes.[49]

The feeling of coherence and meaning in life fits well among the factors many people associate with quality of life. When, in recent times, we have begun to speak of quality of life, it is because we have come to understand that economic growth and increased material welfare do not in themselves lead people to experience life as better to live. One therefore tries to identify other aspects of life that contribute to the experience that life is good and meaningful. Different professional groups, such as psychologists and nurses, have proposed, based on their experience, elements of life content that help to increase quality of life. They emphasize the experience of joy, the sense of community, hope, and meaning.

The concept of quality of life arose as a reaction to the emphasis on living conditions and the one-sided stress on material goods.[50] Quality of life concerns the individual person's experience of the kind of life he or she is living. The criteria for good quality of life are different from objective measures of standard of living. There is, however, no single or official definition of what we call quality of life.

Quality of life is associated with being active, experiencing connectedness, gaining self-esteem, and experiencing an underlying sense of joy.[51] Others emphasize that quality of life has to do with duration—something that encompasses the whole of life—that it involves deeper feelings, and that love and social life play an important role.[52] When nursing researchers review different theories of quality of life, they propose four dimensions that are important within the nurse's field of work. These dimensions are hope, meaning, community, and identity.

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[49] Antonovsky, 1991.

[50] Rustøen, 1991.

[51] Rustøen, 1991, p. 18.

[52] Rustøen, 1991, p. 18.

I will not go too deeply here into the academic debate about what quality of life is. With concepts such as "health" and "quality of life," we are dealing with phenomena that are difficult to define in a single or objective way. From this discussion, one may note that it is important for different professional groups to investigate which dimensions are especially clear and central from the perspective of their own profession. Thus, for example, nurses and psychologists will add important dimensions and forms of understanding based on the professional worlds they know and manage. In the same way, we may ask which dimensions music and cultural workers can contribute to the understanding of the concept of quality of life.

If we turn, for example, to music therapists, we may formulate a somewhat different understanding of what we mean by quality of life. In a study of the relationship between music and identity, we may see how music therapy students have used music in their own lives.[53] This project concerned recalling memories of music and explored how our musical experiences help give us a sense of continuity and belonging in life. In the analysis of interviews and autobiographies, to see what musical experiences mean for our identity and quality of life, a clear pattern emerged: music is a source of strengthened vitality, of the experience of competence and a sense of belonging, and not least of a strong sense of meaning and coherence in life.

In other words, we are dealing with qualities that are important both for identity formation and for the experience of quality of life. The same may be said of the category of possibilities for action, which can be seen in relation to the development of mastery competence, basic social competence, or more generally the ability to step forward and act as a subject. Belonging concerns not only our relation to time and place, but also attachment and our close relationships with other people, the experience of social position, gender identity, ethnicity, or belonging within a more global community. The experience of meaning also appears as an aspect of most narratives about musical experiences. This is especially the case in connection with music's ability to summarize for us central features of identity formation, and the experience of unity and coherence in life.

Music as a Cultural Immunogen

Within psychology, health psychology has become a specialty. Here we encounter the idea that we can live our lives in ways that protect us against illness and

[53] Ruud 1997, 2013a.

accidents. Health psychologists use the concept of "behavioral immunogens" to refer to behaviours that are protective against illness. The concept emerged in American health psychology in the 1980s, when statistical relationships could be observed between risk behaviour and illness. One clear example was the relationship between smoking and cancer. The health psychologist Joseph Matarazzo, who developed the concept, pointed to several lifestyle diseases and risk behaviours that at the time dominated disease statistics. At the same time, he proposed health-promoting measures. These concerned protecting health by taking a number of precautions and following public health recommendations—for example, eating healthily (five portions of fruit and vegetables a day), quitting smoking, using a seat belt, or brushing one's teeth.

Health-promoting work thus emphasizes how we may achieve good health. The aim is to identify the positive active factors that promote health. Important here, therefore, is knowledge of health-protective factors and wellness factors, so-called positive determinants of health.[54]

The idea of music as a "cultural immunogen" is an adaptation from health psychology. I ask, then, whether there is something in our engagement with and involvement in music that may have a health-promoting and preventive effect, now understood as a cultural immunogen. What should be considered is that health psychologists do not face the same threats today as they did fifty years ago, when the concept of behavioral immunogens emerged. While we have succeeded in improving the statistics for a number of somatic illnesses, today's challenges seem to be marked by mental health problems, depression, anxiety, loneliness, and social exclusion. Such conditions must be met with measures other than the traditional advice issued by health authorities.

If we can show that culture and cultural activity are health-promoting, then we may speak of music as a "cultural immunogen," as something that helps keep illness and ill health at a distance.[55] Within immunology, one describes how the body has a biological defence system that is activated when we are attacked by, for example, a virus. The body activates "immunogens" that attack foreign and invading substances. When we speak of "cultural immunogens," we are referring to the use of cultural measures—in this case, music—to counter threats to mental health, measures that improve quality of life and subjective health.

[54] Garsjø, 2018, p. 28.

[55] Ruud, 2002, 2013b, 2020a.

To speak of cultural immunogens is to borrow language and metaphors from biomedical research. The use of the term "immunogen" may of course be misunderstood. Here, a concept is borrowed that became very familiar to us during the COVID-19 pandemic. We were recommended vaccines containing disease-inhibiting substances, that is, substances that protected us against infection. When I speak of cultural immunogens, the word is used figuratively, as a metaphor to suggest that we may think of music, or health musicking, in the same way as biological or behavioral immunogens that protect us against illness.

Music Motivates and Moderates

Before I go on to describe some musical immunogens, it is important to point to connections between a cultural immunology and physical and mental health. Such connections can be found where experiences of life as meaningful influence our management of stress and thus our perceived health. In the following line of argument, I will refer to research that clearly documents that reducing the body's level of stress has beneficial effects on several disease conditions.[56]

The psychologist Tatjana Schnell shows in her research a number of connections between experiencing meaning in life and both mental and physical health.[57] She points out that the more meaningful people experience life to be, the healthier they are, both mentally and physically. They cope with illness differently than those with less meaning in life, they suffer less from the illness, and their symptoms are less pronounced. Schnell supports this by referring to a range of research studies.

Schnell writes that people who experience meaning in life are more optimistic; they experience themselves as more competent, with greater self-determination and better social integration. They find it easier to accept their own weaknesses and faults because they have greater self-compassion. Skills related to belief in one's own efficacy, resilience, and self-regulation are more pronounced. They are better able to activate, motivate, and calm themselves, and to direct attention toward how to cope with mistakes. They have fewer psychological problems, and tests show negative correlations with neuroticism, depression, anxiety, and the severity of post-traumatic stress.

[56] See de Witte et. al., 2022; Fancourt, 2026.

[57] Schnell, 2021. See also the section about existential health.

As regards physical health, research shows that experienced meaning in life is a decisive factor. Moderate correlations have been found between meaningfulness and objective health measures such as the presence of NK cells ("natural killer" cells) and heart rate, as well as moderate relationships between meaning in life and subjectively experienced health, symptom severity, and perceived functional limitations. Large national studies confirm such findings and show that mortality risk is significantly lower for people who experience a high degree of meaning in life.

How can it be that the experience that life has meaning can influence health? Schnell points to two factors that may explain this. If one experiences meaning in life, this will motivate one to take care of one's health. We also saw how meaning in life motivates in Aaron Antonovsky's salutogenic research. For Antonovsky, meaningfulness was the most important component in the experience of coherence in life. The experience of meaning gives significance to actions, and in this sense motivates responsibility for one's own health.

When something moderates, it regulates the relationship between two or more variables, writes Schnell. We may strengthen or weaken the relationship between the variables. Here she refers to research showing how experienced meaning in life may function as a buffer against the experience of symptoms that may accompany illness. This may occur in the experience of after-effects of traumatic events, side effects of cancer treatment, or pain following an operation.

This moderating effect is explained by the fact that people who experience meaning in life have a greater ability to regulate the body's stress level. When there are such strong connections between the experience of meaning and strengthened resistance to illness, this is explained by showing that people with a strong belief in the meaning of life experience less stress. Stress theory tells us that what happens to us may be perceived as challenges, threats, and losses. When we perceive such events and experiences as uncontrollable, genes are activated that place the body in a defensive state. At the same time, the secretion of the stress hormone cortisol increases.

If, however, we experience ourselves as coping with stress, the harmful inflammatory processes may fail to occur. Research on biomarkers related to the immune system, the cardiovascular system, and the neuroendocrine system shows that these values may be positively influenced in people who experience strong meaning in life. And conversely, those who do not experience life as meaningful show poor results on such biomarkers. These measures reveal that one is living with too high a level of stress, also called allostatic stress. The health consequences of living in such a state are extensive, writes Schnell.

Schnell goes one step further and refers to genetic research indicating that the way we perceive stress may be reflected in our genes.[58] Subjective perception of social stress upregulates systemic inflammatory processes with ensuing destructive effects on health. There are genes that are switched on and become active under stress. These promote inflammatory processes while at the same time inhibiting immune responses to viruses and antigens.

Schnell refers to a study in which such chronic stress responses were measured among informants who experienced well-being. The assumption was that those with experienced well-being would show positive health effects. Here, a distinction was made between informants with hedonic and eudaimonic values.[59] Surprisingly, it was found that those with a hedonic orientation (positive mood and satisfaction with life) did not show reactions in the stress system. By contrast, those with a eudaimonic orientation (purpose in life, personal growth, generativity) showed reduced activity in the genes that are switched on during stress reactions.

It is here that the experience of meaningfulness may have a moderating and motivating effect on experience. The many sources of meaning—self-realization, feelings of well-being, relationships, and self-transcendence—may compensate for limitations caused, for example, by illness.

We can now see how music may function preventively and as a health-promoting force in several ways. First, the regulatory use of music for relaxation may reduce stress. Second, music, as a rich source of meaning in life, may play a preventive role as a general form of resistance against illness.

Four Musical Immunogens

Experienced meaning in life has many sources. What follows discusses four aspects of music and quality of life: 1) music, vitality, and emotional regulation, 2) music and agency, 3) belonging and community, and 4) music, meaning, and existential values.

Examples of cultural and protective behaviour may include the ways we use music to regulate our emotions, how music can make us forget negative things, create a free space, give us positive and encouraging experiences and more positive thoughts about ourselves, and create highlights in everyday life.[60] The psychological

[58] See also Fancourt, 2026.

[59] Hedonism is a philosophical tradition which identifies happiness with the experience of pleasure and the absence of pain. Eudaimonism is an ethical theory which focuses on development of virtues, to realize one's own potential and achieve a meaningful life.

[60] Bailey, 2004; DeNora, 2000.

effects of listening to music include increased concentration, the activation of memory, increased self-esteem, the experience of mastery, and the sense of engaging in a creative activity. For quality of life, such emotional experiences are especially important, as are possibilities for acting and directing one's own life, experiencing belonging with other people, groups, and places, and not least finding a larger coherence and meaning in life.[61]

As regards bodily experiences, many people experience music as physically relaxing: it releases tension in the body, releases repressed feelings, reduces stress and fatigue, and gives a sense of living through the rhythm of the music, which in turn gives a feeling of mental renewal.

Not least, we see how musical life provides access to participation and community. Where loneliness and exclusion are serious threats to health, society may respond with musical offerings that have a low threshold for participation.

As for the spiritual or existential dimension, we know that music can provide a transcendent and sometimes transformative experience, a possibility for expressing central, for example religious, values. Aesthetic experiences also play a central role in the function music has in adding meaning and value to life.

There is now a wide range of research findings documenting how independent, or autonomous, use of music has several other consequences for health and well-being. Here we are speaking of everything from the use of music as a self-help strategy, during childbirth and pregnancy, in marginal life situations such as refugee existence, and in transitions between phases of life, such as adolescence or old age.[62]

Vitality, Music, and Emotions

"Vitality" is often used together with concepts such as energy and vigour. There is a spiritual tradition surrounding the concept in ancient history and in Eastern religions, where vitality is described as a life energy or force that flows through living beings. In Greek philosophy, vitality was referred to as *enthusiasm*. In Eastern traditions, there are a number of practices that promote vitality, for example yoga, pilates, reiki, Zen meditation, and tai chi. It is often said that vitality is a basic health-

[61] Ruud, 2001, a.

[62] See McFerran and Lotter, 2024.

related force and energy that can either be enriched or depleted, writes the Finnish researcher Olga Lavrusheva.[63]

As research has increased, so too has the terminology used to designate vitality. In the literature, vitality is now referred to with words such as joy, sensation, experience, state, situation, and positive affect. Researchers describe vitality as a dimension of mental health, even as "health" as such. The studies to which Lavrusheva refers indicate that the experience of vitality may signal and predict well-being.

Lavrusheva has conducted a scoping review of the research related to vitality.[64] This refers to a literature search intended to investigate the extent of and available research on a specific topic—in this case, research in which "vitality" is central.

Research suggests that vitality is important for health: it strengthens physiological dispositions and may increase the effect of rehabilitation. The experience of vitality has positive effects on psychological states by reducing anxiety and increasing self-confidence and self-control. Physiological, psychological, and environmental factors all contribute to the experience of vitality.

There are only beneficial consequences of the experience of vitality, writes Lavrusheva. Vitality increases the capacity to observe one's own health state and leads to several positive effects for mental and physical health. People who report a high degree of vitality show greater resilience when they experience stress in situations or disasters. Vitality reduces the likelihood of heart disease, disability, and mortality. Vitality may improve sleep quality, energy levels, and reduce bodily pain. It produces a sense of well-being, more proactive social behaviour, and better emotional functioning. Vitality brings improved ego strength and self-control, as well as positive consequences for work and everyday life. People who experience themselves as vital are more satisfied with life, Lavrusheva reports.

In general, we may say that music affects our vitality, the feeling of having energy, of being vital or vigorous. There are many situations in which music may be linked to experiences of vitality. A nearby example is how a choir rehearsal can change energy and states of mind, and how exhilarated many people feel after singing.

In the discussion of the history of music therapy, we saw how the idea of a health-promoting use of music that gave rise to "good and pleasant feelings," as it was called, could reduce the effects of harmful affects and strengthen the mind's

[63] Lavrusheva, 2020.

[64] Lavrusheva, 2020.

defenses against illness. In recent times, renewed research interest has grown around so-called positive emotions, which can cast this history into relief.

Psychologist Barbara Fredrickson, who has researched positive emotions, writes that psychologists have most often been concerned with negative emotions such as anxiety, sorrow, and fear.[65] Positive emotions such as joy, interest, and contentment, however, have an entirely different character and function in our lives. Whereas negative emotions cause us to narrow our consciousness, positive emotions create a new orientation that allows us to see new possibilities. Positive emotions may reset the negative ones. Once negative emotions have been neutralized, we are better able to reorient ourselves to think and act more constructively.

The health effect is obvious if we recognize the value of thinking positively, of seeing and expanding our possibilities for action, and when we gain greater control over our lives. The therapies Fredrickson recommends include relaxation and visualization—techniques that are now well integrated into the music therapy repertoire and that may also be used by the client between meetings with the therapist to gain even more from therapy.

Our emotions may be understood as windows into the body, as possibilities for reading the body's condition, writes the American neuropsychologist Antonio Damasio.[66] When we listen to music, we may experience these windows opening. We experience that the body's condition is awakened and released to us, and that we can feel and clarify how the body—and we ourselves— "are doing." If we stay with the feelings, we may put words to them, associate around them, explore them, and place them in context. By using our musical competence, we may express, reflect on, and process the emotions, and ultimately perhaps symbolize and clarify what they mean for us.

Emotions are fundamental to what we experience as valuable in life, to which experiences we consider important to us. We might say that a life without emotions easily becomes an indifferent life. Music is often linked to our emotional life. When, as here, we connect music to health and quality of life, we are thinking especially of the strong emotional experiences music gives us, how music changes states of mind, gives joy, and mobilizes life forces. Sometimes these experiences may have a direct therapeutic effect by giving us a sense of living out burdensome

[65] Fredrickson, 2000.

[66] Damasio, 1994, p. xiv.

emotions. We feel that music creates experiences of strength and energy, or quite simply acts to dissolve stress and unrest.

It is the strong and intense musical experience, or the so-called peak experiences that music creates, that we may associate with an increased quality of life. In interviews with people about their musical experiences, they speak of dramatic—or rather ecstatic—experiences of merging with the music, of being lifted up, or of having powerful bodily experiences. At the same time, they strongly experience themselves as part of something larger—for some, something divine; for others, a global community.[67]

Research tells us that strong musical experiences not only leave traces within us but may also become guiding forces in what we orient ourselves toward in life. Musical autobiographies containing memories of musical experiences show that music gives strong emotional experiences from early childhood onward.[68] Music contributes to the development of emotional awareness—that is, the ability to experience and express emotions. This is linked to perceiving nuances in feelings, becoming aware of intensities in experiences and expressions, and having precise and reflective concepts of emotion. This too is a form of "vitality." And such vitality —the ability to open oneself to the world, to other people, and to oneself—may be a prerequisite for healthy personal development.

In the scholarly literature, we encounter the concept of "vitality" in several contexts. In the work of the infant researcher and psychiatrist Daniel Stern, "vitality affects" designate the early, more diffuse affects or arousal states experienced by the infant. These states have become important for the music researcher to understand because they may remind us of the experiences music creates within us. For we know that music is often not unambiguous in its "description" of emotions, but that musical experience gives ambiguous—or rather multivalent—experiences.

Another understanding of "vitality" may be found in the Norwegian psychologist Jon Monsen, who defines vitality as a combination of impulsivity and reflection. Monsen writes: "By vitality we understand a good reciprocal relationship between how a person feels emotionally and what he does with those feelings in experience and expression. Vitality means living in such a way that the emotions

[67] Gabrielsson, 2008.

[68] Ruud, 2013a.

are activated across a certain breadth and being able to integrate these experiences and express oneself clearly."[69]

Within the psychotherapeutic understanding that underlies Monsen's account, emotional life plays an important role. Emotional awareness, characterized by experiential capacity and expressivity, thus forms an essential prerequisite for mental health in the sense of a strong and resilient self. Because of music's connection with emotions, and not least based on the interpretations we may make of people's musical experiences, Monsen's concept of vitality forms, in my view, an important point of entry to the understanding of quality of life.

A few key points about the significance of vitality in this combination of impulsivity and reflection should be emphasized. We may find ourselves in a situation where we are unable to remain present in our own emotional experiences and where we try to live in such a way as to avoid activating emotions. We may repress our feelings and, in that way, relinquish awareness of ourselves in order to protect ourselves against reality. In serious cases, this may lead us to lose the ability to have personal experiences. Monsen writes that this would inhibit personality development "in that greater or lesser parts of an individual's intrapsychic structures are no longer an open system, that is, in interaction with the environment."[70]

It is the ability to allow oneself to be affected emotionally, together with the fact that the emotional reactions we have are followed up by concept formation and reflection, that can prevent the individual from closing in on themselves. When we reflect on our own musical experiences, many situations we remember—in which music has formed the framework for the activity—have concerned strengthening emotional awareness or bodily awareness. To lose emotional awareness means, among other things, writes Monsen, "to lose contact with a fundamental, pre-linguistic form of communication and with the experiential content aspects of emotions that contain essential information."[71]

He further emphasizes that this involves a binding of physical energy, which may lead to physiological breakdown. We may develop an alienated relationship to ourselves and therefore become more difficult for others to understand and perceive. Monsen writes that this may weaken awareness of one's own motives or reasons for action.

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[69] Monsen, 1991, p. 150.

[70] Monsen, 1991, p. 151.

[71] Monsen, 1991, p. 152.

In other words, we see that attention to one's own body and one's own feelings is an important prerequisite for action and communication. Since music can powerfully affect emotional life, we can see that music becomes an important medium for influencing the conditions for a greater quality of life. We cannot, however, claim that every engagement with music is therapeutic simply because it strengthens emotional awareness. This chapter describes the significance of music for quality of life and health. Therapy concerns goal-directed interventions and collaboration with a therapist, based on shared understandings of conditions, goals, and process.

Music and Emotions

Within the first domain of "immunogens"—music, vitality, and emotional regulation—it is important to shed light on how music affects our emotions and how we may regulate emotions, moods, and energy through listening to or playing music. Music is referred to as a "language of emotions." When we listen to or express ourselves through music, emotions and bodily reactions often arise. We get goosebumps and shivers; we may experience emotional peaks that transcend everyday experience.

Technology has given us access to emotional soundtracks wherever we go. We have programmed playlists that lead us into a particular mood. Music can perk us up, calm us down, intensify daydreaming, and allow us to escape reality for a while. The smartphone has taken on a central role in regulating our emotions.

In psychology and in everyday language, we encounter many different words for feelings. In this presentation, the concept of *affect* is used as an umbrella term for emotions, feelings, moods, and more diffuse bodily states of arousal. Emotion is often used in professional language to designate a short-lived and intense experience—from a few minutes to several hours.[72] Emotions may change rapidly when something important is happening to us. At the same time, changes occur in thoughts and feelings. Physiological changes also occur, along with tendencies toward action and expressive behaviour. This means that our thoughts, associations, cultural background, and the very situation we are in will influence how we experience the emotion.

We say that there is a kind of intentionality behind emotion. This means that when we hope, we hope for something specific. When we are sad, it is in connection

[72] Juslin, 2019.

with a particular event. Feelings refer to how we experience the emotion, the subjective side of the reaction, our private way of experiencing emotions. The feeling is a summary of the emotional reaction.

The emotional reaction expresses itself in bodily responses, as when we get "goosebumps" or tense our muscles. A mood is a more diffuse affective state. Mood has lower intensity and lasts longer. Nor can moods always easily be traced back to a particular cause. Some researchers have called mood a kind of "clinical thermometer," because it can provide information about sleep, health, daily cycles, nutrition, and stress. When a mood changes, the need arises to regulate emotions.[73]

Emotional Regulation

Emotional regulation is a central theme in psychology. Becoming aware of the feelings that arise, being able to name a feeling, tolerate it, and give it expression are all important for a healthy emotional life. We regulate emotions by changing them, making feelings disappear, or making them last longer. We may regulate away unpleasant feelings, calm ourselves down, and remove stress. We may change a dark state of mind into a brighter one.

We have a repertoire of tactics and strategies for dealing with emotions. Music is one of many tactics we use to change a bad mood, raise our energy level, or reduce tension. Musicking is one of many such tactics, aids, or forms of behaviour that contribute to emotional regulation: we may take a bath, go for a run, do breathing exercises, write a diary, sleep, soothe ourselves, and so on. The question is whether music occupies a special position among the many tactics, and whether it plays a particular role in emotional regulation. Given our access to a rich repertoire of different musical forms, artists, and individual pieces, we can see that music is a potentially rich source of emotional regulation.

We use a particular strategy to regulate emotions and states of mind. It may be a matter of confronting unpleasant feelings, thinking through situations, and helping oneself into a better state. Another well-known strategy is *reappraisal*, where we try to think about the situation and the mood in a rational way ("that was probably not meant quite in that way ..."). We also use *rationalization* as a strategy. This means relating realistically to the situation ("this is not the end of everything; it usually passes"). But we may also *vent our emotions*, let them out. Or we may try

[73] Juslin, 2019, p. 47.

active adaptation by doing something about the situation (confronting a person). We may stop postponing something we should have begun long ago. We use *introspection* as a strategy when we try to understand our own feelings. We *suppress emotions* when we avoid feeling them, avoid sensing the mood, or avoid thinking about the situation.

Professors Katrina Skewes McFerran and Carol Lotter propose using the expression "mood regulation" rather than "emotion regulation." Moods are more enduring states, and they refer to the research of the music psychologist and professor Suvi Saarikallio.[74] She points to several strategies for regulating moods through listening to music. These include using music as entertainment, for reliving memories, experiencing strong feelings, allowing music to function as distraction, engaging in mental work, and receiving comfort from music. McFerran and Lotter also refer to research suggesting gender differences in the use of music to regulate moods and emotions. Here, research points in different directions, but the topic is nevertheless worth considering together with other possible factors that influence the regulation process.[75]

Music, or musicking, may form part of the cluster of tactics from which we can choose to gain control over our emotions. Music is closely connected with emotions, and most people have experience of how music has affected their feelings. Playlists are given names for music we know has a particular effect. Lists may be named according to the mood one wishes to enter. In this way, music becomes an effective tactic we use when we wish to influence our own emotions.

We may imagine the following situation:

> *Jonas often sits down in the evening and listens to music. He has just lost a close friend and is struggling with all the feelings that have surfaced afterward. He feels longing and grief and is troubled by emotions he does not fully understand—guilt, regret, sadness. But he also has good memories that color his feelings positively. Altogether, he experiences his emotions as chaotic, and he needs to sort them out and move beyond the negative feelings. Jonas has been deeply interested in music all his life and has built up a considerable collection of CDs and playlists. His tastes are broad, and he enjoys listening to classical music, popular music, and film music. He notices that, when he now listens to music, he recognizes in the music many of the*

[74] Saarikallio, 2011.

[75] McFerran and Lotter, 2024, Chapter 3.

feelings that have arisen in him since his friend died. The music helps him distinguish sadness from melancholy, guilt from longing, joy from dejection.

As he listens more, he notices that he can think about his own situation with a greater degree of overview of his emotions. Music has helped him sort the emotions apart, name them, and think about life events with a little distance. He sees more clearly which artists, genres, or pieces of music can help him in this process. He creates a system in his playlists that makes it easier for him to classify the music according to the mood he is in. Gradually, he becomes aware of how music can help him regulate his own emotions. He now consciously turns to music when he feels a need to change his feelings, or simply preserve the mood he is in.

There are now an increasing number of research articles documenting how people, in different situations and for different purposes, use music to regulate emotions.[76] When we look at the example of Jonas, we see that many processes are taking place, which we may break down and specify more closely in order to understand the role music plays and the mechanisms that are set in motion. Music has given Jonas a free space that he can use for emotional regulation. Through the music, he becomes acquainted with his own feelings; it helps him name them. He becomes better able to tolerate and endure the painful emotions. Gradually, he learns how music becomes an important tactic for him when he wants to regulate feelings. He sees that music provides room for several strategies of emotional regulation. Jonas reflects on the feelings, relaxes, and can relate to his own emotions with a certain degree of distance.

Goals, Strategies, Tactics, and Mechanisms (GSTM)

In a theory on which several researchers build, one distinguishes components involved when music is used in this way.[77] First, it is important to understand the purpose, or goal, that listening or other music use serves. In Jonas's case, it concerned emerging from a chaotic emotional state marked by diffuse affects that he did not fully understand. The goal became to relax, relate more rationally to his own feelings, and process them in a constructive way. Such goals generally concern regulating—that is, controlling and improving—the mood one is in. Self-regulation means regulating the thoughts, emotions, and actions we use when planning and adapting to reach the goals we set ourselves. By regulation of emotion is meant

[76] van Goethem and Sloboda, 2011.

[77] van Goethem and Sloboda, 2011.

here processes involved in monitoring, evaluating, and changing emotional reactions. In our context, this concerns how music is used to create, alter, strengthen, or preserve a particular affective state.

Research shows that most of our music listening takes place in everyday life, when we are at home and can listen by ourselves.[78] At the same time, it is the music we choose ourselves that has the greatest affective impact. Music psychologists have, in several studies, tried to determine the motivations behind music listening. Unsurprisingly, these include passing the time, creating a pleasant atmosphere, finding an outlet for emotions, relaxing, gaining new energy, or awakening memories. We should remember that most listening happens while we are engaged in other activities. It may happen when we are driving, cooking, or vacuuming. In such cases, it may be difficult to separate the effect of music from the other activities. Music may provide space for strategies such as distracting oneself and directing one's thoughts away from what maintains a troubling feeling. A musical free space offers the possibility of "debriefing" oneself, of having a conversation with oneself after a bad episode.

We may also regulate emotions through playing and expressing ourselves through an instrument. In the following imagined example, it is a classical piece of music that initiates emotional regulation:

> *Karen has been playing the piano for some years and has begun to discover that music contains many expressions and moods she recognizes from her own life. Her piano teacher is skilled at pointing out differences in musical expression and relating them to emotions. Karen gradually discovers that music is a way of telling something, and that the story is colored by feelings such as joy, sadness, hope, and fear. By changing the tempo of the music, shifting between major and minor, playing softly or loudly, Karen discovers that she can place her own feelings into the music.*
>
> *Karen is having problems at school because some of the students in her class are bullying her. She responds by withdrawing and often feels sad and helpless. One day, while playing a prelude by Chopin, she discovers that the music expresses something of what she herself feels. She begins to explore the prelude again and finds many different expressions in the music. In some places, she feels she can hear tears in the music. But there are also passages where she finds that the music contains a form of joy. She understands that the composer may perhaps have had experiences like her own. She feels that*

[78] Sloboda, Lamont and Greasley, 2009.

> *there is a comfort in the fact that the music "understands" her feelings. At the same time, she sees that the brighter sides of the music give her hope that she can master the challenges she is experiencing.*

For music psychologists, it is important to understand how music may play a role in emotional regulation. Researchers therefore ask which mechanisms are involved when music is chosen as a tactic in emotional regulation. We saw in Karen's example that she identified with the composer; she recognized herself in the feelings the music brought forth. At the same time, she discovered variations in the music, that she could play it in many ways. She experienced that there was something in the very way the music was constructed that created different feelings and associations. She repeats the piece many times because it gives her rich aesthetic experiences.

The Swedish music psychologist Patrik Juslin and his colleagues have proposed a model of the mechanisms that may be involved when music triggers emotions.[79] Juslin calls this the BRECVEMA theory, where the various letters point to different mechanisms that are set in motion when we music. The **B** (Brain) refers to the role of the brain under the influence of music. Sometimes our brainstem reacts with a reflex when we are surprised by a strong and sudden sound—for example, when we are sitting in a cinema. Here, it is not necessarily the music that creates the feeling, but the sound itself.

The **R** refers to rhythm, which can play a role when feelings are awakened in us. What is called rhythmic entrainment refers to the fact that our bodies begin to interact in time with the music. Even our pulse can be affected.

What Juslin calls **E**valuative conditioning means that a particular piece of music has repeatedly been played at the same time as a particular event that may have made us happy or sad. When we hear this music again, the same feeling arises. This is what in psychology is called conditioning.

Emotional **C**ontagion from music plays an important role. We saw, for example, how Karen felt that the music resembled feelings she herself had. Here, performers and musicians play an important role when they present the music through instruments and voice. The music resembles the feeling; it has a particular gestural character, a dynamic, a vitality form, a contour, an emotional curve that reminds us of a feeling, as Karen experienced. There are many theories and

[79] Juslin, et. al., 2010; Juslin, 2019.

concepts concerning this in music psychology. This indicates that it is a central point in understanding why and how music triggers emotions.

Visual imagery, the images we form in response to music, may help trigger emotions in us. The same applies when music causes us to remember specific **E**pisodes in life, what in psychology is called episodic memory. Best known is the theory referred to as "Darling, they're playing our tune." Here, music reminds us of important events in life and evokes feelings connected to a particular piece of music. Such emotional reactions may be quite incomprehensible to an outsider.

As we saw in Karen's example, features of the music itself—musical structures—had direct significance for which feelings were triggered. Several experiments in music psychology have tried to show how particular elements in music affect emotions. The tempo of the music plays an especially important role in the emotions portrayed, as does whether the music is in major or minor. Here it is relevant that the **M**usic creates expectations that then find their musical resolution. A great deal of music, whether from the classical repertoire or groove-based, is constructed so that tension or intensity builds up. When the music reaches its resolution, or when we are surprised by the turn it takes, we react with an emotion.

For many, the music itself is probably an important factor in emotional reactions, as it was for Karen when she played the piece repeatedly. It may be music we like, music that has accompanied us through life, music that perhaps contains lyrics to which we respond. Altogether, this points to our **A**esthetic response to music.

I would also remind the reader that the context in which music occurs is an important precondition for the experience we have. It may be that the music accompanies other daily activities. We may be dancing to music, singing, or attending a concert. In this way, music may strengthen other tactics and strategies. It is therefore difficult to isolate the mechanisms in BRECVEMA from one another. When music is used for relaxation—which is the most common tactic in emotional regulation—it may be that we become more rational. When we relax, we gain access to more strategies for handling an emotional challenge.

Only Positive Effects?

We saw how the American psychologist Barbara Fredrickson pointed to the great significance of positive emotions for our mental health. She says that positive emotions broaden our repertoire of thought and action. They create a

free space and make us thrive. Positive emotions combat negative thoughts, create reorientation, and give us new possibilities for action.[80]

We easily tend to think of music as something wholly positive, something that always brings something good with it. Music can, however, be used for everything from promoting health to functioning as a component of torture. Music appears in a great many contexts, from use in marketing and as background music, to increasing training effects or bringing memories to life in people with dementia.

Not all emotional regulation is beneficial. Some young people use music to escape from everyday life, to ruminate on negative experiences. Instead of confronting difficult feelings, emotions may be suppressed or vented in ways that reinforce problems. Music may be used to maintain unpleasant feelings, to intensify negative rumination. This means that music may have effects that are unfortunate, sometimes harmful to health. The consequence may be ill health in the form of depression and antisocial behaviour.

Sometimes harmful use of music is linked to particular musical genres and styles. Subgenres within heavy metal are often mentioned, which easily leads to mistaken conclusions. Instead of speaking of potentially harmful music, we ought rather to speak of harmful forms of musicking—ways of using music. For we know that the same music that may intensify anger, sadness, and dejection in some people may be vital for others. But we should be aware that listening over a long period to music and lyrics that express darkness and sadness may contribute to depression in people who are vulnerable to such moods.

At the same time, several studies show that metal fans are happier and more peaceful than the average population. The music has become a robust and stabilizing "axis of resonance" in their lives, writes Hartmut Rosa. As many as forty percent of fans report that metal music has saved their lives at least once.[81]

Researchers now warn against polarizing the effect of music listening as either harmful or beneficial. Katrina Skewes McFerran points out that there may be gradual transitions between listening that creates rumination and isolation, and experiences of withdrawal, escape from problems, and self-comfort. From feeling overwhelmed by stressful emotions and pessimistic thoughts, listening may lead to optimism and vitality. In a more optimistic state, emotions may be regulated

[80] Fredrickson, 2000.

[81] Rosa, 2023, p. 106.

and redirected away from the negative. One may calm down, reappraise situations, and move toward experiences of relaxation and inspiration, allowing oneself to enjoy the music and gain renewed energy.

McFerran emphasizes that the same musical piece may take part in this journey by allowing the listener to define the experience considering his or her situation. Here, intention plays an important role, insofar as the person is aware of what he or she wants to get out of the music.[82] It is here that music therapists may support the person in becoming aware of their music use and in creating new playlists.

Why Do We Like Listening to Music That Makes Us Sad?

A paradox that has challenged music philosophers and music psychologists is why we enjoy listening to music that we perceive as sad, mournful, and melancholic music that makes us feel sad, that may give rise to negative emotional reactions. The music philosopher Jerrold Levinson argues that the reason may be that such emotional responses have no immediate consequences for us in real life.[83] He says that these are experiences framed within an aesthetic context. It is for this reason that we can focus fully on the experience and benefit from it, both aesthetically and perhaps also therapeutically. We may enjoy "sad" music because, in that moment, it is decontextualized from real-life experiences.

Another reward we receive from listening to such music is that we may recognize feelings in the music. As we saw in the example of Karen at the piano, she experienced the music as reminding her of tears. We may draw something positive from such experiences by engaging our imagination and fantasy. We saw in Karen's example that she identified with another person, the composer. There is a reward in such an empathic process. Precisely the experience of this emotional contagion through empathic immersion may lead to emotional release. This happens when we experience that a positive development takes place in the music. This may then be transferred to my own feelings. Altogether, there is an element of self-efficacy in such listening, a feeling of mastering and having control over one's emotions.

[82] McFerran, 2019.

[83] Levinson, 1997.

Anhedonia

We can draw on research from music therapy to illuminate a more serious side of music and emotions. What falls under the diagnosis of anhedonia is a reduced ability to experience joy and pleasure in everyday activities, and it is a common symptom in many chronic and mental disorders. It turns out that daily music listening, dancing, and improvisation can help people find their way back to the joy of living.

In a music therapy case study, the focus was on finding a path out of anhedonia, a condition that for this researcher had arisen because of pain following cancer treatment. The researcher in this study, Lucy Bolger, who is herself a music therapist, instinctively felt that musical activities—listening and dancing—could be a way back to rediscovering the joy of life. The problem was finding the motivation to get started, something typical of all who suffer from this condition. With the support of her colleague and supervisor Katrina Skewes McFerran, who served as guide and co-researcher, they designed a programme that proved effective.[84]

The programme they designed was practically manageable and at the same time provided the basis for thorough and systematic reporting and evaluation. Bolger set aside five minutes every day for 45 days. McFerran followed up with supportive text messages and encouragement. They held conversations and were gradually able to analyze and interpret the data that accumulated during the process. Bolger eventually experienced greater access to pleasurable experiences. This concerned both the ability to look forward to something—so-called *anticipatory pleasure*—and the ability to experience pleasure during the activity itself (*consummatory pleasure*). After 45 days, Lucy's symptoms of anhedonia had disappeared.

The activities Lucy carried out ranged from listening to improvisation, singing, and dancing, with listening and dancing as the most common activities. Some of the activities were planned, though not always followed through. Instead, Lucy followed her mood and impulses in choosing an activity. This could depend on where she was—at home or in the office—whether she could use headphones, or whether other people were present in the room.

It is interesting to understand why musical activities can help open the way to a greater desire for life. Bolger and McFerran point to several possibilities. Perhaps it is more effective to focus on positive experiences than on negative ones, as some

[84] Bolger and McFerran, 2024.

researchers on anxiety disorders suggest. In that case, one should practice giving oneself positive experiences—activities that reactivate such feelings. It may also be that the brain contains connections linking aesthetic experiences to centers of pleasure and reward. We know this from research showing that musical experiences follow the same reward pathways as food, opioids, or sexual experiences. Here it is important to think broadly and contextually, and not to fall into simplified mechanisms of effect that turn music into yet another medication within a medical model.

It is tempting to think that the research of Bolger and McFerran may eventually support procedures that can help people out of this condition, which can paralyze the unfolding of life. Precisely music, which is so often associated with pleasure and joy, may become the way out of an existence without resonance, as the sociologist Hartmut Rosa would say. Music therapists have the ambition to develop a programme that people can carry out on their own, with or without support from a therapist. We are all familiar with the slogan "five portions of fruit and vegetables a day." What about five minutes of health musicking every day?

Mastery and Agency

The next musical immunogen to be discussed concerns music and agency. One of the most important aspects of subjective health is the ability to take responsibility for one's own life and actions, to make independent choices, and to follow through on the plans one has set for oneself. The feeling of powerlessness—that the control of life has been handed over to forces outside us, that we must be "treated"—easily becomes a side effect of a culture in which medical expertise appears to hold all the solutions. Self-management and empowerment are key terms when discussing how musicking can increase competence.

Cultural activities, and not least participation in musical life, can be a source of mastery and self-confidence, of seeing oneself as a competent person who can step forward in a social arena and act. Many people have positive stories to tell about the joy of playing an instrument. The experience of oneself as competent can be linked to mastering an instrument, to a skill gradually acquired through deep and concentrated practice over time. Unfortunately, there are also many less pleasant stories of failure, parental pressure, and cultural clashes with music educators.

The basis of a good life lies in feeling that one can influence one's surroundings by taking part in decisions that concern one's own life. In the broadest sense, this gives a sense of mastery: of managing one's own life, taking responsibility for oneself and one's environment. Perhaps we understand better what this means if we find a word

for its opposite, such as powerlessness. Self-management is, not least, about acquiring a psychological and cultural platform, feeling that one "counts," and having opinions and standpoints.

This last point can be well illustrated by what happens when young people begin to play in rock bands. Studies of how young people learn to play in bands, compose music, and perform for others provide a good illustration of the relationship between music and mastery. Over several years, the anthropologist Odd Are Berkaak and I studied a group of rock musicians in Oslo. Many of the young musicians had begun to play at an early age. At twelve or thirteen, they started their first ensemble playing. Only a year after they had developed an identity as a "band," through gigs in the local community and attention in the media, they began to have opinions of their own about society and politics. From being anonymous boys with little visibility in the local community and no views on the adult world, they suddenly emerged with a shared cultural platform and clearly articulated positions on commercialism, media policy, technology, and social issues.[85]

The starting point for managing one's own life is linked to the experience of healthy self-esteem and personal security. Experiences related to vitality, as we saw in the previous section, are an important precondition for forming a personal base from which to direct one's own life. Especially important are experiences of mastery, of being seen by others, and of feeling that the music we help create has a function in the local community and for the people around us. Such experiences can arise spontaneously and do not necessarily have to be based on specific achievements or skills. They may spring from the joy of playing together, from the sense that one's own contribution forms part of a shared musical whole. The positive experiences we gather in life help increase our possibilities for action, giving us a sense that we have choices.

An active relationship with music can help strengthen the sense of identity. Self-confidence, basic social competence, belonging, and the experience of being at home within a larger context all form part of this musical identity experience. From a developmental psychological perspective, we could emphasize how all musical activity helps strengthen our social and communicative abilities, increase symbolic understanding, and assist us in experiencing, expressing, and articulating emotions.[86] Taken together, such an identity experience increases our possibilities for action.

[85] Berkaak and Ruud, 1994.

[86] Ruud and Stige, 1994.

In relation to agency, our basic social competence is central. The sociologist Ivar Frønes links this competence to the ability to take the perspective of others—that is, the capacity to understand how others evaluate their surroundings, and ourselves.[87] By participating in musical life, for example by taking positions in relation to artists, identifying with some and distancing oneself from others, young people learn about values and positions, about where they themselves belong in a larger social and cultural landscape. This decentering increases personal reflection, which is a prerequisite for participating successfully in a broader social arena. In this way, music becomes an important social resource. We understand our social surroundings and the cultural fields through which we move by decoding how music unfolds in different cultural and social spaces.

Playing an instrument is a skill with high symbolic value in society. When we meet people who have been criticized for their singing voice, whether by music teachers or by insensitive comments, we understand how important it is to be able to express oneself through song. These people often experience great joy in participating in the choirs that have emerged in Norway, Denmark, and Sweden with health-promoting aims.[88]

Many theories show how our capacity to act depends on how and what we think about ourselves, and how we draw conclusions from our experiences. Such theories explain how mastery of different tasks affects our motivation and strengthens our self-esteem, confidence, perseverance, and willingness to overcome difficulties to reach our goals.

Specific theories, such as the psychologist Albert Bandura's concept of self-efficacy, show how belief in our ability to master actions influences the outcome we desire.[89] Through self-observation of feelings, behaviour, and thoughts, we evaluate our behaviour and results, which in turn can strengthen or weaken our self-efficacy. Other people's evaluations, and how we perceive previous success, affect our belief in our own capacity. Positive feedback and encouragement play an important role.

Another important contribution to such theories comes from self-determination theory.[90] This theory argues that the fulfilment of three basic needs promotes health and well-being: autonomy, competence, and relatedness. Autonomy involves

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[87] Frønes, 1994.

[88] Persen, 2005.

[89] Bandura, 1977. In Hartmut Rosa's (2025) theory of resonance, self-efficacy is an important prerequisite for achieving resonance.

[90] Ryan and Deci, 2000.

having control over one's actions and choices, so that our actions are in accordance with our values and interests. Competence is important for experiencing effectiveness in mastering one's environment and achieving the goals one has set. Relatedness involves feeling connected to others, being supported and cared for, and experiencing social belonging—something discussed in the next section.

When these three basic needs are satisfied, we develop intrinsic motivation, driven by internal factors such as self-development, satisfaction, and interest in the task itself. This intrinsic motivation influences our experience of control over our own actions.

The phenomenon of empowerment is important here. The word is captured by a cluster of meanings such as "being enabled," "self-strengthening," "taking power," or "everyday power." In other words, it refers to how we can develop our own abilities to master a life situation, to develop agency. This is a process that springs from the individual, precisely to increase motivation to take responsibility for one's own life and health, and to develop strategies for handling the demands of the world around us.[91]

Empowerment means that individuals or groups gain power and autonomy in their lives, in different circumstances and when decisions are made. Empowerment is achieved by building self-esteem, self-confidence, and self-efficacy, as well as by attaining autonomy, competence, and a sense of social belonging. Empowerment extends beyond purely personal or psychological processes and includes social strengthening. It enables individuals and marginalized groups to gain access to resources, opportunities, and rights, as well as to achieve social recognition and contribute to society. Collective empowerment increases the capacity and power to handle local challenges, distribute resources, redistribute power, challenge oppressive structures, and promote social justice and collective action.

We see here how a view of the human being is brought into the picture: the philosophy of empowerment requires a conception of human beings as capable of making choices and taking responsibility for them.

In this context, it is important to develop an understanding of the causes of structurally conditioned powerlessness, which can block the ability to act. Empowerment thinking takes social dimensions into account and assumes that the individual must have the opportunity to influence the environment. In this way, we

[91] Ryan and Deci, 2000, p. 83.

may speak of self-empowerment and community empowerment, that is, the mobilization of power both at the individual and the social level.[92]

One consequence of this way of thinking for music and health work is the emphasis it places on the value of participants' own influence and co-determination regarding repertoire and situations of use. Music must not be conceived within a reductionist and mechanistic philosophy in which experts decide what music people should be "showered" with, and in what manner. That easily becomes a paternalistic practice in which the individual becomes a recipient rather than a participant. When the individual takes power over their own situation and life circumstances, health—understood as a resource—can increase.

From the very beginning, Norwegian music therapists have emphasized giving people positive experiences of mastery. We say that music therapy is resource-oriented when it asks users what skills and competencies they possess, rather than focusing primarily on disabilities. This resource-oriented way of thinking can be transferred to all situations in which music is used, thereby becoming a central part of cultural immunology.

Music, Community, and Belonging

The next cultural immunogen concerns the importance of experiencing participation and a sense of belonging within a community. Isolation and loneliness are conditions that can lead to illness and are strongly associated with a reduced quality of life. Musical interaction fosters a sense of security and closeness in relationships with others.[93] Providing children with opportunities to sing and make music together may be among the most valuable experiences we can offer. Within the intimate framework created by musical activity, people are connected through shared experiences.

Such experiences are important in a society that increasingly promotes individualistic values. Even though much positive can be said about self-realization and the possibilities of shaping one's own style and expression, we are all vulnerable and exposed, and at some point in life we all need support from the community.

We know how making music in different groups helps integrate the person psychologically into larger social networks. Music groups are strongly socializing

[92] Rolvsjord, 2004.

[93] Stensæth, 2018b.

they give us access to central social experiences and values and connect people through interaction and contact. People who make music together become visible to one another; they feel mutuality and obligation. They begin to care about one another, take part in one another's lives, and often experience genuine concern.[94]

The path into broader society can pass through the contacts that shared musicking makes possible. Other people become door-openers into new communities, and music appears as a social resource for contact, companionship, and conversation. The music group acquires symbolic value because the participants can do something that is highly valued in society. This is particularly important for people with disabilities, and for those who have been excluded from working life through long-term sick leave, and who therefore have a strong need to meet others in similar situations, work through experiences, or feel valued through musical activities.

In a programme developed by the sociologist Kari Bjerke Batt-Rawden, playlists, song sharing, and listening were used intentionally as part of group work with people on long-term sick leave. Participants met regularly over the course of a year to listen to and share music, and to collaborate on creating themed CDs. They reported becoming more aware of music, expanding their repertoire, and developing new skills for self-care. In addition, they experienced increased well-being and discovered new resources to support their own recovery.[95]

Music groups, such as choirs, can create a good balance between the individual and the group. The choir gives each person the experience of being an individual, a distinct person who can contribute something of their own to the collective. At the same time, many people experience the "we-feeling" created by the choir as a strong source of belonging to a larger community.

All of us rely on feeling at home within a broader cultural and social context in order to develop identity and self-awareness. Music helps anchor us in time and place. Through it, we connect with what is locally distinctive, experience ourselves as part of a region, or even as "citizens of the world." It fosters a sense of rootedness and counteracts the dislocation often associated with modern life, where changing jobs and homes is a common experience. At the same time, music contributes to a sense of continuity in our lives. It helps us feel that we are the same person today as we were yesterday—that our lives have an origin and a direction, and that their different phases are meaningfully connected.

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[94] Erdal and Hovden, 1999.

[95] Batt-Rawden 2007; Batt-Rawden, DeNora and Ruud, 2005.

As I wrote at the beginning of this chapter, it is important to see the debate about health in society from a wider perspective than illness and hospitals. Social and community medicine has long sought to show how we must include important determinants of health when this debate is raised. And by that we mean work, education, housing, nutrition, environment, self-respect, power, and belonging. In this debate, it becomes clear that differences in health are caused by social conditions, something also emphasized by the World Health Organization (WHO). Differences in health status are not simply a matter of poverty but are especially related to structural conditions in society that affect the degree of social cohesion and integration.

We now know much about how some of the greatest health problems in our Western societies relate to being socially isolated, with living without the social networks that naturally arise around housing, work, and not least cultural activities. When people become ill or unemployed, they often lose their social connections. This makes it particularly difficult to regain health. People are pushed out into what has been called the in-between space: a critical phase of life arising between illness and ordinary life, between unemployment and work, between struggling with mental health difficulties and feeling belonging and connection with others.

When, with the American social scientist Robert Putnam, we speak of social capital, we mean what binds a society together: reciprocity among people and social networks. People without social networks have a two- to fivefold higher probability of dying from all causes compared with people who live in close ties with family, friends, and the local community. It must be emphasized how important voluntary organisations—what is called the third sector of society—are for developing social capital.[96]

The organizations of musical life can make an important contribution. One example might be inviting new immigrants to participate in choirs or singing and music groups. We know the possibilities inherent in a singing group or choir: making contacts, building larger networks, improving language skills, and providing opportunities for cultural sharing.

Social capital encompasses a sense of belonging and attachment, reciprocity and trust among individuals, neighbourliness and shared activities within the local community, opportunities for co-determination and influence over one's surroundings, and, importantly, a feeling of inclusion. Several of these elements are clearly central to both participation in musical life and to health itself.

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[96] Putnam, 2000; Sund, 2009.

In recent years, social scientists have become increasingly aware of how important our social capital is for how integrated we are in society—that is, for the extent of our social contacts. In fact, this is regarded as the most important factor contributing to the experience of well-being. Putnam has shown how societies in which community-building activities decline quickly develop poorer health statistics. Our ability to form relationships, support and relieve one another, and counteract social isolation is, according to Putnam, the number one enemy of our health.[97]

Music groups are meeting places where people form relationships. Although music groups may vary in the degree to which they are inclusive, they offer opportunities either to strengthen cohesion among people or to open new social contacts—what the literature refers to as bonding and bridging. Bonding refers to strong and close relations and solidarity within groups. Bridging concerns looser connections and the promotion of cooperation.

Participation and Community

Musical "immunogens" that foster a sense of belonging to a community play an important role in quality of life and subjective health. Concepts such as social capital, attachment, networks, bonding, and bridging all point to a form of cultural immunogen that becomes central when musicking is considered from a public health perspective. In preventive health work, the role of community in counteracting isolation and loneliness is consistently emphasized. There are numerous opportunities for participation in choirs, bands, orchestras, and other ensemble groups. Amateur musical life, in particular, represents a rich source of social engagement, enabling the creation of community and the integration of individuals from diverse backgrounds and with varying levels of musical ability.

There is a considerable body of research on how musical communities—ensembles, bands, music groups, choirs, and wind bands—help promote subjective health. Not only have we seen the flourishing of a variety of choirs directed toward specific medical and psychological conditions, such as the new dementia choirs. There are also choirs for people with COPD and breathing difficulties, choirs for the rehabilitation of language after brain injury, and choirs for people with mental health challenges. The literature also discusses choirs for people in special situations, such as choirs for the homeless and choirs in

[97] Putnam, 2000.

prisons. As for instrumental ensembles, there is research on orchestras in refugee camps, laptop orchestras, drum circles, ukulele groups, brass bands, MIDI keyboard ensembles, and rock bands.[98]

How Does a Community Come Into Being?

There are several ways of understanding a community and how it is created. The sociologist Aksel Tjora points out that the core of community concerns social interaction and negotiation among people.[99] Drawing on research methods known as symbolic interactionism and ethnomethodology, we can study the processes and situations in which a community is created and develops. The concepts Tjora introduces apply well to processes in musical ensembles, and can help us perceive the meanings, opportunities, and values connected with musical communities.

From an ethnomethodological perspective, a community is created through the members' interactive production of what is normal and expected. In other words, communities are produced through local practice. It is these negotiations and interactions that constitute the community itself. One need only think of what happens in a rock band during rehearsal—a compositional community, to use my own term—something we can observe by studying rock bands.[100]

Tjora refers to the American sociologist Randall Collins, who writes about chains of interaction rituals. Building on microsociological analyses, Collins shows how social membership arises through shared focus and emotional entrainment. He is cited as demonstrating how social situations can generate self-reinforcing feedback processes that produce "moments of emotional experience." These moments become "motivational magnets" with cultural significance—something that is readily recognizable in musical interaction groups.

If we adopt such an understanding of musical activity, then it is situations that form the starting point of community. Such situations are not isolated events but can, over time, create chains of interaction rituals. According to Collins, this contributes to the generation of an emotional energy released in social contexts.

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[98] English, 2022.

[99] Tjora, 2018.

[100] Berkaak and Ruud, 1994.

Tjora has several terms for community. He speaks of festivals as situational communities, of emotional communities, social attentiveness, a sense of community, interactional pretexts, and focused interaction.

Community can also be understood through the sense that others resemble ourselves. This brings us to central themes in the sociology of music: taste and musical preferences, the use of music as an identity marker, and its role in shaping imagined communities and neo-tribes. Musical artists offer rich opportunities for identification, allowing audiences to rally around shared values and meanings. A musical repertoire can be assembled to facilitate such identification. When musicians curate a concert program, they may seek to appeal to a diverse audience in terms of taste, age, cultural affiliation, or other shared characteristics. Contemporary popular music is marked by a wide array of identification possibilities, engaging communities formed around factors such as age, gender, social class, ethnicity, nationality, (sub)cultural belonging, and specific value systems.

As one of several examples of a communication community, Tjora points to communication among members of a rock band during rehearsal. Here we encounter familiar concepts such as communities of practice (Lave and Wenger) and tribal communities (Maffesoli). Such communities of identification are based on shared recognition of artists and values, knowledge and taste, and even shared musical "enemies," in addition to external markers such as tattoos and clothing.

The music researcher and choir leader Anne Haugland Balsnes sees connections between the anthropologist Etienne Wenger's theory of communities of practice and learning processes, and the consequences these have for health and quality of life.[101] Theories of learning in communities of practice say something about how learning and identity formation are interwoven and integrated into social processes. The choir is an example of such a community of practice, where people work together over time. This community forms a set of relationships among people, activities, and environments. Participation in the choir helps shape not only the musical result, but also our identity—who we are and how we interpret what we do—according to Wenger. At the same time as this musical identity formation takes place, the musical community becomes a space for shaping belonging (socially, culturally, geographically, and temporally), and not least for giving an experience of meaning and coherence in life. In other words, there is a strong connection between musical learning and processes that concern health and quality of life.

[101] Balsnes, 2011; Wenger, 1998.

How Are Musical Communities Experienced?

From a public health perspective, it is important to study how the adult population may benefit from participating in musical ensembles. Karen Burland, Professor of Applied Music Psychology, has investigated how participants in four British instrumental ensembles, all adult amateurs, experience the impact of participation on their identity formation and personal development. She discusses the findings from this musical leisure activity in relation to experiences of participation in working life.[102]

Burland points to five dimensions of participation in such instrumental ensembles: group affiliation, opportunities for learning, joy and renewal, well-being and health, and a more overarching factor she connects with music and identity. As regards group affiliation, participants emphasize the experience of belonging to a group of like-minded others. Joy is linked to the social aspects of musicking, as well as to the reward of accomplishing something together with others. The ability to give oneself over to the collectively created sound provides a sense of self-worth, of making a meaningful contribution. Friendship and belonging, meeting new people, regular social interaction, and feeling part of a community that shares interests all create a sense of responsibility toward the ensemble that goes beyond the individual wish to make music.

The next category concerns the desire to learn and develop new skills, to be challenged within a supportive learning environment. Naturally, the degree of challenge is important, as are the atmosphere and the support one receives from fellow musicians: that mistakes are overlooked and accepted, that one feels encouraged and not overwhelmed. Here, regular rehearsals and a good social atmosphere are important for the joy and trust that develop.

A recurring point is the opportunity to achieve a sense of mastery through participation. This applies especially to participants from underprivileged groups. As we saw, empowerment concerns developing agency, a sense of control, greater autonomy, purpose, and meaning. This category is closely connected to group affiliation, as well as to the musicking itself. The music-making may be experienced as rewarding, as though one receives more than one brings into it. Participants do not experience the music as too demanding; rather, musical participation itself is rewarding. Participation in music is experienced as rejuvenating, while fatigue and anxiety connected to the working day are overcome.

[102] Burland, 2022.

Giving oneself over to the music and entering a state of flow can create a powerful sense of escape: time seems to dissolve, the workday fades, and personal worries recede. In this space, one becomes de-stressed and relaxed. Older participants often describe a sense of enhanced mental flexibility, while those balancing demanding jobs, household responsibilities, and children experience music-making as a rare "free space." It offers a feeling of protection—a dedicated time to do something for oneself—what sociologist Tia DeNora describes as a kind of haven or asylum.[103]

There is also research on choirs for homeless people. This points to the importance of the social communication that takes place between choir participants and audiences.[104] The same applies to choir participation among prison inmates, where one experiences being seen and recognized in a different way than merely as a prisoner or a criminal.

Burland finds that participation in ensembles helps individuals feel special and part of something meaningful, offering a sense of self-realization that extends beyond the identity shaped by their working lives. When compared to work, ensemble participation highlights how musical communities can compensate for many negative aspects of employment, such as stress, repetitive tasks, exhaustion, lack of respect, heavy workloads, and poor leadership. In contrast to these challenges, musicking is experienced as a source of joy, fulfilment, and personal enrichment.

There is now extensive research on music-making in ensembles and its effects on health and quality of life. Much of this research concerns different types of choirs, but there are also examples of research on a wide range of other ensemble forms.[105] When evaluating this research, it is useful to ask whether different kinds of ensembles may produce similar benefits, whether instrumental groups or rock bands. We may ask whether genre plays a role, or whether gender and age are variables worth considering. In discussing effects, we should also ask whether it is the effect of the music itself or of the social practice that is decisive.

Social context is important, and from a public health perspective it would be interesting to know whether choirs and ensembles in workplaces can create a positive working environment. Two choir researchers, Anne Haugland Balsnes and Dag Jansson, have pointed to how workplace choirs can change the way colleagues perceive one another. Shared music-making creates challenges that can

[103] DeNora, 2013.

[104] Bailey and Davidson, 2003, 2005.

[105] Timmers, Bailes and Daffern, 2022.

bring participants slightly out of their comfort zones, which may promote learning processes and break down the hierarchies that can operate in a workplace.[106]

When we ask what it may be about the shared music-making itself that produces such positive experiences, some have pointed to the importance of the socio-emotional synchronization that occurs through making music together. It is natural to think that cooperation, the experience of closeness, and social attachment (bonding) are facilitated by the experience of being in synchrony with others.[107]

Meaning, Identity, and Existential Health

The last cultural immunogen discussed here highlights the importance of meaning in life and existential well-being. The feelings and memories evoked by music can profoundly influence our self-understanding, our sense of purpose, and our overall coherence in life. Music can provide new strength and resilience, helping us navigate difficult experiences and challenging periods. It can assist us in the work of grieving and, importantly, foster hope.

Numerous accounts show how people have found comfort and support through music. Swedish music researcher Lars Lilliestam has documented, through a series of in-depth interviews, many examples of the resilience that music can mobilize, illustrating how individuals in everyday life can use these resources to promote and protect their health. This applies not only to classical music but also to rock and popular music.[108]

Meaning in life is not something that objectively exists "out there," but something that is attributed to an object, an action, or an event by a person in a particular context. Meaning is something we must make, something we must create. What gives meaning to one person may be meaningless to another. What gives me meaning today may not carry the same meaning tomorrow.

Meaning in life consists of many dimensions. Not least, it is shaped by the direction in which we pursue certain goals, and by the purposes we attach to them—and by how we evaluate life as more or less meaningful. Meaning has a dynamic character; it is subjective and relational.[109] The psychologist Tatjana Schnell points

[106] Balsnes and Jansson, 2015.

[107] Rabinowitch and Gill, 2022.

[108] Lilliestam, 2020.

[109] For the following, see Schnell, 2021.

out that a lack of meaning in life does not necessarily imply a crisis. This stands in contrast to Viktor Frankl's existential psychology, which took the will to meaning as a fundamental drive for all human beings. Schnell, however, refers to research showing that many people relate indifferently to such existential questions. They live their lives without worrying about what the meaning is. For the rest of us, then, the question becomes: what is the added value of living a life that is experienced as meaningful?

Schnell's Four Dimensions of Meaning in Life

Schnell works with four dimensions of experienced meaning in life. First, it should be noted that living a life experienced as worth living is not necessarily something we consciously reflect on. The extensive psychological research of Schnell and others suggests that meaning in life can be linked to our evaluation of 1) the experience of coherence in life, 2) the significance we feel our actions have, 3) the goals toward which we orient ourselves, and 4) our experience of belonging in the world. Here, the possibility is opened that music may be one of the many sources of meaning in life.

Coherence in Life

Experiencing coherence and comprehensibility means that what we experience, the actions we perform, and the goals we set make sense—something we also saw in Aaron Antonovsky's theories. Goals and actions should be coherent, not inconsistent, but rather complementary and mutually supportive. When Schnell writes about how therapy can help create meaning in life, one of the methods she mentions is writing one's life story. Here, writing one's musical autobiography may be an opportunity for music therapy to contribute.

The Italian music researcher Maurizio Disoteo writes that the purpose of musical memory work is not to engage in a superficial recollection of memories connected to musical experiences and preferences, but to seek to understand how these encounters with music have shaped us as persons. He emphasizes how encounters with other people, institutions, and values contextualized by music have helped shape us as human beings.[110]This emphasis on values is important, something we can make visible by reflecting on the larger context within which we experienced the music.

Significance

[110] Disoteo, 2022.

The consequences of our behaviour shape our experience of meaning in life. When our actions lack significance—when they are meaningless or without consequence—our sense of meaning diminishes. Music, however, does not hold the same significance for everyone. Some argue that "life is meaningless without music." For those who have deeply invested in music—whether as fans with extensive collections or as musicians dedicating time to practice and social engagement—the absence of music can profoundly affect their sense of meaning. A less dramatic, yet still meaningful, case involves those who use music primarily for hedonic purposes: to enjoy it and derive pleasure. Even this, of course, plays an important role in our experience of life.

Orientation

This dimension concerns having direction—a purpose in life. When equipped with a compass grounded in meaning, it becomes easier to reject options that do not align with one's personal values and goals. Schnell emphasizes that we live in a multi-optional society, where we are constantly presented with choices regarding the interests and values we might pursue. This is particularly relevant for anyone seeking to deepen their engagement with music—for instance, by learning to play an instrument. Such a pursuit requires making many deliberate exclusions; one cannot spend hours aimlessly on social media and simultaneously expect to master an instrument. There is a clear connection between the time invested and the meaningful return, exemplifying the eudaimonic form of happiness.

Belonging

For many people, music is the most important source of experienced meaning in life. Here, belonging is understood in an existential sense, rather than merely as social connection. Of course, we also have numerous examples of how music fosters belonging to social and ethnic groups, to traditions and local communities, and even to a particular historical era. The existential dimension, however, concerns a deeper experience: a sense of being truly at home in the world.

Existential psychotherapists such as Irvin Yalom describe existential isolation as a fundamental condition—the awareness that I alone am responsible for my life and that I alone must shape it. Yet, through our commitment to family, friends, colleagues, religion, and nature, we can counteract this isolation. It is at this point that we can introduce the sociologist Hartmut Rosa's theory of resonance.[111]

[111] Rosa, 2019, 2023, 2025.

A Hierarchical Model of Meaning

These four dimensions form the framework for an individual search for possible sources of meaning in life. Schnell has also developed a pyramidal hierarchical model of meaning. At the top of the pyramid, we find what we consider making life meaningful. Beneath that are placed all the sources of meaning. Below these again are the goals we pursue, then the actions we undertake, and at the base our perceptions—in other words, what we are on the lookout for.

The model can illustrate how what we regard as meaningful guides all activity further down the hierarchy: the goals we pursue, the actions we take, and what we pay attention to. What we perceive, and our actions themselves, are meaningless if they serve no particular purpose. The goals we pursue are experienced as meaningful if they are consistent with values connected to what gives us meaning.

The levels of this pyramid must hold together; they must display vertical integration from bottom to top. At each level, the activities should be consistent and not contradict one another. If, for example, our goals are mutually coherent, we speak of horizontal integration.

A person may, for example, experience music as a powerful source of meaning in life. This influences the person's goals, so that they decide to join a choir, take singing lessons, and attend concerts. The person follows what is happening in musical life and which artists are emerging, how they sing, and whether their style and values correspond to the person's own. This is an example of good vertical integration. When the person joins a choir, they also gain new friends and social contacts. This corresponds to the fact that they place a high value on social membership. In this way, horizontal integrations occur at different levels in the hierarchy.

Multiple Sources of Meaning in Life

Schnell's research has identified no fewer than 26 sources of meaning in life. For example, generativity involves engaging in activities that are not driven by self-interest. This can include doing something for others, contributing to society, or leaving a lasting impact for future generations. Other sources of meaning include religion, spirituality, social commitments, one's relationship with nature, self-knowledge, and maintaining one's health.

According to Schnell, it is beneficial to have multiple sources of meaning in life—ideally three or four. Work can be a significant source of meaning, particularly when it involves caring for others or fulfilling a social commitment. Some people, however, invest themselves entirely in this one source, sometimes to the detriment of friends, family, nature, or art. Relying heavily on a single source of meaning can make a person vulnerable to life crises, potentially resulting in self-sacrifice, stress, or burnout. Without other sources to draw upon, feelings of meaninglessness can quickly emerge.

Breadth, Balance, and Depth

Breadth is thus achieved by cultivating several sources—at least four, Schnell recommends. The more identities one has, the better equipped one is to experience rich meaning in life. But it is not only the number of sources that matters; balance among them is also important. It turns out that when one source is threatened, other paths to meaning in life can open and become more important. The depth of the experience of meaning is connected to the experience of transcending one's individual needs, so-called self-transcendence.

It is less well known that Abraham Maslow revised his hierarchy of needs, in which self-realization originally stood at the top.[112] Maslow later wrote that it was important to overcome egocentricity, selfishness, and preoccupation with oneself, and to open oneself to a larger reality. This striving to transcend self-centeredness was also important for Viktor Frankl in his existential logotherapy. Forgetting oneself, serving and loving others—these are values that sound unfamiliar in today's individualized society, Schnell comments.

Music, Life Crises, and Self-Care

There are many examples in which music helps us overcome life crises, create hope, discover coherence in life, or have intense, surpassing, even transcendent experiences.

[112] Schnell, 2021.

Musical Self-Care in Grief and Life Crisis

The use of music to help us through crises is not unknown, whether in our own culture or in the cultures and musical histories of others. The Polish composer Krzysztof Penderecki wrote his heart-rending *Threnody* in memory of the victims of Hiroshima.[113] Louis Armstrong's classic *Do You Know What It Means to Miss New Orleans* gained new relevance after the flood disaster in New Orleans in 2005, when it was performed by Harry Connick Jr.[114] In the aftermath of the July 22 terrorist attacks in Norway, we saw how artists created new songs in order to process their personal feelings and to comfort the rest of us. They follow in the footsteps of Pink Floyd, who wrote *Wish You Were Here*, an ode to Syd Barrett. Or they follow Eric Clapton, who wrote *Tears in Heaven* after losing his four-year-old son.

A great deal of music—even music already present in our own musical libraries—can be used to process difficult emotions when needed. Not least, we have seen how music makes us turn toward others, seeking belonging and strength in community. Through musical rituals, by standing shoulder to shoulder and singing, we show our feelings in a public space, together with others. The unison singing, synchronized through shared lyrics, rhythm, and pulse, creates bonds with other people. We experience being strengthened, gaining agency and courage to move on and continue the struggle.[115]

But it is not only through lyrics and song that music can release grief and bring relief. The Norwegian jazz pianist Tord Gustavsen has spoken about how his album *The Ground* was created during a phase of life marked by grief after many of his close family members died in a traffic accident. "Writing music again felt double. It was very demanding, but also very meaningful," Gustavsen said in an interview, adding: "The development of the material took place in the aftershocks of the accident, and at the same time as my own grief work. It is not music I made primarily in order to process my own grief. But the grieving process is interwoven with this part of life as well. (…) Music can help create a therapeutic universe. A space in which one can feel one's emotions and set them in motion."[116]

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[113] Ruud, 2012a.

[114] Berger, 2004.

[115] See articles in Knudsen, Skånland and Trondalen (Ed.), 2014.

[116] Holst-Hansen, 2005.

There is hardly such a thing as a special music of grief, written out of a particular situation, which can then simply be used in personal grieving processes. Admittedly, many people will find resonance in Gustavsen's music, something described anecdotally by the journalist in that report. He had received an email from a woman who told him that she listened to Gustavsen's music every day after losing her spouse.

Music, Identity, and Autobiographical Memory

We have already seen how the experience of meaning and coherence in life is an important resistance resource in relation to illness. We can connect this with an understanding of musical identity, and thereby claim that a differentiated, strong, and flexible identity gives people a sense of life mastery that is itself an important resistance resource in relation to illness.

To make the connection between music and identity, a particular understanding of identity is required. Identity is not something with which we are equipped once and for all. Identity is something we construct throughout life. Identity is the sum of all the stories we tell about ourselves.[117]

What is here called "identity" may be understood as a self-in-context. This refers to the many contexts within which I can place myself.[118] I have previously outlined four contexts that are especially important in relation to music.[119] First, music gives rise to experiences associated with emotions, mastery, and self-confidence, as we have already seen. Secondly, the social space in which we move provides important points of reference for identity formation. This includes experiences related to social class, ethnicity, values, gender, and themes such as authenticity and social competence. Not least, our belonging in time and place is important when it comes to shaping identity. Belonging to country and region, local rootedness, historical anchoring, or belonging to a particular era are all important dimensions of identity. Many people also wish to ground their sense of self in the feeling of belonging to a larger whole. In other words, there is a transpersonal space of identity.

Within this framework, identity is understood as a set of narratives we tell about ourselves. These narratives are shaped by memories and by our interpretations of

[117] Ruud, 2013a.

[118] Fitzgerald, 1993.

[119] Ruud, 2013a.

our experiences. Constructing identity relies on a kind of memory work, in which experiences serve as raw material, and language provides the metaphors through which we create understanding and coherence in our lives.

Within this perspective, musical experience assumes a central role. This is because encounters with music are often deeply connected to emotions, and emotions accompany the situations and processes through which we gain the social and personal experiences that contribute to our constructed self-image. We can tell the story of our lives by recounting the episodes in which musical experiences have lodged themselves in our bodies and memories.

These stories always point to a larger context: our relationships with others, our sense of time and place, and our engagement with existential questions. For this reason, accounts of musical experiences—or of "my music"—often become stories about "who I am" or about how I wish to appear to myself and to others. Against this backdrop, writing a musical autobiography offers the opportunity to create coherence and meaning throughout the course of a life.[120]

Transcendent Experiences

Aesthetic experiences can trigger experiences of meaning in life. Such transcending experiences, in which one feels that what is happening is extraordinary, outside the everyday, have been given many names in the literature. People speak, for example, of peak experiences, the term used by the psychologist Abraham Maslow for such phenomena. More recently, the term "kama muta" has appeared as a general designation for these intense emotional experiences.[121] The concept refers to a deep emotional state: being profoundly moved or experiencing deep empathy.

Music is often described as the language of emotions, something confirmed when we have emotional experiences while listening to music. Such experiences, as we have seen, help maintain contact with our emotional life. They give us access to emotions and help us become acquainted with them; something closely connected to quality of life. Several writers point to how engaging with music provides a strong experience of giving oneself over to a kind of flow, as it is called in Mihaly Csikszentmihalyi's theory.[122]

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[120] Ruud, 2013a; Disoteo, 2022.

[121] Swarbrick, 2023.

[122] Cziksentmihalyi, 1990.

This flow experience of entering time and feeling oneself involved in something meaningful is connected with powerful experiences of meaning and coherence. This experience is expressed in the emotions that music opens. Music makes possible experiences of meaning that the listener connects with personal beliefs and systems of value. Because music creates strong and durable emotional memories, life becomes anchored in values that give existence meaning for many people.[123]

Resonance

In order to write such experiences of meaning into a sociological theory, we may turn to the German sociologist Hartmut Rosa and his theory of resonance. Precisely from a public health perspective, it makes sense to draw on sociological theory when arguing for how music and the other arts can have health-promoting effects.

Rosa has written extensively about social development and has especially pointed to how an accelerating development in economics and technology creates a pace and stress in the population that easily lead to a poorer quality of life. Social development, in other words, creates conditions that may cut us off from the possibilities of living a good life. As a sociologist, he focuses on structural and socially created conditions and on how these can affect the existential conditions for living well. If this accelerating social development is the problem, then resonance is the answer, Rosa writes in the introduction to the book of that title.[124]

Resonance is a form of relation to the world in which the individual and the world meet and transform one another. As a physical phenomenon, resonance occurs when one vibrating object causes another object to vibrate, but in its own frequency. Rosa uses the concept metaphorically, and with a romantic connotation of longing. Resonance can be understood as an ethical ideal: striving for meaningful engagement with the world, for something that answers back. We create relationships with the world through active encounters with other people, art, nature, or phenomena that speak to us with their own "voice." When these encounters create resonance in us, we can move beyond our merely instrumental dealings with the world.

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[123] Ruud, 2013a.

[124] Rosa, 2019.

Resonance means creating an experience based on an answer, a response, and not merely an echo. Resonance is not something one can produce at will or order up on demand. The phenomenon has no instrumental character. Rosa says that one of its essential characteristics is precisely that we cannot achieve resonance on command. At best, we can invest time and resources in pursuing our interests and thereby prepare ourselves for the experience of this meaning. In that sense, resonance concerns something uncontrollable.[125]

Growth Philosophy, Acceleration, Alienation, and Instrumentalism

An important concern for Rosa is to identify what blocks access to experiences of resonance. As a sociologist, he has previously written about the increasing acceleration inherent in industrial society's endless pursuit of growth. He describes a logic in which growth requires still more growth, and in which we are trapped in a loop that forces us to increase the tempo, produce more, and live faster. This creates a form of aggression, a condition from which some people burn out. At the same time, Rosa points to our longing for resonance.

What Rosa calls dynamic stabilization describes how we must constantly increase our resources to keep up with a development whose goal is to create stability in the economy. Things must go faster. We must always perform a little more than the year before. It is like walking down an escalator that moves slightly faster every year. This increasing acceleration takes place economically, socially, technologically, and culturally. Technological change illustrates this easily. Ever new technological innovations mean that we must constantly stay updated: new apps, new ways of buying tickets, banking services, changes in word-processing programmes, and so on. All of this creates daily challenges that require us to stay on alert.

This increasing acceleration produces alienation, which Rosa sets up as the very antithesis of resonance. Alienation is experienced as a relation to the world that is mute, cold, rigid, and one in which we are unable to establish a living connection. This may be due to a damaged subjectivity, to social conditions hostile to resonance, or to a lack of correspondence between the subject and some sphere of the world. Alienation can lead to a damaged experience of being cut off from individuals and situations, and the axes of resonance become mute. Burnout, or depression, can create a situation in which the axes of resonance are shut down.

[125] Rosa, 2025.

Rosa has been criticized because his concept of resonance has its origins in Romantic ideology and patterns of thought. Rosa acknowledges this but nevertheless argues that these ideas from Romanticism point to something universally human: a longing for closeness, belonging, fullness, meaning, and transformation. He admits that many of the examples he gives of resonance experiences approach the so-called peak experiences described by Maslow. He continues to research this and tries to formulate what he calls second-order resonance, which is of a slower and more everyday character.

Three Axes of Resonance

Rosa distinguishes between three axes of resonance, or lines of connection. He also calls them spheres of resonance, or axes that create relations to the world. The first axes or lines of connection designate possibilities for resonance linked to family, friends, and politics. These encompass our human relationships and our experiences of community. It is here that our sociability is given a voice: the importance of meaningful relations arising in interaction with other people. Without such relations, human life would be without solidarity and identity.

In the next axis of resonance, we find objects, work, school, sport, and consumption. These belong to a sphere in which we pursue specific goals. Here we encounter an objective world of "things" that, through resonance, acquire a voice. This illustrates our ability to define our place in the world by constructing and reconstructing the material and symbolic conditions of our existence. How a musician can experience the very instrument they play as creating such "resonance," in a transferred sense, is a familiar phenomenon. Many musicians have a deep and personal relationship to the instrument they have found.

Examples from the third sphere of resonance are found in our relation to religion, nature, art, and history. These attain the status of "higher" and possibly "transcendent" spheres of engagement—for example in relation to God or gods, the cosmos, time, or eternity. Here there is expressed the specifically human longing for spheres that offer transcendence in everyday life. This relation allows us to challenge given reality through an ideological and institutional enactment of religious faith.

Music is a good example of an axis of resonance within the sphere of art and religion. Having a strong and deep interest in music can illustrate what is meant by an axis of resonance, in this case a line of connection to art and aesthetic experience. When we listen to music that engages us, often soundtracks we have heard many times before, we wish to confirm a relation to the music—that

is, to confirm something in ourselves. Perhaps we could give analyses and descriptions of this relation if pressed. But we choose to listen to the same music again and again precisely because "it feels good to be" in that listening relationship. Hartmut Rosa himself has testified to music's power to create meaning through describing his own strong and long-lasting relationship to heavy metal music.[126]

Strategies and Responses

At times, we may feel a lack of resonance: situations in which we receive no meaningful response, and which we therefore gradually begin to avoid. Examples might include entering a worn-out gym, hearing music one does not like, feeling a body that is not motivated for exercise, and so on. Or being forced onto a ski trip one cannot manage, where clothes, equipment, wax, cold, and lack of interest all block the possibility of resonance. Yet experiencing resistance and alienation can also mean that the longing for resonance is intensified, so that one becomes mobilized to develop more enduring axes of resonance.

One can search within one's own life for experiences of resonance. We have known what such experiences feel like and thus seek a strategy for reliving them or for creating a more lasting access to resonance. One strategy is to increase one's resources: maximize access and opportunities, earn more, buy more, work more, and so on. But in doing this, we easily develop an instrumental relation to resonance.

What matters is the quality of the way we appropriate the world. It is not the quantity of resources that is important, but whether we genuinely like and are engaged in what we are doing, and whether we experience joy and satisfaction through the activity. We may experience the world as a good and safe place. We look forward to going to work, meeting colleagues, and solving our tasks. We exercise and experience that the body responds well. We feel strength, elasticity, suppleness, and increasing endurance. We experience a physical well-being through being in the gym or out in nature. We take joy in nature, in the music we listen to, in gardening, and in voluntary work. In such ways, we experience our lines of connection to the world as vibrating. We become engaged out of an inner interest, and for the sake of the activity itself.

[126] Rosa, 2023.

Music and Public Health Challenges

So far, I have described some general theoretical frameworks for how one might conceive of an immunogenic practice in which music plays a particular role. From a public health perspective, it is interesting to ask whether there are specific conditions that can be alleviated—or possibly even removed—with the help of music. We have seen that the greatest health challenges in contemporary society are linked to ways of living that lead to increased stress, loss of meaning in life, burnout, anxiety and worry, sleep problems, and depression. These are health challenges that can sometimes be so serious that one must seek professional help or therapy through the healthcare system. At the same time, however, we know that there is considerable health potential in the engagement people can take in their own lives. This may happen by changing one's way of life or by trying new strategies aimed at reducing stress, sleeping better, getting out and meeting new people, attending concerts, and so forth.

The cultural immunogens provide a general basis for understanding music as a health resource. These immunogens primarily address psychological themes such as agency, vitality, the effects of social isolation, and a sense of meaninglessness. Although these immunogens have a beneficial impact on our physiology and bodily states, there is often a need for more focused activities to address persistent health challenges related to stress, anxiety, insomnia, and pain.

Music therapists can teach us something about the strategies and techniques used when we plan to use music for self-help. They have produced self-help literature offering guidance and procedures for using music to relieve stress, pain, anxiety, and insomnia. It must be emphasized, however, that there are no simple solutions when it comes to using music to influence more serious health challenges. We cannot simply put on some music and believe it will help. Learning to use music to regulate health requires sustained, goal-directed effort over time.[127]

Stress and Anxiety

It was the physician and researcher Hans Selye who, around 1940, formulated a theory of stress. Stress is considered a normal reaction to events in everyday life. It may, however, become harmful if it creates excessive changes in body, emotions,

[127] Hanser and Mandel, 2010.

and behaviour. In the worst case, stress contributes to serious somatic and psychological illnesses that reduce quality of life.[128]

Symptoms of stress may include everything from headaches, stomach pain, and chest pain to irregular heartbeat, sweating, dry mouth, and shortness of breath. Many serious somatic illnesses can intensify these reactions. Stress may also manifest psychologically, for example in rapid speech and increased emotional intensity. We commonly distinguish between acute and episodic experiences of stress. The more serious chronic stress can persist long after the immediate stressful situation has passed. It is important to break such a cycle of ongoing stress, which requires awareness of which actions may lead us out of this state. It is here that music therapy offers suggestions for intervention.

We distinguish between so-called stressors, that is, what triggers stress, and the experience of stress itself. External factors that may trigger stress include everything from working conditions, poor finances, discrimination, and generally negative experiences. Internal stressors include, for example, memories, self-criticism, body image, and trauma.[129]

Negative stress is a major source of bodily discomfort and health challenges. Research shows that music can reduce both stress and pain. Listening to music has been shown to lower cortisol levels, the hormone associated with stress. This may reduce the perception of pain, which often itself causes stress.[130]

Music's calming effect on body and mind helps create a relaxing environment and distract from stressful moments. It contributes by creating a calm atmosphere with slow tempo and soft melodies. This helps lower heart rate and breathing, reduce blood pressure, and induce a state of relaxation.[131]

Music therapists Jennifer Sokira and Audrey Hausig point out that music-therapeutic approaches with a particular focus on the body can alleviate acute symptoms of stress. These include music listening that enhances relaxation, such as in autogenic training and progressive muscle relaxation, in GIM, in work with breathing, as well as in music listening more generally and in mindfulness. Re-creative musical activities through singing and playing can also reduce stress by supporting and releasing emotional expression. Distraction is another

[128] Sokira and Hausig, 2025. See also de Witte et. al. 2022.

[129] Sokira and Hausig, 2025, p. 315.

[130] Schnell, 2021.

[131] Hanser, 2024.

mechanism of effect that can come into play when music is used for recreation and as a leisure activity.[132]

There are several individual factors related to musical taste and motivation that influence how music affects us. This applies both when we use music to reduce stress, to help us sleep better, and to move out of states marked by anxiety and depression.

Pain

Music therapy for pain relief may consist of both listening and active participation in music, such as singing or playing instruments. Engagement in music helps promote positive emotions and divert attention away from pain. According to the International Association for the Study of Pain (IASP), pain is defined as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." The definition underscores the importance of the subjective experience of pain and highlights that negative thoughts, especially under stress, can intensify pain.[133]

It further states:

> *Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors. Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons. Through their life experiences, individuals learn the concept of pain. A person's report of an experience as pain should be respected. Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being. Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.*[134]

There are several types of pain: nociceptive, neuropathic, idiopathic, and psychogenic. In addition, procedural pain is often described in the music therapy literature. Nociceptive pain occurs when nociceptors, nerve fibers that transmit pain signals to the brain, are activated because of actual or

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[132] Sokira and Hausig, 2025, p. 323.

[133] https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/ Access date 10.7.2025.

[134] https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/

potential tissue damage. Neuropathic pain is caused by nerve or brain injury. It does not necessarily arise from a pain stimulus and is often regarded as "false" pain. Phantom pain is one example. Idiopathic pain has an unknown cause, such as pain in the back, muscles, neck, and shoulders. Psychogenic pain is caused by psychological factors, where psychological problems manifest themselves as physical symptoms.[135]

Pain may also be categorized as acute, chronic, visceral, or referred. Acute pain is temporary and comes on quickly. Chronic pain lasts more than three months. Visceral pain originates in internal organs. Referred pain is felt in a different part of the body from where the pain originates.[136]

Historically, it was assumed that pain was processed by a specific center in the brain. However, the gate control theory, introduced in the 1960s, suggests that pain signals can be blocked or amplified on their way to the brain, indicating that the brain can alter the experience of pain. The more recent neuromatrix theory connects pain with activity in a network involving several areas of the brain. It suggests that genetics, culture, and learning all influence the pain experience. This theory supports the use of music in medical procedures, since music therapy may modulate the neural patterns associated with pain.[137]

Pain is associated with a lack of relaxation, and the fear of pain increases bodily tension, which in turn increases pain. Music can break this cycle by creating relaxation and distraction, influencing our perception of time and making periods of pain more bearable.

Depression and Music

Depression is a condition characterized by sadness and low mood, loss of interest and pleasure in activities that were previously enjoyable, and a feeling of having less energy than before. Depression is one of the most common mental disorders. In Norway, it is estimated that between 7 and 10 percent of the population will experience a depressive disorder over the course of a year. Women are affected twice as often as men.[138]

[135] Ræder, 2024.
[136] Ræder, 2024.
[137] Hanser, 2024.
[138] Røssberg, 2025.

An internet search using the keywords "music and depression" yields many references to individual studies and meta-analyses showing positive effects of music therapy.[139]

One of the most frequently cited studies is a Finnish RCT study published in the highly respected journal *The British Journal of Psychiatry*[140] In a commentary on this study, three British researchers emphasize that it is the musical activity itself that is decisive for the effect on depression.[141] They can argue this because the Finnish study involved several therapists carrying out musical improvisations according to a carefully specified procedure or protocol. This may mean that it is not the therapist's personality that explains the effect on mood. One might object, however, that relational factors may still have played a role, given that the activities were music-therapeutic.

If the effect can be explained by the musical activity itself, this may indicate potential for transfer to situations involving musical activity without a music therapist being present. The three music therapy researchers Maratos, Crawford, and Procter suggest three factors that may contribute to music having a beneficial effect on low mood and depression.[142]

Regarding the first factor, they argue that the musical activity has an aesthetic value that is meaningful and gives pleasure. Insofar as depression involves a loss of meaning, the aesthetic qualities that arise in musical interaction or in listening to music function as resonant experiences. This is the phenomenon Hartmut Rosa refers to as the "string of resonance" that is so important to maintain.

The next factor is the physical aspect of making music. This involves creating a sense of oneself as physically active. It is connected to music's ability to engage us in musical interaction. Even if we feel unmotivated, we may experience what is called entrainment, where we are drawn into interaction with others and experience cooperation and interplay. The third factor they propose, which may help explain the effects of music, may be seen as an extension of this physical involvement and points to the relational aspect. This experience can be traced back to early experiences of musical interaction, known as communicative musicality.

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139 Aalbers et. al., 2017.

140 Erkkilä, Punkanen, Fachner, Ala-Ruona, Pöntiö, Tervaniemi, 2011. RCT is an abbreviation for "Randomised Controlled Trial". The participants in an RCT study are randomly assigned in different groups, for example a treatment group and a control group. The control group does not receive the treatment or intervention that the treatment group receives.

141 Maratos, Crawford and Procter, 2011.

142 Maratos, Crawford and Procter, 2011.

An online survey including 392 participants contained 84 individuals diagnosed with depression. The study examined relationships between musical sophistication and resilience. Resilience was here defined as the ability to resist stress, something that in turn may be linked to emotional regulation and social support. Active participation in music proved to be highly significant for resilience among all participants, and especially for those who were not depressed. Individuals with a depressive diagnosis more often experienced feelings of calm and peace after stress-reducing music listening compared with the other participants.[143]

When it comes to listening, it is natural to think that music—which is often associated with positive emotions—may help someone emerge from a depressive state. With the important caveat that people should choose their own music, music can contribute to shifting a mood in a positive direction. Yet although research shows that music for most people can evoke memories of positive events in life, this is not always the case for those with depression. In one study in which people with depression listened to music, the music triggered negative autobiographical memories in half of the participants, particularly where associations to childhood and adolescence were awakened. Such negative associations and reflections can, however, become an important starting point for further therapeutic processing.[144] That, however, falls outside the public health perspective.

Compassion Fatigue

Music therapists and music-and-health workers may face specific challenges in meeting users who require them to set aside their own needs to give time and care to others. Music therapist and professor Gro Trondalen has written about how music therapists may encounter compassion fatigue or burnout—what is also described as "compassion fatigue" or "compassion stress."[145] A music therapist has many roles, as therapist and musician, and may additionally carry responsibilities for teaching, supervision, and dissemination of the field. At times, one may find oneself in situations where there is a lack of understanding and support from colleagues, or where one feels vulnerable because of signals about economic restructuring with consequences for one's position.

At the same time, when work is experienced as meaningful and rewarding, it can be easy to overextend oneself. One may feel that there are countless people who

[143] Heck, Reinhardt, Bischoff and Koelsch, 2025.

[144] Sakka and Saarikallio, 2020.

[145] Trondalen, 2016b.

could benefit from music therapy, far more than one can possibly reach. It is precisely in such situations—where the work is deeply meaningful—that it becomes difficult to hold back care for others, making it easier to neglect one's own well-being. After the tragedy in New York on 11 September 2001, music therapists stepped in to support rescue workers and others affected. An anthology was subsequently produced to illustrate how music therapists can provide care for caregivers.[146]

Sleep Challenges

Lack of sleep, sleep difficulties, and serious sleep disorders are major health challenges today. Many people—especially young people—struggle to put away their smartphones before bedtime, something frequently reported in the media along with advice for improving sleep routines. Studies show that around 27 percent of the population have problems with insomnia, including subjective complaints about sleep disturbances. This may concern the quality of sleep, the duration or continuity of sleep, or the time it takes to fall asleep. Insomnia involves difficulty maintaining sleep, waking too early, or not feeling rested after sleeping.[147] There are several classification systems for sleep disorders. *The International Classification of Sleep Disorders (ICSD-3)* contains more than 100 diagnoses divided into six subgroups.[148]

An internet search reveals a large amount of research on sleep problems, including studies on the use of music to alleviate them. These include studies using selected music for small groups, systematic reviews and meta-analyses of individual studies, and research on music choice and the characteristics of "sleep music." In the self-help literature, listening to music in combination with breathing and relaxation techniques is recommended for falling asleep.[149]

Research on sleep architecture concerns the time it takes to fall asleep, the different phases of sleep from light to deep sleep, and the various brain activities from fast to slow brain waves, measured by EEG. Subjective measures, such as questionnaires based on the *Pittsburgh Sleep Quality Index*, are used together with more extensive and objective methods such as polysomnography, which captures a wide range of physiological responses during sleep.

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[146] Loewy, (Ed.), 2007.

[147] Jespersen, Koenig, Jennum and Vuust, 2022.

[148] Waage, 2024.

[149] Hanser, 2024.

Both short-term and long-term sleep deprivation lead to various physical and mental problems. Sleep quality plays a crucial role in well-being and quality of life. Lack of sleep may lead to problems such as poor concentration, anxiety, weakened immune function, high blood pressure, chronic pain, breathing difficulties, fatigue, absence from work, and increased risk of accidents. Medication is not recommended, since its effect declines over time, it can lead to dependency, and it may cause long-term side effects.[150]

Research on Music and Sleep

A Cochrane meta-analysis[151] examined 13 studies with a total of 1007 participants who listened to pre-recorded music for 25–60 minutes each night over a three-month period. The analysis showed moderate to strong evidence that sleep quality improved, especially for those with moderate sleep problems. Improvements included the time it took to fall asleep, sleep duration, and sleep efficiency (that is, the proportion of time spent in bed that was spent sleeping). Listening to music, however, had no effect on interrupted sleep.

The improvement related mainly to the subjective experience of music's effects, with inconsistent results for objective measurements.[152] The authors of the meta-analysis point out that more research is needed to understand the effects of music listening on different subgroups of sleep problems.

Research shows that listening to music before bedtime is one of the most common strategies people use to improve sleep quality. A large online survey shows that 62 percent of respondents had used music to fall asleep at least once. Several other studies likewise suggest that people find music beneficial for improving sleep quality. One study found that listening to music for one hour before bedtime affected the duration of deep sleep that produces slow brain waves (delta waves).[153]

Individual Differences

There is great variation in how people use music to counter sleep problems, and researchers discuss possible causes of individual responses to music. This concerns not only which type of music people prefer to fall asleep to, but also the rituals

[150] Jespersen, Koenig, Jennum and Vuust, 2022.

[151] Cochrane is an organization that produces and distributes systematic reviews of research within the health and medical field.

[152] Jespersen, Koenig, Jennum and Vuust, 2022.

[153] Cordi, Ackermann and Rasch, 2019.

associated with music listening. These may include breathing techniques or cognitive strategies designed to distract from the racing thoughts that prevent sleep. Other beneficial factors are music that masks noise, or the fact that one has learned to use music as an effective strategy for falling asleep. Music's effect on the autonomic nervous system is also mentioned, as is the way music listening reduces stress and anxiety.

One cause of individual differences is variation in motivation. Research shows that people listen to music before sleep for four main reasons: to change their mental state, to feel safer, to distract themselves, or out of habit. Furthermore, motivation is related to musical preferences. It also turns out that music use is most effective for those who are receptive to suggestion.[154]

It is difficult to determine whether a specific type of music or genre is particularly suited to promoting sleep. Earlier research suggested that classical music was the genre people most listened to before bed. With new technology, however, it is now possible to analyze vast quantities of the music people use as a sleep aid. Spotify tracks playlists, genres, and music categories associated with "sleep." This music can be analyzed using modern digital tracking in order to identify common features across different playlists.

One research team found 225,626 tracks on Spotify associated with "sleep."[155] In general, this sleep music was softer, slower, contained fewer lyrics, and used more acoustic instruments than music in Spotify more broadly. There was, however, considerable variation. The researchers identified six subgroups, three of which contained music that was faster, louder, and more energetic than average "sleep music."[156] This highlights the large individual differences in music choice for sleep quality.

Potential Effects of Music on Sleep

As we saw earlier, music's effects on sleep may depend on individual factors, such as susceptibility to suggestion. We may also ask whether there are characteristics in the music itself that explain its effects. We know from other studies that we prefer to listen to music with reduced tempo, energy, and volume at night and in the morning, and again in the evening. Research shows that such music can lower arousal levels, possibly through entrainment with autonomic biological processes

[154] Cordi, Ackermann and Rasch, 2019.

[155] Scarratt, Heggli, Vuust and Jespersen, 2022.

[156] Scarratt, Heggli, Vuust and Jespersen, 2022.

connected to breathing and heart rate during music listening. This entrainment effect also applies to levels of brain activity.[157]

As mentioned, effects may also occur with more energetic music. One example the researchers mention is the use of the lively song Dynamite by the K-pop group BTS, which features syncopation, melodic grooves, and a busy rhythm section. This track appeared in 245 cases as sleep-promoting. One reason why such music may be used in sleep rituals is that it is familiar, allowing listeners easily to predict its course. The brain continuously makes predictions about what may happen next. If something deviates from expectations, the brain becomes alert and formulates new predictions. Familiar music demands less energy from the brain, which may be a hypothesis worth testing in further research.

Music seems to be most effective for milder sleep problems, and it is important that people choose their own music. More research is needed on specific hypotheses, such as how genre preferences, motivation, and music use—in combination with relaxation techniques and sleep rituals—play a role, together with factors such as age, gender, and musical background.

It may be necessary to create effective playlists and to learn relaxation exercises. It is important to remember that people with sleep problems usually do not seek medical help but try to find other solutions on their own. The music chosen for playlists should be tested. According to music therapist Suzanne Hanser, to make a good playlist, one must pay attention to how the body and the breath respond to the music during listening. She has written books suggesting ways people may help themselves through music.[158]

Music as Self-Help

Books are published that offer recipes for how we may use music on our own to promote health. There is self-help literature on musical cures, both serious and unserious, more or less based on research and empirical evidence. For example, in the United States there is a large market for alternative therapies that promise healing through musical miracle cures. The American music therapist Lisa Summer has provided a strong critical review of such dubious offerings.[159]

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[157] Scarratt, Heggli, Vuust and Jespersen, 2022.

[158] Hanser, 2024.

[159] Summer, 1996.

Music can be part of ways of coping with some central and concrete health challenges, such as sleep difficulties, anxiety, stress, and depression. The books by Suzanne Hanser and Susan Mandel are grounded in research, and they give practical guidance by showing many of the approaches music therapists use when working with their clients. They describe processes of assessing symptoms and musical taste, choosing music, setting goals, considering the need for support and guidance, and valuing evaluation. When the music therapist is absent—as is the point in developing programmes for musical self-help—there must be a structured instructional framework that enables the individual to carry out this health-musical intervention independently.

In the book *Manage Your Stress and Pain Through Music*, it is shown how we may address stress and pain through music.[160] This is not, however, a musical quick fix. A high degree of personal effort is required. It is a structured programme in which one first maps and records pain and states of stress. One is asked to tune into the body and register and write down where the pain is felt, how strong it is, and so on. The same applies to musical taste. One must think through what one prefers to listen to, when, in what state, and how the music affects body, thoughts, and feelings.

Systematic reviews have been conducted of research in which people with chronic conditions administered their own music use, so-called self-administered music interventions (SAMIs). This show which factors influence whether such music use is successful. The users' personal qualities are important, such as attentiveness to one's own health state, the ability to identify and use the right music when needed, reflection on what the music has contributed—or what has not worked—and planning future music use.[161]

It is recommended that one create a personal plan for music use. The importance of breathing and breathing exercises in interplay with the music is emphasized. Music can be accompanied by massage, and one can use imagination to find peaceful images, as well as learn to focus on body and music. One may also use singing and recitation, songwriting, playing an instrument, and improvisation.

In another book on musical self-help, Hanser writes about themes such as anxiety, insomnia, calming oneself with music, self-affirmation through music,

[160] Hanser and Mandel, 2010.

[161] For details, see Pakdeesatitwara, Clark and Tamplin, 2025. https://doi.org/10.1080/17533015.2025.2539520

motivation, regulation of energies, creativity, and self-reflection.[162] Here too, strong personal effort is required in order to receive musical support in finding calm, relaxing, reducing anxiety, sleeping better, and exploring one's own psychological challenges.

The practical recommendations proposed describe how to compile playlists, for example with music that evokes emotions such as joy, peace, or sadness. Or how to create playlists that regulate us out of anger, frustration, and restlessness. Some playlists may aim to increase attention, perhaps as a help in the distraction society we now live in. Some playlists give energy, while others may be created to counter sleep problems. Still others may focus on providing supportive and self-affirming messages. The choice of genre is left to the individual.

The composition of playlists is based on the so-called "iso principle", or what today is called entrainment. This means beginning with music that reflects the mood one is in here and now. Then music is added that gradually shifts the mood and energy in the direction one desires. This means that physical movement, breathing, and emotional responses are synchronized with the music.

The lyrics in music may have a special significance for us, something well worth noticing. In situations where we are stressed, music and lyrics may stop the flow of negative thoughts and worries, prevent dysfunctional thought patterns, and interrupt the pessimistic rumination that creates a downward emotional spiral.

Here, self-affirming thoughts may be helpful, and one can create one's own self-affirming "jingles" that strengthen self-esteem. So-called "power songs", of which there are many in popular music, can be used to strengthen one's own sense of agency. Beyoncé's *Run the World* and Lady Gaga's *Born This Way* have been suggested. Other examples include *Truth Hurts* by Lizzo and *Flowers* by Miley Cyrus. Another form of self-affirmation lies in articulating what one wants to achieve, hopes for, is capable of, and believes in. This may form part of a process of self-reflection following an autobiographical exploration.

Hanser refers to research showing that singing or reciting mantras can lower blood pressure, reduce anxiety and depression, increase control over breathing, and create changes in brain waves.[163]There is much wisdom in older singing traditions and musical-cultural forms. In this context, we should also not forget how the other expressive arts therapies contribute ideas about how we may

[162] Hanser, 2024

[163] Hanser, 2024

regulate and stabilize emotions. Dance, movement, visual arts, drama, music, and other performative art forms are resources that can be used in everyday life to create the free space—or asylum—that we saw described by Tia DeNora.[164]Hanser also refers to research from dance therapy confirming positive effects on physiological processes, as well as on blood flow to the brain that helps build brain cells. She also describes the value of drum circles and mindful drumming, supported by research confirming positive effects on health.[165]

Musicality and Health

In the discussion of Hartmut Rosa's theory of resonance, we saw how many people experience the demands of working life for adaptation and increased productivity as exhausting. Music can be a resource in the work of recovering from experiences of being burned out.

Music education is a good investment when it comes to using music as a health resource. Yet there are still many people in society who define themselves as unmusical and who have not received support or music education either at school or in their leisure time. Attitudes toward, and knowledge about, what it means to be musical are important responsibilities for schools to address. The field of music therapy is built on the understanding that all human beings are musical, that musicality is something fundamentally human, and that musical activity is a right and therefore something everyone should have access to.

As we have seen, there are different ways of influencing one's health behaviour through the use of music. As I will elaborate in a later chapter on genres, instruments, and working methods in music therapy, music therapists use four main approaches to health-giving music use: musical performance, music listening, composition/songwriting, and improvisation.

In music therapy, a music therapist is always present to help, guide, and support the individual in achieving health. In connection with the everyday use of music to improve subjective health or regulate stress, anxiety, or mood, we must specify some of the musical strategies and emphasize the personal effort required to bring about changes in behaviour and lifestyle. Using music to

[164] DeNora, 2013.

[165] Hanser, 2024.

strengthen one's health requires planning, lifestyle choices, motivation, and perseverance to achieve the desired goals.

Musical Knowledge, Skills, and Performance

Learning to play an instrument may have lifelong consequences for activating cultural immunogens. Musical knowledge and skills may have lasting effects on self-esteem, self-perception, and the sense of mastery. Musical skills provide access to playing with others, performing one's identity, being part of musical communities, and creating a sense of belonging. Group singing, choirs, rock bands, orchestras, drum circles, and online group improvisation all provide opportunities for network-building and bridge-building between people. Long-term participation is an important source of resonance and meaningful experience.

Listening to Music

Listening to music offers opportunities for emotional regulation, increased energy, and rich aesthetic experiences. Developing musical references and shaping musical taste provides a strong basis for creating strategies of emotional regulation and for making playlists to be used in everyday health musicking. Through emotional and bodily experiences, listening to music can increase the feeling of vitality and contribute to a sense of well-being.

Musical Autobiography

Reflecting on one's musical history—the situations and experiences in which music has touched us or been part of life-changing circumstances—can be recorded in a musical autobiography. As discussed earlier, writing one's autobiography or telling the story of one's life through musical experiences can evoke memories of turning points in life. A musical autobiography helps create a sense of continuity, shape a meaningful lifeline, and contribute to sorting and understanding musical experiences.[166]

A Healthy, Virtuosic Musical Identity

[166] Disoteo, 2022.

When many people choose to define themselves as unmusical, this tells us that they confuse musicality with the polished performances of music in all genres that meet us in the media. It is easy to think that only those with innate talent and thousands of hours of practice can call themselves musical. Two music psychologists, Raymond MacDonald and Suvi Saarikallio, propose broadening our understanding of what they call a virtuosic musical identity. In this identity, no musical genres are excluded. The authors also recognize that there are specific forms of virtuosity in individuals with disabilities. This is meant to challenge our conceptions of virtuosity, which are often grounded in a form of ableism.[167]

It is the very concept of virtuosity that is being reshaped. Being virtuosic does not concern only technical and musical skills; the authors consider that far too narrow an understanding. Not everyone wishes to spend at least 10,000 hours of life reaching the level of technical skill associated with our greatest performers. There is a broader repertoire of skills that characterizes musical virtuosity. Greater emphasis is placed on the creative—on improvising and making music rather than reproducing music others have made. Social skills are to be promoted instead of an exclusive focus on technical skills. Thus, three elements are involved in this healthy virtuosic musical identity: social virtuosity, creative virtuosity, and technical virtuosity.

To be musically virtuosic involves social and relational competence, recognizing music's role in creating community among friends, in the family, at school, and in the neighbourhood. But of course, musical virtuosity also includes the ability to engage musically, to listen to music, perform for others, dance, and co-create.

No one should feel compelled to define themselves as unmusical or not good enough to participate in musical activity. A healthy musical identity should be connected to what music can contribute to general identity construction. This includes everything from personal growth to social relationships. MacDonald and Saarikallio advocate a broad approach to music education in which listening, group work, interdisciplinary projects, composition, making music videos, and putting music into dialogue with drama, the visual arts, and dance all belong.

In addition, a healthy musical identity should not concern only performing music, but also include talking about music, as well as writing and reflecting on it. This identity may also relate to the formation and maintenance of friendship groups, places of socialization, online engagement, and family relationships. Music education, they argue, should be decolonized, and the repertoire should reflect a

[167] MacDonald and Saarikallio, 2024.

diversity of genres. More important than performing music regularly is the experience that making music is satisfying and gives joy.[168]

Music has its basis in nonverbal communication, in intersubjectivity, and in social attachment—what we associate with communicative musicality.[169] Music's primary function is linked to these social-communicative and creative processes, and they form the basis for later musical production and technical skills. Technical virtuosity includes advanced motor coordination, precise musical perception, rhythmic and melodic attentiveness, and the ability to read notation. Using such technical skills to play and improvise with others brings technical ability into interaction with social and creative processes.

MacDonald and Saarikallio show how these integrated social, creative, and technical skills require competence in making choices. Anyone who has taken part in collective improvisation has felt how central the choice of musical responses and contributions is to the creative process. The authors connect these virtuosic skills with emotional competence. In this way, we can see how musicking can give identity to, and support, children and young people in their socio-emotional development.

[168] MacDonald and Saarikallio, 2024.

[169] Malloch and Trevarthen, 2009.

MUSIC THERAPY IN PRACTICE

2

Music Therapy in Practice

As outlined in the introduction, music therapists work across a wide range of practice areas. This chapter provides a more detailed description of these workplaces. Music therapists encounter children, adolescents, adults, and older people with diverse health challenges. Their work requires an understanding of users' needs and resources, as well as the ability to set appropriate therapeutic goals. The chapter also briefly introduces some central working methods.

Music therapists need broad, interdisciplinary knowledge, including developmental psychology, special education, mental health, and geriatric care. We will explore how they work with children and young people in preschool and school settings, supporting their development. In addition, music therapists work with adults facing challenges related to mental health, substance use, and criminal behaviour.

Some users present with somatic health conditions, which require knowledge of areas such as pain management, the relationship between music and the brain, and the role of music in neurological rehabilitation. The chapter also highlights research and evaluation that support music therapy practices. Finally, it discusses different assessment methods in music therapy and considers how mistakes on the part of the therapist may negatively affect the therapeutic process.

Music Therapy in School and in the Development of Children and Young People

Practice settings related to school and upbringing are central fields of work for music therapists on many countries. Work in these areas includes individual interventions aimed at pupils with special educational needs, as well as musical activities implemented as preventive environmental measures to improve classroom and school climates.

Music Therapy in Preschool and School

Many music therapists work in preschools, often with children who need support and adapted teaching. This practice arena must be understood broadly. Norwegian music therapists Mette Kalleberg and Lena Brennskag Nettum write that music therapists working in preschools come into contact with "children with somatic illnesses and sometimes palliative measures, families subject to child welfare interventions, pupils with mental ill-health, adolescents or parents with substance-related problems, traumatized children, pupils with various diagnoses and rare syndromes, attachment difficulties, and problems with regulation."[170] Many of these challenges will be addressed in this chapter. In addition, music-therapeutic approaches related to language, motor development, and hearing, as well as work with pupils with multiple disabilities and people on the autism spectrum, will be discussed later in the chapter.

Regarding the role of music therapists in preschools, Kalleberg and Nettum emphasize that all children who struggle need the positive experiences of mastery and the skills in communication and interaction that music therapists offer. Music therapy in preschools focuses on quality of life, meaning, inclusion, and diversity, and sees the value of bringing music therapy into children's developmental environments.[171]

Music therapists employed at pedagogical resource centers in different districts of Oslo, have provided a good illustration of how they work.[172] The principles guiding their work concern showing a fundamentally acknowledging attitude toward the children. This is expressed by listening closely to the child's forms of expression. Everything the child contributes is regarded as valuable in the attempt to create a

[170] Kalleberg and Nettum, 2024.
[171] Kalleberg and Nettum, 2024.
[172] Nettum, Thiedemann and Aagre, 2011.

shared repertoire of play. On this basis, themes of interaction are created in the interplay between therapist and child. This helps the child expand their competence in interaction. They mirror and imitate the child, catch the child's feelings, and share them with the child—what is referred to as affect attunement. Children with communication difficulties are allowed to feel safe in their space through a form of interaction grounded in the here-and-now situation.[173]

Music therapists are not necessarily concerned with guiding the child toward tasks defined by the adult. Rather, they find a more containing approach by attuning themselves to the child, by adjusting and adapting to the child's energy level, giving emotional responses, and mirroring movements and expressions. Play, spontaneity, and creativity are central in the work of developing autonomy and self-esteem. The ways in which they think and work are inspired by theorists such as Daniel Stern, Colwyn Trevarthen, and Donald Winnicott[174]

It is not, however, desirable that music education should be "therapeutized," with the consequences this would have for pupils with disabilities. These pupils obviously have a right to music education that is directed toward music-centered goals. Sometimes it is difficult to see when a music activity is therapy and when it is music teaching. The difference lies in the goal of the work and the context in which the musical activities occur.

In a new curriculum for compulsory and upper secondary school in Norway in 2019, new interdisciplinary themes were introduced. The theme "health and life mastery" had consequences for the music subject, and potentially also for music therapists, who may be useful in work related to this theme. In the new curriculum, we read the following:

> *In the subject of music, the interdisciplinary theme of public health and life mastery concerns the pupil's development of the ability to express themselves through playing, singing, other vocal expression, and dance. The community formed around music builds relationships between people, provides a sense of mastery, and contributes to a positive self-image, when the professional and aesthetic dimensions of music are safeguarded. Music is a resource for recognizing, putting into words, and handling thoughts and feelings, in both good times and difficult ones. Artistic expressions make it possible to understand both one's own and others' emotional lives more fully, and this provides a basis for good mental health.*[175]

[173] Nettum, Thiedemann and Aagre, 2011.
[174] Nettum, Thiedemann and Aagre, 2011.
[175] Curriculum in Music (MUS01-02). Norwegian Directorate for Education and Training, 2019.

Musical activities may be directed toward individuals, groups, the class, or the school environment as a whole. A holistic approach is important, one that is based on collaboration among music therapists and music educators, the pupils, classroom teachers, school leadership, parents, and resources from the local community.[176]

Work with the classroom climate itself is central. In a class marked by much noise, unrest, and bullying, composing a class song together with the pupils may help create better cohesion in the group.[177] In their book on community music therapy in schools, the music therapists and researchers Daphne Rickson and Katrina Skewes McFerran propose a range of projects that help individual pupils through participation in shared musical projects. Among the interventions they list are everything from music therapy for pupils experiencing loss and grief, to shared music projects in which music teachers lead drum groups during recess, hip-hop and dance programmes, talent competitions, band workshops, or girls' singing groups as a means of building social connections.[178]

Another important preventive measure is strengthening communal singing in schools. A Danish project called *Everyone Can Sing* has shown good results in strengthening classroom community, by creating a supportive environment as a protection against exclusion and bullying.[179] The *Everyone Can Sing* concept is built on the premise that everyone should feel safe in collective singing. Safety and well-being are the best and most natural foundation for choral singing, whether we are speaking of elite choirs or communal singing in the classroom. The choir is organized as a health-promoting offer for pupils in the first four years of primary school. All pupils are offered two additional hours of "class choir," not as a replacement for music education, but as an addition. This is intended to help the children become part of a safe class community in which enjoyment of school, social relations, and mental well-being are strengthened from the very first day.

The work of the class choir is organized according to a number of fixed principles. These point to the importance of co-teaching, that is, close collaboration between the classroom teacher and the choir leader. In each session, the pupils are assigned a new "choir buddy." They work together during choir lessons, and in this way the pupils develop social relationships with one another. Discipline is maintained through musical means, so that the lessons always begin and end calmly.

[176] Rickson and McFerran, 2014.
[177] Byrkjedal, 1992.
[178] Rickson and McFerran, 2014, p. 168–169.
[179] Bonde, 2024.

At the same time, the programme contains several performative elements. Classes perform for one another. In morning assemblies and concerts, they develop competencies in attentive presence. The song repertoire is developed collaboratively between teacher and choir leader and consists of traditional children's songs and pedagogical songs such as traffic songs, mathematics songs, and similar material.

Music Therapy in Lower and Upper Secondary School

Most music therapists employed in schools work with children with disabilities. In recent years, services have been established with a focus on preventing school dropout and school refusal at lower and upper secondary level. There are project-based initiatives directed toward young people at risk of dropping out, or who for various reasons do not thrive in everyday school life.

These services for vulnerable youth are carried out both individually and in groups, and build bridges between milieu therapy, pedagogy, and music therapy. Examples of activities include band work and ensemble playing, songwriting, and performance in concerts. From a music-therapeutic perspective, some of the goals of the practice are to strengthen relationships—both with school staff and with peers—and to create a free space for experiences of mastery and community.

On the website of the Norwegian Association for Music Therapy, the following is stated:

> *Although this field of work is relatively new, there are several studies showing the potential of music-therapeutic practices directed toward young people living in vulnerable life situations. Research has shown, among other things, that music therapy offers opportunities to strengthen self-expression, emotional communication, and social interaction in school and leisure time, and that music therapy can prevent violent episodes among adolescents in lower secondary school," as stated.*[180]

A project in Vestland County in Norway aims to use music therapy as part of the permanent pedagogical provision related to mental health. The intention is

[180] Quoted from https://www.musikkterapi.no/arbeidsfelt/2019/6/13/musikkterapi-i-skolen Access date 26.9.2025.

to use music therapy as a means of inclusion and to contribute to a positive school environment by creating alternative arenas for mastery and learning.[181]

Music Therapy in Work with Young People

In Norway, Professor Viggo Krüger in particular has done important work in showing the possibilities inherent in using music to reach young people in general, and especially in child welfare work.[182] As examples of music-therapeutic experience with young people, one may highlight his work in developing meeting places and forms of interaction and collaboration with youth.

Music therapy is now an established part of work with adolescents involved in child welfare services in Norway, as well as with young people facing health challenges related to substance use and mental health. Music therapists also contribute to broader youth work, where the aim is to create safe environments in which young people can express themselves, build self-confidence, and find meaningful channels for communication and community.

Young people's strong interest in music—whether learning an instrument or playing with others—offers powerful motivation for forming positive relationships with adults. This engagement, combined with their musical competence, including knowledge of genres and understanding of lyrics, creates rich opportunities for dialogue and connection.

Research shows that participation in music affects school students' emotional regulation, well-being, and social functioning, as well as self-confidence and mastery. Musical provision increases school engagement and contributes to the prevention of violent behaviour.[183]

Viggo Krüger and Professor of Education Astrid Strandbu have provided an overview of this work from a rights-based perspective. They pay particular attention to young people's close relationship to the many genres of popular music, and thus to music's significance for adolescent identity formation.[184]

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[181] From POLYFON'S homepage: https://www.uib.no/polyfon Access date 9.8. 2024.

[182] Krüger, 2009.

[183] Krüger et. al., 2024.

[184] Krüger and Strandbu, 2015.

The rights perspective means grounding musical provision in the rights of children and young people, as formulated in the United Nations Convention on the Rights of the Child. In 2003, this became part of Norwegian human rights law and is thus binding for Norwegian authorities. Many of the articles in the Convention refer to the child's right to participation, co-determination, the right to be heard in all matters concerning them, as well as the right to identity, rest, and leisure.[185]

The practice examples Krüger and Strandbu point to in this youth work range from rock bands as a means of creating belonging within a learning community, to the use of revue theatre as a framework for belonging and identity work. These activities are used as interventions for youth in child welfare, band activity within correctional services, work within substance-use care, or as interventions for refugees and asylum seekers. The concept of the music workshop is particularly fruitful as an arena and meeting place for young people in developing identity, a sense of mastery, community, and belonging. An important working method in these meeting places is songwriting. By formulating one's own lyrics and setting them to music, important reflections on one's own life take place, together with opportunities to express oneself and share this with others.

Music Therapy in Child Welfare

Music therapy as an approach within child welfare is developing, and today music therapy practice connected to child welfare services exists in the largest cities in Norway. The services consist of a combination of individual sessions in music workshops, band interaction, and other cultural activities. Many different working methods are used, such as songwriting, ensemble playing, improvisation, and performance.

Music therapists in child welfare work with a number of different target groups. Each user within the various target groups requires individual solutions adapted to their particular surroundings. Music therapists who work with families in child welfare focus, among other things, on the relationship between child and parent or guardian. They work with children and young people in foster homes and institutions, where music therapists will find methods that help create continuity in transitions such as moving from an institution to one's own home.[186] Music

[185] Krüger and Strandbu, 2015, p. 23–26; Krüger and Murphy, 2025.

[186] See Krüger, 2009, 2020.

therapy is an approach through which one works with communication skills and with helping young people become better equipped to enter into new relationships.[187]

Music Therapy with Children and Young People from Refugee Backgrounds

In recent years, music therapists have worked with groups of asylum seekers and refugee children in primary schools and reception centers. Music therapists working with immigrants, refugees, and asylum seekers adapt musical provision to participants from many different countries and in different life situations. Participants include children and families living in reception centers, unaccompanied minor asylum seekers, and adult immigrants attending adult education.

The working methods used change according to participants' wishes and needs, and vary from listening to band playing, play, and concerts. Because of language-related challenges, the activities must be easy to demonstrate to create a low threshold for participation.

On the website of the Norwegian Association for Music Therapy, we can read the following:

> *The services are offered to groups and organized close to where the participants live, such as in asylum reception centers or nearby community arts schools. Some music therapy services are organized as weekend workshops, where one of the tasks is to create positive experiences through play and musical mastery. Other services are weekly, which provides opportunities to work over a longer period, more coherently and sometimes more deeply with the same participants. The music therapist can then work directly with stress-related difficulties, such as sleep problems, unrest, and negative mood. In addition, they work with integration through collaboration with the local community. Music therapists can also work with integration by collaborating with local communities and by supervising, for example, community arts schoolteacher and musicians who work with the group.*[188]

[187] https://www.musikkterapi.no/arbeidsfelt/2019/5/27/musikkterapi-barn-og-unge

[188] https://www.musikkterapi.no/arbeidsfelt/2019/5/27/musikkterapi-barn-og-unge Access date 26.9.2025

Children are vulnerable and exposed after their experiences from their home countries and from the situation in which they now find themselves, often placed in a prolonged state of waiting. Music therapists have approached this work with different emphases. They work with resilience and inclusion through trauma-informed practice. They emphasize the participants' resources. The approach combines elements from resource-oriented, psychodynamic, and community music therapy thinking. Music therapists draw on trauma research and the theory of the window of tolerance.[189]

A good illustration of this work is provided by the music therapists Sofie Mortvedt and Ingrid Dyrnes Svendsen[190] Through the initiative *Music Workshop for Young Asylum Seekers* (MUA), they offered unaccompanied minor refugees a music programme lasting eight months. One special feature of this project was, among other things, that they collaborated with three professional musicians who had extensive knowledge of music from the children's home cultures. With the concept of home-country music, that is, "music from one's own or one's parents' home country," they had a tool for working with emotion and memory, maintaining self-confidence and collective identity.[191] Another reflective foundation for this work lies in a norm-critical awareness that aims to uncover conditions that block participation. It is important not to define refugees through their traumas, but to provide opportunities for them to define their own identities.[192]

Music Therapy with Children Experiencing Trauma-Related Difficulties

Children referred to CAMHS (Child and Adolescent Mental Health Services, outpatient clinic) will need an approach adapted to their own history and needs, to bodily reactions, and to experiences they cannot put into words, writes music therapist and researcher Gunn Karoline Fugle.[193] Children with trauma-related difficulties may have problems with attention and with regulating thoughts, feelings, body, behaviour, and social relationships. Symptoms of trauma-related difficulties may appear as behavioural problems, depression, anxiety,

[189] Interview with psychologist Dag Nordanger by Ingelill Eide, 2018, p. 24–26.

[190] Mortvedt, Svendsen, Karlsen and Stensæth, 2025.

[191] Karlsen, 2013, p. 162.

[192] Balansekunst, 2025.

[193] Fugle, et al. 2025.

concentration difficulties, bodily pain, self-harm, or dissociation. They may have less developed verbal language and struggle when asked to communicate experiences that have not been shared or given meaning.[194]

Play may be highlighted as having particular importance for music therapy with children and young people who have trauma-related difficulties. Children may have difficulty using words to describe what is troubling them. For psychologists, play and therapy are closely connected and have been well explored and communicated.[195] When the psychologists describe the role of play in development and therapy, they take as their point of departure play as a form of self-development, social development, and brain development. The concept of intersubjectivity is central in this understanding and refers to how the child's development of self takes place through a mutually shared world of action and meaning. Music therapist and psychologist Unni Tanum Johns has, in several works, shown how music-therapeutic methods have an important place in child therapy.[196]

Research shows that children coming to CAMHS need treatment that requires broad competence, and that music therapy adds several tools to treatment within interdisciplinary teamwork. In a study based on interviews with 11 therapists in interdisciplinary teams, the therapists reported that music therapy could help children with attention and emotional regulation, give them new opportunities to express their own stories, and strengthen interdisciplinary collaboration by adding new perspectives through a creative channel.[197]

Music Therapy with Complex Trauma

There are children who have been exposed to severe and complex trauma. Working with such cases requires specialist competence. Music therapist Unni Johns, who also has specialist training as a child psychologist, has described her work with an eleven-year-old boy.[198]

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[194] Fugle, et. al. 2025, p. 329.

[195] Stänicke, Johns and Landmark (Ed.), 2021.

[196] Johns, 2021, 2023; Fugle, 2012.

[197] Fugle, et. al. 2025.

[198] Johns, 2023.

The story illustrates a way of working in which Johns uses voice, song, listening, improvisation, and movement. The boy she meets has a refugee background and a dramatic history. The family experienced watching the mother drown during their flight, and the boy feels obliged to take care of his father, who is also deeply affected by what they have been through. Before leaving their home country, the boy had experienced the bombing of his village and had been mistreated by teachers at school. We are thus speaking of a complex trauma.

> *The boy is referred to the child psychologist, who in this case is also a music therapist. He has major concentration difficulties and fantasies that certain people in his head command him to do frightening things. In the first therapy session, he is frightened, confused, and worried about his father, who is now also being offered therapy. He speaks about his fear of teachers and his difficulties with schoolwork because of the images he has in his mind.*
>
> *In the next session, he is asked whether he has memories of good experiences from the time before he came to Norway. He recalls a swing outside the house. The therapist draws the swing, and in the following session the boy is encouraged to recall the pleasant bodily feeling that remembering it gave him. The therapist sings a song about sitting on the swing, and the boy spontaneously sits down on a soft ball in the room and begins to move rhythmically. The therapist uses a small harp, plays an oriental scale, and synchronizes the music with his movements.*
>
> *This ritual continues over the next sessions. The therapist accentuates the music more rhythmically and improvises on a text that orients the boy toward what is happening in the room. He begins to share more of his experiences of being controlled by the frightening images he carries within him. One day, a dramatic incident suddenly occurs at school. The boy jumps out of a window and cuts his arm. He remembers little of the event afterward, and the therapist improvises a narrative for him. While he relaxes to the music, now synchronized with his breathing, he realizes what has happened and tells the story of the event. He begins to open about his mother. His voice acquires a clearer emotional expression. Gradually, he moves out of the negative moods with the help of the improvised songs in the oriental scale.*
>
> *The boy begins cautiously to improvise on several instruments. A turn-taking develops between him and the therapist. The dramatic events are narrated through an operatic-like duet. The father too eventually takes part in these*

improvisations. The boy begins to do better at school, and he ends therapy with a sense of optimism.

The therapist has learned key words related to feelings in the language with which the client is most familiar, and how these words should be pronounced with a specific musical intonation. Knowledge of phenomena such as dissociation, affect integration, and the significance of intersubjective transactions forms part of the therapist's competence in trauma-focused therapy. As a music therapist, Johns has insight into and experience with how music helps to differentiate and express emotions.[199]

Music Therapy in the Community Arts School

Music therapists in the community arts school have varied responsibilities. Like many other music therapists, they work in the field of tension between pedagogy, special education, therapy, and care work. The community arts school can offer music education to pupils with learning difficulties, where instruction and mastery of an instrument are the goal, often in interaction with others.

At the same time, the work may be directed toward special educational tasks, where music is used to reach goals related to the development of basic learning prerequisites such as attention, concentration, motivation, turn-taking, and social development, as well as language and motor development.

The services of music therapists are often sold out to institutions outside the arts school, for example to elder care centers, preschools, schools, and asylum reception centers. This means that music therapists in the community arts school work with people of all ages and in many different life situations. Guidance and training of other professional groups who wish to use music in their work, as well as information work and assessment, are tasks that music therapists in the community arts school may undertake.

In this way, the music therapist may become a link between institutions and the local musical life—for example choirs, bands, dance groups, and so forth. This linking function entails responsibility for contributing to a change in attitudes in society regarding the rights of people with disabilities to participate in musical life.

[199] Summary after Johns, 2023.

Music therapists need to recognize the importance of integrating cultural and societal perspectives into their understanding of the roles and possibilities of music therapy. This requires a systemic approach. Individual interventions and adaptations may have limited impact if the family, local environment, and broader society are not included in the interactional processes necessary to achieve meaningful outcomes. Therefore, it is essential to consider the social, cultural, and structural conditions that shape individuals' lives and development.

Where the music therapist concentrates too one-sidedly on the "clinical reality" that unfolds within the music therapy room, inside an institution, one may forget that there is a larger reality out there that users encounter—and that often confronts them with exclusion and segregation. This systemic thinking is important for the development of community music therapy.

Music therapists possess methods for interaction across individual and cultural differences. This knowledge can be transferred to other interactive groups. Local cultural and musical life—the wind band and the choir—not only provides access to musical experience. It also manages symbols that include people in the local community. Musical life is a resource for network building and friendship, for belonging and social recognition. Precisely this symbolic responsibility gives cultural life a major obligation to include everyone. The mandate is clear: lower the threshold for participation.

Music Therapy in Special Educational Contexts

The field of special education is a central workplace for music therapists and includes children and young people with different disabilities and learning difficulties. This may involve pupils with sensory loss, visual and hearing difficulties, multiple disabilities, children with different syndromes and specific learning difficulties, or pupils with diagnoses on the autism spectrum. As we saw at the beginning of this chapter, music therapists working in preschools, or in clearly defined special educational contexts, will also meet children with mental health challenges or with somatic illnesses and rare diagnoses.

On the website of the *Norwegian Association for Music Therapy*, we read that many of these pupils have Individual Education Plans (IEPs). Some attend regular classes, some are in special classes, and others go to special schools. The text continues:

> *Music therapists in this field may work at the intersection of school, culture, and health. As a rule, they work with basic learning prerequisites such as attention, concentration, motivation, initiative, and mastery. The basis of the*

> *work is to promote experiences of belonging and acceptance. Social and musical interaction are the main focus. Communication is also a main area, and this includes both verbal communication with articulation and conceptual understanding, as well as non-verbal communication through breathing, gaze, and gestures.*[200]

It is further stated that music therapy takes place in both group sessions and individual sessions. Many collaborate with other professional groups such as physiotherapists, occupational therapists, educational-psychological services, and special educators. Guidance of assistants who accompany pupils during lessons is also an important task.

Meeting Vulnerable Children in Vulnerable Relationships

Therapists who work with the most vulnerable children are especially challenged in terms of their view of the human being. There is also a clear view of the person, certain values, and certain forms of work that underlie music-therapeutic work within special education. This concerns how we meet the children, how they are spoken about, and how we initiate good communication.

Taking as her point of departure encounters with children with multiple disabilities, the special educator Turid Horgen writes about how the cultural constructions and ways of understanding with which we meet the child are revealing of our view of the human being.[201] This may show itself in an objectification of people with disabilities that creates an *I–It* relationship to the child. Or we may set aside our cultural assumptions, look beyond diagnoses and functional limitations, and meet the child as a subject in an *I–Thou* relationship. It is the philosopher Martin Buber who stands behind this pair of concepts and the dialogical view of human relations they express.[202]

The music therapist Gro Elisabeth Hallan Tønsberg emphasizes the value of dialogical communication in work with children with pervasive functional impairments. She writes that "by speaking of 'vulnerable children in vulnerable relationships,' we shift the focus away from limitations in the individual—toward the relationship and the possibilities inherent in relational thinking."[203] Such a

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[200] https://www.musikkterapi.no/arbeidsfelt/2019/6/13/musikkterapi-i-skolen Access date 26.9.2025

[201] Horgen, 2010.

[202] See also Garred, 2006.

[203] Tønsberg, 2010, p. 42.

dialogical point of departure shifts the focus from the individual to the relationship. We do not speak primarily about the fact that "the child has communication difficulties," but are concerned with "the challenges involved in creating conditions for growth in communicative encounters and communicative processes."[204] This, in turn, means not primarily learning skills and forms of expression, but experiencing being listened to, being confirmed, and experiencing dignity.

A dialogical communicative relationship is reflected in musical improvisation, as a form of social being-together. Tønsberg refers to the philosopher of play and professor Kjetil Steinsholt, who sees improvisation as involving "saying yes to the other, touching and allowing oneself to be touched by the other, listening, following, and acknowledging the other's right to appear with their face and their expressions."[205]

Improvisation is, indeed, a central working method in music therapy, something to which we shall return several times. We will see that improvisation is connected to theories from infant research, developmental psychology, the theory of communicative musicality, and dialogical philosophy.

Goals, Working Methods, and Theories in Music Therapy

There are many theoretical contributions highlighting music therapy as a valuable educational tool. These emphasize the importance of providing children with experiences of mastery, as well as opportunities for musical and language stimulation. Additionally, music therapy is shown to promote social and communicative skills while supporting motor and emotional development, among other benefits.

The goals that music therapists set are shaped by several factors. First and foremost, they arise from encounters with the child, parents, and other professionals. They are also informed by diagnoses, assessment results, and the institutional culture in which the therapist works. In addition, the therapist's own theoretical and methodological knowledge, as well as their clinical experience, influence the selection of goals and methods. As discussed, the development of interaction, interplay, and communication represents a central area of focus for music therapists in special educational contexts. Other overarching goals include

[204] Tønsberg, 2010, p. 42

[205] Tønsberg, 2010, p. 48. See also Stensæth, 2008, 2010.

fostering a sense of mastery, facilitating positive here-and-now experiences, and supporting emotional regulation.

With their interest in child development, music therapists have sought support in developmental psychological theories. Since dialogue, interaction, relationship, and communication are central in music-therapeutic practice and theory-building, developmental psychology—as shaped by researchers such as Daniel Stern and Colwyn Trevarthen—has become a central source of theoretical inspiration. This theory emphasizes the importance of (social) interaction between the infant and the close adult, and how development is built through rhythms of interaction.

Studies of infant communication show that human interaction can be understood through metaphors borrowed from music. Concepts such as pulse, intensity, narrativity, rhythm, and synchrony are central in this perspective. These elements become particularly evident in imitation and turn-taking within musical interaction.

When music therapists repair disruptions in communication, they often rely on musical means. A warm, flexible, and supportive voice helps establish shared attention and frames experiences. In this way, the child comes to experience that their inner states can be shared, and that others can participate in them.

In what follows, we briefly discuss some important general methods and techniques used in music-therapeutic improvisation.

Some Central Working Methods and Principles in Music-Therapeutic Improvisation

In the tradition of Paul Nordoff and Clive Robbins, many music therapists use improvisation when working with children who require adapted approaches. Tom Næss, a music therapist and associate professor, received direct training from Nordoff and Robbins and has passed their improvisational methods on to students in many countries.

In the book *Sound and Growth*, Næss presents seven main principles in music-therapeutic work with children. These are as follows:

1. The child at the center. This means making use of the qualities and skills the pupil shows, all moods, and all kinds of responses
2. Protecting and developing initiative, for example by using pauses to provide space for the pupil's initiative

3. Stimulating the ability to attend.
4. Using the voice and electronic/digital aids
5. Giving the pupil an experience of interaction
6. Ensuring that the pupil succeeds. Using music to strengthen peak experiences
7. Supporting and preserving all impulses coming from the pupil and continuing and structuring the pupil's initiative.[206]

Central here is the communicative use of music and sound to evoke responses and create initiative in children with reduced motor and cognitive functioning. Through improvisation, one captures the child's attention and uses musical means that match the child's movements and sounds. By changing tempo and volume, singing directly to the child, and drawing out a response, one creates conditions for interaction and for the development of intentionality and initiative in the child.[207] These techniques form part of methods known as clinical or therapeutic improvisation.

Imitation

The music therapist and researcher Kjersti Johansson, in her work with children with multiple disabilities, points to several central working methods in therapeutic improvisation. These methods are also relevant in work with children facing different kinds of challenges. Imitating what the pupils can do and what they show belongs, for example, among the working methods and techniques music therapists use in order to establish contact with the pupils.[208]

It is a well-established principle in music therapy to meet children on the basis of their own conditions and perceptions. In therapeutic improvisation within the Nordoff-Robbins tradition, every initiative and expression shown by the child is received and acknowledged as part of an interaction already in progress.

Imitation is therefore a central music-therapeutic technique. It involves mirroring the child's movements, facial expressions, sounds, and bodily postures. Being attentive to such expressions is essential for establishing contact and initiating interaction. It is important to provide pupils with the experience that they can

[206] Næss, 1989, p. 13.

[207] Næss, 1986, 1989.

[208] Johansson, 2010.

influence their surroundings. Central to this is fostering a sense of intentionality in the pupil, enabling them to experience themselves as agents with ownership and authorship of their actions.

Music therapist and researcher Tamar Hadar has conducted an analysis of Paul Nordoff's improvisations with children with severe developmental disorders, with a particular focus on temporality. She has identified how three temporal techniques are especially prominent in the musical improvisations. The use of pauses stands out. Furthermore, the use of open harmonic structures serves to influence and vary the tempo of the musical interaction, as well as to create conditions for synchronized interplay through so-called "participatory discrepancies".[209]

Attunement and Regulation

Music therapists work with communication and affective attunement to make contact. This occurs through adapting oneself to the client's energy level, mood, affects, and emotional expressions. The contact becomes visible through musical expressions or in "the body's movements, posture, tensions, or facial expressions," as Johansson writes.[210]

Daniel Stern's theories of affective attunement and intersubjectivity are central in this context. In practice, these concepts are expressed through attention to cross-modal responses—for example, how a movement in the child's body is met with a corresponding musical response. The way the music therapist moves, sings, and plays in response to the child's initiatives is crucial to the process of attunement. This often involves exaggerating and repeating observable expressions so that the child can clearly perceive the intensity the therapist is attempting to mirror.

At times, however, it becomes desirable to regulate these expressions. Johansson relates this to Stern's concept of intentional misattunement, which involves deliberately overemphasizing or downplaying the mirroring of the client's intensity, timing, or mode of expression. Such an approach can be useful when the goal is to reduce heightened affect or, conversely, to stimulate increased engagement in the interaction. A range of improvisational techniques can support this regulatory process, including the use of pauses, disruptions of musical expectations, and the introduction of dissonance or surprise.

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[209] Hadar with Ken Aigen, 2024.

[210] Johansson, 2010, p. 28.

Shared Rhythm

Establishing a shared rhythm creates the basis for the sharing of affects and intersubjective experiences. Through the improvised approach to the child, the music therapist picks up the child's tempo and rhythm, uses imitation, and in this way synchronizes the interaction. The child is encouraged to follow the therapist's tempo, pulse, and rhythm. Johansson suggests here using signals from the body, by oneself marking the pulse in the music with bodily movement, or by catching and imitating the child's movements. Contact can also be created by taking the child's breathing as a starting point.[211]

Turn-Giving Signal

By a turn-giving signal, Johansson means "a signal that encourages the client to offer their utterance in the interaction. It is a signal that one has finished one's own contribution and is now waiting for the pupil's response."[212] Since the music therapist wishes to achieve reciprocal turn-taking, they use both voice, instruments, and other expressions to establish a dialogue. It is then important to give the child a clear signal that they should contribute to the interaction. This is achieved by stopping playing, using pauses, or playing a leading chord to invite a response. Here it is important to mark bodily what is expected.

The music therapist Anne Torø Eggen emphasizes the value of shared activity in work with children with severe disabilities.[213] She takes as her point of departure an understanding of communication in which interaction and interplay have reached a level where symbols and codes have developed. When communication occurs, it concerns intended actions, and the experience on both sides of sharing. Torø Eggen draws on the Danish music therapist Ulla Holck's concept of interaction themes. This concerns situations where the child's apparently random sounds or movements are picked up by the music therapist and placed within a musical context, for example as a recurring theme that the two can share and further develop in the improvisation. The child and therapist create a musical expression in which both participate. When this is perceived by both parties, an important development has occurred in the musical interaction. This is the basis of shared activity.[214]

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[211] Johansson, 2010.

[212] Johansson, 2010, p. 35.

[213] Eggen, 2010.

[214] Holck, 2019.

Experiences of Mastery

There are certain values and themes that has been central in music therapy from the very beginning. Experiences of mastery, a low threshold for participation, adapted challenge, and resource orientation are themes that recur in the literature. When music therapists explain aspects of music therapy that promote the client's experience of mastery, they refer to theories from psychology and special education.

The music therapist and researcher Ingeborg Nebelung has reviewed the literature addressing this topic and finds that it refers to social learning theory, positive psychology, and salutogenic thinking. Or to theories such as Maslow's hierarchy of needs, Bandura's concept of self-efficacy, Antonovsky's model of what helps keep us healthy, research on self-concept, and theoretical perspectives on the concept of relationship.[215]

People with Multiple Disabilities

The term multiple disabilities refer to a group of people who have serious and complex functional difficulties and several diagnoses. They may have severe cognitive impairment and difficulties perceiving and understanding what is happening in the world around them. This occurs together with motor, visual, and hearing impairments. Taken together, these impairments create major communication difficulties, which affect learning and the unfolding of life, as Horgen writes.[216] But we should not forget that, from a resource-oriented perspective, many of these individuals often have personalities that may be kind and humorous and can be spontaneous and creative in their interaction.[217]

Work with children with multiple disabilities is a central arena for music therapists. In the 1980s, the music therapists Tonhild Strand Hauge and Gro Elisabeth Hallan Tønsberg developed an approach to people with multiple disabilities based on a resource-oriented perspective. The contact created by sound and music formed the point of departure for a development-oriented practice that was presented in the book *Music, Sound, Movement. Tools for Establishing Basic Communication Skills*.[218]

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[215] Nebelung, 2016.

[216] Horgen, 2010, p. 7.

[217] Thanks to Karette Stensæth for this contribution.

[218] Hallan and Hauge, 1990.

Later, they also produced an analysis of musical elements in pre-verbal social interaction between congenitally deafblind children and sighted-hearing adults.[219]

One challenge in work with people with multiple disabilities is establishing contact and finding shared activities. Contact is a prerequisite for interaction, both musical and social. Kjersti Johansson emphasizes that attention to bodily expressions is important in interaction with people with multiple disabilities.[220] Johansson brings the children's bodily competence into the foreground and downplays a purely cognitive approach. Movements, breathing, touch, facial expression, bodily posture, and gaze become central elements in communication and in communicative music therapy. In this way, the approach to the child involves both bodily and musical channels.

Language and Speech Difficulties

The use of music to strengthen language and speech development in children is another central field of work for music therapists in special education. Many preschool children who need special follow-up have different forms of language difficulties.[221] These are children whose language development is delayed in relation to typical development.

Language and speech difficulties create challenges for children in terms of mutual play and social interaction. Later, this can in turn create difficulties with reading and writing. This increases the risk of acting-out behaviour and later psychological difficulties related to social anxiety and depression, writes the music therapist and associate professor Lise Lotte Ågedal.[222]

We distinguish between language difficulties and speech difficulties. Speech difficulties refer to difficulties in pronouncing speech sounds. Ågedal has researched how specially adapted singing can be used to improve children's pronunciation through music therapy. She has written a handbook on how song can be used to improve children's spoken language.[223]

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[219] Hauge and Tønsberg, 1998.

[220] Johansson, 2010, p. 23 ff

[221] Øvergaard, 2007.

[222] Ågedal, 2021, p. 10

[223] Ågedal, 2021, see also Ågedal, 2016.

Ågedal writes that speech sound disorders show themselves when children mix up the sounds in language. They may substitute one sound for another, as in phonological difficulties. Or they may have trouble pronouncing certain speech sounds, so-called articulation difficulties. Ågedal's song-based programme aims to improve diction (clarity of speech) and phonological processing, that is, getting the speech sounds into the correct order. In addition, she works with speech prosody, so that the child learns to speak with a more natural speech melody.[224]

Some children have general language difficulties caused by underlying factors related to cognitive, sensory, and neurological challenges. This occurs, for example, in children with intellectual disabilities or children with hearing difficulties. Specific language difficulties show themselves through articulation disorders or expressive language difficulties, where the child's ability to express themselves linguistically is below their general level of functioning. With receptive language difficulties, we are speaking of deficits in language comprehension. This may involve semantic difficulties, where children have problems learning and understanding new words.

Through songs and musical activities, music therapists stimulate general language development. They do so by drawing on music's attention-catching function and using repetition, concretizing concepts, providing stimulating sensory impressions, and creating an atmosphere of joy around the activities.

Music therapist Merete Lippert Tobiassen has described how she works with sound and the use of voice.[225] She notes that the concept of "language" can be divided into the three parts content, form/structure, and pragmatics. She works particularly with form and structure. Here, too, one distinguishes between three elements phonology, morphology, and syntax. Phonology describes how the sounds function in language, that is, the "sound" one produces. Morphology refers to how words are built up, how phonemes are organized. Syntax concerns how words are combined into larger units.

Most children with language difficulties face challenges in all these areas. For Tobiassen, it has been most natural to work with oral motor skills, expression, prosody, syllables, and imitation.[226] The pupils choose whether they want to use a microphone, and the music therapist has a repertoire of songs directed specifically toward the challenges and problems the pupils have.[227]

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[224] Ågedal, 2021, p. 9.

[225] Tobiassen, 2013.

[226] Tobiassen, 2013.

[227] Tobiassen, 2013.

People with Hearing Impairments

International pioneers in work with hearing-impaired children and young people have been Claus Bang in Denmark and Carol and Clive Robbins in the United States.[228] People with hearing impairments can derive personal enjoyment from music and music education, while musical activities may also form part of improving communicative ability.

When children with hearing loss gradually began to be offered cochlear implants, a need arose to stimulate the newly available sense of hearing. Music therapists could then offer activities that stimulated auditory perception and language development.[229]There are many musical activities designed to address challenges related to the perception of sound, text, rhythm, and melody, and so on. A good account of this work has been provided by the music therapist Kate Gfeller.[230]

As regards music listening among people with hearing loss who use hearing aids or cochlear implants, studies show that a large proportion still enjoy listening to music. This is the case even though they may have difficulty perceiving musical details such as melody and harmony, particularly in dense orchestral textures. Many report that music can sound distorted, out of tune, dissonant, or emotionally flat. Nevertheless, a surprisingly high number of hearing-impaired listeners continue to find music enjoyable. This is due in part to technological advances that help separate sound sources and clarify the auditory image.[231]

Music Therapy and Movement Stimulation

Collaboration between the music therapist and the physiotherapist to stimulate children's movement and motor development is an established interdisciplinary working method. Many music therapists, in collaboration with physiotherapists, have developed special programmes to stimulate children's movement.[232]

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[228] Robbins and Robbins, 1980; Bang, 1998.

[229] Koestler-Meier, 2005.

[230] Gfeller, 2011.

[231] McFerran and Lotter, 2024.

[232] Music therapist and associate professor Tom Næss has adapted the music therapy methodology and created a program to combine music and movements in water. See also Næss, 1990, 1998, 2003.

An illustrative example is found in the work of a physiotherapist and a music therapist with children with extensive disabilities.[233] These are children without verbal language who are unable to move without assistance. The therapists choose to use the term stimulation rather than training. They want to avoid a language in which children with disabilities spend their whole lives meeting professionals who are going to "train" them. They place great emphasis on reflection in encounters with other professions, with awareness that every profession contains different paradigms, scientific traditions, and value systems. To develop interdisciplinary knowledge means gaining insight into one's own limitations, a form of formation that presupposes reflection, openness, and recognition of difference. The aim is to create a synergy of knowledge in which the expertise of different professionals is clarified, shared, and applied.

Physiotherapist Bente Aars approaches the body from a phenomenological tradition we know from the French philosopher Merleau-Ponty. This philosophy shows how the body must be considered when we seek to understand how we interpret the world around us. It is easy to adopt an instrumental mode of thought in the role of physiotherapist, in which the body appears as an object to be treated. This is why stimulate is a better concept than train. Together with the music therapist Kari Aftret, who accompanies the movements, they create attention, expectations, and a positive atmosphere. Through the music, they structure the process and create good transitions between activities. Both the music therapist and the physiotherapist are concerned with how they sensitively adapt to one another. They call their collaboration Music and Movement. The concept of movement offers a broader and more open understanding, without the connotations of therapy and exercises.[234]

People with Pervasive Developmental Disorders

Music therapy with children with pervasive developmental disorders or autism spectrum conditions is a central field of work in music therapy. In the diagnostic systems, this category includes many subgroups. Among these we find atypical autism, Rett syndrome, other childhood disintegrative disorders, overactivity disorder associated with intellectual disability and stereotyped movements, Asperger syndrome, and others.

[233] Aftret and Aars, 2012.

[234] Aftret and Aars, 2012.

The Autism Spectrum

Within the international music therapy literature, music therapy with people with autism—or autistic people, as many also prefer to describe themselves—has received a great deal of attention. The reason for this is that one has wanted to use a communicative channel with children and young people who do not show ordinary forms of contact and communication. The ways in which music therapists have approached this group have varied.

There is great variation within the autism spectrum. The diagnostic manual DSM-5 classifies autism according to three defining characteristics:

1. difficulties related to social communication,
2. restrictive patterns of activities and interests, and
3. symptoms that appear early in childhood, but do not become clearly visible until social demands challenge the child.

It is now no longer considered appropriate to say people with autism, as we were previously encouraged to do. Autism is not something one has, but something one is. Autistic people wish to say I am autistic—not I have autism. According to music therapist Gustavo Gattino, this is something most people within the autism community agree on.[235] This new terminology reflects research related to neurodiversity. This refers to the fact that there are normal variations in the human brain regarding learning, attention, sociability, mood, and other functions. Neurodiversity is a biological fact. The theory emphasizes that the idea of a "normal" brain is a culturally produced fiction.

Autistic people are not ill; their brains simply function differently from those of neurotypical individuals. They may respond differently to certain experiences and stimuli compared with others. Communication and social interaction can be challenging and understanding how other people think and feel may not come naturally. Bright lights, loud sounds, or crowded environments can feel overwhelming and stressful, and unfamiliar situations may trigger anxiety. Autistic people may also need more time to process information and may continue certain behaviours or thought patterns even in situations where change is expected or desired.[236]

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[235] Gattino, 2022.

[236] This makes it problematic to speak of "autism spectrum disorder", as it is termed in diagnostic manuals. "Disorder" becomes incorrect here, even if it probably still will take time to change language practice when we communicate from the field. Common terms are still "autistic spectrum" (Autism Spectrum Disorder – ASD) or "autistic condition" (Autism Spectrum Condition – AEC). Aspergers Syndrome is also used for autistic people with average or over average intelligence, even if this diagnosis no longer is included in diagnostic manuals such as DSM-V or ICD-11.

Gattino has described how music therapists have worked with autistic people from the 1960s to the present day. He highlights the following tendencies: Nordoff and Robbins, with the method of Creative Music Therapy, have provided an important impulse in music therapy work with autistic individuals. Their improvisation-based approach remains relevant. Gattino writes that there is a growing tendency to use a family-centred approach. He also writes that more and more practitioners are becoming interested in behavioural approaches. This is, however, a controversial topic in the autism debate. Not least, the literature shows an increasing interest in emphasizing autistic culture and identity. Music-therapeutic methods are being increasingly standardized from a global perspective, and there is a general increase in interest in using music therapy with autistic people.

Gattino highlights some essential general aspects in work with autistic people. He points to the importance of cultural respect and sensitivity, and the importance of treating autistic people as individuals, with all the variation this entails within the autism spectrum. Not least, he shows how different treatment approaches and theoretical models will affect, for example, strategies for assessment.[237]

Goals

In general, for many groups of people with disabilities or impairments, there are different views concerning the diagnoses applied to the individual. This will, of course, influence the goals one has for the work. For example, the biomedical model links autism to an abnormal condition, to something that should be treated and rehabilitated so that normality may be achieved as far as possible. As Gattino points out, this model creates inequality in a power relation in which professions and specialists make decisions on behalf of clients.[238]

Within the social model, autism may be understood based on human variation, in the same way that people differ from one another based on ethnicity, sexual orientation, or social class. Social norms can easily place autistic people in a situation where a sense of otherness is produced. That said, it should be remembered that many people affected by autism will feel protected by a diagnosis. Not least, they may receive the educational and psychosocial support to which they are entitled. It should also be added that many autistic people feel that they do not get the access to mental health support they want.[239]

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[237] Gattino, 2022.

[238] Gattino, 2022.

[239] Nilssen, 2022.

Traditionally, music therapists have aimed to promote the development of communication skills in work with autistic people. This includes speech production and expressive language, as well as intonation and fluency in speech. They have also worked with echolalia and repetitive language, receptive language, imitation and powers of observation, as well as eye contact.

Other goals of music therapy are related to social skills, such as appropriate and active participation, turn-taking and sharing, as well as the establishment of relationships and play. Cognitive goals have included identifying situations and making choices, strengthening memory, training categorization, increasing attention, and engaging in creative activity.

Music therapists also work with specifically musical goals in autism work, Gattino writes. This involves responding to music and developing the ability to take in instruction. The training of motor skills, the stimulation of sensory functions, and the improvement of self-perception have also been goals of music therapy. This is in addition to rehabilitative tasks that support the transition to adult life, the development of ego boundaries, and self-realization.[240]

Regarding social communication, this refers to difficulties connected to non-verbal communication and social reciprocity. There may be challenges related to initiating, responding to social signals, and maintaining conversations, sharing interests and attention, as well as emotions and affects. Problems with non-verbal communication involve difficulties with eye contact, facial expression, sign language or gesture, or integrating verbal and non-verbal behaviour.[241] Social reciprocity becomes visible in situations where one shows interest in other children and participates in play.

A Note on Stimming, Culture, and Identity

With regard to the second diagnostic criterion, this concerns stereotyped movements such as stimming. This means self-stimulatory movements or sounds and repetitive speech, the insistence on doing the same thing. It may also involve having specific and fixed interests, as well as hyper- or hypoactivity in response to sensory input, or an unusual interest in particular sensory impressions in the environment.

[240] Gattino 2022, p. 36–37.

[241] Gattino, 2022, p. 23.

Stimming is defined as self-stimulatory behaviour, such as repetitions of movements and sounds. There are several examples in the work of Paul Nordoff and Clive Robbins of music therapy with autistic children in which self-stimulatory behaviour is used as a starting point. Music therapy here is about achieving contact through music. I would argue, however, that we must ask whether the musical approach takes place within a medical framework of thought, where stimming breaks with norms of normality, and where music therapists wish to remove such repetitive and self-stimulatory expressions. Or whether stimming is regarded as a legitimate expression of autistic culture and ways of being and is thus met with supportive musical responses.

How stimming is understood has been described by music therapist Katja Gottschewski.[242] On the basis of personal experience with autism, she has shown how stimming must be understood as a cultural phenomenon and expression, not as behaviour to be suppressed or "normalized." Music therapists have encountered stimming as a form of communication. But we are not certain that the intentions have always been the right ones, or whether this has taken place within a medical or cultural understanding. Music therapists must acknowledge this behaviour as a form of communication and learn this communicative form, Gottschewski emphasizes.

A Broad Spectrum

There is great breadth within the autistic spectrum, and cognitive abilities play a decisive role in relation to the capacity for communication. This means that autistic people with average or above-average intelligence may have strong verbal abilities.

This particularly affects the goals we set for music therapy. The goals may be general and long-term, or formulated as more gradual objectives on the way toward an eventual endpoint of therapy. When autism within a medical model is described as a deviation from normal development, the goals will concern removing symptoms, improving functions, or increasing brain connectivity.

From the perspective of neurodiversity, however, it is natural that autistic people themselves should help decide what the therapy is to achieve. One question is whether so-called ableism[243] is the right perspective when goals are formulated

[242] Gottschewski, 2019, 2022.

[243] Ableism' refers to discrimination against disabled people or people who are different in one way or another.

that imply development measured against a norm, and where people with disabilities are to be "fixed" in some way.

Working Methods

Gattino lists a range of different approaches within autism work.[244] Improvisation seems to be the most widely used working method. The behavioural approach is based on how music reinforces behaviour. The method uses procedures that reinforce behaviour one wishes to promote, weaken unwanted behaviour, strengthen prosocial behaviour, and contribute to language development, among other things.

Neurologic Music Therapy, developed by Michael Thaut, builds further on the behavioural paradigm, with an expanded theoretical understanding and evidence drawn from neurology and brain research. He works with clear behavioural goals and references to music-accompanied activities based on neurological reasoning. A variant of this approach for autistic people is found in a model developed by LaGasse, a so-called neurodevelopmental approach. There is a clear protocol for this work. It includes sessions in which one works systematically with activities intended to promote engagement, sensory organization, cognitive, motor, and socio-communicative skills. The theoretical foundation draws, among other things, on hypotheses about neuroplasticity, Gattino reports.

Gattino also points to models based on parental guidance, community music therapy initiatives, as well as counselling models and general special educational measures aimed at collaboration with other professions in work with autistic people. Several of these collaborative models include parental guidance using model behaviour. An example of a community music therapy approach is found in the work of the Brazilian music therapist André Brandalise, who stages musicals and performances involving autistic people. The different approaches are shaped according to whether they address children, adolescents, or adults in different positions within the autistic spectrum.

The most recent contribution to the understanding of autism points to how important it is to consider the autistic person's identity and cultural background.

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[244] Gattino, 2022.

Music Therapy in Medical Contexts

Music therapists work in several settings within somatic medicine, with all age groups and a range of medical conditions. We find music therapists in oncology wards and pediatric wards, in work with infants and premature babies. Music therapy is offered in neurological rehabilitation, to patients with respiratory problems such as COPD and asthma, and to calm patients during medical procedures, before, during, and after surgery.[245]

Music therapy in medical contexts, also called medical music therapy, includes the use of music in the care of people whose primary problem is medical. Even though this medical problem is the reason music therapy is brought into treatment, the clinical needs are complex. They concern physiological, psychological, social, cognitive, and spiritual needs, or more generally the enhancement of the patients' quality of life.[246]

This kind of music therapy differs from other uses of music within medicine, known as music medicine. The difference between the two approaches is that in medical music therapy there is always a music therapist present when the music is offered, whereas in music medicine there often is not. Research has shown that the relational dimension that arises between therapist and patient has great significance for the outcome of therapy.

On the website of the Norwegian Association for Music Therapy, the following is stated:

> *Music therapy in hospitals has an overall goal of optimizing physical and mental health for patients admitted to hospital with somatic illness, and is offered as supportive therapy within interdisciplinary and medical treatment. The work is based on international research and takes a holistic view of health as its point of departure. The music therapist works both preventively and problem-oriented, with a focus on medical, psychosocial, and milieu-therapeutic aspects.*
>
> *The music therapist primarily offers individually adapted music therapy in the patient's room, but also works with groups and milieu-oriented activities in the hospital's shared spaces. In individual follow-up, the music therapist takes the patient's situation and needs as a point of departure. Space is made for*

[245] Dileo, 2015.

[246] Dileo, 2015.

different music activities and interventions, with a focus on positive experiences through music listening, relaxation, interaction, songwriting, or composition within a therapeutic relationship. Music therapy has different goals in different phases of treatment; for example, creating safety, predictability, and well-being, or supporting the patient in coping with specific symptoms such as pain or nausea.[247]

Music Therapy in Paediatric and Adolescent Wards

Music therapists have been admitted into various departments in somatic hospitals, often in work with children. Here, music therapy is offered to premature infants and their parents. In many hospitals, music therapists work by performing music in the hospital environment, and by giving individual support to children with serious diagnoses. A central part of this work is connected to support during medical procedures.

Music Therapy with Infants and Premature Babies

Music therapists have gained access to neonatal intensive care units. Music therapy with premature babies takes as its point of departure the stimulation of early interaction between the infant and caregivers. If we go back in time, it used to be common for small children to be left in hospital without close contact with parents or other caregivers. Psychological research on attachment documented that many were traumatized by such separation, as the music therapists Ullsten, Söderström Garden, and Mangersnes write.[248] This could shape later development and life. Today, routines have changed, and it is now common for parents to stay continuously with children who must be hospitalized, sometimes for long periods. In work with these children, one therefore speaks of family-centred care.[249]

An important point of departure for this work is the knowledge of how infants feel pain, something that was previously not acknowledged. Pain inflicted on infants has harmful consequences for children's development and can create trauma related to hospital and treatment. Negative experiences affect brain development.

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[247] https://www.musikkterapi.no/arbeidsfelt/2019/6/13/musikkterapi-p-sykehus Access date 21.9.2025

[248] Ullsten, Söderström Garden and Mangersnes, 2020.

[249] Ullsten, Söderström Garden and Mangersnes, 2020.

A rich and stimulating musical environment can have positive long-term effects on the infant's neurological structure and brain chemistry.[250]

Attachment theories provide a strong rationale for not isolating the child. Other theories also shape today's approach to premature infants. In an article, the music therapists Ullsten, Söderström Garden, and Mangersnes mention how they take account of transactional models of development, the importance of mentalization as a basis for sensitive care and psychological preparation for becoming parents, and how the maternal role requires a particular psychological orientation, as in Daniel Stern's theory of the motherhood constellation.[251]

It is important to understand how infants have an innate capacity for social interaction and communication. The expression "communicative musicality" (see later) refers to a concept of music and how musical care from emotionally available adults may help the child develop the ability to self-regulate. Music and caregivers contribute by providing regulatory support, something that is important considering the theory of the "window of tolerance" (see later).

Music therapists must develop a trusting relationship with both the child and the caregivers. They encourage the use of the family's own song repertoire or the learning of new songs. Singing is to be used in giving care, communicating with, and building safe relationships with the child. This work requires cultural and musical sensitivity. The therapist must adapt to and promote the musical resources and repertoire that the family carries with it as part of its tradition. At the same time, it is emphasized that the voice is a primary source of attachment to the child, alongside eye contact, touch, smell, taste, and movement.

Music therapists can play a special role when infants undergo medical procedures. These create pain for the child, as well as stress and anxiety for the caregivers, which in turn can affect the child.

Music Therapy in Medical Procedures

Music therapy is a support for children undergoing medical procedures. Such procedures include blood tests (needle sticks), wound care and changing of dressings, stem cell treatment (bone marrow transplantation), or when scans of the body or head are carried out. These require the child to remain completely

[250] Ullsten, Söderström Garden and Mangersnes, 2020.

[251] Ullsten, Söderström Garden and Mangersnes, 2020.

still. It is easy to imagine that such procedures create stress, anxiety, and pain. The following example illustrates this work:

> *Mother and father are referred to music therapy because they are very anxious about the upcoming birth. When it turns out that the child is born prematurely, and in addition with a serious condition (giant omphalocele) that will require several operations, the music therapist enters a collaboration with the family over several months.*
>
> *The illness requires that the child's dressing be changed every day. This is painful for the child, and the parents experience anxiety and stress. The parents are encouraged to create a comfort song that they can use during dressing changes. They are told how important it is for the child to hear the parents' voices through the song. Singing this song will reduce the mother's anxiety and provide better bodily contact in the period immediately after birth. The song helps the child experience safety in the situation, since the voices will be familiar from the time in the womb.*
>
> *The song they compose together with the music therapist is placed in a low register, in a stepwise descending movement. This is done in order to create a calming and peaceful atmosphere. The therapist also adds some gentle guitar playing and humming. This is adapted to situations that require conversation during the wound-care procedure. The purpose of the song is that it should be used as receptive music therapy for everyone involved—the child, the parents, the nurses, and the doctors.*[252]

The music therapy in this example was designed as support for the procedures surrounding dressing changes. The music therapist sees the need to consider physiological, psychological, emotional, interpersonal, and environmental aspects of this care situation. She evaluates the right moment to let the parents begin singing and when she herself should offer music that is more supportive. She must also assess when there is a need simply to sing on vowels or hum, or when just breathing or guitar playing is enough.

The music therapist considers how the music helps create a bond with the child. The music is to be part of the family's culture and self-expression. She must ensure that the music does not interfere disruptively with the medical procedures. She also sees to it that the music neutralizes the noise in the room. Eventually, the mother takes over the role of changing the dressings. She does this while singing.

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[252] Summary after Andonian, 2023.

The comfort song thus becomes not only a way of creating a less stressful situation for the child. It becomes equally a care song for the parents themselves.

The procedure begins ten minutes before the dressing change itself. Here, the music therapist sings the song together with the mother while everything is prepared for the wound-care procedure. The therapist improvises music adapted to the situation. She calms those present by humming and playing open chords. This period before the procedure itself begins is particularly important. The music becomes a signal to the doctors and nurses that they are ready to begin.[253]

Procedural Pain

Children in hospital may already have experienced an accident or have felt pain and discomfort related to illness. They are anxious, which easily increases the pain experience. The youngest children will not always understand the purpose of these procedures, which creates further insecurity. Even the smallest procedures create feelings of unsafety. Safety, support, comfort, and strengthened self-esteem become important goals of music therapy.[254]

Research shows that so-called procedural pain is what children in hospital experience as most stressful.[255] At the same time, procedural pain, unlike acute pain, is something that it is possible to control. Music therapist Joanne Loewy describes how the music therapist creates an integrated approach. This means involving the patient in procedures that include relaxation, breathing, singing, and playing instruments in a way that builds self-confidence and trust in others.[256]

Research and experience indicate that music therapy helps the child cooperate better during such procedures, Loewy writes. The child experiences that the time passes more quickly, that they feel less anxious about repeating such procedures in the future, and that there is less risk of developing symptoms of traumatic stress.[257] This requires the music therapist to collaborate with the child and possibly the family before, during, and after the procedure.

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[253] Andonian, 2023.

[254] Ullsten a. al., 2018.

[255] Loewy, 2019, p. 57; see also Ullsten a. al., 2017.

[256] Loewy, 2019, p. 57.

[257] See more in Mellingen, 2020.

The therapist uses live music, improvises, and sings familiar songs for the child. This engages the child over a longer span of time than if prerecorded music were used. Through improvisation, the child is invited to participate in the music and contribute with their own creativity. By making use of musical means such as rhythm, one can engage the child in interaction. Through entrainment, synchronization with physiological rhythms arises, helping to remove the focus from the pain.

Distraction or Integration

When musical interventions have a relieving function in procedural pain, it is natural to think that the effect is due to distraction. That is, thoughts and attention are drawn away from the procedure. This well-intentioned attempt to divert the child from impending pain may, however, be experienced as manipulative, Joanne Loewy writes. Even though there is much documentation of positive effects from such an approach, Loewy believes that a critical review is necessary. An approach based on distraction may indeed be one possible choice, but not necessarily something to be taken for granted. Nor should one automatically assume that the parents' presence is always positive for the child. If the parents are stressed, their anxiety can easily be transferred to the child.

The experience of pain may be reduced by distracting the child. Here, tools such as cards, toys, ice, relaxation techniques, or pets are used. Loewy wants to bring these means into an *integrative approach* that she believes has strength and durability. She refers to several studies in which music used as distraction has had good effects. However, she argues that, with an integrative approach, a combination of prerecorded and live music gives a stronger experience of support. This is especially the case when singing is used and when one adapts to needs that arise in the moment.[258]

Loewy writes that by informing patients about techniques for building resilience, one can guide them through painful procedures. By making children attentive to elements in the music, they can be accompanied through the procedures with minimal or no pain. They are not merely distracted; rather, they acquire a new competence that can be transferred to other potentially stressful procedures—what Loewy calls healthy coping behaviour.[259]

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258 Loewy, 2019, p. 59.

259 Loewy refers to a definition: "Procedural support in music therapy is the interactive use of music by a board-certified music therapist during an intensive or painful medical procedure; the music is designed to specifically address a patient's need including reducing anxiety and pain perception, and to encourage healthy coping behaviours". Loewy, 2019, p. 59.

The sociologist of music Tia DeNora has analyzed music therapist Jane Edwards's work with pain relief for a boy with severe burns who must undergo a very demanding treatment. DeNora points to how the music helps to frame the situation. This happens through the transformation of roles, therapeutic relationships, neuropsychological changes, and not least the boy's identification with the aesthetic material of the music itself. The purpose of the analysis is to show how a musical experience transforms bodily states and perceptions. The situation creates new conditions for redefining expectations concerning the treatment. This gives the boy new resources.[260] Such an interpretation shows that many factors come into play when music therapy is used in such procedures.

Milieu-Oriented and Individually Adapted Music Therapy

Some children must spend weeks, months, perhaps years in hospital wards, and some remain in isolation for long periods. These are children receiving intensive medical care. They undergo surgery, receive bone marrow transplants, or must undergo chemotherapy. Their daily life becomes shaped by illness, and they learn a language of blood values and prognoses.

For these children, there may be little opportunity for other experiences, little room to express what it is like to live day by day in a medically technological environment. The sick role can easily become dominant. Dreams, hope, and a different experience of self are easily pushed into the background.

The Children's Clinic at Oslo University Hospital has had a music therapy service since the 1990s.[261] Music therapists in pediatric wards have several roles and functions. They do not work only in the hospital room or therapy room with individual patients but also create music in common spaces that activates and engages patients and relatives.

When the music therapist moves out of the hospital room and engages with the hospital environment, we may, with Professor of Music and Health Trygve Aasgaard as a Norwegian pioneer in music in pediatrics, speak of a form of music milieu therapy. He defines this as follows: "Music therapy is a systematic

[260] DeNora, 2013.

[261] Blichfeldt-Ærø and Aasgaard, 2011.

process in which music is used to promote health in a defined environment within or outside institutions."[262] Musical interaction with the music therapist in the common spaces helps strengthen the experience of safety in the hospital environment, both for the child and for the family. The musical milieu therapy is thus directed not only toward increasing the patients' quality of life, but also toward improving the quality of the hospital environment.

There are many aspects of the hospital environment with which music therapists engage. This may concern time and space, or physical, social, and symbolic aspects of the environment.[263] Music therapists influence the experience of time through regular singing and music groups in the ward, or by marching through the corridors while playing, followed by a trail of musicians and relatives. The hospital has its own institutional rhythm, which is influenced by musical activities and new rituals that break up daily routines.

The physical space may easily be experienced as impersonal and may create distance between the children and the staff. Through shared music-making, new relationships arise, social distance decreases, and there is room for close relationships. Music gatherings become meeting points for social interaction. Here, children, siblings, and parents come together and forget the sick role for a while. Parents may experience a welcome break in the waiting time. A sister or brother may suddenly take on a new role and receive attention as a participant in the music.

Music therapists can create awareness of the sound environment in the institution. We say of people in institutions that they easily become a captive audience.[264] They have, in other words, no possibility of escaping from a sound environment characterized by the technical equipment necessary in modern medical treatment. Or they may be troubled by sounds, voices, and shouting coming from other people. In some places, the sound comes in the form of background music, a radio, or a television left on. Here, the music therapist can take responsibility for creating a better sound environment.

When it comes to the symbolic aspects of the environment, this refers among other things to the cultures, values, social norms, and role expectations that shape the institution and the patients.[265] By sharing musical experiences, music

[262] Aasgaard 1998, p. 168. See also Aasgaard, 1999, 2004.

[263] Aasgaard, 1999, p. 35ff.

[264] Kittay, 2008.

[265] See also Aasgaard, 2004.

therapy leaves its mark on the environment. Participation in musical activities reduces the distance between medical authorities and the patients. Through music, the children experience a new role, now as musicians and perhaps as songwriters. They are no longer identified only based on their diagnosis.

Individual Approach

The music therapists Stine Camilla Blichfeldt-Ærø and Trygve Aasgaard write that the work in question differs in many ways from other practice arenas in which music therapists work. This is visible in the children's illnesses and in the treatment they receive in wards for children with serious somatic disorders.[266] The music therapist encounters children who, in a short time, have become seriously or life-threateningly ill. They may suddenly have an acute need for extensive medical treatment and care. They experience pain, discomfort, and various dysfunctions. They must undergo painful procedures and are exposed to social isolation. They may experience changes in body image, and may feel uncertainty, anxiety, and boredom. The family is affected by relational challenges, and the child risks losing contact with friends and classmates.

By allowing the children to speak about their own situation, and by the music therapist setting their poems and verses to music, a free space is created. They no longer have only the identity of the sick person. In addition to experiencing a brief breathing space from illness, they experience themselves as authors, storytellers, small composers, and musicians. Through telling their own situation, they create concrete and symbolic expressions that can be shared by others. Not least, the family gets to see a new side of the child.[267] The music therapists create opportunities for experiences of mastery. They help process painful experiences, something that is important when the child must undergo necessary medical procedures.

Family-Centered Music Therapy

It is always necessary to take account of family and siblings when an individual child receives health services. Family must here be understood to include not only the child's biological parents, but also grandparents, aunts and uncles, foster parents, adoptive parents, gender-diverse families, and family constellations

[266] Blichfeldt-Ærø and Aasgaard, 2011, p. 145.

[267] Aasgaard, 1996a, b.

included under the collective term rainbow families (lesbian, bisexual, gay, and transgender parents). Not least, it is important to attend to the needs of the child's siblings. They sometimes experience that they have lost attention in a situation where the sick child takes all the focus of parents and the rest of the family.

The shared musical activities in pediatric wards are open to the siblings of children undergoing treatment. For many, it is desirable that the service be extended to include home visits from music therapists. This may happen within the framework of so-called Advanced Home Hospital Care.[268]

Music and the Relief of Pain, Stress, and Anxiety

Music and the role of the music therapist in pain treatment are important topics for both practice and research in connection with medical procedures and other conditions in which pain is experienced. Music therapists who are to work with pain relief should have knowledge of what causes pain and of the role they can play in alleviating it. As music therapist and researcher Joanne Lowey remarks, they should know something about different types of pain, theories of pain, how pain is evaluated, what pain history the patient brings with them, as well as research and practice related to the role of music in pain relief.[269]

I wrote about pain in Chapter 1 on music and public health. Here it is repeated that newer theories of pain are significant for how music and music therapy influence the experience of pain. The theory goes under the name neuromatrix. Here, pain is linked to activity in a network in which several regions of the brain are involved.[270] This again means that pain arises in a complex interaction among many areas of the brain, in which genetics, culture, and learning play a role.[271] This theory supports the integrative use of music in medical procedures. It opens for the possibility that music-therapeutic interventions can alter pain.[272]

Pain is associated with a lack of relaxation. The fear of pain increases tension in the body, which in turn increases the pain. In other words, this is a tight circularity in

[268] Tørrisen, 2023.

[269] Loewy, 2019.

[270] For example, insula, anterior cingulate cortex and thalamus.

[271] Loewy, 2019.

[272] Loewy, 2019, p. 57.

which it is difficult to determine what is cause and what is effect. Music makes us forget pain, relax, and forget fear for a while. Music can break this circularity. Another factor is that music changes our experience of time. Anyone who has felt constant pain knows how long time can seem. Music can help us forget the pain for a while, and time passes more quickly until other forms of relief can come to support us. The following case may illustrate this work:

> *A woman in her late thirties suffers from sickle cell disease, a hereditary blood disorder that causes chronic pain and severe pain episodes. In addition to the pain, the woman is stressed because of racism to which she is exposed, as well as economic and social stress due to poor housing conditions. She has also had negative previous experiences in hospitals.*
>
> *The therapy offered to her is based on listening to music to create images, imaginative associations, and bodily experiences. Based on her own music choices, the music is intended to create relaxation. Her preferred genre is Rhythm and Blues, and she uses pre-programmed sampled music and GarageBand to choose rhythms. Apps with nature sounds are also included. Together with the music therapist, they improvise melodically over pre-programmed diatonic material.*
>
> *The therapy uses a psychoeducational approach to create safety in the situation and to establish good routines. The music therapy takes place through headphones so that they are neither disturbed nor disturbing to others. Everything is recorded on separate tracks and mixed into a finished session that the woman receives on her smartphone. In this way, she can practice every day at home in reducing pain and giving care to herself. Evaluation scales are used before and after each session, with measures of pain, depression, and stress. The psychoeducational approach used is based on cognitive behavioural therapy.*[273]

Music Therapy in Neurological Disorders

Neurological disorders include a wide range of medical diagnoses and conditions. These may include stroke, traumatic brain injury, movement difficulties as in Parkinson's disease, speech and language difficulties, memory problems as in

[273] Summary after Rodgers-Melnick, 2023.

Alzheimer's disease, epilepsy, autoimmune neurological damage, or medical conditions in the brain or nervous system related to cancer or palliative care.[274]

As we know from research on music and the brain, music can stimulate neuroplasticity and contribute to repairing damaged neural processes by finding alternative pathways in the brain. New neural routes and new connections can be created between brain regions that were not previously linked.[275] This has provided evidence for the effect of using musical activities in the rehabilitation of people who have sustained brain injuries. Such injuries may have arisen because of cerebral hemorrhage or stroke, traumatic head injury after an accident, or damage caused by lack of oxygen, as in cardiac arrest, suffocation, or drowning.

Depending on where in the brain the injury occurs, problems may arise with movement, speech, and language. Or the injury may affect cognition, memory, and attention. In addition, brain injury often leads to emotional challenges related to loss of function, which create despair and insecurity, as well as anxiety about the future.

Physical Rehabilitation

The Australian music therapist Jeanette Tamplin has provided an overview of the roles and functions music can have in work with traumatic brain injuries. She mentions how rhythm plays a fundamental role in the coordination of movement. Music can trigger automatic movements, for example when we mark the beat with a foot. Or music may have a motivational function that increases engagement in demanding physical exercises. Music makes us use less effort, which contributes to greater endurance. Playing an instrument provides visual, auditory, and kinesthetic feedback that can strengthen motivation.[276]

There is evidence that music therapy has a positive effect on gait and gross motor function. A music-therapeutic approach may be based on movement to music, playing instruments, or what is called Rhythmic Auditory Stimulation (RAS).[277]Studies show that the motor system is activated by auditory stimuli. This can produce a so-called entrainment effect. This means that rhythmic body movements can be synchronized with the rhythm in the music. RAS makes use of

[274] Devlin, Kang and Pantelyat, 2023.

[275] Levitin, 2024.

[276] Tamplin, 2015. See also Gilbertson and Aldridge, 2009.

[277] Hurt-Thaut and Johnson, 2015.

this, so that rhythm is used to keep time and organize sequences of complex movements. Speed of gait, stride length, symmetry, and movements of the upper body all contribute to improving walking under the influence of music.[278]

Playing different instruments has been shown to have a good effect on movements of the arms and upper body. This can lead to improved coordination between the right and left sides, and can be used strategically to improve planning, as well as the execution and sequencing of movements.[279]

Training movements by playing instruments can affect motor and procedural memory, for example by improving the coordination of certain hand and finger movements, writes Tamplin.[280] She points here to the countless possibilities music therapists have for varying challenges by changing the tempo of the music, using different instruments, changing weight, varying distance, height, and so on. By making use of musical elements—such as increasing tempo, playing ascending and descending melodic movements, and using dynamic contrasts—one can influence the execution of movement. One can also support patients in initiating movement, which may help patients with Parkinson's disease overcome freezing episodes.[281]

Work with Speech and Language

Music therapist and professor Felicity Baker points to many examples of how the music therapist can work with the rehabilitation of neural pathways connecting different areas of the brain.[282] She points especially to how injuries can affect communicative abilities and result in diagnoses such as apraxia, aphasia, and dysarthria. Symptoms appear as difficulties with language comprehension, poor motor control of speech, poor control of the musculature of the mouth, poor breath control, reduced ability to activate vocal-fold vibration, and weakened vocal support.

An example may illustrate how music can be used in the rehabilitation of language impairments:[283]

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[278] It is especially research by Michael Thaut which has given evidence for this. See next chapter about neurologic music therapy.

[279] Hurt-Thaut and Johnson, 2015.

[280] Tamplin, 2015.

[281] Tamplin, 2015.

[282] Baker, 2002.

[283] Murakami, 2023.

> *A young woman has suffered a cerebral hemorrhage, with resulting speech and communication difficulties. She is referred from the speech therapist to the music therapist for help in improving pronunciation. The problem is that the woman has developed flat speech and a monotonous voice with a vocal range of a fourth. She has problems varying intonation, speaks too quickly, and places stress incorrectly on words. This creates communication difficulties. In addition, she often feels misunderstood because of the discrepancy between vocal expression and facial expression.*
>
> *The music therapist uses the woman's smartphone to record all exercises. The exercises are analyzed and evaluated, so that the woman can continue practicing at home. They use an iPad and extract lines from the client's favorite sitcom episodes. They analyze intonation and repeat dialogues. In this way they train communication. They listen, play drums, and sing. They use speech exercises and a metronome to vary tempo. The therapist uses metaphors to describe vocal expression. They finish the session with piano instruction in order to rest the voice and provide other cognitive challenges.*[284]

Singing songs one already knows has a releasing and supportive effect in helping to recall words, coordinate the rhythmic motor aspects of speech, and support patients in producing more fluent speech. Research on music and the brain reveals connections between language centers in the brain and musical perception and performance. One example of this is when patients with damage in the left hemisphere, where language is centered, are nevertheless able to sing the lyrics of a song.[285]

A well-known method is Melodic Intonation Therapy (MIT), which is used to help people with aphasia learn to speak again.[286] Here, simple language phrases are sung by exaggerating normal accentuation, intonation, and melody in spoken language. At the same time, each syllable of the speech is rhythmically marked with the left hand.[287] Music therapist Concetta Tomaino describes other approaches to working with aphasia. These may include singing familiar songs, breathing single-syllable words, supporting speech with music, song, and rhythm, using motor exercises for the mouth, and supporting vocal intonation.[288] Added to this are breathing exercises and the improvement of respiration through singing.

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[284] Summary after Murakami, 2023.

[285] Levitin, 2024.

[286] Aphasia is about a lost ability to speak and/or understand language that occurs after a brain injury

[287] For details, see Tamplin, 2015, p. 460–461.

[288] Tomaino, 2012.

Cognitive Rehabilitation

Music is used in connection with the rehabilitation of cognitive functions. It is employed to help improve memory functions, for example remembering words, events, people, and information. Musical activities may also improve concentration. Among the activities and musical functions mentioned are the ways rhythm and melody help to structure, organize, sequence, and group auditory information. In this way, the information is perceived and retained longer in memory. Research shows that daily music listening improves attention and verbal memory in people who have suffered stroke.[289]

Tamplin writes that songs can be created to convey information about everyday tasks. This helps the patient initiate an activity, divide it into sequences, and plan the motor actions needed to carry out these tasks. These may be songs about how to take a shower or how to use the television remote control.

Short-term memory is trained by including questions about what the song was about, or by asking direct questions through the song text itself. Improvisation is especially mentioned as a means of addressing challenges patients face when they give fragmented, stereotyped, and repetitive responses to musical prompts. Improvisational techniques help the patient develop more flexible musical responses, foster creativity, and in this way strengthen concentration and the duration of participation.[290]

Emotional Regulation

Traumatic brain injuries often lead to emotional difficulties. Mood swings may arise, as well as feelings of anger, grief, guilt, or denial related to loss of future plans, along with loss of authority and self-esteem. Such feelings block motivation for the necessary work of rehabilitation.

Depending on the level of functioning and language ability, music therapists use group singing, songwriting, music listening, discussion of song lyrics, and improvisation in order to meet emotional and existential themes. Listening to music can have a soothing effect on pain or can distract from troubling feelings, promote relaxation, and reduce anxiety. Songwriting offers opportunities to express thoughts and hopes. Work with one's own songs initiates important

[289] Särkämö et. al., 2008.

[290] Tamplin, 2015, p. 463.

processes of reflection, while also making communication with people around oneself possible. Group discussion based on lyrics that touch something personal contributes to increased awareness. Patients who do not have verbal language may improvise on instruments to find an outlet for feelings and frustration.

Parkinson's Disease and Rhythmic Auditory Stimulation

Music therapists have gained an important role in work with Parkinson's disease. Interventions with music here are based on the neurologic music therapy developed by Michael Thaut, especially Rhythmic Auditory Stimulation (RAS). In brief, this means using a metronome or playing music while the patient practices gait function, or possibly movement in the upper body. This is a well-documented method, supported by a considerable body of research.[291]

With RAS, the music therapist may, for example, walk backwards in front of the patient while playing preferred songs on the guitar. The physiotherapist suggests and adapts the tempo as needed. Studies show that playlists on a smartphone help patients feel safer while walking. In this way, they get more out of the training. Especially for patients who experience freezing in gait, music can help initiate movement. The importance of listening for quality of life, and for coping with the psychological aspects of the illness, has also been demonstrated.[292] Other approaches use group singing and singing interventions to affect speech and vocal quality in patients who have difficulties with speech production.[293]

Huntington's Disease

Huntington's disease is another neurological condition in which music therapy is used. A music therapist offered fixed weekly group activities, music sessions, music and movement, individual therapy such as songwriting, as well as support work with relatives.[294] This work was followed up by another music therapist through a

[291] Devlin, Kang and Pantelyat, 2023.

[292] McFerrand and Lotter, 2024, chapter 7.

[293] Elefant et. al., 2012.

[294] Hovde, 2009.

methodology in which one stimulates resources and addresses symptoms.[295] The therapist uses preference-based music and sung phrases to train pronunciation and articulation. At the same time, songwriting is used to build identity and support memory work. Processing feelings, preserving vocabulary through creative activities, and musical improvisation are among the activities offered.

Epilepsy

Within music medicine, there is research suggesting that listening to music can reduce the frequency of seizures in cases of epilepsy where medication does not work, so-called refractory epilepsy. Here, research is carried out by studying EEG recordings, where irregularities in brain activity between seizures can be detected.[296] In this way, one investigates interventions that may lead to fewer seizures. It is thus possible to measure the effect of listening to music.

In such studies, it has emerged that listening to Mozart's music may lead to fewer epileptic seizures. We know from years back how some people claimed to have demonstrated a so-called Mozart effect. An experiment suggested that people became more intelligent by listening to Mozart's *Sonata in D major for Two Pianos* (K448).[297] This was quickly challenged after a series of new experiments. But strangely enough, there was one area in which Mozart's music did seem to have an effect. Several studies showed that this piano sonata, along with other works by Mozart and Haydn, had positive effects on seizure frequency in refractory epilepsy. Other music was also tested, not least preference-based music, without producing the same effect.

This is, of course, unusual, and several theories have been proposed as to why Mozart and other Viennese classical forms might have such an effect. Some point to the periodicity of Mozart's compositions, the use of repetition, and symmetrical forms. Others point to hierarchical structures in the music that correspond to molecular hierarchies in the brain. But all of this remains speculation. One has also not found a universal effect or a standard procedure for this type of music listening, though more research will surely come. This is, moreover, an example of music medical research and not music therapy, since no therapist is present here.[298]

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[295] Kayser, 2016.

[296] See Devlin, Kang and Pantelyat (Ed.), 2023.

[297] Devlin, Kang and Pantelyat (Ed.), 2023.

[298] Devlin, Kang and Pantelyat (Ed.), 2023.

ALS (Amyotrophic Lateral Sclerosis)

ALS is a disease that leads to muscle wasting because the nerve cells that send signals from the brain to the muscles cease to function. This causes patients to lose control over their muscles, which gradually affects movement, speech and voice function, and eventually mental health as well. A good illustration of how the music therapist supports patients with ALS is described by the music therapists Maren Sofie Ek Knutsen and Professor Wolfgang Schmid.[299] During home visits, the music therapists were able to provide the patient and spouse with important support through shared music, conversation, and shared music listening. They summarize the work as follows: "Many themes emerged during therapy. These concerned, for example, presence, what it was like to present one's own music and to listen to the music of others, and how recorded music functioned together with live music."[300]

Serious Lung Diseases

Diseases of the lungs are among the most common illnesses in the world. These are diseases of the lower airways, the lungs, and the pleura. They can affect people of all ages.[301] They may include asthma in early childhood, pneumonia, or COPD. The most common symptoms are shortness of breath (*dyspnoea*) and coughing.

Lung disease, for example COPD, also has psychosocial costs, for instance when it leads to social isolation. Anxiety related to the condition is common. One way of examining lung function is through spirometry. Here, patients are asked to fill their lungs maximally and then exhale as forcefully and completely as possible. In this way, flow rate and volume are measured and compared with established reference values.

There are many studies of how music and music therapy affect problems related to the respiratory system. As far as I can see, there are no studies that definitively establish that singing or participation in a choir has a long-term effect on the lung disease itself. Anecdotal reports and arguments from clinical practice indicate that some individuals experience clear improvement in breathing ability.[302] There is,

[299] Schmid and Knudsen, 2016, p. 86.

[300] Schmid and Knudsen, 2016, p. 86.

[301] Skjønsberg, 2025.

[302] Lewis and Thomas, 2018.

however, agreement across studies that singing and choir participation are of great value for the experience of improved quality of life.

A physiotherapist specializing in respiratory disease writes about the value of singing based on participation in the British movement Singing for Lung Health (SLH). These are singing classes led by singing teachers with relevant skills and knowledge. Here, one learns about the control of breathing and posture in an informal social context, and where the goal is artistic, that is, to sing as well as one can. At the same time, one learns how singing contributes to expanding phrasing and training abdominal muscles, which can make breathing easier. These muscles coordinate inhalation, which can reduce problems with exhalation.[303]

A larger evaluation of SLH singing groups shows, through quantitative data, that singing has the potential to improve health-related quality of life, both in physical aspects and in anxiety levels. No adverse effects have been found from participating in these singing activities. Qualitative data show that the groups are experienced positively and help the participants cope better with the illness.

Music Therapy in Cancer Treatment

Music therapy can be a support in cancer treatment. The aim is to find ways to integrate music into the lives of patients, their families, and healthcare personnel, in order to counter the grief and suffering many undergo.[304] Many people who receive a cancer diagnosis experience shock and a sense of helplessness. Reactions to the diagnosis may include anger, guilt, anxiety, depression, and other psychosocial and emotional challenges. But many also find new hope and new strength in the face of illness and treatment.

Music therapy may involve giving comfort, support, and skills for adapting to the situation of illness and working to improve the patients' quality of life. The therapy may address symptoms such as agitation, confusion, and cognitive impairment. Or it may be directed toward anxiety, pain, and depression, as well as existential challenges. Another task is to promote communication between the patient and the family and create a breathing space and refuge from burdensome and difficult experiences. A family-centered approach may be beneficial here.

[303] Lewis and Thomas, 2018, p. 122; Lewis et. al., 2016.

[304] O'Callagan and Magill, 2016.

Music therapy takes place in the patient's room, at the bedside, or after the patient has been discharged and still needs support and follow-up. When the music therapist enters the hospital room, they bring with them a variety of instruments. In cases where the patient has a weakened immune system, special measures are required, for example sterilization of the instruments.

Some of the most common working methods in encounters with cancer patients are finding music the patient has previously enjoyed, performing and listening to this music together with the family, analyzing lyrics, and refreshing memories. The exploration of new music also takes place, along with improvisation, songwriting, and music teaching. Relaxation, breathing exercises, and receptive music therapy form part of the methodological repertoire.

Music therapists can help children and adolescents through difficult and painful treatments. This applies, for example, in cancer treatment, where chemotherapy may be involved. Ilan Sanfi is a Danish music therapist who has developed the music therapy programme MICO (Music and Imagery in Child Oncology). MICO is a Scandinavian research project whose purpose is to investigate music therapy as a non-medical supplement for reducing the side effects of chemotherapy in children with cancer aged 7–17.[305]

Palliative Music Therapy

Music therapists have made themselves especially visible in work with palliative care. One of the international pioneers in work with music and palliation was the Swiss Canadian music therapist Susan Munro, who in the 1970s began working in a hospice in Montreal.[306] Here, adult patients in the final stage of cancer were offered music therapy. Over time, palliative care has come to include a range of disease conditions for both children and adults. These include chronic diseases related to heart conditions, respiratory diseases, AIDS, diabetes, kidney disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological diseases, dementia, congenital disorders, and medication-resistant illness. Palliative care is not only connected to hospice, but also takes place in hospital wards, day centres, and in the patient's home.[307]

[305] Sanfi et. al., 2021.

[306] Munro, 1984.

[307] For an overview of research, see Schmid et. al., 2018; Dileo and Baroni, 2024.

The World Health Organization (WHO) has defined palliative care as an approach aimed at improving the quality of life of children and adults living with life-threatening illness. Palliative care is intended to prevent and relieve suffering through the assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual.[308] Palliative music therapy includes the use of music within a therapeutic relationship with people living with life-threatening illness, as well as with their close family and friends.[309] Music therapists have shown how music can become a source of joy, diversion, hope, and vitality, even where life-threatening illness shapes the quality of life. Musical activities provide small moments of release and hope for a different life. When one participates actively in music and is creative through formulating one's own expressions, the possibility opens of experiencing meaning right up to the end of life.

Professor Cheryl Dileo suggests three levels of music therapy practice in palliative care: supportive, communicative, and transformative. In short, supportive practice includes everything from regulating breathing and reducing pain, building trust, increasing tolerance for stimuli, enhancing motivation, adapting to changes in body image, and preparing for what lies ahead. Communicative and expressive needs are addressed through conversation, identifying and validating difficult emotions, maintaining identity, accepting loss and limitations, and preserving connections with close relationships. At the transformative level, the work involves addressing issues related to dying, helping to create a life narrative, completing relationships, finding meaning in life, cultivating hope, reducing hopelessness, and experiencing inner peace, among other outcomes.[310]

In addition to direct patient work, music therapists may also support other caregivers, including family members, by helping to reduce stress, cope with loss, enhance self-care, and receive support during the grieving process.

The needs in palliative care are many and include psychosocial, existential, and physical needs. Music therapy is directed toward strengthening self-image, personal control, relationships, and hope. Fear and anxiety related to the outcome of the illness arise not only in the patient, but also among relatives. Feelings such as grief, anger, and frustration may surface, and there is a need to help the ill person communicate these feelings. Experiences of isolation, mood changes involving sadness, depression, guilt, regret, and unresolved life themes may arise. There may

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[308] https://www.who.int/news-room/fact-sheets/detail/palliative-care Access date March, 12.2022.

[309] O'Callaghan, Forrest and Wen, 2015, p. 470.

[310] Dileo, 2024.

also be a wish to complete plans, to share, create, and learn music.[311] The following account from practice may illustrate this work:

> *A female hospice patient, 97 years old and living with Alzheimer's disease, lives at home and is cared for by her daughter, a retired nurse. Music therapy takes place in the woman's home twice a month. The music therapist develops reminiscence work through songs that have had significance for both mother and daughter. The daughter participates actively with song suggestions, and together they find songs that trigger good, shared memories. Over the Rainbow brings associations to the daughter's childhood, to black-and-white films, and to the first television they had. Then come memories from the older woman's own childhood. Que Sera Sera triggers memories of the homes they have lived in through life and the places where the woman met her husband. Memories of the deceased husband lead further to memories of parents and other relatives who have died. These song sessions became important meetings between mother and daughter.*[312]

Some of the activities used in palliative music therapy include performing music connected to the patient's musical autobiography, often together with the patient. This may involve discovering new music, writing songs, and improvising. Listening to music through Guided Imagery and Music (GIM) is also relevant. In the later phases of treatment in particular, a receptive approach may be appropriate.[313]

The importance of cultural sensitivity must be emphasized here as elsewhere. In the following example, the music therapist finds music with lyrics that resonate with the patient and her relatives.

> *In this case, we meet a 92-year-old woman and her caregiving son. The woman is originally Chinese but has lived in the United States for many years. She falls and breaks her hip, which leads to hospitalization and a rapid decline in her general condition. She suffers cardiac arrest, requires mechanical breathing support, and enters a state fluctuating between confusion and coma. It becomes clear that the son is extremely anxious and stressed. He denies the seriousness of the situation and wants the hospital to do everything possible to prolong his mother's life.*

311 O'Callaghan, Forrest and Wen, 2015, p. 471.

312 Summary after Borkholder, 2023.

313 Borkholder, 2023.

The son accepts the offer of music therapy. The music therapist, who grew up in China, finds a selection of classic Chinese pop songs from the 1970s and 1980s to which the mother responds positively. The therapist performs these songs on a traditional Chinese instrument, an erhu (also called the Chinese violin, a two-stringed bowed instrument). The music evokes moments in which mother and son share experiences and feelings of reciprocity. They look into one another's eyes, and the son sings along with the music. The text, with all its symbolism, has great significance within this Chinese cultural context.

Several life-prolonging measures are attempted, but eventually the son must accept that his mother's life is ending. In this phase he is highly stressed, and the music therapist provides care for him, calming him through music that creates peace and relaxation. The therapist attunes to his breathing and helps him breathe with his abdomen. In this way, she sought to stimulate the vagus nerve and activate the parasympathetic nervous system, as she writes.[314]

The environmental aspect should not be forgotten either. When the music therapist performs music, it becomes available to family and friends, and staff on the ward are invited into the music-making. The music therapist may also take responsibility for the sound environment on wards or wherever patients are staying. It is also relevant to offer help in creating playlists based on the patient's musical preferences, and in guiding the use of music for emotional regulation.

For a comprehensive overview of palliative music therapy, see the anthology edited by Cheryl Dileo and Mariagrazia Baroni.[315]

In work with children undergoing cancer treatment, the music therapist will meet some of the greatest challenges. At the same time, music can help both the child and the relatives in a very difficult phase of life. Music therapist Marte Lie Noer has used music and hand puppets to create a shared emotional journey, offering safety and comfort to the child and family all the way to the final farewell.[316]

Music therapy in pediatric palliative care is work that requires great creativity and musical competence. The use of songwriting is a central method here. The point of departure may be the child's favorite songs, to which new lyrics are written. Or parents and child may contribute text that the music therapist sets to music.

[314] Summary after Zhang, 2023.

[315] Dileo and Baroni, 2024.

[316] Noer, 2018

Sometimes recordings are made of the child's heartbeat, which are then used as the basic rhythm for the songs.[317] Recordings of sound and image become a musical legacy after the child is gone. Favorite songs and video recordings from music therapy are experienced as a form of communication with the child even after death.

In this work, collaboration with parents and relatives is particularly important. This is well documented in an anthology in which music therapists have worked together with relatives to describe a range of musical care offerings that accompany the child right to the end. In this family-centered work, music therapy becomes not only a support for the child, but also an important support for the parents undergoing very painful processes.[318]

Music Therapy and Elder Health

The work of music therapists with older adults and elder health has become a large and continuously growing field of work. With the increasing number of older adults in the population, the need for care for people with age-related illnesses is also rising. Not least, this concerns people with memory difficulties, that is, various forms of dementia.

Elder health concerns treatment and professional care, as well as the individual's own self-care. In addition, elder health depends on the well-being and mutual care generated by voluntary engagement and community. "The concept of 'elder health' opens for the consideration of all the biological, psychological, social, and cultural processes that influence health, well-being, and welfare in later life, including the resources that may be mobilized both in the individual and in society," Brynjulf Stige and Hanne Mette Ridder write.[319]

Older people may have health needs related to several disease conditions. The greatest challenge lies in neurodegenerative disorders, which among other things lead to cognitive impairment. We also encounter other health challenges related to anxiety, agitation, depression, and substance use problems. In general, older adults have a great need to remain active, participate in social communities, and take part in stimulating environments.

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[317] Aasmundseth, 2023; Schreck, 2024.

[318] Kammin and Russel, 2025. For a systematic review of the research within this field, see also Overå, 2023.

[319] Stige and Ridder (Ed.), 2016, p. 22. See also Kvamme, 2023.

If we turn to how elder health is presented on the website of the *Norwegian Association for Music Therapy*, we find the following text:

> *Music therapists today work with older adults in a variety of contexts. Some are attached to nursing homes, residential and treatment centers, and rehabilitation centers in municipal health services, while others are attached to hospitals and geriatric psychiatric wards in specialist health services. The music therapist works both directly with users (individually or in groups), and indirectly through transfer of competence, training, and supervision of other health personnel in the purposeful use of music.*
>
> *In the different contexts, music therapy is used both as a complementary treatment to standard medical treatment and as a measure that creates well-being. By focusing on both symptom relief and the activation of resources, the music therapist seeks to care for the whole person and to facilitate mastery and meaning in everyday life.*
>
> *Older adults are a highly heterogeneous group, and music-therapeutic work extends to users with many types of challenges: dementia and anxiety, agitation, aggression, hallucinations and delusions, late-life depression, chronic pain, neurological diseases (Parkinson's disease, MS, epilepsy), stroke, aphasia, the need for activation and meaningful experiences, and the need for palliative care. The evidence-based effects of music therapy are seen in: stabilization of mood and emotional states, less unrest and acting out, improved sleep patterns, greater safety and calm in daily routines and procedures, less isolation and passivity, increased participation and socialization, higher activity levels, greater endurance, more motivation, and improved experience of one's own quality of life and meaning.*[320]

In addition to these aspects, music therapists have responded through several projects to the need to work with older adults living at home. Reference is made later in this section to research projects at the *Norwegian Academy of Music* through CREMAH and to the ALMUTH project at the *University of Bergen* through GAMUT.

[320] https://www.musikkterapi.no/arbeidsfelt/eldrehelse Access date September 24. 2025.

Dementia

There are several conditions in the brain that lead to a general intellectual decline, forgetfulness, disorientation, and impaired judgement. These conditions fall under the designation dementia, and among the most common symptoms we find:

- reduced memory for new information
- impaired ability to orient oneself in time and place
- reduced attention and comprehension.[321]

In addition, many people have problems with poor fluency of speech and verbal communication, and they may face challenges in everyday practical tasks. How severe the symptoms are depends on the kind of brain disease the person has and how advanced it is.

Dementia is often characterized as mild, moderate, or severe. In mild dementia, the person will manage daily life with support and reminders. As the disease progresses, people with moderate dementia will need help in everyday life, perhaps around the clock in assisted living or in a nursing home. Depression and anxiety may occur, sometimes together with hallucinations and delusions. In severe dementia, motor restlessness and apathy may become more prominent.

There are several brain diseases and brain injuries that can lead to dementia. These are linked to different areas of the brain and are classified into three groups:

1. degenerative brain diseases (degenerative dementia),
2. cerebrovascular diseases (vascular dementia), and
3. other brain diseases (secondary dementia).
   The most widespread degenerative form is Alzheimer's disease, which always leads to dementia.[322]

Memory Difficulties

In work with people with memory difficulties, it is important to have knowledge of different forms of memory, such as short-term memory, long-term memory, and working memory, procedural memory, as well as episodic, autobiographical, and nostalgic memory.

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[321] See more in Engedal, 2023 in Store Norske Leksikon, accessed Nov. 30, 2023.

[322] Engedal, 2023.

Our long-term memory contains explicit memories, with episodic and semantic memories for facts and events, in addition to implicit memory with procedural systems for memory. Procedural memory refers to carrying out motor and automated movements, such as riding a bicycle. Autobiographical memories involve remembering specific events in life. A variant of this is referred to as nostalgic memory, which concerns a form of longing for positive experiences from the past.[323]

The music therapists Hanne Mette Ridder and Concetta Tomaino have provided a summary of central forms of memory relevant to music therapy.[324] Memory is connected to processes in the brain through the formation of synaptic connections and new neurons, especially in an area called the hippocampus. Over the course of life, the storage of memories becomes more broadly distributed in the brain. This explains why early memories are more firmly retained than what comes later in life, something that in conditions such as Alzheimer's disease will affect the formation of new memories. Early memories will also change and be reconstructed when they are recalled in new contexts.

Ridder and Tomaino point to how the recall of memories may occur unintentionally, as when nostalgic and autobiographical memories are triggered, for example by music.[325] The recall of autobiographical memories is an important means of preserving a sense of self, one's identity.

Sometimes great emphasis is placed on mechanisms in the brain to explain why and how music affects neurological damage. It is, however, as mentioned above, necessary to point to factors outside the brain and body that stand in an interactive relationship to processes in the brain. It is therefore important to take psychosocial aspects of music-based approaches into consideration.

Person-Centered Approach

In encounters with vulnerable people, we must always think about factors that affect motivation, the experience of mastery, identity, or resistance resources. In other words, music-based interventions, or music therapy for this group of patients, must always take account of psychological and cultural factors.

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[323] Ridder and Tomaino, 2023.

[324] Ridder and Tomaino, 2023.

[325] Ridder and Tomaino, 2023.

In work with elder health, a person-centred approach is recommended, as developed by the British writer Tom Kitwood. Professor Hanne Mette Ridder writes that this implies a relationship-oriented approach to dementia and a biopsychosocial understanding of care. This means that the caregiver takes medical and neurological knowledge into account while also attending to psychological and social needs.[326] Kitwood developed the term "personhood", which means that we should always affirm a person's existence as a human being.

To make this more concrete, Ridder refers to a description developed by the *National Knowledge Centre for Dementia* in Denmark. It states that one should:

- treat the person with dementia as a person with experience, selfhood, and rights
- try to understand what is best for the person from their own perspective
- seek to establish a personal relationship
- protect the person's self-determination and opportunity for co-determination
- see the person as an active collaboration partner
- support the person in their own experience of the world
- strive to involve the person's social network in care and support

Working Methods

There are many possibilities involving music in the promotion of elder health. What is especially emphasized is making use of the musical resources older adults bring with them by strengthening their use of music in everyday life. There are also many musical measures that can be carried out by care personnel or by relatives.

It is important to maintain collaboration with musicians and others who contribute musical offerings. The music therapist works with individuals, groups, and the environment together with others such as physiotherapists and activity coordinators and may also take part in coordinating and preparing concerts with musicians. This gives the music therapist an important role, not only as therapist caring for individual needs, but also through the roles of supervisor and course instructor in contributing to the best possible musical environment in the institution.

[326] Ridder, 2016.

Listening

A method referred to as individualized music was developed by the American nurse Linda Gerdner. The method is based on offering so-called preference-based music. This involves mapping the patient's musical preferences, developing playlists, and making reflective use of the music.

Individual music listening through different digital media, with or without headphones, can be of great value to the individual patient. Music therapist and associate professor Tone Sæther Kvamme, who has written a textbook on music therapy and elder health, presents a number of considerations related to listening, and points out that it is important to integrate music listening into daily or weekly routines.[327] The time of day, energy level, and mood determine what kind of music should be listened to.

Singing, Group Singing, and Care Singing

Experience shows that singing for patients during care routines creates safety and improves communication among those involved. Care singing refers to singing activities in situations where the patient is moving between different situations, during morning care, tooth brushing, showering, and so on.[328] Care singing can be carried out by all caregivers, and here too it is important to use a repertoire that corresponds to the patients' musical preferences. Music and health worker Helene Waage has shown in her research how group singing is useful and applicable for people with memory difficulties who live at home with spouses or partners.[329]

Music Quiz

Listening to music can also form the basis for song sharing in groups, another way of activating memories and creating situations for social exchange. Tom Næss has published four such collections with song, quiz, and movement. These are suitable for use in elder health work and with people with memory difficulties. They may be used in residential care or in the patient's home. Since the accompaniment is available on Spotify, no pianist is required, and the music quiz can be used both by relatives and by healthcare workers.[330]

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[327] Kvamme, 2020, p. 63–65.

[328] https://www.krafttakforsang.no/new-blog/mltce5kw8rzye4ajwejstkmlrf6wz4 Access date September 20, 2025.

[329] Waage, 2022.

[330] See Tom Næss. For sound: https://soundcloud.com/tomnaess/sets/sang-quiz-og-trim-komplette

Choir

Choirs for older adults have been shown to have a community-building function that contributes to preventive health work for older adults. The choir becomes a good and regular meeting point in the week and helps counter loneliness and isolation. The importance of creating a positive social environment is crucial for well-being in the choir, and the choir leader must show an understanding of group dynamics.[331]

'Dementia choir' became a recognized term in 2023 after Norway's national broadcaster aired a series of programs featuring a choir composed of people living with dementia. The value of this initiative quickly became evident to participants, their relatives, and television audiences, leading to the establishment of several similar choirs across the country. Follow-up research has documented positive effects on participants' quality of life.[332]

Dementia researchers at CREMAH and the *Norwegian Academy of Music* who took part in the documentary have since initiated several projects related to dementia choirs together with other actors in elder health. A guide for the establishment and leadership of dementia choirs is one of the resulting products.[333] CREMAH has also initiated, a research and development project in collaboration with the City of Oslo. The project researches how the choirs can best be carried out and what effect choir participation has on loneliness and social inclusion, which were also focus areas the choristers themselves wished to emphasize. In addition, the project explores whether choir participation may have a positive effect on depression, the experience of meaning in life, apathy, and mood, both for the choristers and for their relatives. The analyses also explore caregiver burden and health-economic benefit.[334]

In work with music therapy and elder health, music therapists use many of the same working methods as elsewhere in music therapy. These include interaction on instruments, songwriting, and improvisation, and not least dance and movement.[335]

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331 Fossøy and Hauge, 2016.

332 Stensæth, Asskildt, Brean, Johansson, Stedje and Kvamme, 2022.

333 https://nmh.no/forskning/publikasjoner/etablering-og-ledelse-av-demenskor

334 https://nmh.no/forskning/prosjekter#research_centers[]=cremah

335 Kvamme, 2020.

Outreach and Home-Based Music Therapy

Music therapists can offer services to older adults living at home. Two larger research projects, HOMESIDE and ALMUTH, have been especially directed toward examining services for two people living together, where one partner has dementia.[336] The HOMESIDE research project investigated whether singing, listening, and moving to music together, or reading together, could have a positive effect on couples living at home where one person has dementia or memory difficulties.

No quantitative measures showed improvement in symptoms such as anxiety, apathy, depression, or distress through carrying out these music and reading activities in the home. However, the participants reported good moment-to-moment experiences while carrying out the activities. Singing, playing instruments, or moving to music gave more positive effects than merely listening to music alone. The activities improved the caregiver's resilience, and the use of music activities also improved the quality of the participants' relationship with one another.

In a sub-study of HOMESIDE, music therapist Kristi Stedje explored in her doctoral work how shared musical experiences affected relationship quality in couples living with dementia. The qualitative findings from her study indicate that shared musical experiences can be positive for relationship quality, and that the effects are complex. She found that sharing music could support the couple's relationship by improving communication and the sense of connection, strengthening positive emotions, giving hope, and offering a space for reciprocity. At the same time, she also saw how shared musical experiences revealed and made visible vulnerabilities and difficult feelings within the couple. Stedje introduced the concept of musical couplehood, in a model developed to illustrate the complex influence of music on the relationship in couples living with dementia. Music therapy thus offers not only person-centred but also couple-centred care.[337]

[336] https://www.uib.no/hjernenogmusikk/112855/alzheimer-og-musikk

[337] https://nmh.no/forskning/prosjekter/kristi-stedje-fullfort-phdprosjekt Stedje, 2025.

The Mental Health Field

Music therapy within the mental health field is a broad and well-established area within international music therapy and increasingly also in Norway. The field includes the use of musical activities related to traditional psychiatric conditions such as psychosis, anxiety and depression, and diagnoses such as schizophrenia, bipolar disorders, and personality disorders.

The field is broad, and the interventions employed vary considerably depending on the severity of the condition and the individual's level of functioning. Music therapy approaches likewise differ in accordance with diverse therapeutic traditions, theories, and practices. Some forms of music therapy are closely aligned with analytic and psychodynamic traditions and are typically based on an individual approach. This can be seen, for example, in music therapy with groups of young people with eating disorders. In other contexts, music therapists may work in a band format, where the approach is often informed by community music therapy perspectives, as well as theories of recovery and user involvement.

Within mental health care, music therapists also employ methods such as improvisation, interactional and re-creative activities, songwriting, and receptive music therapy. These methods will be described in greater detail in a later chapter. The present account may be read in conjunction with the chapter reviewing different treatment theories

Returning to the website of the *Norwegian Association for Music Therapy,* we see that music therapy in the field of substance use and mental health is described as "a resource- and community-oriented practice that supports the patient's recovery process."[338] Goals of the work include increasing motivation for treatment, creating experiences of mastery, promoting emotional regulation, fostering social participation, and building networks. Music therapists in this field work in outreach teams, within institutional settings, or by facilitating participation in local music and cultural life.

In the description from the music therapy association, it is stated that music therapists work both in specialist healthcare services and in municipal services, as well as in connection with adult education, community arts schools, and non-profit

338 https://www.musikkterapi.no/arbeidsfelt/2019/6/9/musikkterapi-i-rus-og-psykisk-helsefeltet See also the important links from the Polyfon knowledge cluster on music therapy and mental health for adults: https://www.uib.no/polyfon/166721/musikkterapi-i-rusfeltet#nasjonale-f-ringer and https://www.uib.no/polyfon/166468/musikkterapi-og-psykisk-helse---voksne#nasjonale-f-ringer

services.[339] The association highlights the evidence base for music therapy in this field by referring to the recommendation from the Norwegian Directorate of Health:

> *Music therapy has documented effect in psychotic disorders and depression. In addition, research shows that music therapy reduces depressive symptoms, anxiety, and negative symptoms, and improves general mental health, motivation, emotional awareness, social functioning, and quality of life. This research, together with user experience, gives a strong indication that music therapy is effective both in work with substance-related problems and within mental health care.*[340]

Psychosis and severe mental disorders

Psychotic disorders are "an umbrella term that includes, among other things, schizophrenia, paranoid psychoses (delusional disorders), schizoaffective disorders, substance-induced psychoses, and acute transient psychoses."[341]

We do not know exactly what causes some people to develop a psychotic disorder. Several possible causes have been suggested, ranging from a stress-vulnerability model to stress resulting from psychological and physical strain, loss and experiences of separation, conflict, and wounded self-esteem.[342] So-called positive symptoms are delusions and hallucinations. While delusions involve a belief that is not consistent with reality and is not shared by others, hallucinations refer to having a sensory experience without the sense organs being stimulated. Negative symptoms involve withdrawal, lack of motivation, and apathy.

Schizophrenia

Schizophrenia is regarded as the most severe of the psychoses. Symptoms include delusions, hallucinations, disorganization, flattened affect, affective symptoms, apathy,

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339 https://www.musikkterapi.no/arbeidsfelt/2019/6/9/musikkterapi-i-rus-og-psykisk-helsefeltet Access date Sept. 25, 2025.

340 The Norwegian Directorate of Health has given music therapy a strong recommendation in its national professional guidelines for psychosis treatment. They have also recommended music therapy for treatment of addiction and for detoxification. These guidelines are under revision. At the same time, music therapy still has strong support in a number of public reports and from user organizations. As regards references to the research base, see further under https://www.musikkterapi.no/arbeidsfelt/2019/6/9/musikkterapi-i-rus-og-psykisk-helsefeltet

341 Røssberg, 2024.

342 Røssberg, 2024. See also the section on the Power–Threat–Meaning framework in the next chapter.

impaired functioning, and cognitive problems.[343] It is further stated that schizophrenia is not a homogeneous disorder, "but a collective term for a group of disorders that have approximately the same symptoms and course. It is therefore more correct to speak of a syndrome or 'the group of schizophrenic disorders' rather than schizophrenia as a well-defined disorder with a common cause."[344]

People diagnosed with schizophrenia may be offered music listening, even when they hallucinate or hear sounds or voices. This work requires special experience and competence to be applied in music therapy. Cochrane studies indicate positive effects of music listening on negative symptoms, such as blunted affect and emotional and social withdrawal. But again, the choice of music is important, and a thoughtful approach is required.[345]

Recovery

In recent years, a development has taken place within mental health care in which a so-called recovery perspective plays a central role in work with severe mental disorders. Within recovery philosophy, one moves somewhat away from psychiatric thinking in which patients are treated within a medical model. People speak of clinical and personal recovery.

By clinical recovery, one means that successful treatment involves returning to a normal state. Personal recovery is more about improvement as a process, in which inclusion in the local community and the right to self-determination are central.

A music therapy practice within recovery thinking will be concerned with promoting factors that user-oriented research identifies as important for personal recovery processes. This is about learning to live with one's own problems and limitations, without necessarily achieving full recovery. Emphasis is placed on fostering hope and renewed meaning in life, strengthening a sense of identity, facilitating empowerment in the sense of power and control over one's own life, and developing valued social roles and connectedness to society.

Norwegian music therapy within adult mental health is characterized by community music therapy, recovery thinking, and user involvement. This contrasts with music therapy in many other countries, where psychodynamic and more

[343] Røssberg, 2024.

[344] Røssberg, 2024.

[345] McFerran and Lotter, 2024, kap.7.

traditional psychiatric and medical traditions shape music therapy. In Norway, music therapist and associate professor Hans Petter Solli has been a pioneer of recovery-based music therapy. Through his practice and research in the field, he has charted a course for a music therapy that includes forms of popular music. He has used his musical background as a drummer and his skills on electric guitar to create musical forms of contact with users struggling with psychosis, delusions, and social withdrawal.

> *In a case description from his work in a psychiatric hospital, Solli tells of his encounter with a young man, Marco, who from adolescence and for six years onward has lived a life in and out of hospital.*[346] *Now admitted once again, he has spent the first six weeks in bed. He has given very little verbal response other than revealing that he is going through an inner struggle between life and death. He experiences a battle with forces that want to drag him into the abyss. Despite this, he wants to hold on to the good and positive sides of life, hoping to take part in positive life circumstances that make it possible for him to win this battle against evil forces.*
>
> *Marco's state of mind shifted. He went through days of feeling good about life. On other days, he lay in bed without any apparent contact with the outside world. He did, however, reveal his interest in and great knowledge of music, especially rap. Music was a major resource for him; it represented meaning, hope, and motivation. Music gave him an identity as a rapper, something that gave him strength and agency. With this musical identity, Marco also dreamed of being discovered by the music industry. He wanted to contribute positive values, in contrast to artists who spread negative thoughts and violent attitudes.*
>
> *Marco is invited into the music therapy room. There he explores the instruments, performs familiar songs, and improvises with Solli. Gradually, rap becomes an important component of the musical collaboration. They find their own structure within the improvisations. Marco could begin a sequence with beatboxing, which Solli would copy on the drum set. As soon as Marco felt that the groove worked, he began freestyling, that is, free improvised rap. Here he put together improvised rhyming lines, based on a text with a theme that particularly concerned him that day. He could combine this with material he had written earlier. In a later interview, he says that through these improvisations he could experience musical "flow." There he was able to give expression to thoughts, inspirations, and energies that had built up inside him.*

[346] The following is based upon Solli, 2014.

Marco was one of the patients on the ward with the most serious mental health problems. Solli was nevertheless surprised by how well he functioned in music therapy, how many resources he was able to mobilize, and how structured and concentrated he worked. Marco himself later explained how he experienced music therapy as a freedom from the illness, the psychosis, and everything that troubled him. It felt good for him to come into the music room. He experienced the room itself as peaceful, without negative forces, with instruments that radiated joy.

On a few occasions, when Marco was acutely psychotic and too ill to come to music therapy, Solli visited him on the ward. In such a state, Marco did not want music therapy. When he improved, he could express a wish to be with other people. He would gladly bring friends and other patients with him to music therapy. He was allowed to bring another patient, but this did not function optimally. Even so, this collaboration with other patients on the ward gave him a social network.

One day Marco came to music therapy with a sheet of self-written rap lyrics and some sound files he had made on his computer. He said he wanted to make a CD. This became the beginning of a process that gave a new structure to the sessions. A creative co-production emerged in which they alternated in the roles of musicians and studio workers. Sessions could begin with Marco transferring his music files to the computer and playing them aloud in the room. They then discussed how they could further work on the song. Here Marco could take the song further by rapping, while Solli handled the recording. When Solli played drums, Marco took responsibility for the recording.

In this way, five songs were produced for a CD. They made fifteen copies so that Marco could give them to fellow patients, friends, and family. The hospital ward received a copy, and the music was played in the ward room while people sat down to listen. Marco received positive feedback and wanted ten more copies of his CD.

A month after the CD was finished, the hospital held one of its annual seasonal closing events. This was a collaborative project in which patients were involved in various art projects and cooking groups or contributed to the entertainment. The music therapist encouraged Marco to perform two or three songs as a warm-up act for the professional band that had been invited to play. He responded enthusiastically and positively. The next music therapy sessions were used to prepare the performance and rehearse the songs with playback and drums. They discussed details of the performance,

how to handle nervous pressure, and the possibility of withdrawing if Marco had a bad day.

The performance turned out to go well. The audience danced, clapped, and gave positive responses to what they experienced. After Marco's performance came a concert by the professional musicians. A high point for Marco came when the musicians invited him onto the stage. There he was able to rap his texts freestyle over a groove provided by the experienced professional musicians.

In the following music therapy sessions, they debriefed the experience. Marco clearly expressed how important it had been for him to meet, be with, and collaborate with other people.

A week after the concert, Marco wanted to upload his music to the internet. They created a new user profile and uploaded one of the songs. Marco was excited to see whether any comments would come in. But nothing happened over the next few weeks, which stressed Marco. He saw that several people had listened, but no comments came. Marco was disappointed, but said that, really, music was not all that important to him anyway.

Then one day he came to music therapy clearly upset. A girl had listened to his song and commented that she did not like it at all. She justified this by saying that there was no flow in his rap and questioned whether he was really a rapper.

Marco reacted with irritation and anger. He rationalized the experience by saying that music, after all, was not that important to him. The girl's reaction nevertheless became a theme that filled the music therapy in the following sessions. Solli therefore asked Marco to create a freestyle rap about his frustration. Out of this came a long tirade in interaction with the music therapist on drums.[347] *This rap was the last thing that happened in music therapy with Marco before he was discharged and transferred to another institution.*

Many of the elements that appear in this case description correspond well with the CHIME framework, an acronym for Connection, Hope, Identity, Meaning, and Empowerment. Within recovery philosophy, it has been pointed out how these factors positively affect recovery: Connection, which includes

[347] See Solli, 2014, p. 217 for the text.

support and connectedness with peers, social groups, and the local community; Hope and optimism, meaning belief in one's own recovery, motivation for change, relationships that inspire hope, positive thinking, and valuing one's own efforts, as well as having dreams and aspirations; Identity, which in this context means rebuilding a positive sense of identity and overcoming stigma; Meaning, another important aspect of recovery, meaning finding meaning in experiences of mental health challenges, creating a meaningful life and a social role; and Empowerment, which entails personal responsibility, control over one's own life, and a focus on one's own strengths.[348]

From this framework we can see that many of the activities and experiences music therapists offer align closely with the points in CHIME. Research and experience show that music therapists offer activities, for example playing in a band, that motivate participation and attendance and are thus a good help in overcoming so-called negative symptoms such as withdrawal, which characterize people with psychotic disorders.[349]

FACT – Flexible Assertive Community Treatment

In recent years, music therapists have become employed in so-called FACT teams. The model was originally established in the Netherlands and was adopted in Norway in 2013. Over the last 10 years, nearly 75 FACT teams have been established in Norway.[350]

In Norway, music therapy researchers Hans Petter Solli and Marie Strand Skånland have studied the role of music therapy in FACT. In an interview, Skånland says that, together with the CHIME framework, music therapy makes an important contribution to establishing good relationships and creating a treatment alliance. We know how important the relationship is for therapy and recovery. Through musical interaction and by following users over time, music therapists create good alliances. They can accompany a user on a visit to a guitar shop, to choir rehearsals, and to concerts. Long-term and stable relationships are necessary in social recovery so that the user can eventually live an independent social life.[351]

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[348] http://www.therecoveryplace.co.uk/chime-framework/ Access date Sept. 25, 2025.

[349] See Gold et. al 2009, 2013.

[350] https://www.helsedirektoratet.no/forebygging-diagnose-og-behandling/psykisk-helse-rus-og-avjhengighet/act-og-fact-team

[351] Andersen, 2024. See also Skånland, 2023; Skånland and Trondalen, 2023.

Mentalization-based therapy for personality disorders

Personality disorders occur in about 13 percent of the population and are characterized by a deviation in personality that results in problems in functioning.[352] The causes of personality disorders may be genetic vulnerability and psychological and social factors. This includes unstable upbringing conditions, neglect, trauma, and a lack of good adult role models. People with personality disorders may have problems related to identity, goals and meaning in life, as well as capacity for empathy and closeness.[353]

Therapeutic alliance and common factors

Successful music therapy work with personality disorders depends on building a good alliance with the patient. We know how important the therapeutic alliance is for successful psychotherapy.[354] This is referred to as a working alliance and concerns the bond between patient and therapist, as well as a shared understanding of the tasks of therapy.

The working alliance is considered one of the common factors in psychotherapy, along with empathy, expectations, cultural adaptation, and differences between therapists. These are factors that occur in all psychotherapy regardless of the therapeutic theory or model the therapist works from. Such common factors, of course, also apply in music therapy. At the same time, ruptures in the working alliance and possible subsequent repair may be central elements in treatment.

Mentalization-Based Therapy (MBT)

In mentalization-based psychotherapy, attention is directed toward the ability to mentalize, that is, to become aware of and understand one's own and others' thoughts, feelings, motivations, and intentions. Therapy sheds light on relationships and interactions between people and on how this affects our feelings. There are techniques for regulating emotions and for understanding what lies behind them.

[352] Karterud, 2024.

[353] Karterud, 2024.

[354] Hannibal and Strehlow, 2024.

For music therapists and researchers Niels Hannibal and Gitta Strehlow, psychodynamic theory, and especially mentalization-based therapy, is important in work with clients with personality disorders. They also ground their understanding in a process-oriented music therapy in which musical improvisation is a meaningful form of interaction that does not depend on language with explicit semantic content. The experiences that emerge through improvisation have aesthetic, interpersonal, and intrapersonal meaning. This meaning is not only cognitive, but equally a bodily experience.

Based on the patterns of suffering that characterize people with personality disorders, they are especially sensitive to the interpersonal dynamics that resemble earlier experiences. This dynamic occurs without cognitive control. From the perspective of mentalization theory, the patient cannot see themself from the outside and the other person from the inside. This represents a challenge for therapy, and not least a risk that the client will terminate therapy too early. The following experiences from music therapy with personality disorders provide a good starting point for demonstrating improvisation, individual or clinical music therapy, and the use of mentalization-based therapy (MBT).

This is how Niels Hannibal and Gitte Strehlow write in an article:

> *When patients with personality disorders come to therapy, they are often full of confusion, doubt, anger, poor self-image, and shame. Their mood is often low, filled with thoughts, feelings, and experiences that make life difficult and full of pain and discomfort. When a person in such a state of mind comes to therapy, a great deal is at stake, while at the same time the expectation of possible change is often absent. When a person experiences having a personality disorder, the problems are bound up with relationships. This means that the feeling of who I am, how I feel, what I think, and what I do is generally dependent on the responses of others and on how they perceive the person.*[355]

Against such a background, we understand that clients often experience painful loneliness, emptiness, and meaninglessness that have arisen from an ambivalent and disorganized pattern of attachment efforts. Clients may react to the smallest changes in facial expression, voice, questions asked, and so on, making the first meetings with the therapist highly challenging.

[355] Hannibal and Strehlow, 2024, p. 5.

Challenges in alliance building

The challenges pointed out by music therapists involve doing something that takes clients out of their comfort zone. Given a good working alliance, such challenges are important for moving forward in therapy. But before the alliance has been established, one enters unknown and vulnerable territory.

There are several themes linked to clients' experience of music therapy. It may be that the situation feels unfamiliar, that improvisation is uncontrollable and unpredictable. Clients may ask themselves whether playing a drum really helps with their problems, their insecurity, and their life situation. This is especially so if the person has high expectations of themself and wants to do things perfectly. Feelings of vulnerability, shame, loss of control, and anxiety easily arise. Playing a musical instrument challenges the sense of mastery and therefore the possibility of failing, being humiliated, feeling shame, anxiety, and other emotional themes that in turn awaken earlier attachment patterns and behaviors.

Hearing oneself play or sing provides information about how one feels, one's own state of mind. This, in turn, can create a strong feeling of frustration and anger. Such challenges are relevant in work with all clients within mental health but are probably particularly demanding in work with people with personality disorders.

Music therapists will encounter challenges in building a working alliance. These may involve how one responds to the way the person plays, for example if the person plays very loudly or very softly. If the improvisation takes place in a group, this can be even more demanding, since there may be different wishes among the participants.

Another challenge relates to the phenomenon of countertransference, that is, the strong and potentially unpleasant feelings that may arise in the therapist. These may include experiences of becoming entangled in feelings of shame, helplessness, tension, and fear of failing. If one does not recognize and understand such feelings, this becomes an obstacle to alliance formation and creates mentalization challenges for the therapist.

Such challenges for client and therapist are not something one should try to avoid but rather regard as necessary in the therapeutic process. They must be explained to the client as part of the process that music therapy involves. If a rupture in the alliance occurs, it is important to acknowledge it in order to begin a process of repairing and re-establishing the alliance. Understood within the theory of the working alliance, such ruptures arise because of insecure attachment patterns, negative reactions in transference, defensive responses, and dissociations that

occur in the relational dynamics. Hannibal and Strehlow emphasize that the therapist must be able to recognize their own implicit or automatic responses while regulating the emotional tension in the interaction up or down to an appropriate level. At the same time, they offer suggestions for how this can happen by paying particular attention to and validating the client's reactions as responses to what just happened in the interaction.[356]

Benefits for the client

There are several advantages to using music and improvisation in this approach. These advantages apply generally to all improvised music therapy but are especially important for people with personality disorders. Hannibal and Strehlow mention here how music is effective in changing a mood, giving a sense of vitality and strength. Playing gives the opportunity to be "childlike," to allow oneself to play loudly and aggressively, and to let go of control a little.

Music can offer a safe place, be less challenging and confrontational than using language. The focus shifts more to what it is like to be together than to what we think and talk about. In this way, musical meaning becomes open and unspecific and offers a distraction from troubling thoughts and rumination. Music gives access to bodily experiences and can open joy and humor.

Not least, music creates a framework for relational experiences. Everything we know about improvisation points to its value in establishing contact, creating interaction, and building a relationship. Improvisation methodology has provided several techniques for creating this form of interaction. We speak of the use of music to imitate, mirror, and support, in order to create attunement and entrainment. "The patient may experience a shift from chaos to a sense of community. From being isolated and alone to a subtle experience of attention, empathy, and inclusion; patients have the power either to engage or to distance themselves. They can experience having control," write Hannibal and Strehlow.[357]

Anxiety, sleep difficulties, and depression

In the chapter on music and public health, I wrote about stress and anxiety, and about how many people listen to music in everyday life to enhance well-being and

[356] Hannibal and Strehlow, 2024.

[357] Hannibal and Strehlow, 2024, p. 11.

health without consulting health professionals or music therapists. There is documentation showing how people use music in daily life to calm down, relax, and find peace. For many, this happens without help from health professionals or music therapists. Some, however, need help to get started, find music, and create routines for calming themselves and being more present in life. There is therefore a need to develop ways of working and talking that meet users who need help dealing with anxiety, sleep problems, and changes in mood.

Anxiety

A recent review article highlights that music listening can reduce anxiety and worry.[358] Anxiety is one of our most widespread mental health problems. In the United States, 18 percent of the population have experienced an anxiety disorder during their lifetime, of whom only 20 percent receive treatment.[359]

An anxiety diagnosis involves excessive worry and fear that often negatively affects daily life. After Covid-19, the prevalence of anxiety disorders has increased, along with the need for help. Common treatments for anxiety disorders include medication and cognitive behavioral therapy. With advice and guidance, music therapists can help individuals influence their own mental health. Increased awareness of how music can help may provide more resources to the mental health field. If listening to music can yield positive results, help may reach more people.

There are several possible explanations for why anxiety may be reduced when listening to music. Physiological explanations include stress reduction and effects on heart rate and blood pressure. Emotional self-regulation is another factor, where music is used to alter emotional states.

A literature review showed that music listening significantly reduced anxiety in all groups studied, whether in everyday settings, within correctional services, or among people with memory difficulties.[360] This effect is linked to music's ability to regulate emotions, although the specific mechanisms were not tested. The length of listening, the context, or whether the music was chosen by the researchers did

[358] Harney et. al., 2023.

[359] Harney et. al., 2023.

[360] de Witte, et. al., 2025.

not significantly influence the results, and thus the possibility that the person could manage their own anxiety through music.[361]

Such use of music is available to everyone. Health professionals, music therapists, and individuals themselves can make use of music's possibilities for influencing experiences of anxiety. By creating playlists, anyone can use the regulatory effects of music. An open approach to music, and recognition of how musical taste and identity are connected, makes it possible to create playlists to meet different challenges.

Sleep difficulties

As I wrote in the chapter on music and public health, there is a great deal of research and experience concerning the use of music to improve sleep. It is advisable to identify the musical genre one prefers, make a playlist, and for a few weeks try listening to it before going to bed.[362]

Such a playlist, with relaxing music, should be personal and consist of music that is slow and steady in tempo, with small changes in rhythm. The melody should be predictable, with few leaps and kept within a narrow range. The tonal structure should be simple, with predictable chord progressions. String instruments and woodwinds are preferable, while brass and percussion are avoided. The music should have few dynamic changes, and these should be introduced gradually.[363]

A number of reasons have been proposed for why music helps with insomnia.[364] Not all of them are equally strongly supported by research. There are individual differences in how people use music. It is pointed out that music contributes to physiological and psychological relaxation. This may be due to the distraction that occurs when music diverts attention away from troubling thoughts. The phenomenon of entrainment has also been mentioned, meaning that biological rhythms become synchronized with the beat of the music. Masking, what happens when music covers disturbing background noise, may also help induce sleep. Listening to music one likes, that is, as entertainment, is also mentioned as an

[361] de Witte, et. al., 2025.

[362] de Witte, et. al., 2025.

[363] de Witte, et. al., 2025.

[364] Dickson and Schubert, 2019.

explanation of why music helps people fall asleep. One's own expectations and cultural beliefs about the effects of music also play a role.[365]

Depression

Depression is the most common mental disorder.[366] In the chapter on music and public health, I wrote that depression is a state characterized by sadness and low mood, loss of interest and pleasure in activities that were previously enjoyable, and a feeling of having less energy than before. I pointed out how musical activity, such as playing and singing, can provide a way out of depressive thoughts.

A Cochrane study included nine studies with 421 people of all ages.[367] Here, the effect of music therapy was compared with standard treatment and psychotherapy. Differences between active and receptive music therapy were also examined. The comparisons showed that music therapy in addition to other treatment was more effective than standard treatment alone. Music therapy appeared to reduce depressive symptoms and anxiety. It also helped improve everyday functioning, such as maintaining work, activities, and relationships. The study did not show whether music therapy was better than psychological treatment, or whether one form of music therapy was better than another.[368]

In people with depression, listening to music may trigger negative associations linked to autobiographical memories. This can create resistance to listening to music. Reflection on negative experiences may, however, be an important starting point for further psychotherapeutic work.[369]

Mindfulness

Therapists have tried to combine music listening with techniques from mindfulness. Mindfulness, however, involves a kind of presence or awareness with special attention to how one relates to the present moment. One is supposed to have a non-judgmental attitude toward the experiences that unfold. This is difficult to combine with music because listening to music requires a type of attention that

[365] Dickson and Schubert, 2019.

[366] Røssberg, 2025.

[367] Aalbers, et. al., 2017.

[368] Aalbers et. al., 2017.

[369] See McFerran and Lotter, 2024, p. 86.

distracts from other attention directed toward the surroundings or toward internal stimuli. Different combinations have nevertheless been tried, for example by reducing the music to a faint background.

What has, however, been well tested and supported by research is the use of Guided Music and Imagery. Here, attempts have been made to include techniques from mindfulness in the first induction phase of the music journey. Whatever approach is used, it is important to be aware of where one wants to place the focus: on mindfulness or on music listening, write McFerran and Lotter.[370]

What music?

When it comes to the question of which music is best suited to create relaxation, there are several opinions. Some have pointed to so-called Meditative Binaural Music (MBM). This music has a percussive beat created through small differences in sine waves, combined with a slow tempo and gradual changes in the music. A slow tempo is common in all music proposed as relaxing.

It may be that MBM suits younger people, which some research suggests. Classical music is perceived as more relaxing for older people. There is a great deal of MBM music on YouTube, and the offering is partly commercialized. Since there are differing opinions and many forms of music that work, there may be a placebo effect at play. What seems to be effective is combining music listening with progressive muscle relaxation.[371]

Eating disorders

Eating disorders become apparent when thoughts and behaviors related to food and weight limit one's life and reduce quality of life. This, in turn, may lead to new problematic thoughts and feelings. People with eating disorders are excessively preoccupied with their body, weight, and appearance. They feel controlled by thoughts and feelings related to the body. This has been understood as a way of handling chaotic and difficult feelings, related to what is generally referred to as affect or emotional regulation. In this way, the eating disorder becomes a means of managing and regulating difficult feelings.

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[370] McFerran and Lotter, 2020, Chapt. 3.

[371] See McFerran and Lotter, 2024, p. 86.

There are three main types of eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder. Anorexia involves restricting what and how much one eats. Bulimia is expressed through repeated episodes of binge eating. A binge eating disorder is characterized by repeated episodes of overeating without compensatory or weight-regulating behavior.[372]

Music therapy for eating disorders

Music therapy in the treatment of eating disorders is an important field of practice for music therapists, and there are substantial literature and research in this area. Music therapist and professor Gro Trondalen investigated in her doctoral work how musical interaction through improvisation facilitates "significant moments" for young people with anorexia. She based her theoretical grounding on developmental psychology and Daniel Stern's theories. Trondalen showed how improvisation creates experiences of reciprocity and dialogue. Musical improvisation provided room for regulation, in that the client could act and be affected by the other.

After the improvisation, she conducted conversations and, where relevant, self-listening, that is, listening to the improvisation they had carried out. This conversation entails the possibility of creating new narratives based on jointly created activity. This may lead to an increased ability to manage internal and external tension with a view to loosening relational patterns that have become rigid.[373]

Music therapist and researcher Ingvild Stene's work with women with eating disorders took as its point of departure the use of music as regulatory support in relation to the emotional challenges the women spoke about in group therapy. Music listening and talk therapy formed the basis for the development of the method Therapeutic Music Listening (TML). This clinical method contributes to knowledge about how music affects body and emotions and stimulates awareness of music use in everyday life as part of emotional regulation.[374]

[372] Moen, 2024.

[373] Trondalen, 2004.

[374] Stene, 2023.

Music therapy in the field of substance use

Music therapy has received a recommendation from the Norwegian Directorate of Health as an effective treatment method in substance use treatment and rehabilitation. KORUS, a competence center for the substance use field, writes on its website that music therapy is about making use of the opportunities music offers in relation to mastery, participation, and inclusion in relationship-building activity.[375]

It further states:

> *Music therapy takes place individually or in groups. It is the user who guides the musical interaction, according to what he or she can do and wants to do. Music therapists take a resource-oriented approach in work with substance dependence and mental health. The point of departure is the user's resources, with the aim of promoting health and quality of life.*
>
> *Music therapy makes use of different forms of musical interaction. This may include improvisation, ensemble playing and performance, composition/ songwriting, as well as listening to and talking about music. Music therapy emphasizes user involvement and equal relationships. Music therapy is an option within medication-free treatment and can complement talk therapy and other non-pharmacological approaches.*[376]

Music therapist Monika Overå has written about her experiences in work with people facing substance use challenges in the book *Hooked on Music*.[377] The book offers insight into the users' own experiences and reproduces songs written by the participants. As for working methods, it highlights the importance of relational work, how interaction takes place, and the use of songwriting, as well as singing and improvisation.

A meta-study in the Cochrane database concludes that music therapy, in addition to standard treatment, may lead to a moderate reduction in cravings and can increase motivation for treatment for people undergoing detoxification and rehabilitation.[378] An implementation handbook has also been developed for music therapy in mental health and addiction services.[379]

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375 https://korus.no/vare-fagomrader/musikkterapi Access date September 26.2025

376 https://korus.no/vare-fagomrader/musikkterapi Access date 26.9.2025. Six videos have been made that illustrate the work, see https://napha.no/content/25907/seks-filmer-om-musikkterapi Access date September 26.2025

377 Overå, 2013.

378 Ghetti et. al., 2022.

379 Kielland, Solli and Trondalen, 2024.

Music therapists and researchers Brynjulf Stige, Hans Petter Solli, and Claire Ghetti have provided an overview of the field in a comprehensive anthology on substance use treatment.[380] In the chapter they give an overview of national professional guidelines, reasons why music therapy can be used in substance use treatment, research findings, and examples of working methods, implementation, and music therapy practice. When it comes to the rationale for use, they point to how music therapy can motivate many users, support and supplement existing treatment services, and contribute to renewing services.[381]

Music therapy in correctional services

Experiences of rehabilitation for inmates in prisons show that this is an area that functions poorly. Studies concerning treatment and rehabilitation outcomes about recidivism conclude that prison, with almost no exceptions, has no rehabilitative effect. At the same time, research shows that music therapy offerings in and outside prison have several positive effects.

Music provision in correctional services may aim to make inmates better equipped to cope with everyday life after release, stimulate positive musical and social experiences, and develop the personal, musical, and social resources of inmates and former inmates. Activities used include bands and ensemble playing, songwriting, and performance.

Many inmates, especially those who have lived marginalized lives marked by substance use and crime, may have had limited opportunities to develop social skills that are useful in mainstream society. To live in environments where the law of the strongest prevails can easily have negative consequences for self-reflection, expressive ability, and the capacity to interpret the social and cultural content of interactions.[382] These are the kinds of skills that make up what we call basic social competence. Music groups can largely offer a social field of action in which such competence is tested and developed.

Particularly in rehabilitation contexts, individuals need to develop new forms of basic social competence, new ways of interacting with others, and a renewed sense of identity. A useful starting point for music therapy can be the (rock) band

[380] Stige, Solli and Ghetti, 2025.

[381] Stige, Solli and Ghetti, 2025, p. 455–476.

[382] Mohn, 1998

format, often expanded through the inclusion of additional instruments. Through rehearsal and ensemble performance, participants are given the opportunity to develop both musical and social skills.

If we consider what participation in a music group entail, it becomes clear that it is not only a matter of mastering basic musical abilities. Equally important are skills such as concentration, cooperation, impulse control, and perseverance. Perhaps most crucial in this type of group-based musical work is the development of tolerance, along with the capacity for decentering and perspective-taking. These refer to the ability to view a situation from another person's perspective and to use that understanding to demonstrate consideration and tolerance toward others.

Music in prison and freedom

A Norwegian project *Music in Prison and Freedom* has become a nationwide offer of music education and activities during and after incarceration.[383] The initiative began in a prison for women for women by music therapist Venja Ruud Nilsen and has spread to include music activities in several prisons. The project is organized in three stages: (1) music provision for inmates while they are serving their sentence, (2) music provision that builds on stage 1 but is carried out in freedom, and (3) music as a leisure interest, pursued on the users' own initiative.[384] The project has been well evaluated.[385]

Music groups motivate cooperation that extends over time. They provide opportunities to develop a new vocabulary for resolving conflict. Not least, new musical skills offer the experience of new competence, a new and more positive self-image. In the work of music therapists Venja Ruud Nilsen and Bente Mari Mortensen, women have been offered ensemble playing after release. In this way, many learn, perhaps for the first time, what a leisure activity can be. The women have a fixed drug-free activity to come to. They receive care from a music therapist and through the therapist and musician encounter a positive role model during a difficult transitional phase of life.[386]

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[383] https://www.musikkifengselogfrihet.no Access date September 26, 2025.

[384] https://www.musikkifengselogfrihet.no Access date September 26, 2025.

[385] Gotaas, 2006.

[386] Mortensen and Nilsen, 2019.

An important contribution to music therapy within correctional services comes from music therapist and associate professor Kjetil Hjørnevik. Through research articles, he has communicated some new perspectives on this work. Marked by a community music therapy discourse, he addresses the role of music in everyday life for inmates in a low-security prison. He has focused on the identity work that takes place through musical activities, about the reconstruction of an identity narrative that preserves continuity in identity experience.

A study shows that the music therapy provision represents a fruitful way of creating continuity in life experience and identity, and contributes knowledge about relationships between culture, prison practice, and prevention of recidivism.[387]

Hjørnevik and his colleagues also show how the prison environment is shaped by a form of emotional geography, and how music affects this emotional landscape.[388] The research shows how music creates new zones, or expands the space for emotional nuances and forms of expression among male inmates.[389] The everyday musical practice that the music therapist helps to stage contributes to transforming the prison into a "musical stage." Within this stage, the inmates are offered new opportunities to explore their gender roles, their emotional capital, and to show care for one another, thereby influencing their own self-image.[390]

Music therapist, music educator, and senior lecturer Bente Almås has highlighted the value of linking musicians and music educators to work with inmates in prisons. In the book *Voices from the Inside*, reflections from music students who have participated in the projects are presented, together with diary entries and texts from the inmates.[391]

Music therapy in work with refugees

Since the establishment of music therapy education in many countries, the field of practice for music therapists has gradually expanded. There is no reason to believe that this development will stop. New possibilities and forms of application for

[387] Hjørnevik, Waage and Hansen, 2021.

[388] Hjørnevik and Waage, 2019.

[389] Hjørnevik and Waage, 2019.

[390] Hjørnevik and Waage, 2019.

[391] Almås and Gimmestad, 2020.

music therapy will always continue to emerge. One area that is now being practiced and researched is music therapy for people who are internally displaced within their own country or fleeing to other countries. According to the UN, there were 117 million people displaced from their homes in 2024. Music therapy for this group of people is concerned both with providing trauma-informed care and with creating opportunities for cultural exchange and a positive transition into a new culture.[392]

We have gradually seen many examples of music therapy for children and young people living in refugee camps around the world or who have come to seek refuge. We have seen that aid workers, psychologists, and musicians have found their way into such arenas. Offering children and young people who live under difficult and stressful circumstances a breathing space from a hard everyday life has value and a health-promoting quality.

We often hear of spontaneous initiatives within refugee camps where children are offered various kinds of activities, which is of course positive. When music therapists or other health workers enter such projects, it is important to take the time dimension into account. It is desirable to avoid music therapy becoming a form of tourism in which the therapists leave the scene after a few weeks.

At the *Norwegian Academy of Music*, music educator and senior lecturer Vegar Storsve has, over twenty years, built up a musical program for children and young people in a Palestinian refugee camp in South Lebanon. This has primarily been a music education program with emphasis on instrumental instruction and ensemble playing in a mixed orchestra. But with its emphasis on the connection between culture and health, and with the working methods this project has chosen, we could speak of it as a community music project, or possibly a community music therapy project.

A report from this musical work uses 'hope and recognition' as the heading for the project. Here the work is placed within a broader theoretical framework. The ensemble playing in the orchestra is regarded as a community of practice, where learning and identity development are closely linked. The project draws on the anthropologist Etienne Wenger, who developed theories of learning in which participants are given the opportunity to take on different positions and roles within the community. The young people find a learning pathway that moves from

[392] Coombs, Gracia and Maclean, 2025.

peripheral participation to advancing into roles where they function as teachers for the younger children.[393]

Another important discussion that illustrates this project concerns the relationship between music therapy, here understood as community music therapy, and community music. Since the project is primarily run by music educators, with music therapists in an observer role, interesting questions arise concerning the boundaries between the disciplines. As I will discuss later in relation to music therapeutic identity, in the section on "Similar, but unique" in the chapter on professional knowledge, there are several common features between these pedagogical and therapeutic approaches. This applies especially when community musicians work with health as one of their goals. It is not difficult to observe and argue for the value of this project for the participants' health and quality of life.[394]

In her doctoral work, music therapist and researcher Merete Hoel Roaldsnes investigated what participation in a music group could mean for young people with a background as unaccompanied minor refugees.[395] She gathered a group of young people into a music program over a period of ten months in which they improvised, received instruction on various instruments, sang, and gave private concerts. The study showed that the young people experienced more positive emotions; they felt less tired and less depressed. The music sessions distracted them from worry and problem-related thoughts and gave them hope and a more optimistic outlook on the future. They experienced mastery and self-confidence and found new resources in themselves, a sense of belonging in the music, and belonging within the group. This applied both to belonging to their home country using music from their own culture and to an emerging sense of belonging to Norway.

With regard to aspects of health, the music therapy built up resistance resources. These were interpreted within a framework of trauma-informed work, a resilience perspective, and theories of psychosocial work with unaccompanied refugee children.[396]

Another practice example is found in the doctoral work of music therapist Kaja Elise Enge. She investigated how participation in music therapy in a primary school could prepare refugee children to cooperate with their peers at school. The

[393] Storsve, Westby and Ruud, 2011.

[394] Ruud, 2012b.

[395] Roaldsnes, 2017.

[396] Roaldsnes, 2017.

project showed that music therapy helped the children regulate their emotions, build a shared repertoire of music, and use that knowledge in negotiating with peers in interaction with the other children at school.[397]

How social workers assess the role of music for unaccompanied refugee children has been investigated by music therapist Ole Kristian Einarsen. He finds that social workers, who play a crucial role in these children's lives, see that music therapy supports the children in their emotional challenges and that the music provision promotes dialogue between the children and their surroundings.[398]

An important aspect of this work is the use of music and musicians that are closely connected to the cultural backgrounds and histories of the children and young people involved, as illustrated in the earlier section on music therapy in their development. This is supported through collaboration with musicians who have refugee backgrounds or who possess extensive knowledge of music from the participants' countries of origin. These musicians are familiar with the language, musical traditions, and instruments that the young people recognize from their own cultural contexts.[399]

Contraindications, failure, and harm

It is important to discuss music therapy processes that, in one way or another, do not go as planned. Health professionals such as doctors, nurses, and psychologists have traditions of examining and understanding why things have gone wrong, in order to repair, correct, and learn from mistakes. For music therapists, it is equally important to learn from mistakes to improve practice. Contraindications refer to situations in which music therapy has adverse effects. These are situations where the musical intervention works against its intention, leads to mistakes, and in the worst case harms the client.

To give some examples: when it comes to listening to music, it is entirely possible to choose the wrong music and thereby create negative reactions in participants. One should be aware that music can sometimes evoke strong and overwhelming experiences. It is therefore important to stay alert and change or stop the music when one notices such reactions in listeners. In the case of GIM, that is, listening to music that evokes images and associations, it has been pointed out that the

[397] Enge and Stige, 2022.

[398] Einarsen et. al., 2024.

[399] Mortvedt, Svendsen, Karlsen and Stensæth, 2025.

listener must have the capacity for symbolic thinking. They must be able to distinguish fantasy from reality and be able to share their experiences with the therapist.[400]

Improvisation may create a chaotic situation, especially if it takes place in a group. For some people, this will create a sense of insecurity. For some, the form of improvisation is highly unfamiliar, creates performance anxiety, and leads to withdrawal.

If songwriting is used as a method, one must be aware that the lyrics may touch upon difficult themes and create strong emotional reactions. If users are invited to perform the music, it should have been discussed beforehand how they relate to being exposed, and whether there are risks of stigmatization. To fail musically in front of an audience will leave a damaging mark on self-image.[401]

Failure and harm

There are several terms that refer to an adverse course of events. Here people speak of failure, mistake, impasse, and even harm.[402] However, making a mistake does not necessarily mean that the therapy has failed. Mistakes can be corrected, perhaps already in the same session. If the therapy fails, that does not necessarily mean that the client has been harmed. Precisely the possibility that things can go wrong, that there is a possible danger in using music as treatment, also means that music therapy has the potential to bring health-promoting effects.

Music therapy may go wrong when music is presented in the wrong way. This happens when the music is not adapted to the situation or does not take the user's musical identity, cultural background, power relations, or illness profile into account. Ruptures may occur in the relationship between music therapist and client, something that has been well explored in psychological treatment. Ruptures arise when the therapist misinterprets or overlooks the intention in musical messages. Or therapy fails because of external circumstances, such as lack of cooperation with caregivers or other therapists.

Music therapeutic approaches always involve a certain degree of risk. This is connected to whether users will respond to the music, whether one should

[400] Grocke and Moe, 2015.

[401] See Gilboa and Hakvoort, 2022.

[402] Gilboa and Hakvoort, 2022.

challenge, intensify, or end an improvisation. Risk arises when working with an unfamiliar repertoire, when considering whether the right instruments have been chosen, and through many other factors related to the users' musical tastes or cultural background.

Within GIM, the choice of format may be wrong. This may happen if, in a group, there is no room for individual adaptation of the music, or no possibility of follow-up through individual sessions. The choice of the music itself presents challenges. Within psychodynamic or analytical music therapy, relationships, interpretation, and transference issues create possibilities for error. In medical music therapy, mistakes may arise because of insufficient knowledge about medical conditions and procedures. A music therapy session easily breaks down if too much insecurity is created in the group, when participants lose trust in the music therapist, and a chaotic soundscape emerges.

Other examples occur when the music therapist takes on responsibility and tasks that exceed their own competence. This can happen in work with groups of young people where one tries to build music groups around individuals with special challenges. Lack of knowledge about group dynamics and the different roles participants assume creates problems. A lack of ability to say no when systems and colleagues push for the carrying out of certain tasks easily creates new problems in the next round.

Students who participate in role-play, clinical training, or are newly qualified are especially exposed to making mistakes and experiencing themselves as failures. Mistakes are made, and not everyone handles this equally well. Students may lack musical flexibility. In practice, they may then dare too little or too much. They become too bound by rules, and as newly qualified therapists they may have excessive faith in the possibilities of music therapy because they lack experience of their own limitations. Lack of supervision is sometimes the reason why mistakes are made. We should remember that it takes a long time to rebuild a damaged self-image, also for the therapist themself.

After one discovers that a mistake has been made, feelings usually arise in the therapist — from surprise to guilt and shame, regret, thoughts of blaming others, confusion, and helplessness. Sometimes the recognition grows slowly; in other cases, one immediately understands that this did not go so well. Recognition of mistakes is an important step in moving forward, learning, and perhaps correcting things if possible. Here again, collegial support and supervision are important. It is necessary to analyze one's own mistakes and move on.

Cultural humility

Mistakes and misunderstandings can arise due to cultural differences. Music therapists must therefore be attentive to how musical and cultural factors are closely linked to identity. By reflecting on the musical identities of those receiving therapy, practitioners can better recognize and respect participants' musical values.

Cultural differences often become evident in differing understandings of music—what is considered appropriate, imaginable, or permissible in musical practice. For example, a woman from Ethiopia was once invited to sing a well-known funeral song, which resulted in a distressing and regretful experience. The therapist had not realized that such songs should only be performed within the specific context of a funeral in that cultural setting.

Another example concerns Orthodox Jewish traditions, in which women are not permitted to sing in front of unfamiliar men, as singing is associated with intimacy and close relationships. In one instance, when boys witnessed girls singing during a music therapy session, it led to a serious violation of their religious norms.[403]

Assessment in music therapy

Assessment and evaluation of one's own work in music therapy are important and necessary. However, there is no standard method for assessing clients in music therapy. Several factors influence assessment. The assessment considers which client group one is working with, the institution in which one works, and it must evaluate the musical activity. Most important of all is to reflect on one's theoretical and philosophical position, and how this influences one's view of people in treatment and one's choice of music therapeutic treatment model.

Music therapist and researcher Gustavo Schulz Gattino defines assessment as a structured process of preparation, data collection, interpretation and conclusion, as well as documentation and communication of musical and non-musical data related to the music therapy process. This is done in order to generate information for making decisions, forming hypotheses, getting to know the client better, and achieving a better understanding of the music therapy

[403] Gilboa and Hakvoort, 2022.

process.[404] Assessment takes place after a referral, an order, an observation, or on the initiative of the music therapist.

There are several ways of gaining knowledge of and familiarity with clients in music therapy. We read behavior and note musical expressions, get to know clients and interview relatives. We may read records and speak with other professionals and read literature that shapes our prior understanding. We may use recognized assessment instruments to ensure a solid basis for choosing the right music therapy approach. The assessment should help us formulate good goals for music therapy, make plans for progression, and choose good forms of observation, documentation, and reporting.

We use information from sources provided by other therapists, our own notes from the therapy process, audio recordings, song lyrics, drawings and graphic material, and so on. Or we use interviews, observation, tests, and other measuring instruments. In addition, some develop their own assessment instruments, or adapt and transfer known instruments for use in their own practice.

Knowledge is also gained by reading literature and relating critically to all information about the client.

The assessment should include the client's musical responses in relation to any diagnosis, and a description and interpretation of how musical responses are used in therapy. Finally, one may ask whether what happens in the musical process provides information about therapeutic progress. The process includes not only tests or the use of standard protocols but also developing one's own musical protocols for a client, making in vivo assessments, or using conversation where possible.

Forms of assessment

When it comes to different forms of assessment, the choice of approach will depend on the therapist's goals, the area of practice, and the clinical orientation adopted. Assessment may have a problem-, need-, or resource-oriented focus, writes music therapy theorist Kenneth Bruscia.[405] He outlines several forms of evaluation across a spectrum from pathogenic to salutogenic aims, objective and subjective measurements, or assessments led either by the therapist or by the client. Assessment may have a limited focus, while some forms of assessment

[404] Gattino, 2021.

[405] Bruscia, 2023.

include broader contexts. We find explanatory, descriptive, and interpretive approaches.

Bruscia shows how different practices relate to these forms of evaluation. For example, music therapists in a purely medical context will largely be problem-oriented, concerned with pathogenesis, use objective criteria, and be therapist-determined. They may have a limited focus, be explanatory and categorical, treatment-oriented, individual-oriented, and directed toward the patient's past, present, and future.

Music-centered assessment

The focus of the assessment may be on the music, that is, it may be music-centered. Here the client's musical experiences are assessed. For Bruscia, this means skills, extra-musical associations, as well as other factors in the surroundings that influence reactions to music. A music-centered approach includes receptive music therapy, performance-based and recreative approaches, improvisational methods, and music therapy based on composition and songwriting.

Bruscia writes that when assessing phenomena within each of these music therapy approaches, one may be dealing with biographical factors or a medical and physical domain. It may involve brain activity, physiological responses, biofeedback, or self-reported information. The assessment aims to understand what bodily reactions the client has to music, the extent to which such reactions are harmful, and whether they provide information about the user's condition, needs, and resources.

When we speak of receptive music therapy, that is, listening to music, biographical information will involve assessing the client's musical identity, musical taste, cultural background, music use, and significant experiences. Bodily reactions and brain activity can be measured with EEG or fMRI, and physiological responses through readings of blood pressure, pulse, respiration, temperature, and so on.

Another area of assessment according to Bruscia is directed toward the behavioral.[406] This concerns what becomes visible during music listening, such as pain, stress, and emotional reactions. In the assessment of skills, the task is to register memory, perception, and cognitive skills related to processing music.

[406] Bruscia, 2023.

The assessment shifts focus when new music therapy methods are used. When we use recreative approaches, we observe other aspects of the client. The skill aspect becomes clearer, and both motor and perceptual skills become visible and available for assessment.[407]

With regard to the assessment of improvisational abilities, we seek to understand how clients use and organize the music they create themselves. Here attention is directed toward the degree of intentionality, pattern formation, self-regulated expression, degree of integration and variability, as well as the ability to monitor one's own improvisation. Within each of these areas, Bruscia points to possible approaches and choices regarding what one chooses to highlight.[408]

Person-centered assessment

The assessment may also be individual- or person-centered, where the music therapist, the client, family members, or others are assessed. The assessment may be directed toward the goals of the therapy, or toward the content that becomes visible in behavior, relationships, behavioral patterns, thoughts, and words.

Several aspects of health can be described and assessed, from biographical facts and behavior to medical or physical condition, to sensorimotor, cognitive, or perceptual skills that affect functioning. We can describe how the client experiences music and emotions, as well as relational and communicative aspects.

In the intrapersonal domain, we assess what goes on inside us in terms of thoughts, feelings, and memories. This is something we know well from studies of music and identity, both when it comes to listening and to other forms of musicking. When we work with composition or songwriting, self-reflection and personal expression give the therapist insight into what is happening within the client.

With regard to the relational domain, musical experiences will tell us much about which relationships have been important to us and how we use music to connect with other individuals, friends, or groups in the local community. The relational becomes especially visible when we work with a group, whether in band playing or through improvisation.

Assessment of children and young people must pay particular attention to developmental stages, that is, to what we expect from children at different stages in

[407] Bruscia, 2023.

[408] Bruscia, 2023.

terms of mastering specific skills. For example, when assessing instrumental skills, developmental psychological stages become important with regard to what is expected in motor and cognitive skills.

Assessment provides a basis for deciding which music therapy activity forms the client should be offered: improvisation, recreation, composition, or listening. We must investigate which musical preferences the client has, and assessment may, for example, be directed toward reading and interpreting how a client improvises alone on an instrument. Here Kenneth Bruscia has developed the tool Improvisation Assessment Profiles (IAP), which provides a psychodynamic (Freud) and existential (Binswanger) perspective on the interpretation of musical expressions.[409]

Within receptive music therapy practice, we categorize and assess different kinds of mental images, feelings, associations, and bodily sensations ("images") that occur during music listening. Songs and song experiences provide important clues for understanding the values and projections that become visible in clients.

About the relational domain, the assessment will be directed toward how musical interaction says something about the quality of the relationship between therapist and client. Here, analyses of musical elements from an improvisation provide information about the client. Bruscia refers to the variables of *salience*, that is, which musical parameters dominate or are under-communicated in the interaction. The term *integration* refers to how the client matches, integrates, or differentiates their improvisation in the interaction. *Variability* concerns how the client and therapist vary, repeat, or change the music through mutual coordination. *Tension* may arise, where the amount of energy that accumulates is maintained, modulated, and released through musical elements. By *congruence* Bruscia means the degree to which the feelings and moods expressed through the client's music correspond with those of the therapist. Finally, Bruscia mentions the category *autonomy*, which refers to the extent to which clients lead or follow the therapist in the improvisations.

The client's cultural, social, or institutional context should be included in the assessment. In an ecologically oriented music therapy, the very social systems surrounding the users are important to make visible.

Boundary with research

The boundaries between assessment and research are fluid. This applies to the use of different quantitative and qualitative methods of analysis, philosophy of science,

[409] Bruscia, 2023.

and hermeneutics. "Assessment is a process of gathering data. In many ways, this makes it similar to doing research," writes Bruscia.[410] And as with all other research, the process will depend on our epistemological standpoint, on how and what kind of knowledge one wants to acquire.

Diagnosis-oriented or resource-oriented?

Music therapists should focus on the resources of those they work with, directing attention toward individuals' competencies and capacities for mastery. When a diagnosis is taken as the primary point of departure, users' weaknesses and functional limitations can easily overshadow the strengths and resources that music therapy can build upon. Diagnostic practices based on detailed assessment may also shape and potentially narrow the therapist's perception of the individual.

By contrast, a resource-oriented approach, grounded in the concept of "the competent patient," allows the music therapist to adopt a broader and more balanced perspective—one that extends beyond a purely diagnostic understanding.[411]

[410] Bruscia, 2023, p. 60.

[411] Rolvsjord, 2014.

MUSIC THERAPEUTIC THEORIES AND PERSPECTIVES

3

Music therapeutic theories and perspectives

In this chapter, I present some of the most central theories, models, and methods in music therapy. I have made a pragmatic selection, including approaches based on values, therapeutic theories, working methods, frameworks, and modes of understanding. Some approaches are linked to schools of thought in psychology, while others have been developed from music therapy practice itself, such as Nordoff-Robbins Creative Music Therapy and Helen Bonny's Guided Imagery and Music.

Among the approaches grounded in clinical psychology, we find humanistic-existential music therapy, trauma-informed music therapy, and music therapeutic practices informed by behavior analysis and cognitive therapy. Analytically oriented music therapy has a long tradition in many countries and draws inspiration from psychodynamic and relationally oriented theories.

Neurological music therapy has made a significant impact in medical music therapy, with approaches grounded in brain research and learning psychology. At the same time, there are music therapeutic models that are more strongly informed by cultural and social theory. These are gaining increasing influence, as community music therapy demonstrates through its solid grounding in the user-oriented Norwegian music therapy tradition.

Within this landscape, different modes of understanding in music therapy are presented. This includes both biomedical explanations of music's effects and the ongoing debate regarding the causes of mental illness. I introduce models for explaining mental ill health, including the recently launched power–threat–meaning framework and the recovery philosophy.

Additionally, strong critical traditions within music therapy are highlighted, including feminist perspectives, anti-oppressive approaches, and reflections on how gender diversity and colonialism influence music therapy discourse.

An integrative approach

There are many narratives throughout history about how music has been connected to health and therapy. At the same time, we have seen that those who practice and theorize the field have always found links between prevailing understandings of the causes of illness and health, and the possibilities for corrective musical interventions. As in most sciences, music therapy includes several schools, models, perspectives, approaches, or methods. There are many cultural traditions and different views on science, values, epistemology, views of humanity, and views of music. Sometimes we speak of different paradigms that govern the understanding of what constitutes the right form of music therapy. In some cases, this can lead to a narrow understanding of music's therapeutic possibilities. This can happen when one relies on a theory and working method that is not suited to the clients one is working with. Mark Twain is said to have remarked that "for a person who only has a hammer, everything will look like a nail."

The American music therapist Kenneth Bruscia has argued for an integrated way of approaching music therapy.[412] This implies a form of holistic thinking that takes into account that there are many perspectives and aspects that must be considered when we describe the field, the profession, and music therapy practice. This means that a music therapist should first and foremost attend to the users' needs and not be governed by pre-established theories that claim to be general and universal. "Integral" thinking means accepting that there will always be differing opinions related to practice, theory, and research, and that these differences are necessary for the field to develop, writes Bruscia.[413]

What follows is a selection of theories, models, or approaches to music therapy. Such approaches or perspectives are often centered around a particular value, as Bruscia writes.[414] They may be music-centered or connected to a theory drawn from other disciplines such as psychology, medicine, or the social sciences. Some approaches are linked to a specific music therapy method, such as The Bonny Method of Guided Imagery and Music. Some approaches are concerned with evidence in a particular sense, such as neurological music therapy. Others emphasize the necessity of bringing culture and society into music therapeutic

[412] Bruscia, 2014, Kap 27 – Integral thinking. See also Bruscia, 2026.

[413] Bruscia, 2014.

[414] Bruscia, 2014, p. 258.

approaches. Sometimes the focus is on diagnoses and problems; at other times the thinking is resource oriented.

Kenneth Bruscia emphasizes the necessity of relating reflectively to this diversity. This means that one relates to the larger theories, at a macro level, while at the same time being attentive in the moment to what is happening within the actual music therapy session, at a micro level. And one remains open to what is happening in the moment and willing to consider from which macro level one is working. At the same time, one should keep an eye on the possibilities and challenges that become visible by changing one's way of thinking and ask which other perspectives may be useful for the user.

For example, a music therapist working within a community music therapy paradigm may recognize that some users need to work from a trauma-informed approach, or with affect regulation related to music listening. Or therapists within an analytic and relational approach may benefit from thinking about the value of social integration and belonging to a larger community.

An important aspect of acquiring theory, and this applies across all arenas of music therapy practice, is mastering the professional language encountered in the workplace. Doctors, psychologists, and special educators come from different theoretical traditions and must create a shared language. To participate in the dominant dialogue, the music therapist must know central theories and the professional language used by other health workers. At the same time, it is important that the music therapist communicates their own work in language that others on the team can understand. Music therapists have an important pedagogical task here in communicating their field and their work.

Music *as* therapy or music *in* therapy

Some music therapists emphasize that music has inherent therapeutic qualities, that it is the music itself, used in a therapeutic way, that creates change in the client. This means understanding the shaping forces at work when the individual experiences and acts through music. Here, the aesthetic power of music is emphasized. One does not wish to explain what happens in therapy by referring to or importing psychotherapeutic theories, nor to let other contextual factors explain the outcome of therapy. Here we are talking about music *as* therapy.

Those who emphasize that music is first and foremost an important element *in* therapy will argue that therapeutic change occurs through the relational connection between therapist and client. They stress that the therapist's

interventions are grounded in some form of psychotherapeutic theory. There may also be other important contextual conditions which, in interaction with musical activity, enable the user to achieve better health and quality of life. Yet even if we bring in theories from learning psychology and psychotherapy, we still ought to illuminate how the music itself helps create the conditions for interaction, dialogue, learning, development, change, or health.

It is unfortunate to polarize these two positions in such a way that one excludes the other. Whenever we discuss therapy through music, we inevitably face the task of clarifying what is aesthetically distinctive about music and what makes it effective across different psychotherapeutic or medical approaches. This is why theories from musicology—especially music psychology, aesthetics, anthropology, and sociology—must be brought into the conversation, as I will explore in the chapter on concepts of music and understandings of music. At the same time, music exists within a relational interplay in which the therapeutic alliance unfolds according to the framework of a psychological theory. When music therapy presents itself as a field and as a scientific discipline, all these perspectives must be carefully weighed and balanced.

Music-centered music therapy

In discussions about the active factors in music therapy, emphasis is sometimes placed on the role of the therapist, with their background in psychotherapy theory or special educational competence, that is, music *in* therapy. At other times, as we saw, the discussion concerns the degree to which the therapeutic work happens through the music itself, that is, music *as* therapy.

The American music therapist Kenneth Aigen has, through books and articles, provided strong arguments for why music plays a special role as an agent of change when we justify the use of music as therapy.[415] Aigen's engagement can be read against the background of music therapeutic theories and justifications in which the role of music is downplayed. For example, learning-oriented or behavior-therapeutic theories dominated American music therapy for many years, reducing music to a form of reward or reinforcement.

Such an understanding has downplayed the aesthetic qualities of music. The same applies to theoretical contexts arising out of psychodynamic, neurological, educational, or sociological traditions, Aigen argues. He further

[415] Aigen, 2005, 2014.

claims that such traditions obscure the unique qualities of music therapy. By overlooking these qualities, we hinder the development of music therapy theory. Not least, one forgets that people seek out music therapy because they have a special relationship to music. They want to work through music in order to experience improvement. He sees a danger that by overlooking the role of music, we become too focused on disabilities rather than on health and well-being.

Kenneth Aigen, whose music therapy background comes from Nordoff-Robbins Creative Music Therapy, emphasizes that for him music creates beautiful experiences, a sense of purpose, and meaning. He wants to bring that experience into his work with clients. In doing so, he stresses that there is continuity between how music affects us in life and how it is applied and becomes effective in a therapeutic setting. By emphasizing the role of music, he presents music-centered music therapy as an autonomous discipline, and not as a kind of psychotherapy, special education, or rehabilitation measure.[416]

We must seek in the music itself explanations for why music therapy creates changes in experience and behavior. It is in the forces that unfold in music, in musical processes and structures, and in our experiences of these, that music takes on a special role as a therapeutic factor. To identify these forces, Aigen turns to cognitive psychology, music philosophy and music-aesthetic theory to determine what, fundamentally, is the essence of music. By turning to music psychology and the social sciences, he seeks to understand the cognitive mechanisms involved when we perform, compose, and listen to music. He sees that several subfields in musicology, such as the anthropology and sociology of music, help us understand how the social processes surrounding music illuminate its role in therapy. He also believes that musical analysis helps us understand how musical form and structure illuminate the clinical value of music.

Aigen has discussed several of these aspects in his theory. He particularly points to music-aesthetic theories connected to schema theory and embodied cognition, as presented by the philosopher Mark Johnson.[417] Embodied perception assumes that our concepts of the world and our thinking are shaped through the body and our sensorimotor system. This means that we perceive the world through bodily schemas acquired early in life and active throughout life. With our own body as a reference, we experience something

[416] Aigen, 2014, p. 19.

[417] Johnson, 2007.

as high or low, distant or near, going out of or into something, following a path toward a goal, turning away, or following a trajectory. We transfer such schemas to listening to music, so that we experience music as moving in a particular direction, toward a particular goal, or along a particular path. We experience tension in music through the expectations that are created, as the music psychologist Leonard Meyer described in his theory of music and emotion.[418]

Aigen recognizes that music therapy has extra-musical goals, such as improving communication, changing behavior, or regulating emotions. But such goals are fulfilled through surrendering to the musical processes, through improvisation, performance, and listening.

He makes a distinction between music as a means and music as a medium. This distinction goes back to the pragmatic philosophy of John Dewey. When we use something as a medium, we seek an experience inherent in that medium. When I use something as a means, it is only a tool to reach a goal. In therapy, music in this sense is a medium through which we work and which leads to consequences that are therapeutic. And through the medium we have experienced the values that music has brought to us. Music may nevertheless have functioned both as medium and as means.

The British music therapist Colin Andrew Lee has developed his own version of the music-centered approach, called Aesthetic Music Therapy.[419] He emphasizes improvisation as collaborative processes, the structure and form of music, and the place of composition as a working method in music therapy.

In this way, music-centered music therapy places great emphasis on showing that it is music that is central as the active therapeutic factor. In doing so, it downplays the significance of the therapist's presence and any verbal interventions. Likewise, it downplays the import of theories external to music therapy when explaining and understanding therapeutic change. Rather than setting these two discourses against each other, we may speak of illuminating therapeutic change from different theoretical perspectives.

[418] Meyer, 1956.

[419] Lee, 2003.

Nordoff/Robbins music therapy (Creative Music Therapy)

Nordoff and Robbins came to have decisive importance for the development of music therapy in many countries around the world.[420] They developed a special relationship with the Nordic countries, and several Norwegian music therapists had the opportunity to study their method directly over extended periods. Their method became a central part of Norwegian music therapy professional identity through the place it was given in music therapy education, with Unni Johns and Tom Næss as the first methodology teachers.[421]

The Music Child

A central theoretical concept in Nordoff and Robbins was The Music Child. Nordoff and Robbins defined this "music child" as:

> *the individualized musicality in each child: the term has reference to the universality of musical sensitivity – the heritage of complex sensitivity to the ordering and relationship of tonal and rhythmic movement: it also points to the distinctly personal significance of each child's responsiveness.*[422]

Today, this notion of a form of innate musicality has been connected to the concept of "communicative musicality", developed by Stephen Malloch and Colwyn Trevarthen, and which has points of contact with theories by Daniel Stern.[423] With this empirically grounded developmental psychology, the improvisational approach of Nordoff and Robbins has been incorporated into a broader interaction paradigm. Within this paradigm, emphasis is placed on how children are motivated to form relationships, and how musical interaction forms a basis for mutual sharing and regulation of affects, as Stern's theory of affect attunement and intersubjectivity tells us.

In their improvisations, Nordoff and Robbins often worked through the underlying pulse in the music that the children followed. The children could often have a rigid

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420 See Ruud, 2022.

421 Tom Næss (1991) has provided a retrospective on their many visits to Norway between 1968 and 1976. The initiative originated from a project organized by Nordoff and Robbins in collaboration with the American-Scandinavian Foundation, which funded visits, lectures, and demonstrations in Denmark, Finland, Sweden, Norway, and Iceland from September 1967 to June 1968. For further details, see Ruud (2022).

422 Nordoff and Robbins, 1987/2007, p. 1.

423 Malloch and Trevarthen, 2009.

way of playing. They showed no flexibility in attempting to follow the improvisation and the musical prompts, tempo changes, or melodic and harmonic challenges Paul Nordoff presented them with. Music therapist Tamar Hadar has provided a detailed analysis of the different forms of temporality in Paul Nordoff's approach to improvisation.[424]

If we interpret this attempt to meet the child through music within the framework of humanistic psychology, we see that this therapy places the individual at the center. This individual is to develop toward greater freedom of expression through an inner process in encounter with the music, through expressivity and self-realization.

For Nordoff and Robbins, the starting point was that this inherent and individual musicality might have difficulty realizing itself in children with disabilities. The improvisational approach was meant to awaken and motivate the child to use functions such as perception, recognition, and memory. Engagement in music was to promote intentionality, intelligence, and self-confidence. The child was to become emotionally engaged in their own self-realization and self-integration.

Nordoff and Robbins understood it such that children with disabilities might lack access to this music child within themselves. They called this the conditioned child. This was a child conditioned by disability, whose developmental potential was to be liberated. With the help of music, the therapist was to reach this "music child" and create the conditions for a "new self" to emerge. The previously "conditioned child" was to be led back to the original self. This new self is conscious, active, expressive, engaged, and responsive, in contrast to the old self, which is forgetful, inactive, limited, disengaged, and withdrawn, writes Swedish music therapist AnnaKarin Eriksson.[425] The driving force of this self-realization lies in what is called the being child, which is understood as the core of the music child.

Humanistic-existential approach

The humanistic-existential orientation within psychotherapy has influenced music therapy since as early as the 1960s and 1970s. This orientation is linked to a humanistic tradition in intellectual history, in interaction with ideas from existential philosophy and thought. Music therapy models such as Creative Music Therapy by

[424] Hadar, 2024.

[425] Eriksson, 2001.

Paul Nordoff and Clive Robbins, or The Bonny Method of Guided Imagery and Music (BMGIM), often refer to central theories from humanistic psychology.

Historical and theoretical background

Humanistic music therapy can be understood in a broad sense, as emphasizing humanistic values and a view of humanity, and as an attempt to position itself differently from a natural-science-based music therapy. As we will see in the final chapter, I hold an understanding of the humanities that includes the social sciences, that is, psychology, sociology, and anthropology. At the same time, cultural studies and a critical understanding of society play an important role within such a humanistic tradition.

The humanistic-existential approach in psychology is understood in a narrower sense as a treatment philosophy within clinical psychology. Within this humanistic-existential tradition in psychology, it is particularly emphasized that all human beings have innate capacities to actualize their own unique potentials for health and well-being, given the right conditions and opportunities for change, as the music therapist Brian Abrams writes.[426]

Ideas formulated within the humanistic tradition from the Renaissance onward made their breakthrough in modern psychology in the late 1930s. This psychological tradition came to challenge psychoanalysis, for example Sigmund Freud, and behaviorism, for example John Watson and B. F. Skinner, which had dominated early psychology. Humanistic psychologists were concerned with the significance of values and meaning, and a number of new phenomena became objects of investigation and recognition: being, the self and self-esteem, self-realization, hope, love, creativity, spontaneity, play, courage, humor, individuality, autonomy, responsibility, peak experiences, and more.[427]

Some of the central psychologists who left their mark on this psychotherapeutic tradition include Carl Rogers with his client-centered or person-centered therapy. Not least, the psychologist Abraham Maslow came to mean a great deal for the creative music therapy of Paul Nordoff and Clive Robbins. A number of philosophers within the phenomenological and existential traditions became important for this psychotherapeutic direction.[428] Here we may mention Edmund

[426] Abrams, 2015.

[427] Severin, 1965, p. 4.

[428] Ruud, 1973, 1980b.

Husserl, Maurice Merleau-Ponty, Søren Kierkegaard, Martin Heidegger, and Jean-Paul Sartre. Among psychologists influenced by these thinkers are Rollo May, Viktor Frankl, R. D. Laing, and Irvin Yalom. The positive psychology movement, as well as transpersonal psychology, which emphasizes spirituality and altered or expanded states of consciousness, also belongs within this current in psychology.

Values and view of humanity

The psychotherapist James Bugental formulated a number of postulates underlying humanistic psychology. Among other things, these were that 1) when we speak of "the human being" in humanistic psychology, we are not speaking of an "organism," but of a person. It should concern what makes the human being distinct as something unique and as appearing as a whole. Furthermore, Bugental argues that 2) the human being has its being in a human context, in relationship to other human beings. 3) Human beings are aware. This means that "the unconscious" is not directly accessible to awareness but is nonetheless present. It is understood as something with which we do not directly communicate. It is also argued 4) that as human beings we can choose, that we can initiate a process of change. 5) Human beings possess intentionality. We display intentionality by having a purpose, by orienting ourselves toward what we experience as valuable and meaningful.[429]

Although many of these postulates still stand centrally in this humanistic-existential tradition, they have nevertheless been challenged in recent years through what is termed a critical posthumanism, something that will be commented on more fully in the final chapter.[430]

The Norwegian psychologist Per-Einar Binder sees the humanistic-existential approach as contributing to other psychotherapies by addressing how we relate to existential basic concerns. He formulates these in the following points:

- "Death and the recognition of having a life that is one's own
- freedom and insight into its limitations, and the responsibility for one's own life that this recognition of freedom and limitation gives us
- being-with and the insight that life unfolds within a web of relations, while at the same time we stand alone with our choices and our unique life experience

[429] Bugental, 1963; Ruud, 1973.

[430] Braidotti, 2013.

- meaning, and the insight that this is something we must create ourselves in a world that is ambiguous and often chaotic
- embodiment, and the recognition of this as the seat of both agency, emotional receptivity, and as part of an ecological whole with the world around us."[431]

Music therapeutic application

Music therapists refer to humanistic psychology when they wish to emphasize the value of music as a help to self-expression, mastery, well-being, and the significance of meaning in life. Central working forms in music therapy, such as listening to music, songwriting, improvisation, and performance, can readily be legitimized by pointing to central values within humanistic-existential therapy. Clive Robbins eventually began referring to Abraham Maslow's humanistic psychology in order to describe the consequences that improvisational music therapy could have for the children they worked with, for example for their self-realization.

Within GIM, theories from humanistic psychology are used to describe processes of change and growth. The founder of the BMGIM listening method, Helen Bonny, was concerned with the transcendent values that music could bring forth, the surpassing experiences that clearly touched on existential life themes. Theories of how music could alter states of consciousness were influenced by the philosopher Ken Wilber and the transpersonal psychology of Roberto Assagioli.

Transpersonal and spiritual experiences

It is well known in music therapy how many people experience that music opens experiences that expand consciousness and create contact with religious experiences, various spiritual experiences, or strong experiences of resonance, as described in the discussion of Hartmut Rosa's theory. So-called transpersonal experiences have been explained with reference to analytic theories, psychosynthesis, and theories of altered states of consciousness, as we find in The Bonny Method of Guided Imagery and Music.[432]

[431] Binder, 2023, p. 832.

[432] See more in Bunt and Stige, 2014, p. 45–47; Ruud, 2020.

Community music therapy

When we study different theories and models in music therapy, we might assume they emerge primarily as responses to existing approaches or ways of understanding. Often, a new approach arises when practitioners recognize that certain practices may not fully support users' opportunities for recovery. For example, in the humanistic-existential music therapy approach, there can be a strong focus on the individual's self-realization and personal growth—but this focus may sometimes overshadow important relational, environmental, community, and cultural contexts surrounding the user. Similar limitations can occur in other music therapy approaches, whether clinical or behavior-oriented. In response, music therapy models have been developed that emphasize the individual's need to belong to a larger community, to be recognized for their strengths, and to have meaningful opportunities for participation in broader social and cultural arenas.

With Brynjulf Stige's doctoral dissertation, community music therapy received thorough academic treatment, where some important historical roots were outlined and delimited through an interdisciplinary approach.[433] Stige described community music therapy as follows: "In community music therapy practice, goals are linked both to the individual and to society, the process is participant-led, the arenas are inclusive, and the use of music is ecological."[434]

Working within community music therapy implies responsibility for the interface between the client and society, a particular sensitivity to this vague borderland in which many of our clients move. It means a new language practice in which words such as action, participation, recognition, network, empower, marginalized, solidarity, resources, identity, and health become part of the music therapist's vocabulary. This instead of, or in addition to, concepts such as motor development, attention, behavior, inner resources, conflicts, handicap, and illness.[435] Put differently, we could characterize community music therapy as a discourse field, a theoretical area in which one discusses the significance of seeing music therapy practice in a wider social context, being rights-based, using an anthropological concept of music, expanding the arena of music therapy, finding new identities for the music therapist, and recognizing performance as a relevant method. To work with

[433] Stige, 2003.

[434] Stige 2006, 2004; Ruud, 2004b

[435] Ruud, 2004a.

community music therapy as a perspective means to practice, explain, and understand one's practice by referring to discourses within this field.[436]

Community music therapy presents itself as context-sensitive and resource-oriented practice. It seeks to create music in collaboration with users and to listen to the voices of people in difficult situations, writes Brynjulf Stige.[437] Community music therapy considers that disabilities, barriers, and suffering may originate in discrimination, marginalization, economic and social inequality, or historical causes such as colonial traditions that maintain prejudice.

Community music therapy seeks to bring participants into closer contact with community and cultural life and is based on forms of practice in which integration, network building, and social participation are central. For community music therapists, musicking is central in getting participants involved in interaction, making social contacts, and entering networks. The concept of music here understands music as a form of social capital that can be converted into social integration.[438]

History

There are several historical strands that point toward a community-oriented music therapy. In the European context, the (East) German music therapist Christoph Schwabe was early concerned with the dialectic between the individual and society and how this affected therapeutic practice.[439] The Canadian music therapist Carolyn Kenny was concerned with systems thinking, which means that we must think about how everything is connected, and that what we do at one level has effects at other levels and in other places within the system. Norwegian music therapy, from the beginning, was concerned with bringing in sociological theory and cultural understanding and adopted systems-theoretical thinking. Kenneth Bruscia also included a discussion of these tendencies in the second revised edition of his influential book *Defining Music Therapy*, where he described community music therapy as a form of ecological practice.[440]

Around the year 2000, these tendencies culminated in several articles, the founding of the journal *Voices: A World Forum for Music Therapy*, and anthologies

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436 Ansdell, 2002, 2004.

437 Stige, 2015, p. 233.

438 See articles in Pavlicevic and Ansdell (Ed.), 2004; Stige and Aarø, 2012.

439 Schwabe, 2004.

440 Bruscia, 1998a.

with broad international participation.[441] At the tenth world congress of music therapy in Oxford in 2002, community music therapy became an important topic of discussion, not least thanks to the British music therapist Gary Ansdell.

Brynjulf Stige came to play an important role in the development of community music therapy, not least as an initiator of the journal *Voices* and with the textbook *Invitation to Community Music Therapy*.[442] Today, community music therapy is often cited as an alternative to more clinical and evidence-based practices by therapists concerned with social justice, anti-racist and anti-colonial theories, as well as discriminatory practices toward people belonging to LGBTQIA+ communities.

Theoretical background

An important foundation for the theoretical background of community music therapy is the emphasis on being a rights-based and culture-centered practice.[443] Commitment to the UN Declaration of Human Rights implies social and ethical obligations toward citizens in order to safeguard their dignity and agency. A culture-centered approach means, according to Stige, that music therapy focuses on how human life unfolds in a social and cultural context and how individuals and environments affect one another mutually.[444] This implies that the individual is active in creating the self within an ecological context. This ecological co-creation is grounded in the human capacity to act, which in turn is linked to access to resources, personal as well as social and cultural. Agency implies control over the circumstances in which we participate and is facilitated when the individual and the surrounding society cooperate through mobilizing and redistributing resources. In this context, Bronfenbrenner's theory becomes relevant for providing an overview of the different levels at which one may work, as discussed in the final chapter.[445]

[441] Kenny and Stige (Ed.), 2002; Pavlicevic and Ansdell (Ed.) 2004.

[442] Stige 2003/2012; Stige and Aarø, 2012.

[443] Stige and Aarø, 2012.

[444] Stige, 2015.

[445] Stige, 2015, p. 237–238.

PREPARE

The core, or defining features, of community music therapy are summarized in the acronym PREPARE.[446] Here, the first **P** stands for participation. The values and issues at stake point to valuing democratic processes. Emphasis is placed on inclusion and social participation, as well as recognition of the expertise and competence that users themselves bring. Community music therapy seeks to support and recognize the identity and development of each person, and to think inclusively regarding institutions, groups, and society as a whole, all the way up to the macro level.

R stands for resource orientation and concerns issues such as welfare and equality, mobilizing, providing access to, and redistributing social, cultural, and material resources. Here collaboration, empowerment, and the client's own contribution to music therapy are central.

E stands for ecology and implies a systems-theoretical way of thinking. This means seeing the connections between different levels of work, that changes at the societal level matter for individuals' lives, and vice versa.

The next **P** stands for performance — the way in which, through action and activity, we present ourselves and change ourselves and the world. Here emphasis is placed on health promotion and prevention rather than treatment. Performance is not only about performing music, but about performing and creating oneself and one's identity.

Community music therapy has a clear political, or critical, dimension. **A** stands for activist and the importance of viewing one's work considering limiting and oppressive structures in society. This means being attentive to social injustice and seeking to initiate social change. Reference is made here to the critical Brazilian educator Paulo Freire. The metaphor of "listening to silent voices" stands as a guiding motif for much of community music therapy.

R here stands for reflexivity and points to the value of investigating both processes and outcomes of practice in collaboration with users. Emphasis is placed on recognition, both as persons and as participants in society, as in the work of the social philosopher Axel Honneth.

[446] Stige and Aarø, 2012.

Finally, the **E** in PREPARE stands as an ethical exclamation point. Ethics are summed up in the idea that practice, theory, and research are rights-based.

The Bonny Method of Guided Imagery and Music (BMGIM)

BMGIM is a receptive method developed by the American music therapist Helen Bonny. When practiced in its original form as individual music psychotherapy, it is referred to as the Bonny Method of Guided Imagery and Music. This distinguishes it from other approaches based on music listening (GIM), particularly because it requires postgraduate training and certification.

The method is described as taking its point of departure in deep listening to carefully selected pieces of music of varying length. In classical BMGIM, Western classical music is typically used. Today, programs are also developed that incorporate music from other genres as well as culturally adapted material.

The selected pieces are combined into a program lasting approximately 25 to 45 minutes. The method is usually practiced by music therapists, and occasionally by health professionals with a musical background. It requires postgraduate training that includes personal experience and professional supervision.[447]

Over time, several variants of Helen Bonny's original method have emerged. Under the umbrella term GIM, a number of adaptations and changes to the programs and procedures have developed. These new formats are adapted to age groups and health conditions. A description of these formats is given in the chapter on genres, instruments, and working methods, under listening to music as a working form.

Procedure

The procedure in BMGIM is divided into five steps.[448]

1. Before the listening begins, a conversation takes place between the therapist and the participant. Here, motivation and suitability are clarified, and goals are set for the session and subsequent sessions. The

[447] Grocke (Ed.), 2019.

[448] Grocke, 2019; Ruud, 2020b.

therapist then decides which program and music should be chosen, and a focus is established for the session.

2. Next, relaxation exercises are carried out so that the person becomes deeply relaxed in the body and mentally prepared to listen to the music. Through relaxation, the person is meant to enter an altered state of consciousness and thereby become more receptive to the music and to whatever thoughts, feelings, bodily sensations, and mental images may arise.
3. The therapist then selects a program. While the music is played, the person is encouraged to describe the experiences, or images, that arise. These music programs consist mainly of classical music and have a particular affective intensity contour. The pieces are combined in such a way that they match an emotion and stimulate a spontaneous production of images, sensations, and sensory experiences. The person describes what is being experienced, and the therapist asks questions and supports the person in the journey. Verbal techniques have been developed for guiding these music journeys.
4. After the listening is over, the person is guided back to a normal state of consciousness. They are encouraged to speak about some of the central images or themes that emerged during the music journey.
5. These images are then clarified by drawing them within a circle, a mandala, and the experiences are addressed in a subsequent conversation with the therapist.

An altered state of consciousness

BMGIM is defined as a music-centered exploration of consciousness intended to open possibilities for holistic growth in those who participate. The method acknowledges both transpersonal and psychodynamic aspects of the music journey and seeks to understand the therapeutic significance of the expanded awareness created by the listening process.[449]

Influenced by the psychologist Abraham Maslow, and with a greater openness toward spiritual, religious, and transpersonal experiences, the method aims to work toward self-actualization at all levels of the psyche, including what is called the superconscious. The American philosopher Ken Wilber, as noted, has been drawn in to lend legitimacy to the theoretical foundation.[450]

[449] Grocke and Moe, 2015, p. 21; Ruud, 2020.

[450] See Bonde, 2001.

Trauma-informed music therapy

Working with people exposed to traumatic experiences can be challenging and requires a sensitive approach. Music therapists will in several situations encounter people living with trauma. This may include children and young people exposed to abuse, or women who are victims of intimate partner violence and rape and who need mental health support. The same applies to young people exposed to racism, or children in hospitals with serious diagnoses. Also in major natural disasters, such as earthquakes and, increasingly, destruction caused by climate change, there is a need to implement measures that support those affected, something that also reminds us that the climate changes around us have consequences for music therapy work.

In trauma-informed work, it is particularly important to understand what trauma is and what it entails for the client's mental health. Traumatic events affect parts of the brain. There may be long-term consequences in the form of a range of negative emotional and cognitive reactions. The list of symptoms is very long and includes both bodily and psychological challenges.[451]

Trauma is understood in somewhat different ways, and trauma has more or less serious consequences. Trauma is defined by the *American Psychological Association, APA*, as:

> *an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock or denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea.*[452]

Building resilience is a central goal for music therapy. This means establishing safety and opening up for memory work and grief work. New bonds are to be formed with the past. Resilience must not be understood as merely an individual competence or resource. Resilience must be understood at the social level, as the support and resources found in a family, among friends, in the neighborhood, or at the level of systems and institutions.

It is particularly in the first stage of resilience work that music therapists have much to contribute, where safety, security, and continuity in relationships are

[451] See more in Beer and Birnbaum (Ed.), 2023.

[452] Beer and Birnbaum (Ed.), 2023, p. 9.

created.[453] The next stage, which would concern processing trauma, requires specialist competence and further training. A distinction is therefore made between working trauma-informed and trauma-focused. The risk of retraumatization is always present. Music is a potentially powerful emotional medium that can easily trigger memories one has tried to keep at a distance.

What has become important in recent music therapy literature is increasing reflexivity regarding themes such as cultural differences, power, gender, and language. "Cultural humility" has emerged as an important concept. We should not take it for granted that participants in music therapy will always feel safe, especially if one overlooks the cultural distance between the music therapist and the participant. This applies when participants belong to different social classes, ethnic groups, or sociocultural groups than the practitioners. The possibility of overlooking structural discrimination and violence resulting from oppression, and the legacy and traces of earlier and ongoing colonization, may emerge in therapy sessions and create insecurity.

Experiences from trauma-informed work in major disasters tell us about a number of conditions that must be in place before entering into such work. Cultural competence, support, good organization, and collaboration are necessary in order for services to reach people effectively. So-called drive-by first aid, where help is offered in passing and where helpers disappear after a short time, is cautioned against. Music therapy projects should be integrated into the local culture, and they should have long-term goals and provide support over time. An example from music therapy following an earthquake in Chile in 2010 illustrates this.[454]

Some mechanisms of change

The music therapist Moshe Bensimon points to five elements as possible explanations for why and how music therapy contributes to processes of change in trauma treatment.[455]

1. Polyvagal theory is linked to the importance of the relaxation that the music therapist facilitates in participants through musical means. If we connect this to the model of the window of tolerance, we see that the

[453] Beer and Birnbaum (Ed.), 2023.

[454] Pérez-Martinez, 2023.

[455] Bensimon, 2023.

choice of music, and the creation of safety, contribute to bodily unlearning of unintended stress responses.

2. Practicing a playful attitude and a playful practice promotes creativity, curiosity, positive emotions, humor, and spontaneity. This opens a space of possibility for exploring one's own vulnerability.
3. Music provides the possibility of expressing and experiencing feelings without connecting them directly to words or language. Here Bensimon connects with Patrik Juslin's concept of super-expressive emotions, which indicates that music can convey meaning more intensely than words can express. Moreover, music often involves a kind of emotional contagion. As we saw earlier, this was an important component in Juslin's understanding of the mechanisms through which music evokes emotions.
4. Achieving self-control is important when one's own trauma is to be processed.
5. A fifth factor explaining why music therapy contributes to change processes concerns a form of interpersonal synchronization. Trauma may lead to loneliness, alienation, and a sense of separation from society. Many shut down social engagement that might otherwise become a source of comfort and regulation. The music group offers opportunities for creating positive experiences of community, for example through work with drums and rhythmic interplay, communal singing, or various forms of improvisation.

It should be added here that these points are relevant to music therapeutic work across many practice arenas.

The following narrative may illustrate some of the challenges in trauma-informed music therapy.[456]

Post-traumatic stress disorder

The patient described here was a refugee from Sudan to Ireland after his family was killed in the civil war. He eventually found work, established a family, but was then involved in an accident. He developed chronic headaches and lost his job. Other health problems then emerged, and he was diagnosed with PTSD. After his family was killed in Sudan, he had entered a kind of survival mode and had not processed what had happened. The accident

[456] Summary after Ahessy, 2023.

triggered his earlier trauma and created anxiety and symptoms of post-traumatic stress. He received treatment, but isolated himself, lost motivation, and experienced anxiety.

He was offered music therapy and said that he liked music. He was willing to share his preferences, even though he did not have much faith in his own musical abilities. He wanted to listen to music but declined to write songs. In the first session, he listened together with the music therapist to Stevie Wonder's I Just Called to Say I Love You, a song associated with positive memories because it reminded him of his wedding day. He was then offered instruments and was immediately drawn to the djembe. This was a djembe made in Ghana and familiar to him, although he had never tried playing one before.

He explored the djembe, began to play, and eventually improvised together with the therapist. He had a strong sense of rhythm and a good grasp of the music, maintained eye contact with the therapist, smiled, and expressed satisfaction with the activity. The improvisation culminated in a crescendo, after which the patient took a deep breath and sat back in his chair with satisfaction. In the following weeks, he wanted to begin every session with an improvisation on the djembe, and on some occasions, they improvised for twenty minutes. He then opened verbally and spoke about his background, his anxiety, and his trauma.

At that point, the time seemed right to write a song, and the patient chose a text about his upbringing amid poverty and corruption. He wanted accompaniment from the therapist on keyboard and later with the djembe. In working on the song, the music therapist suggested several minor chords and determined the tempo, rhythmic style, and melodic line. They made recordings, and the patient was happy to share the song with his family.[457]

Psychodynamic music therapy

In many countries there are traditions of psychodynamic music therapy. Such traditions emerge from the legacy of Sigmund Freud. Here we encounter a theoretical framework built on ideas of the unconscious, repression, the use of free association, and the significance of transference and countertransference. There are now countless revisions and schools of thought within the

[457] Ahessy, 2023.

psychodynamic tradition, and several innovations in theory and terminology have been adopted by music therapists.[458]

From analytic to analytically oriented music therapy

Among the first European music therapists who turned toward psychodynamic therapy were Alfred Schmölz in Vienna, Edith Lecourt in Paris, and Juliette Alvin in London. In the United States, Florence Tyson was already proposing the use of psychoanalytic principles in the 1960s. This was not only to help patients discover their strengths, but also to work with deeper unconscious issues that were being stirred up.[459] Over time, a number of music therapists have drawn on theories and concepts from different branches of psychodynamic theory.

A pioneer in this field was the British music therapist Mary Priestley, who developed Analytical Music Therapy.[460] Priestley was influenced by the psychologist Melanie Klein, but insisted that there was a difference between psychoanalysis and music therapy. In her practice, Priestley used improvisation based on piano and a range of other sound sources. She gave participants rules of play and roles, and developed techniques such as holding, containing, and splitting. For example, if a patient has two different perceptions of another person, one can switch roles in the improvisation. In this way, one may improvise an expression of how both sides of the person are experienced. Analytical Music Therapy has since been further developed, not least by the Danish music therapist and professor Inge Nygaard Pedersen, and now goes under the name "analytically oriented" music therapy.

There are traces of psychoanalytic theory in Nordoff and Robbins' therapy when they speak of breaking through the child's resistance and rigid playing. Similarly, in GIM the psychodynamic framework has been used in interpreting the symbolic material that emerges through the images, associations, and sensations reported by the "traveler" in the music.

[458] For an overview, see Isenberg, 2015.

[459] Hadley, 2003, p. 2.

[460] Priestley, 1975.

Different schools of thought

The music therapist and researcher Susan Hadley, in her anthology of case studies from psychodynamic music therapy, has provided an overview of different schools of thought. At the same time, she points to music therapists working within the various psychodynamic models.[461]

Freud and classical drive theory

From Sigmund Freud's classical drive theory, we have inherited a number of concepts that appear in this literature, for example the notions of the id, ego, and superego, the unconscious, and defense mechanisms. This refers to Freud's understanding of our drives and how they may create conflicts in encounters with social taboos. This in turn concerns how we develop defenses against anxiety and guilt, and how symptoms are formed and repeated through transferences onto others. The concept of transference is central in analytic theory and concerns how we relive and repeat important relational patterns from the past in present relationships by projecting them onto other people. Countertransference concerns how the therapist reacts to the client, which in turn is influenced by the therapist's own history. A Freudian successor is the French psychoanalyst Jacques Lacan, who combined psychoanalysis with poststructuralist thought. This involved an emphasis on the role of language in understanding the self.[462]

Ego psychology

With ego psychology, greater emphasis was placed on the role of the ego and its capacity to defend itself against the id and unconscious forces. It was understood that this involved important ego-related processes such as memory, perception, and motor coordination. These were thought to have their own energy, distinct from the id. In music therapy, this led to the line of reasoning that mastery through musicking strengthens the ego and supports the person's development. The psychologist Erik Erikson provided important impulses to such an understanding through his theory of psychosocial stages across the human lifespan.[463]

Object relations

Some psychologists have been especially important for our understanding of children's play. Names often highlighted are Melanie Klein, Anna Freud, and Donald

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[461] Hadley, 2003.
[462] Hadley, 2003.
[463] Hadley, 2003, p. 6.

Winnicott.[464] Object relations theory has shown how the child's close caregivers become important "objects" that the child internalizes, carries in memory, and repeats when entering new relationships. Music therapists often refer to the pediatrician and psychoanalyst Donald Winnicott's theories on the role of play and creativity in development and therapy. Of particular importance here is his concept of a potential space. This is a space between reality and fantasy in which the child uses play and symbols to work through what is experienced as a tension between the inner and outer world. In this space, the child relies on fantasy and imagination.

In order to create meaning, the child uses transitional objects, for example soft toys, music, play, and drawing, to build a bridge between needs for safety, closeness, and meaning, and the outer world. For Winnicott, creativity is a lifelong source of development and participation in society and is inseparably linked to therapeutic development. This presupposes that both the child and the therapist are capable of play.[465]

Play is crucial for Winnicott. It is through play that the child expresses inner or personal reality. Play is a way of creating something shared. Here, the music therapist creates a safe space and helps the child begin to play. As we shall see below, in connection with the development of intersubjectivity, such access to the child through play becomes a way of establishing a relationship.[466]

Self psychology

Within this psychology, emphasis is placed on the person's subjective experiences of how they define themselves in relation to others. The psychologist Heinz Kohut is often seen as representative of this tradition. He emphasized how the infant needs to be mirrored and idealized in order to experience unconditional acceptance. This acceptance must be internalized if the child is to develop a healthy sense of self. The therapist's role then becomes to provide the supportive and affirming response the client needs where development of the self has gone wrong.[467]

[464] Stänicke, Johns and Landmark (Ed.) 2021.

[465] Stänicke, Johns and Landmark (Ed.) 2021, p. 22–23.

[466] See Johns, Landmark and Stänicke, (Ed.) 2025.

[467] Hadley, 2003.

Jungian theory

Carl Gustav Jung was one of Freud's most important students. He later broke with his teacher and developed his own psychology. Instead of speaking of id, ego, and superego, he introduced a system in which personality consisted of the conscious, the personal unconscious, and the collective unconscious. The ego forms the center of consciousness and secures a sense of identity. The personal unconscious consists of repressed desires, memories, and emotions. The collective unconscious is a universal life force, shared by all human beings, and consists of instincts and archetypes. Such archetypes might include the persona, the shadow, anima and animus, the wise old man, Mother Earth, and the Self. The idea of archetypes appears both in Mary Priestley's analytical music therapy and in Helen Bonny's Guided Imagery and Music.[468]

Logotherapy and existential analysis

An analytic psychotherapist who placed questions of meaning and existence at the center was the Austrian Viktor Frankl (1905–1997), also known as the founder of the "Third Viennese School" of psychotherapy. While the first Viennese schools saw the striving for meaning in life as tied to pleasure (Freud) and power (Adler), Frankl saw meaning as a fundamental motivator of human life. Frankl linked the path toward meaning in life to three values: creativity, experience, and attitude formation.

Creativity refers to performance, productivity, and activity. This is something music therapy responds to when it employs songwriting, ensemble playing, and musical performance. The capacity to receive impressions, receptivity, contemplation, and emotionality belong to experiential values and find their place within receptive methods in music therapy. Listening to music corresponds well to the possibility of this kind of meaning in life, together with several of the other values that we previously saw Hartmut Rosa place within the axis that described our relation to nature, art, and history.

The last of the three values emphasized by Frankl refers to the attitudes we adopt in situations marked by suffering. How we bear our fate and mobilize hope and courage for life is described by Frankl as "heroic achievements."[469]

The German music therapy theorist Eric Pfeifer has illustrated how Frankl's techniques from logotherapy have been applied in music therapy. Pfeifer highlights the techniques of dereflection, paradoxical intention, Socratic dialogue,

[468] Hadley, 2003.

[469] Pfeifer, 2021.

and modulation of attitudes. Dereflection involves avoiding a tendency toward compulsive self-reflection, and therapy aims to dismantle excessive rumination and instead direct attention toward something positive. This is recognizable in music therapy, where there is awareness of how music listening can trigger negative thought spirals, and where psychoeducational work around awareness of music listening and the restructuring of playlists can become a task for the music therapist. Finding music that gives an experience of flow in the sense described by Csikszentmihalyi can interrupt streams of negative self-evaluation. Here several music therapy methods come into play in the work of dereflection. Pfeifer highlights GIM and the method of Deep Relaxation Music Therapy and Hypnomusic Therapy (DRMT/HMT), as developed by the German music therapist Hans-Helmut Decker-Voigt.

Paradoxical intention means that the client stops fighting against their problems, illness, or symptoms. Instead, they are encouraged to confront their symptoms and to use humor to create distance and break the vicious circle that often reinforces symptoms. Musical improvisation can create situations in which such paradoxical musical interventions occur.

The following vignette illustrates how Frankl's theories can be applied in music therapy.

> *Eric Pfeifer illustrates Viktor Frankl's principles with a case description of music therapy with a woman receiving palliative care. The woman, in this case a psychotherapist in her sixties, had advanced and incurable cancer. She wanted music therapy in order to break out of an intellectualized mode of life that had dominated her everyday and professional life. Music therapy was able to respond to this by offering live music, dance, movement, and singing. Strong links were thus made to the creative values that Frankl emphasizes. After changes in the illness progressed, and she could no longer play or dance and became bedridden, the mode of work shifted to receptive music therapy. The woman could play an ocean drum, which the therapist placed on her lap and moved gently back and forth. In this way she could feel the vibrations and listen to the pleasant sound of the drum. This activity corresponds to Frankl's experiential values. The woman maintained her inner calm throughout the therapy and until the very end. In this way she demonstrated the heroic attitude Frankl regarded as important for preserving meaning. The principle drawn from music therapy here is how the therapist and the music create a holding space that supports and encourages sparks of hope and meaning in life.*[470]

[470] Pfeifer, 2021.

A shared foundation

Despite differences in theories and approaches, there are certain common understandings among psychodynamic therapists. Kenneth Bruscia has proposed the following points:

Our behavior is generally understood as shaped by the psyche. We interact with and relate to the world through different layers of consciousness, unconscious, preconscious, and conscious. We develop unique patterns of relating to the world. These are based on interactions and relationships we have experienced earlier in life with family members and other close figures. We repeat these and other relational patterns in the present. Both clients and therapists bring their unique ways of relating into therapy, shaped by their life histories. These show themselves in therapy as transferences, countertransferences, and defenses.[471]

Daniel Stern and relational music therapy

Norwegian and international music therapy received strong impulses from the American psychiatrist Daniel Stern. Unni Johns was among the first to contribute to this theoretical universe, which has left a clear mark on music therapy practice.[472] She introduced concepts such as primary and secondary intersubjectivity, proto-conversation, and the affective communication system. Randi Rolvsjord also provided an introduction to this developmental psychology, which for a time went under the name interaction theory.[473] Gro Trondalen integrated these theories into her doctoral work on eating disorders and later in the book Relational Music Therapy.[474] Unni Johns further deepened this work with her doctoral dissertation on the musical dynamics of psychotherapy with children.[475]

Within this "relational turn" in psychotherapy, Daniel Stern's theories are central. Stern was well aware of music therapy through several visits and teaching engagements at the music therapy program at *Aalborg University*, in addition to several keynote lectures at international music therapy conferences. He has left a

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[471] Bruscia, 1998b, after Hadley, 2003, p. 12.

[472] Johns, 1993.

[473] Rolvsjord, 1993, 1996.

[474] Trondalen, 2004, 2016a.

[475] Johns, 2018.

strong mark on music therapy in many countries. What follows is an outline of some of the main points in his theories and how they can be transferred to music therapy.[476]

Intersubjectivity

Intersubjectivity is a central concept and is understood in several ways within psychology. Within empirical developmental psychology, the concept refers to a mutually created and shared world of meaning.[477] Intersubjectivity arises through an immediate and shared synchronization with another mind. This occurs through an intentional and direct exchange of affects, through a joint attention that creates a dialogical frame for development, as Gro Trondalen writes. This contact is procedural, implicit, and nonverbal. Body, experience, and affects are important elements.

Imitation and synchronization between the parties, and what happens moment by moment at a micro level, play an important role. This contact is cross-modal or amodal and occurs through different sensory modalities. Through the microprocesses occurring between the parties, an intersubjective domain is formed. Here the parties influence one another through negotiations, and both ruptures and repairs in communication may occur.

A central assumption in this understanding is that there is an expansion of self-experience and self-understanding in such intersubjective encounters, and that the shared meaning that arises contributes to therapeutic change. Music, whether through ensemble playing, improvisation, or listening, can provide a frame for such intersubjective moments. The interaction opens a possibility for emotional attunement through the vitality forms that arise.

Daniel Stern created a model of how the child's development of self takes place. He operates with five forms of self-experience. A first domain comprises the experience of an emergent self, then a sense of a core self in relation to another. The next relational domain involves the experience of an intersubjective self. When the child learns to speak, a verbal self emerges, followed by a narrative self. The important point to note is that these self-experiences or domains do not

[476] See Trondalen, 2004, 2016a; Hannibal, 2019.

[477] See Trondalen, 2016a, p. 11ff for details.

disappear when the child reaches a new stage of development but continue to operate within us throughout life.[478]

Implicit relational knowing and forms of vitality

Through interactions with others, we acquire knowledge of what it feels like to be in interaction, what is called implicit or inherent relational knowing. It is implicit because it does not depend on semantic knowledge, such as language, metaphors, symbols, and analogies. Such semantic knowledge is called explicit.

Procedural knowledge is traditionally associated with skills acquired through bodily mastery, for example riding a bicycle. Yet the procedural knowledge in question here, that is, implicit relational knowing, is connected to a sense of how one does something together with another.[479] Trondalen illustrates this by comparing it to playing maracas, something learned without needing to be encoded in language. To play together activates this implicit relational knowing, which is both affective and interactive and takes place here and now. Such relational knowing is not generalized but fresh, something lived precisely in the present moment.

By attuning to one another, affect attunement, the interaction may lead to moments or events that contain a shared intersubjective recognition. This can in turn lead to new experiences and new ways of being together with the other, writes Trondalen.[480]

An important concept in this context is what Stern calls moments of meeting. Such moments can occur when the parties share feelings. Here a reorganization may take place in both the client's and the therapist's mental organization, creating a foundation for change. At times in interaction, moments arise that Stern calls present moments. These are moments of uncertainty as to how interaction and communication will develop further. Such a present moment can transform into a moment of meeting. This is a decisive moment in which implicit knowing reorganizes itself and gives rise to new experiences.

I have already referred to so-called categorical emotions, such as joy, grief, anger, and so on. Stern, however, was concerned with the dynamics, form, and intensity of how affects are experienced. He used musical terms to describe these dynamic

478 See Trondalen, 2016a, Chapter 3 for examples of how music therapy meets clients with challenges in different relational domains.

479 Trondalen, 2016a, p. 39.

480 Trondalen, 2016a, p. 40. Thanks to Gro Trondalen for clarifications in these sections.

vitality forms, for example crescendo and decrescendo, accelerando and diminuendo. He initially used the term vitality affects to describe this dynamic. Later he referred to these as vitality forms. Stern connected the experience of dynamic vitality forms to the experience of vitality itself, the feeling of being alive.[481]

A note on qualifications

We can see that Stern's theories can be fruitfully applied to music therapeutic activities as ways of understanding and explaining how change occurs in therapy. When it comes to verbal psychotherapy, however, additional qualifications are required beyond musical ones.

Many music therapists currently do not have a specialization in psychodynamic music therapy beyond an understanding of the dynamics of interpersonal interplay, as exemplified in relational music therapy based on Daniel Stern's theories. Working with trauma, conflict, and the bringing of unconscious material into awareness requires further training and specialization, also for clinical psychologists. Music therapists working within an analytically oriented tradition ought to have personal experience of such music therapeutic processes themselves. I believe they themselves should have undergone music therapy and should have access to supervision from experienced clinicians.

Dialogical and challenging moments in musical improvisation

What follows draws some lines of connection between music therapy, the use of improvisation as a working method, and a musical genre in which improvisation is central, namely jazz. We may ask whether there are differences and similarities between how jazz musicians and music therapists experience improvisation, something that the music therapists Tamar Hadar and Dorit Amir have researched.[482]Whereas the jazz musician improvises with other musicians, the music therapist improvises with a client. Hadar and Amir ask how musicians and therapists respectively experience the dialogical moments that may arise. Are there similarities and differences, and what can music therapists learn from such comparative studies?

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[481] Stern, 2010.

[482] Hadar and Amir, 2021.

We are well acquainted with how musical interplay and improvisation in music therapy create warm and valuable moments, interpersonal I–Thou encounters in Martin Buber's sense, or "golden moments" as Gro Trondalen has described them.[483] At the same time, we have seen how such moments created through synchronized musical co-creation are inscribed into Daniel Stern's theory of the present moment. They are described as significant moments of great importance for the development of shared attention, intersubjectivity, affect attunement, therapeutic relationship formation, and alliance building. We might also call such moments dialogical moments. Another point that could be added from anthropology and philosophy is that such dialogical moments create a strong sense of togetherness, an I–Thou community, or a communitas, as described by the anthropologist Victor Turner.[484]

Hadar and Amir wanted to investigate how jazz musicians and music therapists describe and understand the meaning, similarities, and differences in improvisations and in the dialogical moments that arise with other musicians or with clients. Their analysis of participants' responses showed that dialogical moments had two sides. They included dialogical components or so-called primary moments, as well as conditions that made dialogical moments possible.

For the jazz musicians, these dialogical moments involved listening and attunement, as well as an inner readiness in relation to the other musicians. This had to do with translating and projecting one's own feelings into the music. It was also important for the musician to alternate between their own inner world and the outer world. It concerned moments in which one was oriented outward, by adapting to the other musician.

A further important condition was musical proficiency as a basis for dialogical moments to arise. Among the experienced jazz musicians, this was rooted in their high musical level. For the jazz musicians, improvisation was experienced as a way of establishing connection with other musicians. Such connections or relationships could be brief or more enduring and complex.

Improvisations with other musicians were understood as equal conversations through music, a kind of give-and-take relationship, just as jazz scholar Ingrid Monson has used the conversation metaphor.[485] An encounter with a master

[483] Trondalen, 2007.

[484] Ruud, 1992.

[485] Monson, 1996.

improviser, however, could create a certain sense of humility within a teacher-student relationship, which in turn created a special frame for the musical meeting.

The analyses showed how the jazz musicians shared deep feelings with one another and in this way became more closely connected. Such moments of emotional responsiveness were often experienced as highlights. Words like intimate and closeness appeared in descriptions of these experiences, especially in duo improvisations. These peak experiences, or transcendent relational experiences, were accompanied by a musical flow, in which one was lifted out of one's limitations and fully absorbed by the music created together.[486]

Improvisations could also create complicated and challenging moments accompanied by experiences of irritation. This threatened the relationship and shook and challenged the boundaries of the musicians' comfort zone. The jazz musicians described the importance of challenging one another within the shared improvisation and pointed to different types of relationships that could arise: teacher-student, peer relationships, or relationships that could be described as emotional, intimate, erotic, transcendent, or complex.

Attunement and metaphorical listening

For the music therapists too, listening and attuning to the interplay were fundamental components of these dialogical moments. This, together with what was described as a transformation of the moment, emerged as the most important conditions for dialogue to occur, according to Hadar and Amir.

The music therapists showed a high level of attunement to the various aspects of the client's way of being. One form of listening involved adapting to the client's dynamic level; at other times it involved expanding the dynamic range. The therapists also listened to the client's needs and emotional state, the client's physical state and movements, in addition to the client's musical playing. The therapists showed a greater tendency toward metaphorical listening, focusing on the client's movements and emotional state rather than on purely musical listening to musical parameters.

Regarding the transformation of the moment, the music therapists made use of the temporal dimension in shared improvisation for meaningful moments to emerge. The analyses revealed two almost opposite features of this temporal dimension. On the one hand, there was an immediate and simultaneous response,

[486] Hadar and Amir, 2021.

with instantaneous changes in emotional and musical expression. On the other hand, there was an expanded timeframe that allowed time to be experienced more slowly. Being able to respond with appropriate timing to different aspects of the client's expression proved to be a central technique among the music therapists for making authentic connection possible in the here and now.

Hadar and Amir found that the music therapists used different techniques when applying such temporal gestures. They used many pauses and resting points in the music, in addition to pedal points, repeating riffs, and different harmonic devices to create an open sense of time for the clients. This made synchronization between client and therapist possible. Synchronized discrepancies were used when therapist and client played at different tempi. The therapist could support the client in maintaining their own musical choices and amplify the client's free and elaborated musical expression, affirming it by giving it authority within the dialogue.

The music therapists used several techniques to create new temporal frameworks and increase the client's musical engagement in shared improvisation. The use of pauses created space for the client to express themselves, as the music therapist Julie Sutton has described.[487] Decisive, so-called kairotic moments were created through monotonous, repetitive harmonic frameworks. Other musical devices included pedal points, repetition, synchronized discrepancies, or musical deviations in the form of participatory discrepancies (PD).[488]

Reciprocal moments

For the music therapists, improvisation created several forms of connection between client and therapist. One level concerned how improvisations could resemble the early pre-verbal dialogue between mother and child, what is called proto-conversation. Moments of mutual connection arose in actions that elicited a response, in a principle of give and take. Clients were given the opportunity to become equal partners in these moments. This gave them a chance to strengthen self-esteem by offering surprising exclamations, laughter, and other expressions.

Hadar and Amir use the term reciprocal moments for what occurs in improvisation, with reference to Karette Stensæth's theory of responsiveness in

[487] Sutton, 2006.

[488] Participatory discrepancies is also described under the discussion of the genre of jazz.

music therapeutic improvisation.[489] Moments of mutuality are a more balanced and shared relationship in which both parties support and influence one another. Attention is directed toward collaboration and shared interests, where both parties contribute to and benefit from the relationship, and where both feel ownership of the process. Stepping beyond the therapist-client relationship became visible when musical dialogue brought with it flow, intimacy, equality, shared joy, and shared leadership.

Within the therapist-client relationship too, difficult moments emerged in which the relationship was challenged and in which improvisation could create obstacles to establishing a good relationship. This could involve a struggle over power and control, or emotional blockages. The researchers write that there appears to be a connection between such negotiations taking place between those who play music together and the ability to experience dialogical moments.

Hadar and Amir conclude that shared improvisations reveal the players' authentic expression and enable them to explore musical and para-musical relationships. Among the musicians, these dialogical moments manifested themselves in challenging moments and when the interaction was marked by participatory discrepancies. Among the music therapists, such distinct musical moments also appeared in synchronized musical deviations, in moments when the client presented their individuality in the presence of the other.

Tamar Hadar and Dorit Amir argue that the value of comparing music therapists and jazz musicians lies in exploring improvisation that includes moments of challenge, confrontation, and closeness in musical dialogue with clients. In addition, their analyses of music therapists shed light on the creative and flexible approaches used to transform temporal frameworks to adapt to the client's needs. The extended temporal frameworks created in the shared improvisation between music therapist and client allowed clients to achieve a sense of authority and agency through the musical dialogue.

Behavior analysis and cognitive therapy

Behavior therapy and learning psychology have held a strong position, especially in North American music therapy since the 1960s and 1970s. Initially, the behavior-therapeutic approach played a central role within what is called applied behavioral analysis. Over time, this behavior therapy developed into cognitive therapy. It is on

[489] Stensæth, 2017.

this basis that we now speak of cognitive behavioral therapy. These trends have since been incorporated into a number of music therapeutic approaches and working methods.

Historical and theoretical background

Cognitive behavioral therapy has historical roots in several major religions as well as in classical philosophy.[490] These are theories and belief systems that emphasize that thoughts, feelings, ideas, and behavior are closely interconnected. Both Stoicism and Sophism contain statements pointing to how thought and reflection shape our emotions and behavior. It is not what happens to us that is disturbing, but how we perceive and evaluate what happens in our bodies and feelings.[491] The main idea is that our "emotional reactions and behavior are influenced by our thoughts and cognitions. Situations may give rise to thoughts and feelings spontaneously, but it is our interpretation that determines the consequences they have for us."[492]

The physiologist Pavlov's research on classical conditioning, Pavlov's dog, together with the psychologists Thorndike and Skinner's further development of learning psychology through research on operant conditioning, laid the groundwork for applied behavior analysis. Over time, however, this approach proved insufficient when dealing with complex mental disorders. With psychiatrists Albert Ellis and Aaron Beck, a cognitive therapy developed.

Applied behavior analysis

What the psychologist Thorndike called the law of effect showed that behavior that produces a desirable outcome tends to be repeated. Psychologist Skinner further developed research on operant conditioning by mapping how the consequences of behavior determine the strength and frequency of that behavior. In other words, behavior that is reinforced or rewarded will be repeated. Behavior analysis developed a number of techniques for influencing behavior. Positive and negative reinforcement, punishment, the ignoring of unwanted behavior, and

[490] Hanser, 2017, p. 162.

[491] Hanser, 2017.

[492] Grande and Røssberg, 2023, p. 771.

systematic desensitization training became new techniques based on these learning principles.[493]

For the music therapist, principles from learning psychology can be applied on the basis of music's possibilities for functioning as a reinforcement of behavior. By creating situations and musical activities in which principles from applied behavior analysis can be used, music is employed as a reward to encourage desired behavior. Music was regarded as a useful reinforcer because it offers many and varied modes of experience, and not the same negative side effects as, for example, food used as a reward.[494]

Cognitive therapy

Cognitive behavioral therapy begins from a view of the human being that emphasizes how people act based on thoughts or cognitions. As a psychotherapeutic method, it is concerned with the interplay between thoughts, feelings, behavior, and bodily physiological factors.[495] The therapist is to help the client see connections between ways of acting and the thoughts and feelings that arise in the situation. Central to this approach is identifying and exploring negative automatic thoughts (NATs) and the client's life rules and helping the client find alternative thoughts.

People with mental disorders may have an inner dialogue that is problematic. Some have negative thoughts about themselves or experience anxiety when situations are outside their control. Such reactions may be exaggerated, and they influence feelings and bodily states, and may even lead to stress responses.

The so-called ABC(D) model helps illustrate how therapy may proceed. **A** designates a problematic situation experienced by the patient. **B** refers to the negative and automatic thoughts that arise, while **C** designates the consequences these thoughts have for feelings and behavior. In this model, **D** may refer to alternative suggestions offered by the therapist regarding how one might relate differently.[496]

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[493] Hanser, 2017.

[494] For examples, see Ruud, 1973/1980.

[495] Grande and Røssberg, 2023, p. 770.

[496] Grande and Røssberg, 2023.

Cognitive therapy operates with the assumption that negative automatic thoughts are rooted in negative primary life rules. These are formed by, often negative, experiences earlier in life and become established as stable and global ways of relating to the world. Over the course of development, experiences are stored and shape the knowledge the individual eventually forms about themselves. You may thus experience yourself as valuable or as inadequate depending on how you have been met in life.

When these underlying life rules are activated, we may develop secondary life rules. These rules are meant to protect us from the unpleasant feelings that arise when primary life rules are challenged. These are thoughts or cognitive strategies that help us adapt to the environment and make it possible to cope with life. For example, I may tell myself that I should not contradict others, but instead do what is expected in order to be liked. Such strategies may eventually create greater discomfort.

According to Grande and Røssberg, there are compensatory strategies used to prevent life rules from being challenged and activated. They mention avoidance, withdrawal, rumination, worry, and self-criticism. These are strategies that provide safety in the moment, but do not create the necessary change in the underlying life rules.[497]

Cognitive psychologists have developed a set of techniques and working methods to help patients unlearn dysfunctional thought patterns. The so-called SMART model illustrates general features of the approach. Here **S** stands for specific, meaning that the goal of therapy should be specific; **M** for measurable; **A** for achievable; **R** for realistic; and **T** for timeframe, meaning possible to reach within a certain period. Dialogue-based therapy consists of guided discovery, identifying cognitive distortions, the use of homework assignments, and more.[498]

Cognitive music therapy

Music therapists have applied cognitive behavioral therapy within most music therapy working methods and across a range of practice arenas. Suzanne Hanser has provided examples of the application of cognitive music therapy in mental health, addiction work, and medical music therapy.[499]

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[497] Grande and Røssberg, 2023.

[498] Grande and Røssberg, 2023, p. 773.

[499] Hanser, 2017.

A natural area of practice is work with stress-related conditions and the use of music listening in combination with relaxation exercises. As we saw in the chapter on music therapy and public health, Suzanne Hanser, together with Susan Mandel, developed a self-help book in which music and stress management play a central role.[500] There are also examples of how cognitive behavioral therapy has been linked to GIM. Here music may function in a regulating and relaxing way, challenge existing schemas, and introduce emotional schemas activated during listening. The use of music in work with eating disorders has shown results when music is used both during and after meals to distract from distressing thoughts that arise while eating.

Other examples include the use of cognitive therapy in music listening and discussion of song lyrics. In songwriting, themes related to primary and secondary life rules and compensatory strategies sometimes emerge. Within medical music therapy, cognitive behavioral therapy finds application when music assists medical procedures. In addition, cognitive therapy is used within psychoeducational approaches, for example in work with music and pain relief.

Neurological music therapy

Neurological music therapy is the name given to a cluster of evidence-based practices developed by the German-American Michael Thaut. Thaut is a researcher and neurological music therapist who has made major contributions to this field. He can point to research documenting that music therapy improves executive functions involving flexible mental operations.[501] Here music helps create a richer environment for the brain and contributes to stronger self-organization and self-regulation. This in turn leads to improvements in reasoning, decision-making, and problem solving. Researchers argue that a musical approach enhances brain agility, in other words increasing the flexibility of brain activity and the ability to move quickly and smoothly between different ideas.

Thaut developed a music therapy grounded in an empirically based understanding of the basic mechanisms underlying the perception and performance of music. Through this he seeks to create a functional and goal-directed therapeutic use of music that yields consistent results, as described in explanations of this approach.[502]

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[500] Hanser and Mandel, 2010.

[501] Hurt-Thaut and Johnson, 2015.

[502] Hurt-Thaut and Johnson, 2015.

A central starting point for these music therapeutic approaches is how rhythm affects the body, while rhythm is also of great significance for how we organize bodily movement, both in the legs and the arms. Thaut's research has shown how rhythmic impulses help influence the onset, duration, and variation of EEG patterns in the muscles during the performance of gross motor movements. Research has shown that rhythmic stimulation leads to more efficient use of muscles, so that patients perform tasks with greater precision over a longer period of time.[503]

A number of studies have shown similar results with respect to gait and upper body movement. A Cochrane review of music therapy for stroke patients has shown that what is called rhythmic auditory stimulation (RAS) is useful for improving several aspects of gait. This includes stride length, speed, symmetry, and movement termination.

Music therapeutic application

The theoretical and research foundation of neurological music therapy lies in physiological processes, as well as in the neurological and psychological basis of music perception and production. Applied to music therapy practice, this concerns using music in sensorimotor rehabilitation, in rehabilitation of speech and language, and in relation to cognitive impairments.

Sensorimotor rehabilitation refers to interventions targeting motor functions and abilities in gait and movement, such as strength and endurance, coordination, balance and posture, and range of movement. Three techniques are used to address goals in these areas: Rhythmic Auditory Stimulation (RAS), Patterned Sensory Enhancement (PSE), and Therapeutic Instrumental Music Performance (TIMP).[504]

In speech and language rehabilitation, techniques known as MUSTIM make use of songs, rhymes, musical phrases, speech, and gestures as stimulation. In Melodic Intonation Therapy (MIT), the client's ability to sing is used to promote language use. Melodies resembling prosodic patterns of speech are employed. Through musical phrases or nonspecific therapeutic singing, speech and language ability are stimulated. Exercises involving breathing and motor activity, for example with musical instruments, are among the techniques used to promote speech.

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[503] Hurt-Thaut and Johnson, 2015, p. 221.

[504] Hurt-Thaut and Johnson, 2015.

When it comes to cognitive rehabilitation, this may involve sensory training with the help of music and sound, attention training outside the visual field, control of attention, stimulation of auditory memory, and more.[505]

Developmental psychological and resource-oriented perspectives

As we saw in the previous chapter, there are several arenas in music therapy where developmental psychological goals are relevant. This applies to music therapy within special education, sometimes in pediatrics, and in mental health work with children, adolescents, and adults. There is, however, no single unified theory or method that brings together the various approaches used with these different groups. What we have seen is that all central music therapy working methods are employed. Furthermore, the work is marked by both clinical and pedagogical approaches linked to specific developmental psychological challenges. These may concern physical, psychological, behavioral, and social challenges.

Music therapists work with theories related to motor development and draw on insights from physiotherapy. They need to rely on theories of speech and language development and therefore benefit from speech therapy knowledge. In meeting children and young people with emotional challenges or behavioral problems, they often connect with theories from clinical psychology or with theories of resilience and trauma-informed therapy. Underlying all this work is an understanding of users' rights, as expressed in conventions and legislation.

From mastery-oriented to resource-oriented music therapy

Across all of the developmental areas mentioned above, the goal may be to give users positive experiences of mastery. Through the choice of instruments and by adapting musical challenges, music therapists can create good experiences of mastery for participants. This applies in developmental psychological areas where goals may be to promote sensorimotor development, auditory perception, speech, language and concept development, the development of social abilities, strengthening self-concept, establishing contact and interaction, contributing to awareness of emotional regulation, or fostering musical skills and joy through musical experiences.[506]

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[505] Hurt-Thaut and Johnson, 2015.

[506] Ruud, 1990.

This mastery perspective has accompanied music therapy from the very beginning and was carried forward, deepened, and made relevant to mental health work through Randi Rolvsjord's research.[507] With the concept of resource-oriented music therapy, the focus is on strengthening the user's strong sides and stimulating resources and competencies. Rolvsjord finds support in theory from several traditions such as the philosophy of empowerment, movements related to social rights, feminism, the anti-psychiatry movement, positive psychology, psychotherapy research on common factors and contextual models in psychotherapy, and Antonovsky's salutogenic model.[508]

For music therapy practice, this means, for example, focusing on the client's resources and potentials, recognizing the client's competence in relation to the therapeutic process, and collaborating with the client on goals, working methods, and evaluation. It also means recognizing the client's musical identity and musical competence, being emotionally engaged in the music, and fostering positive emotions.[509]

Many ways of understanding in music therapy

There is no universal explanation for why music has a positive effect on body and mind that produces a curative, palliative, or rehabilitative effect in all the contexts we have described. This applies especially within medical music therapy. Above, I have referred to how neuropsychological processes are involved, and some point toward the ways in which music affects the brain's neuroplasticity. Hormonal changes under the influence of music are mentioned, as are the physiological changes that take place in the body when we react affectively to music.

Music and the brain

Music therapists should understand everything from musical acoustics to the ways in which the brain responds to and interprets musical impulses. The path from sound waves, through the ear, and into the brain has been well mapped. There is now extensive research on which areas of the brain are involved in processing music, whether we are listening to or performing music. Let us briefly address

[507] Rolvsjord, 2007, 2008.

[508] Rolvsjord, 2008, p. 124–125.

[509] Rolvsjord, 2008, p. 133.

some central structures, functions, and mechanisms related to the topic of music and the brain.

An important reminder is that these processes in the brain occur in parallel with our behavior and conscious experiences. In parts of the literature, it sometimes seems as if the brain stands in a causal relationship to experience, as though experience were determined by underlying brain processes. The position taken here, however, is that what occurs in the brain is a necessary condition for experience and action, but not sufficient to explain our responses. The brain is part of the body and stands in an interactive relationship with environment, context, and culture. For music therapy, it is important to understand how the brain interacts with the contexts in which it is embedded. In addition, there are many illnesses that affect the brain, and for which knowledge is needed to plan appropriate interventions.

There is a great deal of specialized literature on this topic. It is easy to get lost in the many terms used to describe the brain's topography and chemistry when trying to understand what is relevant for work in music and health. The Danish music scholar Erik Christensen has given a concise account of how music activates the brain and how the brain's responses to music are integrated with bodily experience and activity.[510] He emphasizes providing a description of the auditory system and the brain's different structures. Likewise, he points to different levels of music processing, from the brainstem via the thalamus to the cortex.

It is especially important to notice the role played by the cortex and how music activates different brain regions, triggers associations, and influences cooperation between the senses. There are also important brain structures that work together with the cortex, such as the amygdala, which plays a particularly important role in the triggering of emotions. It is also worth noting the different functions the brain fulfills. This includes, for example, prediction, especially important when it comes to anticipating events in music. Mirror neurons are often mentioned in the literature, as is the way the brain is divided into two hemispheres. These two halves have somewhat different functions, for example in the processing of musical elements.

The brain researcher and musician Daniel Levitin, an authority in research on music and the brain, warns against oversimplifying the understanding of where in the brain music processing takes place. It turns out that everything in the brain is interconnected, and that it is more accurate to speak of distributed networks that process music than of sharply localized functions. Music is therefore not something

[510] Christensen, 2019.

processed only in specific, isolated brain areas. "Indeed, music appears to recruit nearly every region of the brain that has so far been mapped," he writes.[511]

Neurochemical processes

The brain supports various reward systems, and it's especially dopamine and oxytocin that are linked to musical experience. Basic knowledge of such chemical reactions in the brain, and especially of neurotransmitters, is important in understanding the effects of medication. There are several theories about how brain structures cooperate in dynamic networks.

Mona Lisa Chanda and Daniel Levitin, in a research review, start from the premise that music improves our health by activating the neurochemical system. Here the focus is not on where in the brain music is processed, but on the fact that musical experience can be linked to 1) reward, motivation, and pleasure, 2) stress and arousal, 3) immunity, and 4) social bonding.[512]

They argue that it is important to map which chemical processes are triggered. These four areas are especially central in their overview because they involve everything from emotions and vitality experiences, emotional regulation and stress states affecting mental conditions, to social bonding. What is involved is a complicated interaction between responses to music, different areas of the brain, and the neurochemical system. In accordance with the four points above, 1) dopamine and opioids are linked to reward, motivation, and pleasure, 2) cortisol and other hormones released during stress responses are linked to stress and arousal, 3) serotonin and other peptide derivatives are connected to immunity, while 4) oxytocin is released in connection with social bonding.[513]

As an explanation for anxiety and depression understood within this neurobiological paradigm, Daniel Levitin describes a health risk driven by what he calls cortisol toxicity—the harmful effect of excessive cortisol. These neurobiological mechanisms are complex and not fully understood. One explanation concerns how music trigger emotional and psychological responses. When we listen to music that gives us pleasure, the brain's reward systems are activated and neurotransmitters such as dopamine are released. This can improve mood and reduce symptoms. Engagement in music activates the parasympathetic nervous system, promoting relaxation and

511 Levitin, 2024, p. 27.

512 Chanda and Levitin, 2013.

513 Chanda and Levitin, 2013.

lowering heart rate, blood pressure, and cortisol levels, hormones associated with stress. Music can also serve as a distraction and activate cognitive processes. Whether one is singing, playing an instrument, or listening actively to music, attention may be redirected away from negative thoughts and rumination. Such redirection can interrupt depressive and anxious thinking and offer relief from symptoms.[514]

Psychoneuroimmunology

There is a connection between bodily and mental processes. Within psychoneuroimmunological research, efforts are made to understand how psychological processes may give rise to somatic disorders. There are also attempts to understand how music or other cultural forms of influence may have a preventive or protective effect against illness. Chanda and Levitin have undertaken an extensive review of studies of neurochemical research on the effects of music. Their review shows that music can trigger the innate and non-specific immune system, for example through increased natural killer cell activity. Furthermore, the researchers point to music's anti-inflammatory properties, which are reflected in positive changes in cytokine profiles.[515] These findings are still preliminary, however, and must be followed up with further research.[516]

Neuroplasticity

The brain has the capacity to reorganize itself by forming new synaptic connections. This occurs in connection with learning and after injury has occurred in the brain. That is, the brain may shift functions from a damaged area to another area. With structural plasticity, changes occur in the structure of the brain. This happens when new neurons and synapses are formed, or when existing synaptic connections are strengthened or weakened.

When we are dealing with phenomena such as learning and memory, neuroplasticity is involved. In response to new activities, the brain can change in order to adapt to the challenges, for example when we learn to play an instrument.[517]

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514 Levitin, 2024.

515 Cytokines are proteins that function as signalling molecules in the immune system and play an important role in the regulation of the immune response, inflammation, and cell growth.

516 Chanda and Levitin, 2013. See also Fancourt, 2026.

517 See also Kölsch, 2020.

The vagus nerve

The vagus nerve is referred to as the tenth cranial nerve and has several important functions in the body.[518] The vagus nerve follows the major blood vessels from the brain down to the stomach and back. As part of the parasympathetic nervous system, it regulates several bodily functions such as heart rate, respiration, and digestion. The immune system and stress responses are also influenced through the vagus nerve.

The vagus nerve promotes rest and digestive processes. It plays an important role in modulating the body's responses to stress and anxiety by activating the parasympathetic nervous system. This counteracts the physiological effects of stress. There are a number of studies in which the vagus nerve is involved in explanations of the therapeutic effects of music. It may be that slow and calming music stimulates the vagus nerve and induces a calming response, which is beneficial in cases of anxiety, chronic pain, or sleep disorders.

A particularly clear illustration of how the vagus nerve is relevant to music therapy work is given by the Danish professor of music therapy Hanne Mette Ridder.[519] Ridder has made major research contributions to understanding the role of music in the treatment of people with dementia. She uses polyvagal theory to show how one may create a good procedure for the use of singing in encounters with people with dementia. The theory describes how stimulation of the vagus nerve activates the autonomic nervous system. Stephen Porges, who proposed polyvagal theory—and who has given support to the importance of singing and music therapy—has suggested that there is a form of perception, so-called neuroception, that enables us to perceive something as threatening and dangerous. Not least, persons with advanced dementia often feel overstimulated and lose their sense of orientation, become insecure, and easily go into a freeze response.

In such a situation, the task of music therapy is to create safety. This is a precondition for activating the parasympathetic nervous system. This is where singing and vocal use play an important role. The reason is that the vagal system integrates facial muscles, voice, and breath in affective communication. The music therapist will create recognizable singing routines in which specific songs function as cues for entering a safe situation. This makes it possible to regulate a high arousal level and engage the patient in communication. This in turn requires the therapist to use the musical elements we know from the theory of communicative

[518] For the following, see Jansen and Holck, 2025.

[519] Ridder, 2011.

musicality, namely pulse, narrativity or meaning, and musical qualities in order to synchronize with the patient. The qualitative elements of the music here refer to singing style, melodic and tonal structures, texture and timbre, the way we articulate, and how we use volume and intensity—all of which contribute to creating a mood.[520]

The window of tolerance

The theory of the window of tolerance concerns processes that occur between body and psyche. The theory suggests that there is a bodily state in which we function optimally. This window allows us to tolerate stress and discomfort and to reach a heightened arousal without losing control.

If, for example, we are working with people from a trauma-informed perspective, it is important to pay attention to whether the person is within this safe window of tolerance. If so, they can handle stress and difficult emotions. Even though they experience something as uncomfortable, they will still be able to think clearly, tolerate emotional challenges, regulate themselves, and make use of their empathic capacities.[521]

If, by contrast, one is outside this window of tolerance, too high a level of activation may arise, hyperarousal, which may produce reactions such as anger and anxiety. Too low a level of arousal, hypoarousal, may lead to low mood and dissociation. For therapy, it is important to help the user develop good strategies for staying within their own window of tolerance. Safe others, or the therapist, may provide what we call regulatory support.[522] Music experienced as calming may, for example, be used as such regulatory support.

Biopsychosocial understanding

We see that mechanisms in the brain, or other biological and physiological factors, are invoked to explain why and how music affects body and mind. However, there is also a need to point to factors outside the brain and body that stand in an interactive relationship with processes in the brain. In order to expand the biomedical understanding and create what is referred to as a more holistic

[520] Ridder, 2011.

[521] Nordanger and Braarud, 2017.

[522] Nordanger and Braarud, 2017.

medicine, psychosocial aspects of music-based interventions are highlighted. When working with people in vulnerable life situations, we must always consider factors that influence motivation, experiences of mastery, identity, resistance resources, grief responses, and so on. In other words, music-based interventions, or music therapy in the context of somatic illness, must always relate to psychological and cultural factors. From a biopsychosocial perspective, we must not only think in terms of body and biology. Emotions and existential dimensions of health, as well as broader social contexts such as family and local community, must also be included in explanations and justifications for music therapy interventions.

Different models for explaining mental distress

In the preceding pages, we have seen different explanations for why illness and ill health arise. At times we see that demonstrable bodily diseases or brain injuries lead to impairments in functioning. Even where music will not have a direct curative effect, we still see that music therapy can help users create hope for life, reduce anxiety and stress reactions, or counteract social isolation.

When it comes to explanations of mental distress, however, there is greater disagreement about what the causes are. Within a biomedically oriented framework, one looks for answers in chemical reactions in the brain that explain the causes of psychosis, depression, and the various symptoms that appear. Others argue that such symptoms can be explained in terms of psychological conditions in childhood, psychological trauma, adverse social conditions, and must always be understood in relation to structural conditions in society.

We shall first look at the critique of theories that maintain that there is a direct cause of mental disorders in biological processes. Then follows a presentation of the proposed Power–Threat–Meaning Framework.

Linear or circular explanations?

It is problematic to formulate a linear causal chain between mental illness and biological processes. We cannot simply point to processes in the brain or to other biological, physical, or biochemical conditions as causes of life difficulties. In an essay on defining mental disorders, the psychiatrist Sigmund Karterud writes about the

problems involved in categorizing and diagnosing personality disorders and other psychiatric diagnoses.[523]

Karterud points to the problem of explaining mental disorders by referring to a causal or linear relation, as we do when mental disorders are understood primarily as changes in brain processes. In the DSM-5, mental disorders are defined as follows: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."[524]

This is a descriptive definition, Karterud writes. It says something about what characterizes mental disorders, but not about causes. It says that the disorder reflects a dysfunction in processes. Such definitions of disorders are pragmatic categories intended to help provide the right treatment, as well as the right to treatment, disability benefits, or exemption from punishment.

The categories do not, however, refer to anything substantial. Despite all research on linear causal chains, we cannot point to a single disease-producing factor in body or brain. Mental disorder does not have a substantial component in the same way that, for example, tuberculosis does, writes Karterud. The category "tuberculosis" has a substantial content, namely being infected with the tubercle bacillus.

Now, there are different forms of mental disorder. At the same time, it is unclear where the "dysfunctional processes" take place when there is no simple causal relationship in brain processes. Of course, there are connections between what happens in the brain and psychological processes and disorders. But these changes in brain processes must be understood in such a way that the relationship with the environment also plays a role. These conditions are not a consequence of the disorder, writes Karterud, but an inherent part of it. He continues:

> *Mental disorders arise in interaction with the environment, most often through loss, neglect, trauma, one's own destructive behavior, etc., and are maintained in interaction with the environment through withdrawal, avoidance, acting out, learned helplessness, victim scenarios, etc. The person does something in relation to the environment (avoids, flees, attacks, blames, etc.), and the environment does something in relation to that person (bullies, abuses,*

[523] Karterud, 2023.

[524] Karterud, 2023, p. 689.

> *excludes, gives up, blames, overlooks, etc.). It is this interaction that becomes a circular etiology. Each brings out the worst in the other. What constitutes the disorder is not too high or too low a serotonin, dopamine, or noradrenaline level inside the person's brain, but the person's suffering interaction with other people in the past or present.*[525]

This argument can also be transferred to encounters with other user groups the music therapist meets. We see that such an understanding of mental disorders opens a space for music therapy action. The music therapist can meet the other person with music, use music to do something different that motivates and mobilizes the person to change their relationship to themselves, to other people, to groups, or to society, as is common within psychotherapy.

> *The short version is: if one understands oneself, other people, and interpersonal processes better, one can better understand, accept, and process one's own feelings and thereby act in more appropriate ways toward others, who in turn may become more accepting in return. Circularly—and with symptom improvement as a result. When the symptoms then disappear, or are greatly reduced, it is not because the therapist has cured the mental disorder as some substantial category, but because the person has developed, or the environment has changed, or the interaction has improved (...) We do not treat mental disorders. We treat persons with mental disorders. When it comes to tuberculosis, by contrast, it is more correct to say that we treat the tuberculosis, not the person with tuberculosis.*[526]

The Power–Threat–Meaning Framework

For anyone who has followed the discussion of diagnoses and disease constructs produced by psychiatry throughout the twentieth century and up to the present day, there has now emerged a well-argued alternative to the biomedical view of emotional suffering. A Power–Threat–Meaning Framework (PTMF) may sound somewhat cumbersome to those of us used to navigating among different schools within the mental health field. But this is not a particular theory or model; it is a kind of lens that guides how we think about and explore a field—the mental

[525] Karterud, 2023, p. 691.

[526] Karterud, 2023, p. 693–694.

health field—with the various forms of difficult feelings and ways of being that we call "mental disorders."[527]

This framework does not classify people's difficulties but says something about the causes of how they arose and the circumstances that gave rise to them. And these are circumstances tied to living conditions and social and economic structures that involve inequalities in power relations.[528]

The key ideas in the framework borrow from trauma-informed approaches to emotional distress. Here, we are no longer to ask "What is wrong with you?", but rather "What has happened to you?" This is because the framework is based on the following assumptions:

- Emotional distress, unusual experiences, and many problematic ways of being are understandable considering the person's relationships, life events, and social circumstances, and the standards and expectations we are all expected to live up to.
- There are clear links between distress—whether at the level of the person, the family, or society—and social context. This applies where there are injustice and inequality.
- Different cultural expressions of distress should be accepted and respected.
- We all experience distress from time to time, and the PTMF applies to all of us. There is not a separate group of people who are "mentally ill."
- We all make meaning of what happens to us, and this shapes the way we experience and express our distress.
- With the right support, we can be agents in our own lives rather than being seen as victims of medical illness.
- The PTMF gives us tools to create new, encouraging narratives about the reasons for our distress, narratives that do not rely on psychiatric diagnosis. These different narratives can help us find a way forward as individuals, social groups, or entire societies.[529]

Medical and psychiatric diagnosis

Music therapists working within mental health must relate to the practice of diagnosis and to the discussion surrounding its use. With this framework in mind,

[527] Boyle and Johnstone, 2024.

[528] Boyle and Johnstone, 2024.

[529] For the following, see Boyle and Johnstone, 2024.

we do not use words like "illness," "disorder," "symptom," or "patient," since these imply a medical way of thinking. This fits well with the resource- and user-oriented approach embraced by many music therapists.

In their introduction, Boyle and Johnstone provide a research-based review of the critique of the diagnostic system as reflected in the DSM manual. The PTMF shows how medical, somatic diagnosis is constructed through the identification of objective patterns and signs of bodily problems. The same way of thinking does not apply to psychiatric diagnosis, because researchers still have not been able to identify so-called biomarkers that could yield precise diagnoses. Biomarkers are objective signs, such as genetic abnormalities or deviations in brain chemistry, so-called chemical imbalances. Researchers have attempted—and failed—to find such biomarkers for more than one hundred years, Boyle and Johnstone write.

What remains, then, is that diagnoses are based on subjective judgments and social norms, and on judgments about what are considered normal ways of thinking, feeling, and behaving. The result is that clinicians disagree about when to make a diagnosis, and that people may receive multiple diagnoses. Or that diagnoses offer no explanation. They make medication the first choice in treatment and do not eliminate stigma and discrimination. Instead, diagnoses can remove meaning by severing the links between distress and social context and our interpersonal relationships. Attention is redirected instead toward what may be "wrong" with our brains and bodies, Boyle and Johnstone argue.

"What has happened to you?" is the first core question in the PTMF. It is hardly surprising that there is extensive evidence for the kinds of circumstances and events that create distress and problematic behavior. This includes sexual, physical, and emotional abuse in childhood, neglect, violence in close relationships, bullying, rape and sexual violation, poverty and low social class, unemployment and discrimination based on ethnicity, gender, or other conditions, living in a country with large income inequalities, unsuitable housing, living in an area with much crime, or being a refugee. And if a person experiences several of these conditions, or repeated episodes, the danger that the distress becomes entrenched increases.

That such conditions create emotional challenges cannot be explained adequately by biopsychosocial theories or stress-vulnerability theories. These easily lead us back to biological or genetic explanations, to hypothetical chemical imbalances in the brain or inherited factors. Instead, the PTMF considers inequality in power crucial for understanding mental distress. It is through such an understanding that we can offer constructive help and direct attention toward the need for social action and social justice.

Power in all its forms

The framework documents in detail that power exists everywhere. It exists as biological and bodily power, and as interpersonal power. Biological power concerns the cultural meaning attached to bodily characteristics and features, such as shape, size, or skin color, and how these affect everyday experiences. Interpersonal power refers to the ability to care for or be cared for, to support and protection, to withdrawal, or to withholding love. In this way, interpersonal power, especially in childhood, affects us later in life when we encounter challenges.

Power is first and foremost associated with coercion, with the use of physical violence, aggression, threats, and the like to make us do what the person in power wants. Such negative power is always part of bullying and physical abuse, rape, and sexual assaults. Legal power involves the power to force something through. Or this power may be used to protect our rights. But legal power can also mean that psychiatric measures such as involuntary admission are experienced as harmful by the individual.

Economic and material power is characterized by access to the goods and services we need to maintain our well-being, meet economic obligations, and participate in, for example, leisure activities. Economic power secures food, housing, work, transport, education, medical treatment, safety, and access to cultural activities.

When it comes to power tied to social capital, this can involve access to education and work, qualifications, knowledge, experiences, and connections that make life easier and provide a sense of belonging and security. Social and cultural capital makes it easier to gain access to necessary information that helps us manage demanding situations. A lack of such capital may lead to an experience of being excluded from many services.

The PTMF places strong emphasis on the ideological power embedded in cultural meanings, language, and discourse. This concerns our thoughts and convictions, how we ought to think and feel, how we view ourselves, others, and the world, what we regard as "natural," and what counts as "fact." Here reference is made to the French philosopher Michel Foucault's understanding of how power is embedded in everyday life, in social relations and interactions, and how power creates social norms and standards, identities, desires, and knowledge. It may concern desires to be thin, to be a "real man," to possess certain things—all those aspirations that commercialism exploits in advertising and social media.

Ideological power helps shape cultural narratives of suffering. It is pointed out how neoliberal theories and neoliberal politics help form a worldview. This worldview is characterized by the idea that we should see one another as competitive, and that status is measured in money and power. Yet we know how deeply dependent on and connected to one another we are. Neoliberal politics is in turn associated with emotional distress when it creates insecurity in many areas of life such as work, income, housing, and belonging to community, and when we are encouraged to blame ourselves when life does not run smoothly. The PTMF seeks to prevent psychiatry from stepping in and explaining people's distress as individual problems, without adequately connecting them to social and economic solutions.

Power, threats, and core needs

The PTMF shows what power can lead to, how power affects us, and what kinds of threats it constitutes. At this point the framework concerns our core needs and what happens when such needs are threatened. In short, core needs concern safety, and being valued and cared for in our earliest relationships. But the list is longer, and includes having control over one's own life, being able to acknowledge and handle a range of emotions, participating in meaningful activities, and having a sense of hope, meaning, and purpose in life. These are elements that are very familiar in music therapy.

Threats to core needs may come from relationships with other people. They may also concern poor physical health, emotional difficulties, economic and material problems, or poor housing conditions. They may also involve threats to the possibility of acquiring knowledge and receiving information, and to shaping one's identity and building one's life around basic values.

Meaning

At the center of the PTMF stands meaning-making, the meaning we assign to the life events and circumstances we have been exposed to. "How have you understood what has happened?" and "What meaning do you give to what has happened to you?" are central questions for the user. Meaning-making is the glue in this matrix. It concerns how we interpret what happens to us, how we name our experiences, and how we write them into a narrative. This implies a view of the human being as meaning-making and as trying to understand the surrounding world.

Once meaning is introduced into the framework, it becomes harder to construct simple cause-and-effect relations between events and circumstances on the one hand and distress on the other. Here various therapies may step in and help individuals see that the meanings they have created about themselves and the world can gradually change. This may mean moving from viewing one's problems as symptoms and survival strategies to seeing oneself, over time, as someone who has endured great hardship. The problem with many such therapies is that they do not widen the understanding of meaning to include conditions related to ideological power and social structures.

Threat responses

There are many ways of responding to threats in order to protect our core needs. In line with a trauma-informed approach, psychiatric "symptoms" are reformulated as threat responses and survival strategies used by body and mind to protect themselves from the consequences of burdens we have been exposed to. The body is, of course, involved in such responses. Trauma-informed perspectives show how adversity shapes our body, brain, and mind. But a trauma-informed understanding does not make simplistic claims about biological causes, such as chemical imbalance or genetic deviation. Findings from neuroscience are instead used to show how people use reactions or threat responses to keep themselves safe. Within trauma-informed approaches and the PTMF, threat responses may be understood as well-founded and protective.

Boyle and Johnstone illustrate around fifty such threat responses. These may include freeze responses, panic and phobias, hearing voices and suppressing memories, protest and suspicion, intellectualization, starvation and overeating, self-harm and anger, avoidance behavior, hopelessness and lack of trust in the world, rumination, and silence. Threat responses are shaped by the power resources available. They may at times be socially valued, they change over time, and they vary across cultures. They serve different functions and appear at the societal level through catastrophes such as war, slavery, colonialism, genocide, and natural disasters.

Some general patterns

The PTMF sketches some main patterns of psychological pain and opens dialogue with many therapies and self-help approaches. It points to a form of self-help for people who have struggled with mental distress, or for those who know someone

or work with people facing such challenges. The point of departure is a non-diagnostic way of thinking, and in this respect, it differs from, for example, cognitive behavioral therapy and other therapies, even though these may still be useful. But many psychotherapies do not emphasize the social context and instead locate people's problems and solutions inside the individual. It should be mentioned that the PTMF accepts the use of medication but adds that sufficient information must be given to the user. Although it seeks a non-diagnostic approach, it is realistic about the need to preserve diagnostic practice in the short term. This is because diagnoses are so integrated into the institutional apparatus surrounding psychiatry and thereby help secure users a range of rights.

What, then, about music therapy?

As we know from the history of music therapy, music has always found a place within medical or therapeutic thinking. We know how especially community music therapy, has distinguished itself through recovery-based practice and through user orientation with the involvement of peer consultants. This is very much in line with the PTMF.

The framework can be integrated with other psychotherapeutic approaches. There are several examples of interventions that build on or lie close to the mode of thinking presented here.[530] It is also noted that other elements contribute to healing, and here artistic expression appears together with nature experience, exercise, and social activism.[531]

Boyle and Johnstone highlight artistic expression as important for the narrative that must be rewritten. In the new identity story to be formulated, the person will need to practice and become aware of the competence that lies in musical skills. Everything that strengthens and provides power resources must be mobilized. The ways music is used to build identity, contribute to emotional regulation, provide self-care, and create relationships with others are important resources on which music therapy can build. As care workers, it becomes important for the music therapist to listen to the person's story and to acknowledge their experience of injustice and abuse of power. A core competence for the music therapist is to engage with, interpret, and respond appropriately to other people's stories, and to help users build their own stories.[532]

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[530] Holter, Bøe and Berthelsen, 2024.

[531] Holter, Bøe and Berthelsen, 2024, p. 460.

[532] See also: www.bps.org.uk/power-threat-meaning-framework/resources-training

Recovery

As we saw in the discussion of music therapy in the mental health field, music therapists draw on theories of recovery in their work with adult clients. The roots of this movement can be found at the end of the twentieth century among groups within the mental health field. These argued that people with severe mental distress did not only want a life without symptoms, but a life that also safeguarded personal and social aspects of well-being and quality of life. The medical model in psychiatry was challenged, and with it the power invested in medical expertise.

In a common definition put forward by William Anthony in 1993, and cited on a website, recovery is described as follows: "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 within the limitations caused by illness. (…) Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."[533]

On the *Mad in Norway* website, we read how recovery research showed that persons diagnosed with various labels for severe psychological problems were not passive victims of an illness, but agents in their own lives.[534] Their own stories showed how many tried to manage their problems or "symptoms," alongside contact with friends, relatives, and staff in health and social services. Many figured out how to control unwanted effects of medication.

This also concerned civil rights and the right to participate in planning and decisions concerning one's own treatment. In a critique of Anthony's definition, it is argued that the recovery process should not be seen as an individual process, but as a [535]. It is also pointed out that the recovery process is not an inner psychological process, but always takes place in concrete locations where material conditions are decisive. Recovery should not be understood within a disease model, and a social model is proposed as more appropriate in a revised definition. Recovery is described as:

> *a deeply social, unique, and shared process in which our living conditions, material environments, attitudes, values, feelings, skills and/or roles change.*

[533] Anthony, 1993. See also Solli, 2015; Solli and Rolvsjord, 2008.

[534] https://www.madinnorway.org/2020/05/recovery-sosial-transformasjon/ Access date September 26, 2025.

[535] https://www.madinnorway.org/2020/05/recovery-sosial-transformasjon/ Access date September 26, 2025.

> *It is a way of living satisfying, hopeful lives together with others, even though we may still be distressed, have unusual experiences and disruptive ways of being. Recovery involves engaging in new social and material contexts, and in open dialogues where new ways of understanding and dealing with the situation are created as we move beyond the psychosocial-material crisis.*[536]

An international group of music therapists with experience in research and practice in recovery-based music therapy, has summarized some main characteristics of this approach.[537] These music therapy researchers point out that recovery is not a new music therapy model or treatment ideology. It is more a radically different focus, in which one no longer primarily directs attention toward the individual's weaknesses and the diagnoses imposed by the system. Instead, they point to how music therapy can support the process of recovery itself.

This means respecting the personally lived experience that the user brings. The service user is the expert through their own experience and should participate in setting goals for therapy and in shaping the music offering. People with lived experience must also contribute to service provision as peer consultants. Music therapy should also build on the elements summarized in the CHIME framework, should be resource-oriented, and should support all efforts to integrate users into society as equal citizens. Here community music therapy has shown that music can serve as a bridge to the local community, to friendship, and to social networks.

Critical traditions

Alongside the best-known therapeutic theories and models, there are critical traditions within music therapy. These point out how economic conditions in society, structural causes of poverty and exclusion, discrimination based on gender and race, cultural oppression, harmful treatment practices, and the treatment of vulnerable groups and individuals influence music therapy. Such factors not only block individuals' possibilities for action but may also place such heavy burdens on a person that they lead to bodily and psychological illness.

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[536] McCaffrey et. al., 2018.

[537] Habermas, 1969; Ruud, 1990.

Different research interests

The discipline of music therapy reflects different research interests. If we follow the German philosopher of science Jürgen Habermas, he identifies three interests underlying the production of new knowledge.[538] First, research may have a technical interest when it seeks to uncover lawful relationships. This is a form of knowledge Habermas calls information, something we use to predict or produce an event. An example of music therapy research that strives to discover such relationships is found in positivist behavior therapy or behavior analysis. Through analysis of behavior and studies of how music reinforces behavior, it seeks to create predictable procedures for music therapy. Quantitative research within medical music therapy also has such technical interests through its desire to create evidence-based practices.

Although the natural-scientific interest in knowledge may be emancipatory, it is still interventionist, manipulative, and technical, writes Habermas.[539] The social sciences will, in the same way as the natural sciences, seek to master nature by establishing regularities. Yet when the social sciences have emancipatory interests, this means creating a foundation for the individual's autonomous agency through a critical form of knowledge. When we define music therapy as an attempt to give people new possibilities for action and experience, we consider that such possibilities are limited by material and social conditions. The social sciences should help us uncover the conditions that block the possibility of action. Pointing to social conditions such as economic inequality and how these affect illness and health are important matters for therapists to keep in mind.

Humanistic research, by contrast, has an interpretive, hermeneutic interest in knowledge. This should contribute to creating a coherent understanding of existence. Such interpretive research is central in theoretical work in music therapy. Here the task is to analyze concepts, combine knowledge from several fields, and construct and argue for connections between uses of music and consequences for health.

In a formative phase, music therapy was largely concerned with developing practice in different practice arenas. More recently, music therapists have highlighted a number of themes that had previously been clearly undercommunicated in the profession. These include feminist theories, disability studies, postcolonial perspectives pointing to the presence of racism, and attention

[538] Habermas, 1969.

[539] Habermas, 1969.

to the importance of understanding the multicultural society in which we live. Gender-related issues concerning LGBTQIA+ communities and how we meet people with different gender expressions have also come onto the agenda. Not least, we have a critical tradition linked to community music therapy, a culture- and society-oriented mode of thinking that builds on rights perspectives and draws on cultural studies and critical sociology.

Anti-oppressive therapy

The Canadian music therapist Sue Baines has, in a number of articles, formulated what she calls an anti-oppressive music therapy. Her point of departure is that people considered different are often subjected to discrimination and exclusion. They experience physical, emotional, and psychological pain inflicted by people and institutions, and by dominant groups in society. Such negative treatment leads to mistrust, affects self-confidence, and creates anxiety and fear that in turn affect possibilities for living fully. Baines's critique is directed at music therapy itself, insofar as she asks whether such attitudes also find their way into the way music therapy is practiced. She asks whether music therapy approaches may constitute a practice that reproduces white patriarchal domination and whether music therapy contributes to colonial aims.

Baines is influenced by feminist theory, critical analysis, and radical psychiatry. She is concerned with social justice theory. Within the mental health field, this means that therapists are aware of the social, economic, cultural, and political factors affecting users' lives and mental health. Baines's anti-oppressive therapy may be characterized as an umbrella term that borrows critical approaches from several theories. These include Marxist, feminist, anti-imperialist, and anti-racist theories, together with elements from critical posthumanism and poststructuralism. Taken together, this means pointing out how power imbalances and oppressive structures may be linked to age, class, ethnicity, gender, geographical position, health, ability, race, sexual identity, or income. In response to this, an anti-oppressive stance involves a practice aimed at awakening critical consciousness and solidarity, and at linking users' voices to social justice, social movements, and political work.

In a later article, Baines has updated her engagement and intensified the critique of colonial practices. More specifically, she directs herself against Eurocentric theories—represented in psychology by psychodynamic, cognitive, and behavioral approaches—that contribute to inequality in the mental health field. Several critical currents are drawn in, such as critical race theory, critical pedagogy, disability

studies, and queer and trans music therapy.[540] When Baines points to alternatives, she highlights sociological perspectives and community music therapy as alternative approaches.

Critique of the medical model

Much of the critique has been aimed at music therapy operating within the so-called medical model. This is a strong tradition in music therapy, for example in the United States and the United Kingdom, where music therapists work with the support of health systems and insurance companies as part of medical teams. This medical model, when applied within the mental health field, refers to a particular way of relating to psychological problems. First and foremost, the person's distress is treated as an individual matter belonging to the patient. Secondly, the therapist is regarded as an expert capable of explaining the causes of the illness or problems. From this it follows that it should be possible to determine the mechanisms that lead to change. On that basis, it is thought possible to implement a specific intervention. This intervention is viewed as a means of curing the patient's illness.[541]

This model of thought has been criticized especially by community music therapy. The alternative to such a model involves recovery- and user-oriented theories, collaboration between clients and therapists, greater attention to contextual factors, and the significance of social integration.

Feminist music therapy

The critique from feminist music therapy points out that music therapy has not paid sufficient attention to women's situation. This critique is seen as part of a broader attention to how music therapy discourses are part of a larger political arena, according to music therapy professor Randi Rolvsjord.[542] Discourse in this context means how we speak and write about music, clients, illness, gender, and relationships. The critique is grounded in an understanding that there is power in language. The ways in which we describe phenomena, things in the world, and social practices help shape them.

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[540] Baines, 2021.

[541] Rolvsjord and Stige, 2013.

[542] Rolvsjord, 2006, p. 312.

Rolvsjord points concretely to four areas in music therapy where politics and gender are at play. First, the choice of instruments, musical genres, and the roles offered can shape gender. Music education research has long pointed to how women are assigned instruments such as flute and piano rather than electric guitar. Women are given the role of pop singers, sometimes in a sexualized form. Rolvsjord asks to what extent music therapy helps maintain traditional gender roles. The question is justified, though one can add that within the Norwegian music therapy tradition there is much variation and many good role models among music therapists who break with traditional gender patterns.

Rolvsjord also highlights the critique coming from musicology. Here a scholar such as Susan McClary has shown how music is not gender-neutral but is inscribed within a gender-political discourse.[543] Music is often described using metaphors drawn from masculine and feminine spheres. A principal theme in sonata form, for example, may be described using words such as strong, aggressive, and dominant, qualities associated with the masculine. The feminine secondary theme is linked to the lyrical, the romantic, the weak, and the delicate.[544]

Within research, greater reflexivity is needed regarding the binary thinking that shapes much research, in which the world is still divided into categories such as man/woman, Black/white, and so forth. Instead, research should reflect the diversity of gender identities that exists. Much research has aimed at describing differences between men and women and has thereby helped maintain stereotypical conceptions. This critique is especially important when it comes to studies involving gender diversity.

In music therapy, we see that feminist music therapy has directed attention toward women, both in practice and in research. These include women with chronic pain, women with immigrant backgrounds, teenage girls who have been abused, women who have undergone traumatic experiences, women in mental health care, and women exposed to violence from men.[545]

An especially important concern is how many women are traumatized after being subjected to abuse. Such health challenges must be understood in relation to the oppression of women and not reduced to an individual matter. The ways music therapists write and act in this field should reflect gender-political

[543] McClary, 1991.

[544] McClary, 1991.

[545] Curtis, 2019.

awareness. Within music therapy, specific approaches have gradually developed for women who have been subjected to sexual abuse, or who struggle with substance use and addiction.[546]

A feminist music therapist with a particular focus on violence against women is the Canadian music therapist and professor Sandra Curtis. In her practice with women exposed to violence, Curtis quickly discovered that music could be effective in therapy with women working through physical, emotional, and existential injuries caused by violence. She saw that music therapy could offer a rich range of experiences through listening to and discussing music performed by female singers and songwriters. By singing and performing these songs together with the therapist and analyzing the lyrics, it became possible for the women to internalize and personalize the songs, write their own songs, process their own recordings, and create their own visual artistic expressions.

Curtis emphasizes that there are many forms of feminist music therapy. Her feminist approach is based on a sociopolitical understanding of the experiences women and non-binary individuals have within a patriarchal culture. Feminist music therapy combines a feminist understanding of the oppression of women's voices with a creative approach drawn from music therapy. This approach is especially well suited when it comes to giving women and all marginalized people a voice.

Based on her many years of work with women exposed to violence, Curtis has developed some principles and guidelines. These include:

1. The personal is political. This slogan means that our own and our clients' lives, both in private and public spheres, are shaped by the sociopolitical context in which we live. This is important because the clients we work with are often encouraged to look for personal solutions. In feminist music therapy, the focus is on the sociopolitical sources that affect individuals. Personal change must be worked on to address injuries caused by sociopolitical conditions. At the same time, the work must involve social change.
2. Interpersonal relationships should be egalitarian. This includes the relationships the client is part of, as well as the relationship between client and therapist. Relationships involving violence are characterized by imbalances in power. Even though the therapist–client relationship initially involves a power imbalance, feminist music therapy strives toward a more balanced relationship. This distinguishes feminist music

[546] See Curtis, 2019; Gardstrom and Willenbrink-Conte, 2021.

therapy from therapies that emphasize the therapist as expert and clients as passive recipients.

3. Women and women's perspectives should be valued. There are many examples of how women blame themselves when exposed to violence, take on guilt, and think they could have done something to prevent what happened.

Goals

Curtis outlines four goals for her feminist practice.[547]

1. First, she wants to increase understanding of the sociopolitical background of women, men, and non-binary people. Curtis has made this very clear through the opening chapters of a book she has written on the subject. The knowledge she has developed enters the concrete therapy work, where therapist and client explore together the many themes treated in the music of female performers.
2. Curtis further seeks to promote empowerment in users. Here again it becomes important to gain a full understanding of what power means, the forms it takes, and how it is encountered both in personal relationships and as it is recognizable in culture.
3. It is also important to support the person in their recovery from injuries stemming from oppression and marginalization. This support should help the client process the physical, emotional, and existential burdens to which women have been subjected and which have left deep traces in their lives. Music therapy should increase women's chances of creating meaning in life and building a new life for themselves.
4. Finally, she seeks to work for personal and social change. To send women back into society after supporting them in personal growth would be poor practice if one does not simultaneously work to change a harmful patriarchal culture. This activist element is extremely important in the feminist music therapy Curtis has developed.

Working methods

The music therapy approaches Curtis works from are based on demystification, feminist analyses of gender and gender-role socialization, the validation of women and all those who are marginalized, and social activism. These are integrated into working methods such as lyric analysis, singing, songwriting, and song production.

[547] See Curtis, 2019.

Or into vocal and instrumental improvisation, music performance, and other music therapy experiences that help women find a voice. Relaxation with music is also offered.

Demystification means, as in all music therapy, making the music therapy process less mysterious to the user. This means informing them about what music therapy entails and involving women in decision-making at every stage, that is, in goal setting, assessment, and the choice of working methods. This is important in order to create as much equality and balance as possible in the client–therapist relationship. Here one must consider how much the therapist should share of their own experience and to what extent group music therapy enriches the process. Group therapy is important, not least because the women experience that both the artist, they are listening to and other women in the group have had similar experiences, and that groups provide opportunities to share them.

The feminist analysis of lyrics and listening to music is perhaps the most effective experience music therapy can provide, Curtis writes. When the music affects people emotionally, cognitively, and physiologically, the message can penetrate in an effective way and initiate processes of reflection and awareness. Here we see the value of drawing on a large repertoire of music written and performed by female artists. The task is to find music with themes related to gender socialization.

Curtis's recommended procedure describes how one should first listen to the music in its original form and then sing the song in the group, either together with the recording or to the therapist's accompaniment. Then one may discuss the relevant themes that have emerged in the song and relate them to personal experiences that may surface. Finally, the song is sung together once more.

Songwriting makes it possible to tell one's own story, to present one's own perspective. The song becomes a counterweight to the objectification to which women are subjected and serves as support for the development of self-esteem and self-confidence. When songs are written, one may draw on previous song analyses and look more closely at the words used in songs and the structure or form the song has. Examples may be given of songs with varying levels of formal complexity. It is important, Curtis writes, that the focus remain on the client's attempt to find an authentic focus, rather than on producing something technically correct.

The process should be slow and gradual. Curtis often begins with a fill-in-the-blank song, a five-line song built around the structure of a twelve-bar blues. Within this frame, the women write a song about themselves. In the first line, the client inserts her own name; two new words are added in the second line, three words in the

third, and so on. After that, the client writes a twelve-bar blues with three free-form text lines, where the first two lines are the same. After trying such structured exercises, the therapist lets the women attempt to write their own completely original songs. The process often culminates in a recording.

Gender diversity

Gender diversity has not been adequately addressed in music therapy, something made very clear in a substantial anthology on the topic.[548] Nor has gender diversity been a theme in research, practice, and education until only the very most recent years. It is people belonging to the LGBTQIA+ community and their allies who are now delivering both critique and constructive input into this situation.

This new perspective is written into other critical music therapy traditions, such as anti-oppressive and anti-colonial music therapy. The question may be asked what such a way of approaching music therapy means. Central here is the concept of queering, which must be seen in relation to the term queer, which has many meanings. Queering has a somewhat broader meaning and involves questioning, criticizing, dismantling, and destabilizing assumptions, normative discourses, and other dominant understandings of gender and gender diversity. With such a queering, a critical and destabilizing theoretical inquiry, one seeks a more diverse, inclusive, equality-producing practice in which cultural humility, respect, social justice, and a general anti-oppressive stance find their place.

LGBTQIA+ is an abbreviation for several gender and sexual identities: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and a plus sign. The plus sign refers to all those not encompassed by the preceding letters. This includes so-called two-spirit individuals, non-binary people, pansexual, demisexual, aromantic individuals, people with fluid gender identity, agender individuals, and others.[549]

This new space opened by the critique holds out hope for a development of music therapy with new values and ways of musicking, as well as a new space for research and education. There is creative potential in incorporating queer and trans voices and sounds into music therapy, recognizing the lives and musical histories of queer and trans composers, and acknowledging the cross-cultural queer dimension in music therapy that is central to such a musical philosophy.

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[548] Lee (Ed.), 2024.

[549] See https://www.sfgmc.org/blog/lgbtqia-meaning

It is important to note that when people from LGBTQIA+ communities come to music therapy, they bring with them their own musical identities, shaped by experience, musical taste, and values. Often the music on which music therapists have relied has been marked by heteronormative choices, whether from popular music, jazz, or classical traditions. There are now several artists, for example in popular music, who provide gender-affirming musical responses for trans and queer people. Here one finds music and lyrics that provide a strong point of departure for exploring one's identity, while lyrics can also inspire one's own songwriting based on autobiographical material.

There are many examples of ways of relating to queer composers, opera and musicals, queer jazz, country and western, gospel, and so on. In the 1980s one might dance to music by Bronski Beat and Pet Shop Boys. Today the scene has expanded to include artists from electronic dance music and acid house. Not least, we now have a queer musicology and a new research effort directed toward this segment of musical life.

When it comes to music therapy research, the critique largely concerns the binary thinking that still shapes much research, the way we continue to divide the world into categories such as man/woman, Black/white, and so on.

The music therapists and researchers Michele Forinash and Natasha Thomas have offered a substantial critique of the qualitative research in this area of music therapy.[550] First and foremost, we need more research. But such research must also be attentive to the categories, themes, and meaning units researchers themselves read into the data. Some important questions must be asked: whether the research seeks transformation, whether it rejects the status quo, whether it protects vulnerable members of society, and whether it aims to initiate action, and if so, whether this occurs with the acceptance of the groups concerned.

Autoethnography is highlighted as a good way of bringing forward new knowledge, and there are already strong examples of this.

The authors go on to call for a queering of the ontologies and epistemologies that govern research. The world looks rather different from a queer perspective. The reality we imagine is not fixed and unambiguous but changing. We must ask what counts as evidence, what counts as knowledge, they write. Research methods too can be queered, and above all they require extensive reflexivity.[551]

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[550] Forinash and Thomas, 2024.

[551] Forinash and Thomas, 2024.

Colonialism and postcolonial critique

A central question for music therapists who are in contact with Indigenous peoples or other groups with a distinct health culture is to what extent it is possible to reconcile the role of therapist and health worker within a Western healthcare system while at the same time preserving and drawing upon the wisdom and traditions that have been maintained for centuries by Indigenous populations.[552]

The health traditions often referred to among Indigenous peoples or within other traditional societies point to public health traditions and health-promoting uses of music, possibly also with healing aims. Key concepts include holistic thinking, spirituality, connection to roots and traditions, balance and harmony, self-development, regulation, the relationship to society, community, nature, and not least the land we walk upon. Other values include family and community, often in contrast to Western individualistic thinking.

What is now called the postcolonial period or epoch—that is, the time after many countries achieved independence—gave rise to the term postcolonialism. Put simply, this means that peoples and population groups should have the right to define themselves. Colonialism involves the seizure of territories, the exploitation of resources, and attempts to govern and control the inhabitants of occupied countries, often by force. Political-economic systems such as capitalism are closely linked to colonialism and have led to massive transfers of resources to wealthy countries. Together with imperialism as an ideology, the European project of control introduced concepts of race, created narratives of its own superiority, and used science to justify its actions. Through educational systems, it influenced the thought life, belief systems, identities, and self-understanding of Indigenous peoples. Even after several generations, the aftereffects of colonial systems remain. The transfer of resources has created a gap between social classes that economic liberalism has been unable to eliminate.

Postcolonialism refers to different ways and practices of reading and representing the postcolonial situation, and to the attitudes and values that shape such practice. In relation to music therapy, the issue is how we should understand music therapy practices, theories, and scientific findings. Another term that is used is decolonization, which implies a more confrontational approach.

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[552] For the following, see CAMTI, 2020.

Postcolonial theory offers critical lenses through which to examine and understand how power structures and social norms still privilege whiteness, thereby opening possibilities for critique. Decolonial theory seeks a more radical disengagement from the sources of ongoing inequality that have such deep roots in European imperialism. The term anti-colonial has been used as a counterpoint to postcolonial theory, a kind of theoretical counter-narrative, or political action, a way of understanding lived experience under colonialism.

The critique articulated within this postcolonial discourse in music therapy is multifaceted. At its core, it targets efforts to ignore, suppress, or marginalize the musical and health traditions of Indigenous peoples, whether these are expressed through practices, values, or explanatory systems. This critique of colonialism also extends into broader examinations of Western science and research, at times reaching an extreme position in which all music therapists—regardless of their specific roles or intentions—are seen as inherently reproducing colonial structures. At the same time, there is well-founded criticism concerning the lack of effective countermeasures and programs to address discrimination and ableism within the field.

Another line of critique is aimed at educational institutions that fail to make adequate arrangements for students from other musical-cultural backgrounds or for international applicants. The critique also targets cultural appropriation, that is, the taking of instruments and genres out of their context in ways that strip them of their original functions.[553]

Intersectionality and ableism

Intersectionality is a concept used to describe how different social identities and factors—such as gender, race, class, sexuality, disability, and more—interact and intensify one another in shaping identity. This affects individuals' experiences of discrimination, privilege, and power.[554]

Ableism refers to discrimination against disabled people or people who are different in some way. The concept implies the idea that being non-disabled is treated as the norm. This leads to negative attitudes and condescending treatment of people with disabilities. It may appear in the form of a lack of physical accessibility and accommodation, such as ramps in public buildings or insufficient

[553] CAMTI, 2020.

[554] Thun, 2023.

adaptation in study situations, through language use such as derogatory remarks and condescension, through exclusion from activities, through disbelief that such individuals can contribute to working life or society, and through stereotypical portrayals in the media.[555]

[555] Thun, 2023.

CONCEPTS OF MUSIC IN MUSIC THERAPY

4

Concepts of Music in Music Therapy

In this chapter, I will present different ways of understanding and explaining the role of music in therapy. Here we will turn to musicology to shed light on what underlies musical communication. We encounter theories from music psychology and the sociology of music, as well as from other subfields of musicology such as music anthropology and music aesthetics.

What we are seeking is an understanding of music that can help explain how and why music can be involved in work aimed at influencing health and quality of life. We find answers by examining how music—already from infancy—functions as an important bond between people. Or, as we have seen, how music psychologists identify mechanisms in the brain or in music itself that cause us to react emotionally when we listen.

Researchers of culture and sociologists of music will point out how our cultural belonging helps shape our musical identity and taste, something we must consider when choosing music. At the same time, we can analyze the music used in therapy to investigate whether there is something in the structure of the music itself, or in the way it is performed, that can explain why it creates meaning in a particular situation.

There are several ways of conceptualizing music that can illuminate the roles and functions it has in music therapy practice. Throughout this book we encounter understandings of music as "social capital," "metaphor," and "symbol," as a "field of learning," "emotional capital," and "reward," among others. Through the development of new practices in health musicking, music therapists point to new ways of understanding and using music.

CONCEPTS OF MUSIC AND UNDERSTANDINGS OF MUSIC

Different concepts of music in music therapy

A central question in music therapy is how we are to understand the role of music in therapy. We cannot rely on simplified answers such as "music is a universal language," or that certain frequencies in music cause parts of the body to be affected and healed. There are no simple explanations for how and why music affects us. The attempt to map the effects of music will always confront us with complex answers.

The British music scholar Nicholas Cook captures this well when he writes that music is a small word with infinitely many meanings and uses.[556] There are many ways of defining and describing music—in other words, of forming a concept of music. To have a concept of music means understanding what music may be, what functions it has, how it is used, and how it affects us.

Among music therapists there will be many different views of how music is understood and conceptualized. We assume that the way we view music gives us new possibilities in working with music as a therapeutic medium. If, for example, we begin from the idea that music concerns communication and interaction between people, we can see that such an understanding corresponds well with much of the practice on which music therapists base their work. There is strong theoretical and research support for such an understanding of music in studies of how infants communicate with caregivers, or in research showing the significance of music in connecting people and forming communities.

For a music historian, music may for example be understood as an aesthetic object, a "work" that can be analyzed in terms of historical, cultural, or technological conditions. For a music sociologist or media scholar, music may be viewed as a "commodity," or as an influence that holds our attention. For a musician, music may perhaps be understood as a medium of expression and communication. The concept of "music" is therefore a "floating concept." Even though we all intuitively share a general sense of what music is about, we can see that there are very many ways of conceptualizing these "musicalized" sounds.

[556] Cook, 1998.

Code familiarity and musical cognition

Music therapists want to create an optimal musical situation about communication and interaction. They therefore wish to begin with music that the user already knows. This means choosing music from children's culture, from youth popular music, or from musical genres with which the users are familiar, to increase readiness for musical interaction.

Music psychology helps build the knowledge base for the understanding of music in music therapy. Musical perception and understanding depend on cognitive abilities, in that music we hear repeatedly creates a form of code familiarity within us. This influences musical experiences, and therefore music therapists take these familiar musical codes into account when choosing musical activities. At the same time, these codes are shared and common within a given cultural sphere, or possibly familiar within a subculture.

Memory and code familiarity

Within cognitive music psychology, one maps what happens when sound waves strike the ear, are transmitted to the brain, interpreted, processed, and perceived as music. Memory, and previously stored acoustic memories, help us distinguish individual sounds from other sounds in the environment. There are several forms of such memory: short-term memory, long-term memory, echoic memory, working memory, and episodic memory. In order for us to experience something as music, we rely on these different forms of memory. What we for example call working memory helps us organize sounds into meaningful wholes. Our memory helps us form expectations and predict what is going to happen in the music.[557]

For example, echoic memory makes it possible to retain auditory impressions for a few seconds, like a kind of resonance of the music. Such a brief auditory impression enables us to notice particular features of the sound—the timbre of the tone, its strength, or its pitch. This happens because echoic memory makes it possible to compare that very sound with what is stored in the memory bank of our long-term memory.[558]

[557] See Snyder, 2000 for details about our musical memory.

[558] Snyder, 2000.

Script and code

We also connect individual sounds into longer "sound events." These sound events are organized and grouped based on similarity or temporal proximity, according to principles known from Gestalt psychology. Here short-term memory plays an important role. Sounds that are recognized are retained for a few seconds in short-term memory. With repeated occurrences and surprises, information about the sounds is sent to long-term memory, which functions as a memory bank.

What happens next is that we group sounds that belong together into a musical melody or a rhythmic figure. Creating such meaningful musical units is called chunking in the technical language, and it allows us to create patterns and rules that say something about which sounds belong together.

Such rules are understood as "scripts," as rules of action that tell us how to interpret sounds so that they make sense to us. A script is thus a rule that says something about a specific sequence of actions. Sonata form in classical music or a blues scheme are such scripts that tell us how the music is organized. We have acquired code familiarity when we recognize such scripts for musical forms. This implies that one has specific expectations about how the music is organized and how it will unfold.

By connecting such a cognitive understanding to the way meaning is created in music, one opens the possibility of seeing musical experiences in light of the person and the situation or culture in which an encounter with music takes place. We shape our code familiarity through encounters with different kinds of music, in different situations and cultural contexts.

Users come to music therapy with different musical identities formed through repeated encounters with music. When musical identity becomes a theme in music therapy, music therapists must understand how cognition, context, culture, and identity form important conditions for good musical communication. When we see that such factors work together, we speak of an ecological understanding of music.[559]

To have musical code familiarity means to have certain expectations about the course of the music. When we improvise, for example, we can challenge participants' musical expectations. Through improvisation, we encourage participants to complete and respond to musical invitations. When participants give appropriate responses to musical challenges, or fulfill expectations created by

[559] Ruud, 2020c in Varkøy and Holm (Ed.), 2020.

tonal and rhythmic connections, they show a form of intentionality. This is a basis for conscious action. Perceiving and responding to the expectations created by music is a prerequisite for emotional responses to music, for reciprocity, and for the formation of relationships.

Cognition and emotion

It is equally important to understand the mechanisms that help trigger and regulate our emotions when we respond emotionally to music. This concerns the fact that music creates memories, images, and associations. Reactions to music set in motion processes in the brain that lead to emotional responses. In the chapter on music and public health, we saw how emotional responses to music could be triggered by a number of conditions, as described by the BRECVEMA theory.

Such cognitive and emotional theories help explain how musical communication arises. However, one may still ask whether there is something inherent in the music itself that shapes particular responses or experiences. Some might prefer a simple explanation of music's effects in order to select the "right" music for any given situation. This view, however, implies a belief in a kind of "musical pharmacology"—a deterministic perspective in which meaning and effect are mechanically transmitted from the music to the listener.

Those who live within a particular musical culture will, of course, often share similar ideas about which music or musical elements are calming, are perceived as sad, or feel energizing. But it is a long step from this to believing that a particular form of music in itself triggers particular reactions that everyone responds to in the same way.

Music as communication and interaction

For a music therapist, it is above all important to find music that the participants have a good relationship with, music they perhaps already know and that belongs to the genre they prefer. This touches on themes such as genre understanding and musical taste. Terms such as preference-based music, music and identity, or musical code familiarity point to some central conditions for successful musical communication.

Musical taste is another way of talking about this—that is, which music we like. We speak both of musical taste and musical preference with regard to music we prefer, although preference is a more fluid concept than taste. Musical taste can be linked to cultural and social belonging, personality, musical socialization, and musical and personal identity.

What makes us like a particular music is a theme in music psychology and music sociology. Through upbringing and musical socialization, schooling, being with peers and friends, concert experiences, and music use through media, one acquires more or less lasting musical preferences. Sometimes parents and siblings have influenced us. Other times influence comes from friends, at school and in leisure time, through YouTube or TikTok. We may have had accidental but major musical experiences at concerts or through a smartphone. Some are influenced by a music teacher or by learning to play an instrument.

Music psychology suggests that children are open to all kinds of music. This openness declines at the onset of puberty and rises again with age. What one liked in youth often turns out to have a lasting effect on one's musical taste. In addition to general developmental factors, some psychologists point out that our personality determines what we prefer to listen to or play. This may concern whether we are introverted or extroverted. Some are affected by music that is complex and makes them reflect. Others like music that is intense and rebellious. Some prefer more conventional and entertaining music, while others prefer more energetic and rhythmic music. Some researchers claim that this is related to our personality.[560]

We must also consider that genres contain a number of subgenres. Within popular music there are countless subgenres within electronic dance music, rock, or heavy metal. It is therefore important that the music therapist enters into dialogue with the users about which music they prefer and why that music has a special significance for them.

Communicative musicality

In recent years, music psychologists have drawn on empirical research into communication between infants and caregivers. They have identified clear musical elements in this communication. The research of Steven Malloch and Colwyn Trevarthen, presented in the anthology *Communicative Musicality*, points toward a new view of musicality.[561]

Earlier musicality research was concerned with musicality as being good at distinguishing tones, timbres, and rhythms from one another, or at communicating music with great expressive power. This new view of musicality means using sound

[560] See Bonde, 2009.

[561] Malloch and Trevarthen, 2009.

and music to communicate with and form relationships with other people. This is a view of musicality that musicians from different genres readily recognize. Musicality is no longer understood as a specialized competence possessed by only a few selected individuals. Musicality is a general human capacity that most of us take pleasure in using.

Infant researcher Colwyn Trevarthen was originally concerned with communication between mother and child more generally. He used several video cameras to study the interaction between the mother and the infant. He gradually became interested in how this interaction made use of musical devices and how human interaction can be described in musical terms.

This interaction is characterized by rhythms of interaction and timing, intensity and variation in loudness and timbre, and the building of melodies or small musical narratives. Through studies of this "musical interaction" between child and caregiver, Trevarthen and Malloch argue that musicalized interactions are fundamental components in the development of interpersonal relationships.[562] The renowned infant researcher Daniel Stern also uses musical metaphors when he describes the infant's early development. He has shown how, through interaction with infants, we engage in important "affective attunements" that confirm the infant's bodily experiences.[563]

It should be added here that musicality is quite a fluid concept. It has been given different content throughout the history of music psychology over the last century, and this still affects the way we relate to music today. The use of the concept also has an ethical and political dimension, insofar as we use it to legitimize that only a few selected people should be offered training and opportunities to play an instrument.

That some people have greater talent, motivation, and better socio-musical conditions for realizing their musical abilities is not so mysterious. The same is true of football players as of artists in other expressive forms, those who choose to devote thousands of hours to cultivating their talent. With another concept of musicality, it becomes self-evident that all children have the capacity for musicking. See what has been written about "a healthy musicality" in the chapter on music and public health.[564]

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[562] Malloch and Trevarthen, 2009.

[563] Stern, 2010.

[564] McDonald and Saarikallio, 2024.

From protomusicality to teleomusicality

The early communication through sounds between the child and the close adults has been referred to as a form of protomusicality. We know from discussions in music therapy how problematic it is to designate protomusicality as a form of musicality. At the same time, it is an unfortunate form of reductionism to reduce all musical activity to such early exchanges of sound. There are, however, connections between the infant's sonic and communicative expressions and later forms of musicality. Enactive psychology has broadened our understanding of these connections.[565]

The child's early musicalized expressions are first and foremost part of a communicative situation. The use of sound and movement aims to build relationships. In this protomusicality, neither the music nor the sounds and bodily expressions have a meaning of their own. When the infant grasps a rattle and makes a sound, what fascinates is above all the grasping movement itself and what it produces. At around six months of age, however, a change occurs, because the form of the rattle is now recognizable and the grasping movement is well automated. The sound itself can now come into focus. When the child strikes a drum, meaning may be found in the fact that someone responds, perhaps in a new and challenging way.

It is at this developmental stage that we speak of a shift in attention. The French music psychologist Michel Imberty called this an "attentional shift." This shift means that the child has developed the ability to initiate and recognize musical behavior, to play with nuances in sound generated by musical engagement. It is now that we speak of teleomusicality.

Early communicative musicality is part of an emotional-empathetic form of communication involving rhythmic movement and prosodic sound production. Communicative musicality is part of a desire for attention in order to satisfy needs for care, nourishment, play, and relationship formation. Sonic—or musical—goals are not in themselves goals of protomusical expressions. With this shift in attention, the child becomes motivated by an interest in playing with sound itself, in exploring and acting on the basis of sound. We now speak of an inner motivation to play with sound for its own sake. At the same time, we see that this is the beginning of a further development of motor skills and cognition, something that music therapists in particular take advantage of.

[565] van der Schyff, Schiavio and Elliott, 2022.

There is thus a continuity between protomusicality and teleomusicality. In improvisation, the point is to take protomusical expressions as the starting point and precisely to create this shift in attention that challenges the child to participate in musical exploration. Nordoff and Robbins's concept of "The Music Child" can be understood as a designation for this early musicality—both the protomusical and the teleomusical. This shift in attention means that the child develops a form of intentionality or directedness that lays the foundation for shared attention and further development. In that sense, this understanding is a contribution from music therapy to enactive psychology.

Culture and class

Sociologists and anthropologists of music point out that culture and social class, as well as the context in which music is experienced, co-determine what we like. Altogether, age, gender, place of residence, class and social background, ethnicity, and media influence all function as formative factors in the development of musical taste.

The French cultural sociologist Pierre Bourdieu sees taste and attitudes toward art as connected with different social classes in society. He places our relationship to art and culture within the social game that sustains and maintains power and social hierarchies. For Bourdieu, acquiring taste becomes a form of cultural capital, something worth striving for and possessing. He used the term habitus to designate how our manner of being, our values, and our musical socialization constitute a form of cultural competence. Music therapists have borrowed the concept of capital from Bourdieu when they speak of music as a form of "social capital" and "emotional capital."[566]

Music and identity

In music therapy, it is crucial that the music being used is perceived and given meaning by the user. The idea of using preference-based music rests on an understanding that musical taste and musical preferences are anchored in the recipient's body, emotions, and cognition. One way of communicating this is by showing that there is a connection between music and identity, between the music we prefer and central experiences and memories in our lives.[567]

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[566] See Procter, 2011 for theory about social capital and music therapy.

[567] Ruud, 2013a.

As I wrote earlier, identity is understood as the stories we construct about ourselves. Such stories draw their raw material from the past, from experiences and events that have become fixed in memory. We speak of different forms of memory: that which is connected to words and facts, so-called semantic memory, and that which refers to events in our lives, so-called autobiographical memory.

Music is particularly important to the memories we carry from the past because it creates emotional experiences that become linked to autobiographical memory. These memories are retained over time and can serve as raw material in constructing the narrative of the self.

Our identity is thus linked to the experience of continuity in life, that we experience ourselves as the same, or as the one we were earlier. Here memory plays an important role. Identity, however, also has a component that points toward the future. We may, for example, experience an artist as appealing so strongly to us and our values that we identify with that person. In this way we may adopt aspects of appearance or reinforce values and let this become part of our identity.

In addition to these two dimensions of identity formation, we may sometimes project our musical identity outward as part of how we present our social identity. We choose to reveal something about our musical taste and musical identity, or to keep it hidden, depending on the situation in which we find ourselves. Many young people choose to navigate their musical identity to gain acceptance from different social groups.

I also speak of identity as part of our self-reflection. Here we evaluate different aspects of identity and weigh the values, attitudes, and preferences closest to us.

Within such a matrix—where identity is shaped by memories, identifications, social negotiations, and self-reflection—there is ample space for musical experiences to become integral to identity formation. We carry musical memories tied to early childhood, experiences of mastery, and capacities for emotional regulation. We allow artists to influence us, whether in shaping our appearance, informing gender identity, or guiding the extent to which we align with social norms. Musical preferences also serve as signals to others, expressing our sense of ethnic belonging, individuality, and authenticity.

Music is often tied to specific moments in life, helping us situate different periods in time. What we listen to or play can also be associated with places where we feel we belong. Moreover, deeply affective musical experiences—particularly those of a transcendent nature, such as religious or spiritual moments—can anchor our

values. When music becomes integrated into identity in these ways, it becomes clear why musical taste feels so deeply personal.

Our musical identity is thus a collection of competencies that we bring with us into all situations and a resource for creating meaning and coherence in life. Music therapists work in a resource-oriented way, which means taking as their starting point the skills, competencies, and interests that users bring with them. Meeting a client with a bodily grounded musical identity tied to values and emotional experiences gives music therapy a particular advantage in creating contact and communication.

This strong connection between music and identity provides several possibilities for music therapy working methods. Here it should be pointed out that music listening can be used profitably as part of reminiscence work with people with dementia. Music quizzes, discussion groups, and song-sharing are used in several practice arenas. Sharing one's musical preferences, particular songs, and playlists provides a good starting point for conversation in groups and in individual music therapy. Similarly, songwriting often draws its textual content from one's own identity and autobiographical memories. Song-sharing in groups provides a good opportunity to begin a conversation and allow participants to get to know one another.

Music, meaning, and function

We have seen that a central feature of music-centered music therapy is how the musical experience creates a space for collaboration, shared performance, and possibilities for personal change and growth. Musical experience in turn rests on the assumption that music creates meaning, or resonance in us, as I mentioned earlier. In order to get closer to what it is in the music itself, in the musical structures and what they refer to, we use knowledge from musicology to determine this dimension of meaning.

Affordance and appropriation

In connection with the theory of embodied cognition and musical meaning, we draw on the perceptual psychologist James Gibson's concept of affordance.[568] Gibson developed this concept in connection with his ecological theory of

[568] Gibson, 1979.

perception, in which he wanted to illuminate the interaction between human beings and their surroundings. Gibson arrived at the conclusion that every environment, situation, or object "affords" certain perceptions and actions. A ball, for example, affords being rolled and kicked.

The sociologist of music Tia DeNora was among the first to introduce Gibson's concept into music research.[569] The concept of affordance designates that there is something in the music itself that "offers" to be interpreted and experienced in a particular way. Music in a slow tempo, with a minor quality, will immediately be associated with something sad. If the music is perceived in this way, we say that the person has appropriated the meaning being offered.

Musicking

Other concepts to be discussed here are *musicing* or *musicking*. The idea that music should not be designated as a noun but as a verb became the basis for music educator Christopher Small's concept of musicking. "There is no such thing as music," writes Small. "Music is not a thing at all but an activity, something people do. The apparent thing 'music' is a figment, an abstraction of an action, whose reality disappears as soon as we examine it more closely."[570]

Music is therefore something one does. Depending on who performs which music and where it is experienced, the meaning of the music changes character and significance for those who participate, as listeners or performers. Musicking includes listening to music or other participation that helps bring meaning to a concert, a listening situation, or the like. From this concept of music, the concept of health musicking has further been derived.[571]

Culture and context

To think contextually when choosing music means considering the many factors that influence the experience of music, that is, a person's listening history and the particular embodied modes of listening that guide perception. The situation in which the music is performed, the music itself, and the way it is played will shape the experience of meaning. This means that we do not speak of the meaning or

[569] DeNora, 2000.

[570] Small, 1998, p. 2.

[571] Stige, 2012.

effect of music independently of a particular situation. The situation in which we position ourselves, for example a particular way of listening to music, perhaps in a particular place in the home, helps shape and give meaning to the listening experience itself.

Such a contextual understanding of music tells us that it is difficult to predict what meaning people will draw from music in different situations. We cannot explain how music works through simple cause-effect models. This means that music therapy as a discipline does not provide ready-made musical programs that will work in a specific way for all people in different situations. To cultivate such an idea is a sign that natural-scientific causal models—or, put differently, a particular form of medical culture—are creeping into our ideas about how music affects health.

To claim that people themselves are experts on which music they like, and on how that music affects body and mind in different contexts, means entrusting the choice of music to the users themselves. If we listen to people's accounts of how body and emotions are affected by music, we hear a great deal of wisdom about how people are able to care for themselves through musical rituals, bodily practices, and forms of experience, as we discussed in the chapter on music and public health.[572] That said, it must be added that in some situations the music therapist must take responsibility for the choice of music on the basis of knowledge of the client and of how therapeutic processes unfold.

The musical experience—dimensions of musical meaning

As we have seen, music is experienced as meaningful because it provides emotional and aesthetic experiences. It yields insight and new knowledge about the world and the contemporary moment and fulfills a range of functions for us as individuals and as members of society. Music is a unique resource for forming relationships and for communication. For many people, music provides the basis for identity and serves as an aid in interpreting life and creating life-meaning.

Now it is important to distinguish between the values music gives us, which help provide meaning to musical activity, and musical meaning, or the meaning that arises when we follow what happens in the course of the music. In discussions of music and meaning, some people wish to emphasize a musical experience free of all "utility functions." They want to protect so-called purposeless "pure aesthetic

[572] Ruud 2002, 2005a.

experiences." In what follows, I will sketch four dimensions of the musical object itself and of the situation in which listening to or performing music takes place, dimensions that help create meaning in the musical experience.[573]

In many situations, a musical experience will be the result of an entanglement (following Karen Barad's philosophy) of these dimensions.[574]

The materiality of sound

Sound can trigger immediate reactions leading to spontaneous physiological responses. This happens when we react to the vibrations of sound or to sudden and abrupt sounds that strike us directly in the brainstem. It is here that we speak of the "materiality" of sound or music. It can also be a particular timbre of an instrument or a voice with a special character, "the grain of the voice," as the philosopher Roland Barthes attached to a voice.[575]

Musical structure or syntax

Musical syntax includes the individual elements in music such as timbre, pitch, volume, duration, rhythm, melody, harmony, and pauses. These musical devices are part of the approaches and musical techniques the music therapist uses to invite musical experiences and musical communication. Through improvisation, music therapists create tension, expectation, and intensity in music. Composers introduce musical expectations through tonal and temporal tensions, uncertainty, and surprise, thereby challenging our musical code familiarity. Musicians use rhythmic displacement and accentuation or intensifying techniques to create expectations.[576]

Semantic aspects

Music can remind us of something "extra-musical," that is, refer to images, events, and values. It is here that we say music has a semantic meaning. Such communication of musical meaning and extra-musical associations occurs when

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[573] See Ruud, 2001a, 2016; Bonde, 2009.

[574] See Afterword

[575] Barthes, 1982.

[576] Meyer, 1956; Keil and Feld, 1994.

sender and receiver share the same cultural norms. The popular music scholar Philip Tagg calls such connotation the music's "paramusical field of connotation."[577]

Pragmatic aspects

In Christopher Small's concept of music, music is to be regarded, as we saw, not as a noun but as a verb. We also saw that musical meaning arose through the person's encounter with music in a particular situation. Music is understood as a specific form of human activity. This means that the experience of meaning in music depends on how music is used, on the specific situation in which we find ourselves, and on which musical objects, sounds, and instruments we make use of.

With this as our starting point, instead of asking "how does music affect us?" we can ask about the effects of music as a form of social practice. In this way we ask what a musical practice does to our identity, how we use music to create belonging and communicate our identity.

Music as analogy and metaphor

Music therapists try to formulate what is distinctive about music and what makes it useful in therapy and health-promoting work. So far, I have described the concept of musicking as emphasizing the situational and processual nature of musical meaning-making. It is the situation, the context, and the use that determine what meaning is to be ascribed to the music. The pair of concepts affordance and appropriation likewise emphasizes that no fixed and determining meaning lies embedded in the music. Rather, there are indications in the musical structure that the listener chooses to appropriate. Examples may be that music we experience as relaxing and calming has a slow and stable tempo, few dissonances and unprepared leaps, predictable harmony and melody, repetitions and clear structure, pleasant timbres, and few accents.[578] Within a Western musical culture, most people will easily appropriate such structural elements and give them the designation, or metaphor, "calming," with reference to a particular bodily state.

Music therapists do not uncritically accept the musical-aesthetic principle, following Kant's philosophy, that listening to music should be disinterested, that is, without

[577] Tagg, 2013, Chapter 6 and 7.
[578] Bonde, Pedersen and Wigram, 2001, p. 111–112.

any specific purpose or utility value. Music therapy certainly recognizes that it is entirely possible to adopt an aesthetic attitude toward music, in which attention is directed toward the music itself in order to contemplate it. The philosopher of music Jerrold Levinson emphasizes that a cognitive freedom follows from the musical experience. This means that we tend to fantasize, explore, and discover new aspects of the music. We approach music through an interpretive framework that gives direction to how the music should be perceived, or how we may communicate the experience and meaning of the music through images or metaphors.[579]

The interpretive attitude we bring into a listening relationship, or apply when we improvise, will necessarily be shaped by the therapeutic context in which the musicking takes place. Within such a context, it will be natural to give music a kind of language character, though admittedly without the clear semantic meaning of verbal language. This is the background for the formulation of theories in music therapy about the analogical and metaphorical character of music.

When we express ourselves through music, for example in improvisation with voices or instruments, the Dutch music therapist Henk Smeijsters believes that the music reflects or expresses certain characteristic aspects of the person who is musicking. He argues, for example, that one can read a disease pattern or psychopathological problems in the way some patients play.[580]

In the same way, we can read music as an analogical expression of human characters, states, forces, and tendencies. The American music therapist Kenneth Bruscia has developed a system for mapping musical elements analogous to human traits.[581] His analytic model, called *Improvisational Assessment Profiles* (IAP), uses terms that refer to psychological qualities and characteristics.

Bruscia's analytical framework with six profiles, which was also described in the section on assessment in music therapy, assumes that the music symbolizes certain central aspects of the client's manner of being and personality. He seeks to determine the "character" of the improvisation, which concerns conformity and control. He asks about "integration" and "variability," which refer to rigidity and stability. "Congruence" is another characteristic, pointing to

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[579] Ruud, 2016.

[580] Bonde, Pedersen and Wigram, 2001, p. 131ff.

[581] Bruscia, 1987.

engagement, while "autonomy" says something about dependence and independence. In this way, improvisations can be read as a reflection of the user's way of being-in-the-world.[582] The way a person plays will therefore say something about the user's psychological and bodily needs.

Such an analytical framework belongs within a psychodynamic approach to music therapy. The reading of the music will take place in interaction with the user and in connection with a general understanding of, and insight into, the user's psychodynamics. One must warn against over-interpretation and simplified conclusions about analogical relationships. One important point here is how musical improvisations will develop in step with musical learning and technical skill in expressing oneself on the instrument. In that sense, the music will not only reflect the person's psychodynamics but also communicate a cultural expression that has been acquired in the learning process.

Music therapy as a producer of metaphors

The very concept of music in musicology is challenged when we take into account the varied practice carried out by music therapists. In the review of fields of practice, goals, and methods, we have seen that music has been referred to as a "symbol," a "field of learning," as "competence," or as "emotional and social capital." Music therapy practice will, in other words, lead to the creation of new concepts of music.

Musicology itself has changed in recent years and has placed greater emphasis on investigating new aspects of music. The focus has shifted from studying musical structures, notes, and scores to giving greater attention to the experience of music. Music is no longer regarded only as a "work" created by great masters, but precisely as a way of forming relationships.

In the final chapter, I will summarize a view of music in which ecological and relational aspects play a role in the understanding of music. We will see how musicology has developed in recent years and how the understanding of music as communication and interaction has become important.[583] At the same time, music is understood as something processual, something involving meaning and emotion, something bodily, something that invites participation.[584] Not

[582] Bruscia, 1987, p. 132.

[583] Ruud, 1990.

[584] Ansdell 1997, p. 37, 2003, p. 155–156.

least, the prominent music scholar Nicholas Cook has embraced this understanding and strongly emphasized music's relational character and ability to create contact between people, cultures, and nations.[585]

The functions of music in music therapy

From a musicological perspective, it may be interesting to study the functions music can have in different therapeutic contexts. As we encounter several times in this text, we speak of music's paramusical consequences. These are phenomena that occur alongside the music and that enter a circular process in which music and life affect one another. In this way, music becomes both expression and action, acquiring functions ranging from the bodily and emotional to the social and existential.[586]

Developmental-psychological and cognitive functions

Music fulfills a number of functions that can be described as motor, cognitive, emotional, socio-communicative, and epistemic. It captures attention, structures learning, and functions as a signal for forthcoming actions. When particular musical patterns are repeated, links are established between sound and action—music acquires a signaling function. It signals events to come and gives structure to activities. At the same time, music can support and reinforce actions: we listen, move, or respond with sound.

Emotional functions

Music can regulate and release. It can calm, awaken, inspire, or give expression to feelings that are otherwise difficult to communicate. For people who have limited access to language or traditional forms of expression, music can be a unique medium of communication. Through creative activity, the individual is given the opportunity to express themselves and to experience mastery. Such a channel of expression can have a liberating and healing effect—music becomes a medium for personal expression.

[585] Cook, 2024.

[586] See more in Ruud, 2016, p. 106ff.

Socio-communicative functions

Music creates contact and relationships. It functions as a social glue and can build bridges between people who otherwise have difficulties with social interaction. Concepts such as relationship formation, contact establishment, and interaction describe this function. Musical competence can also function as social capital—a basis for participation and belonging in a community. The social function of music is therefore both communicative and community-building.

Epistemic and symbolic functions

Music can provide insight into one's own and others' experiences. It has a symbolic function—it can express and clarify existential themes and life experiences. In contrast to the signaling function, which triggers automatic responses, the symbolic function opens reflection. When music is used to express personal experiences, it can give form to an "external image" of something internal. This makes it possible to examine and work through one's own experiences—a process that may itself be therapeutic.

Performing one's own identity

Tia DeNora and Gary Ansdell show how music can contribute to "re-furnishing our place in the world." In a music therapy project involving a music café, participants are invited to perform and express themselves musically.[587] Here music is not only aesthetic but also identity-bearing. Through singing and playing, participants make use of cultural expressions that give them authority and room to act in exploring who they may be. Music becomes a place where one can try out and affirm different sides of the self, build resources, and create meaning.

In this way, music shows its potential for change: it can be a musical asylum—a free space for creating, reflecting, interacting, and developing identity.[588] The functions of music are therefore not merely aesthetic, but fundamentally human.

[587] Ansdell and DeNora, 2016.

[588] DeNora, 2013.

GENRES, INSTRUMENTS, AND WORKING METHODS

5

Genres, Instruments, and Working Methods

In this chapter, I will present the musical tools that music therapists use in their work. This concerns working methods, musical approaches, methods, and techniques. The choice of working method is based on professional reflection—a form of didactics—that results in decisions about how music should be used for a particular user or group. The choice is influenced both by the goals of the therapy and by the framework within which the therapy takes place.

When music is to be chosen, the therapist must consider genre, cultural background, musical taste, and the skill level of the users. A music therapist should therefore have an open and nonjudgmental relationship to different musical genres. Broad musical knowledge and curiosity about new trends and artists are often crucial in order to communicate well through music. A solid understanding of genre helps the therapist find music that not only suits the client's taste but also contains musical elements capable of creating the desired mood and atmosphere. This requires familiarity with music from different age groups—children, adolescents, adults, and older people—as well as from different historical periods and local cultural traditions.

Music therapists have many musical activities to choose from in their work. In what follows, I will present the most common working methods, instruments, and possibilities for experience and participation through ensemble playing and music performance. I will describe central methods such as ensemble playing and performance, songwriting, improvisation, listening, and other creative approaches. In addition, I will show how digital technology has given music therapists new tools and users more possibilities for expression. The language we use in therapy is also an important part of the music therapist's competence, and something that both music therapists and music-and-health workers must be aware of.

Different genres

Today's diversity of genres puts the music therapist's repertoire knowledge to the test. In every arena, music therapists will encounter new challenges. Children's television continually creates new musical favorites for the youngest. Young people are exposed to a bombardment of new artists and musical forms, and it takes time and effort to stay updated. Music therapists who work in elder health must consider that different age groups from different musical "cohorts" bring with them music from a particular time period. Many older adults in institutions today grew up with rock and popular music, and with everything that implies for varied taste formation.

In work with older adults, music therapists have come a long way in developing a varied repertoire of genres and music that appeals to different age groups. We should not, however, immediately assume that knowledge of the user's genre preference is enough. Music therapist Xueli Tan distinguishes between so-called trait musical preference and state musical preference.[589] The former category refers to general musical preference and does not always fit equally well. This is especially the case when, for example, people with dementia are exposed to stress or weakened by illness. Then it becomes important to identify a particular artist and perhaps a very specific song.

Here, anyone who has had a strong "fan" relationship to artists will have an advantage going into old age. Professor and music scholar Jill Halstead has pointed precisely to the value of belonging to a loyal fan community.[590] We should also be aware that musical taste can be seen in relation to gender and gender identity. For example, people in the LGBTQIA+ group may have musical preferences that affirm their identity.[591] Those who work with feminist music therapy will benefit from knowing a large repertoire of music performed by women artists. A further aspect of musical taste and preference becomes visible when users accept the genre and the piece of music, but object to the way the music therapist performs it.[592]

A musical genre is a category of music that shares certain common characteristics. It may be music belonging to a specific tradition, sharing musical features, or being

[589] Tan, 2015.

[590] Halstead, 2013.

[591] Lee (Ed.), 2024.

[592] See Ansdell and DeNora, Caring for music, under production.

linked to a mode of dissemination, a lifestyle, or certain values. The most common way of dividing music into genres, however, is by classifying it in broad categories such as popular music, art music, traditional music, or religious music. As I wrote in the previous chapter, genre is linked to musical taste and preferences, which in turn are related to values, cultural currents, as well as musical identity and personal themes. We will see that genres offer different experiences of meaning and fulfill different therapeutic aims depending on whether they are used within an expressive or receptive working method.

Popular music, rock, rap, and hip hop

If we as music therapists work through a band format, it is natural to choose rock and popular music as a good starting point for engaging users. This is especially true for adolescents, without forgetting generations who have played in bands and whom music therapists now encounter in recovery work within mental health settings. At the same time, the genre diversity within rock and popular music is vast and difficult to survey. Here "musical diversity competence" is truly put to the test. The value of one's own band experience, knowledge of the pulse of the market, and the ability to use the internet to listen to, download, and transcribe music and lyrics will be decisive in meeting the musical needs that arise.

As for popular music—which includes everything from pop, country and western, rock, and rap, with myriad subcategories—we are dealing with a wide range of lyrical, visual, and musical expressions that can be integrated into different music therapy working methods. We saw a good example of how this is utilized by the feminist music therapist Sandra Curtis, who has curated a large collection of music videos in which women have authored both the music and the performance.[593] Curtis, who has worked with women subjected to violence, points out how the music and lyrics in this collection express women's negative experiences of living within a patriarchal culture. At the same time, this becomes music and lyrics in which the women recognize themselves and thus experience sharing their experiences with the artists. By analyzing the lyrics together with the women, and supporting the production of their own original songs, Curtis shows how music therapy makes use of the potential of popular music.

[593] Curtis, 2019.

Rap and hip hop

It is impossible here to go into all popular musical forms of our time, such as K-pop, EDM, heavy metal, and so on. There is a substantial body of literature on this within popular music research, and students and music therapists who wish to immerse themselves in specific musical genres of relevance to music therapy practice will find a foundation in that research literature. Rap and hip-hop culture are dominant in many youth groups and have attracted attention among music therapists.[594]

Classical music

Western classical music acquired a special place within GIM, since the founder of the BMGIM method, Helen Bonny, herself came from that genre as a violist. It is often emphasized that because of its complexity, this music has particular potential for use in emotional or analytical work. In recent times, however, we see that other genres also carry out this emotional work. In work with people who do not belong to Western musical culture, classical music may be experienced as entirely foreign and inaccessible. See more about classical music in the section on genre choice, under the working method of listening to music—receptive music therapy.

Jazz

The different musical genres each have something to contribute to music therapy. In the case of jazz, there are many similarities with improvisation as a working method in music therapy. Here we will use jazz to illuminate similarities and differences between the ways musicians and music therapists experience improvisation.

The interaction between jazz musicians creates moments of musical mutual understanding, a reciprocal affective attunement that parallels dialogical moments in music therapeutic improvisation. Such moments, as is well known, have many names: warm moments, golden moments, moments of meeting, and so forth.

Kenneth Aigen has investigated how social interaction in jazz can illuminate and enrich practice in music therapy.[595] He wants to challenge the distinction between

[594] Viega, 2018, 2024. See also Hadley and Yancy, Ed. 2012.

[595] Aigen, 2013.

"clinical" and "musical" improvisation and argues that stylistic and aesthetic elements in music can have therapeutic value when used with clinical intention. He maintains that many core elements of jazz—such as improvisation, listening, emotional attunement, and the balance between structure and freedom—have clear parallels with therapeutic musicking. He finds such parallels wherever emphasis is placed on process rather than product, and on the valuing of improvisation, spontaneity, creativity, intuition, and responsiveness in the moment. He further highlights the clearly defined musical roles of jazz musicians, which require a balance between freedom and structure. These aspects suggest that the study of jazz has much to offer music therapy.

Aigen points particularly to three central points:

1. Jazz as a model for therapeutic interaction. Jazz improvisation presupposes close interaction among musicians, where communication takes place both emotionally and rhythmically. This mirrors therapeutic interaction, in which both client and therapist improvise in the moment and influence each other's expression.
2. Groove and shared synchrony as expressions of togetherness. Creating groove together is a powerful expression of "being with" someone. In music therapy, this form of shared attention and synchrony can give clients an experience of belonging and of relationship that they may not experience elsewhere in life.
3. Therapist–client as rhythm section–soloist. The relationship between rhythm section and soloist in jazz can be compared with the relationship between therapist and client: the therapist supports, structures, and inspires the client's musical expression without dominating it. The therapist's task is to meet the client's expression, respond musically, and enable new directions for exploration of the interaction.

Improvisation as a musical conversational form

There are several aspects of jazz that have parallels with music therapy. Jazz requires a type of interpersonal interaction like that found in music therapy. Aigen refers to jazz scholar Ingrid Monson, who points out that jazz is about interaction between people, and that improvisations may be read as a type of conversation.[596]

Several authors use the conversation metaphor to describe jazz improvisation. Jazz involves an exchange of thoughts, feelings, and content, not only sounds. This form of communication requires listening, absorption, and response—all in real time. In

[596] Monson, 1996.

contrast to verbal conversations, where listening and response occur in a particular sequence, these take place simultaneously in musical improvisations—a demanding activity integrating cognitive, affective, social, and physical skills.

Jazz involves different forms of interaction. There can be interpersonal interaction between musicians, intrapersonal interaction when the musician relates to his or her own reactions, and musical-personal interaction when the musician responds to the dimensions of the music itself.

All of these aspects of the conversation metaphor in jazz also apply to music therapy. Music therapists have many working methods that are structured and goal-directed, and that build on predetermined material. In free improvisation, the task is simpler: therapist and client improvise without predetermined material. Clients may also "converse" with a composition by responding to the musical structure and to personal memories associated with it. Interaction among clients, and between client and therapist, also occurs through musical interaction.

Groove presupposes social interaction

Jazz scholar Paul Berliner describes how establishing a rhythmic "groove" is central in jazz and requires rhythmic attunement among the members of the band, based on listening, response, and mutual understanding. This also involves an emotional disposition in the moment.[597]

Creating a groove is the most important function of a rhythm section. Studies of jazz music, with interviews with musicians and detailed micro-analyses of music, reveal two important features:
(1) Rhythm sections vary what they play in order to adapt to the individual expressive style of different soloists, especially in relation to their characteristic musical phrasing. What creates groove for one soloist may not work for another.
(2) Groove arises through small but necessary deviations from completely synchronous playing. These small variations from exact simultaneity are called participatory discrepancies (PD), a concept given to us by the music anthropologist Charles Keil.[598]

The term refers to the small rhythmic or tonal displacements that occur when we create groove in music. In practice, this means that musicians in the rhythm section

[597] Berliner, 1994.

[598] Keil, 1987.

may play slightly ahead of or slightly behind the beat within a given phrase or metric structure. When those who play together create and fulfill shared musical expectations related to mastering such PDs, the conditions are present for experiencing good moments. It should be added that such participatory discrepancies do not belong only to jazz. They accompany all musical performance, including popular music, folk music, and classical music. This is well documented by Nicholas Cook.[599]

In a music therapy context, the presence of groove can be interpreted as a sign that interpersonal interaction is taking place at a deep musical level, because such interpersonal processes are necessary to establish groove. Sharing the experience of creating groove together is a particular form of interaction, an experience of connectedness. Musical interaction may be conflictual and destructive or collaborative and constructive. Groove creation is an example of the latter. Groove is an experience of "being together with" that is invaluable for most therapy clients, because it is something they may not get to experience in other ways.[600]

One of the strongest links between social interaction in jazz and music therapy is the parallel between the soloist–rhythm section relationship and the client–therapist relationship, writes Aigen. The parallel is based on a shared function: to contain, inspire, and propel the musical expression of the soloist or client. In jazz, the rhythm section creates a musical backdrop for the soloist. This entails several dimensions and responsibilities: defining the pulse, framing the harmonic-rhythmic form of the composition, supporting one another's musical development, and at the same time playing individual parts with their own value and musicality as they develop during performance.

Because jazz is improvised, "mistakes" are not regarded as deviations from a predetermined perfection (as in a notated work), but rather as opportunities to take the music in new directions. This strategy is also essential in clinical improvisation in music therapy. The point is to create contexts around the client's music so that the expression acquires a meaningful, communicative musical function. Treating habitual or unintended actions as though they were conscious musical expressions can awaken the client's capacity for increased self-awareness and intentionality, Aigen writes.

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[599] Cook, 2024.

[600] See also Ruud, 1998.

In free jazz, musicians themselves must take responsibility for defining their roles and contributions. This can be read as a model for music therapy in order to avoid allowing predetermined plans to govern what takes place in the sessions. Strongly structured, pre-planned, and activity-based approaches minimize social interaction, because rules, roles, and interaction are already fixed by the guidelines and structures laid down by the therapist. By contrast, free improvisatory approaches provide greater room for interaction, because they prescribe expected behavior and interaction to a far lesser degree.

The experience of improvising together in jazz, particularly between rhythm section and soloist, creates powerful and unique human bonds and relationships. This connection may take time to develop, but once established it becomes a powerful motivating factor. Aigen points out that music therapists should be attentive to the special feelings that arise between people who create music together. They must be sensitive to those feelings and to their impact on the persons concerned, and to the loss that may arise when people end therapy or groups are dissolved.

Musical interactions are important because they activate processes such as cognition, affective expressiveness, aesthetic experience, and motor control—all typical goal areas in music therapy. For many clients, these musical moments may be the only places in their lives where they experience being in direct contact with another human being. This helps form the basis for a music-centered approach in music therapy.

Music therapists should therefore consider exploring and integrating principles from jazz and other improvisation-based genres, not merely as stylistic choices but as models for social and emotional interaction in music. Recognizing the client's musical intention, responding authentically in the moment, and building community through improvisation can help create more resonant and meaningful therapeutic experiences, Aigen concludes.[601]

Blues

It is important to reflect on which genres or musical forms offer a clear structure and which allow greater freedom, such as free improvisation. A 12-bar blues is a good example of a musical form that provides a fixed framework and a sense of

[601] Aigen, 2013.

safety within which to improvise. Many users will need the predictability that a fixed blues scheme offers.

Film music

Film music has a particular narrative potential, since it is closely associated with actions, moods, and psychological states. Film music can therefore be a natural choice in connection with GIM.

New Age and ambient music

New Age music is not always equally well received in music therapy. Its fluid character sometimes creates uncertainty for the client. Critics argue that the music is attributed effects that cannot be verified, and that the field is driven by economic interests. Music therapist Lisa Summer has offered a critical account of the hype that sometimes surrounds the New Age genre.[602] Ambient music or background music exists in several forms, and in collaboration with users it is possible to find music that is calming or creates a particular atmosphere.

Folk music and world music

Most countries have a rich local tradition of songs, rhymes, and chants that form the backbone of traditional forms of togetherness with children. We can draw on a folk and children's song tradition of lullabies, and ballads that through generations have created natural settings for care and stimulation.

It is not uncommon to combine the Orff instruments with a rich collection of instruments drawn from the musical cultures of the whole world. Tibetan singing bowls, cymbals, Greek sheep bells, and more can create a varied and foreign-sounding soundscape. These instruments make possible both a low threshold for participation and room for creativity. This expanded instrumentarium is often used in connection with group improvisation with adult clients, whether in psychiatry, addiction treatment, or psychosomatic wards. In combination with the Orff instruments, it offers wide scope for improvisation.

Many music therapists have built up a collection of instruments and sound sources. When traveling, for example, one may take the opportunity to visit music shops

[602] Summer, 1996.

and markets. In this way one supports local producers and craftspeople. We have seen, for instance, how African drums have become an important part of the instrumentarium and methodology for many music therapists. Drum circles are a commonly used working method in music therapy. That said, one should be careful not to "appropriate" instruments that may provoke unfortunate reactions among users rooted in the cultures concerned.

In recent times, criticism has been directed toward a European-dominated classical music tradition in music therapy. As a counterweight, music from the global music scene has been brought in, for example Latin American music. Music therapist and jazz musician Patricia Zarate de Perez has developed what she calls Global Music Therapy (GbMT).[603]

Silence and pauses

The importance of pauses and silence is sometimes overlooked when talking about music or when music therapy is discussed. The pause, however, has an important place in music therapy. Moments of silence create space for feelings, reflection, and contemplation. The pause becomes an opportunity for the therapist to express empathy and presence.

Music and psychotherapist Julie Sutton has, through her research, deepened our understanding of the significance of silence in music therapy.[604] She describes how, in conversation, silence can be experienced as uncomfortable and as threatening to the integrity of the dialogue. In music, by contrast, a pause has a positive and integrative function in the form and flow of the music. Not least, the pause helps build tension in the music.

The space that opens between the tones can give the client an experience of separateness and identity, Sutton writes. Those who improvise together have not only heard themselves play, but also the therapist's responses. This creates awareness of the relationship between self and other. If both therapist and client can remain in and tolerate the silence, they may experience something special in the relationship between them.

Silence gives an opportunity to direct attention toward oneself in the moment. The pause and silence open a space in which one communicates with oneself,

[603] de Perez and Wu, 2024; de Perez, (Ed.), 2025.

[604] Sutton, 2006.

while at the same time creating a connection with the outer world. In the space created by pause and silence, the therapist can reflect on the musical course of events and process what the clients have done. This is in line with concepts from developmental psychology, Sutton writes, where Daniel Stern speaks of "time-out episodes," "retuning," and "resettling." These are moments in which patterns of interaction are preserved, regulated, or re-evaluated. Both absence and presence become visible. The therapist experiences "being there with." This silence defines a presence that prevents absence. Silence is an important part of music: "Silences are a hidden music to which we must listen most carefully," Sutton writes.[605]

Instruments in music therapy

There are apparently no limits to which instruments or sound sources may be used in music therapy. If we truly make use of instruments from different cultures and historical periods from all over the world, we have a rich repertoire of interaction and expression at our disposal. Above all, music therapists use instruments well known from their own culture. These may include percussion instruments, string and wind instruments, guitar and other string instruments, piano, accordion, or various special instruments designed specifically for music therapy. Other instrument collections include the Brazilian rainstick, ocean drum, maracas, African drums, bells, Tibetan singing bowls, and so on.[606]

We should, however, be aware that when we use instruments and musical forms of expression from other cultures, these carry meanings and functions of which it is important to be aware. This matters out of respect for users who may know that culture. The music is closely linked to a specific context, to a history, culture, or mode of use of particular value for certain people. Within a postcolonial horizon, some may experience the music as being misused, as becoming merely a tool, a means, and thereby being assigned a new meaning that damages its original functions.[607] What is called "cultural appropriation" should be included in the therapist's reflections, and is something we must think about when we write in what follows about instruments in music therapy.

Not least, music technology has made its entry into music therapy. Electric guitar and electric bass, MIDI-controlled technology connected to keyboards, the use of

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[605] Sutton, 2006, p. 268

[606] See, for example, Garat, 2025 about music therapy in Puerto Rico.

[607] Colonialism and Music Therapy, CAMTI (Ed.), 2022.

switches and software, and digital workstations for music production are becoming increasingly common. In addition, the technology is exploited to the fullest extent. The internet provides access to music and lyrics; iPads and laptops are used to make music with, for example, GarageBand. Smartphones are used to make recordings that can be transferred to the client's phone. Around this production system we have a network of social media that creates challenges, both ethical and legal.

Affordances—what do instruments offer?

All instruments have their own particular characteristics. This concerns the instrument's dynamic range, pitch range, timbre, whether it is a harmonic or rhythmic instrument. The very design of the instrument—whether it resembles a body, like the cello, or has many odd technical features, like the accordion—can be made use of in therapy. Some instruments are experienced as extensions of one's own voice and body. Instruments are used to imitate sounds coming from the client or are suited to eliciting use of the voice. Some instruments create special effects, produce humorous situations, and arouse attention. Certain instruments create vibrations that are important in work with people with hearing impairments. Many instruments are portable and enter physically into interaction and the development of relational conditions. Other instruments, such as the piano, are well suited for accompaniment. Nor should we forget the important point of using instruments that require no prior knowledge and that give easy access to ensemble playing and to the experience of inclusion and community.

When we choose an instrument, there are several things we should consider. We can ask what the instrument has to offer the user as a form of affordance. This refers to what the instrument offers in terms of motor, perceptual, and cognitive challenges. Some instruments are suitable for a client who wants to learn to play. Others are easy to play and are well suited to creating social situations. They combine easily with other instruments and provide opportunities for communication, mastery, emotional expression, and involvement in psychoeducational and reconstructive work.

Instruments can also become means of expression, some help in exploring and expressing qualities of feeling. They can express categorical affects such as anger, sorrow, and anxiety and acquire important symbolic functions.[608]

[608] Johns and Trondalen, 2025.

We may also ask what cultural references the instrument has. For example, some instruments may evoke associations with children's culture and may therefore not be appropriate for many older adults. Some instruments have high status in certain environments—for example synthesizer and electric bass—because they are associated with popular music and youth culture. Instruments may also be associated with specific events or occasions. The cultural references may, in some cultures, imply that the instrument is used in a health context different from our own. This is something postcolonial theory reminds us of, and which I suggested in the section on cultural appropriation.[609]

A gender dimension should also be noted, for example when instruments and role models are taken from a male world. This is something one should be conscious of when rock and popular culture form the musical context for the methodology.[610] It may be that the instrument is experienced as resonating with personal identity, with body and emotions. For example, an acoustic double bass may be experienced as having a large and warm sound that answers a felt sense of longing. A good illustration of this is found in the account of jazz bassist Wenjun Wu's path toward finding an appropriate musical expression for his identity as a trans man.[611]

We should consider the practical consequences of instrument choice with respect to mobility and flexibility. Although there is, of course, much to be said for the piano and its functional range, there will always be a limitation connected to sitting on a piano bench with one's back fully or partly turned toward the client, at least if one is working alone. Instruments such as guitar and accordion are, in that respect, more versatile.

Piano, cymbal, snare drum, and one-tone horn were central ingredients in the musical working methods that the first music therapists inherited from Nordoff and Robbins. In addition came specially adapted instruments, such as a one-string cello and similar inventions. Here it should be noted how anthroposophical music therapists have contributed instruments of particularly high craftsmanship quality to music therapy. These are often marketed and sold at international music therapy conferences. The tonal quality of the instrument is especially important for anthroposophists. Their attitude toward instruments appears to differ from that of music therapists who use homemade instruments based on everything from used packaging to whatever they may find at refuse sites.

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609 CAMTI, 2022.

610 Rolvsjord and Halstead, 2013.

611 de Perez and Wu, 2024.

When music therapists describe their preferred instrument, emphasis is placed on the personal relationship developed through many hours of practice. Knowing the expressive repertoire of the instrument and mastering its technical challenges means that music therapists bring quality into the musical relationship and experience.

It is important to think through what conditions are required of the user in order to master the instrument. At the same time, we should assess what risk we expose users to if they do not master its use. In that regard, we should be aware of possible contraindications connected with the use of a particular instrument, for example how incorrect voice use may lead to damage to the vocal cords.

The voice

Our voice is one of the most fundamental resources we have when creating good conditions for development and therapy. Music therapist Diane Austin, known for her vocal psychotherapy, writes that the voice is the instrument we are born with, the most intimate of all instruments. She writes:

> *We produce sound with our own body as we use the support of our own breath. Our musical tones vibrate inside us, connecting us with physical sensations and breaking up blocked energy, freeing us from emotional stress and tension. Equally important is that our voice connects us with others. The exchange of sound and energy enables us to experience resonance with one another, breaking through walls of loneliness and isolation in order to create friendship and community.*[612]

Randi Rolvsjord and Jill Halstead remind us that through the voice we perform our identity and, in that connection, also our gender identity.[613] Music therapy is a social arena, they write, where gender is negotiated, where one can "do" gender, or possibly alter one's gender expression. Women with a low vocal range may be perceived as less "feminine" within a stereotypical understanding of the connection between vocal expression and gender. For some, this negatively affects self-esteem. This may become a theme in music therapy, leading either to work toward accepting one's vocal expression, or to attempts to adapt that expression to certain norms.

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612 Austin, 2011.

613 Rolvsjord and Halstead, 2013.

Trans people are particularly vulnerable when, after a gender transition, they still retain their previous vocal range. Music therapist and researcher Ruth Eckhoff has, in collaboration with a speech therapist, developed a service for people who experience incongruence related to voice use. A course guide has also been developed for music therapists and speech therapists who will work with voice and gender incongruence.[614]

Specially adapted instruments

There are traditions in music therapy of developing specially adapted instruments. This involves simple ways of making an instrument accessible for the child. One might, for example, wrap foam rubber around a mallet so that the child gets a better grip. Some build drums that one can sit on, or use stands that prevent physical disabilities from hindering one's ability to hold the instrument. The use of various instrument stands, universal clamps, and couplings to tam-tam drums increases accessibility for users.[615]

The Orff instrumentarium

Alternative educational movements from the early twentieth century, with pioneers such as Émile Jaques-Dalcroze, Carl Orff, and influences from anthroposophical ideas of the time, contributed musical impulses and practices later adopted by music therapists. Perhaps particularly important were the music methodology and instruments developed by Carl Orff. Orff instruments are easy to play. The metallophone produces long tones and requires no more from the student than the ability to strike with a mallet. One can remove bars, perhaps use only two, and prepare for improvisation.[616]

The varied instrumentarium, the many sound sources, and the possibility of combining them with other instruments and with singing make the Orff instruments well suited for individual adaptation. Ensemble playing in groups can be easily organized, also for children with more limited intellectual abilities or motor challenges. A central principle in music therapy methodology is to facilitate participation for everyone based on their resources.

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[614] Eckhoff and Stensæth, 2024.

[615] Obrestad, 2011.

[616] Bentsen, 1978.

Self-made instruments

If one searches the internet for, for example, "instruments in music therapy," a range of suggestions appears. Not least, one finds instructions on how to make one's own instruments from materials available in everyday life.

Classical instruments and band instruments

Music therapists have backgrounds and training on different instruments from the fields of popular music, classical music traditions, and folk music, or from musical cultures other than the Western ones. Each instrument has its possibilities and limitations in therapy, in accordance with what has been discussed above.

Music technology and digital tools

With the development of digital technology and the MIDI system, instruments can be connected, integrated, and controlled via the computer. Software is created that mixes different sound recordings and soundtracks, thereby moving editing and composition processes into the computer. Musicians, educators, and music therapists have gained a new tool for controlling and creating with sound.

A great deal is happening within music technology that finds application in music therapy. The development is rapid, and we now have technologies that create virtual realities. We have laptops, smartphones, and tablets with countless apps that can perform, create, edit, and distribute music. We have long had software and assistive technologies that make it possible to perform music by means of sensors that capture movements of the body or eyes.

Assistive and co-creative tools

Music therapists have gradually become familiar with how movement can be transformed into sound, as with Soundbeam. They have adopted workstations with software (DAW) that make it possible to edit and produce music. GarageBand is a useful tool, known to and accessible for most users.

Workstation

Music therapists have adopted the digital audio workstation (DAW) in work with clients who want to compose, record, edit, and release their own audio tracks. A DAW is an advanced electronic program that makes it possible to combine the functions of a synthesizer, a sequencer, and sampling systems. This enables recording in and outside a studio, as well as use in live performances. The system makes possible a range of effects such as reverb, delay, and compression. It is also possible to connect to other MIDI devices to expand functionality.

Music therapist Michael Viega has shown how knowledge of music production adds dimensions to the client's expression that deepen and characterize the experience the client wishes to communicate. This includes various techniques of sound morphing, that is, sound processing in the broadest sense.[617]

Here one should also mention the pioneering work of the music therapist Marcus Aasely Ekløf. He has developed an outreach approach within mental health and addiction services. He has outfitted an electric van with a functioning music studio in the cargo space. This has become a mobile music studio, allowing him to travel to where the user lives and invite them into music production.[618]

And the development continues. What was cutting-edge technology a few years ago is now obsolete, replaced by new digital gadgets, new software, and entirely new technologies. This makes use of earlier research difficult, as music therapy professor Wendy Magee noted in a commentary on the field some years ago.[619]

As the health sector increasingly embraces technological innovation, such as digital musical instruments, virtual reality, and biofeedback systems, this offers transformative possibilities in music therapy and rehabilitation. These technological tools do not merely support traditional therapeutic practice. They redefine the very way in which the music therapist connects with clients and open doors to new forms of expression, growth, and recovery.[620]

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[617] Viega, 2024.

[618] https://napha.no/kunnskapsbasen/24920/studio-pa-hjul---oppsokende-musikkterapi Access date June 1, 2026

[619] Magee, 2018.

[620] Partesotti and Magee, 2025.

These new possibilities suggest a view of technology as an extension of mind and body. Technology is not merely something that assists clients but must be understood as an integrated part of the client's cognitive and therapeutic processes. This view resonates well with ideas from posthumanism, where technological aids such as glasses, hearing aids, wheelchairs, artificial limbs, and one may certainly include the smartphone, are seen as extensions of the body. Altogether, these strengthen sensory experiences and expand memory and mind. What I have forgotten, or knowledge and concepts I do not fully understand or am not familiar with, lie in my hand. With the press of a button and a prompt, I immediately receive an answer from my AI chat.

Magee emphasizes the need to reflect on the use of this technology and not merely view it as a tool.[621] She refers to Karette Stensæth's meta-reflections around the RHYME project, where she writes that the music therapist should direct attention toward being "the good close other with a dialogical mind-set."[622] This is meant to increase the users' potential for co-creation, interaction, and the sharing of meaningful experiences.

This presupposes, however, a kind of flexible programming that allows for surprises, so that one matches the user's individual expression. This belongs to the music therapist's competence. It was precisely this collaboration among music therapists, information theorists, designers, composers, and programmers that made the RHYME project so unique.[623]

Sonification and assistive technologies

Sonification is a technology that generates sound from movement, with sensors translating parameters in the movements (speed, loudness, force, etc.) into numerical values, which are then processed by special sound-synthesizing operations. The sound—or preferably the music—provides real-time feedback regarding how the movement has been carried out. In this way, the acquisition of efficient motor movement patterns is promoted.[624] For example, one can create music through a head movement that breaks a beam of light.

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[621] Magee, 2018.

[622] Stensæth, 2018a.

[623] Stensæth (Ed.), 2014.

[624] Raglio, 2025.

Soundbeam

Soundbeam is an electronic device consisting of a sensor that registers movement. The motion sensor resembles a parking sensor on a car, writes music therapist Tom Næss. When you are far away, it emits a particular sound. As you approach an object, the sound changes proportionally according to how much closer you come.

The sensor in a Soundbeam is connected to a converter, which in turn sends signals to a synthesizer. This has virtually unlimited access to a large selection of sounds. By moving a body part toward or away from the sensor, one can play different tone sequences. This may be an ordinary scale, a whole-tone scale, or a pentatonic scale.[625] Tom Næss has used Soundbeam in work with a woman who suffered severe traffic-related injuries. This entire story is told in a book chapter, with audio and images from the therapy available online.[626]

Some examples from practice

New technology is continually being developed for people with physical disabilities, especially those with reduced mobility. One example is GlassOuse, which resembles a pair of glasses and makes it possible for the user to control computers, iPads, smartphones, and other electronic media using head movements connected via Bluetooth.

There is an account of a patient with tetraplegia, that is, paralysis of the upper body caused by damage to the spinal cord. Such paralysis creates not only difficulties for identity, independence, and coping with everyday challenges. It also creates barriers to participation in musical activities. This is where assistive technology comes in and offers opportunities for greater access to creative expression through playing and composing music.

In this case, the music therapist used GlassOuse technology to enable the patient to make music on an iPad using the GarageBand app. The work yielded good results in the form of creative self-expression both in the music therapy sessions and in the person's leisure time. This affected emotional state, sense of self-efficacy, and identity experience, and laid the foundation for carrying out rhythm-based motor tasks.[627]

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[625] Næss, 2017.

[626] Næss, 2017.

[627] Glaubitz, 2025.

A group of Brazilian researchers has developed a prototype for an electronic ocarina used in work with patients with COPD.[628] The ocarina is an ancient instrument found in various cultures and ethnic groups in Asia, Latin America, and Africa. It is easy to blow into and make sound with and has a few finger holes that can produce simple melodies. We know that playing acoustic wind instruments has been used in music therapy to strengthen lung and breathing capacity in people with chronic obstructive pulmonary disease (COPD). Research has shown good effects of such training.[629] Many traditional acoustic wind instruments are, however, too demanding for people with breathing difficulties.

The ocarina requires little breath, is known in many cultures, is inexpensive, and readily available. Research on electronic wind instruments (EWI) shows good effects when breath is registered and the tones are adjusted via MIDI connection. By making the ocarina electronic and digitizing it, it becomes possible to adapt the instrument to the individual user's capacity, register the effect, and adjust according to the user's rehabilitation needs. Work is continuing on a MIDI-based adaptation.

Algorithms and artificial intelligence

With new "neurotechnological" tools, such as advanced sensors and virtual reality, it is possible to facilitate and rehabilitate motor function. So-called immersive technology is used in work aimed at promoting physical rehabilitation. This technology forms part of the broader umbrella category of systems that create virtual, mixed, or augmented reality. By means of this technology, environments are created in which users interact with real and virtual elements in order to increase engagement and therapeutic benefit. It is here that we see possibilities for multifaceted therapeutic experiences and therapeutic gains that support neurological changes. The potential exists to stimulate the brain's capacity for neuroplasticity.[630]

Algorithms and computer programs are being developed that make it possible to create music specially adapted for therapeutic purposes. Artificial intelligence is being used to compose music tailored to the specific rehabilitation needs of individual clients. Laboratory experiments point to positive results, even if they primarily seem to indicate future development.[631]

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[628] Goncalves et. al. 2025.

[629] Goncalves et. al. 2025.

[630] Partesotti and Magee, 2025.

[631] Raglio, 2025.

Machine learning techniques can be used to identify factors that predict the effects of therapeutic interventions involving music. As I wrote earlier, musical taste is complex, and we all have different experiences with music through upbringing that shape our musical identity. Machine learning, that is, the use of artificial intelligence to create algorithms and models, enables us to learn and make predictions and decisions. This is used to create predictability concerning which music works in which way for a given individual, for example which music has a relaxing effect.[632]

Tablets

There are many possibilities for creativity and musical expression in the use of tablets in music therapy. Research shows that collaboration in music creation and production using, for example, an iPad yields good results with adolescents in need of mental health support. In areas we associate with subjective health and quality of life, such as vitality and emotional regulation, social connectedness, agency, and meaning in life, research shows positive findings from users and their therapists.[633]

It is emphasized that the technological competence required is important, just as skill is needed in order to master traditional instruments. Musician and musicologist Kjetil Jonassen points to the necessity of mastering this technological craft. He has an overview of an arsenal of apps to offer the adolescents with whom he works. And this adaptation is important, because different apps offer different possibilities for musicking and co-creation. Thus, they can be adapted to users' interests, musical taste, and musical and personal identity.

Jonassen highlights some important aspects of the iPad and portable technology more generally that make these tools especially useful in music therapy. The iPad is flexible, easy to move, and has graphics that offer and invite co-creation. It is easy to adapt, access to apps is extensive, and, not least, it contains a user-friendly technology that lowers the threshold for performing and creating music.[634] Is this not everything a music therapist could wish for in an instrument?

Internet and smartphones

[632] Raglio, 2025.

[633] Jonassen, 2021, 2023.

[634] Jonassen, 2021, 2023.

New music technology in interaction with the internet provides access to the music of the whole world, something that affects music therapy both as a discipline, a profession, and a practice. By using the internet as a source of music and lyrics, the music therapist can meet virtually any musical wish from users. Smartphones have made it possible to carry personal soundtracks with us, organized in playlists programmed to regulate feelings and energy in everyday life. Here a new field of work and a new professional role open up for music therapists as consultants and guides in what may develop into a more conscious public health practice.

Working methods

In the following I will describe more closely which working methods, methods, and techniques music therapists make use of. The most common music therapy working methods are

1. re-creation and performance of music, such as group singing and choir, ensemble playing in bands/groups, or song and play activities,
2. improvisation,
3. songwriting, composition, and music production, and
4. listening to music.

In addition, there is the use of other creative arts therapy methods drawn, for example, from drama therapy, play therapy, dance and movement, and so on. If we expand working methods to include musicking in Christopher Small's definition, then other activities related to musical activity also belong among the working methods. This may include, for example, participation in musical productions by setting up lights and stage, mixing sound, and the like.[635] Conversation is also an important part of the working methods and will be treated in a separate section. In many cases, the music therapist will combine several of these working methods within a single session.

"Working methods" is a common designation for musical activities in music therapy. Sometimes one speaks of music therapy methods, a musical approach, or the use of techniques. For example, a technique is used when we improvise in order to get a co-player to change tempo. We will see examples of such techniques when we describe improvisation as a working method.

[635] Thanks to Brynjulf Stige for the input.

"Methodology" is used as a collective term when referring to different working methods. We speak of music therapeutic didactics that concerns how musical activities are adapted to different situations, client groups, therapeutic aims, and practice arenas. Some will use the term "method" when the working methods are placed within a broader whole. Here, a systematic approach, protocol, individualization, assessment and evaluation, as well as theoretical justifications, form the basis for the choice of activity.

Sometimes people speak of a music therapeutic "model." Then the methodology is framed within a treatment theory, which in turn points to a basis in research, philosophy of science, and a view of the human being. Examples of such models are "Analytically oriented music therapy" or "Humanistic/existential music therapy," as discussed earlier.

The diversity of working methods and methods is great, and the methodological repertoire constitutes part of the core of music therapy professional identity and professional formation. A distinction is often made between active (expressive) and receptive forms of music therapy. Among the active forms we find improvisation, the reproduction of music, composition, and song and lyric writing. Receptive methods make use of purposeful and focused listening to music.

Here the most common expressive or active working methods are described first. The emphasis is on describing how the methods are used and what therapeutic possibilities they offer.

Re-creative and performance-based music therapy

Re-creative methods refer to activities in which the user reproduces musical patterns, parts of songs, or whole songs or pieces of music. This means that the user learns, imitates, and performs the music alone, together with another person, or in a group.[636] Performance-based methods refer to situations in which the user, possibly in collaboration with other users or a therapist, performs a musical product in a situation where other listeners and possibly a larger public witness the music. Such performances occur when children play at the end of the school year for other children, school staff, and parents. Or at concerts under names such as *Rockovery*, which have become annual events in several cities in Norway.

[636] Gardstrom et. al., 2025, p. 12.

In work with children with disabilities, an important principle is to lower the threshold for participation. This is done by adapting instruments and arranging the music so that everyone is given a role in the ensemble playing. There are simple instruments that everyone can play. A progression in difficulty is planned and adjusted to users' abilities. The experience of mastery stands at the center, and the necessity of creating a good and safe process on the way toward the performances must be emphasized. It is important to be aware that there is always a risk of loss of self-esteem in bringing people onto a stage to be exposed to an audience. Often the process toward a musical product will be more important than the performance itself.

Performance-based music therapy has an important place in community music therapy. The rock band has become an important arena for participation, visibility, motivation, and the experience of community. The different roles musicians take on in a rock band provide important experiences in finding one's place within social groups. Music is understood here as carrying competence, as conveying emotional, musical, or social competence. When musical performance is central, the music becomes an expression in which this competence appears in emotional skill, social capital, and musical mastery. Performing music also involves performing one's own identity, as community music therapy points out.

Music therapists form choirs and group singing groups, drum circles, and other ensemble groups in order to motivate self-activity and musical interaction. In addition, they create social networks, provide experiences of mastery, and offer opportunities to perform and communicate music from a stage.

Both ensemble playing in bands and orchestras, more informal group singing, and organized choral singing are musical expressions with corresponding degrees of aesthetic and experiential components. Singing and playing together and performing music for others also have several functions and effects that go beyond the musical, what are referred to as extra-musical or "paramusical" effects. Examples mentioned include social and communicative competence, cognitive skills, motor skills, as well as emotional experiences, among others.

Procedures for Implementation

As we understand, there are several factors that should be taken into consideration when choosing a working method and putting it into practice. What is at stake are some general procedures that should be followed and reflections that should be made in encounters with users.

Procedures for implementing a working method describe which variant of the method should be chosen, for example whether to work in a group, use singing, group singing, or playing instruments. The activity is selected based on what it has to offer (affordance) in relation to the working goals that have been set. The procedure includes an assessment of the participants' prerequisites, a plan for which activities are to be chosen, the possibilities and challenges inherent in each activity, and how one should proceed in order to engage the users.

Specific techniques, for example leadership techniques, are introduced and followed up with accompaniment from the therapist on his or her instrument. Observation of the process is part of the procedure. In addition, contraindications must be considered, for example whether the user is able to play the instrument or whether it must be adapted. It may be necessary for the therapist to intervene to help the user. Risks and possible adaptations must be assessed together with the challenges that arise in the process. The process must be summarized and evaluated with respect to the user's development before the session is concluded, possibly with a discussion with the participants and plans for continuation.[637]

Outcome-oriented or experience-oriented?

In music therapy, the work is often oriented toward fulfilling a clearly defined goal. Or it may be that music therapy opens experiences and processes that provide further direction for the work. In an outcome-oriented approach, music therapy will address the user's needs as these have emerged through an assessment process. Here the point is to stimulate or reward a desired response, encourage the use of specific skills, and support a treatment protocol with clearly defined and measurable objectives. Music becomes here a means of realizing extra-musical goals. This working method belongs within evidence-based practice and may be required in cases where music therapy must relate to, for example, insurance arrangements, as is often the case in a privately financed health system. The working method often implies a medical diagnosis or model of understanding.

The experience-oriented approach belongs where health-related goals are for various reasons unknown, unclear, or directed toward exploring one's own feelings and experiences. Here therapy may concern a general concern that has led the user to therapy, and where the treatment process develops during the user's engagement with the music. In other words, this is not a matter of a cause-and-effect relationship between intervention and outcome, as in the outcome-oriented

[637] Gardstrom et. al., 2025.

approach. In the experience-oriented working method, music functions as a medium for experiences in which clinical goals are identified and clarified, and in which the user's resources and possibilities are explored. This working method belongs more within a contextual model in mental health care, where the client's values and understanding of his or her illness are given highest priority, as in personal recovery.[638] It should be added that both outcome-oriented and process-oriented approaches may occur in complementary ways.

The theories behind clinical decisions

In an earlier chapter, we saw a discussion of various theoretical orientations and treatment ideologies available to music therapists. To connect with these theories, some relationships between theory and method will be briefly illustrated here. A behavior-analytic approach will be relevant when working with concrete goals, as in the outcome-oriented working method. An example would be if one wishes to train a user toward improved articulation. Cognitive behavioral theory comes into play when a client shows signs of performance anxiety and can help redefine that anxiety into more self-affirming expressions.

Within a humanistic-existential practice, emphasis will be placed on the user's experience of musicking, and on how the therapeutic relationship promotes the user's growth and self-actualization. In addition, the user will be given an experience of self-awareness, agency, choice, and responsibility. In the analytic approach, music is perceived as a representation of and symbolic expression for the user's inner life and personality, something that is to be read through the way the user expresses him- or herself musically.

The music-centered perspective implies that musical engagement is considered therapeutic. Through the music, the client will activate and demonstrate intelligence, sociability, agency, and other aspects of possessing health. When the therapist thinks in a resource-oriented way, this points to the importance of nurturing the user's strengths, their (musical) resources, and emphasizing collaboration with the therapist. Within a community music therapy model, great emphasis will be placed on initiating collaboration with the local community, so that the user finds grounding and fellowship through music in the local musical life.[639]

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[638] Gardstrom et. al., 2025.

[639] See more in Gardstrom et. al., 2025.

Vocal re-creation

The two central working methods within the re-creative methods are vocal re-creation and the use of instruments. Within each of these approaches there are several variants. Music therapist James Hiller has written an overview of the use of voice, breath, and other intentional ways of producing sound through the vocal apparatus. He does not restrict the understanding of the vocal to singing, but understands re-creative sound production to include humming, groaning, sighing, whispering, breathing sounds, and whistling. What are called oral-motor sounds include tongue-clicking, lip sounds, and hissing. In addition to singing and song, the working forms include chanting (rhythmically repeated words or phrases), rap, beatboxing, imitation of sounds from the environment, or reading a text with musical accompaniment.[640]

Goals and affordances

As regards what therapeutic goals re-creative vocal forms of expression offer, reference is made to everything from training articulation and oral motor skills, breathing, and language difficulties to distraction during painful medical procedures, as well as emotional expression and psychological insight. These working forms involve exploring relationships, learning social skills, and opportunities to participate in musical activities in society.

At the same time, Hiller reviews the affordances such activities possess:

1. physical (training muscles related to breathing and vocalization, stress reduction),
2. cognitive and communicative (concentration and memory, creativity and problem-solving, access to images, associations and memories, training language and speech skills),
3. psychological-emotional (increased self-awareness, release of emotional energy, increased personal agency, access to different mood states, creating trust in a therapeutic relationship or with other group members, support in risk),
4. spiritual, such as the experience of being in contact with higher powers and a sense of meaning and purpose in life.

[640] Hiller, 2025.

Risk and contraindication

With regard to risk, it is pointed out that incorrect voice use can be harmful to the vocal cords. Psychological challenges must also be addressed, such as the risk involved in revealing something about oneself through the quality of one's voice. Or that the client experiences their voice as not good enough compared with what is heard in the media. We should not forget here that artists often have their singing voices streamlined through electronic production.

Contraindications include pain during vocalization, hoarseness, unexpected change in pitch, or reduced vocal volume. Singing may lead to increased voice-related shame and a diminished self-image. A warning to the music therapist is never to pressure users into singing if they do not feel ready. There is a danger of retraumatization where song lyrics may trigger bad memories of traumatic moments.

Songs, singing games, and musical activities

Music therapists who work with performance-based activities often build a repertoire of functional songs. It is common practice to alter and adapt songs, so they better fit the needs of the target group. Many music therapists also compose original material. A key source of inspiration within this tradition can be found in the work of Paul Nordoff and Clive Robbins, particularly in their collections of children's play songs.

Musical plays, revue, cabaret, music workshop

Music therapists also work with longer and more composite forms such as revue, cabaret, and musical plays. Where levels of functioning, individual prerequisites, and challenges vary, such working forms provide opportunities for individual adaptation. The music-dramatic works of Nordoff and Robbins can be highlighted because of their high musical quality and roles with varying degrees of difficulty. The revue form offers opportunities for young people to contribute their own texts and music, and in this way communicate thoughts and feelings about their own life situation.

Group singing, choir, and voice work

Group singing takes place in situations where people sing together across generations or cultures. It may be singing in the family, between spouses, in the classroom, or in church. Group singing occurs during Christmas celebrations or in collective rituals. Choral singing, by contrast, is a more organized activity, with a conductor, explicit musical goals, and a pedagogical orientation.

Choral singing has received great attention from music therapists and from researchers interested in the relationship between culture and health. There are many examples of choirs for different groups beyond what we traditionally know as "ordinary choirs." We find choirs for homeless people, retirement and elderly choirs, and, not least, dementia choirs. Choirs have also been established for people with shared diagnoses or health challenges. There are choirs for people with COPD and respiratory illnesses, or choirs for people with mental health challenges.

Voice work in music psychotherapy

Voice work is a distinct working method in music (psycho)therapy in which the voice is used for expression, communication, and the processing of feelings. Voice and emotion are closely connected, and the use of the voice can become an entry point to sensing and expressing feelings. Improvisation is used here, where the user is encouraged to use the voice freely, often simply with sound and without melody. Trauma and emotional blockages can become lodged in the voice, and work with the voice is intended to foster awareness of one's own voice and release of expression

The American music psychotherapist Diane Austin has further developed voice work in a psychodynamic direction. She has developed a theoretical framework and specific methods and techniques in this work, which she teaches through courses for therapists who wish to become certified in her method.[641]

Research

Research is being conducted on how participation in bands and choirs affects health and quality of life. Such research was mentioned in the chapter on public health. With regard to research on participation in rock bands, music therapist and

[641] Austin, 2011.

associate professor Lars Tuastad and his colleagues, in collaboration with users and peer consultants, have carried out several studies.[642]

We have several good examples of research and projects showing the value of choir singing for different age groups or for people with specific health challenges. Professor and choir conductor Anne Balsnes conducted a major review of research on the health effects of choir singing.[643] Some of the findings in this research show quantitative measures of bodily changes. These are measurements indicating changes in substances that affect the immune system. Such biomedical effect measures are, however, difficult to measure and are interpreted in many ways. For example, changes in substances affecting the immune system may also relate to the effect of standing close together, as one does when singing, and thus not specifically to the effect of choir singing itself.[644] This says something about the complexity of such research.

What nevertheless emerges in several qualitative studies are changes in subjective measures of health and quality of life. The British choir researchers Stephen Clift and Grenville Hancox have identified four factors associated with the health effect of choir participation:

1. the experience of positive emotions,
2. focused attention,
3. deep breathing, and
4. social support.[645]

Balsnes writes about how choir participation provides social support and friendship that counteract experiences of isolation and loneliness. The choir becomes an arena for establishing relationships with others, "uniting with people in such a way that status and boundaries cease or become insignificant," Balsnes writes.[646] Reciprocity, cooperation, and coordination are experienced. In this way, the choir reflects an "ideal social relationship," as Christopher Small points out in his book and theory of musicking.[647] The presence of the bodily and emotional dimensions strengthens experiences connected to choir and group singing in this way.

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[642] Tuastad et. al., 2018, 2023.

[643] Balsnes, 2010.

[644] Beck, et. al., 2000.

[645] Clift, et. al, 2010; Clift, 2012.

[646] Balsnes, 2010, p. 38.

[647] Small, 1998.

Professor of music education Torill Vist finds that group singing leaves traces in experience when she investigates how music conveys emotional experiences. In her empirical material she finds examples of how safety, fellowship, love, and quality of life emerge as central themes. She points to qualities of group singing linked to shared experiences across generations and cultures. In addition, she refers to the significance of the dyadic fellowship in close relationships, as it appears between children and parents or children and grandparents.[648]

Use of instruments in re-creative methods

In the same way as under the vocal method variant, the choice of instruments will be assessed in terms of what they have to offer in relation to the therapeutic goals in question, what prerequisites (motor, cognitive, and communicative) are required to participate, and the various risks and contraindications.

Re-creative musical activities concern structured working forms such as sound games, songs, and drama activities. These can be used in a special education context, where music becomes a medium for promoting extra-musical learning goals, and where musicking is understood as a field of learning. Here musical devices that create attention, structure for action, and the transfer of information produce a situation that is used for therapeutic purposes.

Within mental health work, the use of instruments is central. Here training on instruments, group ensemble playing, and stage performance are sometimes part of treatment and personal recovery.

It will always be the case that engagement with music entails a number of psychological and social consequences. This applies both when we perform and when we listen to music. Playing and creating music require motor and cognitive skills and involve communicative and social competence. Such resources are activated when one engages in music.[649] This is why, as mentioned, we speak of paramusical consequences of performing music. We have activities aimed at creating emotional attention, strengthening cohesion in a group, training social skills, or rehabilitating motor functions.

Sound games

[648] Vist, 2022.

[649] Ruud, 1990.

Creating situations in which the threshold for participation is low is a good way to include everyone present in a musical fellowship. We find examples of such less goal-directed music use when the Swede Nisse Lindgren, already in the 1950s, traveled around activating children with instruments in what at that time was called a "rattle orchestra." Here drums, triangles, recorders, and rattles sometimes created a delightful musical chaos. The point was to create joy in music and engagement, without much regard for individual approaches or a use of music adapted to special educational goals.[650]

Purposeful play with sound, sound games, draws impulses from British music education and music therapy. Composer and music educator John Paynter's creativity pedagogy liberated musical joy of expression and creativity. The English musician David Ward became an inspiration for music therapists through the courses he held.

Collections of so-called "sound games" based on English and German literature in the field have been published.[651] The intention behind the use of sound games is to activate the senses, interpret sounds, listen, and concentrate. Or to initiate musical and social interaction among the participants.

Sound games aimed at stimulating and developing the use of the auditory function, and the interpretation of sound impressions, provide training in "thinking with sounds."[652] These games are presented so that participants get practice in discovering sounds and distinguishing components such as pitch, loudness, duration, and timbre. Participants are to learn to distinguish sounds from one another, distinguish sound from background, localize sound in space, remember the sequence of sounds, move to sound, create sound for movement, or attach words and concepts to sounds.[653]

For some children, a breakdown may occur in the ability to organize and interpret sound impressions. This does not necessarily have to do with hearing impairment. It may be connected to difficulties in integrating thoughts with the information conveyed by hearing. The exercises may help to further develop the ability to interpret sound. For some, this may in turn be a help in mastering language and reading difficulties.

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650 Ruud, 1990.

651 Ruud, 1980c; Næss, 1981.

652 Ruud, 1980c, p. 8.

653 Næss, 1981.

Through musical interaction, social interaction also takes place. We use sound games to express one's own experiences and how one reacts to situations. The play is used to develop mutual trust and create closeness among participants. By creating role-plays around themes such as conflict/anger, participants gain new tools for resolving conflicts. The games become a starting point for conversations about feelings, for learning a language that describes emotional reactions. In this way, sound games become a tool for clarifying what is happening within the individual and between participants.

Drum circles

Group drumming has been shown to have a beneficial effect on stress and burnout, something documented in research.[654] Drum circles refer to bringing percussion instruments into a circle with fellow musicians and creating shared rhythmic patterns, imitating and challenging one another toward improvisation and synchronized interaction. Drum circles require few resources, have a low threshold for participation, promote motor skills, attention, and social connectedness, and provide opportunities for emotional expression.

Band interaction

The rock band is a good example of creating a musical community built on different roles and competencies. These may include the role of front figure or songwriter, a more withdrawn accompanying role, or that of a drummer or electric bassist who creates a solid musical foundation. The band activates social skills and is a good arena for experiencing fellowship and belonging, in addition to creating opportunities for connecting with local musical life.

Music workshops

Several municipalities have established music workshops inspired by music therapeutic working methods. Music therapists often participate as leaders or staff members, in collaboration with, for example, teachers, milieu therapists, and former users. Participants are recruited voluntarily through child welfare services, schools, or others responsible for children and youth. The work takes place individually or in groups. Participants receive instruction on instruments and in the

[654] Chanda and Levitin, 2013.

use of music technology and computers in collaboration with other young people. Other activities include listening to and talking about music, lyric and songwriting, movement to music, improvisation, ensemble playing, instruction, and guidance.[655]

Concerts and festivals

As an example of how music performance can create ripple effects for participants in festivals and concerts, one may look to music therapist Lars Tuastad's research on rock festivals for people with mental health challenges. From an autoethnographic perspective, he describes how festival concerts provide a framework in which participants perform not only music, but also themselves and their identities. Stepping onto the stage to communicate music and lyrics rooted in one's own lived experience can be an important step toward recognition and self-acceptance. In this sense, performance becomes an expression of one's own health."Such a health performance involves stepping forward with the whole spectrum of oneself and can have both a self-repairing and self-developing function," Tuastad writes.[656]

Tuastad further characterizes the festival as an emotional community. The festival gives participants experiences that form the basis for developing solidarity, cohesion, and trust. The festival creates an activist community. This has roots in the countercultural past of rock culture and in the struggle for social rights. It is now carried forward in the struggle against treatment and illness ideologies, an excessive focus on the individual, perceived abuse of power, and a dominant expert culture rooted in medical thinking. In this way, the festival is seen in relation to community music therapy's emphasis on activism, user participation, and community-oriented perspectives. In this context, Tuastad highlights the important role played by peer consultants.

Improvisation

Improvisation is an important working method in music therapy and is used in many practice arenas. Improvisation here refers to process-oriented musical activities in which the relationship between two or more people is regulated through a shared exploration and shaping of the music. The improvisation emerges

[655] Krüger and Strandbu, 2015.

[656] Tuastad, 2024, p. 17.

through the shared musical work that occurs in the process. Central music therapy methods or models in which improvisation plays a central role are Analytic (or Analytically oriented) music therapy and Creative music therapy. Improvisation is also used in combination with other working methods, for example band interaction in community music therapy.

If we take a closer look at the use of improvisation in music therapy, we can point to how musical improvisations create possibilities for shared expression and the sharing of time. Experiences of community and connectedness are created through participation in a common activity. Through playful interaction, musical expectations arise which, through delay and fulfillment, create favorable conditions for the unfolding of action and intentionality. Furthermore, improvisation offers good opportunities for sharing feelings and creating intersubjective experiences, as I touched on in the discussion of Daniel Stern's theories.

Improvisation involves several processes that we know from general communication. It concerns sending a message and responding, sharing an experience, reciprocity and intentionality, shared attention, and recognition. Improvisation is experienced as a more symmetrical relationship and as a space for finding expression for feelings. At the same time, control over and mastery of the music are sources of experienced agency, empowerment, and personal efficacy.

Improvisations are flexible and dynamic and create room for change and transformation. Regarding the aims of improvisation or the changes one wishes to achieve, these will depend on the client group one is working with and the music therapy model guiding the work.

Traditions and formats

Several pioneers in music therapy emphasized musical improvisation as a central working method in music therapy. This was true, for example, of the British music therapist Juliette Alvin, who introduced free improvisation into the education of music therapists at the Guildhall School of Music and Drama in London as early as the 1960s. In Vienna, under the music therapist Alfred Schmölz, emphasis was placed on improvisation, often based on the Orff instrumentarium. This form developed into group improvisation or "collective improvisation" using many sound sources. In London, another music therapist, Mary Priestley, developed a range of improvisational techniques and methods connected to an analytical understanding. Priestley's approaches spread from the 1970s onward to what was then West Germany (with Johannes Th. Eschen) and to Danish music therapy with Inge Nygaard Pedersen and Benedicte Scheiby. The latter brought this working form to

New York when she established herself there. Not least, Paul Nordoff and Clive Robbins developed improvisation as an approach in their Creative Music Therapy.

There are many forms or variants of improvisation in music therapy.[657] Improvisation is used as an approach when the music therapist must change planned music activities, adapt to the situation and the moment, the participants' musical taste, and so forth.

Improvisations may be purely musical and non-referential. This means that they do not have any extra-musical theme. When improvisations become referential, a theme is chosen that one wishes to improvise on. Improvisations occur in groups, as group improvisation, or with a single user, as individual improvisation.

Nordoff and Robbins

Of particular importance for the development of music therapy were the music therapists Paul Nordoff and Clive Robbins and their clinical improvisation, as the method was originally called. Clinical improvisation was eventually developed into one of the main models in music therapy under the name Creative Music Therapy. It was connected to humanistic psychology in a tradition following the psychologist, Abraham Maslow. In the 2000s, the method was integrated into community music therapy, not least through the work of Gary Ansdell.

Many of the improvisational forms developed by these music therapy pioneers had their musical roots in Western classical music traditions. Gradually, elements from popular music were mixed in, Latin American rhythms were used, unconventional instruments were included, digital aids were adopted, and the percussion repertoire was expanded.

Analytical (or analytically oriented) music therapy

As we saw in the discussion of psychodynamic music therapy, improvisation was a central working method for the British music therapist Mary Priestley. Improvisation also remains central within revised forms of psychodynamic music therapy. By choosing themes for the improvisation, the music is given a symbolic content, which is then interpreted based on psychodynamic theory. Some challenges related to improvisation can be found in the section on music therapy with personality disorders.

[657] See Bruscia, 1987.

Group music therapy

Music therapy in groups, so-called collective improvisations, has been common in work with clients facing mental health challenges. The use of the Orff instrumentarium together with other sound sources creates a basis for shared improvisation with a low threshold for participation. This offers many opportunities for training in social contact, communication, and self-presentation.

A new generation of music therapists brought elements from rock and popular music into improvisation by introducing drum kit, electric bass, and electric guitar as core elements. Music therapist and associate professor Hans-Petter Solli uses improvisation as a working method with clients in mental health care. For this target group, the aims are to emphasize mastery, build defenses against one's own vulnerability, identify personal resources, build identity, and create a holding and structuring framework that makes it possible to feel emotions.[658]

The instrumentarium Solli offers consists of xylophone and metallophones, djembe, conga, drums, a cabasa, 2–3 shakers, a pair of maracas, 2 tambourines, and an acoustic guitar. He himself plays electric guitar, which he finds especially useful. The electric guitar makes it possible to play rhythmically, adjust the volume, fill bass functions, and switch from clean to distorted sound, so that one approaches styles such as rock and heavy metal. The electric guitar is well suited as an accompanying instrument. If one wants to lower the volume, one uses a pick and moves into the background, Solli writes.[659]

Techniques and methods

Kenneth Bruscia's monumental documentation *Improvisational Models of Music Therapy* clearly testifies to the fact that musical improvisation as a working form and way of thinking has held a central place in music therapy since the latter half of the previous century.[660] Another music therapist who has contributed a textbook on music therapeutic improvisation is the English music therapist Tony Wigram, who for many years was professor of music therapy at Aalborg University.

Improvisation in music therapy involves change and transformation. Both Bruscia and Wigram describe a range of techniques intended to create an empathic relationship, a musical structure, stimulate references and associations, explore emotions, and provide

[658] Solli, 2003.

[659] Solli, 2003.

[660] Bruscia, 1987.

a basis for discussing therapeutic themes.[661] Bruscia lists as many as 64 techniques under some main categories, for example: techniques for creating empathy (imitation, synchronization, incorporation, etc.), structuring techniques (rhythmic grounding, tonal centering), intimizing techniques (sharing an instrument, playing for the client), eliciting techniques (repeating, modeling, creating space), techniques for creating a new direction in the improvisation (creating change in the music, modulating, intensifying, calming), techniques for exploring feelings (holding, contrasting, creating transitions), as well as referring techniques (symbolizing, recalling, free association, storytelling).[662]

Tony Wigram discusses in his book fundamental techniques such as matching, empathic improvisation, and musical dialogue. He provides examples of transitions, thematic improvisation, and group improvisation. Wigram's book offers a number of practical and technical exercises for preparing to improvise.[663]

Theories of improvisation

There have been several attempts to give a theoretical justification for why musical improvisation provides the music therapist with a good tool for reaching different goals. It has been pointed out that improvisation in general concerns creating, arranging something here and now, putting something together, making something in the process out of the resources that are available.[664] In connection with music, improvisation has been defined as "the art of spontaneously creating music while playing, rather than performing a composition already written."[665] Other attempts at verbal clarification use formulations such as "to try out, mess around, sniff around without a plan."[666]

Musical processes

Explanations are sought by pointing to something distinctive about what happens in the music when one improvises. Improvisation contains an element of prepared planlessness. Improvisations may, however, be well planned in the sense that a

[661] Bruscia, 1987, p. 537.

[662] Bruscia 1987, Chapter 37.

[663] Wigram, 2004.

[664] Ruud, 1992.

[665] Bruscia, 1987, p. 5–6.

[666] Grootaers, 1983, p. 245–246.

range of elements are present beforehand, without the sequence and extent being fixed. Themes are thought through without having to appear as necessary.

The jazz musician, for example, has acquired an arsenal of formulas, scales, runs, or rules for how musical material is presented and recreated. A particular jazz style presupposes knowledge of the material and stylistic familiarity. A successful improvisation is a play with and against the tendencies linked to musical conventions. In music therapy, the stylistic constraints are fewer. Improvisations are often free, unless certain guidelines have been laid down regarding group processes, associations, and extra-musical themes belonging to the context.

In the discussion of jazz as a musical genre, we encountered the expression participatory discrepancies. This referred to the way music-internal and performance-based musical processes help sustain the interaction, create dialogical moments, or conditions for flow-like states.[667] We saw that when those who play together create and fulfill shared musical expectations related to mastering such rhythmic deviations, good, dialogical moments may arise. In this way, we shape relationships, emotions, and insights through improvisations.

Music therapists refer to music-psychological theories that emphasize music-internal features as explanations of how meaning in music arises, as I discussed in the chapter on the concept of music. The music psychologist Leonard B. Meyer's theories on how musical sequences create expectations are used through improvisations to draw clients into the interaction.[668]

Relational and communicative aspects

Musical improvisations are compared with what happens when people communicate through language and bodily movement. It has been pointed out how musical improvisations make it possible for us to create a reciprocal relational bond, "a mutual tuning-in relationship," as the sociologist Alfred Schütz described it. Music creates a situation "that arises in the possibility of living together in simultaneity within specific dimensions of time," Schütz writes.[669] To synchronize with one another through improvisation creates a contact that gives clients an

[667] Keil and Feld, 1994.

[668] See also Hadar, 2024.

[669] Schütz 1951, p. 78.

opportunity to step out of social isolation and enter a relationship here and now.[670]

Music therapists Gary Ansdell and Mercédès Pavlicevic have described how communication grows forth as a mutual coordination of intentions and actions.[671] If communication functions poorly, it can be "repaired" or restored musically through the improvisational techniques that music therapists have developed.[672]

Liminality and communitas

Anthropological theory has been drawn in to illuminate processes that occur in musical improvisation. What are called rites of passage, after the Belgian anthropologist Arnold Van Gennep, are rituals that take place during a transition from one position in the social structure to another. This happens at birth, initiation into society, confirmation, weddings, and funerals. Such rituals begin with a period of separation and include a transition phase in which the person belongs neither to the old nor the new life. In this phase, the person experiences him- or herself as role-less and marked by ambiguity and insecurity. In the final phase of the ritual, the person is brought back into society again, now with a new role.

The transition phase is referred to as a liminal period, after the Latin *limen*, meaning "threshold." This phase is interesting in connection with improvisation. In such a threshold situation, the person is neither "here nor there," inside nor outside, writes the anthropologist Victor Turner. Those who find themselves in such a liminal state tend to develop intense friendship and to experience a social mode of being Turner called communitas.[673]

Such liminal states or processes are said to be marked by confusion, uncertainty, dissolution of fixed reference points and conventional meaning. "The same thing may mean several things at once; meanings are in transformation and must be interpreted anew. The unambiguous is displaced by ambiguity; ambivalences come into focus. What until now has appeared unified and coherent suddenly appears as if glued together from something entirely different; what once was associated with calm suddenly reveals itself as uncanny."[674]

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[670] Ruud, 1992, p. 148; Ansdell and Pavlicevic, 2005.

[671] Ansdell and Pavlicevic, 2005, p. 199.

[672] Ansdell and Pavlicevic, 2005, p. 201.

[673] Turner, 1974.

[674] Ruud, 1992, p. 143.

Improvisation resets traditional role expectations. Instead, one seeks a competence-free and immediate musical fellowship through collective free improvisations. Here complementarity and symmetry in social relations may arise spontaneously out of the musical interaction. The improvisation comes into being through a shared process in which emotions are important for the credibility of the experience.

The experience of closeness and equality that arises through an improvisation and creates liminality and an experience of communitas has been compared with Martin Buber's I–Thou relation. Buber writes of this:

> *The relation to the Thou is immediate. Between I and Thou there is no conceptual scheme, no prior knowledge and no fantasy, and memory itself is transformed when from the separated details it plunges into the whole. Between I and Thou there is no purpose, no desire, and no anticipation, and longing itself is transformed when from the dream it plunges into revelation. Every means is an obstacle. Only where every means has fallen away does the meeting occur.*[675]

This reference to Buber resonates well with a humanistic music therapy that emphasizes the subject–subject experience as beneficial for therapeutic relationships, something noted by music therapists.[676]

Improvisation as play

Improvisation shares many elements with play. Play is characterized by a way of organizing activities rather than by specific types of activities. During play, we change the rules and the frame of the activity. We introduce a meta-perspective on the activity that tells us this is either "play" or "ordinary life." This places a cognitive frame around the activity that tells us that "everything from now until we stop is exempt from the demands of everyday life."[677]

Anthropologists Schultz and Lavenda write that play has an important function in creating a space where alternative ways of acting are possible.[678]Applied to improvisation, we see that this is a good basis for working with processes of

[675] Buber, 1968, p. 13.

[676] Ruud, 1973/1980; Garred, 2006.

[677] Schultz and Lavenda, 1990, p. 158; Ruud, 1992.

[678] Schultz and Lavenda, 1990.

change. This is called the paradox of play. The play activity is both play and seriousness, an "as if" activity. At the same time, play has real consequences if it is taken outside the play frame. "The paradox of play consists in the fact that, while it is assumed to be separate from reality, it is full of consequences for real life. The literature on play is full of examples of how play helps prepare children—socially, motorically, intellectually, and imaginatively—for real life."[679]

Music therapist Karette Stensæth has referred to theories of play and the functions of carnival to illustrate what happens when children play.[680] Stensæth uses Mikhail Bakhtin's carnival metaphor to bring out the complexity of improvisation. She writes that in its essence the metaphor makes room for both dissonance and the foreign, in addition to harmony and laughter. She continues:

> *These elements, which also characterize play, have a function and a meaning. They are there in order to create the necessary tension and renewed interest required to continue the improvisation. For if this does not happen, the participants may lose interest, which causes the improvisation to weaken and eventually cease, die out. Carnival is, in a transferred sense, like improvisation and play: a procession in which participants are invited to use masks and try out new identities. The rule of the game is that those who join the procession must accept its premises. If they are to participate, they must also dare to risk something. Herein lies the alluring and magical quality of carnival, just as it does in improvisation and play.*[681]

Songwriting

Songwriting is a central working method in music therapy and is used in a wide variety of settings. Songwriting is defined here as a process in which the user, possibly in collaboration with the therapist within a therapeutic relationship, creates, writes down, performs, and records lyrics and music. This is done with the intention of helping the user address psychosocial, emotional, and communicative challenges.[682]

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[679] Ruud, 1992, p. 139.

[680] Stensæth, 2002.

[681] Thanks to Stensæth for this section.

[682] After Baker and Wigram, 2005, p. 16.

Songwriting can be helpful in neurorehabilitation to exercise language and speech. The method is used within pediatrics, where children formulate their experiences of being in hospital. Writing songs can also be used in connection with psychotherapy as a way of putting difficult themes into words.

The aim of songwriting will depend on the target group one is working with and the theoretical perspective to which one relates. Sometimes songwriting aims at rehabilitating functions, as within medical music therapy or in music therapy with a pedagogical, cognitive, or behavioral focus. Songwriting may be experience-oriented, as found within a psychotherapeutic or humanistic-existential tradition. Or songwriting may be an identity-promoting project in which psychology, cultural sociology, sociology, and anthropology frame one's own identity narrative.[683]

Techniques for songwriting

There are many ways to begin a process that leads to a song.[684] The therapist may present a familiar song but omit certain key words, a so-called fill-in-the-blank technique. The client is then encouraged to find a new word. One may also ask the client to create a new verse for the song. Another method is for the client to choose a song and replace the entire text with his or her own newly written lyrics while keeping the original music unchanged.

Clients can also create an entirely new song from scratch. One technique used here is to create a word list from free associations and then ask the clients to choose certain key words. These words then form the starting point for a song lyric. Another procedure is to give the client a theme as the basis for the song text. Clients will sometimes bring their own texts or poems that they would like help setting to music. The process of writing a song takes place both in individual therapy and in groups.

When it comes to composing music for the lyrics, collaboration with the client is important. Suggestions for melodies, rhythm, and harmonies can be tried out together. The use of chorus and verses is often a solution with respect to song form. Free musical improvisation generates phrases and rhythms that are used in the process.

[683] Baker, 2015.

[684] Baker and Wigram, 2005, p. 15ff.

Songwriting across different practice settings

Writing songs together with clients is applicable in many arenas within music therapy. When one expresses oneself about one's own situation—whether as a child during a long hospital stay, as an inmate in prison, or as a user within the mental health field—text and music offer an opportunity to create distance from one's own experiences, and to process and express how one is feeling.

Songwriting may also have a more functional character, as when the method is used in neurorehabilitation, for training language and speech functions, improving communication, and promoting group processes.

Mental health

Writing lyrics and adding music helps with the symbolic representation of the world and with finding metaphors to make sense of what is happening to us. Within popular culture there is a diversity of genres and styles with songs that contain autobiographical material. Folk songs, religious songs, and popular music lyrics all contain narratives of illness, disability, death, and health-related religious belief. Listening to this music offers an opportunity to enter the moral universe and feel empathy with the artist's pain, sorrow, and possible joys. These songs have narrative elements we recognize from other literary genres. They have plot or action, characters, and perspectives. One of these narratives is called a restitution narrative and expresses a desire for health to be restored. So-called chaos narratives are dominated by overwhelming loss and pain; they are often fragmented without following a typical narrative structure yet bear witness to suffering in all its forms. In a narrative called the quest narrative, illness is described as a series of attempts leading to a kind of meaningful insight.[685]

Music therapists make use of the familiarity of song form to help the client formulate, ventilate, express, and communicate some of his or her most personal wishes and thoughts. The song gives the client a new context, a free space, and a strength to overcome personal vulnerability. Song form offers opportunities for self-expression and allows us to touch upon themes and relationships one has tried to avoid for a long time. Through the song, an aesthetic context is offered in which to explore one's own life, possibilities,

[685] Childress and Lou, 2023.

losses, and aspirations. An illustrative example was given in the section on feminist music therapy.

Children in hospital

Songwriting is a good way for children in hospital to formulate how they experience the hospital stay and to put difficult situations into words. Trygve Aasgaard has provided examples of songs in which children created new lyrics to well-known children's songs. In these songs the children tell about how they experience encounters with needles and medical procedures.[686]

Correctional services

Music therapist Bente Mari Mortensen has given a good account of how songwriting functions as a working method with female inmates in prison. She provides examples from her work with women in a project named *Music in Prison and Freedom*.[687] Mortensen writes that becoming a songwriter can lead to changes in the participant in the form of increased self-confidence and the initiation of self-development processes. Songwriting also provides relational experiences with others in the music group, as well as with the music therapist who accompanies the process.

Mortensen summarizes the following reasons why songwriting is used in the women's prison: songs are a familiar mode of expression; they can be kept and stored, shared, repeated, and communicate something to others. They are both close and distant at the same time. The song has a clarifying and awareness-raising function; it can be both highly personal and entirely impersonal. Songwriting is a skill that is socially recognized; it is both process and product at the same time.[688]

Child welfare and youth work

In work with youth, many forms and role models from popular music provide inspiration for creating songs with autobiographical content. The genre of rap has become a central form of expression for many young people. Through his engagement in music workshops and revue work among youth in the care of child welfare services, Professor Viggo Krüger has given good examples of how

[686] Aasgaard, 2002.

[687] Mortensen, 2008.

[688] Mortensen and Nilsen, 2019.

songwriting gives young people an opportunity to tell the surrounding world about their situation.[689]

Neurorehabilitation

Within neurorehabilitation, songwriting is a tool for improving communication, language, and speech skills. See the earlier discussion of music therapy in neurological conditions.

Writing one's life

Writing songs may be seen in connection with telling one's own life story. One entryway to this is to write one's musical autobiography and, through memories of music, map important events in life.[690]

So-called expressive writing is a major topic within experimental psychology as well as biomedical research. In these experiments, participants are asked to write briefly about their life experiences, repeatedly over several days. Such exercises appear to have health benefits. A common explanation is that opening and telling about oneself—so-called emotional disclosure—is the reason for the health effect.

In this context, it is important to point out that not all attempts to write about one's life experiences have positive health effects, especially when they concern traumatic experiences. Then the writing may be harmful, just as excessive rumination leads to depression and physical symptoms. Experiments show, for example, that when students are asked to think about their worst experiences for fifteen minutes every day for three days, participants report being less satisfied with life compared with a control group.

Thinking or writing?

Research shows that people who regularly write about their life experiences find it valuable, even when they write about painful experiences. This contrasts with those who are asked to think about painful events instead of writing about them. Here it turns out that there is a striking difference between thinking about and writing about negative life experiences. Participants in the writing group report greater satisfaction with life, better mental health, better social functioning, and fewer physical health symptoms compared with

[689] Krüger, 2009, 2015, 2020.
[690] Ruud, 2013a.

participants in the thinking group. Participants in such expressive writing groups report a wide range of positive effects on health, including physical health.

In other words, we know that something happens. The writing has an effect, but we do not fully know why. There are several hypotheses, ranging from psychoanalytic theory and cognitive learning theory to theories of self-regulation and social attachment. A common hypothesis is that when difficult life experiences are kept hidden or secret, this has negative consequences. By contrast, creating a structured narrative, disclosing something about oneself, and confronting painful and perhaps traumatic experiences are assumed to have beneficial consequences. There are also biomedical attempts at explanation. For example, that there are neural pathways in the brain that dampen the effects of stress, or that there are specialized neural networks handling such effects. These theories are not incompatible with the psychological effect described above.

The narrative creates meaning

Literary critics and philosophers have long argued that narratives are psychologically essential for us as human beings to create meaning out of our experiences. This is in line with discoveries in neuropsychology, which point to the brain as containing a cognitive subsystem specialized in making sense of unexpected events through narratives. Studies have been conducted on people with brain injuries affecting the connections between the cerebral hemispheres. These studies show that the left hemisphere supports a system of cognitive processes that makes it possible to generate hypothetical narratives for events and experiences requiring explanation. The neuroscientist Michael Gazzaniga argues that these processes in the left hemisphere create narratives that form the basis for our subjective sense of being a unified self. He calls this hemisphere "the interpreter" and writes: "The interpreter is the glue that keeps our story unified and creates our sense of being a coherent, rational agent."[691]

Such an understanding of narratives as a kind of glue creating unity in our experience of being is in accordance with the concept of narrativity proposed by the French philosopher Paul Ricoeur, which concerns narrative identity. One consequence of this is that writing about one's life goals is as useful for the writer's health as telling about one's life traumas.

[691] Valtonen, 2021.

Narrative universals

Experiments show that writing about illness and difficult life events and writing about everyday things or one's goals in life, may have the same positive health effect. This creates difficulties for psychologists, because it does not fit the hypothesis behind expressive writing. That hypothesis assumes that it is the disclosure of painful experiences that produces the health effect. How, then, can one explain that writing about everyday matters also has a health effect?

Several experiments have been carried out in which people are asked to write about everyday events and their goals in life. Humanistic researchers have identified several narrative universals, elements that tend to appear in narratives. For example, narratives almost always contain a character, a protagonist or hero striving toward a goal. In this perspective, a text about one's life goals will not merely be a description of something one wants but will also contain elements of challenge and conflict.

One hypothesis is that writing is a method that allows the author to discover and explore important sources of conflict in life. These are conflicts now felt to be subjectively important, and about which the writer reflects further regarding their meaning. Without conflict, events would predictably follow an expected path and thus be experienced as unimportant.

Distance and reflection

So why is there a difference between thinking about life experiences and writing about life events and life goals? Constructing a narrative that is written down or told to others creates a distance from the experiences in question. This temporal distance allows us to adopt a reflective and observing position through a remove that was not possible to perceive while the event was taking place. Closeness and intimacy in the autobiographical account arise because the narrator appears in the story as responsible for the events being disclosed. In this way, one has a personal interest in how others will respond to the story. This very idea that writing creates distance has been used in music therapy, for example by the German music therapist Isabelle Frohne-Hagemann, who is inspired by Gestalt therapy.

An important point here is that writing autobiographical accounts is not merely a documentation of who we are, but a way of creating our self-understanding, as we know from theories of identity.[692] The story about ourselves helps us develop what Aristotle called phronesis, a practical life wisdom that develops through a

[692] Disoteo, 2022.

combination of experience and reflection.[693] With regard to how listening to music produces images, bodily states, thoughts, and associations—as in GIM—and how we often use metaphors to designate such experiences, several possibilities emerge for strengthening our understanding of the role of narrative.

Listening to music – receptive music therapy

Listening to music is a useful working method and often provides the starting point for a first meeting with clients. Listening is a less demanding activity and can create experiences of safety, relaxation, and calm. Receptive music therapy is used in several areas.

Within elder care, the work concerns individually adapted music to stimulate memory and evoke recollections. Here listening to music may also help reduce agitation and anxiety. Listening can be used in psychodynamic contexts and form the basis for deepened experiences and conversations.

Listening to music is referred to as receptive music therapy. It is important to emphasize that "receptive" in this context does not mean a passive relation to music, but an intentional, purposeful, and focused kind of listening. There is also a use of music listening in medical settings, so-called music medicine, where no music therapist is present. In receptive music therapy, the music therapist plays an important role both in the choice of music and through the relationship formed between client and therapist.

In the chapter on music and public health, we saw how many people listen to music in everyday life to regulate emotions, relieve pain, and reduce stress. In the chapter on music therapy for children in hospital, we saw how children undergoing painful procedures are distracted from pain when the music therapist sings and plays. We know that music listening and song sharing are good starting points for initiating conversations in groups.

The music that is listened to may be live or recorded, created and performed by the client, or retrieved from the internet and organized, for example, into playlists. The listening is aimed at promoting bodily relaxation, eliciting emotional reactions, leading to associations, images and fantasies, thoughts and ideas, or creating transcendent peak experiences.

[693] Valtonen, 2021.

Guided Imagery and Music (GIM)

There are several approaches to listening within receptive music therapy. In the tradition following Helen Bonny and her method (BMGIM), which was discussed in the chapter on music therapy theories and perspectives, several new formats have developed.

These consider different groups, cultures, and situations that the music therapist encounters. The GIM therapists Dennis Grocke and Torben Moe describe three main forms in the use of music to stimulate associations, imagery, and bodily sensations.[694]

In addition to the classical BMGIM, procedures have been developed for music and imagery (MI), both for individual therapy and for groups. MI is used to stimulate deeper relaxation by introducing images and representations that create a focus for listening. Typically, the listener is asked to imagine a favorite place, perhaps in nature or at home in a comfortable chair. When these images are introduced, it is desirable that the music be experienced with all the senses: visually, aurally, even tactilely or as smell.

We also find guided GIM, used individually and sometimes for groups. GIM operates in much the same way as MI, but here the therapist takes on a more active role as guide. This happens through the listener reporting his or her experiences, while the therapist is present with supportive comments and questions that deepen the images and sensations that emerge.

Adaptations and changes are made in program and procedures compared with BMGIM. The relaxation phase is shortened, the music program is reduced to shorter journeys, and music from other genres is chosen. Music listening also takes place in other contexts, such as in hospitals for children and young people, or for relatives who need a breathing space.[695] Listening can also take place in schools or with other client groups, for example in palliative care.[696]

Examples of such adaptations include Lisa Summer's Continuum Model, Margareta Wärja's Short Music Journeys, and Ingvild Stene's Therapeutic Music Listening.[697]

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[694] See Grocke and Moe, 2015 for an overview of adaptations and modifications of GIM.

[695] Noer, 2020.

[696] Grocke and Moe, 2015.

[697] McFerran and Grocke, 2022; Stene 2023.

Personal Music

As we have seen earlier, everyone has their own personal reactions to music. Music that affects me in a particular way may have a completely different effect on someone else.

In music therapy, it is crucial to find music that the user likes, what we called preference-based music. At the same time, it is important to make the user aware of how this music can be used in ways that promote health and well-being. It is therefore important that the user learns to listen intentionally, in other words with a specific goal and purpose. In this context, the music therapist must talk with the user and, through collaboration, identify which music works in the best possible way.

The music therapists Katrina Skewes McFerran and Carol Lotter have provided several guidelines for how such a conversation takes place.[698] The conversation may concern what kind of music becomes a resource for the user's health and well-being, or what music diverts the user from addressing their challenges. The conversation may focus on which music distracts from pain, provides comfort, or is relaxing.

This is a different way of listening from an aesthetic approach to music, where we more or less consciously allow the music to carry us to places we have not planned to go. The intentional form of listening means being oriented toward music as part of self-care related to health challenges. It is therefore important to create a focus on building a connection between the music and the intention, something that requires experimentation.

In this connection, awareness of context, time, and place is important. Sometimes the situation itself will influence how we experience the music. The possible use of headphones and paying attention to the surroundings are important.

Musical Elements

In selecting music, account must be taken of the participants' musical background and preferences, age, group composition, goals, and group dynamics. The choice of music may be led by the therapist or made in collaboration with the participants. McFerran and Grocke write that there are several situations in which the therapist must take responsibility for the music choice. This happens

[698] McFerran and Lotter, 2024, Chapter 1.

when participants are too young to choose, may be confused because of trauma or dementia, lack language, or have a cognitive impairment. It may also happen when time is limited or where decision-making would take too long. When people are unable to choose, as in palliative or other treatment contexts, the therapist must guide the choices.[699]

There are many good reasons why participants themselves should determine or help determine the music choice. In that way, one ensures that the user is heard, that the music is familiar, and that personal memories and possible projections are connected to the selected music.

Once such factors have been considered, the question becomes what music to choose—genre, musical features, mood in the music, and so on. We begin from the familiar musical elements when evaluating the music: melody, rhythm, tempo, harmony, dynamics, and instrumentation. McFerran and Grocke suggest that we assess the combination of these elements in relation to the music's ability to arouse energy and emotion in us, so-called arousal. For example, a complex rhythm will be more stimulating than a simpler and more repetitive rhythm. The degree to which the music is predictable will influence how we experience it. We create a sense of safety by playing music with a simple, repetitive, and predictable melody. How the music induces a particular mood in us can also be considered. The use of minor harmony may create a melancholic and reflective atmosphere, to take one example.[700]

It is useful to begin from how we experience intensity and complexity in music. The experienced BMGIM therapists Margretha Wärja and Lars Ole Bonde have proposed classifying music according to whether it is supportive, mixed supportive, or challenging. Supportive music creates a safe frame around the session; one should feel secure in order to explore whatever images and thoughts may arise. The mixed category contains music that is supportive both initially and toward the end. However, the music may contain more challenging episodes by introducing a greater degree of unpredictability in melody, rhythm, and harmony. Challenging music is intended to be intense, powerful, and dramatic. This may be rhapsodic music, or music experienced as mysterious and transformative.[701]

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[699] McFerran and Grocke, 2024, p. 32.

[700] McFerran and Grocke, 2024, p. 33–34.

[701] Wärja and Bonde, 2014.

Choice of Genre

Among the genres most often used in receptive music therapy we find film music and ambient music, various forms of classical music, jazz and popular music, as well as music from the category of "world music." We find music that is easy to listen to, so-called supportive music, in all genres. This is music that does not challenge and that maintains a consistently low-tension level. It may be a slow movement from the classical repertoire, or music from newer modern (minimalist) music, for example Arvo Pärt's *Spiegel im Spiegel*, an Indian raga, or something from ambient music. Film music offers atmosphere- and image-producing music and creates associations with films and actors that provide a good basis for group discussion.

Arguments have been made that classical music contains many examples of pieces with built-up tension, music that creates expectations which are then released and generate emotions in the listener. There is classical music with great variation in emotional expression that stimulates imagery and activates memories. Particularly within BMGIM, the classical repertoire has held a prominent place, although this has been challenged in recent years.

As for contemporary popular music, this concerns an enormous diversity of genres with a multitude of subgenres. Young people often have great competence and in-depth familiarity with contemporary artists, music, and lyrics. For the music therapist, it will be necessary to enter dialogue with users and turn to the internet in order to stay updated on this diversity.

Conversations About Music and Analysis of Lyrics

Listening to music provides a good basis for sharing musical experiences with others and communicating the thoughts and feelings that arise while listening. This takes place either in individual sessions with the therapist or in a group. Songs and song lyrics may evoke important memories of people who have meant a great deal to us or give rise to associations with values and experiences that have helped shape us. We may identify with the content of song lyrics and with the artist conveying the song. Music becomes a "mirror of memories" and a projection screen onto which we transfer (un)conscious thoughts and attitudes with which we do not always communicate well to ourselves.

Songs provide an opportunity to do emotional work. They are important means for talking about ourselves and for becoming an entry point to contacting others.

A central question in the literature is who should choose the music to be listened to.[702] There is no standard answer to this, and there are reasons why in many situations the therapist should choose the music. At the same time, it is easy to argue that the music participants themselves bring with them forms a good basis for emotional work. Genre is of course an important issue here. Based on an understanding of the relationship between music and identity, as well as music-sociological research on musical taste as described in the previous chapter, music choice in today's media environment is a challenging issue. Broad genres, such as hip hop, heavy metal, or K-pop, carry cultural values and orientations that may resonate strongly within some (youth) groups while creating distance for others. The same applies to lyrics that connect to general themes in contemporary life or that have an individual and special significance for particular people.

Different Levels

Conversations about music and musical experiences move across different levels. At an introductory level, one simply asks whether the participant likes the music and what they think about the performance, write McFerran and Grocke. At the next level, one asks whether there is anything in the song lyrics that has special significance, whether it makes sense in a particular way, and whether it resonates with the participant's life events. At a third level, one may ask whether there is something about this song that means something for the participant's life situation here and now, why this particular song was chosen, what feelings it evokes, and what images and thoughts arise.

We can see that these levels reflect how far we wish to move from descriptions of the music and the artists toward a more insight-oriented approach. Furthermore, the conversation about the music may lead to what is referred to as reconstructive therapy. Here the task is to identify connections between an embodied music experience and its significance for the person's life.

We see that conversations about musical experiences are a powerful tool in music therapy, and that they require experience and caution in monitoring the processes that may occur in a group. Music may trigger strong reactions, and the therapist must be prepared to contain anxiety responses and aggression. The therapist must monitor possible reactions such as rumination, meaning that participants become stuck in the music and repeat thoughts that lead to depression.

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[702] See McFerran and Grocke, 2022, Chapter 5.

Playlists and Music Apps

Everyone can now easily choose music and create playlists based on particular criteria. Playlists are put together based on genres, mood, feelings, memories, and so on. When selecting tracks for a specific playlist, it is wise to give the list a clear name. It may for example be called: *Music and Good Memories*, *Music for Relaxation*, *Music that Gives Hope*, *Music for Focus*, and similar titles.

Playlists have come into use within health care, and it is not only music therapists who use them. Often the playlists are very general, and their use is aimed at creating a pleasant sound environment in an institution, reducing noise levels, or distracting patients from unwanted behavior. The use of the concept "playlist" referred to here means, according to McFerran and Grocke, "a set of songs selected and sequenced with a specific purpose, and which creates meaning for an individual or a group when the list is used with the aim of achieving a therapeutic goal."[703]

There are music therapy literature and research in which playlists have, among other things, been used in the (re)construction of identity or in work with young people with health challenges.[704] Music therapists at Aalborg University have developed a service involving playlists and technical facilitation at the psychiatric hospital in Aalborg. The system is called *MusicStar*, and a description of the research behind the project and its practical use has been provided by the researchers.[705] The playlists are available via an app, and the target group is described as people with symptoms of anxiety, depression, fatigue, stress, and sleep difficulties.

Within group therapy, one should have a clear aim when constructing a playlist and at the same time base the list on assessment of the recipients. For McFerran and Grocke, this also means taking varied goals into account. These may include managing a particular mood, processing emotions, capturing a life course, promoting sleep, counteracting distraction and creating focus, inducing relaxation, reducing agitation, working with identity, strengthening relationships, or supporting an activity.

When it comes to sequencing, meaning the order of the tracks or musical pieces, this may be based on the so-called iso principle. This was developed by the

[703] McFerran and Grocke, 2022, p. 68.

[704] McFerran and Grocke, 2022 for an overview.

[705] https://www.themusicstar.dk/om-musikstjernen/ Access date Sept, 26, 2025; Lund, Bertelsen and Bonde, 2016.

psychiatrist Ira Altschuler in the 1940s. The iso principle means taking the user's current mood or emotional state as the starting point and choosing music that matches it. One then gradually introduces music that changes feelings and mood in the direction one wishes.

When creating playlists with a clear purpose, McFerran and Lotter provide concrete guidance regarding the kinds of conversations that help clarify a person's musical taste and music experiences. They also cannot emphasize strongly enough how important it is to create a personal playlist based on one's own experience and understanding of how music affects oneself. In a process of personal recovery, one may need help in becoming aware of this.

Research and Documentation

As we can see, there are many possibilities for using listening as a working method in music therapy. In what follows, practices and research findings described in Lotter and McFerran's book *The Psychology of Music Listening for Health and Wellbeing Professionals* will be discussed.[706]

There is extensive documentation of how people use music in everyday life to reduce stress, relax, and find calm, write McFerran and Lotter. For many, this happens without help from health professionals or music therapists. Some need help getting started, finding music, and creating routines for regulating themselves downward and becoming more present in life. Listening to music has direct implications for our neurophysiological system.[707]

As regards autonomous or independent music listening, that is, what happens in everyday life and outside a professional context, there is now a great deal of music-psychological research showing how listening to music has health consequences for many people.[708] In the chapter on music and public health, it was pointed out how people use music in grief work, to counter stress, relieve pain, provide hope, find coherence in life, use music as a social resource, or as support and self-care after natural disasters.

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[706] McFerran and Lotter, 2024.

[707] See also Levitin, 2025.

[708] See, for example, Lilliestam (2020) for a series of in-depth interviews which specifically show how, not least, popular music artists provide lyrics and music that many people appropriate in caring for their own health and well-being.

We are now beginning to see research results concerning the use of music during the Covid-19 pandemic. It appears that music and listening to music meant a great deal to many during that difficult period. We are familiar with the way music connected people through singing from balconies. Many who followed livestream concerts online had meaningful music experiences that were also shared with others. Research now shows that purely private listening has provided comfort and support for many who felt socially isolated.[709]

We have seen how the use of music to improve sleep is supported by research and experience. It has been suggested that one identify a preferred music genre, create a playlist, and over a few weeks try listening to the playlist before going to bed. McFerran and Lotter write that such a playlist should be personal and consist of music that is slow and in an even tempo, with small rhythmic changes, a predictable melody, few leaps and within a narrow range, a clear tonal structure, predictable chord progressions, string instruments and woodwinds rather than brass and percussion. There should be few dynamic changes, and these should be introduced gradually.

We should, however, be aware that music does not always promote sleep. Sometimes music may trigger memories that lead to disturbing thoughts. In cases where music "gets stuck," goes on repeat, what in English is called earworms, music may create difficulties in falling asleep.

Music Listening in Life Transitions

Listening to music is important during different life circumstances, in transitions between phases of life, or in more dramatic and involuntary displacements. Women around the world make use of music during childbirth itself. At the same time, music listening may provide support during pregnancy, when one is adjusting to a change in identity and role. There are many studies pointing to positive effects of music listening in this area. For example, half an hour of daily music listening is recommended for pregnant women to counter anxiety and protect against postpartum depression, especially for women who initially experience reduced well-being.

Adolescence is a period in which interest in music is strong and intense, and in which music listening often becomes an important source of emotional enrichment and social competence.

[709] Swarbrick, 2023.

Music listening may support refugees who are forced to leave their home country. Music becomes a means of preserving cultural belonging and identity, of safeguarding the musical roots that provide good memories of where one comes from. Or music becomes a way of adapting to a new situation, in a refugee camp or in a new country with a new school and new friends. This is shown in music therapist Kaja Enge's research on musical interactions between immigrant children and Norwegian schoolchildren.[710]

Many older people experience that opportunities for social activities connected to music become more limited. Social isolation is countered by creating meeting places for listening to and sharing music. Music experiences provide access to memories, and we know how autobiographical memories create coherence and meaning in life during this phase. Meaning in life, and existential and spiritual aspects of life, may also become pressing themes at this stage.

Music Listening in Medical Contexts

Music listening is used with various somatic illnesses and medical procedures. This includes listening to music before surgery and in pain management. Listening is used in infant and neonatal units, and with musicians and live music on hospital wards. There is also extensive research in these settings, even though it is not always easy to draw unequivocal conclusions. This is because people come to hospitals for different reasons, and because there are various ways and vocabularies for describing interventions involving listening within a medical context. Some researchers focus on promoting greater relaxation, while others emphasize reducing anxiety. Some describe reductions in the perception of pain, while others emphasize self-management. In this way there are overlaps and possibilities for confusion when interpreting the research, write Lotter and McFerran.

Pain reduction is obviously central, especially since we now know that pain is not an objective phenomenon but is influenced by and stands in an interactive relationship with subjective psychosocial factors. How music reduces pain, often in combination with relaxation techniques, is well documented. But it is less clear to what extent preference-based music should be recommended. This is because patients may then choose music full of tension and energy, and thus not necessarily useful for relaxation. On the other hand, that very preference-based music may evoke good memories and associations and lead to effective distraction

[710] Enge and Stige, 2020.

in the situation. Distraction draws attention away from the situation but does not necessarily calm anxious individuals or relieve their pain and tension.

As we saw earlier in the section on music in pediatrics, music therapists differed in their views on the extent to which one should use distraction versus invite patients into the procedure by supporting their own mastery of the discomfort.

Listening in Neurological Injury

There are several conditions within the category of neurological injury where listening is used—for example traumatic brain injury, Parkinson's disease, and dementia. Since music therapy or listening does not necessarily repair damage in the brain and nervous system, the aim of music listening in neurology becomes increasing quality of life, with all that entails in terms of vitality, relationships, belonging, and meaning in life.

We must keep in mind that the videos circulating online are not necessarily representative of what is possible to achieve. The effect of the music may be due to the fact that these individuals have very specific brain injuries or a particularly strong relationship to music earlier in life.

That said, research shows that playing or singing, and using live or recorded music, reaches people who have sustained traumatic brain injuries after head trauma, according to McFerran and Lotter. But there are many reservations to make. One must take musical taste into account, the complexity of the music may need to be adjusted, volume and noise conditions must be managed, and the family should be involved. There is research showing that patients in coma may be reached through music. Beneficial physiological reactions occur in the body, and attention is drawn to the need for vigilance regarding even the smallest reactions that arise during music listening.

In relation to people diagnosed with schizophrenia, McFerran and Lotter recommend music listening, even where people hallucinate or hear sounds or voices. But this requires special experience and competence to work with. It turns out that music listening here is helpful rather than harmful. Cochrane reviews again point to positive effects of music listening on negative symptoms such as blunted affect and social withdrawal. But again, the choice of music is important, and a careful approach is required.[711]

[711] McFerran and Lotter, 2024.

As for Parkinson's disease, we know how listening to music is used in relation to gait training. We have seen that neurological music therapy has shown good effects from so-called rhythmic auditory stimulation (RAS). We saw that in RAS, the music therapist walks backward while playing preference-based songs on the guitar at a tempo suggested by the physiotherapist. There are now several studies indicating that playlists on a smartphone help these patients feel safer while walking, and in that way gain more benefit from the training. Especially for patients who experience a "freeze" in gait, the music can help initiate movement. The importance of listening for quality of life and for coping with the psychological aspects of the illness has also been demonstrated.

In cases of dementia and among people with memory challenges, we know that the person benefits greatly from music listening. There is now a large amount of research on this, something again well documented with references and discussion by McFerran and Lotter.[712]

Rehabilitation and Special Education

Listening to music may be linked to the development of physical and cognitive functions, in early intervention and within special education. Music listening is used as support for language and communication, in physical rehabilitation, in special school classes, and as an aid for users with cochlear implants.

McFerran and Lotter write that there is a considerable amount of research on how listening to music affects physical performance, something especially evident in research on sports performance. In relation to language rehabilitation, researchers are investigating whether perception and auditory processing of music and sound lead to greater ability to understand speech and language. Here again the results are mixed, although regular listening to music does appear to have an effect.

Music may increase well-being and performance in the workplace, in learning contexts, or within elite sports performance. There is research here showing how different conditions, contexts, and forms of music affect learning and performance, as well as the challenges encountered when music is to be chosen. Some people prefer a certain kind of music or sound environment when studying and learning, while others want silence.

[712] McFerran and Lotter, 2024.

Practical Advice and Therapeutic Guidance

Safety during listening is especially important. Therapeutic sensitivity and the building of trust are key concepts. And we must not forget that what is a safe and secure musical choice for one person may be experienced as the exact opposite by others in a group.

Song analysis is a good working method, but it requires careful thought about who should choose the songs—the therapist or the users. Both possibilities must be considered, and each choice brings both challenges and opportunities. Listening to music can trigger strong emotions, memories, associations, images, and bodily experiences. As we know from GIM, these experiences provide access to more or less conscious processes and experiences that we have not always communicated adequately to ourselves. Within psychodynamic traditions, the aim is to make this unconscious material conscious. For the therapist with a humanistic-existential approach, music opens the way to transcendent experiences and existential dilemmas. Entering such processes requires further training and personal experience, as those who undergo certification in BMGIM know well.

A conversation can help people find their personal music. The function of the therapist or health worker is to support people who are in a transitional phase of life. This means providing support and help in finding songs that have given a sense of strength and empowerment earlier in life. Or helping users discover what resources they possess in facing the challenges they experience in the present moment. The future, too, can be prepared through listening to music. Here it is important to help users create good daily routines for music listening. We know that precisely such daily use of music helps build a bridge between everyday music use and the professional support one receives from music therapists and others.[713]

Music listening may be associated with risks of increased rumination and depressive thoughts, aggressive behavior, prejudice, and destructive actions. This includes everything from watching misogynistic music videos to listening to lyrics perceived as offensive. It may be music that generates aggressive energy and belonging to criminal groups or ideologically charged networks. There is also research on music that glorifies one's own religion while denigrating others' religious faith.

[713] McFerran and Lotter, 2024.

Across all these areas there are many research findings. Sometimes researchers show that listening to so-called "problematic music," often heavy and hard rock, is associated with unwanted behavior or negative moods. But a distinction is not always made between causation and correlation. There is no causal connection between a particular music genre and typical or specific reactions. On the other hand, it does seem that people in vulnerable, susceptible situations are drawn toward harder genres—for example the genre called Depressive Suicidal Black Metal. It is not the music itself we must blame, however, but the way it is listened to and the situation in which the listener uses it.

We know that young people in particular who are at risk need help in managing their playlists and becoming aware of unhelpful listening habits. Here the therapeutic conversation and counseling become important. For everyone working with vulnerable young people, reflection on how one talks, asks questions, raises awareness, and offers advice to users is extremely important. This applies in prevention, early intervention, and the treatment of people who have developed unhelpful listening habits.

What makes interpretation of this research so difficult is the many contradictory research findings. We are speaking here of research on listening in work with people with severe depressive disorders, post-traumatic stress disorder, women who have been exposed to sexual abuse, or in the treatment of substance misuse. On the one hand, there is always a danger that music may lead to more rumination and depressive thoughts, trigger traumatic experiences, or increase cravings for new intoxication. But there are also research and meta-studies in all four of these areas that clearly indicate positive benefit from properly supported music listening.

In such a situation, it becomes crucial how the music therapist assesses music use together with clients, asks the right questions, raises awareness of music's effects, and creates safe conditions for listening. Equally important for therapeutic music listening to succeed is that the user has a clear motivation, a willingness and intention to give the music a chance to help. Once music is found that offers help, the challenge becomes the extent to which the user receives and makes use of the emotions, bodily experiences, and reflections that the music evokes.

Music Listening in Groups

Listening to music in groups can be of great value. But for many this is challenging because of differences in musical taste and the emotional reactions that may arise, or because of how one should relate to prejudices that develop in a group

process. A simple genre division is often not sufficient when working with youth. All the subgenres, for example countless variants of electronic dance music, are often marked by identity signals, which easily create friction when young people listen together to one another's music.

We should not forget listening to music for purely aesthetic purposes, listening to create joy and pleasurable experiences. Music listening is a good basis for support groups for caregivers or health workers threatened by burnout. Relatives of patients with cancer or dementia need support and time to process their situation. Listening groups with conversation are a good form of support for participants.

Although listening within mental health care may have purely aesthetic aims, listening with analytical purposes should be led by therapists with special training to handle the processes that may arise.

Dance, Drama, and Other Expressive Therapy Forms

There is a longstanding tradition among music therapists of collaborating with professionals such as physiotherapists and other arts therapists. Collaboration with physiotherapists is often employed in work aimed at strengthening movement and motor functions in children. Theories developed by physiotherapist Veronica Sherborne have been incorporated into this practice, and music has been created to support exercises emphasizing qualities such as "strength" and "tension." Today, this type of work is further supported by neurological music therapy, which provides strong evidence for the connection between music and movement.

Over the years, several music therapists have combined musical approaches with expression from other art forms. The boundaries between music, dance, drama, theatre, image-making, and modeling are crossed, and the interplay between these expressive possibilities is explored. The Swedish music and expressive arts therapist Margareta Wärja has played a leading role in Scandinavia within expressive arts therapy. This is described as a multimodal approach combining visual arts, music, dance/movement, drama, photography/film, writing and literature therapy, and other creative processes in psychotherapy.[714]

[714] Wärja, 2015.

A central theoretical concept concerns the intermodal aspects of expressive arts therapies. This refers to the fact that we experience the world through different senses, such as sight, smell, touch, taste, and hearing. The different art forms are based on different modalities linked to these various senses, such as music for hearing, visual art for sight, and so on. All of this, in turn, arises from the body's capacity for sensation, writes Wärja.

Understanding how the senses are interconnected becomes important for expressive therapists. It is possible to move between the different modalities or senses. A client may draw a picture; the picture gives rise to verbal reflection that then leads into a particular rhythm or tonal space. Images may contain the seed of a story or give impulse to movement. The therapist will make use of these possibilities and create an intermodal transfer by shifting the mode of expression.

Expressive arts therapy is grounded in existential phenomenology and psychotherapy, with references to philosophers such as Heidegger and Merleau-Ponty in its theoretical foundation. It also refers to theories from neuropsychology, Daniel Stern's theory of intersubjectivity, and Winnicott's psychotherapy theory. As a GIM therapist, Wärja has developed a method for *Short Music Journeys*.[715]

Related Arts Therapies

Music therapy is closely related to other creative approaches such as art therapy, bibliotherapy, creative writing, drama and theatre, dance and movement. There are several common features among the different artistic forms of expression. Music therapists can make use of shared experiences with other arts therapists and create professional communities and collaborations around the possibility-space that the arts therapies open.[716]

An important point of departure is how the creative approach can occupy a central place in the users' world of experience.[717] Some people find it difficult to speak and talk about their difficulties. Artistic expression provides opportunities for the individual and distinctive to emerge. It creates a distance from experience that makes it possible to work through something painful and find new paths toward self-development. Expression may create a space for entering dialogue with oneself. It provides an opportunity to develop representations for what is not

715 Wärja, 2010.

716 A theorist who is often highlighted is the British analyst Donald Winnicott, who writes about the "potential space" that opens through a creative approach, about creativity as creating the self.

717 For the following, see Tanum Johns, Landmark and Indrevoll Stänicke (Ed.), 2025.

yet thinkable or mentalized. Such representations may help organize impressions, memories, and emotions, and provide corrective emotional experiences through new intersubjective encounters. Artistic representation may contribute to preventing disorganization and help to organize impressions. Memories and emotions are brought into play, and a corrective emotional experience becomes possible through a new intersubjective experience.

A relational expansion of awareness of oneself and one's relation to others may occur. The patient may move out of fixed patterns of interaction and discover new aspects of self, others, and surroundings. Creating one's own expressions may surprise oneself and provide an experience of self-agency, understood as the power to influence. For some patients, this may be experienced as something that "comes into being," something whose outcome one does not know, and which is surprising.

For some patients, the desire to hold onto conversation and the verbal may offer a kind of protection. Language becomes a shield in relation to unpleasant experiences stored in the body but not articulated or represented. To play allows the possibility of losing control, in that play "plays" with us, as the psychologists state.[718] Play creates shared attention, initiative-sharing, and a vitality that becomes a driving force in the interaction. Play and artistic experiences provide experiences of being present here and now. Play can open bodily intersubjective forms of response. These experiences may create meaningful coherence and continuity in one's own life and history and contribute to the development of self-understanding and mentalization.

Body-Based Approaches

Body- and movement-oriented interventions include a range of traditions, from yoga to character analysis, sensorimotor psychotherapy, and dance therapy. We know that mental suffering can be expressed through the body. The self is not experienced only in the head. Body- and movement-oriented interventions promote self-experience and self-regulation.

Within a phenomenological tradition, the body is our primary source for understanding and recognizing ourselves, others, and the world. Through the body we communicate and contact our surroundings. Body-based interventions may aim to strengthen fundamental bodily resources that foster experiences of stability and safety. Key terms here are centering and balance, bodily feelings of freedom and positive movement experiences, mindful presence, and bodily awareness.

[718] Tanum Johns, Landmark and Indrevoll Stänicke (Ed.), 2025.

Self-regulation depends on somatic experience. Sadness is experienced as tension in the diaphragm, heaviness in the chest, and constriction in the throat. Increased access to the body can promote access to emotional information and the capacity for affect awareness. The use of meditative breathing exercises in work with anxiety and respiration has significance for the regulation of emotions. Body and movement in connection with relaxation regulate the nervous system, counteract stress, and promote rest and well-being.[719]

Digital Creativity

We know a great deal about the risk factors involved in excessive use of digital and social media, especially for children and young people in vulnerable situations. But we can also view the use of the digital space more broadly. Media can become a means of regulating, expressing, and sharing difficult feelings. Media also provide opportunities to produce creative expression. We have image and drawing programs, possibilities for music production, and other forms of digital creativity.[720]

Bibliotherapy – Shared Reading and Reading Communities

Bibliotherapy builds on the reader's identification with a character or a group of people. Here there may be both projection, catharsis, and new self-recognition. Shared reading and reading communities provide many opportunities for exchanging thoughts and experiences. Group discussions encourage the reader to think and feel, something that can break habitual patterns of thought. Shared reading creates conditions for affect attunement among participants. Reading deepens the relationship to others and can create a richer experience of the text.

Bibliotherapy offers opportunities for emotional identification, where central life themes may be projected. Reading can become a formative act that helps shape identity. Reading may transform one's own subjectivity and lead to new ideas and insights. Conversations around the text provide space for empathy with the people in the text.

Reading poetry and engaging poetically can open experiences of existential wonder. The treatment's focus on change is replaced by a focus on wonder, as stated in the discussion of bibliotherapy. The patient is offered a new language, and

[719] Lorentzen and Halvorsen, 2025.

[720] Stänicke, 2025.

a space of possibility is opened. The reading community becomes a good basis for self-determination and a support in personal recovery.[721]

Creative Writing

Writing gives access to a creative and poetic language. The writing process can become a place for healing and personal recovery; processes we know from recovery thinking and CHIME. Creative writing creates meaning, supports subject formation and identity. It provides an opportunity to work through difficult feelings and experiences and fosters community in the group.

Creative writing processes invite people to see the world in new ways or from a new perspective and create a potential for seeing other possibilities. Creative writing places more emphasis on literary qualities than expressive writing. It creates openness to using language in new and unfamiliar ways. The ambiguity and openness of poetic language create a different gaze, a sensitizing gaze. The writing process can address difficulties without disclosing what one is writing about.

We understand ourselves through the linguistic discourse available to us. At the same time, poetic language can provide access to fundamental bodily processes.[722]

Art Therapy

The use of painting, drawing, ceramics, or other creative activities is part of art therapy. Drawing and painting provide an opportunity to project one's own psychic content into images and to process the expression through conversation. Since visual memory precedes verbal memory, visual expression may concern making the unconscious conscious. The unconscious becomes visible, and images may be understood as manifestations of symbols carrying personally charged meaning. A dialogue emerges with different parts of the self, something that can contribute to the regulation of emotions and increased mentalization.[723]

Drama Therapy

Drama therapy can also give participants opportunities to explore thoughts and feelings in a safe environment. Role play and improvisation can provide insight into one's own reactions and behavioral patterns. Drama therapy makes it possible to

[721] Løes, 2025.

[722] Synnes, Romm and Bondevik, 2025.

[723] Johns, S., 2025.

express oneself through body, movement, and character. Participants may improve their communication skills, both verbal and nonverbal.

Through working with different roles, participants can explore and practice solutions to personal or social problems. This may contribute to strengthening self-confidence and giving participants a sense of control and mastery. It also opens opportunities for collaboration and interaction with other participants. In this way, drama therapy may promote better relationships and social cohesion and contribute to a sense of belonging.

In connection with drama therapy, a particular form has developed called psychodrama.[724] Psychodrama was developed by the Austrian Joseph Moreno. His nephew, the American music therapist of the same name, has continued the work of combining music and psychodrama.

Humor

Humor and play also have an important place in the therapy room. Humor can be an effective form of intersubjective regulation.[725] It can be liberating and may be the adult's expression of playfulness. Some would object that humor distracts from the seriousness of therapy. But the premise of play is that it is make-believe. Humor can therefore be regarded as a creative act that makes possible new perspectives, relief, and freedom in life.

Humor can help reduce anxiety and symptoms of depression. One form of humor is good-natured teasing through paradoxical exaggeration, which requires safety in the relationship and attentiveness to risk. Relief humor, such as joking, is another form of humor. Laughter can be regarded as the nervous system's safety valve and as a form of release from reality. The use of humor allows an outlet for forbidden thoughts and feelings without experiencing guilt.

Humor can also be understood as a cognitive play with ideas. One may delight in absurdities. Humor involves taking an interpretive distance from reality. Humor can also create moments of meeting. Through humor, the therapist appears as an authentic person and humor becomes a form of attachment behavior.

All in all, we can say that for some, the creative approach means opportunities for reparative work. Others achieve the vitality and freedom that play offers, while

[724] https://nafkam.no/psykodramaterapi

[725] Almenningen and Hobbesland, 2025.

others again use the creation of humor as rebellion, as a way of exercising critique against what is experienced as destructive, confining, or problematic.

The creative therapist requires courage and the ability to create safety. Daring to move beyond one's comfort zone is something many music therapists have experienced. One must tolerate uncertainty and adapt one's competence in a flexible way.

Verbalization

Music therapists cannot do without words and conversation. It is important to be aware of how language is used, something that should be emphasized in training alongside the other working methods. The role of conversation and the significance of verbal interventions have traditionally received little emphasis in music therapy. This is connected to the way music therapy in the United States, from the 1950s and 1960s onward, was presented as something entirely unique, based on a musical approach in contrast to other therapeutic approaches. Over the past decades, there have been several important efforts to give conversation its rightful place in music therapy.[726]

When conversation has received greater attention, this is connected to the recognition of several therapeutic models. These include, for example, different forms of GIM, analytic and psychodynamic approaches, variants of Nordoff and Robbins' clinical improvisation, as well as cognitive behavioral therapy and other psychoeducational forms of conversation. In all these cases, there is an interplay between music and conversation, where the music is of course important in a process of change.

There are numerous single studies and meta-studies on the effects of music therapy. We saw earlier that contradictory results easily arise, and that music may have both positive and negative effects. It is important for music therapy to relate to this research, because it serves as a reminder that the role of the music therapist itself is important in relation to the effects of music therapy. The way the conversation is conducted, the questions that are asked, and the way music therapy is carried out require sensitivity on the part of the therapist, in addition to the ability to create safety and trust. At the same time, alongside a clarifying conversation, it is important that the user's attitude is decisive for whether the music will have an effect or not. The user must have an intention that the music

[726] See Schwartz, 2019, for the following.

really will be helpful. This, we saw, was well illustrated by the music therapists Katrina McFerran and Carol Lotter in their recommendations for receptive use of music.[727]

Some Historical Milestones

The leading music therapy theorist Kenneth Bruscia plays an important role in the history of verbalization, with his monumental review of forms of improvisation in music therapy. Here he includes analytical music therapy, in which verbal interventions play a role just as important as the music.[728] Bruscia does not make any hierarchical distinction between approaches with and without conversation, but instead establishes criteria for when music or conversation is appropriate.

Others who have discussed, researched, or formulated guidelines for the use of verbal interventions in music therapy include Mercédès Pavlicevic, Dorit Amir, Susan Gardstrom, Paul Nolan, and Ronald Borczon. The role language plays in music therapy depends on what kind of music therapy we are talking about. Music therapist Barbara Wheeler, for example, has proposed a distinction between three levels in therapy: music therapy as an activity therapy, an insight-oriented music therapy with re-educative goals, and an insight-oriented music therapy with reconstructive goals. Elizabeth Schwartz refers to Kenneth Bruscia's "levels of practice" as a framework for illustrating how the level at which we work will influence the form of conversation.[729]

Music therapy at an auxiliary practice level uses simple and informative language. When we speak about music therapy at a primary level, it is a matter of providing insight that requires intervening questions. We see that this touches on themes such as boundary-setting and ethical awareness, as well as education, experience, further training, and specialization, all of which each individual music therapist must reflect upon.

Four Forms of Verbalization

Schwartz builds further on many of the reflections and concrete guidelines from music therapists who have written about this subject. She develops four categories

[727] McFerran and Lotter, 2024.

[728] Bruscia, 1987.

[729] Schwartz, 2019.

or forms of verbalization and conversation. The first category she calls verbal framing, and it refers to the words and verbalizations we must use when we lead and instruct clients. Here we use simple, clear, and focused language directed toward the situation, the room, and the immediate circumstances. We do not expect any response from the client here. Schwartz reminds us that clients have different cognitive abilities, and that we must adapt to what the client understands or take into account identity and cultural background.

As regards this first category, it is of course a matter of verbalizing, as we always must when we provide instructions or information about instruments and ways of playing. It involves establishing certain rules, setting boundaries, and creating a structure for what will happen in the session. It is here that we introduce ourselves, set the tone and create an atmosphere, provide guidelines for music-making, and define and describe the kinds of experiences that await.

Verbal Exchanges

In the first category, where we provide information and create a frame for the therapy session, this happens through one-way communication. We do not expect any answer to our information. What Schwartz calls verbal exchanges, however, concerns situations in which therapist and client exchange mutual information in response to the instructions that are given. Here too, the focus lies on the situation and the immediate circumstances.

It is in this exchange that we gather information about the client, answer questions, gain acceptance for our suggestions, and reach agreement about rules and procedures. These are central verbal exchanges for creating a clear, safe, and solid foundation on which to build therapy. As examples of this category of conversation, Schwartz mentions how we invite the client to enter the therapeutic space. There may be comments directed toward how the client perceives the room, how they feel today, and whether the client feels comfortable with the instruments.

Gathering information about the client is a sensitive process and requires attentiveness to boundaries. Furthermore, this conversation should lead to agreement about what the therapy is intended to address, what goals one has, and how the music-making helps the client.

This concerns responsibilities and obligations, everything that leads the client to give informed consent on the best possible basis. Not least, a conversation about boundary-setting will be important. Such boundaries relate to physical distance,

sensory experiences, musical taste and preferences, social conditions, emotional experiences, and spiritual or religious concerns.

In conversation it may be necessary to discuss the roles each person takes, for example in cases where someone leads and dominates too much. Or we may need to clarify who will guide the music and what each person expects from the other.

Verbal Interactions

When it comes to the third category, verbal interactions, verbalization is used to create and maintain a relationship and to share meaningful information about the musical experience. Conversation can communicate the social and emotional content related to the music, as well as provide feedback that reflects understanding of the communication or the responses that have emerged during the therapy session. The words and language the therapist uses relate to the conscious material that the client presents in the situation. Verbal interaction generally leads back to the musical activity to resolve challenges that may in turn lead further to verbal interventions.

We note that in this form of conversation, the words should not primarily concern external circumstances; rather, the focus shifts toward the self and the relationships connected to experiences of self. Interaction implies interplay, mutual action, and mutual influence. The contract now includes a shared understanding that the relationship should be personal and meaningful for the client. We are now within what Barbara Wheeler called insight-oriented music therapy with re-educative goals. Or on an augmentative or intensive level in Bruscia's taxonomy.

Music therapists who work with counseling use verbal techniques that involve asking questions and giving feedback, paraphrasing and summarizing what is said, writes Schwartz. They reflect on meaning and feelings, interpret, confront, disclose, use role-play, encourage, draw logical consequences, and carry out psychoeducational interventions. Within psychotherapy, it is important to create a therapeutic alliance, counteract social isolation, propose explanations, instill hope, and motivate change. Furthermore, one aims to activate resources, provide or correct affective experiences, work with emotional regulation and cognitive restructuring. One uses mentalization, behavior regulation, points to experiences of mastery and self-efficacy expectations, or creates new narratives and identity stories with existential themes.

Themes may concern how words help create and maintain a therapeutic relationship, for example where therapist and client experience that they share

interests and values. Empathy is another central theme, which Kenneth Bruscia has made concrete in his (musical) techniques through imitation, matching the client's tempo (pacing), and reflecting on what the client says (or plays). Respect is maintained through the way we use words.

We use words to create a connection ("I like jazz – what do you like?"). Boundaries of intimacy may be touched upon, and it is important to be aware of this and be clear about it. Words are also used to validate negative reactions toward the therapist and the situation (projections) ("I sense that you seem angry today; can we play that out in the music?"). Not least, we use words to share information about how we experience the music. This happens by pointing to details in the music. Themes that may be addressed include how the music came into being, possible physical reactions, social aspects, emotional responses connected to the musical experience, or spiritual or transpersonal experiences.

Overall, verbalization becomes central when it comes to communicating about the social and emotional content related to the music. By commenting on the music, the client is given an opportunity to discover and articulate thoughts and feelings about themselves and others. Here the therapist needs language to provide feedback, reflect on, and interpret the client's responses to the music. In that case, the music is the primary agent of change; it is the music that helps the client open and share. But since verbalization relates to one's own feelings and other people, it is a short step to the next category: verbal interventions.

Verbal Interventions

In this final category, verbal interventions, it is the words and language that are the primary agents of change. Here verbalization is designed to "process, uncover, explore, and confront therapeutic issues that lead to insight for the client," writes Schwartz. Here verbal interventions involve discussions around immediate experiences of both conscious and unconscious material that are brought up in conversation, either by the client or by the therapist. There is an exhortation here to be aware of one's own competence and one's ability to see and set boundaries: "Don't open the door if you are not ready to deal with what is behind it," as Schwartz puts it.

Whereas the earlier forms of verbalization were directed toward music as the primary therapeutic intervention, this will not be sufficient for some clients. It is the words and the cognitive implications of understanding oneself through language that lay the foundation for therapeutic change. It is here that the music therapist truly needs further training, whether in GIM, analytically oriented music therapy, or vocal psychotherapy.

Many people react to the term intervention. It evokes associations with power, hierarchy, and a passive client. Such possible connotations were what led Bruscia, in 2014, in the latest revision of *Defining Music Therapy*, to remove the term. He justified this by arguing that intervening did not belong in certain forms of music therapy. Therefore, he could not use it in a definition without excluding some forms of music therapy.

Schwartz has considered other terms for this category. She sees, for example, that processing has been proposed to designate such verbalizations. But this easily becomes such a broad and unclear definition that ambiguities arise when music therapists describe their practice in encounters with, for example, psychotherapists.

By using intervention as the term for this type of verbalization, it becomes clear that further education and specialization are required to work in this way. Even with a master's degree in music therapy, specialization and supervised practice will be necessary to work through language as the primary agent of change.

Intervening Techniques

The verbal techniques in question describe conversational forms in which one probes for information, reinforces, deepens, projects, uses role-play, describes and analyzes, reality-tests, uses free association, confronts, advises, connects, discloses, clarifies, summarizes, interprets, acknowledges, influences, and checks reactions.

By *connecting* words with musical experiences, one attends to relationships between actions, responses, events, feelings, and thoughts. Pointing out such connections is intended to give the client an aha-experience. What kinds of connections are involved will of course depend on the therapeutic orientation. This may concern whether the therapist is focused on unconscious experiences, as analytically oriented therapists are, or on unformulated life themes, as cognitive therapists tend to practice.

When one asks for more information, this requires that there is a good relationship of trust between therapist and client. Such probing may be uncomfortable for both client and therapist. *Clarifying* is another approach. Here one aims to make clearer and elaborate what has emerged ("could you please say a little more about that," "if you say a little more about this, we can explore it further"). Interpretation occurs when the therapist offers possible explanations for the client's problems. *Disclosing* occurs where the therapist reveals something about themselves ("sometimes I feel the same way"). Through *confrontation*, the

client is challenged when ambiguities arise regarding what the client is telling ("may I suggest a different explanation?").

Finally, we find *summarizing*, as an important synthetic verbalization. Here one summarizes what has been the focus and goal of the therapy, important therapeutic experiences, verbal and musical details, statements drawn from the other interventions, an emphasis on insights, therapeutic progress, and future plans for therapy.

Common Factors and the Therapeutic Relationship

Psychotherapy research has pointed out how the therapeutic relationship between user and therapist has decisive significance for the outcome of therapy. What are referred to as 'common factors' in treatment are those elements shared across different therapeutic approaches that contribute to the outcome of therapy. Even though methods and theories differ, such common factors may explain why a treatment is effective.

The most common common factors are therapeutic alliance, the patient's expectations and belief in the therapy, empathy and support, as well as the insight and awareness the user gains that contribute to self-understanding and change. The information the user receives about their own condition and help in handling their own challenges is important. Overall, such factors point to the fact that human and relational factors have a decisive influence on the result of therapy.

Power, (A)Symmetry, and Complementary Relationships

In the same way as other approaches, music therapy depends on meeting relational challenges. At the same time, music therapists have a working tool and some working forms that offer challenges and possibilities for creating a good relationship with users. It turns out that music therapists can create an alliance with patients who for a long time have shown resistance toward the health system and toward therapists.

One advantage music therapists have in certain contexts is that they come with a competence and a role that is not immediately identified with therapy. As "musicians" who invite participation in music-making, they shift the focus away from illness and symptoms and toward music and the competence the user

possesses. User experiences indicate that they experience the music as "a breathing space," a more natural way of being themselves, and as something that offers an opportunity to share feelings through the music. Music therapy makes it possible for the user to choose whether they want to remain more on the surface or go into deeper work with themselves and their feelings.

When music therapists improvise, a feeling of equality in roles easily arises. The interaction provides possibilities for symmetry in the relationship, a way of complementing one another in a musical dialogue. This has led to a shift of power from therapist to user. Nevertheless, we should not forget that the therapist, by virtue of carrying the therapeutic role, will always hold power through their participation in a larger team, in an institution, and within a helping system.

It must be added that, through their role as musician, band colleague, or educator, the music therapist must be aware of the borderland in which they find themselves. Standards have been developed for professional contact between helpers and users, not least to protect users. But we are dealing here with a borderland, where a music therapist may, through rich shared musical experiences, or through long-term work with clients and families, come very close to others.

We know that music therapists attend funerals after having worked with clients in palliative care, something that feels natural after long-term work with the patient and family. It may be natural to offer clients transportation to rehearsals and concerts. At times, the time spent together and the conversation in the rehearsal room may extend far beyond the allotted session time.

Music and health researcher Marie Skånland has pointed to some of the dilemmas that arise in such close therapist relationships after conducting qualitative interviews with music therapists in FACT. Relationships may be misunderstood, roles may become unclear, insecurity may arise for both patient and therapist, and responsibility for the therapy may become blurred. In this way, difficulties may arise in relation to ending the therapeutic relationship.[730]

[730] Marie Skånland, from a lecture in a FACT-seminar, January 18.2024.

PROFESSIONAL KNOWLEDGE

6

Professional Knowledge

In this chapter I will illuminate music therapy as a profession, with particular emphasis on professional identity, roles, and forms of collaboration. I will provide an overview of the various professional roles music therapists may have, and how these are shaped in encounters with different fields and practices.

Music therapists today work across a broad spectrum of contexts. Some music therapists work closely in relation to the role of the educator, whether as special educator or music educator. Others lead musical communities such as choirs, bands, or groups for collective music-making, and in such contexts may step into roles as performing or improvising musicians.

Some music therapists work in a more psychotherapeutically oriented way, for example with receptive approaches such as Guided Imagery and Music (GIM), or with verbal reflection and therapeutic conversation following improvisation or songwriting. Within community music therapy, we also find music therapists who function as project leaders, collaborators, and facilitators in local musical environments.

Furthermore, I will discuss the music therapist's role as collaborator, supervisor, and course leader, as well as questions related to professional boundaries and responsibility in relation to other music and health workers. In extension of this, ethical issues and professional ethical guidelines also become a central theme.

A Lifelong Path of Qualification[731]

Qualification for a profession occurs through a combination of formal education and practical experience. It involves not only identifying with a field of work and a profession but also seeing oneself as a professional practitioner. The qualification pathway is considered to begin when one enters a professional education program.

The researcher Kåre Heggen distinguishes between *professional identity* and *professional practitioner identity*. National music therapy associations should be responsible for safeguarding the identity of the profession, including its diversity of professional identities, theoretical foundations, musical and methodological approaches, and the ethical framework it upholds.

A professional practitioner identity, by contrast, refers to how the individual music therapist understands their own role and practice.[732] The following sections will therefore focus on the different professional practitioner identities of music therapists.

When we adopt an identity perspective on professional education, Heggen notes that this usually coincides with a period in life as adolescent/young adult, during which important identity work generally takes place. Researchers of the professions speak of anticipatory socialization. This refers to the fact that people aspiring to future membership in a group, or here a profession, often early on internalize values, skills, and knowledge in preparation for this future occupation. Many who choose the music therapy profession share a strong interest in music, as well as skill on an instrument. In addition, they hold values related to care and an interest in working with people.

For some, interest in music will be such a strong driving force that the wish to live as a musician or from music is dominant. Many music therapists have reached a professional level in their musical skills. They have performed in concerts, released music, and some still combine the role of musician with the profession of music therapist. For others, the musician's profession, with its ongoing competitive conditions in the market, is experienced as so overwhelming that they turn toward a profession with a fixed income. As music therapists, they confirm and live out their musical skills through their daily work. Some realize early on that they do not

[731] Much of this text is taken from Ruud (2022), the anniversary publication of the *Norwegian Association for Music Therapy*.
[732] Heggen, 2008.

identify with the musician role and are aware that the music therapy profession is precisely what they primarily want.

This mixture of social interest, values of care, and musical skills forms the starting point for the professional path the music therapy student embarks upon. This is a qualification trajectory that will last a lifetime. Learning and the development of professional identity continue after graduation, and competence is acquired in concrete contexts and social communities throughout one's working life.

Professional Identities

It is impossible to produce an exhaustive list of the skills, knowledge, and attitudes that define a music therapist in a way that resonates equally with everyone. However, by examining the subject descriptions across different music therapy training programs, as well as the priorities emphasized by professional organizations, a broad picture of the profession begins to emerge. This picture is not fixed; it varies from country to country depending on cultural and social conditions, the structure of healthcare systems, and the paradigmatic frameworks that shape understandings of therapy.

At a fundamental level, an approved education is required in order to call oneself a music therapist. Formal training at the bachelor's and, preferably, master's levels provide the foundation for professional identity, equipping practitioners with the competencies, perspectives, and ethical grounding necessary for responsible and effective practice.

If one were to suggest a provisional list of required skills, competencies, and responsibilities—with the assistance of AI—the following could serve as a starting point for further discussion.

> *Effective music therapy practice rests on a combination of strong musical ability, clinical and psychological knowledge, and well-developed therapeutic and interpersonal skills. These competencies are grounded in ethical, collaborative, and research-informed practice, ensuring that therapists can respond responsibly and effectively to diverse users' needs.*
>
> *At the core are solid music foundations. A therapist must possess a broad understanding of music, including theory, history, styles, and aural skills, alongside knowledge of musical cultural diversity. This includes awareness of different musical traditions, practices, and meanings across cultures, as well as a commitment to cultural humility in engaging with clients' musical identities.*

This knowledge is complemented by performance proficiency on a primary instrument or voice, along with experience in ensemble playing. In addition, functional musical skills are essential, such as basic competence in voice, piano, guitar, and percussion, as well as strong improvisational ability. Improvisation is central to music therapy, enabling the therapist to respond flexibly and creatively to clients in the moment, support emotional expression, and co-create meaningful musical interactions. Therapists are also expected to create and adapt music through composition, arranging, and songwriting, using these skills to help clients express themselves and shape therapeutic experiences. They also lead musical and movement-based experiences through conducting and guided activities.

Equally important are clinical foundations. Music therapists draw on therapeutic knowledge that includes an understanding of various conditions, human development, basic neuroscience, and a sociological perspective on health and wellbeing. This involves a foundational understanding of how structural forces in society—such as inequality, marginalization, discrimination, and access to resources—can contribute to mental health challenges and disabilities. Such awareness supports a more holistic view of clients' experiences beyond individual pathology. Therapists apply key therapy principles, such as building effective client relationships, understanding group dynamics, and working within major therapeutic approaches. Central to this is the therapeutic relationship itself, which requires self-awareness, empathy, strong communication skills, and cultural sensitivity, supported by an attitude of cultural humility.

In practice, music therapists integrate their musical, clinical, and sociological understanding to support clients in meaningful ways. This includes knowledge of music therapy methods, as well as an understanding of the psychological and physiological effects of music and the use of relevant technology. Therapists assess clients' needs, strengths, and musical abilities within their broader life contexts, interpret and communicate assessment findings, and set appropriate goals. They design and deliver music-based services, often drawing on improvisation and songwriting to adapt in real time to client responses, and to support engagement, identity, and communication throughout sessions. Ongoing responsibilities include monitoring progress, adjusting treatment plans, ensuring client safety, maintaining accurate documentation, and planning appropriate endings to therapy, while remaining attentive to social and environmental factors that may influence outcomes.

Finally, ethical and professional responsibilities underpin all aspects of the role. Music therapists are expected to follow ethical standards, legal requirements, and principles of cultural competence. They demonstrate accountability, professionalism, and self-awareness while working effectively within interdisciplinary teams. Their role also involves engaging in supervision, managing resources, handling administrative tasks, and integrating research into practice through an evidence-based approach. This includes developing research skills such as critical appraisal, data collection, and evaluation, as well as an understanding of philosophies of science, which support reflective, rigorous, and theoretically grounded practice. A sociological underpinning further strengthens the discipline by encouraging critical reflection on power, context, and equity in both research and clinical work.

The Many Roles of the Music Therapist

There are many roles, tasks, and forms of collaboration that a music therapist encounters. Here, I will briefly discuss some of the occupational, or professional, identities that characterize the field. A useful starting point for examining these roles is the distinction between the music therapist as caregiver, educator/musician/instructor, and (psycho)therapist. Exploring these distinctions can help clarify the values embedded within each role, while also highlighting how these values and roles may evolve over time.

Within this complex interplay of knowledge, experiences, attitudes, activities, and principles lies the foundation for what can be described as an identity profile for music therapists. It is important to recognize that two types of identity are at play when examining the various roles, practices, fields of work, and treatment ideologies that together define the profession of music therapy and the occupational role of the music therapist. These include both a professional identity and a practitioner identity, each of which has developed and transformed over the past decades.[733]

Music Educator or Music Therapist?

Several music therapists have backgrounds as musicians and music educators. Distinguishing music therapists from music educators is not always easy, especially in situations where the work takes place in an educational context, or where

[733] Heggen, 2008.

music instruction is a natural part of providing experiences of mastery to pupils and users.

One way of distinguishing the two has been to emphasize that music therapy has different goals from music education. It has been pointed out that the music therapist has special educational goals such as strengthening different aspects of children's development—social, linguistic, motor, emotional, and communicative. This clearly pupil-centered attitude, however, is not always sufficient to distinguish the two disciplines of music therapy and music education from each other. This is because many music educators work from clearly pupil-centered goals. The fact that there also exists an "educational music therapy" creates further ambiguity in role understanding. With the emergence of the field of community music, the distinction between the disciplines has in many situations become more difficult to maintain, also because community music may resemble community music therapy.

Taking Norway as an example, the situation in the 1970s—when music therapy was becoming established—was that many children with disabilities lacked access to music education. This created fertile ground for a reform movement aimed at lowering barriers to participation in music-making. The goal was to promote a more process-oriented approach to music education and, ultimately, to position music and cultural life as arenas for integration. These ideas were later carried forward in what became known as the Responsibility Reform.

Through their education, methodologies, attitudes, and knowledge, music therapists were well positioned to respond to these shifts in cultural policy and evolving perspectives on the rights of people with disabilities. They were able to offer courses, develop working methods, and implement local solutions that supported integration. In doing so, they entered a field of practice to which music educators, musicians, and other professions had not adequately responded.

Establishing clear boundaries between the roles of music therapist and music teacher is neither always possible nor necessarily desirable. In some contexts, music educators may work toward health-related goals, just as music therapists may provide instruction in music and instrumental performance. Likewise, there are instances of music education that are so strongly product-oriented and focused on professionalization that students' well-being may be compromised. At the same time, music therapists often aim to facilitate meaningful musical experiences, incorporating ecological adaptations to align with local aesthetic norms.

In the 2000s, changes occurred in roles and ideologies both within music education and in music therapy in Norway. With the emergence of community

music therapy and with theories from recovery philosophy, user-directed and medication-free approaches as a backdrop, the role of the music therapist moved in the direction of the musician, music instructor, and music educator role. At the same time, the emerging field within music education, community music, has emphasized musical practices outside the classroom and institutionalized music instruction. Goals here relate to identity development and local belonging. These educators may share views with therapists on the concepts of music and health. Some also have relevant experience, continuing education, or a health-related background. This can create uncertainty around the communication of professional identity. We may also ask whether professional role has become dependent on education and degree, rather than real competence.

We saw in an earlier chapter how music therapists have regarded the school as a natural arena for music therapy work. Here they use their competence within the ordinary school day, in work to improve the classroom environment, or as a service for pupils with challenges. By extending music therapy from music teaching, and by emphasizing a goal that regards the promotion of well-being and personal development as a central task of the music subject, the health aspect of the music therapy profession is strengthened. This is also in line with the aims of the new life-skills subject in school.

The Music Therapist in Individually Adapted Education

We have seen that there are many shared tasks connected to collaboration between the music therapist and other professions in a special school or class. What was previously called special education has now been replaced with the expression individually adapted education. When music therapists work with language development and motor skills, develop social and communicative competence among pupils, or stimulate emotional development, they quickly move into the domain of the special educator or physiotherapist. We have seen how this is addressed through good forms of collaboration. At the same time, we see that the roles music therapists take within the field of special education assume a hybrid form. The music therapist may provide supportive measures relating to a range of the developmental areas the child goes through.

The Care Worker

Music therapists who work within the somatic health field, whether in institutions for older adults or on hospital wards, will have their role shaped in interaction with

nurses and physicians within a curative and often biomedically influenced environment. When the aims of music therapy are not curative or educational, the care the music therapist provides becomes particularly important. A good example is found when music therapists assist supportively during medical procedures with children. Musical care work for children in hospital also includes working to release the child's thoughts and feelings through songwriting and creating an environment on the wards in which the child experiences distraction, creativity, and mastery. The caregiving role is also evident in the music therapist's work with older adult health.

The Music Therapist in (Music)Psychotherapeutic Work

For most people hearing about music therapy for the first time, it is natural to think about music's emotional effects. Ideas of how music regulates emotions and energy, triggers associations and thoughts, and contributes to personal well-being are rooted in historical and cultural ideas about the functions of music. We have seen that music and psychotherapy, or music as psychotherapy, belong within several music therapy arenas. How, or how broadly, we define psychotherapy will, however, help determine how this affects the role of the music therapist.

If we say that psychotherapy aims to influence identity, emotions, and relationship formation, we see that it is difficult to work as a music therapist without such issues being touched upon. In all therapeutic relationships, the relationship itself between therapist, client, pupil, or user will be important for the outcome of therapy. At this level, psychotherapeutic aspects of the music therapist's role will always be present.

Music therapists who work with people experiencing psychological challenges must relate to the psychotherapeutic domain. We are here faced with a boundary issue between, for example, psychologists, who are trained in talk therapy, and a music therapist, who primarily uses musical interventions or interactions. The character of psychotherapy will depend on the working methods the music therapist chooses and on the level at which one wishes to collaborate or intervene. The therapy may be supportive, transformative, or insight-oriented. The therapist's background, continuing education, and experience will play an important role in the choice of how to conduct the therapy.

It is difficult to work with individual improvisation without touching on matters of a personal nature rooted in the therapeutic contract. Songwriting is another approach that easily leads to themes originating in lived life shaping the music therapeutic processes.

Those working within a band format, using a recovery-oriented or user-directed approach, may focus on fostering mastery, social networks, and empowerment, as well as emotional and relational insight. Experiences from community music therapy grounded in a trauma-informed approach indicate that this practice can help establish stable relationships over time. Furthermore, a sense of safety developed within these relationships can positively impact psychological challenges.

There are within music therapy approaches that build on analytic theory. We see that in many countries the music therapy profession is tied more closely to psychotherapy in one form or another. What perhaps comes closest to a psychotherapeutic approach in music therapy in some countries is the presence of receptive music therapy such as Guided Imagery and Music (GIM). Here, the aim is precisely to assist a "music journey" in which bodily sensations, associations, thoughts, and feelings are linked to work with personal growth and mental health.

Cultural Worker, Cultural and Project Leader

Music therapy is not only about therapy in the sense of curative work but also encompasses health-promoting and preventive activity. When health involves creating possibilities for action, in the sense of helping people advance vital goals in life, opportunities arise for cultural means to positively influence people's life situations. It is here that we see the significance of preventive and health-promoting measures and where new roles for the music therapist are needed.

The role of the supervisor was clearly articulated by Brynjulf Stige when he outlined connections between an alternative concept of health and emerging tasks for the music therapist.[734] In his discussion of health—particularly through a critical lens on a one-sided biomedical model—Stige emphasized the importance of preventive work and health promotion.

Importantly, the growing integration of culture and health has introduced a health-promoting approach that requires the development of new types of projects. Within these contexts, music therapists have increasingly taken on roles as project leaders, supervisors, advisers, or consultants. Thus, the music therapist as supervisor and project leader has emerged from a shift in practice grounded in a broader understanding of the value of health-promoting cultural work.

Two examples may illustrate this trend. The music therapist Kari Aftret has provided clear examples of how a municipal music therapist combines clinical practice with

[734] Stige, 2001.

responsibilities as a project leader. Within her local community, she has used music in work with children, young people, and adults, both with and without disabilities. Many of these initiatives involve the development of projects that can achieve lasting value within the municipality.

One such initiative is the interdisciplinary and interdepartmental project *Music at the Beginning of Life*, in which the health station, the school sector, and the cultural sector collaborated. The aim was to use music to promote interaction and togetherness between parents and children, as well as to support and preserve local singing and musical traditions through the sharing of folk music, rhymes, and chants.

The role of project leader was further challenged when Aftret took responsibility for music teaching in a small village school. She understands these initiatives as health-promoting efforts shaped by ecological thinking. Although the municipality emphasizes interdisciplinary collaboration, responsibility for follow-up is often unclear. "Within this context, the music therapist bears the mark of being a project leader—someone who works across boundaries and draws on knowledge from pedagogy, psychology, health, and culture to include all people within a musical community," writes Aftret.[735]

In the same way that Trygve Aasgaard envisioned the whole hospital ward as an ecological context, Aftret sees a village school, a choir, a music and culture school, or an entire municipality as forming such ecological units. Even if the music therapist is not always working with therapeutic goals, we still see the value in this work if we adopt a health-promoting view of the projects. This is what today we could call public health work through music.

Cultural Leader

The position of cultural leader in institutions for older adults is also held by music therapists. Such a position involves bringing in performers for different events, alongside personally singing and playing in the house daily or carrying out music therapy tasks. The music therapist as cultural leader may organize common programs and communicate these to all departments. Such an offer may, for example, consist of communal singing on wards for people with memory challenges. Different cultural elements with various themes can inspire and motivate togetherness. Regular concerts in the house are a fine way to gather everyone and close the week.[736]

[735] Aftret, 2002, p. 17.
[736] Kirkaas, 2006.

Milieu Worker

Several pioneers in music therapy worked with children and young people with psychological disabilities from the 1950s onward. As this group of children and young people became more integrated into the wider society and ordinary school classes, much of the basis for a therapeutic approach disappeared. In Norway, the large county institutions were decided to be phased out under the Responsibility Reform in 1991, and over the years music therapists have encountered the children within the school system and culture schools.

Some people with intellectual disabilities, however, have such great challenges that they must live in institutions and be cared for by health personnel, social educators, and milieu workers. They may have challenges related to mental health that manifest as anxiety, withdrawal, psychological episodes, and aggression. Brynjulf Stige has illustrated the music therapist's role in milieu work aimed at meeting users with major mental health challenges.[737]

> *In this constructed narrative about a young man with an intellectual disability, the music therapist assumes an important role in collaboration with a social educator. In this case, the individual has experienced psychotic episodes, is often reluctant to participate in communal activities, and shows signs of withdrawal. Efforts by social educators to encourage participation have been unsuccessful, as he tends to isolate himself.*
>
> *The municipality has employed a music therapist, and the institution reaches out to initiate collaboration around this individual. The music therapist works together with the social educator to map his musical preferences. At the same time, the social educator is encouraged and supported in using singing as a way to connect with him, which contributes to improved communication and cooperation.*
>
> *The music therapist also works with the man in his apartment, gradually motivating him to participate in a music workshop involving group-based activities. Over time, he accepts the invitation to join the music group and becomes an active participant in group improvisation and ensemble playing.*

This example illustrates the value of collaboration and how the musical resources of other professional groups can be stimulated. Here music therapists have an important role to play in the environment by supporting and making use of the musical skills possessed by staff. This is especially important because the music therapist often participates only on a weekly basis, whereas staff have daily contact with the users.

[737] Summary after Stige, 2022.

Music Therapist and Musician

Several music therapists can point to a professional background as performing musicians. They come from rock bands, classical orchestras, jazz and folk music, or as popular music artists. They have skills in composition and arranging, and experience with studio production. In the encounter with music therapy studies and the role of music therapist, this musician identity is challenged. Dilemmas arise when a career must be set aside or put on hold. It creates practical problems to continue two parallel careers. But we also see that the two occupational roles can enrich each other. The musician is challenged by the therapist and inspired toward musical development and not least reflective communication. A strong musician identity also gives a musical security that is a strength in daily encounters with users.

Music therapists, in collaboration with students, have carried out several projects in which they communicate music in institutions, at festivals, or during major arts festivals. This occurs in interaction with musicians or music students who primarily aim to become performing musicians. Music therapist and senior lecturer Bente Almås has led music projects with inmates in different prisons and at a police immigration detention center, which is documented in her book *Voices from the Inside*.[738]

The Music Therapist in Private Practice

There are many challenges associated with running a private practice as a music therapist. These concern financing, marketing, and access to administrative, legal, and financial expertise. A private practice music therapist needs suitable premises with equipment and instruments, office facilities, and the financial backbone to bear costs while building up the practice. "Being able to cover investment costs, rent, accountant, legal help, pension costs, and administration requires a financial surplus that in turn requires considerable income/resources," writes music therapist Henning Bøgh.[739] Others have found a simpler way to organize themselves by creating a sole proprietorship.

Another Profession + Music Therapy

Since admission to music therapy programs may require or allow prior education before entering a master's degree, many music therapists have dual professional

[738] Almås and Gimmestad, 2020.
[739] Bøgh, 2002.

affiliations. For example, they may have backgrounds as nurses or preschool teachers before pursuing music therapy studies. In some cases, knowledge from these professions is integrated, adding an extra dimension to their professional role.

This dual identity can also provide access to practice settings that might not otherwise be immediately available to music therapists. For instance, those with a nursing background may find opportunities to work in palliative care or with cancer patients. Similarly, some physicians have combined medical and musical expertise with a commitment to music therapy or have developed extensive experience applying music therapy methods in their daily clinical practice.

Communicator, Consultant, Educator, and Researcher

Several music therapists early on entered the role of course leaders, as teachers in music therapy both on the methodological and theoretical side. They are also used as consultants to provide advice on the use of music. Some enter the role of researcher and eventually become further specialized as research supervisors.

The Music Therapist as Collaborator, Supervisor, and Course Leader

We can create a false impression of the professional role of the music therapist if we only imagine a music therapist working alone. In a great many contexts, the music therapist works in a team and collaborates with other professionals from other professions. Or the music therapist collaborates with parents, relatives, families, people close to the users—and not least with the users themselves. The music therapist is often supported by assistants who accompany the users, or by students on placement. In order to communicate their field to other staff, the music therapist will often give presentations. In many cases, it is desirable that the music therapist train other staff in singing and musical activities. This can enrich the environment and give users continuous access to music adapted to their needs.

Interdisciplinary, Multidisciplinary, and Shared-Disciplinary

Music therapists must relate to multidisciplinarity, interdisciplinarity, and shared-disciplinarity. As regards multidisciplinarity, professional groups work alongside one another with strongly separate disciplinary areas, often with a hierarchical

relationship between groups. Interdisciplinarity involves an engaged gathering around a shared project, a common standpoint where one seeks to reach decisions by consensus. There is an integration of the foundations and new knowledge of other professional groups, creating a shared body of knowledge. Shared-disciplinarity is found where the professional groups possess shared knowledge and understanding, tasks are delegated, there is a strong focus on a holistic perspective, and shared responsibility is a central concern.[740]

Music therapists Ruth Eckhoff has elaborated her view of interdisciplinary collaboration in an article where she reports from her work with stroke patients on an acute medical hospital ward.[741] She operates with the concepts of interdisciplinary, multidisciplinary, and multidisciplinary-collaborative work and discusses different levels of collaboration.

At the lowest level, professionals from many different professions and fields are employed. At this level, one works separately within one's own field in a form of work column. At the next level, there is more willingness to collaborate, a positive tone among staff, but for the most part one still works separately. Characteristically, some speak while others remain silent, writes Eckhoff. The collaborative process is to a small extent itself a topic for discussion, and we are speaking about multidisciplinary collaboration with weak integration.

At the third level, one is less concerned with one's own profession and discipline. One engages actively in learning from one another and encourages and acknowledges each other's work. Measures are coordinated, and one ensures that the measures reach the patients at the right time. Eckhoff further writes that such collaboration is based on the idea that professionals need one another to see patients with sufficient nuance. One recognizes that one needs one another for confirmation and reciprocity on a personal level. Such a level of collaboration Eckhoff calls grounded collegiality, after the gestalt therapist Hilarion Petzold. In such a collaborative climate, emergent phenomena may occur, that is, new and good solutions and insights arise and reach a new level. Here we speak of a strong degree of professional integration.

In connection with a discussion about recognition of music therapy as a profession, we may bring in the significance of this interdisciplinary collaboration. Music therapist, child welfare pedagogue, and associate professor Ingelill Eide points to research within professional theory on the importance of informing, collaborating with, and "educating" colleagues in music therapeutic methods and ways of

[740] Berger, 2007.
[741] Eckhoff, 2007.

thinking. This should not only increase awareness of music therapy but also change the mindsets that interpret music therapeutic actions. This can occur in encounter with the values, belief systems, and interpretive modes that constitute the institutional logic prevailing in the workplace.[742]

Collaborator

Music therapist, psychologist, and associate professor Unni Tanum Johns early on addressed the question of the music therapist as collaborator in an interdisciplinary team. Johns describes challenges she encountered related to working in a team as a music therapist together with, among others, physiotherapists, speech therapists, psychologists, and special educators. The experiences she describes still remain relevant, not only within special education but also in other fields of work.[743]

Johns first describes the necessity of professional confidence and identity, awareness of one's own function, solid theoretical and practical-methodological grounding in the field, and a critical and professional attitude toward the field and oneself. Collaboration within the team is emphasized. At the same time, there is a challenge in wishing to perceive oneself as unique, in the sense that "only I can do what I do." She writes:

> *Do the others in the professional team feel that the music therapist is stomping with seven-league boots into their areas? She works with music as a means toward better body awareness and motor skills (the physiotherapist's area?), activities of daily living training (the occupational therapist's area?), language development (the speech therapist's role?), concept training and concentration training (the special educator's area?), and so on. But this applies to all the members of the team. The educator treads in the psychologist's flowerbed when she is concerned with social and emotional blocks to learning or family dynamics problems.*[744]

In addition to this hybrid occupational identity, which easily characterizes a music therapist, Johns points out that the music therapist's medium, namely music, may be difficult for others to relate to. This is because music has an aesthetic dimension to which everyone has a subjective relationship, and which is moreover difficult to communicate verbally. This challenge may be addressed by inviting observation behind one-way mirrors or using audio recordings and video. Oral communication

[742] Eide, 2020.
[743] Johns, 1978.
[744] Johns, 1978, p. 17.

of music therapy encounters difficulties because of a lack of specific theoretical basic concepts. Variation may be great, depending on where one works.

When collaboration is the subject, we should also not forget how the client, parents, and relatives are important collaborators for the music therapist. It is parents or relatives who most often know the musical codes, repertoire, or musical taste of the users that music therapists encounter.

The Music Therapist as Supervisor

Too few music therapists are trained relative to the need. Therefore, several music therapists have made use of their competence in observation, interaction, and communication to guide parents and other educators and helpers in their daily dealings with users. Or they may offer courses and training in music for staff at institutions for older adults.

"Supervision" is a term with many meanings and is used in different ways depending on professional standpoint and field of work. Related concepts are consultation, counseling, and supervision in the stricter sense, all with somewhat different meanings. In what follows, supervision is used as an overarching term.

Guidance of other collaborators, assistants, and staff at the institutions where music therapists work, and not least supervision of students on placement, are tasks many music therapists encounter. Informational work is important, as is determining which parts of the music therapist's tasks may possibly be transferred to other staff. When music therapists work with users who are accompanied by an assistant, special challenges arise regarding supervision.

So-called model teaching takes many forms and is used in several situations. An example is when music therapists enter health clinics or work to encourage parents to sing to their newborn child. Work with music and children with disabilities has taught music therapists much about the importance of music for normal infant development. Health clinics may, for example, offer music groups that provide training in forgotten singing traditions. The health clinic, in an expanded sense of "health," can become a meeting place between cultural and health workers. Not merely a place where health is monitored, but where the foundation for health, development, and quality of life is laid.

One reason why the supervisory role becomes important for the music therapist is that it is beneficial to guide parents and staff while at the same time working directly with the child. Research shows the significance of a both-and perspective

by involving everyone around the child. Music therapists often think systemically, that is, causes of both development and problems do not lie only "within" the individual child. It is a matter of strengthening the transactions between the child and the environment.

We exist in reciprocal relationships within systems of human interaction. A child who does not take the initiative to sing may, for example, be stimulated daily by parents and staff. At the same time, a music therapist can help foster the child's musical initiative and enjoyment. This, in turn, can stimulate and influence the caregiver's own initiative and joy in engaging in musical activities with the child.

In this way, it becomes essential that those around the child experience meaning in musical interaction. It is not always sufficient for the music therapist, as a "music expert," to sing and play with the child once a week if the surrounding environment does not receive guidance and support to participate actively.[745] This perspective applies not only to work with children receiving individually adapted education, but also, for example, to work with older adults in institutional settings.

The Marte Meo Method

Music therapists use recognized methods from other professions. One example is the use of the Marte Meo method, where one films the person being supervised together with the target person.[746] One then analyzes the film in the light of certain developmental psychological principles. This may concern the significance of establishing eye contact and following the child's initiative. It is important to name and speak in an accepting way about what the child experiences or is occupied with. The form of communication should have a dialogic quality, and one should respond to desirable behavior by imitating it, praising it, or commenting on it with an accepting voice and attitude. One should confirm that what the child wished to communicate has been perceived and understood. The supervisor should help create as good an emotional atmosphere as possible to communicate joy and positive feelings.

Through the Marte Meo method the focus shifts toward the parents' way of interacting with the child, and that the music therapist directs attention to the good interactions that are elicited.[747] The emphasis is not on mastery and copying as such, and no new skills are simply transferred. The person being supervised is to be supported through the supervisor's verbalization of positive elements in the

[745] Thanks to Unni Johns for input in this section.
[746] Isene, 2007.
[747] Isene, 2007.

interaction. The music therapist wishes to strengthen the quality of communication between the person being supervised and the target person by creating shared attention and establishing intersubjectivity.[748]

Supervising Assistants

Supervision is fundamentally a matter of attitude, write music therapists Anne Torunn Eggen and Siri Johansen.[749] They have expectations of assistants and want to be good role models. They want to demonstrate how they wish assistants to be together with the pupils. But it is not enough merely to show; they must verbally explain what they do, what they think, and why something should be done in a particular way. They want to develop thinking and reflective assistants and encourage questions. They want to be clear about their areas of responsibility, and here collaboration through regular conversations and staff meetings becomes important. They have arranged evening meetings and used role-play to clarify their working methods. During sessions, therefore, the task is not only to observe the pupils, but also to observe the adults participating in the activities and to be clear about what is expected of them.

Among the positive attitudes and skills important for the assistant who accompanies are knowledge of the goals for the pupil in the session. Furthermore, emphasis is placed on being psychologically present here and now, being equal partners in the activity, attuning to the pupil while remaining grounded in oneself. Assistants are encouraged to be sensitive and responsive toward the pupil and the person leading the activities, to focus on the pupil's resources, and to have an enthusiastic attitude toward the sessions. Assistants should understand that the music and/or movement guides the session, that as little spoken language as possible is used, and know when to hand-guide or lead. It is important that assistants understand that they are natural role models for the pupil, and that they know and follow procedures for handling challenging behavior.[750]

The Music Therapist as Practice Teacher

Another aspect of the supervisory task is found where the music therapist steps into the role of practice teacher.[751] Music therapist Merete Lippert Tobiassen

[748] Isene, 2007.
[749] Eggen and Johansen, 2004.
[750] Roaldsnes, Tobiassen and Wold, 2011.
[751] Arnesen, 2005.

describes practice teaching—that is, the instruction and learning process that takes place at the students' placement sites under the guidance of music therapists—as a form of apprenticeship.

This old tradition in so-called non-scholastic learning experienced a renaissance at the end of the twentieth century and was relaunched within nursing, teacher education, sports, and not least within music education, that is, instrumental teaching.

Apprenticeship draws its theoretical basis from situated learning theories. Situated learning means learning that takes place by participating in different social situations. It is learning through participation in a community of practice with mutual obligations between master and apprentice. At the same time, it is learning intended to abolish or reduce the distinction between *know what* and *know how*. Skills learning is a form of acquisition of "tacit knowledge."

Four concepts are brought in when such learning processes are described, and these become relevant when the music therapy student receives practice education: *model learning*, where the apprentice observes the music therapist. Furthermore, *scaffolding* is used, where the student receives support and feedback from the practice teacher when carrying out activities. *Fading* means that the "master" gradually withdraws and the student is given increased responsibility. *Coaching* takes place throughout the process, where the practice teacher chooses tasks, clarifies strategies, evaluates work, diagnoses problems, and in this way maintains oversight of the learning process.

Included in this picture is the fact that views of model learning have changed. For a period, one feared that modeling could imply a kind of unreflective copying. "Reflection on action" was introduced as a measure, as we saw above when Eggen and Johansen described their experiences with supervising assistants. Tobiassen supports a combination of model learning and reflection. Tobiassen draws on Dreyfus and Dreyfus's theory of stages in the acquisition of skills. Here we see a development from novice and advanced beginner to increasing competence and proficiency. Eventually expertise is achieved, and in some cases perhaps innovation.

Indirect Music Therapy

Indirect music therapy concerns the roles music therapists take when they teach, advise, and supervise. This may involve guidance and counseling to other staff at the institution, supervision of assistants, course activities, practice supervision of

music therapy students, or where different forms of model learning take place, for example for relatives.

Music therapist and associate professor Tone Sæther Kvamme has provided a good example of a course program for health workers in an institution for older adults. Such a course would contain several sessions and introduce why music is a helpful tool in work with people with dementia and how to find each patient's musical preferences. One session may be devoted to how one works and in what ways one documents the effect. An important theme is how to implement music into daily life and routines at the workplace. Not least, it is important that the course offers the possibility of follow-up and supervision by a music therapist.[752]

Another example is given below, where a music therapist and choir leader shows how she transfers her knowledge of choir leadership for patients with chronic respiratory illness to music educators and choir conductors.

> *Phoene Cave has broad expertise as a music therapist, singing teacher, and choir conductor. She has experience leading choirs for patients with chronic respiratory diseases and is well equipped to train other choir leaders to undertake similar work. Her experience suggests that some musicians face challenges in providing constructive feedback, particularly when their training has emphasized technically polished performances. She also notes that while singers may be well trained in vocal technique, they often have limited knowledge of voice anatomy and physiology.*
>
> *When working with patients with chronic respiratory disease, patience and empathy are essential, along with trust, strong commitment, and a clear understanding of one's practice. Detailed knowledge of the voice and respiratory systems is important. At the same time, practitioners must be aware of their own breathing and vocal mechanisms in order to better understand those of choir participants. A broad repertoire and a well-structured rehearsal plan are also necessary. Repertoire should include phrasing of an appropriate length to support breathing. Such attitudes and knowledge can be effectively conveyed through training courses and observation.*[753]

[752] Kvamme, 2020.
[753] Summary after Higgins and Willingham, 2017, p. 113; Ruud, 2020, p. 204.

Roles and Boundary Setting

In all contexts in which the music therapist operates, issues arise such as the relationship between therapist and user, situations requiring reflective adaptation, and awareness of boundaries. Such boundaries involve ethical issues and touch on themes such as where the therapy takes place (office, clinic, rehearsal room, performance arena), how the therapy is to begin and end, how long sessions should last, and whether therapy takes place individually or in groups. Reflection around boundaries includes themes such as the use of physical touch and distance to the user, how personal the therapist should be in sharing their own experiences, or what kind of clothes one should wear.[754]

It is important to reflect on cultural differences in encounters with people from other cultural backgrounds. It is necessary to think through norms that protect the users' personal and cultural integrity. In some cultures, the therapist's role may take the form of being a friend or a family member. Roles are challenged when the therapist meets users outside the therapeutic context. How one relates to gifts is another relevant theme, or whether one should share transport to and from concerts and sessions. Similar challenges apply to whether the therapist should participate in ceremonies important to the user or the family. Sometimes the music therapist is asked to play at the funeral of patients, something that must be weighed in each individual case.[755]

A Reflective Practitioner

Traditionally, the knowledge base of music therapy has been linked to the music therapist's knowledge of service users, the choice of working methods, musical skills, and related areas. In recent years, however, music therapists have increasingly focused on knowledge, attitudes, and competencies shared with other health professionals, or those that form an important part of general education. This may include developing greater awareness of social and cultural conditions that affect clients and may limit their possibilities for action.

The starting point for reflective practice is the choices that must be made in a therapeutic situation.[756] These relate to goals, working methods, theoretical positions, forms of evaluation, and so on. Reflective practice involves the ability to examine and reflect on practice to respond as well as possible to the client's

[754] Singh, 2022.
[755] Singh, 2022, p. 252–257.
[756] See Heiderscheit and Jackson (Ed.), 2023.

needs and wishes. We must learn to ask the right questions to help us in the process of reflection. Such reflective questions concern what we ask before the session, in the planning itself. Or during the session, where we read the client's reactions and, for example, may need to assess whether we should change activity. After the session, we ask whether something special happened, whether certain moments were important to build further on. We ask whether there are other needs that should be addressed, whether we should introduce new working methods, and so forth.

Reflective practice involves understanding the strengths, competence, musical preferences, cultural background, identity, and intersectional conditions that characterize the client. Everything from gender, ethnicity, age, language, religion, social class, sexual orientation, mental and physical health, and more comes under consideration. The therapist asks how contextual conditions affect the therapy and the choices that must be made. Choices are made based on the responses emerging in the session, how the therapeutic relationship develops, what becomes visible through the music, how my values influence the course, the significance of my own theoretical affiliation, and not least my own clinical experience.

The questions we ask ourselves are meant to increase awareness around the choices made. This becomes an exercise in critical thinking, observation, interpretation, evaluation, and explanation. At the same time, it leads to a deeper engagement with the client. The therapist must train themselves in self-observation and in asking questions about their own practice. In addition, it is important to engage the user in giving feedback, taking responsibility, and owning the process—what we call user participation. Conversations with colleagues are part of the reflective process, and supervision provides an important contribution.

Included in this reflection are the themes followed up in critical music therapy. Here one must consider how intersectionality, diversity competence, microaggression, ableism, gender studies, and other themes related to oppressive practices influence our own practice.

Collaboration and Delimitation

Some questions that naturally arise when music, health, and therapy are the subject relate to the difference between various professional approaches. What is the difference between a music therapist and a music and health worker? Or what distinguishes music therapists from other occupational groups and professions that use music to promote therapeutic or health-related aims?

Different Levels of Music Use

We ask whether music therapists always have the same ambitions and goals for their work. Earlier, in connection with the use of verbal language in therapy, we saw how the American music therapist Kenneth Bruscia operates with a hierarchy of levels when describing situations in which music appears in health work.[757] At the periphery of music therapeutic practice we find a type of music use Bruscia places at an *auxiliary level.* This is a use of music where neither goals, working methods, nor relationships between user and musical caregiver qualify to be described as therapeutic.

The use of music is not part of a strategy to create change in the recipient, who is moreover not defined as a "client" in this situation. Nor is the person offering music defined as a "therapist." Examples of such music use are found where people with disabilities receive music instruction, as well as in personal use of music for recreation, reducing stress, relaxing, or counteracting loneliness, and so forth, writes Bruscia.[758]

To this latter point, we see that even though such personal music use falls outside music therapeutic practice and professional activity, it is still important to include it within the discipline of music and health. Seen from a public health perspective, as we saw earlier, it becomes important to highlight the value of personal music use for regulating feelings and bodily states or using music as a social resource that has health-promoting effects. Nor should we underestimate the significance of the musical entertainment often offered to older adults in institutions. These represent important breaks from institutional routines and offer social contact and experiences of community.

Bruscia's next level is referred to as *augmentative*. Here music is used to reinforce the effect of another type of treatment and to support the client's health. This concerns users receiving musical services within an educational or therapeutic setting, or the use of music to support the user's personal development. This means that music therapy occurs within the framework of goals formulated by other helping professions and, through its contribution, plays a supportive and important role. This involves using the client's resources, making use of music's non-verbal advantages, or using music as reinforcement. Examples of music therapy at this level are the use of music as support during medical procedures, to promote developmental psychological goals related to language development, social behavior, motor development, emotional regulation, and more.

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[757] Bruscia, 2014, p. 207–209.
[758] Bruscia, 2014, p. 207.

At an *intensive level*, we find a practice where music therapy has a central role. Music therapy is directed toward the client's primary health-related goals and results in a significant change in the client's health condition. Here the music therapist works on equal footing with other therapists or as a primary caregiver and therapist. This level may be compared to a re-educative level where the client undergoes intensive supportive treatment and learns new ways of solving problems. Examples of music therapy at this level are music therapy that improves family relationships, the use of music to change the individual and their relationship to the community, insight-oriented music psychotherapy, the use of music to meet biopsychosocial and spiritual needs among patients under medical treatment, or for users needing support in relation to developmental challenges.

The final level Bruscia describes he calls the *primary level*. Here we are dealing with reconstructive treatment, where music therapy plays an indispensable role in meeting the client's therapeutic needs, and where an extensive change occurs in the client's life and health condition. The change is to have consequences beyond the primary goal. For example, changes in self-perception and social skills will have consequences for the client's participation in society and integration into social networks.

Borderlands and Delimitation

If we look at the many roles and forms of professional identity that music therapists seek to uphold, a question of jurisdiction arises. That is, who has the right to administer a particular body of knowledge, skill, or competence. It is not only the case that music therapists have moved into fields of work where other professions have traditionally operated. Rather, music therapists have in recent times been challenged by other professional groups making use of music within the practice of their own professions.

Within the postcolonial discourse on music therapy, it is also emphasized how music therapy, when encountering traditional music and healing traditions among Indigenous peoples and various cultural groups, must find forms of collaboration that consider users' often ancient traditions.[759]

In attempting to examine the boundaries between music therapy and other music practitioners in the health field, it is important to discuss some demarcations.[760] When we look more closely at the competence possessed by music therapists, we

[759] See CAMTI, 2022; Singh, 2022; de Perez, 2025.
[760] See also Ruud, 2020.

soon discover that there is an overlap with the knowledge, attitudes, and skills of other professions. Five such areas are discussed in the following: musical competence, methodological competence, knowledge of target groups, relational and communicative competence, and theory, research, and evaluation.

Musical competence is, of course, shared with musicians and music educators. Performance competence may be higher in educators or musicians, which can create role confusion if the professional identity of the music therapist is based solely on musical skill. Many health workers also possess solid musical competence, even if it may be limited to a particular genre or specific skill set.

This raises important questions about what musical competence consists of, and what makes it specific and valuable in music and health work. When other actors in the health field use music, they often draw on specialized but sometimes limited competence. This may function well in certain contexts, but individuals with restricted musical skills may encounter challenges when moving into other arenas. It is here that musical competence linked to music therapeutic methodology can make a difference.

Methodological competence. An important area in music therapy education is knowledge of, and skill in, musical methods of working and music therapeutic methodology. Music therapists work with music as communication and encounter people of all ages, cultural backgrounds, ethnicities, and gender expressions, as well as individuals with highly diverse musical preferences. In order to reach people through music, one must master a range of genres, be familiar with traditional music theory, improvise, lead choirs and bands, provide instruction where necessary, organize musical productions, and otherwise serve as a skilled musical support partner.

Admittedly, many of these working methods overlap with those of musicians and music educators, particularly in instrumental instruction, band work, music technology, and choir or orchestra leadership. However, there are also methods that are specific to the field of music therapy, such as Guided Imagery and Music. At the same time, this method does not necessarily require advanced musical craftsmanship and may be conducted by psychologists, for example, provided they have a basic foundation in musical knowledge.

Specialized songwriting methods have also been developed within music therapy, although these must be handled with particular care, especially when working with texts from vulnerable clients in clinical contexts. The same applies to therapeutic or clinical improvisation (Creative Music Therapy). Methodological competence therefore includes a range of techniques that are important for reaching specific

client groups through music, including improvisational approaches and methods for leading groups.

Knowledge of target groups. Music therapy education is designed so that students must engage with subjects such as psychology and pedagogy, as well as music psychology and music pedagogy, music and brain research, musicology, special education, and not least knowledge of different target groups. Many specialize in different practice arenas through their master's theses. This interdisciplinary knowledge also includes music therapy theory.

Some of these areas of competence may be unfamiliar to the music educator and the musician, especially those concerning client knowledge. The health worker will often be familiar with such knowledge, which, in combination with musical skills, means that several health professionals, physicians as well as nurses, have moved into the field of music therapy.

Relational and communicative competence. A good relationship is marked by mutual confirmation and recognition.[761] Empathy is a key concept here, implying a willingness to enter into another person's situation, thoughts, and feelings.[762] This is a competence that musicians, educators, and health workers may possess. It is important, however, to emphasize that musicians will fall short here if they see their task as displaying their own skills, highlighting themselves and their own playing, and thereby creating distance from the client. Music therapists are expected to be open to intersubjectivity, that is, to sharing and exchanging feelings, intentions, and thoughts through musical interactions unfolding in the here and now. When the music therapist adjusts and attunes their own musical activity to the other person's, for example in relation to the need for pauses and emotional regulation, music becomes a supportive scaffold for self-development, relational competence, and greater expression.[763]

Music therapy differs from music medicine in that the music therapist stands in a direct relationship with the users. Music therapy does not consist merely of playing or performing music without a relationship to other people being formed in the working process. Music therapy is based on long-term work in which knowledge of the user, collaboration with the user and with other professionals or a local community, often together with individual plans and ongoing evaluation of the process, forms the basis of the work. Self-experience and relational competence are important for all practitioners: the ability to regulate closeness and distance to

[761] Trondalen, 2016a.
[762] dos Santos, 2022.
[763] Johns, 2017.

others, and not to invade. Awareness of the limits of one's own competence is central in the practice teaching that music therapists receive under the supervision of experienced music therapists.

Theory, research, and evaluation. In many countries, a music therapist is expected to have education at the master's degree level. This means a completed master's thesis, together with the competence to read research literature, to know something about philosophies of science, research methods, and criteria for evidence, to be familiar with music therapy databases, and to be able to communicate the field in writing. Knowledge of research is familiar to music educators and many health workers. When it comes to theory, music therapists, like music educators, will be familiar with musicological thinking as grounded in the psychology, pedagogy, sociology, and anthropology of music. An understanding of the concept of music and the significance of musical identity appears to be important in many contexts and in encounters with clients.

There is a theoretical tradition that is distinctive to music therapy.[764] In many cases, especially for health workers, this theoretical foundation will not be part of their reflective framework. Presumably, a great deal of "invisible" competence lies precisely in this shared foundation of reflection that music therapy continues to develop. Here lie important ethical guidelines, as well as awareness of professional responsibility and professional limits. Finally, it should be mentioned that several assessment procedures have been developed within music therapy. These may be specific to music therapeutic methods of work and target areas, as we saw in an earlier section.[765]

The Sixth Competence – the Professional Music Therapist

From time to time, we see nurses, physicians, musicians, and music educators wanting to work with music as a health resource, because they cover one or more of the fields of competence outlined above. Other professional groups may in principle apply for vacant positions, or use the title music therapist, which the authorities in many countries have not protected through licensure. It is therefore important to make clear that a degree in music therapy is required to fulfill the qualifications for positions advertised as music therapist positions.

When other occupational groups or professions successfully use music in health work, it is because they are sufficiently good musicians and/or have another

[764] see Aigen, 2014; Bonde (Ed.), 2014.
[765] For more details, see Ruud, 2020.

approved health-related education. In order to distinguish the music therapy profession from other professions, we might, instead of defining the practice itself, look at the interplay among the various competencies. We could say that it is the sum of the five competencies outlined above that together constitutes the professional identity and professional practitioner identity associated with the music therapist and the discipline of music therapy. This is what we call *the sixth competence*. And we see that this is a demanding role that connects musical craftsmanship and methodological skills, the ability to communicate and form relationships, health-related knowledge, as well as theoretical knowledge and reflection through engagement with research. It is precisely this totality of competencies that constitutes the music therapy profession.

Boundary Lines, Border Areas, and Collaboration

Music therapists may choose different strategies when it comes to exercising their role and profession in the workplace. Brynjulf Stige and Frode Aass Kristiansen have proposed three possible strategies regarding positioning oneself.[766] One may choose an autonomy, assimilation, or hybrid strategy. If one chooses to be autonomous, one will mark oneself as an independent and equal profession among other professions in the workplace. Great emphasis is placed on documenting goals, clarifying working methods, and applying assessment instruments. The risk of such a strategy is that one does not participate sufficiently in the interdisciplinary environment, becomes invisible to other professional groups, and is perceived as exclusive.

With an assimilation strategy, one adapts to the wishes and expectations of colleagues, tries to offer music to as many people as possible, and is actively present in the environment on the service side. Here, one risks acquiring a more indistinct role and may easily become associated with cultural work and entertainment. Stige and Kristiansen instead recommend the hybrid strategy. Here, one seeks to balance the two previous strategies by offering music therapy in a person-centered form while also offering other staff training and supervision.

We have seen that the question of the delimitation of professions in relation to other occupational groups is referred to by the term jurisdiction. Brynjulf Stige and Randi Rolvsjord refer to research on the emergence of music therapy within the Norwegian prison system, where three strategies of jurisdiction are outlined: full jurisdiction, subordination, and field-sharing.[767] Full jurisdiction is found where a

[766] Stige and Kristiansen, 2016.
[767] Stige and Rolvsjord, 2009, p. 21–22.

profession seeks to reserve an area and certain work tasks for itself alone. Subordination means that some professions have a helping function in relation to others. Field-sharing concerns areas of practice where different professions recognize one another by taking different, often complementary, roles. Field-sharing may involve greater contact and collaboration with other groups.[768]

In this context, concepts are drawn from the sociologist Richard Sennett's distinction between "boundary" and "border." By focusing on the border areas between disciplines rather than establishing clear-cut lines and divisions, opportunities for collaboration are created.

Music therapists have strong traditions of collaboration. By fostering dialogue-oriented competence, music therapists can make valuable contributions in interdisciplinary work, whether within health, education, or music and cultural fields.

The example we saw earlier, involving choir leadership for people with chronic lung diseases, shows that a combination of knowledge about choir leadership and music therapeutic competence is necessary in order to do a good job. Since there will in many places be a shortage of music therapists, this competence can be transferred to music educators and choir conductors through courses and observations.

Ethics

Ethics concerns theories of right and wrong, the moral principles and values that govern our behavior. There are numerous theories within so-called normative ethics about which actions are morally right, for example utilitarianism and deontology. Descriptive ethics examines what people think and do in situations where moral questions arise. In applied ethics, concrete ethical questions are discussed. Applied ethics is especially important in the everyday life of the music therapist, where choices about how to prioritize work tasks require ethical balancing.

We also have specific sub-disciplines such as research ethics and professional ethical guidelines. Research ethics is intended to safeguard the safety of participants and ensure that private matters are not disclosed and that the research process itself does not harm those involved. Central key concepts in research ethics are confidentiality, the duty to inform, informed consent, and the right to withdraw from a study.

[768] Stige and Rolvsjord, 2009.

Metaethics

When it comes to what is called metaethics, we are dealing with philosophical questions related to how moral values have arisen, what moral concepts mean and imply, and how we can know which moral choices are important.

Emmanuel Lévinas

I will not here describe the many ethical systems and thinkers who have contributed to ethics.[769] One philosopher who often appears in music therapy literature, however, is Emmanuel Lévinas. His ethics corresponds well with a music therapy that is relationally oriented and emphasizes our responsibility toward other human beings. For Lévinas, precisely the encounter with the Other is a fundamental point of departure for ethics.[770]

The concept of the Other refers to people who are different from us. We have a responsibility toward the Other that goes beyond selfishness and self-interest. In this way we recognize the Other's unique value. We are ethically obligated to help and protect the Other, a responsibility that is never fully exhausted, but rests upon us as a constant obligation and forms the basis of an ethical life.

Central to Lévinas is the encounter with the Other's *face*. This face represents the uniqueness and vulnerability of the Other and appeals to our responsibility. Gro Trondalen writes that we are called to responsibility in the presence of the Other's Face. To see the Other's Face means both to see and to understand. It is our duty to be present for the Other. I become both receptive and responsible, and in that way, I become something I could not have become on my own.[771]

Gary Ansdell illustrates this with the question: "How can we hear the call of the others? How can we respond?"[772] Our response should not necessarily demand expectations of reciprocity but rather be marked by presence and care. In this way, Lévinas's ethical theory challenges other idealistic and rationalistic theories by prioritizing relationship and responsibility for truly seeing people.

Social Media Creates New Ethical Challenges

[769] For further discussions, see Trondalen, 2023; Zanders, 2024.
[770] Ansdell, 2014; Trondalen, 2023.
[771] Trondalen, 2023, p. 14.
[772] Ansdell, 2014, p. 158.

Social media has challenged music therapists and called for ethical reflection regarding the recording and dissemination of the music being produced. Clients may wish to share their musical products, and it is easy to post music in various forums on the internet.[773] The challenges here are related to consent and privacy.

Music therapist Eirik Sæle writes that music therapists can:

> *avoid legal uncertainties in connection with recording and publication if the activity is undertaken as a result of the user's initiative. In that case, the music therapist must provide consent, since sharing material from therapy may lead to a breach of confidentiality. Legally, consent is not required in cases where the information has already been made public, or where the information is shared at a public event. Even though consent may not necessarily be legally required in such cases, verbal or written consent will reduce uncertainty for both parties, especially in borderline cases.*[774]

Informed consent should provide information about where the content will be shared, how long the content will be stored locally, and how long the content will remain on the internet. The consent should specify that it may always be withdrawn, that it can easily be adjusted, and that it is not a condition for receiving other services.

The considerations the music therapist must make concern how sharing on social media may affect the user's health and what such openness means for other people. Furthermore, one must ensure that the relationship between user and therapist is not exposed and consider which parts of the user's and therapist's private life should be publicly accessible on social media. Possibilities for stigmatization and discrimination must be assessed, along with how the therapist may have a clear supportive function afterward as well. Power relations must be considered, together with the user's competence to consent and possible conflicts of interest.[775]

Professional Ethics: Ethical Guidelines for the Profession

The Norwegian Association for Music Therapy, in collaboration with the Musicians' Union, worked for many years on the development of ethical guidelines. The

[773] Sæle, 2021; Sæle and Gilbertson, 2024.
[774] Sæle, 2021, p. 70–71.
[775] Sæle, 2021, p. 71

revised guidelines are reproduced below as an example of ethical standards for music therapists.

1. Introduction

The music therapist belongs to a professional group working in many different arenas. It is the task of the music therapist to contribute to improved health, increased quality of life, and social participation. The music therapist uses music and its qualities as a nuanced tool in their work. Music offers many possibilities but also requires caution and awareness. The music therapist must be aware of the distinctive nature of music and its effects on people, and of the risk of harmful use and practice.

To whom do the guidelines apply?

The professional ethical guidelines apply to all music therapists who have an approved music therapy education from Norway or an equivalent education assessed from abroad. The ethical guidelines cannot cover every possible situation. As a rule, all affected parties should be considered. If this is not possible, it is the music therapist's responsibility to point this out and consider whether it is ethically defensible to continue the task under the given conditions. Each individual music therapist is personally responsible for adhering to the ethical guidelines. It is emphasized that music therapeutic practice is subject to the applicable legislation in the relevant sectors.

1.2 Purpose and Foundation

The purpose of the ethical guidelines is to ensure an ethically sound level of music therapeutic professional practice, both within clinical practice, counseling, teaching and research, and other work in which the music therapist is involved. The purpose of the guidelines is:

- to provide an ethical foundation for music therapeutic professional practice and research
- to support music therapists when they must take a position on professional ethical questions
- to protect clients and groups against inappropriate and/or harmful treatment

Ethical thinking implies an ongoing reflection on one's own attitudes, values, and actions, and is part of all music therapeutic professional practice. In their work, the music therapist must respect fundamental human rights and humanistic values.

These values include principles of co-determination, equality, informed consent, and personal integrity.

1.3 Clarification of Terms

The term client is used consistently throughout the ethical guidelines. This is an editorial simplification. *Client* also covers the terms *patient, user, participant,* and *pupil*, all of which are relevant for designating persons who receive music therapy services.

2. Ethical Values and Principles

2.1 Values

Music therapeutic work is practiced in encounters between people. The way the music therapist meets individuals and groups is crucial in order to provide services and help. To show respect, trust, and care requires ethical wisdom and a conscious professional relationship to one's own motives and values. Music can be a powerful medium with both possibilities and risks, and it is important that the music therapist is ethically aware of this. Respect for the individual, self-determination, and life values are fundamental in music therapeutic work. This is especially important where the client has limited opportunities to express their own wishes and needs. Music therapeutic work is based on a holistic view of health and of how the individual and society mutually influence one another. The music therapist therefore also works to realize fair and equal access to services and provisions.

2.2 Principles

Discrimination based on nationality, skin color, language, culture, class, gender, sexual orientation, age, disability, religious belief, or political views is not acceptable. This includes respecting the client's musical preferences. The music therapist must not exploit professional connections to obtain unreasonable advantages or gains. For example: when music is recorded or performed publicly, the client's integrity, needs, and rights must be safeguarded. And: when treatment or counseling is available within the public sector, a music therapist in private practice must inform the client of this. The music therapist must act in accordance with copyright law in connection with the publication of music created in collaboration with clients. The music therapist must avoid extra-professional relationships with a client when this may lead to conflicts of interest or exploitation. The music therapist must contribute to assessment, evaluation, documentation, and follow-up, based on the client's needs and the requirements for adequate practice in the relevant context.

The music therapist must not undertake tasks for which they do not have sufficient competence. Responsibility for this lies with the individual therapist. If a music therapist has personal problems of such a nature and to such a degree that they affect professional practice, they should seek professional help. It is expected that each music therapist keeps professionally up to date.

3. The Relationship Between Music Therapist and Client

3.1 The Roles of the Music Therapist

With their knowledge, the music therapist functions in many roles and professional relationships across a wide spectrum of working methods. It is important that the music therapist be aware of the relationship between the client's self-determination and the use of power and coercion. The music therapist normally does not participate in activities that use physical or psychological coercive measures. When physical and/or psychological coercion is exceptionally necessary, the music therapist must actively help safeguard the client's legal rights. The music therapist must not misuse their power and position by exploiting the client's dependence and trust.

The music therapist's primary loyalty should lie with the client, but the music therapist must also be able to manage several loyalties simultaneously. The music therapist may find themselves in situations where loyalty to the client and various ethical principles are challenged, for example when the client threatens the integrity of other people. Conflicts of loyalty may also arise in relation to economic priorities that affect the client's rights and needs.

3.2 The Client's Autonomy and Participation

The music therapist must ensure that the client's autonomy and right to participation are safeguarded. This includes the client's right to choose to enter the therapeutic relationship, to participate in the process as it unfolds, and, if necessary, to terminate the therapeutic relationship.

3.3 Confidentiality and Professional Secrecy

The music therapist must respect the duty of confidentiality and the client's right to confidentiality in accordance with Sections 13 ff. of the Public Administration Act. Exemptions from confidentiality may be made with the client's consent. This also applies in connection with supervision, guidance, teaching, research, and other work carried out by the music therapist. All documentation, such as written reports, records, and audiovisual material, must be stored and managed in accordance with the Personal Data Act Sections 8 ff. and the guidelines of the

Norwegian Data Protection Authority. The music therapist must exercise caution in connection with the use of social media, in accordance with the Norwegian Data Protection Authority's guidelines. This also includes guidance of the client regarding publication, appearance in the media, and sharing in social media. It is emphasized that when sharing events from practice on social media, the necessary clarification must be obtained from the clients.

4. Research

In music therapeutic research, professional secrecy and participants' rights to confidentiality, autonomy, and participation must be respected in the same way as in music therapeutic practice (see the sections above). If the research project involves the processing of personal data, approval from the Norwegian Centre for Research Data is required before data collection begins. In medical and health-related research, prior approval from the Regional Committee for Medical and Health Research Ethics is required.

5. Conditions for Professional Practice

The music therapist must respect the competence, obligations, and responsibilities of other colleagues. The music therapist must strive for interdisciplinary collaboration and work to ensure that the client receives a holistic service, also in regard to prevention, follow-up, and coordinated care. The ethical guidelines must also be followed in professional situations where the content cannot immediately be characterized as music therapeutic professional practice, but which are carried out by music therapists and build on skills acquired through music therapy education. The music therapist must strive for objectivity and accuracy when making statements about music therapeutic professional practice. The music therapist must provide adequate information about their qualifications, education, experience, competence, and professional affiliation, and may use only the professional titles to which their education and position entitle them. The music therapist must ensure that the terms of employment do not contain conditions that conflict with their professional ethical guidelines. The music therapist has the right to report censurable conditions in the workplace, cf. Sections 2-4 and 2-5 of the Working Environment Act.

6. Evaluation

Discussion of, and development of, professional ethical guidelines is an ongoing process. The guidelines nevertheless reflect fundamental human and interpersonal conditions and therefore possess a stability not easily affected. Formal evaluation takes place every fourth year.

MUSIC THERAPY AS A DISCIPLINE AND ITS KNOWLEDGE BASE

7

Music Therapy as a Discipline and Its Knowledge Base

This chapter examines music therapy as a field of knowledge and research. It discusses the types of knowledge on which music therapy is based, as well as the challenges arising from the field's complex and diverse knowledge base.

First, various definitions of music therapy as formulated by organizations and theorists are considered. At the same time, it is important to address the value foundations of the field. Accordingly, this chapter summarizes central perspectives on the human being, music, and health that inform music therapy.

A key question concerns the professional identity of music therapy. What characterizes this identity, and is there a distinct humanistic tradition within music therapy? What values have shaped the development of this tradition? In relation to these questions, key aspects of a humanistically oriented approach to music therapy are presented.

As a scientific discipline, music therapy investigates the relationship between music and health. Research in the field draws on theories from areas such as music psychology, sociology, and anthropology, and it also explores the neuropsychological foundations of musical experience. In addition, the field is informed by psychotherapeutic, medical, and special education theories, depending on the client groups with whom the music therapist works.

Regarding research and knowledge development, it is essential to understand different philosophies of science and to employ research methods that accommodate empirical, interpretive, and experiential forms of knowledge.

Definitions of Music Therapy

When presenting oneself as a discipline, as a profession, or by referring to practice, it is important precisely to distinguish among these three fields. A particular aspect of building a profession is creating an identity that is easily understood from the outside, by society, so that one is accepted and gains access to the arenas in which one wishes to serve. For music therapy, this poses more challenges than for many other occupations or professions. Being a physiotherapist or a psychologist is a familiar profession, and we know what those professions consist of. This is not always the case for music therapists, and some people think that music therapy is a form of music pedagogy for people with disabilities. Others see it as a kind of self-therapy that, for some, is translated into a more esoteric form of "healing," as music therapy has been promoted at alternative fairs.

There have been many attempts to define music therapy. When the American music therapist Kenneth Bruscia first published his book *Defining Music Therapy* in 1989, he reproduced definitions from several music therapy organizations around the world. What is striking is not least the sheer number and variation of the definitions, and the way the definitions in individual countries are shaped by local traditions and theories.

It is not always easy to give a simple answer to what music therapy is. When music therapists are asked the question "what is music therapy?", they often immediately search for a brief answer. Perhaps the best answer lies in describing who one works with, how one works, and what one wants to achieve. At the same time, one often wants to find an answer that is valid for all music therapists. A simple definition would therefore be desirable. When we look at all the proposals circulating internationally, we understand that the matter is by no means simple.

In the following, I will illustrate differences in definitions with five examples. First comes the definition of the *World Federation of Music Therapy* (WFMT). Then follows the definition by the American music therapy theorist Kenneth Bruscia. Through the various editions of *Defining Music Therapy*, Bruscia has formulated a definition that is widely used[776]. After that comes my own attempt at a definition, before I present the definition of the American Association for Music Therapy (AAMT). Brynjulf Stige has related critically and analytically to these definitional attempts and has made an important contribution by distinguishing definitions of music therapy as practice, profession, and discipline.

[776] Bruscia, 2014.

World Federation of Music Therapy

To begin with the definition of the world organization (WFMT), we read the following on their website from 2011:

> *Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts.*[777]

As Brynjulf Stige has noted, this wordy definition is the result of many countries and many music therapists having helped shape it.[778] One may react here to the use of the word *intervention*. As we shall see in the following, Bruscia uses the word *help* in his latest revised definition.

Kenneth Bruscia

After the latest editing in the 2014 edition of his book, Bruscia's definition reads as follows:

> *Music therapy is a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change.*[779]

Now, this definition has undergone several changes since the first edition in 1989. For example, the word *intervention*, which he used at first, was replaced by *helps*. We might immediately ask why *collaborates* would not have fitted better, since reciprocity and collaboration are part of many cooperative processes. Some would point to the individualistic focus on therapy and call for a broader social and cultural understanding built into the definition. But definitions ought to be short, and Bruscia has instead chosen to write an entire book of 387 pages in which he discusses every single concept in the definition. Another weakness Stige points out is that the definition addresses music therapy as a practice.

[777] https://www.wfmt.info Access date 25.11.2024.
[778] Stige, 2007.
[779] Bruscia, 2014, p. 36.

Even Ruud

This also applies to my own definition from 1979, which originally stated that "music therapy is the use of music to give disabled children, adolescents, and adults new possibilities for action."[780] By bringing in the concept of action, there was an intention to view music therapy within a broader sociological perspective. This was especially with a view to not forgetting the economic, material, logistical, or structural barriers that exclude people with disabilities from participation in society, and that make them disabled. That is why we may also speak of people who are functionally hindered.

This definition of music therapy now reads: "Music therapy is the use of music to provide new possibilities for action and experience for people with disabilities and health challenges." In this definition, the term is no longer *disabled* but has been replaced with *disability*.[781] In addition, *possibilities for experience* has been added to the original definition. The thinking behind the revision is that the word *action*, or better, *agency*, implies certain cognitive capacities that are not always present or available for use because of organic impairment. There are conditions in which the action aspect is not so prominent, for example in advanced dementia, in palliative care, or in some highly complex disabilities. Yet experiences of joy, presence, mastery, and recognition are still possible. Moreover, the concept of action can imply a certain instrumentalism. And where the concept of *ableism* reminds us that we should not one-sidedly cultivate and favor qualities associated with being skilled and capable of action, a certain caution in the use of words is called for.

Now, one may object that this definition gives too little concrete knowledge of what music therapy as a discipline is about. It places one-sided emphasis on music therapy as a practice, even if it has functioned well in contexts where music therapy has been placed within a larger social and cultural context. Likewise, the concept of action has been discussed so extensively in sociology that a chapter ought probably to be written about it in connection with the definition.

American Association for Music Therapy

Stige makes a good point when he notes that definitions often, if not always, are shaped as responses to shortcomings in other definitions or forms of understanding. Or they are clearly marked by a social context that delimits the possibilities of music therapy. For example, American definitions will easily be

[780] See also Ruud, 2007b.
[781] Ruud, 2020a, p. 104f.

shaped by the conditions of therapy within a capitalist system that intervenes so strongly in the private health-care sector. We see, for example, that the *American Association for Music Therapy* (AAMT) has created a definition that is clearly profession-oriented, and that can be read as a poster directed at private hospitals and the insurance sector:

> *Music Therapy is the clinical & evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy interventions can address a variety of healthcare & educational goals and many can benefit from music therapy services. The base of evidence in music therapy research is extensive and strong.*[782]

Here we see that the profession of music therapy is naturally promoted by the professional organization, and that the evidence-based, educational, and clinical dimensions give music therapy a clearly delimited framing. Another understanding of music therapy, in which community music therapy, user-oriented, and relational approaches form substantial pillars, does not seem to occupy a prominent place in this picture American music therapists draw of their field and profession.

Brynjulf Stige

It is precisely this distinction between defining profession, practice, or discipline that Stige emphasizes when, in 2002/2007, he defines the various aspects of the field.[783]

- *Music therapy understood as a discipline concerns the study and learning of the relationship between music and health.*
- *Music therapy as a profession is a group of academics and practitioners who have a recognized education and competence that qualifies them for a social role (as music and health workers), with particular obligations and rights toward clients, colleagues, other professions, and the public.*
- *Music therapy as a professional practice is situated health musicking within a planned collaborative process between client and therapist.*

When Stige defines practice as *situated*, there is an implicit critique of definitions in which the cultural and social dimension is barely visible. We also see that the situationally dependent approach is now taken care of through a collaborative way of working.

[782] https://www.musictherapy.org/about/musictherapy/ Access date 25.11.2024.
[783] Stige, 2007, p. 30, my translation.

An Overview of the Field of Music Therapy

We have seen that music therapy and music-and-health work are present in several practice arenas. The music therapist belongs to a profession with different occupational roles and clear ethical standards. At the same time, music therapy is a discipline—a cross- or multidisciplinary field of knowledge and research.

When music therapy appears as a discipline, there have been several attempts to map the entire field of music and health. Here I take as my starting point a model further developed by the Danish professor of music and health, Lars Ole Bonde. With this model he has drawn a map of music therapy.[784] Bonde's presentation derives from the American philosopher Ken Wilber, who, with his quadrant model, sought to capture all dimensions of our health. Kenneth Bruscia refers to Wilber's model as an integrative perspective and says that the quadrants refer both to objective and subjective dimensions of the individual and of the social and physical environment.[785] In the revised edition of the *Music Therapy Handbook* from 2025, music therapy professor Brian Abrams has also used the model and Wilber's philosophy to illustrate the complex field of knowledge that characterizes the discipline of music therapy.[786]

The model is chosen here because it provides an overview of music therapeutic traditions, practice arenas, and ideologies. It is important to know this model because it is often used by music therapy theorists as a philosophical basis for the narrative of music therapy. However, I adopt a critical perspective toward this philosophy here, and the model should therefore be read without necessarily referring to Wilber. Later, I shall describe some of the criticism directed at Wilber's philosophy, not least pointing to weaknesses that arise in the binary constructions on which the model seems to rest.

A Subjective inner experiences. **B** Objective and observable aspects

C Shared psychological and cultural aspects. **D** Systemic aspects

In brief, this is a four-field model in which one quadrant (upper left – A) designates music therapeutic practice representing subjective and inner experiences in the individual (emotions, consciousness, self-awareness).[787] The quadrant in the upper

[784] Bonde, 2001; Bonde, Stensæth and Ruud, 2023. https://prod-aaudxp-cms-001-app.azurewebsites.net/media/fwmnuadw/music-and-health-2023-final.pdf

[785] Bruscia, 2023, p. 242f; see also Zanders, 2024. For an updated version, see Bruscia, 2026.

[786] Abrams, 2025.

[787] See the link to Bonde, Stensæth, and Ruud (2023) for a graphical illustration and accompanying explanatory text. https://prod-aaudxp-cms-001-app.azurewebsites.net/media/fwmnuadw/music-and-health-2023-final.pdf

right (B) refers to objective and observable aspects of the individual, our body, behavior, and biological processes. The lower left quadrant (C) refers to shared psychological and cultural aspects, common identity and worldview. The last quadrant in the lower right (D) is called the "collective exterior" and refers to systemic aspects of our existence (social structures, institutions and organizations, as well as our physical environment).

In this way we can create a presentation of music therapy by placing various practices and treatment theories within these four fields or areas. In the first area (upper left – A) we find music therapy and music-and-health work aimed at supporting people in identity development, addressing existential needs, working with personal problems, or supporting needs for self-realization and the development of relationships with others. In other words, this field encompasses the subjective and the individual—our thoughts, feelings, and values, which must be interpreted to be understood. This work is carried out by music therapists through different psychotherapeutic approaches, whether from analytical, humanistic-existential, or cognitive therapy traditions, as well as music therapy based on developmental psychological models and special education theory.

Since the discipline of *music and health* not only includes music therapeutic interventions, but also the use of music to regulate one's own health in everyday life, we may include several forms of health musicking in this quadrant. Examples of this are listening to music in everyday life in order to regulate emotions and energy. Or the use of music in which identity formation and development are part of a project of self-development. Some keywords from this field are goals such as self-insight and self-realization, identity formation, relational health, self-regulation, experiences of mastery, and empowerment.

The next field of work (upper right quadrant – B) refers to music therapy aimed at the body, biological needs, and medical conditions. Here we find music therapists who work in somatic hospitals with medical music therapy, as well as those who work with music medicine. Health here includes all aspects of individual health that can be observed and measured objectively in relation to body and behavior.

This field of work is intended to address what are called the "individual objective" aspects of health. Here we see that medical music therapy belongs, along with all approaches that concern the body and the physical. In a broader perspective on the field of music and health, we must include music medicine, or the use of specially composed music and playlists with individually adapted music. Many interventions within this field are directed toward reducing anxiety and stress, relieving pain, improving sleep quality, and widening the window of tolerance.

The next field of work (lower left quadrant – C) includes the intersubjective collective. That is to say, our individual health is affected by a range of external factors in our sociocultural world. This includes, for example, cultures, shared belief systems, and values. The target group for music-and-health work is expanded to include collaboration with groups and communities. Here, there is a need to create networks and strengthen community and belonging.

This third field draws in a larger social and societal context with significance for health and quality of life. It is referred to as the "intersubjective collective," with music therapeutic interventions that we know from community music therapy and community music, as well as musical group activities in amateur music life, such as participation in choirs, bands, orchestras, and other groupings. Some keywords from this approach are social integration, network formation, belonging, personal recovery, user participation, and human rights. Participation in amateur music life, writing one's own songs, or actively attending concert life is an aspect of public health work that contributes to increased quality of life and perceived health.

The fourth and final field (lower right quadrant – D) concerns an ecological way of thinking in which the sound environment and the role of music in developing sustainable local communities are viewed in a health perspective. This field is designated as the "interobjective collective." That is, all the external aspects of our physical surroundings that affect us, for example soundscapes, the biosphere, nature, social institutions, and political systems.

Within this field we find ourselves at a "macro level," where we are influenced by factors linked to institutional, societal, or social conditions that we best control through political measures. One illustrative example is how a poor sound environment, in which we are exposed to noise from heavy traffic, aircraft, machinery, or loud music from the neighbor, leads to serious health problems, both physical and psychological.[788]

Here, too, we may apply a public health perspective. It would involve expanding the health perspective from the individual and social to looking at systemic forces at a macro level. If we draw on concepts such as *ecology* and *sustainability*, we may ask for examples in which musicking has helped improve people's health and living conditions at the societal level.[789]

In this overview, we see that health encompasses biological, psychological, and social aspects—what is usually referred to as the "biopsychosocial" theory of

[788] See Ruud, 2005a.
[789] Hesser (2020) provides an overview with examples of music-related sustainable initiatives around the world.

health. Furthermore, systemic forces at the macro level that affect health are emphasized. Such conditions include social and global inequality, poverty, forced displacement of groups of people, structural racism, war, and political oppression. In other words, there are social and economic causes of illness, poor health, and diminished quality of life. Burnout, stress, and anxiety reactions can be seen in relation to social development and life conditions. Social fragmentation means that more people experience loneliness. Such elements must be incorporated into music therapy if we are to avoid pathologizing life problems that are socially produced by living conditions.

Criticism of the Quadrant Model

Wilber's quadrant model has been criticized for its inadequate account of power and social class, and of the dynamics of power that shape human experience. Examples include postcolonial and feminist criticism, where it is pointed out that Wilber fails to address the deeper structures that sustain class, race, and gender. Critics have pointed to an insufficient discussion of social justice and of how power and privilege affect individual and collective experience. This leads to a diversion away from current social problems such as racism, class differences, and injustice.

Some critics claim that Wilber focuses too strongly on individual consciousness and development. This results in collective problems related to power and injustice being individualized instead of recognized as deeply integrated into structures and systems. Another criticism that is easy to agree with is that the quadrants are not necessarily so separate. Even if one, for example, places cultural and culturally relative viewpoints in a separate quadrant (lower left), such cultural relativizations will of course operate within the other quadrants as well. It is easy to find examples within each quadrant in which practice will be shaped both by subjective inner experiences, measurable and observable aspects, and intersubjective and systemic cultural aspects.

I could claim that every practice arena the music therapist enters can be characterized as an *entanglement* of all the active elements in a practice situation.[790] The question then becomes whether the four-field model is the right way to conceptualize and locate music therapeutic practice. In the afterword to the book, another conceptual apparatus is proposed, built on an alternative

[790] The concept of 'entanglement' refers to Karen Barad's understanding that entities do not exist prior to their interactions but instead emerge from and are constituted by the ways in which they interact (Barad, 2007).

theoretical and philosophical foundation, in order to capture the dynamics and complexity of music therapy as practice and as a scientific discipline.

I do not, however, intend here to endorse this criticism or to determine how Wilber himself might relate to it. There are at least a thousand articles online, and dedicated websites for discussion of Wilber's "integral theory." Some maintain that one may well keep the quadrants, but at the same time remain open to discussing the content of each quadrant. But when it comes to philosophical criticism from post-structuralism, which seeks to deconstruct all such universal structures, the whole quadrant model may collapse. That means the model rests on a philosophical foundation that can be contested.[791]

Bronfenbrenner's Levels

The preceding overview places the center of gravity of music therapeutic practice within one of the four fields. That does not mean, however, that work within the somatic sphere, where the music therapist works with bodily conditions, will not also touch on psychological or existential themes. We must think systemically about how music therapists work. Work in one area may influence other areas of work, and that this influence is reciprocal.

Such a systemic or ecological way of thinking means that there is always a larger context influencing the music therapist's work. In this presentation, we may introduce an additional dimension by drawing on theories from the Russian-American psychologist Urie Bronfenbrenner.[792] He operates with five levels that further situate music therapeutic practice—music therapy at the micro-, meso-, macro-, and exo-levels, as well as a chronosystem, a temporal dimension within a developmental ecology.

Bronfenbrenner pointed out that activities at the *micro level* concern situations in which we act face-to-face with one another. In music therapy, we find such situations where a client interacts with a music therapist, or where relatives, a teacher, or an assistant participates in the interaction.

When decisions made in a forum outside the practice situation itself have consequences for the music therapist, we speak of interactions at a *meso level*. At the meso level, the music therapist operates within a larger social or institutional context, and is influenced by, while also attempting to influence, the surroundings

[791] See Bruscia (2026) for an updated model of music therapy based upon Wilber.
[792] Stige, 2002.

or environment. An illustrative example of music therapy at the meso level is found when music therapists work in hospital wards with children, something we refer to as environmental music therapy. Another example is found in the music therapists Ane Bergset Mandal and Liv-Jorun Bergset, who have worked through home visits with children in foster care. By connecting with the children's everyday lives and meeting parents, they help create links among situations and services. Mandal and Bergset describe themselves as "meso-agents" to designate this role.[793] If we extend the context to include the local community and neighborhood, we see that community music therapy gives us examples of how music becomes a gateway and a link to participation in society. What characterizes the meso level, then, is that there is an interplay between two arenas in which the child or person in development participates.

At the *macro level*, the issue is how music therapeutic activity, both practice and professional work, is influenced by a larger ideological, cultural, and institutional context. Legislation and regulations, economics and political decisions, and changes in paradigms and treatment ideologies will affect who is offered therapy, where, and in what manner. Bronfenbrenner also operates with an *exo level* that concerns time and development.

A Humanistic Tradition of Music Therapy

I ask whether there is a distinct humanistic identity for music therapy. There are traces of something like that. We should, however, be cautious about creating an identity in which not everyone feels at home, or that acts as a limitation on future development. The roots of humanistic music therapy are found in the music-centered and creative music therapy of Paul Nordoff and Clive Robbins. Gradually, this approach was inscribed within humanistic *psychology* and was expanded into a more comprehensive humanistic *perspective* on music therapy.[794] There is an important difference here. This perspective has a strong element of cultural theory, sociology, and critical theory. The musical forms have expanded to include all genres, and the instrumentarium includes digitalized instruments. Qualitative research has gained an important place. At the same time, music therapists understand the necessity of quantitative studies, often as participants in international collaborations with large populations.

[793] Mandal and Bergset, 2016.
[794] Ruud, 2010.

In addition, there has been a development in the direction of community music therapy. Music therapists who previously, and still, define themselves within the Nordoff and Robbins tradition are today leading community music therapists. For example, the British music therapist Gary Ansdell writes that the legacy from Nordoff and Robbins is important to him when it comes to showing musical vigilance. This implies a present and attentive focus on each participant's musical contributions, which can lead to meaningful and affirming encounters.[795]

What we say in addition is that humanistic music therapy is music-centered. A good illustration of such a music-centered approach is found in the book *Caring for Music. Musical Life, Late Life* by Gary Ansdell and Tia DeNora.[796] It becomes very clear there how, through music, we create situations that foster contact and communication among participants in a music group of older adults in a nursing home. In this presentation, we see how the music therapist becomes an important facilitator in creating the atmosphere and capturing the initiatives, often at the micro level, that draw participants out of themselves and into shared participation.

When music therapists present themselves to the public, they are sometimes not simply "music therapists," but "humanistic music therapists," "community music therapists," or "analytically" or "relationally oriented" music therapists, among others. This may create confusion about how the discipline and profession are understood. It therefore raises the question of whether such distinctions are necessary or useful. Music therapy can encompass all these perspectives and approaches.

There is no need to define oneself in opposition to medical or natural scientific traditions, or to quantitative research paradigms. In many contexts, music therapists are integrated into biopsychosocial models of healthcare, and there is little reason to create distance or opposition. Often, music therapists work within the same medical paradigm; at other times, their work is complementary. It is also important to recognize that many medical professionals draw on phenomenological and qualitative traditions. "Medicine" is not a fixed or uniform concept—medical research and practice are continually evolving, just as music therapy is. Music therapy can thus be understood as complementary, supportive, and collaborative. It also plays an important role in prevention and health promotion.

In our time, user-oriented and resource-oriented approaches are accepted within mental health work and in the field of substance abuse and rehabilitation. Here, music therapists work alongside physicians and other health personnel who see

[795] Ansdell 2014; Ansdell and DeNora, 2016.
[796] Ansdell and DeNora, *Caring for music*, under production.

the value of a recovery-oriented approach. In such contexts, it is not necessarily important to emphasize a special professional identity, unless one is in dialogue with people who already know something about music therapy. For this is about dialogue and rhetoric, about being understood and accepted.

That said, one might add that sometimes it is necessary to mark a standpoint within the humanities. This is where one feels overridden by a biomedical view of the human being and an excluding positivist approach to research. Then it is necessary to remind others that the view of the human being encompasses more than biology, and that research also means capturing meaning and creating understanding.

It is helpful to point to a shared identity. It is appropriate to explain one's work by noting that within the discipline of music therapy there are several professional or theoretical traditions, and that some of these are important to the practice in which one is engaged. In most contexts, all are first and foremost music therapists —and this means that they have incorporated relational, music-centered, culture- and context-sensitive, rights-based, as well as resource- and user-oriented perspectives into their work.

Humanistic Values in Music Therapy

We have seen that music therapy as a discipline, profession, and practice is a composite field of knowledge encompassing a range of forms of practice, varied professional roles, and a multi- and interdisciplinary theoretical field with roots in different research traditions, philosophies of science, and value systems. As a natural-scientifically influenced field, music therapy is linked to research in biomedicine, physiology, neuropsychology, or behavioral psychology, and can point to quantitative research that maps the effects of music. This may involve physiological reactions, reactions in the brain, or demonstrable changes in behavior and experience. Music therapeutic research shows that there is a great deal of "quantitative" evidence in research supporting music therapeutic practice.

As a humanistic field, music therapy encompasses knowledge of *how* music affects feelings and thoughts in light of our historical and cultural situatedness, as well as knowledge of the conditions for interpretation and musical meaning-making. Humanistic or interpretive music therapy gives us foundations for understanding people's lifeworlds, with their distinctive intentionality, capacity for symbol formation, and conditions for autonomy and self-determination. At the same time, such a humanistic position should also incorporate critical perspectives, in which

therapies are seen in relation to values and ideologies in society. In recent years, critical posthumanism has challenged the traditional humanistic view of the human being. We have received important input from theories connected to postcolonialism and intersectionality, disability studies, and so forth, which influence the development of the field of music therapy.

Music therapists sometimes answer that they have a humanistic basic outlook, that they are humanistic music therapists, when challenged about where they belong within music therapeutic traditions, schools, and models. The choice of such a humanistic perspective on theories and professional identity is a value choice grounded in a particular view of the human being, which in turn entails a particular view of knowledge and reality.

At a time when health fields are under pressure to deliver so-called evidence-based treatment, music therapy is being pushed in the direction of a natural-scientific paradigm. To satisfy the sometimes rigorous demands for natural-scientific evidence, researchers are forced to formulate hypotheses and create research designs in which a more naturalistic view of the human being advances at the expense of a humanistic one. This view of evidence often entails a particular interpretation of the concept of knowledge within a positivist hegemonic tradition in the health sciences.

The View of the Human Being

In applying *humanism* as an overarching perspective on music therapy, one connects oneself to the original relationship of humanism to medical practice in antiquity. As the Danish philosopher Uffe Juul Jensen points out, the medical practice of antiquity entails a care for the individual that we readily associate with the basic ideas of humanism.[797] Jensen writes that humanism is a phenomenon that appears in different linguistic forms. As a concept from the Renaissance, it refers to an anthropology, a teaching about what the human being can be, what possibilities we human beings have at our disposal, and which societal barriers hinder the unfolding of the human.[798] Within such a humanistic anthropology, or what Juul Jensen calls a critical tradition within humanism, music therapy will "give people new possibilities for action and experience through music," as the definition stated.[799]

[797] Jensen, 2002.
[798] Bredsdorff, Larsen and Thyssen, 1979.
[799] Ruud 1979, 2020a.

A humanistic perspective enriches the field of music therapy and provides sound guidelines for a broad and varied practice. A humanistic perspective creates a foundation for developing a professional identity, with all that this entails for professional language, the question-culture of the field, a certain gaze or disposition for using music in therapy and health work.[800]

Naturalism, Humanism, and Philosophy of Science

In order to avoid an unnecessary polarization between a humanistic and a natural-scientifically oriented music therapy, it is important to emphasize that the medical practice prevailing today, even though it is largely based on a natural-scientific foundation, in many ways stands within a humanistic tradition. When today's medical practice is criticized, it is often on the grounds that medicine and doctors focus too strongly on disease, on partial components of the body, and on what have been called "mechanical faults." In doing so, one forgets that the experiencing human being who carries the illness is a historical and cultural being, with distinctive psychological characteristics and capacities for communication and autonomy. This tension between a holistic humanistic handling of human suffering and a scientific manipulation of delimited disease entities has been present in the history of medicine ever since antiquity.[801]

In the discussion of music therapeutic schools of thought and models, it was pointed out how underlying philosophies of science and research methods helped shape music therapy. A philosophy of science concerns the criteria for what counts as valid knowledge and how we are to gain access to it. A main distinction runs between empiricism and rationalism. While empiricists emphasize observation through the senses, rationalists argue that knowledge can be acquired through reason and logical argument.

We have seen that, for example, natural-scientific research and behavior analysis in psychology are linked to *positivist* philosophies of science and research methods in which the registration and measurement of data, the use of tests, surveys, controlled studies, and statistics are employed. Research referred to as qualitative relies on *hermeneutic theory* and emphasizes interpretation and theory development. Here, data are gathered through interviews and fieldwork, participant observation, and action research.

[800] Wackerhauser, 2002.
[801] Jensen, 2002.

Another direction is *social constructivism*, which adopts a more critical attitude toward knowledge that we take for granted. This theory regards language as a condition for the construction of knowledge and points out how our social position helps shape the way we see the world.

The naturalistic view of the human being that we encounter in medicine and natural-scientific research is based on a view of reality in which propositions and facts can, within a reductionist line of thinking, be traced back to simpler and more detailed facts. Positivism supports the naturalistic view of the human being, and with it also biologism, which often leads to chemical, physiological, and biologically underlying causes being given priority as explanations of experience and behavior.

Materialism, or an understanding that matter is fundamental and the basis for all thoughts, ideas, and feelings, sometimes comes along with it. Human beings are often compared to a machine in which body and psyche function according to mechanical laws, in conformity with physics and chemistry. The naturalistic view of the human being sees the human as part of nature. It is thought that by gaining insight into determining forces one will liberate oneself from a deterministic basic attitude in which the human being is determined by internal and external factors. In this way one achieves what is called relative indeterminism. Human dignity is, within such a philosophical anthropology, toned down, since the human being is essentially on a par with animals. This creates unclear boundaries regarding what the human being is.

To put it sharply, one might say that humanism presents a concept of reality that sets human reason, will, and choice against naturalism's concepts of nature, matter, and determinism. With an indeterministic view of the human being, humanism postulates that human beings make their own choices, steer their own destiny, set their own goals, and use their will to carry out their plans. In this way the human being overcomes barriers to the unfolding of the human. Within a humanistic understanding of reality, not only the material is real. Symbols and language create a reality that initiates actions.

In order to understand action and meaning, one relies on hermeneutics as an interpretive science. When we understand music as sign and symbol, we cannot reduce musical experiences to simpler physiological reactions based on a mechanistic process.

Within humanism, the human being comes to the center, and human dignity has been given special protection, especially within Christian humanism. Human rights are a clear marking of the fact that all human beings have equal value. Another value that follows is the emphasis on tolerance, that many truths live side by side.

The biomedical tradition has been challenged from several directions. First, one wants a medicine that is not only curative but also preventive and health-promoting. User participation is central in many discussions, and here the individual person's own influence on health and health behavior is emphasized. In addition, there are movements in the health field toward a more humanistic holistic perspective, where room is opened for supplementary or alternative understandings of health, and for critical and corrective perspectives on prevailing practice. We find a search for new forms of practice or methods of treatment that are effective with regard to the major and dominant health problems of our time, what is linked to long-term or chronic illness. This may involve physical complaints, depression, burnout, substance abuse problems, or social isolation.

A Critical Posthumanism

In recent years, humanistic basic values have been subjected to criticism. The criticism points to the necessity of examining the value base that informs humanistic philosophy and thought. This is in a time marked by crises concerning nature, ecology, our treatment of animals, views of disability, as well as all tendencies toward intolerance, racism, homophobia, and so on.[802] Critiques of capitalism, neoliberalism, and postcolonial critique add to this picture.

It is through the development of critical posthumanism in recent decades that we encounter a sustained critique of the humanist conception of the human being. This critique targets, in particular, the foundational image of the human as the center of existence. Within this view, human beings have attributed to themselves rights that elevate them above all other living beings, and especially above nature. This position is further grounded in the belief that humans are rational agents—sovereign and autonomous individuals capable of making choices with moral consequences.

This view of the human being has afforded human dignity special protection and has brought progress on many fronts in science and welfare. But, joined together with an untamed philosophy of economic growth, whether socialist or capitalist, it has led to ruthless exploitation of nature, of animals, and of colonized peoples. Given the problems societies in our globalized world are facing—and here one thinks of increasing economic inequality among people, poverty, problems related to drugs, crime, and loneliness—it is timely for all health professions to seek to understand and perhaps influence the mechanisms that create conditions for ill

[802] Ruud, 2020a.

health. Even if music therapy cannot intervene directly to change such conditions, it is still important to be aware that many health challenges in society may be connected to life conditions such as perceived isolation, alienation, and lack of community, with loss of meaning and the resulting mental health problems.

Within such a posthumanist perspective, a music therapeutic focus should be directed toward our vulnerability and how dependent we are on communal solutions. We live within networks of people, technologies, ideas, and social arrangements on which we depend. Such an awareness can counteract the strong tendencies toward individualism that characterize many contemporary attitudes and that become visible in popular culture and social media.

Musical Experience Subjectivizes

By cultivating a humanistic perspective on music therapy, one wishes to create a counterweight to therapy and treatment that reduce the human being to an object. This is something we may encounter in a one-sidedly biomedical therapy, or within a reductionist psychology where the human being is governed by the environment or by neurophysiological processes. This does not mean that such a humanistic perspective on music therapy fails to acknowledge body or biology as central conditions for working with health and therapy. Music therapy does not appear as an alternative form of therapy, in the sense that it rejects knowledge grounded in the natural sciences or practice built on such research. Rather, the necessity of working in teams with other professional groups, of supplementing and complementing rather than replacing, is emphasized.

Human beings must be understood considering their history and context, culture and social setting. Musical experience, which forms the basis for therapeutic interaction and intervention, is no reflection of musical structures. It is an experience of meaning that arises in interaction and dialogue between a person and a musical object within a particular historical and cultural situation.

In a treatment setting where people are often met with assessments, medications, tests, examinations, and diagnoses, the music therapist should offer time and presence, create trust, and listen. Humanistically grounded music therapy is directed toward play and imagination, expression and experience, and offers affirming encounters through music. This music therapy does not proceed only from explanations of illness and interventions built on the client's deficits, but builds on, collaborates with, and expands the client's resources. Further, we have seen how a critical humanism emphasizes social aspects, human rights, and the importance of participation and experiences of community.

Critiques of natural-scientific medicine often carry a desire to present alternatives to medical treatment. We should, however, be cautious with such criticism, since both medicine and humanistic health research fundamentally aim at a liberating practice, as described earlier.[803] To create a counterweight to what objectifies and reduces means assigning value to subjectivity and action, to enabling people to manage their own lives in the best possible way. Objectification is encountered where human beings are reduced to objects that are treated, for example with medication, without this being placed within a relational context.

A Relational Understanding

The opposite of one-sided objectification and a mechanistic understanding of the human being is to meet people with care, trust, time, and love, to build relationships and create hope. This is time- and resource-intensive. It means that the human being is met with empathy and expectations of reciprocity. The relationship becomes central: people are not treated *with* music but are met by a music therapist in a shared musical experience that forms the basis of a relationship.

As we have seen in the description of music therapeutic methods of working, it is through negotiations of a musical mutual understanding that an interaction is established. This happens through playing together and the experience of musical synchrony, using music therapeutic techniques such as mirroring, matching, imitation, and the like. Interaction is also created through eye contact, attentiveness to bodily expressions, and turn-taking. On this basis, the relationship is built, and this is how an "I" is established.

This relational understanding means that our sense of self is fundamentally constituted through people's relationships with one another, writes music scholar Nicholas Cook. This entails a continual participation in one another's becoming. In other words, we come into being through one another.[804]

It is the notion that we have a *self* separate from others, the idea that we are all autonomous individuals, that the psychologist Kenneth Gergen reacts against. The fact that we are so-called *bounded beings*, as Gergen calls it, means that we are fundamentally alienated from each other. We look each other in the eyes, yet our private worlds are inaccessible to one another. In contrast to this "bounded being," Gergen claims that the relationship is a precondition for the self, rather than the

[803] Elsass and Lauritzen, 2006.
[804] Cook, 2024.

other way around. The word "I" does not designate the origin of an action but is a relational production.

It is through interaction that we become individuals with our individual identities. For Gergen, this means that through interaction we are constantly innovative by being sensitive to the diversity of relationships in which we are involved.[805]

Gergen's idea of the relational individual has found resonance in music therapy, namely that we come into being through a relation to others, that we are social beings from the start. Nor is music something that exists only inside our heads, but between us and the world. The idea that music creates an environment that facilitates an encounter, or that music is suited to cultivating the relational individual, is a fundamental assumption in music therapy.

In Brief

If I were to summarize some main points in the humanistic tradition with consequences for a humanistic perspective on music therapy, these could be gathered into five points:

a) The importance of care for the individual and of mutual care.
b) The importance of the relationship and of entering the other.
c) The importance of autonomy, intentionality, action, and self-determination.
d) The importance of the critical.
e) The importance of signs and symbols as carriers of meaning.

A Multidimensional View of the Human Being

As we have seen above, the view of the human being is central when we are to formulate theories and chart a practice for music therapy. Our view of the human being will have consequences for the view of music we adopt, in other words what we fundamentally understand to be the nature and tasks of music. In the following, a multidimensional view of the human being is argued for, in which the human being is understood both as an organism, a person, and a social being.

[805] Gergen, 2009.

The Human Being as Organism

Musical experiences and musical actions rest on a neurophysiological foundation, and reactions to music are accompanied by physiological changes in the body. Bodily gestures form the basis of musical interaction, while the body is also a fundamental reference for the cognitive schemas that govern our perception.[806] Recognition of the body as the basis for perception, interpretation, and reaction to music should not, however, lead to a form of dualism whereby bodily reactions are supposed to explain the effects of music in full.

The body is inherently action and experience, and a prereflective foundation for embodied cognition with the intentional actions that follow from it. At the same time, the brain's processing of musical stimuli is a necessary biological correlate of musical experience and action, but not sufficient to explain musical meaning-making and musical action.

The Human Being as Person

In contrast to the biological view of the human being, many philosophers and psychologists emphasize distinctly human capacities such as language, reflection, choice, responsibility, and, not least, the ability to communicate through symbols. From this perspective, music is understood as an aesthetic phenomenon, opening space for exploring the relationship between musical structure, meaning-making, and the context in which the experience occurs. Whereas a naturalistic view assigns music primarily a signal function, a humanistic perspective places decisive emphasis on the symbolic processes surrounding music and the polysemic meanings it conveys. Within a view of the human being that highlights the importance of language and reflection in human change, music becomes a means of generating associations and metaphors that can be used therapeutically to explore and illuminate life experiences.

The Human Being as Cultural and Social Being

Music therapy is limited when its social dimensions are insufficiently considered. It becomes problematic if the human being is understood exclusively either as an organism or as an individual person, while the social and societal context is neglected. The focus is often placed on the individual's growth and adaptation to

[806] Ruud, 2007a.

society, and more rarely on how society itself might be shaped to better include people and their musical expressions.

The socio-political aspects of the relationship between music and the human being have frequently been overlooked in foundational music therapy theory. To recognize music as a socially constructed institution is to acknowledge the cultural contexts that link music and identity and that provide a language for articulating musical experience. Such awareness enables music therapists to create more supportive conditions for musical communication. Engaging with the receiver's repertoire of musical codes not only strengthens the basis for meaningful musical dialogue but also expresses a fundamental respect for and recognition of the receiver's musical identity and human dignity.

However, attempts to explain how society and structural-economic conditions influence musical socialization—and our understanding of the human being—are not without challenges. The perspective often described as mechanical materialism, which seeks to explain the human being as wholly shaped and determined by society, risks denying individuals their status as subjects. In doing so, it overlooks the human being's grounding in the body, emotions, language, and the capacity for reflection.

A Complexity Paradigm

Rather than reducing the view of music and the human being to one dimension of existence, it seems especially important for the field of music therapy to emphasize interdisciplinarity, the composite nature of the discipline. Music therapy must hold fast to a concept of the human being in which biological, psychological, sociological, and anthropological factors form the basis for understanding the relationship to music, and how this is shaped and placed within a therapeutic strategy. This implies adherence to a complexity paradigm rather than a unity paradigm.

The Concept of Music

As we have seen, there is a relationship between one's view of the human being and one's view of music. A music therapy grounded in a humanistic and relational view of the human being can align itself with a view of music that emphasizes precisely that music is about building relationships among people, groups, and cultures.

A contextual and ecological understanding of music

As we saw in the section on the humanistic view of the human being and of life, the understanding of the human being as a user and interpreter of signs and symbols is central. Within such a horizon, music is understood as narrative texts that give us access to realities, emotions, and the lifeworlds of other people. For music therapy, such an understanding of the concept of music provides guidance for how musical meaning arises, is interpreted, and sets action in motion.

There are many forms of music and musical activities that are sources of health. This means that "music," or "musicking," in this context does not point to particular composers, a special musical genre, or a specific way of listening to or performing music. How we experience music and how music affects us depend on our musical background, influences, the music we ourselves have chosen to use, and the situation within which we experience the music. In other words, music, the person, and the situation work together in a relational or reciprocal relationship in which it is impossible to remove any one of these components without changing the meaning.

This is an important premise for music therapy and music-based health work. In other words, we cannot buy music at the pharmacy that, independently of learning, situation, and mode of use, will work positively. People are their own experts when it comes to knowing what works in different situations. Music that is relaxing for one person in a particular situation may, for others, be provoking and disruptive to peace of mind. The reason this is emphasized here is in connection with some of the humanistic values outlined initially, where autonomy and self-determination were central.

An ecological concept of music

As we saw in the chapter on practice arenas in music therapy, this concerns broad fields of work in which music therapists meet people with health challenges related to bodily, psychological, and social conditions. It is hardly possible to create a universal theory or explanation of why music therapy succeeds under such varied circumstances. There will always be factors related to the person, the health challenge, the context in which the therapy takes place, the method chosen, the relationship to the therapist, and more, that help determine the outcome.

In all situations in which music therapy is applied, there are certain factors that are always present. First, we have the relationship between therapist and client; next, we have the music. But as we know, neither relationships nor music are constant

quantities. What we will try to identify in the following is whether there are traits in music that make it effective in the many different situations that may potentially face music therapists.

For music therapy, music is a medium, a means of promoting what are referred to as extra-musical goals. This is a contested concept of music for positions within culture that wish to hold onto an autonomy-based aesthetic understanding of music. In other words, for those who want music not to have utilitarian functions, but rather to have a purely aesthetic function. That is, in the sense that music and musical experience have intrinsic value, and that one should approach music without thoughts of any "added value" beyond the purely aesthetic or experiential.

Music therapists, however, do not see any decisive contradiction between such an aesthetic understanding and the values that may follow in the wake of involvement in music. Music therapists are also musicians who know how to appreciate musical qualities. They see the value of strong musical experiences. But for music therapists, there will always be certain so-called "paramusical consequences," things that happen in the wake of musical activity, and which are important to safeguard and develop. You gain new friends by taking part in a choir, your sense of mastery is strengthened when you learn to play an instrument, you connect to your home place when you play local folk music, and so on. This applies both to listening to music and to taking part in musical activities. We may therefore say that aesthetic experiences are "useful" in the sense that they enrich life, provide meaning, and influence belonging, identity formation, and existential health.

What has been important for music therapists is to consider the processes that accompany musical activity. For the music therapist, such processes may be just as important as the finished musical product. That is why it is not only "product quality" that counts for the music therapist, but also "process quality," the "ecological quality" that arises when music serves relationship-building, experiences of community, and local belonging.

Music therapists contribute to musicology a new way of understanding and defining music. The discipline of music therapy has expanded our understanding of what music "is" and what it "can be used" for. "How to do things with music" is a rather apt description of music therapeutic practice.[807]

The music therapist Gary Ansdell has offered important contributions to an ecological understanding of music.[808] For Ansdell, this means that everything is

[807] See Ruud 2016.
[808] Ansdell, 2014, Chapter 1.

connected and interrelated in reciprocity. This applies not only to phenomena in nature, but also among people and in society. A flexible, resilient, and sustainable ecosystem depends on processes related to improvisation, cooperation, communication, and reuse.

It is common to think that musical meaning arises at the intersection of a person, the music, and the situation in which musical activity takes place. Ansdell elaborates this by saying that musical use-situations or scenarios involve a specific place, a specific point in time, and specific people. In addition to these dimensions, we must consider further key factors, Ansdell writes. The person involved in musical activity uses specific artifacts, is connected to particular relationships, and is also part of the activity.[809]

If we are to understand musical events, we must grasp the composite ecology linked to the dimensions of music, person, and situation. We must then look at all the connections that exist, not only among these three factors, but also the internal connections and relationships that arise within them. For example, we must study the internal connections among tones, sounds, or musical structures as defined in the musical "text," and as they are performed and experienced by the listener. We must study the relationships among individuals, that is, among the musicians themselves and among the audience. And we must look at the interplay among different groups, such as between the audience and the musicians, or among different audience groups. Ansdell wants us to study all the relationships that arise in the situation, among sounds/tones, individuals or groups, and the physical situation—the size of the room, the acoustics, and the social and cultural meaning attached to the event.[810]

A relational musicology

Musicology provides an important knowledge base for music therapy. This is a broad and extensive field with several subdisciplines, such as musical analysis, music psychology, music aesthetics, and more.[811]

Gary Ansdell draws on musicology when discussing the concept of music. He points to a development that has taken place within musicology which corresponds with what he sees in music therapy practice. What is characteristic of this concept of music is that music must be regarded as:

[809] Ansdell, 2014, p. 26.
[810] Ansdell, 2014, p. 30.
[811] See Ruud, 2016.

- process rather than structure
- something intimately tied to meaning and human affect
- something fundamentally social, which invites participation
- determined by culture and context
- performed, improvised, and "lived" as much as notated and reproduced
- personally embodied and deeply human
- not merely an intellectual phenomenon, but something that happens between bodies
- something that allows for a "performance of the self."[812]

The British music scholar Nicholas Cook has taken musicology in the direction of music therapy.[813] With reference to Gary Ansdell, he has developed a musicology that emphasizes the relational dimensions of music. This is evident in the reciprocal adjustments musicians make in ensemble playing, where everyone's musical intentions must be adapted to those of the other musicians in order to produce synchrony.

All performed music is, in a sense, improvised, Cook claims. The music we create and perform depends on choices made in the moment, through the reciprocal adjustments musicians must make. Underlying musicking are the intimate affective processes that can be observed in parent-infant communication, what I referred to as communicative musicality. We saw how this "proto-musical" communication formed the basis for a somewhat later "teleological" musical communication. Here, sound in itself became of interest to the child, and we could trace the beginning of a musical development with affective roots in the relational.[814]

Nicholas Cook emphasizes how music binds people together, creates empathy, and other dimensions of community. He finds these relational dimensions in classical music, popular music, and world music alike. They appear both in concerts and in recorded music, in community music and music therapy, as well as in other musical practices that fall outside traditional areas of musicology, he writes.

With this, Cook wants to build a general model for how music is understood as collaborative work. This is in order to counter musicology's emphasis on individual expression and stylistic history, something that has come at the expense of music's relational dimensions. Cook takes as his starting point how improvising means

[812] Ansdell, 1997, p. 37, 2003, p. 155–156.
[813] Cook, 2024.
[814] van der Schyff, Schiavio and Elliott, 2022.

working together in real time to achieve close temporal coordination in an ongoing and highly uncertain situation. The interactive processes that occur are a primary source of creativity.

Cook illustrates such musical interactions with two concepts: "entailment" and "the emergent." Everything a musician plays has implications for what is to happen next. Some things continue meaningfully, others do not. Each subsequent intervention will therefore narrow down or eliminate certain possibilities in the continuation, while perhaps opening other pathways—this is what is meant by "entailment." As the musicians play and the music unfolds, such successive implications will lead to "the emergent"—that which arises and appears as something coming into being. In other words, a musical process appears to be in constant change, jointly produced and owned by all who collaborate, and conditioning what is to follow in the music.

In this way, an infinite number of possibilities arise from each participant's utterances, which in turn creates an unpredictable musical course. These two concepts are characterized by collaborative creativity. Creativity thus becomes a property of a larger system surrounding it, while agency is relative, distributed, and relational.

Dialogue and relationship

As mentioned, there is a close link between humanistic thinking and care for the individual. There is an important difference between individualism and emphasizing the individuality of other people. As a counterweight to individualism, it is said that we become human through other human beings.

Music therapists read a desire for contact, attachment, and relationship-building into all musicalized expressions that arise in musical interaction. Such expressions may be cross-modal, that is, they manifest themselves in small movements, gestures, and sounds. It is the music therapist's attentiveness and ability to respond to such approaches that are decisive for how the interactions develop. Such intentional approaches, where playing together becomes interaction and reciprocal communication, form the basis for building a relationship, a dialogue. This dimension was recognized early on within the improvisation tradition on which music therapy is based. In the musical improvisation between two or more people, one saw the possibility of creating symmetry and complementarity in the interactions, a subject-subject relationship built on equality.[815] This "dialogue

[815] Ruud, 1990.

tradition" has been theoretically further developed by music therapists such as Rudy Garred and Karette Stensæth, respectively with Martin Buber and Mikhail Bakhtin as their references.[816]

Central to what is called the "relational turn" in psychotherapy is the view of what constitutes the fundamental driving forces or instincts in a child's life. From early psychology, we know of several attempts to explain what lies behind human action and the search for experience. For example, Freud wanted to explain behavior based on two fundamental drives in the human being: sexuality and aggression. Our interest in art or musical experiences is understood within this theory as a channeling—or sublimation—of more basic biological drives.

Psychologist Abraham Maslow's theory of the hierarchy of needs and the need for self-actualization is another motivational theory that has taken root in humanistic-existential music therapy. Here it should be added that Maslow, as I noted earier, revised his view of this pyramid, with self-actualization at the top of the hierarchy. Maslow later wrote about how it was important to overcome egocentricity, selfishness, and self-absorption, and to open oneself to a greater reality.[817]

Psychologist Ellen Hartmann refers to the psychologist Joseph D. Lichtenstein, who, on the basis of a review of empirical studies from infant research, assumes that the human being has five basic needs: the need for psychic regulation of physiological conditions, the need for attachment and belonging, the need for exploration and self-assertion, the need for distancing, and the need for sexual pleasure or sexual arousal.[818] The driving forces behind action, our motives, are understood as motivational systems developed in connection with these basic needs.

Within such a system, the relational basic motive becomes important: the human being is regarded as fundamentally contact-seeking and meaning-making. "The search for a response in another human mind, creativity and playfulness is what primarily drives us, and it is these motives that give meaning to our experiences of bodily drive, rather than the other way around," it is said.[819] With support from the analyst Stephen A. Mitchell, regarded as the originator of the term "relational psychoanalysis," this search for contact is described as the individual emerging and finding itself within a "relational matrix." Here, self-experience becomes possible through the individual being an agent interacting with others, both outwardly and inwardly. We get points of reference for who we are through a "dance" in which our initiatives and emotional approaches are answered and met by others.

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816 Garred, 2006; Stensæth, 2008.
817 Schnell, 2021.
818 Hartmann, 2000; Ruud 2004c.
819 Binder, Nielsen, Vøllestad, Holgersen and Schanche, 2006, p. 900.

We have seen that music therapeutic improvisation contains this relational matrix. It is understood as a staging of the reciprocal transferences and countertransferences that provide information about the relationship. At the same time, improvisation offers a new form of contact, not least because of the freedom offered in the musical dynamics, the symmetry in the form of interaction—in other words, as a mutual experience of the other as subject.

This form of contact has been described by analyst Jessica Benjamin as a form of "thirdness." The contact is experienced in the "co-created rhythm and melody of parent-child interaction."[820] This can be seen as analogous to the "emotional dance" between mother and infant described by Colwyn Trevarthen,[821] and which is made possible by the functions of mirror neurons.[822] When we read analysts' descriptions of this "third," with all their use of musical metaphors, we understand that the path is short to seeing music therapeutic improvisation as precisely a musical concretization of human interaction and relationship formation, with all that this entails in terms of possibilities for creating a shared space of reflection.[823]

This form of "thirdness" is an alternative understanding and metaphor for good ways of being together in the therapeutic encounter.[824] These are the good encounters that in music therapy have been described as "golden moments," "meaningful moments," and so forth. How such encounters are placed within a relational context was described earlier by Gro Trondalen in her relationally oriented music therapy.[825] By viewing such theories in connection with musical improvisation, in musical interaction that "grooves" and is experienced as characterized by "flow," we see that music therapy has strong prerequisites for creating such a "thirdness."

Participation, community, mastery, and resource orientation

When music therapy is integrated into special education for children requiring adapted instruction, two key prerequisites emerge: (a) an inclusive approach that lowers the threshold for participation, and (b) the adaptation of music and instruments to enable participants to experience a sense of mastery.

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820 Binder, Nielsen, Vøllestad, Holgersen and Schanche, 2006, p. 903.
821 Trevarthen, 2002.
822 Stern, 2004, p. 79. Mirror neurons are nerve cells which activate both when one oneself performs an action, and when one sees someone else perform the same action. Mirror neurons play a role in empathy and social understanding, imitation, language and motor control.
823 Trondalen, 2004; Trondalen and Skårderud, 2007.
824 Veseth and Moltu, 2006, p. 925.
825 Trondalen, 2004.

Such adaptation may involve drawing on the student's resources as they become evident when the student shows attention and responds to the music. In this way, music can help organize sensory impressions, support exploration of the external world, and facilitate the formation of social bonds. Providing experiences of mastery is essential for strengthening students' self-confidence and enhancing their belief in their ability to cope with challenges and tasks—what I have previously referred to as self-efficacy.

As music therapy has moved into new fields of practice, this attitude toward the importance of mastery has been carried forward. Within the mental health field, Randi Rolvsjord has developed a practice and a theory gathered in a model of "resource-oriented music therapy."[826] Here music therapy, as we saw earlies, is placed in relation to theories from salutogenic thinking, feminist theory, empowerment philosophy, and positive psychology, as well as psychotherapy research on effective factors in therapy. When attention is directed toward the client's resources, while at the same time seeing the user's life problems in a broader social context, the user is offered a new space for action in which their own resources are more fully used.

With the development of community music therapy, the value of participation and community becomes an important concern in music therapeutic work.

Health, illness, and care

Earlier, we saw that "health" has many dimensions and is understood in many ways. Health encompasses everything from biological conditions and psychological and social well-being to mutual care and quality of life. We have seen that health concerns the ability to act, existential concerns, and the experience of meaning in life. I have linked health to quality of life and emphasized that health is about subjectively experienced health.

The Australian philosopher Stan van Hooft points out that the key to good care practice lies in a sensitivity toward users' particular life situations, and in a relationship with the user that acknowledges the person's own experience of their health status.[827] This presupposes something more than an objective description of health conditions.

[826] Rolvsjord, 2007.
[827] van Hooft, 2006, p. 107.

van Hooft points to four health models that shape discussion of the concept of health. I have described some of these models in the chapter on music and public health. Through descriptions of music therapy in various practice arenas and in the discussion of different theories and models in music therapy, we have encountered several conceptions of health and illness. These have ranged from purely medical conditions and explanations of illness in terms of brain damage, to understandings from clinical psychology to frameworks that point to structural conditions in society that link power and threat with ill health.

The first health model is the clinical one, which regards health along a continuum extending from the absence of symptoms of illness to an obvious presence of signs of disease. What is called the "role-performance model" pointed to how health can be identified based on our capacity for action and the degree to which we can fulfill our social roles. A third, "adaptive model" of health emphasizes how the organism adapts to and interacts with its surroundings, something that can be supported by sociological theory. We also encountered a "eudaimonic" model, in which health was understood as a resource, as vitality, as a form of existential health.

van Hooft recognizes how these four models safeguard medical, sociological, and humanistic values alike. He nevertheless stresses the significance of our subjective perception of our health condition, or more generally, the importance of subjectivity for the understanding of health. Thus, physician Edvin Schei writes that health can be understood as the ability to act as a subject, with integrity and self-respect, in committed and nurturing relationships. Impaired health means that the ability to be oneself as subject and person has been affected.[828]

For van Hooft, then, health becomes a prerequisite for subjectivity.[829] He elaborates this by saying that becoming a person requires at least four forms of subjectivity—the material, the pragmatic, the conative, and the integrative.

He links these four forms of subjectivity to health in the following ways: The *material* refers to processes in the organism that are necessary for biological life, and therefore forms the basis for the biomedical approach. We have encountered music therapeutic and health-musicking practices aimed at such biological processes when it has concerned the effects of music on stress and pain, or procedures intended to influence bodily processes. It is here that music therapy meets the clinical model.

[828] Schei, 2009.
[829] van Hooft, 1997.

The *pragmatic mode* of subjectivity consists of our everyday practical concerns and activities. It concerns how we fulfill our roles, are effective in everyday life, and live up to an ideal of rationality. Here, health manifests itself through an absence of problems. It is here that we can see the value of linking health to lifestyle and of practicing a cultural immunology that, for example, helps promote participation and counter disease-producing behavior arising through social isolation.

An important form of subjectivity in our context is what van Hooft calls the *conative*. This is a form of subjectivity that feels absent from our self-awareness. In other words, we do not think that it has anything to do with our health if everything is functioning well. Conative subjectivity refers to something we strive for, and it occupies a space lying between the purely bodily and the mental. This experience of subjectivity links desire, emotion, and inclination, van Hooft says. It is here that we can place the need to form a relationship and attachment to other people. As said, the search for a relationship is a fundamental human drive.[830]

For van Hooft, desire and care are central characteristics of the conative form of subjectivity. This is shown in the need to reach beyond oneself, to direct oneself toward other people and take possession of the world, to nourish oneself and achieve satisfaction. This is a form of subjectivity that opens experiences of pleasure and joy. van Hooft draws here on the philosopher Levinas, who brings joy in as a basis for our engagement with the world. Pleasure and joy are not least linked to musical experiences and constitute an important source of experiences of subjectivity.

We see this motivation to reach toward the world in connection with what I wrote about the importance of forming a relationship. I have placed this relational dimension at the very center of the understanding of the possibilities for change that music therapy offers. This is justified based on a relational view of music. Now we can also connect it to an important aspect of health.

It is in van Hooft's final mode of subjectivity, the *integrative*, that we integrate music, identity, aesthetic experience, and health. The integrative form of subjectivity concerns our striving for meaning in life. The integrative dimension seeks to connect life's events and experiences with our self-understanding, and to articulate this meaning by linking past, present, and future together in a narrative, a story about ourselves, an identity. This mode creates coherence in existence, an overarching worldview, and expresses a basic trust in life.[831] In this form of existential health, music becomes an important source of the experience of

[830] See Leonard and dos Santos, 2025.
[831] Schei, 2009.

meaning, of resonance, and of raw material and glue in the autobiographical narrative. It is here that we can draw on Hartmut Rosa's understanding of the importance of developing sources of resonant experiences.

I have pointed to such aspects of health in the discussion of existential health. We have seen how musical experiences can provide raw material in the story that constitutes our identity, and how engagement in music can be a source of experienced meaning in life. Autobiographical memories and reflections on the values accompanying situations in which musical experience has taken place help create continuity and coherence in life, which is the hallmark of integrative subjectivity. I have pointed to the value of writing life stories into text and music, reflecting on music and values, and opening axes of resonance that create existential health.

Society, culture, and systemic aspects

Humanistic traditions in music therapy incorporate strong elements of social scientific theory, drawing on contributions from sociology, anthropology, and cultural studies. This is reflected in an understanding of music therapy as a situated practice. In other words, it requires attention to the broader context in which music therapy takes place. Such an approach calls for sensitivity to, and awareness of, the cultural, contextual, and systemic—or ecological—relationships that shape the practice.

Context

A central premise in music therapy is the need for context sensitivity. This implies that therapists should not approach practice with a fixed method applied uniformly across individuals, regardless of differences in age, ability, culture, or institutional setting. While the extent to which this occurs may be debated, there are clear examples of music therapy—or the use of music in therapeutic contexts—that lack such sensitivity. For instance, the assumption that the same piece of music will have identical effects across different groups overlooks the importance of context.

A contextual perspective on music holds that meaning emerges through a dynamic interaction between the listener, the performed musical object, and the specific situation. Within this triangular relationship, musical meaning shifts when any one of these elements changes—whether through altered listening strategies,

variations in the music or its performance, or transformations in the performance context, such as a move from a concert hall to digitally mediated listening.

Such context sensitivity has led improvisation to become a central method in music therapy. The possibilities for individual adaptation that improvisation offers in terms of meeting the client directly at the level of their musical code-understanding or cultural and historical background have given music therapists a particularly strong tool for creating contact, dialogue, and relationship.

In music therapy, however, the concept of context is understood in several ways. Randi Rolvsjord and Brynjulf Stige have explored this concept theoretically and suggest that it is used in three distinct senses. First, music therapy is always seen as taking place within some form of context, and therapists must remain attentive to how the frameworks surrounding practice influence therapeutic processes. These contexts are not limited to material or institutional conditions; they also include ideas and therapeutic paradigms that shape how therapists interpret situations and plan interventions. In this sense, context can be understood as a cognitive frame applied to a situation, influencing how events are perceived and interpreted. [832]

Rolvsjord and Stige write that we can understand music therapy itself as a context. This means that there are many factors within the music therapy situation itself that influence the course. Psychotherapy researchers, for example, have pointed out that personal and sociocultural factors influence the outcome of therapy. It concerns the relationship between therapist and client, hope and placebo effects, the therapist's personal characteristics, and possibly other external factors. Music therapy is thus regarded as a complex intervention, which creates difficulties in standardizing research conditions sufficiently for results to be comparable, as one wish in RCT studies.

A third way of understanding the concept of context is through the metaphor "link," which points back to the original Latin meaning of the concept: *con* (together) and *textere* (to weave). This gives us "music therapy as interacting contexts," write Rolvsjord and Stige.[833] Here music therapy can be seen in a broader ecological connection, something Bronfenbrenner's theories illustrate. In such contexts, the music therapist operates in the client's local environment, within an institutional context, within a music culture, a health policy, and a multidisciplinary academic discourse. The point here is that these contexts interact, which means that music therapy will in turn affect the surrounding context. Community music therapy becomes an example of a cultural practice aimed at social change that is beneficial

[832] Ruud and Kvifte, 1987/2000, https://www.hf.uio.no/imv/personer/vit/emeriti/evenru/musikk-og-identitet/
[833] Rolvsjord and Stige, 2013, p. 57ff.

to the users of music therapy. In other words, music therapy can lead to changes in how people, places, and events are linked together, and changes can occur at the systems level.[834]

Culture

I have emphasized the importance of considering musical cognition and musical codes, viewing musical language as something learned within a cultural context. To establish meaningful contact through music, it is therefore appropriate to draw on codes that are familiar to clients. In many cases, this may involve music from children's television, well-known children's songs, popular music, or other forms of music that are familiar within a given age group.

The concept of "code familiarity" acknowledges the importance of cultural conditions in music therapy. The organization of musical language into codes is not merely a cognitive structuring into autonomous schemas; rather, it involves the learning of rules shaped by cultural content. To understand music is to decode its multiple layers of meaning, a process that presupposes cultural knowledge and participation. The same applies to language and action more broadly. In this sense, all human behavior is embedded in cultural forms, making culture an integral dimension of any interpretation of human action.

The notion of code familiarity encompasses both cognitive and emotional aspects of music perception. At the same time, musical identity is closely linked to experiences informed by values, which themselves are rooted in social and historical contexts. These values are often experienced as part of enduring cultural traditions.

This perspective is particularly emphasized in postcolonial critiques of music therapy, which highlight the risks of overlooking musical and health-related traditions that remain vital within the communities practitioners engage with. Accordingly, music therapists must cultivate a strong sense of cultural humility in their work.

A systemic/ecological perspective

Working with music and individuals must be seen within a broader context. It is important to look beyond classrooms and institutions and seek to create contact

[834] Rolvsjord and Stige, 2013, p. 56.

with the larger society. Creating a bridge to society, facilitating integration, gives music therapy effects of longer duration. Thinking holistically, or systemically, is a challenge for music therapy. Systemic thinking presupposes that many conditions are woven together. This means that many relationships are indirectly established and maintained by working in unconventional arenas.

Concepts such as environmentally oriented (Aasgaard) and ecological (Bruscia) music therapy capture essential aspects of the systemic and ecological way of thinking and working. Aasgaard sees the necessity of working with the environment in the institution, changing some of the local institutional contexts, for example doing something about the environment on the hospital ward itself. Bruscia links his ecological understanding to systems theory, which emphasizes that changes within a system have effects in quite different places from where the intervention is applied.

Performance-based

In the establishment phase, music therapists could sometimes have a somewhat ambivalent relationship to performances or the concert format. Often it is the process that stands at the center of music therapy, not the product itself. At the same time, there are many situations in which it is natural and important to show what one has worked on, both to challenge one's own abilities and to show the outside world what one can do. Performance is often involved in music therapy as part of what Gary Ansdell calls an individual-community continuum.[835]

Performance-based methods must be conceived in such a way that participants are seen in a particular way by their surroundings, and that this results in their being connected to their local environment, or that the local environment changes to receive them. This again is a prerequisite for a greater degree of integration and social participation. Precisely this systemic perspective on performance is a distinguishing characteristic of a music therapy that has integration and social participation as its goal.

Theory and knowledge development

Theoretical foundational research is not aimed at measuring the effect of music therapy, that is, the degree to which we register and measure change. Rather, we

[835] Ansdell, 2006.

want to understand the effective processes within the therapy course, and the prerequisites and contextual conditions for successful therapy. This may involve understanding what lies in concepts such as "communication," "context," "participation," "identity," and so forth. These are concepts or phenomena explored in other fields, often in sociology, psychology, and anthropology, or in hyphenated disciplines such as music psychology, music sociology, and music anthropology. Working with theoretical development in music therapy requires an overview not only of one's own field, but also familiarity with theories from the field from which one wants to draw insights.

Theoretical development within music therapy concerns using insights, knowledge, and theories from other disciplines to understand music therapy practice, as well as developing theory and understanding through practice and experience. We have seen how theories from psychotherapy, medicine, and musicology help build some of the foundation for our understanding of how music affects us and becomes part of a process of change.

In the following, I will outline some challenges related to demands for scientificity. This includes issues touching on elements of research practice, the question of evidence, and challenges related to music therapy's interdisciplinary and multidisciplinary identity. We ask what happens when music therapy borrows its conceptual understanding from other disciplines.

Some central principles of research

As I wrote, a humanistically oriented music therapy recognizes both quantitative and qualitative research. The requirement for evidence-based knowledge should not be tied first and foremost to empirical quantitative research but acknowledge that forms of understanding used in the qualitative exploration of people's lifeworlds provide valuable knowledge about relationships between the use of music and the attainment of health.[836]

We must assume that there is a health practice out there that can be described. In other words, the point of departure here is not purely constructivist. A standpoint called "expressionism" emphasizes that there are features of reality that can be brought forward and made visible in a description. At the same time, reflexivity, together with some other central research principles, becomes important in the sense of making one's pre-understanding and theoretical position visible.[837]

[836] Daly et. al., 2007.
[837] Alvesson and Sköldberg, 1994; dos Santos, 2025. See also Ruud, 2010.

Empirical closeness

Closeness to the empirical material and attention to its details are important for good research. Whether music therapy research takes place within positivist or phenomenological traditions, analyses and interpretations of practice, effect studies, and theory-building depend on good data gathered through controlled and systematic procedures. The empirical material must secure the basis for verifiability, not only in the sense that experiments can be repeated, but also in the sense that, in qualitative studies, one should be able to follow an argument or interpretation all the way back to the empirical material.

Interpretation and pre-understanding

Just as important as the quality of the empirical material is an understanding of the role of interpretation. This involves understanding that one's own pre-understanding influences research questions, focus, and the selection of theory. It also involves understanding that interpretations are influenced by theories and theoretical imagination. Literature studies form part of interpretation, and theory development takes place within a synthesis of the interdisciplinary and multidisciplinary field inhabited by music therapy.

Critical position

Music therapy should always adopt a critical stance toward its historical and social role. It should attend to the consequences of music therapy both for the individual user and for cultural practices in society. Such reflexivity means bringing theoretical traditions from critical theory, feminism and gender studies, critical posthumanism, post-structural theory, and postcolonial critiques into the field.

Reflexivity in language and metaphors

It is important to understand the significance of the language and metaphors one uses to describe what happens in therapy and in research. An awareness of the role of discourses in the shaping of reality, together with an analytical attitude toward the choice of theoretical terms, concepts, and metaphors, will reveal the positions one invests in and thus defends. There is power in discourses, for better and for worse. Reflexivity should help make visible the relationship between language, power, and reality.[838]

[838] Ruud, 2005b. See dos Santos 2025 for a detailed and thorough discussion of reflexivity.

Research traditions and evidence-based practice

What should be central in the following are the different scientific traditions, views of the human being, and values that shape and create differences between the criteria to be used as a basis for evidence in research. The health care system is not a uniform entity but consists of many professional groups with different scientific foundations. At the same time, there are two main cultures in the scientific world. One is naturalistic, from which quantitative research derives. Another is humanistic, marked by hermeneutic theory, and forms the basis for the use of qualitative methods.

Those who defend a natural-scientific and quantitative research tradition in music therapy emphasize control, effectiveness, and quality as important standards, just as in medical treatments. This has formed the background for important music therapy research within several randomized studies conducted in collaboration with researchers and music therapists from several countries. The humanistic tradition in music therapy has also promoted a qualitative and theoretical research tradition. Not least, the establishment of the *Nordic Journal of Music Therapy* became an important forum for presenting qualitative research. This tradition is concerned with understanding, not merely effect measures, which makes the use of qualitative methods natural.

The two research traditions ask different questions. Within the humanistic or hermeneutic tradition, the researcher will try to understand rather than to prove in numerical form how and why a therapy form is valid or effective. In this type of interpretive research, one wishes to gain a more holistic picture of the therapeutic situation in question, including the experiences of the user, relatives, and other professions. Both the music, the user group, and the therapy are complex phenomena. There are forms of therapeutic interventions and events that are not measurable and that are not well suited to quantitative effect measurement.[839] A good example here is music therapy with children in palliative care.[840]

The view one has of illness and health naturally plays a role. Music therapists do not primarily focus on curative treatment of somatic injuries and diseases. Music therapy focuses primarily on health-promoting measures and is concerned with facilitating interaction, mastery, and participation.

[839] See Kristiansen, Stige and Helle-Valle, 2023 for an example of interpretive research.
[840] See Kammin and Russel (Ed.), 2025.

Evidence-based practice (EBP)

We have encountered the term "evidence-based practice" several times in this text. Psychology professor and psychotherapy researcher Michael Helge Rønnestad asks what kind of knowledge should underlie professional practice, to what extent practice should be research-based, what kind of research practice should be grounded in, and not least whether professional (clinical) expertise is a legitimate knowledge base.[841]

Evidence-based practice should be based on "evidence."[842] This means relevant research-based knowledge. Documentation and interpretation of collected data should be controlled, carried out with a clear methodology, and include a philosophy-of-science perspective. Results should be represented in systematic meta-studies or Cochrane reviews.

A hierarchy of evidence has been created, in which evidence from meta-studies ranks highest. Then come so-called RCT studies, systematic reviews of studies with homogeneous results, cohort studies, systematic reviews of case studies, case-based evidence, and finally expert opinions without explicit critical evaluation.

We have seen that music therapy provides many kinds of empirical evidence for its work. Not least, music therapy today can point to a range of meta-studies in the form of Cochrane reports. These incorporate and analyze a number of sub-studies according to specific inclusion criteria. Biomedical, behavioral therapeutic, and other traditions in music therapy all point to quantified results, even if not always in the "gold standard" that seems to stand at the top of the evidence hierarchy.

However, the requirement for a specific type of quantification in music therapy research runs into methodological problems that may exceed what music and arts therapies can solve without doing violence to forms of practice and aesthetic specificity. Submitting to quantifiable evidence requirements can lead to certain methods of work and practice arenas becoming overemphasized at the expense of some client groups, human problems, and professional questions. There is a danger that such research weakens the ecological validity that is safeguarded when music therapy research takes place in relation to a diverse practice reality.

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841 Rønnestad, 2008.
842 Jacobsen, Pedersen and Bonde (Ed.), 2019, p. 437ff.

Psychology professor Helge Rønnestad is likewise critical of the experimental and biomedical evidence requirement that psychologists may face. He recommends following the American psychologists' definition of evidence-based practice, which states:

> *"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."*

Rønnestad also has a broad view of research, in which, for example, clinical observation and qualitative research must be taken into account. He also defines clinical expertise, which includes using interpersonal expertise, for example the ability to create an alliance with the patient, maintain ongoing self-reflection, and be aware of one's own limitations. When it comes to taking patient characteristics, culture, and preferences into account, gender and gender identity, ethnicity, social class, environmental context such as racism, and stressors such as unemployment and significant life events all matter. Knowledge from a broad spectrum of fields is important, as is knowledge of and emphasis on the client's treatment preferences. "User participation is thus part of the understanding of evidence-based practice," Rønnestad concludes.[843]

Critique of evidence-based practice

In addition to the requirements that may be placed on psychologists, we may also ask whether there are other aspects of the arts-therapeutic approach represented by music therapy that must be taken into account when assessing what kinds of evidential demands are appropriate. Kenneth Aigen has discussed the consequences for music therapy if its evidential basis becomes too narrowly defined.[844] This concern is particularly relevant when an evidence hierarchy becomes decisive for which practices are considered legitimate, and when meta-analyses of randomized controlled trials (RCTs) are placed at the top of that hierarchy.

Aigen argues against a model of music therapy that simply adapts itself to the framework of evidence-based medicine. Instead, he points to alternative traditions within music therapy that are resource-oriented, culture-centered, relational, and humanistic in their value orientation. These approaches contrast with the biomedical perspective and the disease model on which it is grounded. Aigen

[843] Rønnestad, 2008
[844] Aigen, 2015.

offers a strong critique of the dominant notion of evidence, distinguishing between "evidence" and "proof."

We have seen that music-centered music therapists have wanted a less instrumental approach to clients. They have emphasized the very experience of music as an important element in music therapy. This has been difficult to articulate and not easy to use as a basis for legitimization, given how hard it is to find words for music therapy processes. This is part of the reason why the music therapist has chosen to borrow language from special educators, psychologists, and medical professionals in order to enter into dialogue with other professions.

We saw how Kenneth Aigen was a spokesperson for so-called "music-centered" music therapy. Here, musical participation and aesthetic experiences are themselves the motivation and driving force in therapy, and what creates the foundation for change.[845] This is documented through audio recordings, video, conversations, observations, case descriptions, and the like. If only so-called "gold standard," randomized and controlled studies are allowed to dominate, this will result in users losing valuable music-based services. An exemplary illustration of descriptions and interpretations of a music-centered practice can be found in Gary Ansdell and Tia DeNora's research project *Care for Music*.[846]

It should be added here that RCT studies are difficult to carry out in music therapy. This is because it is challenging to create large enough studies with control groups. In addition, it is problematic to construct standardized procedures or protocols for music interventions that include improvisation and in which the relationship between therapist and user is so decisive. One point in this connection is the critique that has developed from evidence theory itself. This problematizes how research that has provided evidence of effect in one context will not necessarily work in entirely different contexts where a number of unpredictable conditions will always be at play.[847]

Theories, models, and explanations

I have described the many practice arenas in music therapy, with different forms of musical and methodological approaches, as well as different professional roles and forms of collaboration. In addition, I have described music therapy as a

[845] Aigen, 2005.
[846] Ansdell and DeNora, *Caring for music* (under production).
[847] Cartwright and Hardie, 2012.

subject, or a discipline, within a network of other disciplines such as psychology, musicology, philosophy, medicine, and more.

The question then becomes what characterizes this discipline, what it encompasses, how it is described, and how it relates to adjacent disciplines. The discipline of music therapy is something more than what has so far been described as different forms of practice or professional activity. Music therapy in its entirety refers to the relationship between music and health. This encompasses not only the professional practice pursued by the music therapist, but also a public health aspect, in which we are concerned with how music is used and influences health and quality of life in everyday contexts. We may expand the perspective still further and ask how our entire sound environment, not only music, affects our health.

It is not only music therapists, but also other professional groups and research disciplines, that are concerned with how music and health are connected. Besides music therapists, there are a number of actors concerned with this relationship. Here one should mention music educators and not least those working within community music. Musicians in many countries are engaged within the health services. We find health personnel who use music in milieu treatment, care, and research. In addition, we have researchers concerned with public health and how many people listen to music in everyday life in order to regulate their health. Music researchers point to how music contributes to emotional experiences and creates community through ensemble playing and concert experiences, both through physical participation and on the internet.

A heterogeneous knowledge base

Music therapy knowledge rests on a multidisciplinary foundation, on experience-based knowledge, and on knowledge of the user groups with whom we work. Philosopher Harald Grimen asks in a book about professional knowledge how unified the knowledge base of professions actually is.[848] He discusses this in light of different views of knowledge, so-called epistemic dimensions. One dimension concerns the degree of homogeneity in the knowledge base.

Homogeneity concerns where the elements in a profession's knowledge come from, whether they derive from the same scientific discipline or field of knowledge, for example from physics, chemistry, or biology.

[848] Grimen, 2008.

When the knowledge base is composed of different scientific disciplines or fields of knowledge, we speak of a heterogeneous knowledge base. A look at the knowledge base of music therapy tells us that the degree of heterogeneity is high. Music therapy theory draws its knowledge base from medical research, biology, physiology, and neuropsychology, as well as from the humanities and social sciences. An important dimension we should not forget is the element of knowledge derived from artistic research, in which aesthetic and musicological disciplines help shape theory.

Another dimension in this knowledge base, Grimen writes, is the degree of integration among the elements of knowledge. This refers to whether the elements are connected in a system, or whether they are highly fragmented with few or no logical connections among them. If the elements are drawn from a heterogeneous field, integration will easily be weak. This applies, for example, to the social sciences, where research traditions stand in conflict with one another. Music therapy theory faces a considerable challenge in integrating elements from different, and fragmented, fields of knowledge.

Some choose to emphasize knowledge and explanations that point back to a single field. This happens, for example, when descriptions and explanations seek support in neuropsychological research, as in music and brain research. It is often possible to support reactions to music by pointing to how certain regions and networks in the brain are touched or activated by musical impulses. The amygdala has been pointed to with regard to emotions, or the hippocampus when we speak about memory. As music-and-brain researchers become increasingly skilled at identifying specific connections between music and brain activity, the arguments that support descriptions of why music and music therapy have their particular effects are strengthened.

Without bringing contextual, relational, or cultural aspects of the situation into the picture, it will always remain a question whether such explanations are sufficiently adequate. This may, for example, become apparent when simplified conclusions are drawn about the therapeutic effects of music by pointing to reactions in certain areas of the brain. Brynjulf Stige points out that there is a difference between activation and activity.[849] Activation takes place in the brain, and it is always linked to an activity, be it listening to or performing music. And such activity always takes place in some context, always in relation to other people, to technology, instruments, environment, culture, and so on. In other words, we cannot create explanations that leave out large parts of the situation in which musicking human

[849] Stige, 2022, p. 556-557.

beings find themselves. This is consistent with a relational ontology that grants ontological status to relationality.

The next dimension concerns the ability to create integration in knowledge. This is about theoretical and practical syntheses. In a practical synthesis, the issue is the demands placed by the profession's exercise of practice, where not all knowledge elements necessarily need to cohere. The question Grimen then asks is: What creates unity in a profession's knowledge?

This question is not easy to answer from a music therapy theoretical standpoint. Yet some of the central discussions in music therapy have concerned the extent to which music therapy practice should seek support in an overarching theory of treatment, for example learning psychology/behavior therapy or humanistic psychology. Or whether it is possible to create synthesizing explanations and understandings without importing treatment theories, and instead develop a music-centered knowledge base.[850] Other attempts to integrate the heterogeneous knowledge base on which music therapy rests can be found in approaches such as "community music therapy,"[851] "culture-centered music therapy," or "humanistic music therapy."[852]

Practical and tacit knowledge

There is knowledge referred to as "tacit" or "practical." This is knowledge that shows itself in the application of practical skills, through the use of music therapeutic methods. This knowledge appears in clinical, relational, and craft-based skills linked to musical performance.

Harald Grimen has problematized the relationship between theory and practice, which is a central issue for the professions. This applies not least to a profession such as music therapy, where the exercise of the profession rests on musical skills in interaction situations, and where language is often neither necessary nor applicable. When the relationship between practice and theory is discussed, it often concerns theoretical knowledge and research that verifies claims. This concept of knowledge builds on an idea of correspondence between the world and our linguistic representations. Tacit knowledge, however, cannot be articulated in this way.

850 See Aigen, 2005.
851 Stige and Aarø, 2012.
852 Ruud, 2010.

Grimen points out that in the professions one often complains that theory and practice are not well integrated.[853] We encounter this in music therapy in the attempt to connect music therapy theory with practice experience, for example by bringing them closer together. There are, however, two different ways of understanding the relationship between theory and practice. One view is that practice can be derived from theory, that practice is theory put into operation. An example of this might be that we have a theory that we experience emotions when music fulfills, frustrates, or surprises our expectations, as music psychologist Leonard Meyer proposed in his theory. Such an understanding can be tested in practice by the music therapist improvising in a way that creates musical tensions and expectations, and then inviting the client to respond. This can yield responses that generate musical meaning, create experiences of intersubjectivity, and foster the development of intentionality.

There is also theory in music therapy that cannot immediately be translated into practice. Examples can be drawn from knowledge of music and brain research, which admittedly tells us how and where music is processed in different brain regions. Yet it is difficult to find a concrete application for this knowledge. Much of what music therapists do may also lack any clearly defined theoretical basis.

The knowledge base will often be heterogeneous and rest more on a practical synthesis than on a specific homogeneous and coherent theoretical foundation. Another way of understanding knowledge is to regard theoretical knowledge as something floating on a base of practice, Grimen writes. Theoretical knowledge then becomes a way of articulating practice. The theory of musical expectations is, in other words, primarily derived from our practical engagement with or listening to music. Grimen refers to the philosopher Wittgenstein, who says that practice must speak for itself.

Knowledge that cannot be immediately expressed in language, or that does not meet the requirements placed on knowledge as "true representations" of reality, has been given designations such as "tacit knowledge," "intuitive knowledge," "everyday knowledge," or "action knowledge." Philosopher Gilbert Ryle speaks of "knowing how"—being able to do something—as opposed to "knowing that," which concerns knowing something.[854]

Practical, or tacit, knowledge is characterized by what is called "indexicality." This means that it appears in a way that shows where it comes from. If one has learned to improvise with Paul Nordoff as a model, this will reveal itself in practice—we

[853] Grimen, 2008.
[854] Grimen, 2008.

speak of an "improvisation school." Here, origin, context of use, and bearer of the knowledge are not interchangeable. This knowledge is expressed in actions, judgments, assessments, and discernment, Grimen maintains. In the philosophy of knowledge, such knowledge is referred to as *phronesis*, a concept derived from Aristotle. This entails a type of skill in assessing a situation, one that is acquired primarily through experience and grows with experience.

This indexed, practical, and tacit knowledge is bodily. It is deposited in the body through practiced skills in specific situations. It can only be acquired from a first-person perspective and is to a large extent specific to the activity, says Grimen. The statement "we can know more than we can say" has many interpretations pointing toward the characteristics of tacit knowledge. An example from music therapy may illustrate this. When we improvise with a client, we are not thinking about harmonic rules or theories of communication. The large theoretical field of knowledge that may be linked to music therapeutic improvisation is subsidiary in the situation itself, and not in focus. Nor do we have full command of this knowledge. If this knowledge is brought in explicitly, improvisation is easily disrupted. Much of what one does in such a situation is therefore linguistically inarticulable.

Mastering a musical instrument rests on practical knowledge that has similarities with learning to ride a bicycle. This is knowledge that does not consist of propositions. But even if such knowledge cannot easily be articulated through language, it can nevertheless be articulated through action. Language may be inadequate when such familiarity knowledge is to be learned. Again after Wittgenstein, this is learning through examples and guided instruction. One cannot learn how music therapy is carried out in practice, how it "sounds," without being present or using one's hearing. This is why physical presence linked to practical training must be central in the education of music therapists.

Even though language is not sufficient when such familiarity knowledge is to be learned, language is still important when used to point out how a problem is solved. We saw that this played an important role in theory and practice related to guidance in music therapy, whether it concerned guidance of the child, parents, other professions, assistants, or students in practical supervision.

Are there universal explanations in music therapy?

Given the diversity of practice forms and arenas in music therapy, and not least what has been described above concerning the knowledge base of music therapy, it is difficult to imagine that there is only one explanation, or one answer, to why

music therapy is an effective form of therapy. Such explanations are sometimes sought in romanticized notions of "music as a universal language" and the like. But we see that the practice forms and goals of music therapy are so varied that such universalizing explanations are not adequate.

Local explanations

When we cannot justify or formulate an overarching answer, we are left with explaining why music therapy works at the local level, that is, for the individual client, in a particular situation, within a specified method of work, and carried out in relation with a particular music therapist. At best, one seeks to generalize such an explanation to apply to groups of users within a specific field of practice, or with a common health challenge.

The problem of heterogeneity in the knowledge base is that the field itself becomes fragmented and that tensions arise among different traditions in the philosophy of science, followed by a splitting into a range of models or paradigms. In that respect, it would be beneficial to seek theories and modes of understanding that have an integrating effect on the field.

Even if it does not succeed in finding a unifying theory for music therapy, there is nevertheless something common to all music therapy—namely music itself. If one wishes to find something that unites all forms of music therapy, all goals and methods, all situations and contexts both locally and globally, one must seek to determine whether there is something substantial in musical expression and interaction that becomes operative in the field of health. Earlier I pointed to an ecological view of music as a proposal for a unifying concept of music in music therapy.[855]

[855] Ruud, 2020a.

AFTERWORD – A DIVERSE DISCIPLINE IN CONSTANT DEVELOPMENT

8

Afterword – A Diverse Discipline in Constant Development

With this afterword, I wish to summarize some key insights that are important for the further development of music therapy. We have seen that both research and clinical experience suggest that a sociological perspective on music therapy is highly relevant—not least in light of Hartmut Rosa's sociology. The relationship between experiences of resonance, relational experiences, and existential health constitutes an important contribution to understanding how music, as a cultural immunogen, may play a role in public health work.

Furthermore, through this account of knowledge, I have become aware of how the field of practice continues to expand, and how the volume of research findings is steadily increasing. New practice arenas are being established continuously, and a growing body of studies and research reviews testifies to a discipline in ongoing development. At the same time, we have seen challenges related to describing music therapy through a quadrant model intended to provide a holistic understanding of this fragmented field of knowledge. I have referred to existing critiques, and I see a need to develop a new theoretical framework for describing the discipline.

One possible way forward may be to draw on insights from poststructuralist theory and agential realism—a perspective I wish to point toward in these concluding remarks.

A SOCIOLOGICAL FRAMEWORK

When Kenneth Bruscia wrote the foreword to Brynjulf Stige's *Culture-Centered Music Therapy*, he pointed out how psychology, throughout its history, had been influenced by several theories and schools of thought, or "forces of thought," as he called them. These currents of thought were all gradually integrated into the discipline. In a somewhat different sequence, he believed that music therapy had undergone a similar development after it became established in the United States in the 1950s.[856]

At the start of modern music therapy, people were concerned with how music affected our biology and physiology. This led, among other things, to natural scientific research into our physiological reactions while listening to music. Later, attention turned to learning psychology, and behavior-analytic music therapy was developed, yielding measurable results. At the same time, there was interest in how music could reveal unconscious dimensions of musical experience and what consequences this might have for music therapy. This is what we know from analytically oriented music therapy.

Over time, greater attention was given to music's role in self-experience and spiritual development. It is here that we find humanistic-existential music therapy, and its transpersonal continuation. The culture-centered approach thus represents, according to Bruscia, a provisional final stage in this development.

It must be added, however, that all these approaches now exist side by side. As an extension of the first phase, we have, for example, developed a strong tradition of music and brain research. Behavior therapy, now also in the form of cognitive therapy, as well as analytical, humanistic, and transpersonal music therapy, are all well represented. Likewise, culture-centered thinking has made its way into community music therapy and into other music-therapeutic approaches.

Since this development does not appear to be stopping, could we then imagine a further stage in it—adding theoretical perspectives that take up and expand the field of music therapy?

[856] Bruscia in Stige, 2002.

The sociological perspective – an expansion of the field of practice?

This is where we can see a more clearly sociologically grounded music therapy as an expansion of the field of music therapy.[857] If one assumes such a development, it naturally becomes necessary to present arguments showing that such an understanding of music therapy really does designate a necessary perspective. Here there will likely be several overlaps with other approaches, not least with community music therapy and the culture-centered turn, which incorporates rights-based, political, and socio-ecological aspects.

If we return to the quadrant model, such a sociologically grounded music therapy would be located in the lower-right quadrant. This was described as the "collective exterior" and refers to systemic aspects of our existence: social structures, institutions and organizations, as well as our physical environment. It is here that we see the development of a more overtly political music therapy, one concerned with questions of power and social class, and with how material and structural conditions in society help hinder people in their capacity to act. It is in this connection that we have drawn upon Hartmut Rosa's theories of acceleration and resonance. This quadrant can be filled with content that draws it away from the universal or archetypally shared-human elements that are sometimes attributed to it.

If we return to the definition of music therapy as an attempt to expand people's possibilities for action and experience, it was strongly emphasized that such possibilities are blocked by material, structural, and socially produced conditions. Disabilities and mental health challenges can in this way be understood as the result of such blockages, and not solely as individual problems. We may consider how human problems—what has been referred to as mental ill health—become intelligible within the Power-Threat-Meaning framework.

Throughout this text, I have referred to a range of new critical themes that are now entering music therapy. Much of this critique is summarized under the umbrella of critical music therapy. Here, one must briefly mention the connections between economic inequality, poverty, and illness; ill health among refugees and in situations of forced migration; the aftereffects of colonialism; and the oppression of groups with different sexual identities. Likewise, we may point to how social media affects the field of health through social pressure, the development of individualism, and the breakdown of traditional social networks. The sound

[857] Ruud, 2020a.

environment surrounding us is also especially important when we speak of influences at the macro level.

A contribution to public health work

Such a sociological perspective resonates well with the idea of music therapy as a cultural movement and not merely as a new therapeutic discipline. This is an idea that emerged early in my writings.[858]This sociological and cultural framing also became visible in my own definition of music therapy. If we carry this idea further, we see that this sociological perspective opens the way for thinking of music therapy as part of public health work.

Throughout this book, we have seen that parts of the knowledge and methods that emerge from music therapy research and practice can contribute to how people may use music to regulate their own health. Just as in antiquity, when music was considered part of medical advice and guidelines for maintaining a good life, we now see that this knowledge can be documented. Music as a source of existential health, and its contribution to motivating us to preserve our health, deserves greater attention. How music moderates bodily and illness-producing processes by lowering stress levels is well grounded. By offering emotional regulation, participation and community, experiences of mastery and meaning, music deserves a role as a cultural immunogen.

With a concept of music that points to how music creates relationships, together with an integrative concept of health that encompasses several dimensions of our subjectivity, we have a foundation on which to defend music's place in preventive and health-promoting work.

Agential realism and post-structural theory

By building further on such a sociological perspective on music therapy, I have further complicated the picture of a discipline that was already composite and threatened by fragmentation. This brings us back to the question of how we can describe the discipline, preserve its diversity, and create a space for the continued development of the field without creating binary oppositions. The question is whether there exists a language capable of describing this diversity of knowledge and the practice we encounter in music therapy. In what follows, I will suggest one

[858] Ruud, 1980a, 1998a, 1998b; Ruud and Mahns, 1992.

possible way forward. Considerable theoretical work would, however, be required to develop such an understanding further.

I wish, then, to describe the field of music therapy with a language that makes room for the tensions, energies, and forces at work within it. The description should avoid producing binary oppositions between different understandings and practices, and should instead attend to how music-therapeutic situations might better be described using concepts such as multiplicity, entanglement, intra-action, rhizome, centering, and becoming. These are concepts drawn from the post-structural philosophy of Deleuze and Guattari and from Karen Barad's agential realism.

The field of music therapy can be thought through such concepts, with its many connections to a wide range of other disciplines. Positioned between the arts, the humanities, the natural sciences, medicine, information technology, and the life sciences, music therapy opens an endless field of possibilities for connections with different areas of knowledge. Music therapists seem to thrive in this interdisciplinary connectivity, which unfolds in a landscape marked by crossing disciplines.

At the same time, we have encountered tendencies toward dichotomous thinking in many places in this text. This can be seen, for example, when we draw a sharp distinction between music education and music therapy, music medicine and medical music therapy, or when we construct an opposition between a music-centered explanation and other understandings that bring in treatment theories and other contextual conditions in order to understand the mechanisms of change in music therapy.

Multiplicity

We have seen that music therapists and music-and-health practitioners are confronted with a multiplicity of aims, practice arenas, and ways of working. When we add the different treatment ideologies and theories that surround the work, the multiplicity becomes even greater. We have seen that music therapy is a discipline that must relate to fields such as musicology, psychology, sociology, and anthropology. In addition to the humanities, the arts, and the social sciences, the natural sciences contribute knowledge of biology, physiology, neuropsychology, and medicine.

Such an interdisciplinary or multidisciplinary discipline could easily fall apart, become fragmented, and split up. The attempt to hold the different knowledge

and practice areas together takes place through the construction of models, as we saw above with the model of the four quadrants. Another way of thinking about the field is the one Leslie Bunt and Brynjulf Stige use when they describe music therapy as a hybrid discipline.[859] Hybrids are understood as something composed of elements from different sources, systems, or types. The idea suggests that being hybrid means drawing on the strengths of the different components of which the discipline is composed.

As an extension of viewing music therapy as a hybrid construction, with elements that build upon and support one another, we may think of it as a multiplicity. Music therapy theorist William Matney has used precisely the concept of multiplicity in a discussion of what characterizes the field of music therapy.[860]

Throughout this text, we have encountered a multiplicity of music-therapeutic practices, professional roles, therapeutic models, theoretical explanations, understandings of music, genres, musical identities, working methods, views of the human being, concepts of health, scientific traditions and paradigms, as well as the heterogeneous knowledge base. We have seen that within each of these elements, in turn, we encounter a multiplicity of perspectives, viewpoints, traditions, and theories.

Within the philosophy of Deleuze and Guattari, the concept of *assemblage* (French: *agencement*), is used to describe and understand how such apparently separate phenomena can constitute a multiplicity. They say that such assemblages consist of components or "sites" derived from heterogeneous milieus. These "sites" are connected within a "territory," in this conceptual vocabulary. Such configurations are not merely collections of objects or networks of humans, materials, and technologies. Rather, they may be understood as a number of components, things, elements, and aspects, forces, materialities, discourses, affects, and expressions that interact and continuously transform complex wholes that have no permanent identity or organization.[861]

Entanglement

At several points in the text, we have noted how the components constituting such dynamic configurations become entangled when music therapists seek to describe and explain their work. I wrote that by placing this multiplicity within

[859] Bunt and Stige, 2014.
[860] Matney, 2021.
[861] Coffey, 2025, p. 53.

models of separate frames, such as the quadrant model, problems easily arise when trying to keep practice forms and theoretical perspectives apart. Instead, I pointed to how elements are entangled, in an understanding drawn from Karen Barad's philosophy, known as agential realism. Here, I pointed out how the elements in this weave take shape through their relation to other elements, and through inter- or intra-acting with other elements in the situation. Such an understanding has consequences when we discuss which mechanisms of change music therapy may activate.

When music therapists point to possible mechanisms of change in order to explain what happens in music therapy, some point to forces in the music, while others point to relational and psychotherapeutic aspects. We saw this in the discussion of music *as* or *in* therapy. When one brings in all the imaginable elements affecting a music-therapeutic situation, it becomes difficult to single out one component to which decisive weight should be given. Karen Barad speaks of an "agential cut" that constitutes what is to separate the elements in a situation from one another. Such "cuts" are relational and depend on the context in which they are made.

Intra-action

Music-therapeutic activity facilitates the creation of interaction among people. We commonly speak of musical interactions arising in joint music-making and helping to build relationships. In a traditional understanding of interaction, it is assumed that agents—or, here, the people musicking—exist as separate and independent entities before they meet. Within agential realism, however, one thinks that it is through "intra-action" that participants are constituted through their actions. This can in turn be understood as meaning that we become through one another, as relational psychology also suggests, and that this occurs through an "intra-action."[862]

Rhizomatic thinking

Another metaphor that may be used to describe the multiplicity and composition of the field of music therapy is the *rhizome*, drawn from the philosophy of Deleuze and Guattari.[863] A rhizome is a type of root growth characterized by sending out

[862] Fjeldstad, 2023, p. 66.

[863] See Ruud, 2020a; dos Santos, 2018, 2020; Matney, 2021; Fjeldstad, 2023; Coffey, 2025 for references to Karen Barad and Deleuze and Guattari.

shoots in many directions. We may imagine a piece of ginger or a cluster of potatoes—before we have dug them up from the soil. To understand the significance of the rhizome metaphor, we may contrast it with a tree, which metaphorically represents a strict hierarchical way of thinking. In a tree, we find clear lines of descent. Thinking in line with the tree metaphor is characterized as "arborescent thinking." The rhizome is the opposite of the tree, and we are dependent on both rhizomatic and arborescent thinking. When we describe the historical background of music and health thinking, we are applying arborescent thinking.

The rhizome is anti-hierarchical. There are no necessary relations between any of the nodes or nodal points. We may imagine the entire field of knowledge behind musical therapeutic forms through the rhizome metaphor. Rhizomes do not spread through bounded hierarchies, but grow laterally through underground stems, where every part may send out new shoots in all directions—upward or downward. Rhizomes are ever-growing horizontal networks of connections between heterogeneous nodes. They may be both discursive and material. There are no beginnings and no endpoints. The rhizome continually creates something new. It is impossible to predict its lines of development, and it follows no linear pattern of growth and reproduction.

Rhizomatic thinking opens up new perspectives on established ways of seeing things. The rhizome, as a metaphor for the multiplicity in music therapy, moves in all directions and occupies new territories. "A rhizome ceaselessly establishes connections between semiotic chains, organizations of power, and circumstances," write Deleuze and Guattari.[864] With the rhizome as metaphor, I think that within this multiplicity, tensions are created—both within the individual elements or the discipline itself, and between the elements. This dynamic leads to the formation of new "shoots" from the rhizome; new territories and new practices for music therapy are created, contributing to a horizontal expansion of the field.

We see that the rhizome emerges as an apt metaphor for the whole field of music therapy, or health-promoting musicking, since it continues to develop and send out shoots into new practice areas. At the same time, we must not overlook how the field of music and health also has its arborescent roots in history.

Multiplicity refers to the way in which, within the rhizome, there are no fixed points or positions, but only lines organized as fleeting horizontal relations that continually proliferate. "Multiplicity celebrates plurality, proliferating ways of

[864] Deleuze and Guattari, 1987/2013, p. 7.

thinking, acting, and being—in contrast to unitary, static, binary, and totalizing ways," write education researchers Adrian Martin and George Kamberelis.[865]

Another principle is that the rhizome may be broken at any point, but will start up again along one of its old lines—or along new ones. In this way, movements and flows are always rerouted around disturbances. According to Martin and Kamberelis, severed connections can regenerate themselves and continue to grow, creating new lines, flows, and paths.

Becoming

A music therapy theorist who builds on the philosophy of Deleuze and Guattari is Andeline dos Santos.[866] In addition to the concepts of rhizome and multiplicity, she emphasizes how we are always developing, always becoming, always in some initiated state—"in becoming." For Deleuze and Guattari, there is no origin or determination, only becoming and what lies in-between. We are all "embodied be(com)ings)," dos Santos notes.[867] A music therapist is a "becoming-music therapist," and our clients are likewise in a fluid, intra-acting, and transforming process. The same perspective may be applied to the field of music therapy itself, as something always in development, and becoming through a dynamic interplay among all the elements in the composite weave that constitutes the multiplicity.

Centering

William Matney points out how specific theories and models center explanations and approaches in music therapy. They intensify central features of music-therapeutic processes and actions. For example, a music-centered approach will precisely center, or concentrate, the significance of music's role in therapy. In the same way, community music therapy rightly points out how culture and society, socio-political processes, and rights-based approaches are important ingredients in music therapy.

In many ways, we see that such models make important contributions to an expanded understanding of the multiplicity in music therapy. At the same time, we see that we need an understanding capable of including different forms of understanding and knowledge within a dynamic field.

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[865] Martin and Kamberelis, 2014, p. 670.
[866] dos Santos 2018, 2020.
[867] dos Santos 2020, p. 151.

APPENDIX

9

Knowledge resources

This book is equipped with a number of footnotes and a bibliography that provide a possible starting point if one seeks more information on a topic. Considerable research is being conducted in music therapy using methods drawn from both quantitative and qualitative research. If one is looking for information on research findings, there are a number of possibilities for literature searches. In Norway, Both the Grieg Academy Music Therapy Research Centre at the *University of Bergen* (GAMUT) and the Centre for Research in Music and Health (CREMAH) at the *Norwegian Academy of Music* provide references to literature and research in music therapy on their websites.

Music therapy organizations also feature videos and links to music therapy on their websites. In addition, one may search databases for music therapy research. There are also several introductory books on music therapy that are recommended. A number of major anthologies or handbooks provide detailed overviews of different practice arenas and therapeutic models. Journals, podcasts, and the use of artificial intelligence further help us keep track of developments in the field.

Educational institutions

At the *Grieg Academy, Department of Music* at the *University of Bergen*, searching especially the websites of *GAMUT* and *Polyfon* will provide information about music therapy. GAMUT is the abbreviation for the Grieg Academy Music Therapy Research Centre and provides, among other things, information on ongoing and previous research projects.

See: https://www.uib.no/gamut

Polyfon is a knowledge cluster that brings together and builds national collaboration on music therapy and music and health, with a focus on service development, research, education, and dissemination. On its website, the Polyfon knowledge cluster has a portal containing a collection of links with information about music therapy. Here one finds information about open-access books and links to organizations and websites. It also contains links on how to establish and develop practice.

The Polyfon website includes links to research summaries and knowledge descriptions, for example to CEDOMUS, the Centre for Documentation and Research in Music Therapy at *Aalborg University*.

https://www.kommunikation.aau.dk/forskning/forskningsgrupper/forskningsgruppen-musikterapi/cedomus

Polyfon's website points to international music therapy organizations, in addition to information about conferences, concerts, and festivals. It provides links to podcasts, videos, journals, and educational institutions offering education and courses in music therapy and music and health.

See: https://www.uib.no/polyfon/165662/lenkesamling

On Polyfon's website we also find some important knowledge descriptions. These are produced by experts in different knowledge areas and provide syntheses of research-informed knowledge in various fields. At the time of writing, the following areas are covered:

- Music therapy and children's and young people's upbringing
- Music therapy in the field of addiction
- Music therapy and mental health – adults
- Music therapy and elderly health
- Digital music therapy

CREMAH at the *Norwegian Academy of Music* is an abbreviation for the Centre for Research in Music and Health, and its website provides overviews of collaborative projects and priority areas. The website includes references to a number of publications, including doctoral dissertations, monographs, and anthologies. CREMAH has published a series of anthologies dealing with different practice arenas. Many of these publications are freely available via the Academy library and downloadable from the National Research Archive.

CREMAH: https://nmh.no/forskning/sentre/cremah

Journals

Research findings are published in journals such as *Journal of Music Therapy*, *Nordic Journal of Music Therapy*, *British Journal of Music Therapy*, *Music Therapy Perspectives*, *Musiktherapeutische Umschau*, or in the internet-based journal *Voices – A World Forum for Music Therapy*.

- *Journal of Music Therapy*: https://academic.oup.com/jmt?login=false
- *Nordic Journal of Music Therapy*: https://www.tandfonline.com/journals/rnjm20
- Voices – A World Forum for Music Therapy: https://voices.no

- *Music Therapy Perspectives*: https://academic.oup.com/mtp
- *British Journal of Music Therapy*: https://journals.sagepub.com/home/bjm
- *Musiktherapeutische* Umschau: https://www.musiktherapie.de/publikationen/musiktherapeutische-umschau/
- *Australian Journal of Music Therapy*: https://www.austmta.org.au/australian-journal-of-music-therapy/read/
- *Canadian Journal of Music Therapy*: https://cjmt-rcm.musictherapy.ca/index.php/cjmt-rcm
- Brazilian Journal of Music Therapy: https://musicoterapia.revistademusicoterapia.mus.br/index.php/rbmt/issue/view/44
- *Musica et Terapia: Quaderni italiani di Musicoterapia*: https://musicaterapia.it/musicoterapia-libri-musica-et-terapia/
- *Misostenido, revista de Música, Educación y Terapia*: https://www.revistamisostenido.com/index.php/misostenido/index
- *La Revue Française de Musicothérapie* https://francemusicotherapie.fr/revue-francaise-musicotherapie/

Other major medical journals also publish articles on music therapy. See:

- *JAMA* (Journal of the American Medical Association): https://jamanetwork.com/journals/jama
- *The Lancet*: https://www.thelancet.com

Databases

There are a number of meta-studies on the effects of music on a range of illnesses and human problems in the fields of somatic and mental health. These studies are listed in the Cochrane databases. A systematic search in different databases is important for gaining an overview of a field. One example of such a database is Cochrane:

https://www.cochrane.org/search/site/Music%20Therapy

Other databases to search include, for example, Oria, Google Scholar, PubMed, PsycINFO, and others.

Introduction to music therapy

Leslie Bunt and Brynjulf Stige (2014). *Music Therapy: An Art Beyond Words*. Routledge.

Handbooks in music therapy

A good starting point for seeking knowledge about a particular area of work in music therapy is to turn to the many handbooks published over the last ten years. These are anthologies with chapters written by experts and experienced therapists within the different areas of practice. Here are some suggestions:

- Jacobsen, S. L., Pedersen, I. N. & Bonde, L. O. (Eds.) (2019). *A Comprehensive Guide to Music Therapy*. Jessica Kingsley Publishers.
- Viega, M., dos Santos, A. & Wheeler, B. L. (Eds.) (2025). *Music Therapy Handbook*. The Guilford Press, Second Edition.
- Edwards, J. (Ed.) (2016). *The Oxford Handbook of Music Therapy*. Oxford University Press.
- Bunt, L., Hoskyns, S. & Swamy, S. (Eds.) (2024). *The Handbook of Music Therapy*. Second Edition. Routledge.
- McFerran, K., Derrington, P. & Saarikallio, S. (Eds.) (2019). *Handbook of Music, Adolescents, and Wellbeing*. Oxford University Press.
- MacDonald, R., Kreutz, G. & Mitchell, L. (Eds.) (2012). *Handbook of Music and Well-being*. Oxford University Press.
- CAMTI (Ed.) (2020). *Colonialism and Music Therapy*. Barcelona Publishers.
- Lee, C. (Ed.) (2024). *The Oxford Handbook of Queer and Trans Music Therapy*. Oxford University Press.

Podcasts and websites

There are a number of podcasts about music therapy. An internet search will also point to a number of podcasts about music therapy. Here, the podcasts of the British Society for Music Therapy with Luke Annesley are recommended:

https://www.bamt.org/updates-and-events/podcasts

Likewise, in the Spanish-speaking context, the podcast *MUTCAST musicoterapia*, hosted by David J. Gamella from Spain, stands out:

MUTCAST musicoterapia in Spotify

Also see the website https://www.evenruud.no for a number of book reviews and blog posts.

Artificial intelligence

The development of artificial intelligence is happening at great speed and is an important source for finding knowledge about music therapy. If one searches for general topics, one will often get good and clear answers in simple language. But one should always try to double-check the information by using other sources. If one asks for more detailed and concrete information—for example, names of people—the answer may be imprecise or incorrect.

LITERATURE

10

Literature

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About the author

Even Ruud, dr. philos., is professor emeritus at the Norwegian Academy of Music and the University of Oslo. He has conducted research, taught, and supervised within musicological disciplines such as music psychology, music education, music culture understanding, and music therapy.

Ruud was first trained as a healthcare assistant and piano pedagogue, and later as a music therapist with a master's degree from Florida State University. He also holds a cand.philol. degree with a master in musicology from the University of Oslo, where he wrote his doctoral dissertation on music therapy. Ruud is a certified psychologist (cand. psychol.) from the University of Oslo and a certified BMGIM therapist.

Ruud has written numerous books, several of which have been published in English and translated into Spanish, Portuguese, Japanese, and German. He is an honorary member of the Norwegian Association for Music Therapy, a member of the Norwegian Academy of Science and Letters, and received the King's Medal of Merit in 2018 for his contributions to music therapy in Norway.

Music, Health, and Therapy: A Work That Redefines the Field

In this book, Even Ruud — one of the most influential voices in contemporary music therapy — offers a unique overview of a discipline that, over the past fifty years, has transformed the way we understand the relationship between music, health, and well-being. With the authority of someone who helped build the Norwegian music therapy tradition, and the sensitivity of someone who has devoted his life to listening — to music as much as to people — Ruud weaves together theory, research, and clinical practice into a coherent and deeply human account.

From the concept of "musicking" to his original theory of music as a "cultural immunogen," and drawing on Hartmut Rosa's theory of resonance, the author builds a bridge between the biological, the social, and the existential. An essential read for students, professionals, and anyone who senses that music can be far more than sound: it can be health, community, and meaning.

EDITORIAL