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Toward Understanding Music Therapy as a Recovery-Oriented Practice within Mental Health Care: A Meta-Synthesis of Service Users' Experiences

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Background: *The perspective of mental health recovery is increasingly shaping mental health care policies. Current texts in music therapy identify the importance of this critical and user-oriented perspective, but the relevance and implications for music therapy need to be outlined.*
Objective: *This study explores service users' experiences of music therapy in mental health care, and the potential role of music therapy in the development of recovery-oriented service provision.*
Methods: *We conducted a qualitative meta-synthesis of studies examining service users' experiences in music therapy; included were 14 studies with a total of 113 participants. Both first-hand account of participants and the researchers' representations of such statements were taken into account in the analysis.*
Findings: *A taxonomy of four areas of users' experiences was identified: "having a good time;" "being together;" "feeling;" and "being someone." These core categories point towards music therapy as an arena that can be used by persons with mental health problems in their personal and social recovery process. Music therapy can contribute to the quality of mental health care by providing an arena for stimulation and development of strengths and resources that may contribute to growth of positive identity and hope for people with mental illness.*
Conclusions: *The findings from this meta-synthesis indicate that the provision of music therapy closely resembles recognized benefits of a*

recovery-oriented practice. Awareness of users' self-determination and the development of a strength-based and contextual approach to music therapy that fosters mutual empowering relationships are recommended.

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The purpose of this article is to explore service users' experiences with music therapy in the field of mental health care. Music therapy has developed within mental health care according to the growing demands for evidence based practice resulting in an increasing body of research into effects of music therapy with various (diagnostically described) client populations (Gold, Solli, Krüger, & Lie, 2009; Maratos, Gold, Wang, & Crawford, 2008; Mössler, Chen, Heldal, & Gold, 2011). This has been interlinked with a focus on expert interventions based on diagnostic criteria in music therapy practices (Odell-Miller, 2007). However, evidence based medicine (EBM) and evidence based practice (EBP) have been defined within a three-pronged structure consisting of the best available research, clinician expertise, and client values (Sackett et al., 2000). It has been argued that the latter component, client values, has received comparably little attention both in practice and research (Kristiansen & Mooney, 2006; Slade, 2009).

In this article, we will introduce a recent critical and user-oriented perspective on mental illness and mental health care referred to as *recovery*. This perspective has gained increased attention in music therapy in recent years (Chhina, 2004; Grocke, Block, & Castle, 2008; Jensen, 2008; Kaser, 2011; Kooij, 2009; Maguire & Merrick, 2013; McCaffrey, Edwards, & Fannon, 2011; Solli, 2009, 2012; Solli & Rolvsjord, 2008). We intend to explore the potentials of music therapy in processes of recovery by focusing on how service users[1] experience their participation in music therapy.

The concept of mental health recovery developed in the 1960s and 1970s in the context of civil rights and independent living movements, as a response to a long history of expert-led and deficit-oriented treatment of persons with severe mental illness in huge psychiatric institutions, which contributed to stigmatisation

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[1]In this text, the term "service user" has been applied to describe people receiving mental health care.

and deindividuation (Slade, 2009). As a result, the notion of mental health recovery grew as a liberating movement and academic field to help people diagnosed with a mental illness reclaim their "right to a safe, dignified, and personal and gratifying life in the community despite his or her psychiatric condition" (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009, p. 11).

An underlying context for the development of the recovery perspective is that general expectations of clinical recovery from severe mental illnesses (especially the schizophrenias) have traditionally been pessimistic whereby progressive deterioration has been held to be the most expected outcome (Slade, 2009). This understanding has been challenged from two angles. First, longitudinal studies have found that one third to more than half of these service users have experienced partial or full recovery (Liberman & Kopelowi, 2002; WHO 1973[2]). Second, personal accounts from people affected by mental illness (Deegan, 1996; Read & Reynolds, 1996) and research on user-perspectives (Borg & Kristiansen, 2008; Davidson, 2003; Davidson et al., 2005; Davidson, Shahar, Lawless, Sells, & Tondora, 2006) have provided new insights into life with an on-going mental health condition which point out potential obstacles and facilities for a better life. This new body of knowledge which comes from first-hand accounts of service users, longitudinal studies, and qualitative research on the user-perspective have reclaimed and redefined the term recovery. While clinical recovery refers to full symptom remission (Liberman, Kopelowicz, Ventura, & Gutin, 2002) which means "getting back to normal" (Slade, 2009), mental health recovery[3] refers to:

> a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness, recovery involves the development of new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 7)

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[2]Research challenging the persistence of schizophrenia can be found as early as in the late 1970s.

[3]While there is no explicit consensus about the meaning of the term recovery, Anthony's (1993) definition is frequently cited.

Anthony's (1993) definition describes aspects of *personal recovery* and focuses on the personal and unique process of learning to live life with on-going challenges and to control difficulties as they arise (Slade, 2009). A complementary notion of mental health recovery highlights a contextual and social approach, focusing on social relationships, social roles and social inclusion. This orientation can be referred to as *social recovery* (Repper & Perkins, 2003; Tew et al., 2011; Topor, Borg, Di Girolamo, & Davidson, 2011).

Knowledge about how persons with mental health problems experience processes of recovery is crucial for development of recovery-oriented mental health practices. Research on personal and social recovery gives primacy to idiographic knowledge, arguing that persons with a mental illness are "experts by experience" and therefore in a position to provide valuable insight to what fosters and hinders a good life for the individual person in a community. From this research important factors for recovery have been outlined, of which three central factors are particularly relevant for our study. First, research highlights the importance of people with serious mental illnesses being self-determined, taking back control in life, and being able to make their own choices— hence, playing an active role in their own recovery processes (Davidson et al., 2009). Second, processes linked to social inclusion and citizenship are found to be important for recovery. These include aspects related to the person's social relationships as well as how environmental conditions afford social integration (Onken, Craig, Ridgway, Ralph, & Cook, 2007; Repper & Perkins, 2003; Tew et al., 2011). Third, well-being and positive events have been found to be vital for recovery processes and that practices need to be strength-based allowing the person's resources and preferences to become the centre of attention (Davidson et al., 2006; Slade, 2010).

Mental health recovery has been described as a new paradigm in how mental health and mental illness is understood with distinct values, beliefs, practices and terminologies (Onken et al., 2007). Within the last two decades recovery has gained vast attention worldwide and has increasingly become associated with visions for mental health policy and practices in several countries, such as the USA, Canada, England, Scotland, Australia, New Zealand, Hong Kong and the Nordic countries (Borg, Jensen, Topor, & Andersen, 2011; Slade, Adams, & O'Hagan, 2012). As an example, the United States government has declared a recovery

orientation as the "single most important goal" to be adopted by the mental health service delivery system (DHHS, 2006, p. 1).

The objective of this study is to explore the potentials of music therapy as a recovery oriented practice. We will do this through two research questions addressing two levels of recovery:

  (a) In which ways can music therapy support the recovery processes of persons with mental health problems?
  (b) How can music therapy contribute to recovery-oriented services in mental health care?

Music Therapy and Recovery

Recent developments in music therapy resonate with the perspective of recovery. Community music therapy proponents have articulated a contextual understanding of illness and health in response to overtly individualised treatment models (Ansdell, 2002). In community music therapy, the potentials of music therapeutic engagement in community contexts are highlighted and music therapy is targeted as a way of working with social inclusion and participation (Ansdell, 2002; Ansdell & DeNora, 2012; Stige, 2012; Stige & Aarø, 2012). The elaboration of a resource-oriented approach to music therapy in mental health care (Rolvsjord, 2010) has accentuated a focus on promotion of strengths and positive health, and highlighted aspects of self-determination and a collaborative relationship. Additionally there is music therapy literature related to the recovery perspective through its emphases on empowerment and consumer involvement (e.g., Baines, 2003; Procter, 2002).

Finally, related to the development of such contextual and resource-oriented approaches, there seems to be an increasing awareness in music therapy concerning the health promoting potentials of music in everyday life contexts (Ansdell & DeNora, 2012; Rolvsjord, 2010, 2013; Ruud, 2010; Stige & Aarø, 2012). This development resembles a growing multidisciplinary field of research concerned with music and health (MacDonald, Kreutz & Mitchell, 2012).

In spite of such developments, the recovery perspective has not received much attention in the music therapy literature. However, a few recent contributions more explicitly link music therapy to recovery. Chhina (2004) discussed possibilities for enabling

individuals to live a satisfying life in the community by focusing on hope, empowerment and partnership. Jensen (2008) elaborated on how music therapy facilitates social inclusion, partnership and accountability in a community practice. Grocke, Block, and Castle (2008) suggested recovery as a model for the future development in music therapy as a consequence of mental health services being increasingly situated in community settings. Solli and Rolvsjord (2008) and Solli (2009) discussed the concept of recovery in their presentation of a contextual and resource-oriented approach to music therapy for people with serious mental illness. In one study Kooij (2009) reviewed song lyrics created in music therapy as themes of recovery and another text has connected the model of recovery to a case vignette of a "mentally ill offender"(Kaser, 2011). A more thorough introduction to the recovery perspective in music therapy has been provided by McCaffrey and colleagues (2011) and Solli (2012). Most recently, Maguire and Merrick (2013) have written about recovery in relation to a high security hospital context.

Although there is still a need to elaborate on the concept of recovery and its implications in relation to music therapy, all of these texts clearly indicate a match between music therapy and the notion of mental health recovery. However, none of the listed texts have explored the user-perspective in music therapy by studying service users' own articulated experiences. The following meta-synthesis is an attempt to gather new knowledge about service users' experiences with music therapy.

Methodology

Given the primacy of the user-perspective in the recovery movement and development of recovery-oriented health care, it is crucial to include user-perspectives in our explorations of the potential role of music therapy in promoting recovery processes. One first step in this direction is a qualitative inquiry of how service users' experience participation in music therapy. While there has been an increased number of music therapy efficacy studies in mental health (Mössler et al., 2011), it is evident in Aigen's comprehensive review of music therapy qualitative research that few studies have explored service users' experiences in mental health care (see Aigen, 2008a, b). However, in recent years more qualitative studies have been published making it

possible to begin exploring user-perspectives in music therapy by doing a meta-synthesis where useful lessons from existing qualitative research can be drawn.

A meta-synthesis can be described as an "umbrella term referring to the synthesis of findings across multiple qualitative reports to create a new interpretation" (Finfgeld, 2003, p. 895). Thus, doing a meta-synthesis involves a systematic collection and analysis of qualitative studies, a focus on the findings from those studies, and the use of qualitative methodology to synthesize findings. Despite similarities with quantitative meta-analysis it is argued that "qualitative meta-synthesis is less about the reduction of data than the amplification of data and interpretive innovation" (Sandelowski & Barosso, 2003, p. 154). The goal of a qualitative meta-synthesis is to produce a new and integrated interpretation of findings that is more substantial than those resulting from the individual investigations (Finfgeld, 2003).

The applied methodology in the following meta-synthesis is informed by theoretical contributions from meta-ethnography, an interpretative approach to synthesis originally developed by Noblit and Hare (1988). As a guiding structure for our meta-synthesis we relied on their seven phases, including: (a) getting started, (b) deciding what is relevant to the initial interest, (c) reading the studies, (d) determining how the studies are related, (e) translating the studies into one another, (f) synthesising translations, and (g) expressing the synthesis. These phases were often overlapping and partly repeated during the process.

Search Strategy and Study Selection

We included qualitative studies of adult mental health service users' experiences of music therapy, written in English and Scandinavian languages[4]. In accordance with Sandelowski and Barroso (2003, p. 154), we liberally defined qualitative studies as "empirical research with human participants conducted in any research paradigm that used what are commonly viewed as qualitative methods for sampling, data collection, data analysis, and interpretation." The following types of studies were included: (a) studies of music therapy in mental health care or psychiatry that explored service users' experiences, and (b) studies that

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[4]All three authors read these languages fluently.

included qualitative interviews of service users or other sampling of free verbal reflection. We excluded: (a) case studies without a clear description of methodology for collection of user accounts, (b) mixed-methods studies in which qualitative findings could not be separated from quantitative findings, (c) unpublished masters studies and narrative accounts of user experiences included in conference papers, press material, and other nonresearch sources, and (d) studies focusing on substance abuse situated outside mental health care/psychiatry.

Keywords selected were (music therapy) AND (mental OR Psychiatr*) AND (experience OR interview). The following databases were used: Ovid/Medline, Pubmed, RILM, PsycInfo, ERIC, and BIBSYS Ask. From these searches 386 articles were reviewed. In addition a search in Google Scholar was done. The *British Journal of Music Therapy* and relevant books from *Barcelona Publishers* and *Jessica Kingsley Publishers* were hand searched. A total of 14 studies met the inclusion criteria, with a total of 113 participants (see Table 1). The studies represented a broad range of approaches to music therapy.

Synthesis

Our approach to reading the studies was to follow Schutz's (1971) notion of first, second, and third order constructs, an approach further elaborated by Atkins and colleagues (2008). The first step, or first order construct, was to read and reread the included studies, and identify themes and patterns. Here we focused on direct quotes (in vivo) from the 113 participants in order to ground the analysis as close to users' subjective experiences as possible, in line with the discourse of recovery. The second step, or second order construct, focused on the researchers' representations of the stories from the participants (i.e., service users). Following Atkins (2008), we approached the reciprocal translation by first arranging each paper chronologically, thereafter comparing the themes and patterns from Paper 1 with Paper 2, and the synthesis of these two papers with Paper 3, and so on. Translation first involved a comparison of themes from all the included studies followed by a process of matching themes from different studies while making sure that the key themes captured findings from the other studies (Britten el al., 2002).

TABLE 1
Characteristics of Studies Reviewed

	Study	Research methodology	N	Music therapy approach	Music therapy setting
1	Ansdell & Meehan (2010)	Qualitative study. Interviews	19	Nordoff-Robbins Music Therapy. Improvisational music making. (Individual)	Mental health care
2	Carr, d'Ardenne, Sloboda, Scott, Wang & Priebe (2011)	Mixed methods. Interviews	8	Active and receptive activities with emphasis on free improvisation (Groups)	"A specialized National Health Service"
3	Clemencic-Jones (1998)	Questionnaire with open ended questions	6	Improvisation, listening to music, performing original music, music and relaxation activities, singing along, discussing lyrics (Groups)	Acute inpatient mental health care
4	Grocke, Bloch, & Castle (2009)	Mixed methods. Semi-structured focus group interview	17	Song writing (Groups)	Community mental health service
5	Hammel-Gormley (1995)	Qualitative study. Interviews	6	Singing songs (Individual)	Outpatient mental health care
6	Jampel (2006)	Qualitative study. Interviews.	10	Playing in band (Community music therapy)	Community mental health service
7	Moe (2000a); Moe, Roesen, & Raben (2000b)	Interviews and qualitative questionnaire	9	GIM (Guided Imagery and Music) (Groups)	Inpatient mental health care
8	Rolvsjord (2010)	Qualitative case study design. Interviews	2	Song writing, singing songs (individual)	Inpatient mental health care
9	Rolvsjord (2013)	Qualitative single case study. Interviews	1	Singing, playing instruments (Individual)	Outpatient mental health care

TABLE 1
Continued

	Study	Research methodology	N	Music therapy approach	Music therapy setting
10	Rowland & Reed (2011)	Questionnaire with open ended questions	2	"Musically based". Clinical improvisation. (Groups)	Inpatient mental health care
11	Silverman (2010)	Mixed method. Interviews	15	Music games, sing-along, lyric analysis and song-writing (Groups)	Inpatient mental health care
12	Stige (1999)	Case study. Qualitative interview	1	Improvisation, music listening, music and movement, song writing, performance of popular or traditional songs (Individual)	Outpatient mental health care
13	Stige (2012)	Qualitative case study. Interviews and participatory observation	1	Improvisation, music listening, modified GIM (Individual)	In- and outpatient mental health care
14	Eyre (2011)	Survey. Qualitative questions	16	Community choir	Outpatient mental health care

The third step, or third order construct, included synthesis of the findings from the first and second order constructs into a taxonomic model. Since this study has such a clear theoretical frame, the analytic process also had abductive components, meaning there was a process of dialogue and reflexivity between data and theory (Alvesson & Sköldberg, 2000). The constructed taxonomy categorized the findings into key domains, each with three sub-domains (see Table 2). Although the second and third order construct were important in the process of identifying the key themes, we have highlighted users' quotes. First-hand accounts of users provided the foundation for our development of conceptual descriptions (and a model) of music therapy as a recovery-focused approach to mental health care (Sandelowski & Barosso, 2003, p. 158).

An underlying assumption for a meta-synthesis like ours is that studies are commensurable and that categories are transferable across settings (Britten et al., 2002). However, it can be argued that turning idiographic knowledge such as data from qualitative research with various methodology into data for synthesis represents "an unconscionable loss of the uniqueness of individual projects" (Sandelowski, Docherty, & Emden 1997, p. 366). Clearly, a meta-synthesis involves both the interpretations of other researcher's interpretations and accounts of their data-material. Thus, there is a significant distance to the original data material, and in our case, to the participants' first-hand accounts.

TABLE 2
Areas of Experience

Having a good time	a) Pleasure and joy
	b) Freedom and relaxation
	c) Motivation and hope
Being together	a) Belonging
	b) Teamwork
	c) Social participation
Feeling	a) Awareness of emotions
	b) Expressing emotions
	c) Emotion regulation
Being someone	a) Identity
	b) Mastery
	c) Regaining music

This calls for reflexivity and awareness of the various philosophical stances in qualitative research (Zimmer, 2006).

Findings

The overarching themes and sub-categories developed from the meta-synthesis are listed in Table 2. In the following section, the categories are presented with informant (i.e., users) quotes from the included studies. It should be noted that qualitative studies rich on direct citations are overrepresented in the following presentation, because they provide the most nuanced and detailed descriptions. However, the categories are based on analysis of all 14 studies and similar themes were found in the studies referred to less frequently.

Having a Good Time

Music therapy was extensively experienced by users as a way of "having a good time". This category comprises a spectrum of well-being and positive experiences, including pleasure and joy, freedom and relaxation, and motivation and hope.

Pleasure and joy. One of the most prominent categories in this study was the experience of pleasure and joy. Some participants in Silverman's (2010 p. 267) study expressed: "It made me feel good," "I liked it. It was great. It was a great activity" and "I think it was very enjoyable." Another informant said:

> It has happened many times that I'm feeling a bit depressed when I come, and then I sing, and everything is just fine (laugh). At least I feel it's getting better. That is actually true. It sounds a bit "too simple" in a way (…)Take today for example, I didn't feel very good, but then…I felt a bit better, and now I feel good. (Rolvsjord, 2010, p. 116)

Similarly, in the context of live performances in a community music therapy setting, joy was experienced after a concert:

> It feels good. If I can make somebody feel good and they go home and they feel good and they come back looking for more, hey that's great. It heals my heart and my mind. It makes me feel much better. (Jampel, 2006, p. 67)

Freedom and relaxation. Several studies reported that music therapy provided a space for freedom that was connected to

increased well-being. In Ansdell and Meehan's (2010, p. 33) study an informant said: "Has music therapy had anything to do with my illness? No, not really … except it takes my mind OFF my illness…" Several participants reported music therapy to promote relaxation, sometimes in relation to experiences of freedom. One informant said:

> Music makes me feel free. It's getting out of myself pure freedom. It helps me get apart from myself. When I hear music that moves me, it helps me move out of myself, carries me along or carries me away. It calms me down. It's almost like a Lithium. (Hammel-Gormley, 1995, p. 172)

Hope and motivation. Hope and motivation was another category that was widely reported to be connected with participation in music therapy. In Stige's (2012) study, a man said:

> This experience of being able to contribute in a positive way has given me a stronger will not to give up in my crisis, to put it this way… It feels good to be able to contribute in a positive way. I feel I have found that I have a right to live, a right to take space. (p. 308)

For some of the participants, hopefulness was connected to spirituality, like in Rolvsjord's (2013) study where a woman said:

> I sing songs about how good everything will be when the pain I experience here has passed. Then one will get peace and happiness. (…)Through my songs I get strengths to continue. I get food for my soul at the same time. That is why I choose religious songs. (p. 211)

In Stige's (2012) study, one informant expressed how he found motivation through participation in music therapy:

> Quite often I have come to the sessions with flat batteries. Then we just found something to do. Then I have gone from music therapy with the feeling that *it is possible* to do something although you have not planned it, and it can be good for you. … (p. 308)

Motivation was also connected to the use of music, as in Ansdell and Meehan's (2010) study where an informant expressed:

> I forgot about music…and coming to music therapy has rekindled the interest in music I had as a teenager… . In the

old days it [music] always lifted my mood—and now sometimes it does again. … (p. 33)

Being Together

Music therapy was widely reported as a good arena for being together with other people and making social connections. These experiences were connected both to a sense of belonging or relatedness in the therapy setting, but also to experiences of teamwork and increased social participation in everyday life contexts.

Belonging and relatedness. Social belonging was reported to be a valuable aspect of music therapy, particularly during group activities. In Eyre's (2011, p. 163) study, participants commented that the best part of being in the community choir was "being with other choir members," "being part of the group," "meeting friends in the group," and "acceptance by members of the group." Similarly in Moe's study (2000, p. 277, our translation), reflections on positive aspects of a GIM group included: "That several people were gathered during therapy"; "To hear about the lives of others;" "Regular companionship;" and "A good relationship to the others in the group."

Teamwork. Being together with the therapist and fellow participants in music therapy was reported to be a place to learn and practice teamwork. One informant in Jampel's (2006, p. 109) study talked about how he enjoyed how his group evolved: "The way that they develop cues, pockets, grooves, sharpen instincts, go with an idea, move together, look at each other at certain instants, and lift off together." In Rowland and Reed's (2011, pp. 54–57) study, participants commented on what they had learned from participating in the music therapy group: "listening to others," "we tuned in," "joining in harmoniously," "even very quiet people have something interesting to say," "work together with other people," and "teamwork."

Social participation. Finally, many participants emphasised experiences related to social participation. They report that they started to connect with other people in their community when using music or by participating in musical activities. In Hammel-Gormley's study (1995, p. 170) the social participation started carefully with a roommate: "Now I can play my guitar again and

listen to music. Before I couldn't do that. I even can do it with my new roommate too!" In Moe's (2000, p. 277, our translation) study an informant explained why music therapy had been good for him: "To get myself out of the house and be together with others who also had problems." Finally, as an outcome of music therapy, a man in Stige's (2012) study started connecting to other people in his community by joining a choir:

> (…) to find the courage to join a choir… and to hear my voice together with the others. To have that experience: "This is fun" So that was something, from being just afraid and wanting to hide [and then] to be able to experience that there are good things with being with others. And to sing—to express myself in the presence of others. (…) So—even if I was a person who had fallen, and who did not handle all the challenges in life, it was all right to participate. (p. 317)

Feeling

Music and music therapy seem to be strongly connected to emotional experiences. In our analysis we identified both awareness, expression, and regulation of emotions as important for participants in music therapy.

Awareness of emotion. In relation to awareness of emotions, music seemed to promote courage and strength to deal with difficult emotions, as in the case of an informant in Rolvsjord's (2010) study:

> Through music, I have dared to feel my loneliness, I have dared to feel that I want to move on, but that I don't really dare to. I have dared to feel what happened when I was little, and I have dared to feel when I want my life to end—and at the same time, I have been able to tell it to you people that have been around. (p. 155)

In Stige's (2012) study the awareness of emotions was linked to music being a bridge between verbal knowledge and emotional, nonverbal knowledge:

> I have lived very separated from my own feelings…I have placed them in another room within myself … [In music] I have allowed myself to go back in my own life. I have reached for my childish right to express myself in other ways than with words. (p. 314)

Expressing emotions. This quote links to the next aspect — how music therapy can be helpful for expressing emotions. Many service users seem to relate strongly to the metaphor of "letting feelings out," like in Ansdell and Meehan's (2010) study where one informant expressed:

> When you're feeling low, you can hardly talk, your voice doesn't hardly project, and you're silent…And by making some sound come out, maybe it's letting some feelings out …because I'm actually making some noise in the world… (p. 33)

Musical expression of emotions was also linked to the physical aspects of playing an instrument. An informant in Carr and colleague's study (2011, p. 12) said: "It helps to feel if you're hitting something…you release your anger through your arm into the music." Additionally, relational aspects in musical interplay were experienced for expression of emotions, in that participants felt supported in a rather unique way. In Rolvsjord's study (2010, pp. 156–157), one informant said: "I think it's helped me a lot that it has been expressed through music, because that way it is not only me expressing it, but you, too: You have sung the songs for me and together with me. (…) You take part in what I feel."

Emotion regulation. The last emotional aspect found in our analysis was the experience of emotion regulation. In Moe, Roesen, and Raben's study (2000, p. 46), music listening sessions seemed to provide a sort of cognitive aid for handling and regulating emotions, as one man said: "I have got more control over my thoughts and problems now. I have got them into boxes, which I can take out and look at if I want." In Carr and colleagues' study (2011, p. 17), one man reported that participation in music therapy had affected his anger: "I don't feel so angry. I really don't. Whereas before I was angry all the time, frustrated, but now I take a lot of it out playing on the music." Last, we also identified that music was used to regulate emotions outside therapy, in everyday life situations, like when a woman in Rolvsjord's study (2013, p. 214) explained: "(…) especially if I need to go anywhere then I play some songs in the morning in order to calm down a bit."

Being Someone

Many studies reported that music therapy allows people to experience and be reminded of "being someone." Subcategories

linked to this are identity, mastery, and experiences of regaining music.

Identity. Mental illness is often associated with stigmatisation, and because of long time hospitalization, deficits and problems may become a defining feature of a person's identity, which again adds to the stigmatisation (Rüsch, Angermeyer, & Corrigan, 2005). In contrast, music therapy seems to promote an identity of being a normal and healthy person with value and resources. In Clemencic-Jones' study (1998, p. 267), one informant simply expressed: "The music has helped me feel normal again." A community choir participant in Eyre's study said: "It makes me feel important; even when I'm not at choir, my self-esteem has improved" (2011, p. 160). In Ansdell and Meehan's (2010) study, the relationship with the music therapist seemed to have contributed to strengthened experience of respect, mutuality and worthiness:

> It's to do with meeting each other on equal terms. As musicians you do meet on equal terms—whereas in "outer life" you don't always … but in music therapy there doesn't seem to be a roleplay, it seems to be a meeting of equal minds. (p. 38)

In Stige's study, one informant experienced a new way of practicing his performance of self, expressing that music therapy is "like a private corner where you…make yourself ready and aware of who you are,… and that you shall express yourself in a way or another" (Stige, 2012, p. 318).

Mastery. Mastery was another central element linked to the experience of "being someone." In Rolvsjord's (2013) study, one informant said:

> When you are ill or feeling bad and then you don't feel you manage anything at all…everything stops and you don't get anything done. But when I come to the organ and I manage to learn something new, then I think that "well, actually I manage!" And when you manage there, then you dare trying something else again. (p. 214)

Repeated experiences of mastery in music therapy seem to increase self-confidence and self-esteem. In Hammel-Gormley's (1995, p. 182) study one informant said: "I like Music Therapy sessions. I get to play songs that are very dear to me. Without music, my life is a drag. Music Therapy helps me to build my self confidence." In community music

therapy settings, fellow users contribute to experiences of mastery, as expressed by one informant in Jampel's (2006) study:

> They just put my self-esteem sky-high. I was blushing especially with no teeth in my mouth. My peers convinced me, you got it. They all made me feel so good, you got it Betty. I do? They convinced me. Each time we are together my peers convinced me, you got it, your not bad…To be able to finish the song to the best of my ability, it made me see that I still had it. (p. 84)

Regaining music. It appeared that many participants perceived that the illness had made them stop using music as an inspiration in life, and music therapy helped them to reintegrate music back into their lives, which supported the experience of being someone. In Ansdell and Meehan's (2010) study, one informant said:

> Music's always been a very important thing to me. But during this period of depression I found that I couldn't listen to any music for a long period of time—for like over a year. And it's been nice to feel that I can again here [in music therapy]. Because music's very emotion-provoking, and here you can really experience that, but in a safe environment. But because I always did enjoy music, it can make me feel better … it can put me back in touch here with how it could make me feel better … and when I was at school I was very musical … but you lose touch with all that … (p. 32)

One informant in Rolvsjord's study (2010) expressed that she regained her right to music through music therapy:

> It doesn't matter so much anymore … I don't need to perform so well all the time with music anymore. I can use music exactly the way I want. And I don't need to be so amazingly good to use it. I'm much more daring now than I used to be. Now I can use music in my work, and I can sing at church. Last time I was in the hospital, I even sang for all the others in the ward. I'm much more daring like that now than before. (…) It's nice to be able to use music again, to dare to use music. (pp. 153–154)

Sometimes a restored relationship with music brings practical consequences in a person's everyday life. In Stige's study (1999, p. 70), the informant explained that after participating in music therapy, he unlocked the old electric organ in his house, on which

he had not played for several years, and started to play again. Similarly, in Stige's (2012) study, a man stated: "I've started to learn how to dance a waltz! That's a victory over my history," indicating that music therapy had promoted courage and motivation enough for him to start dancing (and later joining a choir) together with other members of his community (p. 305).

Discussion

In which ways can music therapy support the recovery processes of persons with mental health problems?

There are clear similarities between our findings and accounts of service users' experiences of recovery processes as identified through research in recovery. One clear similarity is that experiences of music therapy "go beyond" experiences of symptom reduction and clinical recovery from mental illness. A central assumption of the recovery perspective is that personal and social recovery is dependent on the person's efforts placing the main responsibility and agency in the person with mental illness (Davidson et al., 2009; Slade, 2009). Thus, the users' agency and involvement is a key to success when exploring the potentials of music therapy in supporting the recovery processes. The present meta-synthesis does indeed depict music therapy as an arena where service users can be such active agents.

Following the main categories, participation in music therapy afforded service users possibilities of: (a) having a good time through engagement in music, contributing to various aspects of wellbeing and promoting meaning in present life and hope for a future life; (b) being together with other people, in the clinic, in the community and in everyday life, providing arenas for engaging in interpersonal relations, teamwork, and social participation in ways that facilitated processes of social inclusion; (c) experiencing and expressing emotions through music in ways that facilitated wellbeing and emotional life; and (d) strengthening the feeling of being someone through offering an arena where strengths, interests and talents could be explored, used and flourished, promoting experiences of mastery and a stronger and more healthy identity.

Interestingly, we noticed that one of the main categories of users' experiences that were identified in this study, feeling, is

more rarely described in the literature of recovery. In our material such emotional experiences seemed to be of high relevance to personal wellbeing. Indeed the emotional experiences included in this category are more typically described as crucial to processes of psychotherapy. Although it needs to be acknowledged that our data material also includes users' experiences of music therapy in settings that would be described as clinical or psychotherapeutic, an orientation towards users' strengths and resources as identified in this meta-synthesis does not exclude possibilities for experiencing and exploring difficult feelings in the musical interaction (Rolvsjord, 2010). Thus, we do not think that emotional experiences highlighted in this category are conflicting with processes of recovery, as it is important to acknowledge feelings as a crucial part of recovery and not just part of the illness (Anthony, 1993, p. 535).

While this study is about service users' experiences of music therapy and not about recovery in particular, our data provide some information about how the different experiences in music therapy are linked together. A content analysis, such as the one applied in the present study, can only explore experiences and not connections between experiences. However, we speculate that some of the experiences are interlinked as opposed to isolated phenomena. Clear causal relationships may not be identified, but links may be best understood as spirals of experiences and development.

One possible spiral is the combination of experiences of joy, hope, and social participation which appeared in several of the studies. As an example, a man in Stige's (2012) study explained how he gained new hope through music therapy: "This experience of being able to contribute in a positive way has given me a stronger will not to give up in my crisis (p. 308). Later the same man joined a choir and started going to dance classes. His account of this was: "I feel that when I go out in the world (…) I enjoy it in a new way" (p. 319). In a qualitative study of play and pleasure in recovery processes, Davidson and colleagues (2006) proposed a connection between hope and social agency, which may be fruitful to look into in order to understand music therapy in promoting recovery. They suggested an interlinked process where positive experiences, enjoyment, and pleasure may reawaken hope that one's life can improve, and further that this hope is necessary for successful

reconstruction of a sense of social agency. We can only speculate if such interlinked processes are relevant for our understanding of the potentials of music therapy in recovery. This hypothesis supports a similar spiral of positive processes of joy and mastery, hope, agency, and social participation. Knowledge about these kinds of interlinked processes in music therapy is an important area for future research.

Included in our data material are experiences of music therapy within a variety of institutional contexts and settings. In the included studies, music therapy was provided in clinics and hospitals in individual (psychotherapeutic), groups, or open settings. In other studies we examined, music therapy was organized through various community services, in the form of choirs and bands. However, a general feature across studies was that service users brought their music and musical engagement into their everyday life contexts. We found first-hand accounts of how service users started picking up instruments they had not played for a long time, started to play music for and with friends and families or joined recreational activities in their community, such as choirs and dance gatherings. Such links between music therapy and the use of music in everyday life seemed crucial given the current policies of reducing the length of admissions in hospitals worldwide. Music therapy services in clinical contexts are typically offered at times of admissions, while persons with mental health problems spend most of their time at home or in shorter admissions. Entering valued social roles and contributing to the life of others, are seen as important recovery-promoting factors (Davidson et al., 2009). We argue that music therapy should remain flexible in its approach. This flexibility includes both the large variability of contexts and settings of music therapeutic practice, and the tendency that people use music across several different life-contexts. We think this flexibility makes music therapy a valuable and adaptable approach in recovery-oriented mental health care.

How can music therapy contribute to recovery-oriented services in mental health care?

As mental health recovery is dependent upon the agency of persons affected with mental illness (Slade, 2009), the mental health practitioner's support and facilitation of the person's own

efforts and acknowledgement of their needs, preferences, and goals are central to a recovery-oriented service (Davidson et al., 2009). Slade (2009, p. 92–93), argues that the task of mental health professionals is to (a) support hope by fostering relationships,(b) support the development of a positive identity by promoting well-being, (c) support the person to find their own meaning in their experiences, and (d) support personal responsibility and self-management. Additionally, research indicates that service users prefer professionals who use their skills and expertise in a collaborative and mutual partnership (Borg & Kristiansen, 2004). Further, if service users experience their relationship with the professional helper as empowering, this is a strong predictor of recovery outcomes (Crane-Ross, Lutz, & Roth, 2006).

It is not evident, however, that all the listed recovery-promoting facets are embedded in any one music therapy practice. There are structural conditions that can be challenging, if not contradictory, for all practitioners, including music therapists, in their effort of promoting personal and social recovery. Working in mental health practices within the health care systems today implies following regulations organized by New Public Management approaches. Standardized evidence based guidelines and manuals built on diagnostic groups are provided, and effectiveness and outcomes of treatment are constantly measured. Combining a recovery-oriented approach, where the service user guides the process and the goals, within these structural frames, is a challenge that is widely acknowledged in the recovery literature (Slade, 2009). Further, a strong adherence to a bio-medical model and/or illness ideology (where focus is on accurate assessment leading to specific treatment interventions), might foster an unequal therapeutic relationship where the therapist's actions and interventions are regarded as more important than the service users' contributions. According to Slade, mental health services that do not provide sufficient self-determination and convey pessimism and hopelessness can hinder processes of recovery. Raising awareness of issues of empowerment and recovery is one way of meeting these challenges. We argue that by developing and nurturing orientations to music therapy that highlight a focus on resources and strengths, community inclusion, and humanistic values in general are ways of increasing the potentials of music therapy as a recovery-oriented service.

It is also important to explore the role of music therapy within the context of a recovery-oriented mental health service system. Through this study, we have identified three aspects of recovery-oriented service provision where music therapy could contribute. First, new approaches that are strength-based and promote wellbeing are requested widely in the recovery literature (Davidson et al., 2006; Slade, 2010; WHO, 2005). Davidson and colleagues argue for the importance of "identifying those areas of competence and health that have survived the illness relatively intact and/or discovering previously untapped areas of interest and strength which thereby offer opportunities for developing new competencies" (2006, p. 158). Our findings point towards music therapy as a place for participants to use their strengths and resources in creative interplay with other people and it fosters experiences of positive emotions, freedom and relaxation, motivation and hope—basically having a good time. Thus, we argue that music therapy can contribute to increase the quality of mental health care by providing an arena for broadening and developing strengths and resources that contribute to growth of positive identity and hope for people with mental illness.

Second, there is a strong request for services that facilitate participation and active engagement for people with mental illness (Davidson et al., 2009; Slade, 2009; Tew et al., 2011). Outcome studies in music therapy have documented significant effects of music therapy on negative symptoms and social functioning (Mössler et al., 2011). This meta-synthesis has expanded the body of knowledge on this field by suggesting that the positive results of music therapy for people with severe mental illness are interlinked with processes of mutual empowerment, enablement, and active participation. Other research indicates that participation in any activity is not necessarily promoting recovery—to facilitate a sense of personal fulfillment and connection to the outside world, activities needs to be regarded as meaningful (Tew et al., 2011).

Third, there is a request for practices that create links between different mental health care services (Repper & Perkins, 2003). Our study indicates that music therapy situated both in clinical settings (e.g., individual & group music therapy inside hospitals) as well as in community settings (e.g., band & choir) promotes processes closely linked to personal and social recovery. In this way service users can use music therapy as an approach for taking back control in life and working on their recovery also in acute faces of

the illness. Further, we also saw that service users experienced that music therapy contributed positively outside clinical and community services, in the participants' everyday life (e.g., nontherapeutic activities like choir & dancing, and playing for friends & families).

Thus, music therapy seemed to be a flexible form of therapy that is capable of promoting recovery in various practice and natural settings. Music therapy's ability to work successfully in clinic, community, and in people's everyday lives contributes possibilities for social inclusion with friends, families, social systems and communities. Further development of such a range of sites and institutional contexts for music therapy is warranted.

Study Limitations

The present meta-synthesis includes information about service users' experiences from a broad range of studies in terms of approaches, contexts, and diagnosis. Whilst this is a strength in terms of giving a broad picture of the user-perspective, a meta-synthesis poses several methodological challenges including reliability of data retrieval, sampling bias, loss of detailed information, heterogeneity of method and quality, differing levels of analysis, and exaggeration of descriptions and interpretations (Jensen & Allen, 1996, p. 556). These are all challenges relevant to identifying limitations in the present study. In particular, our search for the user-perspective in previous studies was challenged by the fact that all first-hand accounts (first order constructs) were quotations that already had been selected from a full dataset by the study authors. Thus, quotations did not represent the totality of the participants' experiences (Atkins et al., 2008). Neither did we have access to the rich information which direct contact with participants provide, such as facial expressions, body language, or tone of voice, which increased possibilities for misinterpreting statements. By triangulating participants' accounts with authors reflections (i.e., second order construct) a thicker description was provided, but this also potentially affected our interpretations in ways that were dissimilar to the intended meaning of participants.

Conclusion

This meta-synthesis has contributed to the body of knowledge about music therapy in mental health care by focusing on first-hand

accounts of people with mental illness. The main finding is that music therapy is experienced in relation to four areas of experience: having a good time, being together, feeling, and being someone. By comparing the findings with the tenets of a recovery perspective we have argued that these four aspects of music therapy contribute to many of the central aspects found important for a person's personal and social recovery process. This indicates that much of the work music therapist already do is contributing positively to processes of personal and social recovery for their users. However, in order to support users' processes of recovery in the best possible way a strength-based and contextual approach to music therapy that fosters mutual empowering relationships are recommended. Further constructive development of recovery-oriented music therapy practices will best be ensured by building on existing recovery research and conducting studies that further explore the user-perspective in music therapy.

Literature in the broader field of mental health care has called for new approaches where mental health workers increase wellbeing rather than treat illness (Slade, 2010; WHO, 2005). This meta-synthesis indicates that music therapy can be such an approach. In accordance with previous authors (Slade, 2009; Topor et al., 2011), we believe that in the same way as service users have to go through a process of figuring out what recovery means for them, professional helpers and therapy professions must go through a similar process of adapting to the notion of mental health recovery. This is also the case for music therapy as a practice and a profession. With the findings from this study, we have documented a good fit between service users' experiences of participation in music and music therapy and aspects commonly identified with personal and social recovery. As the word *person* is said to be derived from the word *personare*, meaning "to sound through," music therapy seems to be a valuable and promising contribution for people in recovery striving after the "human vocation of becoming more deeply, more fully human" (Deegan, 1996).

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