

Music Therapy in Everyday Life, with ‘the Organ as the Third Therapist’

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Music therapy in mental health care usually unfolds over a limited time and in a limited space, often through weekly sessions which last for a certain period during a person’s stay at an institution. Nevertheless, music therapy is inevitably situated in a broader social, cultural and political context, and to various degrees will the engagement in music therapy involve levels of interaction with other contexts in turn, such as the client’s everyday life context.

In this text I will explore the interaction between music therapy and the use of music in everyday life contexts. The empirical basis for this exploration is interviews with a client and her music therapist. This is in turn linked to a multiple case study aiming towards more understanding of client’s agency in the process of music therapy, that is, what clients do to make music therapy work. The study is situated within a resource-oriented perspective of music therapy practice in mental health care, and combine theoretical perspectives from contextual models in psychotherapy and recovery. The text provides an individual narrative of how music therapy is intertwined with and a part of everyday life uses of music. The main focus will be the client’s agency in linking experiences and pursue goals across various contexts.

Introductory Vignette

K: I have the organ, and that is the basis. I use the organ as a therapist. I see it as my third therapist. I have my psychiatrist, I have my music therapist and I have the organ.

Kristin is a middle-aged woman with long experience with mental health services, mostly as an outpatient. She has struggled with mental health problems most of her life yet comes across as a remarkably resourceful and engaged woman who is able to talk about her experiences with music (and music therapy) with passion and conviction. Her story, and her means of telling it, makes a powerful impression, as she draws the line of her engagement in music through time and space, in everyday life and music therapy.

Kristin's story goes back to her childhood experiences of music making; her experiences of family psalm singing every evening, and organ lessons with a friendly schoolteacher that noticed her personal struggles. As an adult, she has been a dedicated and enthusiastic choir singer, and at home she has established a tradition of singing together and listening to music as part of her family's life. Music has always helped Kristin cope with daily life and her mental health problems.

She started in music therapy during a time in her life when a physical condition affected her voice and severely minimised her engagement with music. In music therapy, she revisited the skills in organ playing that she had acquired in early childhood, in order to renew her engagement with music. Developing these skills and playing beloved songs were central to her collaboration with her music therapist. The meanings and implications of this renewed engagement with music, however, goes far beyond the playing of psalms in the music therapy room, as her story explores the organ as a therapist.

Music Therapy and Music in Everyday Life

In recent years, we have seen a growing music therapy discourse around the health-related use of music in everyday life settings. One obvious reason for this is that such uses of music contribute to a rationale for the therapeutic power of music in general (Ansdell, 1997). Another reason could be the developments in community music therapy that has emphasized the cultural, social and political contexts, and the interaction between individuals and community as a concern for music therapy. In general, community music therapy has contributed to an increased awareness of the uses of music in non-medical, community and everyday-life contexts, and it has sought to address health concerns on structural and political levels as well as individual levels (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Rolvsjord, 2010; Stige, 2002; 2003; Stige, Ansdell, Elefant & Pavlicevic, 2010; Stige & Aaroe, 2012).

This interest towards the uses of music in everyday life in music therapy discourse resembles a growing scholarly interest emerging from a broader landscape of related interdisciplinary fields as well, such as music sociology and music psychology. Through

studies in these areas, it has been documented that people indeed use music in everyday life in ways that could be described as health enhancing or otherwise related to well-being and quality of life (Bonde, 2009; DeNora, 2000; Juslin & Sloboda, 2010; MacDonald, Kreutz, & Mitchell, 2012a; Sloboda, 2005). This conscious and active engagement with music takes place within various relevant interpersonal and social contexts (North, Hargreaves & Hargreaves, 2004, p. 75). Everyday uses of music are also described in terms of emotional regulation, a sense of embodiment, the construction of identity and the facilitation of social interaction, among other ways (Butterton, 2004; DeNora, 2000; Frith, 2003; Ruud, 1997, 2005; Sloboda & O'Neill, 2001; Sloboda, 2005).

The above references, taken together, comprise a 'therapeutic repertoire' of various health-related uses of music originating not only with professional health service providers, such as music therapists, but also with regular people in their everyday lives (Rolvsjord, 2010). MacDonald, Kreutz & Mitchell observe that the utilisation of music related to health and well-being is shared by different 'fields of practice' including music therapy, community music, music education and everyday uses of music (2012b, p. 8). Thus, in their conceptual framework, various professional practices interact with the non-professional, private and social domains. Likewise, Stige finds health-related engagements with music to span "a gamut of practices and perspectives" (Stige, 2012, p. 181) and involve a variety of arenas, agents, activities and artefacts which, he observes, potentially form a very complex web of relationships (Stige, 2012, p. 188). Here, however, we continue to need more insight into the interactions among the various practices involved with the health-related use of music, including how music therapy interacts with a client's use of music in everyday life.

In a study focusing on client's experiences in music therapy, Ansdell and Meehan (2010) found that the benefits of music therapy can be described in terms of a 'music-health-illness narrative'. The clients' experience of the relationship between their lives and their music therapy is brought into relief, and the study's findings imply that music therapy does contribute to their reconnection with music when illness has disrupted the musical engagement. Ansdell and Meehan's work is compelling because it so clearly points to continuity between everyday life and therapy. Rolvsjord (2007; 2010) similarly describes 'regaining rights to music' as essential to the experience of music therapy in a single case study about a client whose enjoyment of music had ceased in the wake of overbearing demands upon her musical abilities. Through music therapy, the client was able to repair her relationship with music so that she could again enjoy singing and listening to music. As Ansdell and Meehan indicate, music therapy can be seen as a mobilisation of music as a "health promoting resource for people in times of illness" (2010, p. 35). Furthermore, as these studies document, the

use of music in everyday life is an important aspect of many clients' stories about how music therapy proved successful for them.

However, the aforementioned studies (Ansdell & Meehan, 2010; Rolvsjord, 2007; 2010) do tend to focus on pre- and post-therapy experiences and relationships with music, rather than on the continuous interaction between experiences in music therapy and experiences in everyday life. In a different case study, Stige (2011) explores both the private and public aspects of the latter interaction and suggests that the client's activities in everyday life and involvement with music should be seen as "an integrated and essential part of the music therapy process" (p. 418). Elsewhere, he develops a theoretical approach to the contextual dimensions of music therapy using a context-inclusive model and the notions of arena, agenda, activities and artefacts (Stige, 2002, p. 209; Stige, 2003, pp. 358ff). Krüger (2011) also proposes a possible framework for linking the experiences of music therapy with the use of music in everyday life, drawing upon Giddens's concept of structuring resources in order to explore how participation in a community music therapy project had significance in other contexts for the participants.

Clients' Engagement in Everyday Life and Therapy

People go in therapy because of a desire or need to make some changes in their everyday lives. The hope is that the therapy in one way another might have some consequences for the client's life in that broader context, such as improved quality of life, increased coping with symptoms, hassles and stressors, or better interaction with significant others. Such intentions resonate with a conceptualization of health as involved with, and performed within, a social and cultural context.

With this as a background, the boundaried act of psychotherapy in general and music therapy in specific is rather paradoxical. Some of the complexities related to this paradox have been explored through recovery perspectives that center upon the mental health client's everyday life (Slade, 2009; Davidson, 2003). The notion of *recovery in mental illness* has the last years been used to express a more wide implication of how people recover to live with their mental health problems. This involves an expanded focus that includes, but moves beyond, aspects of reduction of, and coping with, mental health problems, also including aspects of life and living 'outside' of the illness (Davidson, 2012). Davidson's (2003) research into mental health clients' experiences of recovery describes wide implications and potentials of processes of recovery. By describing the journey of personal recovery he outlines a broad range

of areas such as the redefinition of self, the acceptance of one's illness, overcoming stigma, the renewal of hope and commitment, resuming control and responsibility, exercising citizenship, managing symptoms, being supported by others and being involved in meaningful activities and expanded social roles (Davidson, 2003, pp. 46ff). In this way recovery can be described as a process of engagement that "has to do with pursuing and participating actively in a meaningful and pleasurable life within the limitations imposed by the disability" (Davidson, 2012, p. 255).

However, Davidson questions the role of therapy with regard to recovery, noting that treatment might disturb the recovery process or otherwise add to the stigmatisation and social isolation (Davidson, 2003, p. 48). In addition, he draws a distinction between the processes of recovery (something that the person with a mental health problem does) and rehabilitation and health care service (something that helpers do). We can argue that such a distinction makes less sense if framing therapy within a *contextual common factors model* that emphasises the client's efforts (Bohart, 2000; Bohart & Tallmann, 1999; Duncan & Miller, 2000; Hubble & Miller, 2004; Wampold, 2002). Regardless, though, if professional services are warranted, the goal of the provider must be to support a person's recovery rather than impede it (Davidson, 2003, p.48). This implicates an embrace of the client's position in 'the 'driver's seat' of their own lives as well as their therapy processes (Solli, 2012).

In a contextual common factors model, the client's role as an active agent in psychotherapy encompasses both the extra-therapeutic (that is, the ways in which processes outside of the therapy sessions contribute to the outcome of therapy) as well as to client's efforts in the sessions. Outcome research in psychotherapy has documented, in support of this model, the relatively small contribution to the overall effectiveness of psychotherapy that is made by the specific factors or specific therapeutic techniques (Lambert, 1992; Wampold, 2001). In the explorations of common factors in psychotherapy following the so-called Dodo-bird convict (Luborsky, Singer & Luborsky, 1976), a large portion of the effectiveness of psychotherapy has been linked to client factors and extra-therapeutic factors (Asay & Lambert, 1999; Lambert, 1992; Lambert & Barley, 2002; Wampold, 2001).

This emphasis upon extra-therapeutic factors and client factors is not surprising, given the limitations in time and space of psychotherapy. Psychotherapy (and music therapy) is most commonly practiced in forty-five- to sixty-minute weekly sessions in a defined and bounded space. This so, even whether the actual session or project take place in a closed music therapy room or in a more open arena as in community music therapy projects. It is up to the client, then, to extend the benefits of these sessions to the rest of the week, spent engaging in his or her everyday life pursuits. The concept of extra-therapeutic factors explicates facets of how therapy is dependent

upon the active efforts of a client. Lambert (1992; see also Asay & Lambert, 1999) calculated that as much as 40 per cent of the outcome of therapy was related to factors that were independent of the therapeutic sessions themselves. Within the realm of the extra-therapeutic. Lambert included factors that are part of the individual client and factors that are part of the environment (Lambert, 1992, p. 97). Drisko (2004) in turn criticises Lambert for ignoring the impact of policy and agency contexts within the extra-therapeutic. He proposes an alternative trifold scheme: the policy and agency context, the client's context, and the client as a common factor (her/his personality and personal resources) (Drisko, 2004, p. 85).

The notion of extra-therapeutic factors is identified by several authors as an argument for the importance of client's efforts, pointing towards the client as a potent common factor (Bohart & Tallmann, 1999; 2010; Hubble & Miller, 2004). Bohart and Tallmann (1999; 2010) emphasise the client's naturally occurring self-healing outside of therapy, and propose a similar agency in therapy. Mackrill (2009), however, finds such a distinction between agency in therapy and agency in everyday life contexts too simplified, arguing that it depicts an erroneous independency between the clients' agency in sessions and everyday life (Mackrill, 2009, p. 196). In order to understand how clients make therapy work, Mackrill suggests instead, we must draw upon perspectives that encompass the client's efforts in relating experiences in therapy to everyday life contexts and vice versa.

Dreier (2008; 2009) proposes a theory of social practices to help us reconcile experiences in therapy to everyday life. In a qualitative case study of family therapy, he explored how the members made use of their therapy as they moved within and between different contexts and social practices. Rather than seeing life changes as the results of changes in therapy sessions, he mapped a complex web of change within several social contexts and social practices. Dreier found therapy to be constantly interacting with other contexts, with the participants (or clients) actively involved in negotiating and reflecting upon their participation, positions and abilities within various social contexts and social practices. Clients pursue concerns and change across contexts, and are actively linking experiences in psychotherapy to their engagement in other contexts (Dreier, 2008). With regard to music therapy, such concerns across contexts might for example be centred on ways of using music to promote health, as will be explored in the following.

Methodology

In this text, I report on findings from a qualitative single case study that is part of a larger multiple case study intended to explore what clients do to make music therapy work. This single case study explores a theme emerging from the preliminary analysis of the multiple case study. In this way this case study can be described as instrumental (Stake, 1995). The selection of this particular case is purposive (Creswell, 1998, p. 118) as this informant in particular provided rich descriptions regarding the theme that I wanted to explore.

The empirical material for the single case study presented in this text derives from two qualitative semi-structured interviews (Kvale, 1996) with the client and one interview with the therapist. The first client interview centered on the use of music in everyday life, and the second explored the therapeutic interaction and the client's active engagement in the music therapy sessions. In preparation for the first interview, the client documented her/his use of music in everyday life for a week. A video recording of a single music therapy session preceded the second client interview and the interview with the music therapist. Excerpts from the video recording were used during the interviews as an aid to recall events, feelings and thoughts in the music therapy session, informed by the procedure of Interpersonal Process Recall (IPR) (Elliot, 1986).

A combination of narrative approaches, thematic analysis and microanalysis was used on the data. Categories and narratives were first identified through a thematic analysis of the transcriptions of the client interviews that relied upon a process of coding units of meaning (Miles & Huberman, 1994; Ryen, 2002). These categories and narratives were then triangulated with other parts of the empirical material (the video recordings and the interview with the therapist) to nuance them and allow for thick descriptions (Kvale, 1996; Ryen, 2002).

This project was approved by the Norwegian Regional Committee for Medical Research Ethics (REK-vest). Nevertheless, the reporting of rich qualitative data can compromise anonymity even in the intentional absence of direct identifiable information (McLeod, 2001, p. 15). The total amount of non-identifiable information discussed in this text was approved by the informant.

Pursuing Goals Across Contexts

In her two interviews, Kristin talks about several contexts in her life in which music has played and plays an important role. She defines these contexts in time and space as she moves around in her life history and within her various social communities and life arenas—her home life context (involving the personal, family and socially intimacy); her broader social and religious community context; the context of her mental health services; and the music therapy setting. In addition her story ranges across her life span, from her childhood home to her present life as a grandmother. It includes a life-long history of membership in religious communities and choirs. Her story about the mental health care system ranges from her first experiences with being admitted to a large institution to her present experiences as an outpatient in a local mental health centre.

In line with Dreier (2008), I will explore Kristin's story across these contexts in time and space. I will focus on how she pursues three health-related goals across various contexts, comprising both her everyday life and her therapy: (1) pursuing possibilities for participation in music; 2) pursuing religious experiences and identity; and (3) pursuing coping with her mental health problems. As an overarching theme, her story highlights how her active engagement with music in everyday life interacts with her music therapy in her continuous pursue of these goals.

Pursuing Possibilities for Participation in Music

All her life, Kristin had actively participated in music whenever she had the chance. In her childhood, her grandparents gathered the family together every evening to sing. She also eagerly embraced the opportunity to learn to play the organ with her teacher. As an adult, she continued the family tradition of singing with her children and grandchildren at celebrations and occasions where they gathered. Her participation in choirs and singalongs in church and other local gatherings was crucial to her engagement and sense of belonging in those social contexts. Not surprisingly, for Kristin, the experienced loss of her ability to sing added to her burden of mental health problems:

K: What happened is that I think I got a depression ...I simply think that I got a depression from losing my voice. And I got a grief reaction, because I couldn't participate in any of the choirs anymore. . . Nobody talked with

me about how I could rehearse my voice [after losing the ability to sing]. I used to have a very reliable alto voice, and sometimes I used to sing the alto voice alone in the choir in the church, because I had such a powerful voice.

After the first period of her voice problems, she tried to start up again as a choir singer, but she gave up as her problems escalated because of her physical condition. She tried to continue singing with her grandchildren but eventually gave that up too. The musical silence, however, didn't stop with that. It affected the whole family, and their habits of singing together almost ceased:

K: When I didn't sing anymore at home, it was, in a way, the end of our tradition of singing around the Christmas tree.

This musical silence characterized the situation when Kristin started her music therapy. There she developed her skills in organ playing while also working on her voice and her relationship to her voice. As she developed a renewed trust in her voice (and an acknowledgment of its limitations), she started singing again. With pride and satisfaction she talks about a funeral in which she took part in the singing:

R: What does it mean to you to sing together?

K: It means a lot! I realised that when I was in a funeral and managed to sing along in all the songs.

R: Yes!

K: Well, it was songs that were in a good pitch for me to sing, so of course that mattered. It was an expected death, but she was a great woman. And that I could join in with singing songs at the end of her life . . . that was just amazing.

R: That sounds good.

K: To be part of this for an old religious woman that had lived so quiet and great, a gorgeous sweet woman. I have never noticed anything affecting me like that in a funeral . . . that I could actually sing with the others, even if people around me did not sing. I think many people don't sing much. But I wasn't afraid of hearing my own voice. I sang along.

Kristin learned to enjoy singing despite the limitations of her new voice, and she gradually started singing again with her family. Especially she enjoyed singing with as well, teaching her grandchildren children's songs.

At the time of the second interview, however, she was confronted with new problems with her voice and a further surgical operation that could possibly reduce her ability to use her voice even further. She was therefore preparing to compensate for her eventual inability to sing by rehearsing the organ:

K: I am losing track of the melodies—it takes only a few words . . . I can only sing a few notes . . . but then I think: ‘But I still have the music!’

R: Yes, you have your organ.

K: Yes, I can play the organ, the melody, and the grandchildren can sing while I am playing. They will sing about Christmas. So I have got something instead of the voice. Perhaps you don’t understand what?

R: It’s like a new voice?

K: A new voice!

Her new confidence in her organ playing and the new possibilities it offered her for musical participation, made the impending operation (and its further threat to her voice) less upsetting. In the music therapy session that was videotaped and discussed in the interview, she rehearses Christmas carols. Her comment in the interview makes no doubts: ‘This year Grandma can play the organ and the others can sing!’

For Kristin, music participation delivers a sense of belonging, as her descriptions of singing so beautifully indicate. Musicking is basically a social activity (Small, 1998), and several authors describe experiences of musicking in term of social belonging, identity and *communitas* (Ruud, 1997; 1998; Stige et al., 2010). By substituting the organ for her voice around the Christmas tree, then, Kristin is not only negotiating her participation to her own satisfaction but also creatively ‘performing community’ (Ansdell, 2010)—in this case, her sense of belonging in her family and affirmation of its cultural values. While she uses music therapy to work with her voice and adjust to her new condition regarding her voice (and the organ), she uses the everyday life contexts of family and church to gradually participate in actual singing again.

Pursuing Religious Experiences and Identity

Kristin grew up in a religious family and community, and all her life she cultivated a religious identity and participated actively in religious practices. Music had been a natural part of her religious and spiritual practice. Her musical identity is closely connected to her religious identity; thus, when she is singing, going to music therapy,

or playing her organ, she generally performs religious songs. Singing/playing these songs affirms her religious faith, helps her find comfort in their words and allows her to find hope through prayer. At times, singing or playing songs about salvation and heaven helps her get on with her life:

K: I sing songs about how good everything will be when the pain I experience here has passed. Then one will have peace and happiness. In those periods, I have used lots of 'heaven songs', as I call them. And my children say, "Are you listening to those heaven songs again?" "Yes, just think about it", I say, "isn't it great how happy we will be?"

In the interviews, Kristin talked about her experience with the mental health care system in relation to her religiosity. She puts forward one episode many years ago at the time of her first admission to a psychiatric hospital as particularly important: As a way of dealing with a dramatic incident that had occurred just before her admission, she had brought some religious songs with her, only to find her songbook (as well as her Bible) taken away from her:

K: That did something to me that is painful even today. They took it away and that value that I had . . . in a way got lost for a period of time.

R: Something that you actually had to find comfort and could use . . .

K: They took it; you shouldn't do that. My Bible was locked in.

R: Oh no!

K: You shouldn't bring religion into it, that's it! That was the rule those days.

Kristin goes on to explain that this experience with the prohibition of religious songs had for many years made her very skeptical about music therapy. She worried that she would not be allowed to sing the songs she loved, and that she might lose her musical identity in the mental health care setting. One strategy to deal with such worries had been to protect her religious songs by keeping them away from this context. However, after she started music therapy, she was pleasantly surprised to find that her religious songs were welcomed and acknowledged by the music therapist. This embrace of her religious identity contributed to her sense of personal wholeness in this mental health care context:

K: I take those songs with me into music therapy, and I am allowed to do that. No one has stopped me. For me it is important that you can play songs that give meaning. Because you have both body and soul, and it is important

to build up the whole person. It is great to have more normal therapy sessions as well, but in a way it does not take into account the spiritual. Through my songs I find the strength to continue. I get food for my soul at the same time. That is why I choose religious songs.

Religion and spirituality constitute a resource for many people with mental health problems—they might strengthen a sense of self and self-esteem, present coping strategies or act as a source of social support or simply hope (Fallot, 2007). Recently there are indeed more awareness of the importance of religion and spirituality within the field of mental health and mental health care (Awara & Fasey, 2008; Fallon, 2007; Galek, Flannelly, Koenig & Fogg, 2007; Slade, 2009), as well as in music therapy (Aigen, 2008; Potvin, 2012). Kristin's religious practice had served as a resource for coping in everyday life, and was intimately tied into her sense of identity and social and cultural belonging. Thus, through her engagement with religious songs in music therapy she was able to bring this into the mental health care context.

Pursuing Coping with Mental Health Problems

Lastly, Kristin's goals with her music were explicitly related to her mental health problems, and to her aspirations for living a good life in spite of her symptoms and challenges. For years, she had used music as a resource for coping with her life and to help her relax, to reduce her anxiety, to regulate her emotions, and to provide a sense of mastery. Her competence in this regard goes back to her childhood, when she had observed her grandfather's use of music to control his own anxiety, and when her school teacher provided music (organ lessons) in response to her struggles.

K: Music and singing have had such a central role in my life, and that is why I have coped so well in spite of the anxiety that I have struggled with since I was five years old.

Her engagement as a choir singer was also a longtime part of her use of music to control and cope with her anxiety:

K: My singing was almost sacred to me. Even when I had children, I just had to go to the choir rehearsals. I had to, because I knew already back then what singing did for my anxiety.

For years, as well, Kristin had used active music listening for personal emotional regulation and the easing of anxiety and depression. At times she used techniques such as lying down and focusing upon classical music as a way to soothe herself. More often, in recent years, she selected music with lyrics that fit her mood. Depending on her emotional state then, listening to the selected songs could either help her to relax, alternatively to find motivation or energy. She explained that music therapy made her more conscious about the ways in which she had always used music. In her daily life at the time of our interview, she had arranged her house so as to always have a radio, CD player or television close by:

K: I have a radio with a cassette player at my kitchen table. I have a radio with a CD player in my dining room, where I have my sewing equipment. And then I have my TV, and if I go out from the living room, I have my organ. So in a small radius I have much to choose from, depending on my mood and what I want.

Still, she notes that it is not always easy to turn to music. Even if she by experience knows what would be helpful to do, it takes tremendous efforts to actually do it in the midst of anxiety or depression:

K: Well, it isn't done in one day. I have been in music therapy for about one and a half years—not longer than that. You have to learn along the way. It's not like snapping your fingers—'Get music therapy and learn to use music'. You have to go through a phase, find the music you used to like [while] thinking about what helped and what did not help. And then it is to manage . . . it is terribly difficult when you are in a state of restlessness and anxiety to be able to put on the music, so in periods it is a bit like, 'Oh no, I can't do that'. And then I go and lay down on the sofa.

Interestingly, her use of music in everyday life was seldom explicitly explored in her music therapy sessions, even though the music therapy experience stimulated her to use music more and in new, health-related ways. Crucial to her new and more explicitly and conscious health related use of music is the organ that she was able to get hold on and bring to her house:

R: Do you play the organ every day?

K: Yes, almost. It isn't many days I don't. Either I play a little tune in the morning . . . well, I am usually feeling terrible in the morning, so sometimes

especially if I need to go anywhere then I play some songs in the morning in order to calm down a bit.

In the music therapy sessions, the music therapist helps her with chords and guides her through songs. This is significant to her as she emphasize that having someone at her side while she practices gives her a sense of support and helps her to accomplish more. At home, however, there is no one to ask for help, but in this case, if negative thoughts drag her down, she plays one of the songs she learned as a child:

K: There are a couple of songs that I know really well, and if I don't manage so well, then I play one of those in order to avoid a sense of defeat. One of them is one of my husband's favourite songs, so then he'll come in and tell me that I am playing well.

As we have seen, learning to play the organ is very important to Kristin at this point in her life, because it allows her to participate in music once again despite her reduced capacity for singing. But learning the organ also gives her 'something to strive for' or work toward; it contributes to a sense of self-efficacy, a more general belief that she can cope with and manage things (Bandura, 1997). A successful time with the organ helps her start to get her work done:

K: 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, 'Well, actually I can manage!'

R: Yes . . . ?

K: . . . And when you manage there, then you dare trying something else again.

R: What sort of things?

K: It could be housework—dusting, for example—or daring to sit down with a difficult craft that you struggle with. I sew, and at times it is like, 'No, I am not able [to do it]'. Then I don't even dare to start, because I don't think I will manage. But after I have managed something at the organ, I can actually start with the most difficult tasks.

Kristin's use of music resembles a common and conscious everyday use of music that has been documented extensively in other studies (DeNora, 2000; North & Hargreaves, 2004; Sloboda & O'Neill, 2001; Saarikallio & Erkkilä, 2007). With regard

to her mental health, her use of music might be understood as a self-management strategy (Slade, 2009), one that involves certain musical 'experience skills' (Rolvsjord, 2010) that she has gained through a lifelong engagement with music. In tandem, she uses music therapy to learn more about music and to learn more music skills to apply in her everyday life in order to control and manage her health.

Concluding Discussion: 'The Organ as the Third Therapist'

From Kristin's story here, we find that her experience with music therapy fits with several goals and aspects that are commonly identified with, and situated within, a continuous process of recovery (Davidson, 2003, 2012; Slade, 2009). The importance of music therapy in this process was strongly emphasised by her as well as by her music therapist. Interestingly, when the music therapist talked about the outcome of music therapy in Kristin's case, she/he also emphasised her use of music at home rather than any development that was observed in therapy sessions. The focus of the present text, however, is not to identify outcomes of the therapeutic process but to explore how the client's engagement in music therapy interacts with her/his engagements with music in other contexts. Clearly, Kristin's process of health musicking extends far beyond her music therapy sessions. In particular she emphasized the significance of her procurement of the organ:

K:... if I hadn't been able to get hold of that organ that I have at home, I wouldn't have gained so much from the music therapy.

From this quote we understand that her procurement of, and use of, the organ is significantly related to her experiences with music therapy. Still, as we saw earlier in this text, her use of the organ was only one part of a larger engagement with music in several contexts of her everyday life. Understood as a metaphor, we might extend her description of the organ as the 'third therapist' to the continuous engagement with music in her everyday life—that is, to any use of music outside of music therapy. Her 'third therapist', then, is her own agency in a bi-directional linking of the music therapy process with pursuits and engagement across other contexts of life.

According to Dreier (2008; 2009), as mentioned above, therapy should be approached as part of a much greater whole:

Therapy does not and cannot work abstractly as the only cause of change. It works in conjunction with other conditions, events, activities, co-participants, social relations, and contexts in clients' lives. Indeed, for therapy to work involves much varied work on the part of the client between sessions, elsewhere and later. (Dreier, 2009, p. 206)

Following this, we may say that Kristin's pursue of the goals mentioned in this text, of musical participation, of religious identity and spirituality and her use of music in coping is definitively part of her engagement in music therapy. However, this engagement in music therapy is in interaction with a similar and continuous engagement across several contexts, such as her home and family, her religious community and her mental health care institution.

Kristin's pursuit of health and quality of life involves an active and continuous engagement with music in several social practices that include music therapy. Music therapy, in consequence is one possible resource within a larger strategy of service provision for mental health that needs to include personal levels as well as organisational and community levels (Prilleltensky & Prilleltensky, 2006). However, if the therapeutic strategy is extended to an engagement with client's everyday life contexts, we need to have a critical stance towards the possibilities and consequences of implementing professional conducts into people's everyday life (Dreier, 2008, p.17). Indeed we should not reduce life to a therapeutic process. Thus, it is crucial to recognize the client's agency in terms of this process of linking the experiences in music therapy to other contexts of life through a continuous engagement across contexts in time and space.

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