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Music therapy and community participation: Selfhood and artistic citizenship within and beyond the clinic

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Abstract

Music therapy practices evolve in specific contexts, which suggests that the conceptual and theoretical claims we make should be continuously challenged by practical realities. In this paper, I challenge tendencies to *polarize* clinical music therapy and community music therapy, by elaborating on two main themes: a) Possibilities and limitations of connecting community music therapy and cultural participation in music therapy within mental health clinics; b) Ways of relating to the argument that, as professionals, music therapists must heed established models of thinking in the clinic. This theoretical article takes inspiration from two integrative metatheoretical traditions; the bioecological and sociocultural tradition and contemporary enactivist perspectives. The examples that I present in this paper are based in practice contexts within mental healthcare in Bergen, Norway. A “Three-Stage Model” is outlined, with emphasis on the ecological transitions from i) clinical music therapy, to ii) municipal follow-up services, to iii) independent cultural participation in the local community. The affordances and limitations of the notion of *artistic citizenship* in relation to the Three-Stage Model are explored and related to the notions of *personhood* and *selfhood*. The relationships between the Three-Stage Model and organisational culture of mental health clinics in Norway are discussed, and areas of future research indicated.

Keywords

clinical music therapy,
community music therapy,
artistic citizenship,
personhood,
selfhood,
organisational culture,
integrative theory,
ecological transitions

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Introduction

Music therapy practices evolve in specific contexts within certain groups and people with their own dreams, agendas, values, and perspectives. This implies that the conceptual and theoretical claims we make should be continuously challenged by these practical realities (Stige, 2015). Also, it suggests that there is limited value in defining music therapy in an exact way. It is more helpful to think of music

therapy as a family of practices, with some family resemblances that are shared to a higher or lower degree. With regards to community music therapy such characteristics can be communicated by the acronym PREPARE: participatory, resource-oriented, ecological, performative, activist, reflective, and ethics-driven (Stige & Aarø, 2012). The family resemblance metaphor indicates that the boundaries between practices that do or do not identify themselves as community music therapy are often fluid and permeable. The research literature does not always reflect this, however. In this paper I challenge tendencies to polarise clinical music therapy and community music therapy and examine conceptual and theoretical implications of exploring relationships between such practices.¹

Practices that we today might think of as community music therapy emerged many decades ago, but the term 'community music therapy' started to be used and known internationally only around the turn of the millennium. This was often linked to discussions about the role of culture and context in music therapy as well as about the identity of the profession. Some of these discussions occurred in *Voices: A World Forum for Music Therapy*. An anthology from this international journal (Kenny & Stige, 2002) included an influential discussion paper on community music therapy by Gary Ansdell (2002). Responses varied. In reviewing the book, the Finnish music therapy professor Jaakko Erkkilä (2003) acknowledged the significance of the debates that the various chapters invited but also described parts of the book as "irritating." In a broader evaluation of the book, published on a journal website that is no longer available, Erkkilä discussed Ansdell's chapter in more depth and described concerns about the risk of committing "professional suicide." Erkkilä's appraisal was that to integrate some "community aspects" in the practical work of the music therapist might be defensible for the therapist and helpful for the client, but that the basis for the professional identity of music therapists should be psychiatric and medical.² Erkkilä's comments belong to an era when the notion of community music therapy was relatively new, but the more general idea that the identity of music therapy should conform to a medical logic is not so new and lingers on. Consider, for instance, how the language that AMTA chooses to use when defining music therapy is coloured by a medical logic: "Music Therapy is the clinical & evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship" (AMTA, n.d.).³

We probably learn more from people who disagree with us than from those who agree, so part of the value of the discourse on community music therapy has been that it has raised discussions on music therapy's relationship to the medical model and to the culture of the clinic. I am concerned, however, about the fact that more recent descriptions of the field of music therapy still separate the

¹ I use the phrase "clinical music therapy" to refer to practice in specific contexts, not to a model of practice. As used here, clinical contexts are settings dealing with management and therapy, informed by medical diagnoses. Whether all professions need to adhere to a medical model of thinking is part of what this paper is about.

² The term "medical," when referring to a model of thinking, is polysemic, as it might refer to the biomedical model or the expanded biopsychosocial model. For decades, many theorists have critiqued the reductionism and dualism of the biomedical model, and Engel (1977) launched a biopsychosocial model that is now a well-established framework for medicine and healthcare. The biopsychosocial model is also under substantial critique, however, and the biomedical framework remains strong, also in psychiatry. There are still considerable problems with the conceptual foundations of contemporary medicine and healthcare (Bolton & Gillett, 2019).

³ On their website, AMTA does not make an explicit claim about this definition being in accordance with the medical model of thinking, but I argue that the definition conforms to this model, by highlighting music therapy as an evidence-based intervention with individualised goals, with no recognition of the situated and collaborative dimensions of music therapy practice.

clinic and the community (and the body and the mind) in ways that might stifle our capacity to see connections that matter to practice and to the people we work with. One example can illustrate my point: Consider how music therapy is discussed in the WHO's scoping review on arts and health (Fancourt & Finn, 2019). In this review there is no discussion of community music therapy whatsoever. The underlying assumption seems to be that music therapy's place is clinical treatment and management, that this is distinct from prevention and promotion in the community, and that no connections need to be made.

In this paper I will not go into the theoretical complexities of how to categorise the field but explore how more integrative ideas about music therapy might be helpful in specific contexts of practice. I will focus upon community music therapy practices as part of and supplemental to music therapy within mental health clinics in the Norwegian health care system. With examples from such contexts, I hope to illuminate trajectories from music therapy to community participation. I will elaborate on two main themes:

1. Affordances and limitations of connecting community music therapy and cultural participation to music therapy in mental health clinics.
2. Ways of relating to the argument that as professionals, music therapists must pay attention to established models of thinking in the clinic.

The article is theoretical but starts with a description of music therapy practices in Bergen, Norway. This approach is informed by the "practice turn" in philosophy and social studies, a tradition that prioritises practical examples as an approach to the exploration and clarification of concepts (Stige, 2015). The practice examples that follow are not presented as data, then, but as basis for the development of theoretical arguments.

My arguments take inspiration from two integrative metatheoretical traditions, namely the bioecological tradition that has grown out of cultural psychology (Stige, 2002) and contemporary enactivist perspectives on the human mind as a dynamic process arising from interactions between the brain, the body, and the environment (Høffding et al., 2024). One of the strengths of these integrative frameworks, compared to Engel's (1977) biopsychosocial model, is that they give better accounts of and more significance to culture and to first-person (subjective) experience. I choose to return to these frameworks in this article because I am not satisfied with my previous attempts of discussing relationships between clinical music therapy and community music therapy. In *Culture-Centered Music Therapy* (Stige, 2002, pp. 207-229), for instance, I tried to point at relationships between practices by introducing the notion of *health-musicking* as arena-flexible practice with evolving agendas. Affordances of connecting clinical music therapy and community music therapy were not explored in any depth, however.

The three-stage model linking practices in the clinic and the community

The example that I will present here is based in practice contexts that are part of Polyfon Knowledge Cluster for Music Therapy, a consortium established to support systematic and research informed

implementation of music therapy in Norway.⁴ The consortium consists of partners across academia, the hospital sector, the municipal sector, regional child welfare services, and the arts sector. Input from service users and experts by experience is central to the collaborative processes within the cluster. Today, Polyfon is a national collaboration, but it started in 2013-2014 as a dialogue between the University of Bergen and potential partners in the Bergen area. Through the ensuing collaboration, Bergen Hospital Trust (one out of six university hospitals in Norway) in 2017 became the first hospital in the country to establish the policy that music therapy services should be available in every mental health clinic. In this paper, I will focus on innovations that followed, particularly the linking of practices between the clinic and the community.

I have previously written about relationships between music therapy in clinical contexts and practices oriented towards community participation (Stige, 2018). The project MOT82 is a case in point. This project started in 2014-2015, and user experiences of the project were evaluated after a couple of years (Bjotveit et al., 2016). The survey demonstrated diversity in the participants'⁵ preferences, but also a high degree of agreement about the general value of the project. All 20 participants were "satisfied" or "very satisfied" with the activities they had taken part in, 14 out of 20 felt that music had become an important part of their everyday life, and 17 out of 20 found that the music activities made it easier for them to socialise and get out and about:

[It's the] Only social [thing] I do during the week.

Music therapy balances negative emotions so that they do not stand in the way of social interaction with other people.

(participants in MOT82, in Bjotveit et al., 2016, pp. 12-17)⁶

Good community services cost money. Undeveloped services can be more expensive, in terms of hospital stays and disability benefits. MOT82 did not stop when the project period was over. It was taken over by the city of Bergen in 2019, as an ongoing service. Similar community services are now being developed in other parts of the city. They all build upon the idea that it is helpful to link music therapy practices between the clinic and in the community.

The WHO has produced a film that gives glimpses of such practice. In the video we meet Arve, who has had serious mental health and substance use challenges over many years. To Arve, music therapy is nurturing and stimulating in a unique way, although the first sessions were challenging. When trust and communication improved, he started to write songs together with the music therapist, which influenced his identity and his motivation for community participation:

⁴ Polyfon Knowledge Cluster for Music Therapy is hosted by the Grieg Academy, University of Bergen. For the sake of transparency: I am the leader of this cluster, but I have not been responsible for developing the Three-Stage Model that I am describing here. Local music therapists and experts by experience have had that role.

⁵ I use the term *participant* to refer to persons taking part in music therapy, because I refer to practices of various contexts and because I argue that *participation* is central to music therapy (Stige, 2006).

⁶ These quotes are my translations of the Norwegian originals.

Now I'm not just a former drug addict; I'm actually a songwriter. It's part of my new identity. It's important to me. (Arve, in the WHO film Arts and Health Stories: Arve)⁷

The kind of practice that Arve experienced has been developed over the years, with substantial service user input. In one evaluation report, the participants raised several questions about barriers to cultural participation, mechanisms of inclusion and exclusion, and challenges related to stigma (Tuastad et al., 2018). In a more recent report, the participants confirmed the findings of the previous reports when it comes to the value of music in everyday life. They also raised concerns and critical questions about how to best support the transitions from clinic to community and how to best support the diverse needs and interests of participants (Tuastad et al., 2021).

In the last report, a “Three-Stage Model” is outlined in some detail emphasising the need to support people in the transitions from i) clinical music therapy, to ii) municipal follow-up services, to iii) independent cultural participation in the local community.⁸ This model is inspired by previous ecological and collaborative music therapy projects in Norway, such as the Gloppen music and community participation project in the 1980s (Kleive & Stige, 1988) and the Custody and Liberty project in the 1990s (Nilsen, 1996; 2007). Equally important; the model is based on feedback from service users who reported that they benefited from music therapy at the clinic but experienced a void afterwards. They asked questions such as “Why shouldn't it be possible to be musically active in everyday life as well?”

The Three-Stage Model has been given different names at various times in different parts of the city. One such name is Tonetrinn (ToneSteps), using the notes in a melody as metaphor: “The duration of the steps, their frequency, and the movements between them become a melody where none of the steps is inherently more valuable than another”.⁹ This highlights that change is not necessarily a linear process and that the Three-Stage Model should not be understood as a hierarchy, where all participants should take steps in the same direction or sequence. Another way of reconceptualising the model was developed by Wikne, Myrseth and Tuastad (2024), who found that participants describe the different musical settings as *recovery-nurturing havens* that facilitate coping, mastery, and recovery. The authors therefore reconceptualised the model into a *Haven Model*.¹⁰

Obviously, the Three-Stage Model is still developing. Several music therapists working with the model in Bergen have recently undertaken a qualitative research study with the purpose of exploring its qualities and limitations and ways to conceptualise it (Østerholt et al., in press). Hopefully, this will inspire more research on the implementation of music therapy in the Norwegian health care system. There are some studies to build on already, such as Rolvsjord's (2018) study of stakeholder experiences of the implementation of music therapy in a (personal) recovery-oriented unit, and Ødegaard and associates' (2022) study of health care workers' perspectives on the challenges and

⁷ The video can be seen here: https://www.youtube.com/watch?v=y7UhiJ_VTbk&t=38s

⁸ The word “model” is not used to indicate specific procedures or techniques. The Three-Stage Model is a flexible template with some similarities to Wood's (2016) matrix for community music therapy practices.

⁹ My translation to English of personal communication in Norwegian, from music therapist Alexander Bjotveit Østerholt. For information about this service, see: <https://www.solli.no/nyheter/tonetrinn/>

¹⁰ Tia DeNora's (2013) work on *music asylums* is one of the inspirations to this choice of metaphor.

possibilities of music therapy within medication-free treatment services for patients with psychotic disorders.

The Three-Stage Model emphasises that music can be a powerful driver for positive change. Music is mobilised as a resource for health and quality of life, both during clinical music therapy, in follow-up services in the community, and in everyday life. To strengthen the opportunities for independent musical activity and cultural participation in the community, the NGO *Gjenklang* (Resonance) was established in 2022. This NGO supports participants throughout the year and hosts an annual festival that celebrates music, community, and the right to cultural participation. To make this a reality, the NGO works closely with the health and social care sector and with business and cultural actors in the Bergen area, allowing musicians with mental health and substance use challenges to perform at established, high-quality cultural venues.¹¹

Music therapy and artistic citizenship

As indicated above, boundaries between practices that do or do not identify themselves as community music therapy are characterised by fluidity, and the music therapists working in the way I have described above have not been informed by the community music therapy literature only, but by an array of influences, not least resource-oriented music therapy (Rolvsjord, 2010) and perspectives on personal and social recovery (Slade, 2009; Solli et al., 2013). This means that the question “What matters to you?” is more central than the question “What is the matter?” in these practices.¹²

The music therapy literature describes the potential of community-oriented practice in several ways; it might for instance afford social support, identity development, and a sense of belonging. It might also facilitate optimal moments of collaborative musicking, give voice to previously unheard voices, and create possibilities for social activism (Stige et al., 2010). Participants that join *Gjenklang* or perform in the concerts and festivals organised by this NGO, often identify as *artists* (Østerholt et al., in press). With the question “What matters to you?” in mind, I will now explore the affordances and limitations of the notion of *artistic citizenship* in relation to the Three-Stage Model.

Artistic citizenship is a complex and evolving notion referring to relationships between artistic activity, civic life, and social change (Stige, 2021). The traditional view of the artist as an expert creator of autonomous objects is challenged, and the idea of artists as engaged members of society with a responsibility to use their artistic practice for the public good is explored. There are at least two dimensions to the notion, then; the ways artists act as citizens *and* the ways citizenship can develop through the arts. In other words, citizenship is not treated as a legal term related to the institutions of state and nationhood but understood as practice, where social responsibility, active engagement, inclusion, diversity, and participatory process are key factors (Campbell & Martin, 2006; Elliott et al., 2016).

¹¹ See here for more information about the NGO *Gjenklang* (Resonance): <https://www.gjenklang.info/>

¹² The question “*What matters to you?*” –central to Barry and Edgman-Levitan’s (2012) argument for the relevance of shared decision-making in healthcare– has become very influential in contemporary person-centred and recovery-oriented practices as well.

These metaphorical uses of the notion of citizenship are relevant here because of its inclusive and democratic ethos. The notion of artistic citizenship might throw new light on established notions of art, artistic quality, roles, and responsibilities. This is pertinent to community music therapy practices that build trajectories to community participation for people who experience marginalisation, such as persons with serious mental health challenges (Lydvo, 2017).¹³

We should also pay attention to relevant critique, including the one developed by Deborah Bradley (2018). She has explored tensions between metaphorical concepts of citizenship and citizenship as an institution related to state and nationhood. Bradley addresses questions on what the terminology of artistic citizenship might mean for the stateless and other persons vulnerable to the political manoeuvrings of states. She acknowledges that the literature on artistic citizenship challenges dominant understandings of who can engage in arts. She also reminds us, however, about harsh realities linked to citizenship as a legal term: It represents a discourse of inclusion but also one of exclusion. Therefore, a discourse of citizenship can amount to a discourse of privilege that recreates violence against vulnerable peoples. If we discuss citizenship in legal terms, we discuss power, not least the lack of power that is afforded to some citizens in contrast to others (Bartlett & O'Connor, 2007, p. 211).

Instead of rejecting the notion of artistic citizenship because of its ambivalent nature, we might employ it with a focus upon empowerment and social justice. Even with its many complexities and contradictions, the discourse on artistic citizenship might help us realise problematic aspects of the standard assumption in modern societies that most community members are *not* artists. To separate art and everyday life, or individuals and communities, is an exercise that might contribute to continued exclusion and marginalisation of vulnerable groups and individuals. The notion of artistic citizenship challenges the idea that art is created by the most gifted individuals only, that it belongs to another sphere than everyday life, and that it is always or necessarily technically advanced. This is not to suggest that craft and skills are not involved, but actions and experiences are related to social contexts and practices. “Arts,” “artists,” and “artistic” can be treated as open terms referring to people’s engagement with the arts, in all walks of life and at any levels of skills and experience.

Maintaining personhood and caring about selfhood

Relevant as all of this is to community music therapy, there are real world limitations linked to local, cultural traditions as well as to potential challenges at the personal level. There are situations where people are not open to welcome new artists, performances, and practices. And there are times when a person might not be ready or motivated for exploration of the affordances of community participation. If we do not take such real-world limitations into consideration, use of the term artistic citizenship might amount to wishful thinking about the human right to cultural participation.

These real-world limitations of course also indicate that public practice does involve risks when working with vulnerable persons. As indicated by the PREPARE acronym, the basis of this practice is ethics-driven; it reflects responsiveness and responsibility in relation to social problems, including marginalisation and exclusion (Stige & Aarø, 2012, pp. 166-170). At the same time, sensitivity to the

¹³ For related ideas about rights to musical participation, see MacDonald and Saarikallio (2024) on healthy musical identities and new virtuosities.

strengths and vulnerabilities of each person is key (Turry, 2005). I have previously argued that community music therapy practices – which are arena-flexible and participatory – do need to be adaptable both when it comes to boundaries of time and space (Stige & Aarø, 2012, p. 281). Boundaries as traditionally managed within therapeutic practice in a clinic are not necessarily relevant in practices such as those informed by the Three-Stage Model. Some basic principles might be shared, however, such as the premise that we need to pay attention to and manage conflicts of interest. Psychotherapy literature that distinguishes between boundary violations and boundary crossings might be helpful here:

Boundary violations are defined by their exploitative nature and harmful effects on the client. Boundary crossings involve the therapist stepping out of the usual framework in some way but the action does not harm the client. In some cases it could advance the therapeutic alliance and the effect of the therapy process (Gutheil and Brodsky, 2008, paraphrased in Stige & Aarø, 2012, pp. 283-284).

In this light, the community music therapy practices that I have described could be perceived as careful cultivation of boundary crossings that might benefit participants in relation to activities and arenas that matter to them. Since the purpose of this article is to suggest theoretical concepts that can inform practice, I will not go deeper into issues of professional boundaries and ethics here, but I do acknowledge that they are important.¹⁴

I will return to the fact that a community is not necessarily welcoming and a person not always ready for community participation. What are the theoretical implications of this basic fact? I suggest that an examination of relational and social dimensions of *personhood* and *selfhood* will give us conceptual tools that will supplement and inform our understanding of the notion of artistic citizenship.

Aspects of *personhood* that philosophers typically have discussed are rationality, self-consciousness, command of communication, and agency (Stige & Strand, 2016). These aspects might be under pressure if you for instance face disruptions in self-experiences and severe mental health challenges. At times of vulnerability, we might all doubt the rationality of our thoughts and the moral worth of our actions. Some scholars, such as Taylor (1985), therefore reject the established performance criteria of personhood and advocate for a significance-based view: What is crucial to a person is that things matter to them. This version of what it means to be a person is more *relational*, and our capacity and willingness as fellow citizens to see and hear other people comes under scrutiny.

Other scholars go even further and define personhood as “a standing or status that is bestowed upon one human being by others in the context of particular social relationships and institutional arrangements” (Kitwood, 1997, p. 7). Personhood – in this perspective – requires *collaborative activity in context*. In my appraisal, Kitwood’s argument indicates that community music therapy should be developed as person-centred practice that maintains and nourishes personhood – understood relationally and socially. A supportive social environment based on love and recognition – meeting

¹⁴The ethical dilemmas of practice within the arena-flexible Three-Stage Model in some ways are similar to those encountered in Flexible Assertive Community Treatment (FACT-teams). This is a growing area of practice in Norway, which increasingly also include music therapists (Skånland, 2025).

central psychosocial needs – is a prerequisite to any ambition of working in the direction of artistic citizenship.

Clinics can take an approach that grants participants the status of personhood by supporting them musically and socially for community participation and artistic citizenship. This addresses the question of how we prepare for citizen participation. The argument I have made indicates that caring for music and caring for self and others become interrelated processes (see also Stige et al., 2010). We can start here with a reconsideration of WHO's video about Arve's music therapy process, discussed earlier in the paper. We remember that Arve experienced that music therapy made him feel supported and motivated to community participation, with a new identity as a songwriter.

This was not the whole story, however. In the first two minutes of the video Arve talks about substantial mental health and substance use challenges over years. The music therapist shares his memory of the first meeting with Arve at an inpatient ward for severe mental illness: "When I met Arve, he was in a dark, incoherent, and introverted place. It was difficult to make contact with him. He looked down a lot and spoke very quietly." Arve was not ready for songwriting, performances, and community participation at this point.

This example illuminates how notions of artistic citizenship can be exclusive if we do not take a person's *subjective experience* and personal challenges into consideration. Mutual musical care is often a precondition for the development of artistic citizenship. When someone like Arve experiences severe challenges, we need to make sure that music's possibilities for emotional attunement and intersubjectivity are employed in an ethical way. Arve's music therapist described this part of the process in the following way: "At the beginning of our process, our focus was on building a safe atmosphere, based on Arve's positive resources."

At this stage of a process, participatory and embodied sensemaking, where gestures and rhythms build contact and communication, are often key (Fuchs & de Jaegher, 2009). From this, trust and collaboration in the direction of songwriting and performance could be created.

Collaboration and participation require self-awareness, and the question of how and why music therapy might affect *selfhood* and enhanced mental health comes into focus. Phenomenological research indicates that disruptions in self-experiences are linked to mental health challenges. One of the strengths of interactive music therapy with people with severe mental illness might therefore be its capacity to strengthen and flex the disturbed *sense of self and agency* (Høffding et al., 2024; Maiese, 2023). Selfhood and attunement with the world are then related processes that allow for synchronisation and collaboration (Stige et al., 2026).

The arguments made in the previous paragraph are based on enactivist perspectives that inform the view that our minds are both embodied, embedded, enacted, and extended. What I have described as *caring for selfhood* can be considered an enactivist reconceptualisation of work with negative symptoms, such as the impairments of motivation and of the ability to express oneself and to relate to others. The description of such symptoms is part of the diagnostic language, informed by a medical logic, that forms the basis for Cochrane reviews on the effects of music therapy (e.g. Geretsegger et al., 2017).¹⁵ When Norwegian health authorities started to recommend music therapy for patients with psychotic disorders (Helsedirektoratet, 2013), this was the language used.

¹⁵ A more ambitious attempt of an enactivist reconceptualisation of the medical model itself is developed by Maiese (2021).

The need for reconceptualisation of people's challenges is one dimension of the broader question of how music therapists could and should relate to professional contexts and cultures.¹⁶

Ways of relating to established models of thinking in the clinic

In this section I will address the second main theme of this article, namely how music therapists must pay attention to established models of thinking in the clinic. As outlined in the Introduction, many music therapists have suggested that the discipline and profession should develop an identity compatible with the medical model of thinking. My scepticism to this claim should be evident by now. It is easy, however, to be critical when writing books and articles. In the everyday practice in the clinic, things are often less clear and simple. I assume that this might be part of the reason why the community music therapy literature sometimes has been met with concerns about the risk of harming the profession.

The Three-Stage Model that I outlined in the first parts of the article supports the idea that to build musical resources for cultural participation in the community is not something that becomes relevant only after the participant is discharged from the clinic. I have argued that artistic citizenship is a relevant goal in music therapy practice, not only in the community, but also in the clinic. This argument is hardly in accordance with a medical model of thinking. It doesn't focus on the symptoms and functions of the individual, but upon social and cultural relationships in context.

This might provoke discussions about the role of the music therapist in the clinic. Will the arguments in this article, and in other parts of the community music therapy literature, make the working lives of music therapists harder if they choose to apply them in the context of cross-professional collaboration? Many music therapists would probably think so, and this might indeed be the case in some clinics. However, the practical example used as the foundation for the theoretical arguments in this article indicates that this is not necessarily so. The Three-Stage Model was not developed just anywhere in Norway, but within the catchment area of Bergen Hospital Trust, which is by far the leading hospital in Norway when it comes to the systematic implementation of music therapy.

The claim that music therapists need to relate to values and regulations of professional contexts still warrants consideration. I will explore this with a focus on *professional cultures*, which are significant elements of an organisational culture in the health care sector. While professional cultures sometimes might be barriers to teamwork and cross-professional collaboration, they can also be resources for innovation and development (Bloor & Dawson, 1994). I therefore argue that the profession of music therapy can do more than adjust to the current cultures and models of thinking, even though it is one of the smallest professions in the health care sector in most countries. I am interested in the music therapy profession's possibilities for contributing to development and positive change in the clinic.

Bloor and Dawson (1994, p. 275) understand organisational culture as a routinised system of perceptions, meanings, and beliefs that facilitates sense-making and guides individual behaviour in a workplace. They argue that "organizational culture is historically and socially constructed, holistic and

¹⁶ Some enactive attempts of reconceptualising psychiatry do exist already, see for instance (de Haan, 2020).

difficult to change.” The authors also argue, however, that reciprocal patterns of influence are formed over time. Specifically, in the health care sector, several different professional subcultures can exist at the same time, influence each other, and contribute to change of the organisational culture. In other words, Bloor and Dawson (1994) describe professional cultures as co-existing subcultures of the organisational culture. They argue that there are subcultures that in various ways and to various degrees maintain the status quo, but there are also *dissenting subcultures* that might create friction as well as innovation within the organisation. In their case example (Home-Care Service in Australia) they suggest that social workers represent a dissenting subculture:

[...] whilst they are not directly opposed to a culture of health care, their philosophy of home-care service provision is often at odds with other professional groups and the dominant medical subculture. They therefore represent a dissenting professional subculture in holding an alternative pattern of shared values and practices. (Bloor & Dawson, 1994, p. 283)

These arguments suggest that subordination to the dominant culture in the clinic is not the only possibility. Bloor and Dawson’s (1994) work indicates that there are other possibilities; diverse professions might agree to disagree and still be able to maintain collaborative relationships. How much a dissenting subculture can affect organisational culture depends on the strength of that subculture but also on attitudes and expectations from the cultures of the surrounding society, Bloor and Dawson argue.

Our understanding of the last point can be enhanced if we study a contribution to the music therapy literature that specifically focuses on relationships between the music therapy profession and organisational culture: Eide (2020, p. 467) argues that in any organisation there are several “institutional orders” that afford different, sometimes even contradictory, frames of reference for sensemaking and action. Such logics should not be treated as pre-determined and fixed, she argues. They are not only embedded in the social interactions between groups and individuals, but potentially also changed by them. Eide therefore argues that if music therapists can identify gaps between logics (values, norms, and standards) in the organisational context where they work, they might also be able to act as institutional entrepreneurs who creatively contribute to change in existing mind-sets, values and practices.

The music therapy profession is small, so one might question its capacity to influence health care organisations. I have tried to demonstrate how the practical example of the Three-Stage Model and some studies on organisational culture indicate that possibilities do exist. Both Bloor and Dawson (1994) and Eide (2020) refer to the fact that organisations to some degree are open systems that are influenced by conditions and cultural values of society at large. A profession’s capacity to relate to and refer to shared societal values and national policy documents is therefore part of the explanation for why even very small groups might have some influence on organisational culture (or, at least, have enough license to act a bit differently). In the case of Norwegian music therapy in mental health clinics, which is the example I have discussed in this paper, there are several societal values and national policy documents that support the tenets of The Three-Stage Model. Examples include the democratic value of shared decision making (Ødegaard et al., 2022), the relevance of supplementing a focus on

clinical recovery with personal and social recovery (Rolvsjord, 2018), and the need to develop more holistic practices to support the health and quality of life of persons with severe mental health challenges (Meld. St. 23 (2022–2023)).

Concluding remarks

We have seen how the notion of artistic citizenship can frame the right of every person to take part in the cultural life of a community, at least if artistic citizenship is understood as a relational process that maintains personhood and builds selfhood.

In some contexts, music therapists have found it relevant to build connections between practices in clinical contexts and community contexts, as exemplified by the Three-Stage Model within mental health care that has been developed in Bergen. The relationships outlined in this paper between personhood, selfhood, and citizenship indicate the practical and theoretical relevance of such connections.

Several areas for future study are suggested by the argument developed, such as a) investigations of stakeholder experiences of various practices where music therapy in clinical contexts and community contexts have been connected in various ways, b) development of integrative theories that can connect diverse areas and dimensions of practice, c) a reconsideration of how research methodologies are valued and evaluated, d) investigations of how music therapy can be part of innovative professional subcultures in various organisations, including clinics.

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Author contributions

Brynjulf Stige was the sole author of this paper and responsible for conceptualisation, methodology, visualisation, and writing (drafting, reviewing, and editing).

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Ελληνική περίληψη | Greek abstract

Μουσικοθεραπεία και κοινοτική συμμετοχή: Η αίσθηση του εαυτού και η καλλιτεχνική ιδιότητα του πολίτη εντός και εκτός του κλινικού πλαισίου

Brynjulf Stige

Μετάφραση: Μαρία Ραπτοπούλου

Περίληψη

Οι μουσικοθεραπευτικές πρακτικές εξελίσσονται σε συγκεκριμένα πλαίσια, γεγονός που υποδηλώνει ότι οι εννοιολογικές και θεωρητικές θέσεις που διατυπώνουμε πρέπει να αμφισβητούνται συνεχώς από τα πρακτικά δεδομένα. Στο παρόν άρθρο αμφισβητώ τις τάσεις πόλωσης μεταξύ της κλινικής μουσικοθεραπείας και της κοινοτικής μουσικοθεραπείας, αναλύοντας δύο βασικά θέματα: α) τις δυνατότητες και τους περιορισμούς της σύνδεσης της κοινοτικής μουσικοθεραπείας και της πολιτιστικής συμμετοχής στη μουσικοθεραπεία εντός κλινικών ψυχικής υγείας, β) τους τρόπους προσέγγισης του επιχειρήματος ότι, ως επαγγελματίες, οι μουσικοθεραπευτές πρέπει να δίνουν προσοχή στα καθιερωμένα μοντέλα σκέψης στο

κλινικό περιβάλλον. Αυτό το θεωρητικό άρθρο εμπνέεται από δύο ενοποιητικές μεταθεωρητικές παραδόσεις: τη βιο-οικολογική και την κοινωνικο-πολιτισμική παράδοση, καθώς και τις σύγχρονες ενακτιβιστικές προοπτικές. Τα παραδείγματα που παρουσιάζω στο άρθρο βασίζονται σε πλαίσια πρακτικής εντός της ψυχικής υγείας στο Μπέργκεν της Νορβηγίας. Περιγράφεται ένα «Μοντέλο Τριών Σταδίων», με έμφαση στις οικολογικές μεταβάσεις από i) την κλινική μουσικοθεραπεία, προς ii) τις δημοτικές υπηρεσίες παρακολούθησης, προς iii) την ανεξάρτητη πολιτιστική συμμετοχή στην τοπική κοινότητα. Διερευνώνται οι προσφερόμενες δυνατότητες και οι περιορισμοί της έννοιας της καλλιτεχνικής ιδιότητας του πολίτη σε σχέση με το Μοντέλο Τριών Σταδίων και συσχετίζονται με τις έννοιες της *προσωποσύνης* και της *αίσθησης του εαυτού*. Συζητούνται οι σχέσεις μεταξύ του Μοντέλου Τριών Σταδίων και της οργανωτικής κουλτούρας των κλινικών ψυχικής υγείας στη Νορβηγία, ενώ επισημαίνονται τομείς μελλοντικής έρευνας.

Λέξεις κλειδιά

κλινική μουσικοθεραπεία, κοινοτική μουσικοθεραπεία, καλλιτεχνική ιδιότητα του πολίτη, προσωποσύνη, αίσθηση του εαυτού, οργανωτική κουλτούρα, ενοποιητική θεωρία, οικολογικές μεταβάσεις